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PSYCHOLOGICAL BASICS OF MEDICAL PRACTICAL ACTIVITY

Study Manual

Cheboksary
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МИНИСТЕРСТВО НАУКИ И ВЫСШЕГО ОБРАЗОВАНИЯ
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ПСИХОЛОГИЧЕСКИЕ ОСНОВЫ ВРАЧЕБНОЙ ДЕЯТЕЛЬНОСТИ

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Aimed at a better understanding of study material on the subject «Psychological basics of medical practical activity», it allows shaping the knowledge on main trends of Psychology, Personality Psychology, Psychology of Communication, Basics of Psychosomatics, peculiarities of psychological processes and conditions of patient, psychological factors in prevention of nosogeny of diseases, different aspects of business communication. The first chapter presents clinical psychological basics of professional activity in medicine. The second chapter includes a list of themes for practical classes and instructions for them.

Aimed at medical students, lecturers, psychologists practitioners.

Editor-in-chief: Doctor in Medicine professor E.L. Nikolaev

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Предназначено для лучшего осмысления учебного материала по дисциплине «Психологические основы врачебной деятельности». Позволяет студентам получить знания по основным направлениям психологии, психологии личности, психологии общения, основам психосоматики, об особенностях протекания психических процессов и состояний у больного человека, психологических факторах в предупреждении возникновения и развития болезни, особенностях делового общения.

В первом разделе представлены клинико-психологические основы профессиональной деятельности в медицине. Второй раздел пособия содержит перечень практических занятий, методических рекомендаций для их проведения.

Для студентов медицинского факультета, преподавателей, практических психологов.

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INTRODUCTION

The manual is aimed at a better understanding of study material on the subject «Psychological basics of medical practical activity». It allows shaping the knowledge on main trends of Psychology, Personality Psychology, Psychology of Communication, Basics of Psychosomatics, peculiarities of psychological processes and conditions of patient, psychological factors in prevention of nosogeny of diseases, different aspects of business communication.

Another purpose of the manual is to build the following effective competences: team skills; skills to help in stress with the means of basic techniques of self regulation; skills to carry out psychological support to a patient and the people around him/her; skills to control and solve conflicts, to interact with patients and colleagues in the process of professional activity creating favorable psychological atmosphere at a medical facility.

CHAPTER 1. Lectures

1. Medicine and Psychology

1.1. The role and importance of psychology in the professional activity of a medical professional

The efficiency of medical treatment and diagnostic measures, on the one hand, can be conditioned by their updating and development: accessibility of qualified medical aid, implementation of modern technologies and application of smart instrumental diagnostic methods, qualitative professional training and other factors. On the other side, it is affected much by patients' loyalty in following doctor's prescriptions and instructions.

The aim of a doctor – patient contact is efficient qualified medical aid. Its good results depend on both the correctness of prescriptions and treatment and such factors as psychological and emotional patient's willingness to recover, professional aims and motivation of medical specialist, and besides special relations and atmosphere between a patient and personnel of a medical institution.

Patients refer to the following factors of medical aid as negative: «absence of skills or unwillingness to listen to a patient», «indifference and hardheartedness in relation to patient's complaints», «concentration on filing medical forms rather than on a patient's needs», «professional incompetence of doctors».

Doctors in their turn also point out a number of negative aspects affecting efficiency of medical aid: «patients' inability to objectively explain the nature of their condition and complaints», «absence of motivation of recovering when a patient has some profits from the disease», «willingness for self treatment, turning for treatment information to the internet or to traditional medicine».

The reason of mutual claims lies in psychological and emotional aspects of interpersonal relationsof patients and medical personnel. Psychological characteristics of a patient come into contact with psychological ones of a medical specialist. Positive feedback on a doctor may include the following: «…the doctor listened to my complaints very attentively…», «there was a very calm atmosphere

during my visit to a doctor…», «I‘ve got profound prescriptions…» and so on. As result, patients are set towards the process of treatment very positively, which, from psychological point of view, plays a very important part in the process of treatment.

1.2. Psychology of health

Psychology of Health is a science studying psychological nature of health, methods and means of its maintenance, strengthening and evolvement. Psychology of health has the following *directions* of study:

– Identification of the role of psychological factors in strengthening human health.

– Formation of an internal picture of health; psychological state of relations to health.

– Search for optimal methods of psychological impact on the development of a healthy personality.

– Establishment of a health education system.

The positive definition of health, given by WHO, "a state of complete physical, mental and social well-being but not only the absence of disease and physical defects", was widely recognized (WHO Constitution, 1946). Thus, health consists of three components: physical, mental and social. And at the present time, health is treated as an ability of self-preservation and self-development, an ability to resist and adapt to an increasingly meaningful life in an increasingly diverse environment (Lishuk V.A., 1994). Thanks to the positive definition of health in medicine, along with the pathocentric approach (fighting disease), sanocentric approach (focus on health and its provision) is also affirmed.

Five models of health

– Biological model: health is defined as the absence of disease; the normal functioning of the organism at all levels of its organization, i.e. a functional state that provides life expectancy, physical and mental ability, the function of reproducing healthy offspring.

– Medical model: health is a state of complete physical, mental and social well-being, and not just the absence of disease. This

model was proposed by the World Health Ministry of the UN, it is considered ideal.

– Biomedical model: health is the state of the organism, when the functioning of all its organs and systems is balanced with the external environment; there are no painful manifestations and a subjective feeling unhealthy.

– Value-social model: health is a value for a person, a necessary prerequisite for a full-fledged life, satisfaction of material needs and participation in different types of activities.

– Biosocial model (Lisitsyn): health is a harmonious unity of social and biological qualities of a person, allowing him to successfully adapt to the constantly changing conditions of the external environment and to be a full member of the family and society.

Objectives of the psychology of health:

1) raising the level of psychological culture (the degree of perfection in mastering psychological knowledge and activities);

2) increasing the level of communication culture (the degree of perfection in the field of external and internal communication);

3) determination of ways and conditions for self-realization, disclosure of one's creative and spiritual potential.

In the psychology of health, there are two basic concepts: mental health and psychological health. If the term "mental health" refers primarily to individual mental processes and mechanisms, the term "psychological health" refers to the person as a whole, it is closely related to the higher manifestations of the human spirit and allows us to distinguish the psychological aspect of the problem of mental health, in contrast to medical, sociological and other aspects.

Psychological health is determined by two signs:

1. Observance of the principle of optimum or "golden mean" in the main forms of the manifestation of life activity.

2. Effective adaptation (social, socio-psychological, intrapsychic).

Mental Health Criteria:

– awareness and sense of continuity, constancy and identity of one's physical and mental "Self";

– sense of permanence and identity of experiences in the same type of situations;

– criticism of oneself and own mental activity and to its results;

– correspondence of mental reactions to the strength and frequency of environmental influences to social circumstances and situations;

– ability to self-control in accordance with social norms, rules and laws;

– ability to plan and realize one's own life;

– ability to change the way of behavior depending on the change of life situations and circumstances.

Criteria of psychological health (according to A. Ellis):

1. Interest to oneself: a sensitive and emotionally healthy person puts her/his interests a little above the interests of others, to some extent sacrifices her/himself for those who she/he cares about, but not completely.

2. Public interest: if a person acts immorally, does not defend the interests of others and encourages social selection, it is unlikely that he will build a world in which he can live comfortably and happily.

3. Self-management (self-control): the ability to take responsibility for one's own life and at the same time the desire to unite with others without the requirement of significant support.

4. High frustration stability: granting the right to oneself and others to make mistakes without condemning one’s personality or the identity of another.

5. Flexibility: plasticity of thought, openness to change; a person does not set himself and other rigid unchanging rules.

6. Acceptance of uncertainty: a person lives in a world of probabilities and an event in which there will never be complete certainty.

7. Orientation to creative plans: creative interests occupy the greater part of a person's existence and require from her/his side of involvement.

8. "Scientific" thinking: the desire to be more objective, rational. Regulation of feelings and actions by reacting and assessing their consequences in accordance with the degree of their influence on the achievement of close and distant goals.

9. Acceptance of oneself: refusal to evaluate intrinsic values on external achievements or under the influence of evaluation by others; the desire to rather enjoy life than to assert oneself ("I love myself already because I live and have the opportunity to rejoice").

10. Risk: an emotionally healthy person is prone to take risks and is justified in doing what she/he wants, even when there is a possibility of failure; she/he wants to be enterprising, but not brazenly brave.

11. Prolonged hedonism: a person is looking for pleasure both from the current moment, and from a possible future; she/he believes that it is better to think of both today and tomorrow, and is not obsessed with immediate satisfaction.

12. Nonutopism: rejection of an unrealistic desire for all-embracing happiness, joy, perfection, or complete absence of anxiety, depression, degradation of self-worth and hostility.

13. Responsibility for emotional disorders: the tendency to take on most of the responsibility for actions, rather than striving to protect oneself by blaming others or social conditions.

Factors affecting human health: 1) lifestyle (50%) – bad habits, nutrition, activity, sexual behavior, stress, medical activity; 2) the external environment (20%) – climate, ecology, working conditions, material and living conditions; 3) biological factors (20%) – heredity, gender, age and constitutional; 4) medical care (8-10%).

1.3. Placebo effect and its importance for medicine

The placebo effect was identified by physicians. It is based on a purposeful or unconscious suggestion by a doctor or an experimenter that a certain factor (drug, mode of action) should lead to the desired result. Faith of the patients can really work miracles, although the factor itself does not play any role. If patients expect that the drug should improve their condition, then they actually have changes for the better.

In medicine, placebo (Latin *Placere* – like) means a drug that does not have medicinal properties ("counterfeit medicines"). The term "placebo effect" was introduced into scientific circulation by the American physician Henry Beecher in 1955, who found out that about a third of the patients recover from the "dummy" tablets that

do not contain active substances. A serious study of the placebo effect unfolded during the Second World War. When the anesthesiologist Henry Beecher lacked painkillers in the war hospital, he was convinced that in some cases the injection of physiological solution had practically the same effect as the real medicine. Returning from the war, the doctor with a group of colleagues from Harvard University began to study this phenomenon.He summed up the results of his studies in 1955 in the article "Strong-acting placebo."

The strongest factor of placebo effect is the faith of doctors and staff in virtue of medicines. A lot of double-blind experiments were performed in which a placebo effect was demonstrated.

Test questions

1. Define the concepts of "health", "psychological health", and "mental health".
2. List the criteria of mental and psychological health.
3. Define the IPD and name its levels.
4. Placebo effect and its importance for medicine.

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2. Psychology of Stress

2.1. Definition of the notion of «stress» from the perspective of different approaches

The term *"stress"* is borrowed from technology, where this word is used to refer to an external force applied to a physical object and causing its tension, that is, a temporary or permanent change in the structure of an object.

In modern scientific literature, the term "stress" is used in at least three meanings.

First, the concept of stress can be defined as any external stimuli or events that cause tension or excitement in a person. At the present time in this sense the terms "stressor", "stress factor" are used more often.

Secondly, stress can relate to a subjective reaction and in this sense it reflects the inner mental state of stress and excitement; this state is interpreted as emotions, defensive reactions and coping processes occurring in the person himself. Such processes can promote the development and improvement of functional systems, as well as cause psychic tension.

Finally, thirdly, stress can be the body's physical response to the demand or harmful effect. W. Cannon and H. Selye used this term in this very sense. The function of these physical (physiological) reactions is probably to support behavioral actions and mental processes to overcome this condition.

Due to the absence of a general theory of stress, there is no generally accepted definition.

In accordance with the content aspects of the concepts, all the presented directions of the study of stress, conditionally speaking, fit into two main approaches.

Within the framework of the first approach, a direct comparison of the psychological characteristics of the state with the physiological indices and performance of the activity was made. In this case, physiological indicators and changes in behavior were considered as indicators of psychological stress.

The second approach was based on the desire to study the psychological nature of stress, to uncover the psychological prerequisites and patterns of manifestation of various external reactions that are considered only as indicators of mental processes.

Initially, the concept of stress was introduced by the Canadian physiologist H. Selye (1936) to designate the nonspecific reaction of the organism (the "general adaptation syndrome") in response to any adverse effect. Later it was used to describe the states of an individual under extreme conditions at the physiological, biochemical, psychological, and behavioral levels.

They define:

1) eustress is a normal stress that serves the purposes of preserving and sustaining life,

2) distress – pathological stress, manifested in painful symptoms.

The most popular practically oriented concepts include, in particular, the cognitive concept of stress presented in the works of R. Lazarus, which was a logical continuation of the theory of H. Selye. The author of this concept believed that adaptation to the environment is determined by emotions. However, exclusively cognitive processes determine both the quality and intensity of these emotional reactions. In his works the author tries to differentiate the concept of physiological stress from psychological stress, by

introducing a cognitive component into the structure of the concept of stress. According to R. Lazarus, physiological and psychological stresses differ significantly:

– by the features of the stimuli,

– by the mechanism of its development and the nature of the responses.

To clarify the concept of stress R. Lazarus formulated two main points.

First, the terminological confusion and contradictions in the definition of the term "stress" can be eliminated if, in analyzing psychological stress, not only external observed stressful stimuli and reactions are considered, but also some psychological processes related to stress, for example, the threat assessment process.

Secondly, the stress reaction can only be understood if the protective processes generated by the threat are taken into account – the physiological and behavioral systems of reaction to the threat are associated with the internal psychological structure of the personality, its role in the subject's desire to cope with this threat. The nature of the stress reaction is causally related to the psychological structure of the personality, interacting with the external situation through evaluation and self-defense processes.

Despite some contradictions within the framework of this author's approach, he was highlighted several important *provisions of stress:*

– the same external events may or may not be stressful for different people;

– the same people can perceive the same event as stressful in one case be and in the other – as usual, normal.

In addition, the cognitive theory of stress reflected the notions that, firstly, the interaction of man and the environment under certain adaptation conditions is constantly being changed. Secondly, in order for the relationship between these variables to be stressful, a person should be interested and highly motivated to achieve results. Thirdly, psychological stress occurs only when a person assesses that external and internal demands cause excessive tension of forces or surpass his resources.

Not less popular was the behavioral line of development of the concept of stress, first proposed by R. Lazarus and S. Folkman, and

later revised by S. Hobfoll and others. The authors believe that not life events in themselves (job change, housing exchange and etc.), but associated with these events loss of any life position – the loss of status, earnings, power, the change of habitual means of labor, loss of self-esteem, etc. are stressful.

The central concept of S. Hobfoll's theory is the concept of "coping", introduced for the first time by R. Lazarus with the aim of removing the contradiction between physiological nonspecificity and psychological selectivity of stress. Defining the content of this concept, the authors concentrate their attention not only on the main provisions of the theory of stress, but also focus on various forms of behavior leading to adaptation or disadaptation of the individual. At the same time, R. Lazarus stressed the importance of coping with stress in comparison with nature, the magnitude and frequency of occurrence of the most stressful effects.

In the works of modern psychologists, the term "coping" was replaced by the Russian word "tackling", the essence of which reflects the essence of the concept proposed by these authors more. In accordance with the content of the concept, "coping with the situation" means in time and accurately recognize the causes that caused the difficult situation, in time and adequately respond to certain circumstances of the living environment.

2.2. Types of protective response to stress

Analyzing the manifestations of a protective response to stress, four levels of the human protective system are distinguished: somato-vegetative, behavioral, psychological defense and coping behavior.

Somato-vegetative (physiological). At this level adaptation to stress is carried out through automatic changes in the activity of various body systems (cardiovascular, respiratory, digestive, excretory, endocrine, nervous and vegetative, etc.). The patient has sleeping, breathing, digesting disorders, the temperature rises, other physical symptoms appear, which indicates physical health disturbance and requires immediate help. Such organism response to harmfulness, originally characteristic of children in the early period of development (from 0 to 3 years), then manifests itself in stress situations of people of other ages.

Behavioral (psychomotor) level. Adaptation to stress occurs as a result of an automatic change in the general pattern of human behavior, that is, the volume and nature of its overall motor activity (behavioral reactions of rejection, opposition, imitation, compensation).

The level of psychological defense (unconscious psyche). Psychological protection is a system of mechanisms of personality stabilization aimed at protecting the consciousness from unpleasant, traumatic experiences associated with internal and external conflicts. Psychological protection is carried out through a special processing of disturbing information in the psyche. A whole complex of psychological mechanisms participates in the defense: denial, suppression, rationalization, displacement, projection, identification, substitution, dreaming, sublimation, catharsis, alienation, etc. By automatically engaging in a psychological trauma situation, these mechanisms act as peculiar barriers on the path of information in the psyche. As a result of the actions of these mechanisms, information that is alarming for the person is either ignored, distorted or falsified. Thus, a specific state of consciousness is formed in the form of an unrealistic image of the world and an unrealistic image of a person's "I" (positive illusions), which allows a person to maintain stability and balance despite the stress situation.

For example, the life style of a person may be characterized by the perception of the world around him and himself in "pink color" (negation), complete or partial forgetting psycho traumatic situations or the true motives of one's actions (displacement), self-justification and justification of others (rationalization), replacing one's guilt with others (projection), not corresponding to age and social status, irresponsible behavior (regression), search for available targets for the relaxation of physical and verbal aggression (substitution), etc. Psychological protection, along with coping behavior, is considered to be the most important processes of personal adaptation to stress.

The level of coping behavior (tackling). Coping behavior (tackling) is one of the central concepts in the psychology of stress and adaptation (Kryukova T.L., 2005). It is aimed at the active interaction of the individual with the situation and leads:

– to the change of the situation (if it is amenable to control);

– to adaptation to the situation (in case the situation is not controlled).

Attempts to find the answer to the question "Why do some people get sick under the influence of psycho-stressors under the same environmental conditions, while others do not?" led to the following two conclusions:

– in the interval between stress and response, there are coping processes;

– the way people cope with stress, overcome it, in general is even more important for social functioning, health and well-being than the nature of the stressor and the frequency of its impact, etc. (Lazarus R., 1966 Roskies E., Lazarus R., 1980).

Coping behavior of the personality is realized due to:

– perception of the difficulties encountered,

– emotional assessment of them as dangerous to life, health, personal and social well-being,

– incorporating thinking to find and analyze knowledge how to overcome these situations,

– the ability to apply these strategies in practice.

Only at this level of protection, in conjunction with others, the strategy of planning and the concrete solution of the problems facing the person functions.

The tasks of coping behavior according to R. Lazarus:

– Minimization of negative effects of circumstances and increasing opportunities for the restoration of active activities.

– Patience, adaptation or regulation and transformation of difficult situations.

– Maintaining a positive image of self and self-confidence.

– Maintaining emotional balance.

– Maintaining and keeping close enough relationships with other people.

They identify the strategies and styles of coping behavior.

Coping strategies are numerous actions that a person consciously and purposefully implements in situations of threat to life and well-being. The main coping strategies according to R. Lazarus include problem solution planning, social support search, self-control, responsibility acceptance (self-incrimination), positive reassessment of the situation, confrontation, distancing, escape-avoidance.

Coping strategies are implemented through cognitive (intellectual) and emotional processing of disturbing information, as

well as the implementation of specific behavioral acts (E. Heim, 1988).

Cognitive coping strategies: problem analysis, setting one's own value, maintaining self-control, understanding the perceived complexity, giving it special meaning, religiosity, humility, etc.

Emotional coping strategies: protest, optimism, emotional discharge, suppression of emotions, self-incrimination, submissiveness, aggressiveness, etc.

Behavioral coping strategies: constructive activity, cooperation, seeking help, caring for other people (altruism), distraction from the situation, its active avoidance, compensation behavior, etc.

The choice of these or other coping strategies is correlated with the peculiarities of the individual and the stressful situation. It can be adaptive, relatively adaptive and non-adaptive. Styles of coping behavior are personally conditioned stable patterns of behavior in stressful situations. There are three main styles of coping behavior (Endler N.S., Parker J.D.A., 1990):

1. Problem-oriented. Preliminary analysis of the problem. Focusing on it and finding possible ways to solve it. The desire to manage the time better, the choice of personal priorities. Appeal to own experience of tackling similar problems. The desire to control the situation. Forming a mindset forsolving a problem. Practical implementation of plans.

2. Emotional-oriented coping is an emotional solution of problems (suppression of emotions or emotional reaction).

3. Avoidance, including substructures:

– distraction (distancing from an alarming situation, switching attention and getting pleasure from things not directly related to the stress situation: eating, buying, walking, distracting, etc.);

– social distraction (search for social support);

– actual avoidance (refusal of mental and behavioral efforts to resolve the situation).

Problem-oriented copying-style usually correlates with more perfect adaptation, and emotion-oriented copying with insufficient adaptation. However, it is shown that certain coping functions are more successful for coping with certain types of stressors (Conway V.J, Terry D.J., 1994; Zeidner M., Endler N.S., 1996):

– Problem-oriented coping is more adaptive, effective in controlled situations, where there are more opportunities to change the circumstances;

– Emotion-oriented coping is more useful in less controlled situations, which provide fewer opportunities for changing circumstances.

Criteria for effective coping behavior:

– Elimination of physiological and psychological manifestations of tension.

– Ability to restore the previous level of activity.

– Prevention of distress and development of mental development.

Characteristics of the individual and social environment, facilitating or making possible successful adaptation, are called coping resources (tackling resources).

S. Tailor differentiates between external and internal coping resources:

– external: the availability of money, the level of education, a high level of social life, the existence of a social support network, the absence of life stressors, the availability of time;

– internal: optimism, perseverance, perceived control over the situation, explanatory thinking style, positive self-esteem, self-confidence, social skills, religiosity, ability to quickly reinstate forces after stress.

Test questions

1. Give the definition of stress from the position of different approaches.
2. What are the differences between physiological and psychological stress?
3. List the main types of stress response.
4. Analyze the differences in understanding the mechanisms of psychological protection, coping behavior and coping strategies.
5. Give examples of psychological protection in a situation of illness.
6. Give examples of adaptive and non-adaptive coping strategies in the situation of the disease.
7. What are the criteria of effective coping behavior

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3. Personality and Disease

3.1. The concept of the internal picture of the disease, its levels

Internal picture of the disease (IDP), the patient's complete image of his/her disease, was introduced by R.A. Luria (1977). Compared with a number of similar terms in medical psychology ("experiencing the disease", "disease consciousness", "attitude towards illness", etc.), the term "IDP" is the most general and integrative.

The initial idea of the structure of IDP, which includes two levels (sensible and intellectual), was further differentiated by identifying four levels:

1. Sensual – a complex of painful sensations;
2. Emotional – the experience of the disease and its consequences;
3. Intellectual – knowledge about the disease and its real assessment;
4. Motivational – the development of a certain attitude towards the disease, changing the way of life and actualization of activities aimed at recovery.

IDP usually acts as a holistic, undifferentiated entity. The formation of IDP is influenced by various factors: the nature of the disease, its severity and pace of development, personality characteristics in the period preceding the illness, etc.

So, in the basis of the concept of V.D. Mendelevich ("Terminological foundations of phenomenological diagnosis") is the notion that the type of response to a particular disease is determined by two characteristics: the objective severity of the disease (determined by the criterion of lethality and the probability of disability) and the subjective severity of the disease (self assessment of the patient's condition).

The idea of the subjective severity of the disease consists of socio-constitutional characteristics, including sex, age and profession of the individual. For each age group, there is a register of the severity of the disease – a peculiar distribution of diseases by socio-psychological significance and severity.

So, in adolescence, the most severe psychological reactions can be caused not by diseases that are objectively threatening the health of the body from a medical point of view, and those that change its appearance make it unattractive. This is due to the existence in the adolescent's mind of the basic need – "satisfaction with one's own appearance satisfaction».

Persons of mature age will react more psychologically to chronic and disabling diseases. "This is connected with the value system and reflects the aspiration of a mature person to satisfy such social needs as the need for well-being, welfare, independence, etc." In this regard, the most intense experiences are associated with

cancer diseases. For the elderly and the old, the most significant are diseases that can lead to death, loss of work and work capacity.

Individual psychological characteristics affecting the specifics of the experience of the disease include the features of temperament (with respect to the following criteria: emotionality, tolerance of pain, as a sign of emotionality, and limitations of movement and immobility), as well as features of the character of a person, his/her personality (ideological attitudes, the level of education).

Culture has a significant impact on health. I.K. Zola researched the Irish and Italians and revealed the propensity of the first to poverty complaints and the preferential attribution of them to the eyes, ears and throat and the propensity of the others to an increased number of complaints and referring them to the body. This is due to cultural orientation based on life problems. So the expressiveness of Italians is a psychological defense, a dramatization, which helps them to overcome daily life difficulties. Irish culture is inherent in ignoring negative events, and such a form of negation leads to wretchedness of symptoms and complaints.

3.2. Types of attitude towards the disease

Psychological personality reactions to disease

1. Normosomonosognosia:

– an adequate assessment of the disease, corresponding to its real severity and danger.

– typical for patients who were before the illness strong, balanced, harmonious personalities.

2. Hyper somatosognosia – reassessing the danger, severity of the disease, its consequences:

– elements of anxiety, panic, mood reduction; thoughts and attention are focused on the illness; great activity.

– reduced mood without anxiety, apathy, monotony, pessimistic forecasts. Following the doctor's instructions, catching every word of it. Prior to the disease, anxious-hypochondriacal traits predominate, or "stick" in the experience.

3. Hyposomonosognosia – underestimation of the severity of the disease:

– geting used to the disease, observation the regime are complacent. Reduction of the emotional component of the IDP.

– negative attitude to treatment, ignoring everything connected with the disease. Observed in sthenic personalities, standing closer to the rigid type with elements of "hyper-sociality".

4. Dissomatosonosognosia: denial of the presence of the disease and its symptoms for the purpose of dissimulation, as well as fear of its consequences.

– signs of the disease are poorly expressed, but dangerous, or the results of behavior condemned by moral standards (hide syphilis or AIDS).

– repression of thoughts about the disease, reluctance to talk about it for this reason.

Types of reactions to information about the disease (D. Lipovski, 1983)

– illness-threat (reactions: opposition, anxiety, care, struggle);

– disease-loss (reactions: depression, hypochondria, confusion, grief, attempt to attract attention);

– sickness-gain (reactions: indifference, cheerfulness, hostility towards the doctor);

– illness-punishment (reactions: shame, oppression, anger).

Typology of response to the disease A.E. Lichko and N.Ya. Ivanova ("Medical &psychological study of somatic patients") includes 13 types of psychological response to the disease, identified on the basis of an assessment of the influence of three factors: the nature of the somatic disease itself, the type of personality, in which the most important component determines the type of accentuation of the character and attitude to this disease in the significant for the patient group.

The first block includes those types of attitude towards the disease, in which there is no significant violation of adaptation:

Harmonious: this type of response is characterized by a sober assessment of their condition without a tendency to exaggerate its severity and to see everything in a gloomy light without reason , but without underestimating the severity of the disease; the desire to actively promote the success of treatment; reluctance to burden others with the hardships of caring for them.In case of an unfavorable prognosis in terms of disability, switching the interests to those areas of life that will remain accessible to the patient; in case

of an unfavorable forecast switching the attention, concern, interests on the fate of relatives, business.

Ergopathic: "withdrawal from illness to work" is characteristic. Even with the severity of the illness and suffering, they try to continue to work, no matter what. They work with bitterness, with even greater zeal than before illness, all the time is given to work, and they try to be treated and to be examined so that it leaves room for further work.

Anosognosic: the active rejection of the thought of the disease, of its possible consequences, the denial of the obvious in the manifestation of the disease, attribution to accidental circumstances or other non-serious diseases, refusal from examination and treatment, the desire to do with their means is characteristic.

The second block includes the types of response to the disease, characterized by the presence of mental disadaptation:

Anxious: this type of response is characterized by continuous anxiety and suspicion regarding the unfavorable course of the disease, possible complications, inefficiency and even the danger of treatment; search for new ways of treatment, thirst for additional information about the disease, possible complications, methods of treatment, continuous search for "authorities". In contrast to hypochondria, objective data about the disease (the result of analyzes, conclusions of specialists) are more interesting than their own sensations. Therefore, they prefer to listen more to the statements of others than to submit their complaints without end. The mood is above all alarming; oppression is the result of this anxiety).

Hypochondriac: is characterized by concentration on subjective painful and other unpleasant sensations; the desire to constantly talk about them to others; on this basis, the exaggeration of the real and the search for nonexistent diseases and sufferings; exaggerated side effect of drugs; a combination of the desire to heal and disbelief in success, the requirements of a thorough examination and fear of harm and soreness of the procedures.

Neurasthenic: behavior is typical of the type of "irritable weakness" is characterized by outbreaks of irritation, especially with pain, with discomfort, with failure of treatment, adverse survey data. Irritation is often poured out on the first one and ends with repentance and tears. There is intolerance to pain, impatience,

disability to wait for relief. In the future – remorse for anxiety and incontinence.

Melancholic: is characterized by dejection of the disease, lack of faith in recovery, in possible improvement, in the effect of treatment; active depressive statements down to suicidal thoughts; pessimistic view of everything around, disbelief in the success of treatment, even with favorable objective data.

*Euphoric:*is characterized by an unreasonably high mood, often faked; neglect, frivolous attitude towards illness and treatment; hope that "everything will manage itself "; the desire to receive everything from life, despite the disease; the ease of violation of the regime, although these violations can adversely affect the course of the disease.

Apathetic: is characterized by complete indifference to his fate, the outcome of the disease, to the results of treatment; passive submission to the procedures and treatment with persistent motivation from the outside, loss of interest in everything that previously excited.

Obsessive-phobic: is characterized by anxious suspiciousness, imaginary concerns of not real, but unlikely complications of the disease, failure of treatment, and possible (but little-grounded) failures in life, work, family situation due to illness. Imagined dangers worry more than real. Signs and rituals become protection from anxiety.

Sensitive: there is an excessive concern about a possible adverse impression that information about your illnesscan produce on others. Fears that others will be avoided, considered defective, disregarded or cautious about treating, gossiping or unfavorable information about the cause and nature of the disease. Fear of becoming a burden for loved ones due to illness and disreputable attitude on their part in connection with this.

Egocentric: "Leaving for illness" is typical, exposing their sufferings and experiences to loved ones and others with the aim of completely capturing their attention. The requirement of exceptional care – everyone should forget and abandon everything and take care only of the patient. The conversations of those around you are quickly translated "on yourself." In others, which also require attention and care, they see only "competitors" and treat them with

hostility. Constant desire to show their special position, their exclusiveness in relation to the disease.

Paranoiac: it is typical that the disease is the result of someone's malicious intent. Extreme suspicion of drugs and procedures. The desire to attribute possible complications of treatment and side effects of drugs to negligence or malicious intent of doctors and staff. Charges and demands of punishments in connection with this.

Dysphoric (characteristically melancholy-embittered mood).

Interaction with some of these patients can bring the doctor a pronounced psychological discomfort. However, knowing the psychological basis of this type of patient behavior will help the doctor better understand his needs, expectations, fears and emotional reactions, optimally organize the process of interaction with him, use certain instruments of influence. It is important to understand that, even showing complete indifference to the outcome of treatment, the patient wants to hear the words of hope and needs to strengthen his faith in the best.

Patients who are constantly worried about their condition need a calm, optimistic and attentive conversation with the doctor, and patients demonstrating the reactions of aggression to others and the doctor – the authoritative confident position of the doctor, which will help to cope with the deepest fear in his life that is hidden in the soul.

Stages of the formation of the IDP

1. Sensological stageincludes:

– an uncomfortable component (unpleasant sensations of varying severity with indeterminate localization are early symptoms of a somatic disease threat, discomfort is an early psychological sign of morphofunctional changes),

– an algic component (discomfort can develop into painful sensations);

– deficient component (experiencing feelings of inferiority, limitations of opportunities).

2. Evaluation stage.

The result of intrapsychic processing of sensory data. It is at this stage that the IDP of a sick person is mostly formed. Depending on the premorbid characteristics of his personality, the situation in which he is (in the family, at work, etc.), the specific nature of the IPD acquires an individual color.

3.3. Typological features of patients

To understand the characteristics of psychological reactions to the disease, a general practitioner should also know the individual and typological characteristics of patients:

Synthonous patients, who are characterized by emotional openness, cheerfulness, adapt more easily to a traumatic situation. It is very important for them to establish an open, trusting relationship with a doctor, they easily cooperate.

Patients with a *cyclothymic* character of emotional reaction in a psycho traumatic situation are characterized by a change in mood, easily fall into depression. In working with them, it is recommended to focus on mobilizing positive emotions, organizing leisure and available entertainment.

Patients of the *schizoid* type, demonstrating emotional insufficiency, predominance of intellectual interests, isolation, right up to authorization, are less in need of communication. It is important to organize the right entertainment – reading, engaging in interesting creativity.

Patients of an *excitable* type, poorly control affect and come into conflict with a doctor and relatives. It is important not to provoke such reactions, and in case of their occurrence calmly react to emotions.

Patients with *hysteric* traits can be mobilized by accentuation of their "outstanding" qualities. One should not engage in confrontation with them, refuting their "exclusiveness", one must skillfully use their desire to be in the center of attention.

Anxious and hypochondriac patients who easily fall into a panic are prone to exhaustion and depression and need a very careful attitude. To remove the alarm requires the organization of available activities.

It is also necessary to take into account the types of psychiatric compensatory reactions characteristic of patients:

– denial, repression of information about the presence of the disease dominates in hysteric individuals;

– uncertain attitude towards the diagnosis with full resignation to fate, the doctor is shown by anxious-hypochondriac persons;

– partial recognition of the diagnosis is characteristic of schizoids;

– a realistic attitude is typical for synthonous patients – the acceptance of the fact of the disease occurs with the setting for active treatment with the belief in recovery.

Stages of experiencing a serious illness

1. *Stage of negation*

– A person is shocked and does not realize the severity of his illness, can stop going to doctors, but time goes by.

– A person needs to decide whether or not to go to a doctor.

2. *Stage of the first trade*

– When a person reaches this stage, he consciously estimates the disease as a punishment, even if he is an unbeliever or not superstitious.

– "Why should I do this?" – he asks himself, "I will try to correct the evil and recover."

– There is a deal with oneself and with God, correcting one's mistakes, donating to charity, refusing bad habits, reconciliation with enemies, etc.

3. *Stage of anger*

– Focused on others.

– "They do not understand how I suffer, they continue to live their lives. How can they smile, watch TV, dance when I'm doomed?"

– All this is aimed at their loved ones, they want to punish their relatives for their misunderstanding and inattention.

4. *Stage of depression*

– Depressed mood, sense of meaninglessness of their existence, feelings of helplessness and hopelessness, loss of appetite etc.

– Suicidal attempts are possible. The phase is characterized by doubts and anxieties about the disease.

– The breaking of the life stereotype is characteristic. There is isolation from family, work, friends.

5. *Stage of the second trade*

– The person sets himself the same internal conditions as in the first trade, but already related to the duration of life.

6. *Stage of reconciliation with the disease*

– A person says to himself: "I will live, I do not know how much, but I will. I'll admire the sunset, dawn, children and

grandchildren (if there are any), I'll drink a little if I like it etc.". The stress disappears; the person accepts the disease and himself in a disease.

7. *Stage of surrender*

– The patient is not looking for a new way of treatment. Sometimes, at this stage, people become stubborn and may even stop treating themselves.

– Some patients develop compensatory mechanisms, i.e. setting the device on the benefits of the disease.

3.4. The concept of compliance and adherence to treatment

The term "compliance" means "unity, mechanism, fidelity, separation of views, zeal" (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

The term "compliance" is fixed in the medical literature, although it has several meanings. The most common definition of compliance is understood as consent to treatment, joint work with the doctor and the fulfillment of all claims of therapy (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). A different meaning of the term "compliance" means a clear and conscious execution of the doctor's advice in the process of healing, and is widely used by practical physicians both in the West and in Russia in discussing the difficulties associated with pharmaceutical therapy (Banshchikov F.R., 2006; .Kots Ya.I., 2007).

The term "adherence to therapy" which means "compliance with the doctor's instructions" (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014) is also widely used. "Adherence to therapy" is oriented also as a characteristic of the behavior of the patient associated with healing (for example, taking the drug, dieting, changing the lifestyle, visiting the clinic) and its correlation with the doctor's recommendations (Lutova N.B., 2005; Banshchikov F.R., 2006). Despite insignificant differences, the term "adherence to therapy" is close in its content to the term "compliance" and in medical practice it often replaces it.

D. Schmidt, I.E. Leppik in determining the compliance base on three components: the type of behavior, the degree of compliance

and the degree of purposefulness of the patient (Schmidt D., Leppik I.E., 1988; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

Thus, the term "compliance" in the medical literature is characterized as the patient's conscious compliance with the physician's prescriptions, in the process of their joint interaction, the degree of compliance of the patient's behavior with the recommendations of the doctor, primarily regarding the intake of medications.

If we consider compliance, as adherence to treatment or "patient behavior," then the question arises, what lies at its basis – motivation. In this case, it is possible to approach from the position of the formation of the setting for treatment in patient's mind. This approach is reflected in the work of V.D. Mendelevich, who notes that compliance has a complex structure, which consists of *three functional blocks:*

– sensory-emotional block includes immediate impressions and experiences caused by the situation of treatment;

– logical block represents a system of estimates and judgments to explain the need for treatment and its effects;

– behavioral block is formed by motives, actions and actions for the implementation of the therapeutic program (Mendelevich V.D., 1988; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

Thus, the awareness of patients about the nature of the disease, the successful outcomes of therapy, generates an emotionally positive response to the impact on the part of medical personnel and the desire to comply with the prescription of the doctor. Resistance to treatment by the patient may be due to the presence of a negative attitude towards medical intervention based on negative (inconsistent, incomplete) information about his character.

Dissonance in the structure of the mindset components can lead to conflicting actions and reactions on the part of the individual.

For example, the patient's understanding of the need for treatment, based on knowledge of the dangers of the disease, and the availability of information on the side effects of therapy, can cause him to have conflicting feelings, especially if the disease does not

show painful symptoms, and as a result, inconsistent compliance with the prescription of the doctor .

If we consider adherence to treatment as a patient's behavior based on conscious and consistent following doctor's prescriptions, including taking medications, changing the way of life as a whole, observing the rest regime, diet, etc., the question arises what factors can cause it.

From the position of medicine, much attention is paid to clinical factors affecting the patient's compliance (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). Numerous clinical observations show that at the initial stages of the disease, when the symptoms are still insignificant, the reaction to the disease can be manifested by its negation, or by minimizing the significance of the consequences and possible complications, as evidenced by psychodiagnostic studies (Uzlov N.D., 2013). Conversely, the presence of painful sensations, like bodily sensations, can contribute to the fact that treatment will be perceived as the only salvation and the opportunity to get rid of suffering. That is, the more a patient experiences discomfort from the disease, the more physically he suffers, the higher the likelihood of his prompt treatment and willingness to cooperate. In this situation, the appointment of medications and treatment is perceived by the patient as salvation. On the other hand, there is a danger that once the goal – the reduction of painful symptoms is achieved, the patient can interrupt treatment. On the background of treatment with improvement in well-being, therapeutic cooperation may be disrupted (Kravchenko S.S., 2003; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). In this context, the subjective perception of the patient by the disease, as well as the peculiarities of their mental states (Grigoryeva N.V., 2015) is important.

The nature of the course of the disease is important. In the treatment of chronic diseases, therapeutic cooperation is unstable compared with acute pathological conditions. Suddenly arisen, acute pathology is accompanied by a sharp deterioration in the patient's condition and does not imply long-term treatment. In addition, in the acute or exacerbation of a chronic illness, medical care is mostly stationary, and the monitoring of the implementation of recommendations is carried out by a doctor and nurses. In chronic

pathologies, treatment is often performed on an outpatient basis, and most of the responsibility for taking medications and dieting is placed on the patient (Konradi A.O., 2004; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

The next group of factors influencing compliance is a set of features of drug therapy (therapeutic factors) (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

It is established that the duration of administration of drugs also significantly affects the dynamics of compliance. With prolonged therapy, the patient must constantly monitor compliance with the treatment regimen, so therapeutic cooperation can be disrupted because patients forget to take the medicine. In the conditions of long-term treatment, the value of therapy in the eyes of the patient decreases, he gets used to the diagnosis, realizes the impossibility of complete recovery (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

One of the main obstacles to the formation of the follow-up therapy is the side effects of treatment (Shamov I.A., 1986). Fear of a possible or unexpected deterioration or the appearance of painful symptoms after the start of taking medication, can trigger a patient's refusal of treatment. Therefore, the information-educational work has an important role here (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

A significant therapeutic factor affecting compliance is the drug regimen. Convenience and simplicity of the scheme of therapy (a small amount of drugs, an easy method of dosing) contribute to patient compliance with prescription of the doctor. Conversely, a large number of different drugs, the need to take medications several times a day at strictly defined times, the difficulty of dosing serves as a source of violation of the drug regimen (Naumova E.A., 2006; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

One of no less significance groups of factors affecting compliance is the category of social factors (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). The presence of social support from the micro-social environment (family, friends, and colleagues) has a positive role in the course of treatment and in some cases is the only stimulus in therapy. In a crisis situation, the family helps to cope with feelings of fear; helplessness; helps to overcome negative

stereotypes regarding medical care. The family can perform an intermediary function. Interacting with the family, the doctor can influence the patient, interpreting the need for medication and compliance with recommendations.

The inadequate behavior of individual members of the family creates the prerequisites for the emergence of conflicts, the accumulation of family tension, and, as a result, the decrease in the level of compliance (Danilov D.S., 2008; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

A great impact on the patient's consciousness regarding compliance with therapeutic prescriptions has the adverse effect of some patients on others, which is denoted by the term egrotogeny (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). Usually this happens when people have a lot of free time in close contact, for example, when they are in a hospital ward, in line for an outpatient appointment to a doctor (Piliptsevich N.N., 2003). This phenomenon manifests itself in the form of tension, anxiety, sometimes mental shock or panic (Stukalov A.F., 2003).

The system of relations between the patient and the doctor has a decisive role in following and following the medical prescriptions (Shamov I.A., 1986; Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014).

Adherence to treatment is the patient's behavior based on the establishment of consciously and consistently meeting the prescriptions of the doctor, including taking medication, changing the way of life in general, observing rest, diet, etc. Compliance is due not only to the responsibility and nature of the patient's behavior, but also to adequate actions the side of medical personnel. This behavior reflects the complex interaction of a number of factors that can be divided into four groups (Butova Yu.S., Skripkina Yu.K., Ivanova O.L., 2013):

1. The factors associated with the patient's personality (the patient's socio-demographic status, the control locus, the value system, etc.), the patient's attitude toward the disease and his awareness of the specificity of the disease and treatment;

2. Interaction of the patient with the social environment (presence or absence of support);

3. The nature of the patient's relationship with medical personnel;

4. Factors associated with therapy (duration of treatment, hospitalization etc.).

Thus, compliance in the literature is mainly considered from a medical point of view, while its psychological aspect is still poorly understood. In this connection, the complex approach proposed by R.V. Kadyrov is interesting., who proposes to consider compliance through factors conducive to adherence to treatment, namely, social, psychological, therapeutic and clinical (Kadyrov R.V., Asriyan O.B., Kovalchuk S.A., 2014). An empirical study of these compliance components is proposed to be carried out through a special questionnaire "Level of Compliance", developed, tested and implemented in practice in medical institutions in Vladivostok and Primorsky Disrtict. This questionnaire identifies levels of compliance (low, medium, high), each of which is characterized by a combination of three components of the compliance:

– social compliance – the desire to comply with the recommendations of the doctor;

– emotional – the tendency to comply with the doctor's prescriptions, based on increased sensitivity and sensitivity;

– behavioral compliance – the perception of the disease as an obstacle, which must be eliminated by overcoming the disease.

Test questions

1. Define the IDP and characterize its levels.
2. List the existing classifications of attitude to the disease types.
3. Name the factors causing the formation of the IDP.
4. Characterize the stages of the reaction to a serious disease.
5. The concept of compliance and adherence to treatment.

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4. Psychology of Communication in Medicine

4.1. Communication, its means, mechanisms and functions

Communication is the process of interaction of at least two persons aimed at mutual knowledge, the establishment and development of relationships, the provision of mutual influence on conditions, views and behavior, as well as the regulation of their joint activities.

Three interrelated parties are singled out in communication:

1. The *communicative side* of communication consists in the exchange of information between people.

2. The *interactive side* is the organization of interaction between people, for example, it is necessary to coordinate actions, distribute functions or influence the mood, behavior, convictions of the neighbor.

3. The *perceptive side* of communication includes the process of perceiving each other by partners in communication and establishing a mutual understanding on this basis.

The means of communication include:

1. Language is a system of words, expressions and rules for their combination into meaningful utterances used for communication.

2. Intonation, emotional expressiveness, which is capable of giving different meaning to the same phrase.

3. Mimicry, posture, the interlocutor's view can strengthen, supplement or disprove the meaning of the phrase.

4. Gestures as a means of communication can be either universally accepted, i.e., have values assigned to them or expressive, i.e., serve for greater expressiveness of speech.

5. The distance at which the interlocutors communicate depends on the cultural, national traditions, on the degree of confidence in the interlocutor.

The following stages are distinguished in the communication procedure:

1. The need for communication (it is necessary to inform or learn information, to influence the interlocutor, etc.) allows a person to come into contact with other people.

2. Orientation in order to communicate, in a communication situation.

3. Orientation in the person's interlocutor.

4. Planning the content of their communication, a person imagines (usually unconsciously) what exactly he will say.

5. Unconsciously (sometimes consciously) a person chooses specific means, speech phrases that he will use, decides how to talk, how to behave.

6. Perception and evaluation of the respondent's response, control of the effectiveness of communication on the basis of feedback.

7. Correction of direction, style, methods of communication.

If any part of the act of communication is violated, then the speaker cannot achieve the expected results of communication – it will prove ineffective. These skills are called "social intelligence", "practically-psychological mind", "communicative competence", "communication skills".

Communicative competence is the ability to establish and maintain the necessary contacts with other people. Effective

communication is characterized by the achievement of mutual understanding of partners, a better understanding of the situation and the subject of communication (achieving greater certainty in understanding the situation contributes to solving problems, ensures the achievement of goals with optimal use of resources). Communicative competence is considered as a system of internal resources necessary for building effective communication in a certain range of situations of interpersonal interaction.

Causes of poor communication can be:

– stereotypes – simplified opinions about individuals or situations, as a result there is no objective analysis and understanding of people, situations, problems;

– "pre conceived notions" – the tendency to reject everything that contradicts one's own views, what's new, unusual ("We believe what we want to believe"). We seldom realize that the interpretation of events by another person is just as legitimate as our own;

– bad relations between people, because if the attitude of a person is hostile, it is difficult to convince him of the fairness of your view;

– lack of attention and interest of the interlocutor, and interest arises when a person realizes the importance of information for himself: with the help of this information, one can get what you want or prevent unwanted developments;

– neglect of facts, i.e., the habit of drawing inferences and conclusions in the absence of a sufficient number of facts;

– errors in the construction of utterances: incorrect choice of words, the complexity of the message, weak persuasiveness, illogicality, etc.

– wrong choice of strategy and tactics of communication.

Communication strategies:

– open – closed communication;

– monological – dialogical;

– role (based on the social role) – personal (communication "heart to heart").

Tactics of communication – the implementation in a particular situation of communicative strategy based on the knowledge of the techniques and knowledge of the rules of communication. The

technique of communication is the aggregate of specific communicative abilities to speak and the ability to listen.

Social perception is the perception, understanding and evaluation people by other people, themselves, as well as various social objects.

Structure of perception of another person:

– perception of external signs,

– correlating them with the personal characteristics of the perceived individual;

– interpretation on this basis of actions.

The main task of perception is the formation of the first impression of a person. On the basis of numerous studies, psychologists came to the conclusion that the first impression is formed under the influence of three factors – the factor of superiority, the factor of attractiveness and the factor of attitude to the observer.

The essence of *the factor of superiority* is that the partners in communication tend to systematically overestimate the various qualities of those people who surpass them in some essential for them parameter. If they deal with partners whom they believe to be superior in some ways, then the first ones underestimate the others. If we like the person (outwardly!), at the same time we tend to think that he is better, smarter, more interesting, etc., that is, to overestimate his psychological characteristics.

The attractiveness factor ensures the implementation of the following scheme: the more outwardly attractive to us a person is the better he is in all respects for us. If he is unattractive, then the rest of his qualities are underestimated. Attractive is the partner in communication, who seeks to approach the type of appearance most approved by the social group to which he belongs.

The factor of the relation to the observer regulates the perception according to the following scheme: a positive attitude towards us causes a tendency to attribute positive qualities to the partner and rejection, neglecting negative ones. Conversely, an explicit negative attitude causes a stable tendency to ignore the positive and to stick out negative (the closer the opinion of another person to one's own, the higher the evaluation of this person, and

vice versa: the higher a person was evaluated, the greater was the similarity of his views to his own).

There are direct and indirect signs of agreement that form the considered factor. To direct attributes refer: the opinion of the interlocutor, similar to ours: the closer it is to ours, the higher the assessment of the interlocutor in our eyes. Indirect signs are encouraging and approving nods, a natural smile from time to time appearing in the right places, exclamations of "Yes", "That's it", "Of course", "Naturally", etc.

Mechanisms of mutual perception

Stereotyping – leads to the appearance of prejudices and to a certain simplification of the process of studying another person. For situations of managerial communication common stereotype expressions will be such as "a rude boss", "a lazy subordinate", etc.

There are a number of effects in the process of the mechanism of stereotyping:

– *halo effect* is a rough generalization, evaluation in black and white colors;

– *the effect of leniency* is a too positive assessment of the observed events, actions;

– *the effect of the central tendency* is the desire to average the estimates of the observed processes and phenomena;

– *aureole effect* is the tendency to connect the characterization of one character trait with other human properties. For example, a high scientific intellect, in the view of most people, is associated with high nobility or a well-developed sense of public duty. Externally attractive people are often credited with noble character traits;

– *the effect of contrast* is the tendency to emphasize traitsopposite to their ownpositive features;

– *the effect of projection* is the tendency to attribute negative properties of one's character, as well as the motives of one's behavior to others. So a person who often tells lies most often does not believe others.

Stereotypes are a tool of *"rough adjustment"*, allowing a person to "save" psychological resources and time.

The mechanisms of *"fine tuning"* include identification, empathy, attraction, reflection, causal attribution.

Identification (Latin *Identifico* – I identify) is a way of studying another person, in which the assumption of the inner state of the interlocutor is based on attempts to put oneself in the place of this interlocutor. That is, there is an assimilation of oneself with the other person. When identified with others, their norms, values, behavior, tastes and habits are learned.

Empathy is an emotional empathy or empathy for others. Through the emotional response we understand the inner state of others. Empathy is based on the ability to correctly imagine what is happening inside the other person, what he feels like, the way he estimates the world around him.

Attraction (Attraction, literally – attraction, attraction) is the ability to achieve a favorable, persistent positive attitude of the interlocutor to us; this is the ability to positively arrange, adjust it to us. In this case, the understanding of the communication partner arises from the formation of attachment to him, a friendly or deep intimate-personal relationship.

Reflection (Late Latin *Reflexio*) is a mechanism of self-cognition in the process of formation, which is based on a person's ability to represent and realize the way he is perceived by the communication partner.

Causal attribution (Latin *causalis*– causality) is a mechanism for interpreting the actions and feelings of another person, striving to find out the reasons for the behavior of the subject. The individual has his own "favorite" schemes of causality, that is, the usual explanations for someone else's behavior (the propensity to find the culprit of what happened, to attribute the reason to what happened to a particular person, circumstances or himself, and the reason for success is most often attributed to himself, and failure to the circumstances).

4.2. Communication and its importance in therapeutic activity

Psychological characteristics of the patient in the context of medical relationships and interaction come into contact with the

psychological characteristics of the medical worker. In addition, persons involved in contact with the patient may be a doctor, a psychologist, a nurse, a social worker.

In medical activities, a special relationship is formed; a special relationship between medical workers and patients is the relationship between the doctor and the patient, the nurse and the patient. Forms, according to I. Hardi, the connection "a doctor, a nurse, patient". Everyday medical activity is connected with psychological and emotional factors in many aspects. The relationship between the doctor and the patient is the basis of any medical activity (I. Hardi).

In order for the process of the patient's relationship with the medical worker to be effective, it is necessary to study the psychological aspects of such interaction. For medical psychology, the motives and values of the doctor, his idea of the ideal patient, as well as the patient's expectations from the process of diagnosis, treatment, prevention and rehabilitation, the behavior of a doctor or a nurse are of great interest.

We also can talk about the importance for the effective and conflictfree interaction of the patient with medical workers of such a concept as communicative competence, i.e. the ability to establish and maintain the necessary contacts with other people. This process implies the achievement of mutual understanding between the partners in communication, a better understanding of the situation and the subject of communication. It should be noted that communicative competence is a professionally significant characteristic of a doctor and a nurse. However, despite the fact that in a clinic the patient is forced to seek help from a doctor, communicative competence is important for the patient himself.

With good contact with the doctor, the patient recovers soon, and the treatment used has a better effect, there are far fewer side effects and complications.

One of the bases of therapeutic activity is the ability of a health worker to understand a sick person.

In the process of therapeutic activity, an important part is the ability to listen to the patient, which is necessary to form a contact between him and the health worker, in particular, the doctor. Theability to listen to a sick person not only helps to determinea disease to which the patient can be exposed, but also the listening

process itself provides a favorable interaction for the psychological contact of the doctor and the patient.

It is important to note that it is necessary to take into account the peculiarities of the disease in contact with the patient, since patients in the most widely spread clinical areas are in the therapeutic departments have different diagnoses.These, for example, can be patients with diseases of the cardiovascular system, gastrointestinal tract, respiratory organs, kidneys, etc. And often their painful conditions require long-term treatment, which also affects the process of the relationship between the health worker and the patient. Long-term separation from the family and professional activity, as well as anxiety for the state of their health, causes a complex of various psychogenic reactions in patients.

But not only these factors affect the psychological atmosphere and the patient's condition. As a result, psychogeny can complicate the course of the main somatic disease, which, in turn, worsens the mental state of patients. And, in addition, in therapeutic departments there are patients being examined and treated with complaints about the activities of internal organs, often without even suspecting that these somatic disorders are psychogenic.

In the profile of internal diseases, specialists deal with somatogenic and psychogenic disorders. And in those and other cases, patients express a large number of different complaints and are very wary of their condition.

Somatogenic-caused mental disorders often occur in anxious-suspicious patients with hypochondriac fixation on their condition. Their complaints contain in addition to those caused by the main disease many neurosis-like symptoms, for example, complaints of weakness, lethargy, fatigue, headache, disturbance of sleep, fear for its condition, excessive sweating, palpitations, etc. Various affective disorders in the form of recurring anxiety and depression of varying severityare even observed. Such disorders are often observed in patients with hypertension, coronary heart disease, in persons suffering from gastric ulcer and duodenal ulcer. Neurosis-like symptoms can often mask the clinic of the main disease. As a result of this phenomenon, sick people turn to specialists in various fields.

Differences in the views of the doctor (nurse) and the patient may be due to their social roles, as well as other factors.

For example, a doctor is, first of all, inclined to look for objective signs of the disease. He tries to limit the history to further determine the prerequisites for further somatic examination, etc., and for the patient his subjective, personal experience of the disease is always in the center of attention and interests. In this regard, the doctor should consider these subjective feelings as real factors. He should even try to feel or catch the patient's experiences, understand and evaluate them, find the causes of anxiety and experiences support their positive aspects, and use them to more effectively assist the patient in his examination and treatment.

The differences in all views and points of view of the doctor (nurse) and the patient are quite natural and predetermined in this situation by their different social roles. However, the doctor (nurse) should ensure that these differences do not go into deeper contradictions. These contradictions can jeopardize the relationship of medical staff and the patient, thus complicating the provision of assistance to the patient, complicating the treatment process.

Types of communication and their features in therapeutic activity

The following types of communication are identified (Samygin S.I.):

"Contact of masks" is a formal communication. There is no desire to understand and take into account the personality of the interlocutor.Parties communicate using the usual masks (politeness, courtesy, modesty, compassion, etc.), a set of facial expressions, gestures, standard phrases that allow to hide the true emotions, attitude towards the interlocutor.

Within the framework of diagnostic and therapeutic interaction, it manifests itself in cases of little interest of the doctor or patient in the results of interaction. This can happen, for example, during the mandatory preventive examination in which the patient feels dependent, and the doctor – who does not have the necessary data to conduct an objective and comprehensive examination and make an informed conclusion.

Primitive communication. Parties assess another person as a necessary or interfering object, if necessary – then actively come into contact, if it interferes – repel.

This kind of communication can occur in the context of manipulative communication between the doctor and the patient in cases when the goal of seeking treatment is getting any dividends. For example, a sick list, a certificate, a formal expert opinion, etc. On the other hand, the formation of a primitive type of communication can occur at the request of the doctor – in cases when the patient turns out to be a person on whom the well-being of a doctor can depend, for example, the boss. Interest in the contact person in such cases disappears immediately after obtaining the desired result.

Formally, role communication. It is regulated both by the content and means of communication, and instead of learning the nature of the interlocutors; they limit themselves by the knowledge of their social roles.

Such a choice of communication on the part of the doctor may be due to professional overload, for example, the district doctor at the reception.

Business conversation. Communication that takes into account the personality, character, age, mood of the interlocutor in the focus on the interests of the case, and not on possible personal differences.

When a doctor communicates with a patient, this kind of interaction becomes unequal. The doctor considers the patient's problems from the standpoint of his own knowledge, and he is inclined to make decisions in a directive without agreement with another participant in the communication and the person concerned.

Spiritual interpersonal communication. It implies the possibility to touch any topic in the conversation, to share any intimate problem to each of the participants in the conversation.

Diagnostic and therapeutic interaction does not imply such contact, at least it does not provide for the professionalism of the medical profession.

Manipulation communication. As well as the primitive one it is aimed at extracting the benefits from the interlocutor with the help of special techniques. Many may be aware of a manipulative technique, often referred to as "hypochondria of a patient".

Its essence lies in presenting the doctor's conclusion about the patient's state of health in the course of the apparent exaggeration of the severity of the detected disorders. The purpose of such manipulation can be:

– decrease in patient's expectations in the success of treatment due to avoidance of medical responsibility in case of unexpected deterioration of the patient's health

– demonstration of the need for additional and more qualified influences on the part of the health specialist in order to receive a bribe.

Communication between the health worker and the patient, in principle, can be called forced communication. One way or another, but the main motive for meetings and conversations of a sick person with a health worker is the emergence of health problems among one participant in such interaction. On the part of the doctor and the nurse, there is the necessity of choosing the subject of communication, which is conditioned by his profession, his social role. And if the patient's treatment to the doctor is conditioned, as a rule, by the search for medical assistance, then the interest of the doctor in the patient is explained by considerations of his professional activity.

The interaction between the patient and the doctor is not something fixed for ever. Under the influence of various circumstances, they can change; they may be affected by a more attentive attitude towards the patient, a deeper attention to his problems. In this case, the very good relations between the health worker and the patient contribute to a greater effectiveness of treatment. Conversely, positive results of treatment improve the interaction between the patient and the health worker.

Currently, many experts believe that it is necessary to gradually derive concepts such as "the sick" from the process of communication and lexicon, replacing the concept with "the patient", in view of the fact that the very concept of "the sick" has a certain psychological load. Addressingpatients like: "How are you, the sick?", is unacceptable, and it is necessary to try to replace this type of addressing the patient with calling by name, patronymic, especially as the very name for a person, its pronunciation, is psychologically comfortable.

4.3. Communicative barriers in communication

The communication barrier is a psychological obstacle to the adequate transfer of information between communication partners.

There are two main types of barriers – objective and subjective. Physical noise, poor telephone communication, etc. – all this refers to the independent of the subjects of communication objective barriers. Subjective barriers are more diverse, we will focus on their characteristics as they are most relevant to the problem at hand.

Subjective barriers are divided into the following categories:

The barrier of understanding (misunderstanding), which is usually associated with a number of reasons, both psychological and others.

This barrier includes:

1. Phonetic barrier of misunderstanding, which occurs in the following cases:
   – when they speak a foreign language;
   – use a large number of foreign words or special terminology;
   – when they speak quickly, indistinctly and with an accent.
2. The semantic barrier of misunderstanding arises when phonetically the language is "ours", but according to the transmitted meaning "alien"
   – any word has usually not one but several meanings;
   – "semantic" fields in different people are different
   – slang words, secret languages are often used, images, examples used by specific groups.
3. A stylistic barrier arises when there is a discrepancy between the form and content of communication.
4. Logical barrier of misunderstanding. It occurs when the logic of reasoning suggested by the communicator is either too complex for the recipient to perceive, or appears to be incorrect to him, or contradicts the inherent manner of proof.

Barriers to socio-cultural differences are social, political, religious and professional differences that lead to different interpretations of certain concepts used in the communication process. As a barrier, the perception of a partner in communication as a person of a certain profession, a certain ethnicity of gender and age, can act.

Barriers of relations are purely psychological phenomena that arise in the process of communication between the communicator and the recipient, which include the emergence of a feeling of dislike, distrust towards one communicator, which also affects the transmitted information.

Any information addressing the recipient carries in itself an element of influence on his behavior, opinions, attitudes and desires with a view to their partial or complete change. In this sense, the communicative barrier is a form of psychological protection from extraneous psychological influence carried out in the process of information exchange between participants.

The psychological barrier is a stable attitude or mental attitude of a person, fixed already on the result achieved, which hinders the further mobilization and use of the person's spiritual potential.

Barriers of perception – an ambiguous understanding or interpretation of information as a result of the first impression, stereotypes, certain internal attitudes, a conflict situation, personal rejection of the topic or interlocutor, etc. Perceptual barriers also include:

– barriers of ignorance – often interlocutors, after hearing a word or concept they do not know, are embarrassed to ask or confess their own incompetence, so they are silent. At the same time, as it is not difficult to guess, understanding the general meaning of the message is lost or greatly distorted.

– barriers of interest arise in the event that the topic of discussion of interlocutors is far from their range of interests.

– emotional state of the interlocutor

– inability or unwillingness to listen is the most common reason for inefficient communication.

Barrier of "authority". Dividing all people on the authoritative and unauthoritative, the person trusts only the first and refuses trust in others. Thus, trust and mistrust are personified and depend not on the characteristics of the transmitted information, but on the person who speaks. For example, the elderly listen poorly to the advice of the young.

The "avoidance" barrier. The essence of this barrier is that, during communication, a person avoids sources of influence, evades contact with the interlocutor. If it is impossible to avoid, then he

makes every effort not to perceive the message (inattentive, does not listen, does not look at the interlocutor, uses any excuse to stop the conversation).

Barriers to communication may be ignorance of the main channels for obtaining information and inability of interlocutors to determine the leading way to assimilate information by each other.

4.4. Psychological basis of communication barriers in professional communication between a doctor and a patient

The communication barrier in professional communication between a doctor and a patient is a psychological obstacle to the adequate transfer of information in communication between the doctor and the patient.

Most often, communication barriers in the professional communication of a doctor with a patient can arise due to the inability or unwillingness of a doctor to feel the patient, to feel his needs, cares, or pain in a different word – due to his indifference to the patient, and also because of distortion of information or its lack; because of the patient's psychological defense against information about the state of health.

A phonetic barrier can arise when the doctor and patient speak quickly and inexpressively or in different languages and dialects, have speech defects and diction. The doctor can overcome it if he tries to speak clearly, legibly and loudly enough, without a tongue twister; if he takes into account the individual characteristics of his patients (the worse a person knows the subject of discussion, the slower he is to speak, there is more need to be explained; people of different nationalities speak at different rates; in the North more slowly, in the South faster; the old people do not perceive a quick speech, etc.). Similarly, the doctor to avoidance the barrier in question must ensure that there is feedback from the patient.

The semantic barrier is associated with the problem of jargon peculiar to people of certain age groups, occupations or social status (for example, the language of adolescents, drug addicts, seamen, hackers, residents of remote areas, etc.). Removing such a barrier is an urgent problem for representatives of the medical profession,

since the success of therapeutic contact depends on overcoming it. Therefore, the doctor must have the skills to assimilate other people's semantic systems. This is especially important for an emergency doctor. The specifics of work in the emergency service obliges the doctor to fully possess all the methods of psychology of communication and to be able to quickly orientate and establish contact with patients, as well as with relatives, witnesses of incidents, police officers, etc. In emergency situations, a correctly collected history, quick contact with the patient often costs a person's life. On the other hand, it happens that the health worker himself provokes the emergence of a semantic barrier in the patient using professional terms without need. In the future, this can lead to the development of pathological reactions due to adverse effects on the patient's psyche.

The emergence of *a stylistic barrier* is possible if the speech of the doctor does not correspond to the situation of communication, for example, when his familiar behavior, when he calls all the patients older than a certain age "grandma" and "grandfather", does not take into account the psychological characteristics of people and their psychological state (change of consciousness due to disease or medication preparations). In this case, the patient does not understand or refuses to understand what is reported by the doctor. It should also be noted that the stylistic barrier can arise due to incorrect structuring of information (its inconsistency with the expectations of the interlocutor). To overcome this barrier, it is useful to first indicate the goal, prospects and expected results of communication, and at the end of the conversation – to sum up, to show the retrospective and to note the degree of achievement of the goals. So it is necessary to structure the content of communication, so that it is not just a formless heap of various information, it must somehow be built, connected in a chain, "listed".

When a physician conducts psycho-prophylactic talks with patients before all sorts of interventions, teaches them how to take medicines, uses equipment, introduces various methods of healthy lifestyles, there may be *a barrier to logical misunderstanding,* i.e. the logic of the doctor's reasoning may be either too complicated for the patient, or to appear to him incorrect or unconvincing. There is different logic: female, child, age, etc. Every person thinks, lives and

acts according to his own logic, the doctor must take this into account, correlate his logic and the logic of the patient, have a clear idea of his logic, and if the doctor does not adhere to all this, then a barrier of logical misunderstanding arises. When you overcome this barrier, you also need the doctor's correct argumentation of his views and decisions about the patient's illness.

The reason for the emergence of *socio-cultural barriers* may be the perception of the patient as a person of a certain profession, a certain nationality, sex, age, social status. The physician should be ready for the emergence of this barrier, to the fact that for a certain part of the patients his authority is insufficient.

In the process of communication between the doctor and the patient, there may also be *barriers to the relationship.* It is about the negative emotions that a person causes, and the reason for this is often difficult to understand.

Negative attitude is formed on the information transmitted by one of the partners. For example: the doctor prescribed the pill to the patient, but the patient refuses to accept them and argues his refusal by saying that the neighbor told him that these pills are harmful, and this is the reason for the doctor's barrier of treatment. In this sense, the communicative barrier is a form of psychological protection from extraneous psychological influence carried out in the process of information exchange between participants. Also, the barrier in question can also be formed in the patient due to the incompetence of the professional communication of the doctor.

Considering the essence of the psychological barrier, one cannot help noticing that any of them is, first of all, the protection that the patient builds in the way of the information offered to him. For example, if you imagine an inveterate smoker who feels bad and turns for advice to his friend – a professional physician. A friend, assessing the state of his health, declares the need to quit smoking, giving the following argument: "Your breathing becomes hard, and the heart weakens." If a person does not want to spend effort and part with a stable habit, he can protect himself from such unpleasant and traumatic information with the help of the following psychological barriers:

– distortion of information, increased attention to all the facts contradicting it ("Today I feel much better, my heart is calm – it was a temporary phenomenon");

– decrease in authority of the source of information ("Of course, he is a doctor, but he has been engaged in gastroenterology for many years." He doesn't understand a lot about heart diseases!);

– protection through misunderstanding ("If he knew what a really bad breath is, takemy neighbor, for example, and nothing, he does smoke").

The perception barrier can arise in the event that the doctor is affected by an unpleasant previous experience of professional communication. This barrier can also arise in the patient due to an unsuccessful meeting with another doctor earlier or because of the stories he has heard from acquaintances about negative cases with medical workers, i.e. the patient has a certain stereotype on the doctor; due to misinterpretation or understanding of information; because of the influence of a certain emotional state of the patient or doctor on the course of communication. Undoubtedly, most often, the barrier under consideration arises from inability or unwillingness to listen to a doctor to listen. Do not use the doctor's techniques of active or reflective listening, inattention to the patient interfere with the correct, holistic and adequate perception of information. Accordingly, in order to avoid this barrier, the physician must possess techniques of active and reflective listening, must take into account the patient's condition during communication with him and, first of all, he must be as competent as possible with the patient and try not to use professional terms in the conversation (they may not be understandable to the patient).

The "authority" barrier in communicating with the patient can arise if the patient underestimates the authority of the doctor (for example, older patients have little trust in young specialists); if the doctor for some reason does not confirm his status (for example, his inappropriate appearance). To overcome it, the physician must look appropriate, be fully competent and benevolent in talking with the patient.

The "avoidance" barrier in communicating with the patient can arise if the patient during the communication avoids the information about his health, does not agree with it, he then shies away from contact with the doctor. If it is impossible to avoid, then he makes every effort not to perceive the message (he is inattentive, does not listen, does not look at the interlocutor, and uses any excuse to stop

the conversation). Most often this barrier is accompanied by some degree of inattention. Therefore, only by controlling the patient's attention, it is possible to overcome this barrier. So to avoid this barrier, the doctor can use the "accent" technique to emphasize the importance of the problem in question ("Please pay attention to the fact that if you stop taking this medicine, your condition will deteriorate extremely", etc.). Also, to overcome this barrier, a doctor can use the "attraction" method. The doctor says something that is difficult to perceive by the patient, for example, speaks very quietly, monotonously or illegibly, the patient under such condition has to make special efforts to understand something. These efforts also involve concentration of attention. As a result, the doctor "attracts" the listener to his "networks". In other words, the doctor provokes the patient himself to apply methods of concentration of attention, and then uses them.

Thus, it should be concluded that the emergence of each of these barriers is not the result of conscious, arbitrary and directed protection from the impact of information. Their action is contradictory. To achieve constructive communication in the "doctor-patient" system, the doctor should try to overcome these barriers.

Test questions

1. What are the verbal and non-verbal means of communication?
2. What are the causes of poor communication?
3. List the main aspects of communication.
4. Describe the factors that determine the formation of the first impression.
5. Describe the main mechanisms of mutual perception.
6. List the main barriers in communication.
7. Give examples of communication barriers in professional communication between a doctor and a patient.

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5. Psychosomatic Correlations

5.1. The definition of the notion of «psychosomatics». Ethological reasons of psychosomatic diseases

Psychosomatics (Greek *Psyche* – soul, *soma* – body) is a direction in medicine and psychology, dealing with the study of the influence of psychological (predominantly psychogenic) factors on the emergence and subsequent dynamics of somatic diseases.

According to the basic postulate of this science, the basis for psychosomatic disease is the reaction to emotional experience, accompanied by functional changes and pathological disorders in the organs. An appropriate predisposition can influence the choice of the affected organ or system. In 1818 the German psychiatrist J. Heinroth defined the concept of internal conflict as the leading cause of mental illness by the term "psychosomatics". In 1822, the other German doctor, Jacobi (M. Jakobi) introduced the concept of "somatopsychic", stressing that mental illness is caused by completely material causes, but not by inaccessible to empirical verification psychological conflicts.

Any psychosomatic disease is a property of the human body as a system. It is not deduced individually either from the psychic or from the physiological (including hereditary) properties of the individual, it cannot be explained by examining the properties of any of the subsystems – mental or somatic. Only the interaction between these subsystems and the environment can lead to a new state of the body, defined as a psychosomatic disease. And only an understanding of these links can provide an opportunity to effectively influence the disease, including the methods of psychotherapy.

The pathogenesis of psychosomatic disorders is extremely complex and is determined by:

– nonspecific hereditary and congenital complications with somatic impairments and defects;

– hereditary predisposition to psychosomatic disorders;

– neuro dynamic changes (disorders of the central nervous system);

– personality traits;

– mental and physical state during the time of the action of psycho traumatic events;

– the background of unfavorable family and other social factors;

– features of psycho traumatic events.

These factors not only contribute to the origin of psychosomatic disorders, but also make an individual vulnerable to psycho emotional stresses, hamper psychological and biological protection, facilitate the occurrence and degree of somatic disorders.

5.2. Psychosomatic theories and models

There is a rather large number of theories and models of the emergence of psychosomatic diseases and ways of their classification.

Clinical-empirical approach (Developed by W. Osler, R. Konechny, M. Bouchal). Considers psychosomatic relations from the aspect of a psychosomatic process, a certain mental state or a change of states that cause a recorded physiological response of the organism, and from the somato psychic process – a certain the state of the body that causes a psychic reaction.

Classical psychoanalysis (S. Freud, K. Jung, A. Adler). This concept introduced the defensive mechanisms of the individual, methodical access to the unconscious through dreams, free associations, clerks and reservations, as well as the theory of the collective unconscious, from which came out the "theory of the symbolic language of organs" (S. Ferenczi).

The theory of emotional conflict (F. Alexander) shows that emotional states of stress (emotional conflict situations and their physiological correlates) is of the crucial effect on the function of organs.

The concept of personality profiles (F. Dunbar)establishes a correlation between somatic types of reactions and constant personal parameters in the form of certain personal radicals, patterns and behavioral patterns, which found its greatest expression in the popular concept of the behavioral type "A" (D. Friedman).

Theories of "alexithymia" (inability to emotional resonance) and "operational thinking" (concrete thinking, freedom from dreams), stipulates thatpsychosomatic patients have a special pathognomonism of intrapsychic processing of intrapersonal conflicts and specificity of verbal behavior (I. Ruzov).

Consequences of stress (H. Selye, F.Z. Meerson et al.), which determine the influence of extreme stress situations on the susceptibility and features of the pathogenesis, course and therapy of psychosomatic diseases. Moreover, in this direction there are a very large number of separate areas for studying psychosomatic pathology (stress and adaptive reactions, stress and stress damage, stress factors and a picture of their subjective experience, etc.).

Psychophysiological direction (A.S. Gevins, R Jonson, F.B. Berezin, Yu.M. Gubachev, P.K. Anokhin, K.V. Sudakov et al.), which is based on the desire to establish the relationship between individual psycho-physiological characteristics (for example, some neocortical-limbic characteristics or sympathetic-parasympathico-trophic manifestations) and the dynamics of visceral manifestations (activation of organ functions). The fundamental basis of the concept is the provision on functional systems.

Psychoendocrine and psychoimmune direction (V.M. Uspensky, Ya.S. Zimmerman, V.A. Vinogradov, I.P. Myagkaya), which studies a wide range of neuroendocrine and neurohumoral phenomena in patients with psychosomatic diseases (psychoendocrine testing of the features and level of synthesis of catecholamines, pituitary and thyroid hormones, specificity of immunograms). The search for "specific neurohormonal support" of emotional response showed that a high level of personal and situational anxiety is associated with multidirectional neurohormonal shifts.

Neurophysiological direction (I.T. Kurtsin, P.K. Anokhin, N.P. Bekhtereva, V.D. Topolyansky), which studies the neurophysiological supply of persistent pathological conditions and explains the occurrence of psychosomatic disorders by disturbed cortico-visceral relationships. The essence of this theory is that violations of cortical functions are considered as a cause of the development of visceral pathology. It is taken into account that all internal organs have their representation in the cerebral cortex. The influence of the cerebral cortex on the internal organs is realized by the limbic-reticular, autonomic and endocrine systems.

Behavioral medicine. Within the framework of "behavioral medicine" a pathogenesis model based on "visceral training" as well as behavioral learning is proposed. This model of the pathogenesis of psychosomatic disorders is primarily explained by the way of life of a person and the peculiarities of his personality (B.D. Karvasarskii, Yu.M. Gubachev).

Functional asymmetry of the brain. Theory of the violation of "functional brain asymmetry" as the cause of psychosomatic pathology (N.I. Kosenkov). As social adaptation occurs, there is an increase in the functional asymmetry of the brain, which does not go over a certain boundary – the "critical zone". In the case of social

disadaptation, the functional asymmetry of the brain reaches the "critical zone" and this leads to the emergence of psychosomatic pathology. The work of functionally asymmetric (having a temporary asymmetry in the secretory and motor activity) of the physiological systems of the organism changes, which contributes to the release of functional asymmetry of the brain from the "critical zone". This leads to the onset of a remission phase of psychosomatic pathology, which may have a different duration of flow. There is a vicious circle of psychosomatic illness, which can trigger both changes in the central nervous system and pathological disorders in peripheral organs and systems involved in the painful process.

5.3. The role of personality in the emergence of psychosomatic diseases

Personal profiles are premorbid personality characteristics predisposing to certain diseases, as well as mental reactions and conditions associated with the existing disease.

F. Dunbar (Helen Flanders Dunbar, 1902-1953) in "*The concept of personal profiles*" believed that emotional reactions to problematic life situations are derived from the personality structure. Coronary, hypertonic, allergic and prone to damage types of personality are defined.

Personality profile Type A. They differ in energy, restlessness, impatience, desire to achieve maximum results as quickly as possible, with ambition, competitiveness, and hostility. Anger, intolerance, personal inclusiveness, "energetic manner of speaking", irritation, experienced from standing in lines. Men are extraverted, impulsive, aggressive, dominant, self-confident, risk-averse, quick to think. The incidence of CVD is 75% of all cases (first described by American cardiologists R. Roseman and M. Friedman).

Personality profile Type B. More inhibited, introverted, submissive, respectful, conscientious. Attempts to passively adapt to the environment. More often (in comparison with representatives of type A) are susceptible to cancer and gastrointestinal diseases. Rarely suffer heart diseases up to 70 years, no matter what they do and what their habits are.

Comparison of characteristics of types A and B

Type A	Type B
– active desire to change the situation; – with uncontrolled stress – depression; – secretory activity of adrenal medulla (adrenaline); – in the experiment on animals: low content of progesterone in pregnancy (termination of pregnancy with a slight external effect).	– passive adaptation to environmental changes; – optimal for chronic stress; – secretory activity of the cortical layer of the adrenal glands (cortisol); – in the experiment on animals: high content of progesterone in pregnancy (stability of the flow); – inherited dominantly.

Personality profile Type C.

– high, reaching an extreme degree, the intensity of the desire to observe social norms and rules (conventional behavior) in behavior;

– use of non-adaptive (dysfunctional) coping strategies in stressful situations;

– a decrease in the ability to adequately express experienced negative emotions, especially anger and irritation;

– constant search for consent and support from others, fear of social rejection or disapproval (Italian psychoneuroendocrinologist M. Biondi)

Personality profile Type D.

– a combination of an increased level of negative emotions with an intense tendency to suppress them in social contacts;
– anxiety, depression and anger are not the leading elements of this personal "profile";
– the likelihood of traits of this type is higher in women. Risk factor for complications of CVD (reduction of the left ventricular ejection fraction in the development of CHF) (J. Denollet and S. Pedersen).

5.4. Psychological factors of psychosomatic disorders

Anxiety is a logical psychophysiological reaction to an unknown stimulus.

Psychosomatic anxiety is a significant emotional state, leading to the development of vasospastic reactions in angina pectoris, which are noted in 1/3 of patients with typical angina. The active inclusion of anxiety in the pathogenesis of peptic ulcer, bronchial asthma, rheumatoid arthritis, etc. has been proved.

Cognitive styles (pessimism, optimism). Among the pessimistic patients, the death rate is higher than that of the optimists. The severity of pessimism correlates with the intensity of atherosclerotic lesion of the carotid arteries. A negative influence of the pessimistic explanatory style on the level of immunoglobulin A in the human body (the factor of immunodeficiency states) was noted.

Depression increases the risk of stroke in hypertension, acute myocardial infarction in ischemic heart disease. With depression, the rate of sudden cardiac death is several times higher than when it is absent. Depression accompanies diabetes mellitus, diseases of the gastrointestinal tract, bronchial asthma in 40–70% of cases.

The level of subjective control – internality (J. Rotter) – the tendency to attribute performance results, including failure to internal factors. People with a high internal control locus are more self-confident, more optimistic, calm and benevolent, more personally mature; they make more of their own efforts for successful adaptation in the social environment, are more active and initiative in interpersonal communications, experience less hostility to the environment and successfully resist the impact of stress due to their more developed social support system. Internally oriented individuals, when confronted with frustrating situations, experience less anxiety and less often demonstrate depressive disorders.

Externality (conviction that life events result from external factors) is interrelated with high anxiety and depression, as well as with higher levels of hostility and aggressiveness, which can be considered as a complex of psychological factors of psychosomatic risk.

Hostility is seen as one of the key, probably even the most "toxic" elements of the behavioral type A, predisposing to the development of CVD.

It is noted that persons with features of behavioral type A are characterized, along with other psychological qualities, by ambition and aggressiveness, are emotionally involved in situations that frustrate them much more actively than individuals without such psychological characteristics, which significantly increases the number of extrapunit reactions, demands for encirclement and strengthens the desire for active control of the situation.

Alexithymia (difficulty in understanding and interpreting one's own emotions) "somatizes" many psychopathological syndromes. One of the reasons for increasing the intensity of physiological reactions in psychosomatic disorders can be considered a reduced ability to adequately respond to negative emotions. Violations in the sphere of awareness and verbalization of emotions in alexithymia form a tendency to hyperactivation of the sympathetic-adrenal system.

Socio-psychological factors, such as the level of education, the nature of work, social status, income level, social support, can also serve as factors of psychosomatic risk.

Factors of psychosomatic pathologies

There are eight main sources of psychosomatic diseases:

1. The internal conflict of the parts of the individual, conscious and unconscious, single combat between which leads to the destructive "victory" of one of them over another.

2. Motivation by the type of conditional benefit, when the symptom carries a conditional benefit for the patient. For example, getting rid of migraines can "open your eyes" to many problems that "prevent seeing" a headache, and then the patient will face the need to solve them.

3. The effect of suggestion (by another person). It is known that if a child is often called "fool, fool, dumb, greedy," and so on, very often this child begins to show behavior that corresponds to the inspired, which automatically turns into adulthood.

4. Elements of organic speech. Disease can be the physical embodiment of a phrase. For example, the words "my heart hurts for him", "I'm mad at it" can turn into real symptoms.

5. Identification, an attempt to be like someone. Constantly imitating the other, a person seems to be moving away from his own body.

6. Self-punishment. If a person commits an act that is unseemly, in his opinion, he sometimes unconsciously punishes himself. Self-punishment is a very common cause of many injuries and somatic disorders.

7. Traumatic experience of the past. As a rule, these are mental traumas of the early childhood period.

8. Alexithymia.

Test questions

1. Give a definition of the concept of "psychosomatics".
2. Describe the basic psychosomatic approaches and concepts.
3. What is the role of the individual in the formation of psychosomatic manifestations?
4. List psychological factors of the formation of psychosomatic disorders.

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6. The Personality of a Medical Professional

6.1. Professionally significant qualities of a doctor

The main requirements for the doctor position are as follows: high professionalism, the desire to constantly enrich knowledge with a high level of morality.

The dynamic model of the doctor's personality includes the interaction of three components:

– *"core", invariant*, comprising a set of professionally important qualities, developing in the process of professionalization of a person;

– *specific*, characteristic for doctors of various specializations and at different stages of the professional cycle;

– *variable*, reflecting the integral individuality of the dynamically developing personality of the doctor.

Four structural levels of the doctor's personality are:

1. The level of socially-conditioned qualities of a doctor's personality.
2. The level that systematizes the quality due to the experience and the process of professionalization.
3. The level reflecting the peculiarities of cognitive processes.
4. The level characterizing the neurodynamic properties of the personality.

Features of the cognitive mental processes of the doctor:

– systemic thinking,
– advanced memory,
– high volume and selectivity of attention.

Neurodynamic requirements for the physician's personality are: a combination *of weakness of the nervous processes regarding excitation and inhibition*, high sensitivity of the analyzers and at the same time high endurance of the nervous system, maintaining a high level of performance for a long time under extreme conditions.

Specific doctor PSQs are as follows:

– volitional personality traits – for a specialist in the field of surgery, an anesthesiologist, resuscitation and outpatient therapy;

– performance properties – for the resuscitator;

– properties of psychomotor behavior – for a dentist and a surgeon;

– a set of emotional and personal qualities – for a pediatrician;

– dynamic unity of supporting and developing motives that form its professional and personal orientation, with a significant predominance of the highest moral and ethical values;

– high severity of need to achieve;

– medium-high level of development of communicative and organizational resources;

– for doctors of a therapeutic profile, predominance of strategies for cooperation in conflict situations is typical;

– doctors of the surgical, anesthesiology and reanimation areas reliably more often prefer authoritarian conflict resolution strategies.

6.2. Doctor Personality Types

1. "Kindhearted" – compassionate, empathic, easily responding to the suffering of the patient.

2. "Pragmatic" – working with patients, takes into account only the objective side of the disease does not pay attention to the experiences of patients.

3. "Moralist" – prone to moralizing, indignant if the patient questions or does not follow his recommendations.

4. "Workaholic" – conscientious in work, serious, diligent, hardworking, not inclined to joke with patients.

5. "The activist" (social activist) – prefers the solution of various organizational issues, the implementation of public assignments in a medical institution; to work with patients.

6. "Dogmatic" – strictly follows the learned diagnostic and therapeutic installations and schemes, hardly perceives the new.

7. "Technocrat" – overestimates the value of laboratory and hardware data, does not attach importance to the complaints of patients and other subjective aspects of the disease.

8. "Psychotherapist" – tries to penetrate into the patient's experiences, helps him with advice, persuasion.

9. "Sybarite" – loves convenience and comfort, patients annoy with their complaints, doesn't consider their opinion, tends to a bohemian way of life.

10. "Artist" – inclined to demonstrate his knowledge and professional skills to the sick and their relatives, plays, depending on

the situation, the role of a different doctor – "hesitant", "attentive", "luminaries", etc.

11. "Bored idler" – has a high self-esteem with a rather modest stock of knowledge, stereotypedness in making diagnoses and prescribing treatment, dismissive attitude to the inquisitive ones.

12. "Misanthrope" – a doctor without a vocation to it; has no a call to medical activity, no such qualities as empathy, manifestsbenevolence, as well as rudeness, squeamish attitude towards patients, and evil jokes.

In the harmoniously developed personality of the physician, the described types should be combined, except for: a misanthrope, a sybarite, a bored idler.

6.3. Models of doctor and patient relationships

1. *Technical*. In this model, the patient is a "malfunctioning mechanism that needs to be repaired." The identity of the patient is not taken into account. There is only a physical problem that needs to be fixed.

2. *Paternalistic*. The doctor here is considered as a "parent", and the patient as an "unreasonable child." The doctor himself determines what is good for the patient. Here attention is paid to the personality of the patient, but only from the point of view of moral support.

3. *Collegial*. This model in its extreme form is patient-centered. The patient here plays an active role; all decisions of the doctor are coordinated with him.

4. *Contract*. The relationship between the doctor and the patient is based on an unspoken (in some cases, however, procedurally legalized) agreement on mutual respect for each other's rights. The patient is informed about how the treatment is taking place, the information is not hidden from him, but the decision is made by the doctor, justifying it for the patient.

6.4. Emotional burnout in medicine

The burnout syndrome (eng. Staff burn-out syndrome), a concept that was introduced in 1974 by the American psychiatrist Herbert Freudenberger (H.J. Freundenberger), means "the defeat,

exhaustion, or deterioration that occurs in a person as a result of sharply exaggerated demands on their own resources and forces".

Changes in burnout syndrome

Behavior:

– often looks at his watch;
– resistance to work is increasing;
– postpones meetings with patients;
– often late;
– loses creative approaches to solving problems;
– works harder and longer, and less achievements;
– retires and avoids colleagues;
– assigns property to an institution;
– increases the use of mood-altering psychoactive substances (including caffeine and nicotine);
– loses the ability to meet their needs for entertainment and recovery of health;
– prone to accidents.

Feelings:

– loss of sense of humor or hangman humor;
– a constant sense of failure, guilt, and self-incrimination;
– often experiences anger, resentment, and bitterness;
– irritability at work and at home;
– feeling as if they were being fooled;
– sense of discouragement and indifference;
– powerlessness;
– stress relief, not a creative activity.

Thinking:

– more and more persistent thoughts about leaving work;
– being not able to focus;
– rigid thinking, resisting change;
– increased suspicion and distrust;
– cynical, condemning attitude and inhuman attitude towards patients;
– the mentality of the victim;
– concern about their own needs and personal survival.

Health:

– disturbed sleep;
– frequent, long-term current minor ailments;

– increased susceptibility to infectious diseases;
– fatigue – tiredness and exhaustion for the whole day;
– acceleration of mental and somatic health disorders.

Signs of physical exhaustion:

– chronic feeling of tiredness, weakness, boredom;
– energy reduction;
– frequent headaches,
– back pain,
– muscle tension
– sleep disturbance,
– nausea
– susceptibility to diseases.

Signs of emotional exhaustion:

– feeling of depression, helplessness, hopelessness;
– heightened tension and conflict in the family;
– an increase in the frequency and intensity of negative emotions (irritability, anger, impatience, etc.);
– decrease in the frequency and level of positive emotional states (sympathy, friendliness, caring, politeness, etc.).

Signs of mental exhaustion:

– dissatisfaction and negative attitude towards oneself, work and life in general;
– more frequent forms of behavior associated with avoiding work (absenteeism, frequent stay on sick leave, etc.).

Personal factors of development of emotional burnout:

– Type of stress response
– Selfless work (workaholism)
– Lack of autonomy, overcontrol
– Dissatisfaction with professional growth and support.

Role factors in the development of burnout:

– Joint actions not agreed, no integration of efforts
– There is competition.

Organizational factors for the development of emotional burnout:

– Long hours, hard to measure, not properly evaluated work
– Uncertainty, lack of responsibility
– The nature of leadership by the administration does not match the content of the work

Recommendations for the prevention of burnout (WHO,1998):

1. Avoiding making too high demands on those who help other people.
2. Ensuring an even distribution of satisfying tasks among employees.
3. Training employees in time distribution and relaxation techniques.
4. Modifying work that causes too much stress.
5. Encouraging the formation of support groups.
6. Having the opportunity to work on part time basis.
7. Encouraging employees to participate in making decisions that affect working conditions.

Test questions

1. Characterize the professionally significant qualities of a doctor.
2. List the types of doctors.
3. List the model of the relationship of the doctor and patient.
4. List the main signs of burnout and methods of its prevention.

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7. Psychological Environment of a Medical Institution

7.1. Professional stress

The causes of emotional stress are associated with extreme impacts, primarily with the influence of organizational, social, environmental and technical features of the activity. It is based on violations of information and cognitive processes of regulation of activity. And in this regard, all those life events that are accompanied by mental tension (regardless of the sphere of human activity) can be a source of emotional stress or influence its development.

Consequently, the development of emotional stress in a person is connected not only with the peculiarities of his working process, but also with the most diverse events in his life, with different areas of his activity, communication, and cognition of the surrounding world. Therefore, the division of the causes of emotional stress should be carried out taking into account the peculiarities of the influence of various life events of a person that can be a source of stress. Chronic role tension develops under the influence of adverse conditions over a long period of time that do not pose an immediate threat to life.

Some life circumstances are a combination of chronic stress (role tension) and short periods of injury. These life events can be of different durations, but they differ from role tensions in that they have a clearly defined beginning and end. Troubles (collisions "conflicts) are events with a short duration, usually minor, but they can be included in the context of a long life event or role tension, which may increase their significance.

The source of the traumatic impact can be natural and man-made disasters, war and related problems (for example, hunger), as well as individual injuries. As a result of the growing research interest in this problem, stressors have been identified, but still there is no clear and generally accepted categorization of them. In addition to the above categories, S.A. Razumov in 1976 divided the stressors directly or indirectly involved in the organization of anxiety and stress response in humans into four groups:

1. Stressors of vigorous activity:

– extreme stressors (battles, space flights, diving, parachute jumps, demining, etc.);

– production stressors (associated with high responsibility, lack of time);

– stressors of psychosocial motivation (competitions, contests, exams).

2. Evaluation stressors (evaluation of upcoming, present or past activities):

– "start"-stressors and memory stressors (upcoming contests, medical procedures, recollection of grief experienced, expectation of threat);

– victories and defeats (winning the competition, success in school, love, defeat, death or illness of a loved one);

– spectacles.

3. Stressors of disagreement of activity:

– dissociation (conflicts in the family, at work, threat or unexpected, but significant news);

– psychosocial and physiological limitations (sensory deprivation, muscular deprivation, diseases, parental discomfort, hunger).

4. Physical and natural stressors (muscular loads, injuries, darkness, strong sound, pitching, height, heat, earthquake).

Stress can be caused by factors related to the work and activities of the organization or the events of a person's personal life.

Organizational factors. Consider the factors acting within the organization that cause stress.

1. Overload or too low workload, i.e. a task that should be completed in a specific period of time.

The employee was simply assigned an exorbitant number of tasks or an unreasonable level of output for a given period of time. In this case, there is usually anxiety, frustration (a sense of ruin), as well as a sense of hopelessness and material loss. However, underloading can cause exactly the same feelings. An employee who does not get a job that matches his abilities usually feels frustrated, anxious about his value and position in the social structure of the organization and feels clearly unremunerated.

2. The conflict of roles.

Role conflict occurs when conflicting demands are placed on the worker. For example, a seller may receive an assignment to immediately respond to customer requests, but when they see him

talking to a customer, they say that he should not forget to fill the shelves with goods.

Role conflict can also occur as a result of violation of the principle of unity of command. Two leaders in the hierarchy may give conflicting instructions to the employee. For example, a plant manager may require the shop manager to maximize production, while the head of the technical control department requires compliance with quality standards.

Role conflict may also arise as a result of differences between the norms of the informal group and the requirements of the formal organization. In this situation, the individual may feel stress and anxiety, because he wants to be accepted by the group, on the one hand, and to comply with the requirements of the management, on the other.

3. Uncertainty of roles.

Uncertainty of roles occurs when an employee is not sure what is expected of him. In contrast to the conflict of roles, the requirements here are not contradictory, but also evasive and uncertain. People should have a correct understanding of management expectations – what they should do, how they should do and how they will be assessed after that.

4. Uninteresting work.

Some studies show that individuals who have more interesting work are less anxious and less prone to physical ailments than those who do uninteresting work. However, the views on the concept of "interesting" work are different for people: what seems interesting or boring for one will not necessarily be interesting for others.

5. There are also other factors.

Stress can occur as a result of poor physical conditions, such as deviations in room temperature, poor lighting or excessive noise. Wrong relationships between authority and responsibility, poor communication channels in the organization, and unreasonable employee requirements for each other can also cause stress.

Factors associated with a decrease in the likelihood of stress include maintaining proper nutrition, keeping yourself in shape through exercise and achieving overall balance in life.

Personal factors. If you pay attention to life situations and events that can cause stress, you will see that some of them are positive and

have a positive effect on our lives (wedding, personal success, childbirth, successful exams). In addition, during the life we experience other positive feelings: for example, joy (graduation from school, institute, meeting with friends and family, winning a favorite team), love, creative inspiration, achieving outstanding sports results, etc. However, stress can cause both positive and negative situations. In order to somehow distinguish the sources of stress, and even the stresses themselves, positive ones were identified by a special name – eustress (eustress), negative ones were left as just stress (distress).

Some life situations that cause stress can be foreseen. For example, a change in the phases of development and formation of a family, or biologically determined changes in the body, characteristic of each of us. Other situations are unexpected and unpredictable, especially sudden (accidents, natural disasters, death of a loved one). There are also situations caused by human behavior, the adoption of certain decisions, a certain course of events (divorce, change of place of work or place of residence, etc.), as well as conflicts. Each of these situations can cause spiritual discomfort.

7.2. Conflict psychology

A conflict is a collision of opposing interests (goals, positions, opinions, attitudes, etc.) on the basis of rivalry; the lack of understanding on various issues is associated with acute emotional experiences.

The conflict situation is the accumulated contradictions associated with the activities of the subjects of social interaction and creating the basis for a real confrontation between them. Conflict gene is any word or action that touches the interlocutor, offensive gestures, an offensive look, a refusal to continue communication, which can lead to a conflict situation and develop into a conflict. Conflict gene is a provocative factor.

An incident is a collision of the parties, an unpleasant incident caused by some action or statement of one of the parties, perceived by the other as threatening its interests.

Structural elements of the conflict

1. Parties to a conflict are subjects of social interaction that are in a state of conflict or explicitly or implicitly supporting the conflicting.

2. The subject of the conflict is the issue which causes the conflict.

3. The image of a conflict situation is a display of the subject of the conflict in the minds of the subjects of conflict interaction.

4. The motives of the conflict are internal motivating forces pushing the subjects of social interaction to the conflict (motives appear in the form of needs, interests, goals, ideals, beliefs).

5. The positions of the conflicting parties are what they declare to each other during the conflict or in the negotiation process.

Conflicts perform various functions. The main ones are destructive, constructive and diagnostic. The destructive function manifests itself in the negative consequences of the conflict: hostility, emotional tension, mental trauma, violations of the law, morality, discipline, military clashes, and pathogenic consequences. The constructive function of a conflict is to overcome the difficulties and crises. Positive conflict contributes to the affirmation of socially positive norms of communication, a situation of mutual exactingness, leads to the abandonment of pro-rational actions, an increase in the level of organization, and an improvement in the psychological climate.

The main stages of the conflict

1. The emergence and development of a conflict situation. A conflict situation is created by one or several subjects of social interaction and is a prerequisite for conflict.

2. Awareness of a conflict situation by at least one of the participants in social interaction and the emotional experience of this fact. Consequences and external manifestations of such awareness and related emotional experiences can be: a change in mood, critical and unfriendly statements about a potential adversary, restriction of contacts with him, etc.

3. Beginning of open conflict interaction. This stage is expressed in the fact that one of the participants of social interaction, who realized the conflict situation, moves to active actions (in the form of a demarche, statements, warnings, etc.) aimed at damaging the "enemy". At the same time, the other participant is aware that these actions are directed against him, and, in turn, is taking an active response against the initiator of the conflict.

4. Development of an open conflict. At this stage, the parties to the conflict openly declare their positions and make demands. However, they may not be aware of their own interests and do not understand the essence and subject of the conflict.

5. Conflict resolution. Depending on the content, the resolution of the conflict can be achieved by two methods (means): pedagogical (talk, persuasion, request, clarification, etc.) and administrative (transfer to another job, dismissal, decisions of commissions, order of the head, court decision, etc.)

Brief description of conflict resolution types

According to these two main dimensions K. Thomas identifies the following methods of conflict management:

1. Rivalry (competition, competition) as the desire to achieve the interests at the expense of the other.

2. Adaptation, meaning, in contrast to rivalry, the sacrifice of one's own interests for the sake of the other.

3. Compromise.

4. Avoidance, which is characterized by a lack of desire for cooperation, and the lack of a tendency to achieve their own goals.

5. Cooperation, when the participants in the situation come to an alternative that fully satisfies the interests of both parties.

The person using the style of *competition (rivalry)* is active and prefers to go to the resolution of the conflict in his own way. He is not interested in cooperating with others and reaches the goal using his volitional qualities. He tries, first of all, to satisfy his own interests to the detriment of the interests of others, forcing them to take the solution he needs.

The style of *avoidance* means that the individual does not assert his rights, does not cooperate with anyone to come up with a solution, or shies away from resolving the conflict. This is done by avoiding the problem (leaving the room, changing the topic, etc.), ignoring it, shifting responsibility for the decision to another, postponing the decision, etc.

Adaptation is an action together with another person without an attempt to defend one's own interests. In contrast to evasion, this style takes part in the situation and agrees to do what the other wants. This is a style of concessions, consent and sacrificing self-interest.

The one who follows the style of *cooperation*, actively participates in the resolution of the conflict and defends his interests, but at the same time tries to cooperate with another person. This style is more time-consuming than the others, since the needs, concerns and interests of both parties are advanced, and then they are discussed. This is a good way to satisfy the interests of both parties, which requires an understanding of the causes of the conflict and a joint search for new alternatives to solve it. Among other styles *cooperation* is the most difficult, but the most effective style in complicated and important conflict situations.

When using the *compromise* style, both sides are a little inferior in their interests in order to satisfy them in the rest, often the main things. This is done by bargaining and exchange, concessions. In contrast to cooperation, a compromise is reached at a more superficial level – one is inferior in something, the other party also subsides, as a result, it is possible to arrive at a common solution. In a compromise, there is no search for hidden interests; only what everyone says about his desires is *considered*. In this case, the causes of the conflict are not affected. There is not a search for their elimination, but finding a solution that satisfies the short-term interests of both parties.

Conditions for constructive conflict resolution

1. Termination of conflict interaction.
2. Search for close or even common points of contact (conflict map).
3. Reducing the intensity of negative emotions.
4. Elimination of the "image of the enemy".
5. An objective look at the problem.
6. Taking into account each other's statuses.
7. Choosing the optimal resolution strategy.

Factors for constructive conflict resolution

– time: reducing time is likely to leads to choosing aggressive behavior

– third party: the participation of third parties seeking to resolve the conflict leads to a more peaceful course and speedy resolution

– timeliness: the earlier the parties get down to the settlement, the better

– balance of power: if the sides are approximately equal, they have no other choice. In addition to finding a compromise

– experience: having experience in resolving a conflict, at least at one of the parties leads to an acceleration of its resolution

– relations: good relations between the parties before the conflict speeds up its resolution

Emotionally challenging situations behaviour

Tension Reduction	Tension Boost
Providing a partner with the opportunity to speak out	Interrupting partner
Verbalization of the emotional state: – one's own; – partner's	Ignoring the emotional state: – one's own; – partner's
Emphasizing unity with a partner (similarity of interests, opinions, unity of purpose, etc.).	Emphasizing differences between oneself and the partner, minimizing the other's contribution to common affairs and exaggerating one's own.
Showing interest in partner problems.	Demonstration of disinterest in the problem of the partner.
Emphasizing the importance of a partner, his opinions in your eyes.	Downgrading the partner, negative assessment of the partner's identity.
If you are wrong, immediately recognizing it.	Postponing of the moment of recognition of one's wrongfulness or denial of it.
Offering a concrete way out of this situation.	Searching for the guilty and charging the partner.
Appealing to the facts.	The transition to "personality."
Calm confident pace of speech.	A sharp increase in the rate of speech (the transition to the cry).
Maintaining optimal distance, angle of rotation and eye contact.	Avoiding spatial proximity and tilting of the body.

Test questions

1. List the sources of organizational stress.
2. Define a conflict; list its structural elements and stages.
3. Characterize the ways of behavior in the conflict.
4. List the conditions and factors for constructive resolution of conflict situations.

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8. Psychotherapy, Psycho-hygiene and Psycho Prophylaxis

8.1. The concept of psychotherapy and its role in medicine

Psychological intervention is a psychological intervention in a person's personal space, the purpose of which is to stimulate certain positive changes. Interventions in medicine can be:

- drug (pharmacotherapy);
- surgical (surgery);
- physical (physiotherapy);
- psychological (psychotherapy).

Psychological interventions can be: *teacher-psychological* (pedagogical psychology), *labor and organizational-psychological* (labor psychology and organizational psychology), *clinical psychological* (clinical psychology).

Types of psychological intervention

1. *Psychological correction* – directed psychological impact on certain psychological structures in order to ensure the full development and functioning of the individual (in the West is similar to the concept of "psychological intervention", in Russia – the concept of "psychotherapy").

2. *Psychological counseling* – professional assistance to a person or group of people (organization) in finding ways to resolve or solving a certain difficult or problematic situation. The main directions of psychological counseling are:

- problem-oriented, focusing on the analysis of the nature and external causes of the problem, finding ways to solve it;
- personality-oriented, aimed at analyzing individual, personal causes of problem and conflict situations and ways to prevent them in the future (near PT);
- resource oriented to solve the problem.

3. Psychotherapy is a system of psychological influence on the psyche of an individual in order to achieve harmonious biological and social functioning.

Methods of psychotherapy:

– as specific methods or techniques (hypnosis, relaxation, conversation, discussion, psycho-gymnastics);

– in the sense of defining conditions (SPT, inpatient and outpatient psychotherapy);

– in the meaning of the main impact tool (IPT, GPT);

– in the meaning of therapeutic interventions, which are considered in the parameters of style (prescriptive and non-directive) or the theoretical approach, which determines the nature of these interventions (interpretation, learning, interpersonal interaction).

The main directions of psychotherapy

Direction	**Basic theoretical principles**
Psycho analytic direction	The essence of man is determined by the psychic energy of a sexual nature and the experience of early childhood. The basis of the personality structure consists of three instances: id, ego and superego. Behavior is motivated by aggressive and sexual motives. Pathology arises from conflicts suppressed in childhood. Normal development is based on the timely alternation of the stages of sexual development and integration
Adlerian direction	The positive nature of man is emphasized. Every person in his early childhood forms a unique lifestyle; a person creates his own destiny. Human behavior is motivated by the desire to achieve goals and social interests. Life difficulties contribute to the formation of an unfavorable lifestyle. Normal personality development implies adequate lifegoals.
Behavior Therapy	Man is a product of the environment and at the same time its creator. Behavior is formed in the learning process. Normal behavior is taught through reinforcement and imitation. Problems arise as a result of poor learning.

Direction	Basic theoretical principles
Rational-emotional therapy (A. Ellis)	A person is born with a tendency to rational thinking, but at the same time with a tendency to paralogicality. He may become a victim of irrational ideas. Life problems arise because of erroneous beliefs. The basis of normal behavior are rational thinking and timely correction of decisions
Customer-oriented therapy (C. Rogers)	The positive nature of man is emphasized – his innate desire for self-realization. Problems arise when driving out certain feelings from the field of consciousness and distorting the evaluation of experience. The basis of mental health is constituted by the correspondence of the "ideal Self" – to the "real Self", achieved by the realization of the potential of one's own personality, and the striving for self-knowledge, self-confidence, spontaneity.
Existential therapy	The focus is on a person's ability to experience his inner world, freely choose his fate, responsibility and existential anxiety as the main motivating factor, search for a unique meaning in a meaningless world, loneliness and relationships with others, life temporality and the problem of death. Normal personality development is based on the uniqueness of each individual.

8.2. The concept of psycho correction, psycho-hygiene and psycho prophylaxis

Psychological correction is a directional psychological impact for the full development and functioning of the individual. The task of psychological correction is to develop and master the skills optimal for the individual and effective for maintaining the health of mental activity that promotes personal growth and human adaptation in society (Mendelevich V.D., 1998).

The term "psychological correction" was extended in the early 1970s of the twentieth century. During this period, psychologists began to work actively in the field of psychotherapy, primarily

group. Long discussions about whether a psychologist can be engaged in medical (psychotherapeutic) work have been mainly theoretical. In practice, psychologists not only wanted, could and successfully implemented this opportunity, but at the time, at the expense of basic psychological education, were more prepared for this kind of activity, at least, to work as group psychotherapists. But since psychotherapy is a medical practice, and according to the law, only a doctor with higher medical education can deal with it, the extension of the term "psychological correction" was to a certain extent aimed at overcoming this situation: the doctor is engaged in psychotherapy, and the psychologist is engaged in psychological correction. However, the question of the relationship between the concept of "psychotherapy" and "psychological correction" remains open today.

Psychohygiene is a system of special events designed to preserve and strengthen the mental health of a person and society as a whole. In a broad sense, it is a branch of medical knowledge that studies factors and environmental conditions that influence mental development and the mental state of a person and develops recommendations for the preservation and strengthening of mental health.

The content of mental health is a system of measures aimed at improving human environment, as well as improving stability of mental health and mental resistance to the action of various pathogenic factors. Mental health means well-being of the whole body.

Methods of mental hygiene and psycho-prophylaxis: psycho-correctional work within the framework of counseling centers, "hotlines" and other organizations focused on psychological help to healthy people; mass surveys to identify so-called risk groups and preventive work with them; public awareness, etc.

Thus, mental health as a scientific branch of hygiene examines the state of the neuropsychic health of the population, its dynamics due to the influence of various environmental factors (natural, industrial, social) on the human body, and develops based on these studies scientifically-reasoned measures of active influence on the environment and functions of the human body in order to create the most favorable conditions for the preservation and strengthening of

human health. Until recently, the duty of hygiene as a science was mainly to study the impact of external conditions on the somatic health of a person; however, at present the subject of its main concerns is the analysis of the influence of the environment on the neuropsychic status of the population, and especially the younger generation. The principles of mental hygiene are the most reasonable and advanced, the initial position of which is based on the idea that the world is material in nature that matter is in constant motion, that mental processes are the product of higher nervous activity and are carried out according to the same laws of nature. In mental health there are the following sections:

- age-specific psychiatry;
- psycho-hygiene of life;
- psycho-hygiene of family life;
- psycho-hygiene of work and education.

The section on age-related psycho-hygiene includes psycho-hygienic studies and recommendations related primarily to childhood and old age, since the differences in the psyche of a child, adolescent, adult and elderly person are significant. The psycho-hygiene of childhood should be based on the peculiarities of the child's psyche and ensure the harmony of its formation. It is necessary to take into account that the developing nervous system of the child reacts sensitively to the slightest physical and mental effects, therefore the importance of proper and sensitive child rearing is great. The main conditions of education are:

- development and training of braking processes,
- nurturing emotions
- learning to overcome difficulties.

Psycho-hygienic problems have their own specifics in the elderly and senile age, when, against the background of a decrease in the intensity of metabolism, the overall performance, functions of memory and attention decrease, characterological personality traits are sharpened. The psyche of an elderly person becomes more vulnerable to mental trauma, breaking the stereotype is especially painful.

Maintaining mental health in old age is promoted by the observance of general hygienic rules and daily routine, walks in the fresh air, and tireless work.

Psychohygiene of daily life. A person spends most of the time in communication with other people. Kind words, friendly support and participation contribute to cheerfulness, good mood. And on the contrary, rudeness, harsh or dismissive tone can become a psycho trauma, especially for sensitive people.

A friendly and cohesive team can create a favorable psychological climate. People who "take everything too close to the heart," give undeserved attention to trifles, do not know how to inhibit negative emotions. They should cultivate the right attitude towards the inevitable difficulties in everyday life. To do this, you need to learn to correctly assess what is happening, manage your emotions, and when necessary, suppress them.

Psychohygiene of family life. The family is a group in which the foundations of the personality are laid, its initial development takes place. The nature of the relationship between family members significantly affects the fate of a person and therefore has an enormous vital importance for each person and for society as a whole.

A favorable atmosphere in the family is created with mutual respect, love, friendship, and common views. Emotional communication, mutual understanding and pliability have a great influence on the formation of family relations. Such environment contributes to the creation of a happy family – an indispensable condition for the proper upbringing of children.

Psychohygiene of work and education. A person spends much of his time at work, therefore an emotional relationship to work is important. The choice of profession is a crucial step in the life of every person; therefore it is necessary that the chosen profession should correspond to the interests, abilities and preparedness of the individual. Only with this, work can bring positive emotions: joy, moral satisfaction, and ultimately, mental health.

In the mental hygiene of labor, an important role is played by industrial aesthetics: the modern forms of machines; comfortable workplace, well decorated rooms. It is advisable to have rooms for rest and psychological relaxation rooms, reducing fatigue and improving the emotional state of workers.

The mental health of mental labor is important. Mental work is associated with a high consumption of nervous energy. In the process

of mental activity attention, memory, thinking, creative imaginationare mobilized. People of school and student age are closely associated with learning. Improper organization of classes can cause overwork and even a nervous breakdown, especially often occurring during the exam period.

In protecting the health of the younger generation, the mental hygiene of school classes plays a leading role, since almost all children study for 10 years, and 2 dangerous crises (7-8 years and puberty 13-15 years) can occur during these years, when growing body is especially reactive and most susceptible to neurotic effects.

Psycho-prophylaxis is a branch of medicine that develops measures to prevent the occurrence of mental illness or its transition to a chronic course.

Using the data of mental hygiene, psycho-prophylaxis develops a system of measures leading to a reduction in neuropsychiatric morbidity and contributing to their implementation in life and health care practice. Methods of psycho-prophylaxis include the study of the dynamics of the neuro-psychological state of a person in the process of work, as well as in everyday life. Psycho prophylaxis is usually divided into individual and social, and, primary, secondary and tertiary.

Primary prevention includes complex of events, aimed at preventing the very fact of the occurrence of the disease. This includes a broad system of legislative measures to protect public health. Secondary prevention is the maximum detection of the initial manifestations of mental diseases and their active treatment, i.e. this type of prevention, which contributes to a more favorable course of the disease and leads to more rapid recovery.

Tertiary prevention is the prevention of recurrence, achieved by carrying out activities aimed at eliminating the factors that impede the patient's work activity.

The efforts of doctors and teachers unite in order to carry out the relevant psycho-hygienic and psycho-prophylactic work in relation to the education of the younger generation.

Mental health is one of the main indicators of the health of society and the nation as a whole. Psycho-prophylaxis solves the following tasks:

1. Taking into account that the psychogenic origin of many mental disorders, as well as diseases of the cardiovascular, immune and endocrine systems, and the gastrointestinal tract can now be considered proven, measures to protect human health from their painful effects. The most important here are people from the risk group:

– with varying degrees of stress adaptation mechanisms, but without signs of depletion;

– with signs of exhaustion;

2. Early detection, diagnosis and complex treatment of neuropsychiatric disorders;

3. Prevention of relapse and the transition of the disease in a protracted or chronic form.

The most important tasks of psycho-prophylaxis are the organization and upbringing of a healthy lifestyle for people, improvement of their life, working conditions, overcoming psychocratic situations, refusal from acute and chronic alcoholic and drug intoxication. The questions of mental hygiene and psycho-prophylaxis should not be based on the "what is good and what is bad" dilemma, but be a serious program of preserving health and an optimal lifestyle. These issues deal with valeology. A way of thinking, including the idea of health, generates a favorable reaction of the body. Waiting for the deterioration of health contributes to the development of an already begun pathological process.

It is useful to visualize the positive result that you want to get. The process of visualization is the process of creating with the help of the imagination an image of the desired, an attempt to see, hear, feel the desired as if it had already happened, became a reality. It is useful to create an image of a positive goal that you want to achieve. The image of the goal is created at the turn of growth, as some next point to which a person moves along the path of his own development. The real assessment of its growth line does not allow considerations to slip into fantasies that are not destined to be realized. It makes no sense, perhaps, to dream that it is absolutely impossible (to live forever, to become younger, to have other parents, to be born in another country).

To maintain a positive mindset, it is useful to use positive statements that get in your eyes (on paper) or are periodically

pronounced (especially during the awakening period from sleeping or falling asleep).

Visualization combined with positive affirmations is widely used to maintain a positive mindset. In Western countries, the process of imaging is now being trained by the staff of clinics working with patients suffering from oncological diseases. It is also necessary for the nurse to cultivate a positive outlook on life and to maintain positive images in the patient, to support his hope.

Creating conditions for positive experiences:

1. Art therapy – assisting with the help of art. The therapeutic effect of music, color, architecture has long been known. But art should be distinguished from popular culture. Bad music sores head, mass pop music dulls, tires.

2. Music therapy is a universal language of feelings. Modern studies of the influence of music on a person suggest considering the patient's musical culture, his tastes, individual perception of music, attitude to music in general, and specifically to this musical work, as well as to its performer, the patient's current state, age, gender, and other factors. The musical impact is highly individualized and it is better for the patient to listen to music through headphones, so as not to disturb others. Music affects mood, reduces anxiety, tension.

3. Functional music is the background music on the periphery of consciousness. The music should be pleasant, rhythmic, to bring pleasure, to cause a state of slight excitement.

4. Bibliotherapy – a type of psychotherapy that uses an art book as a form of treatment with the word enclosed in an art form. It assumes a positive impact on a person with the help of books, which can contribute to the development of personal qualities, raise mood, distract from pain.

5. Color therapy – effects on a person with the help of color. The color of the room, clothing affects the emotional state of patients. Features of color perception depend on the individual characteristics of a person, culture.

6. Aromatherapy – a positive effect on a person through odors. The body reacts instantly if a smell causes pleasant or unpleasant associations and memories.

7. Nature psychotherapy – positive emotional impact of nature on a person (sanatorium-resort treatment). Positive effect: positive

emotional impact, calming, distracting, activating effects, aesthetic impact of nature.

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CHAPTER 2. Practical Course

1. Psychological health

1.1. Preliminary and additional reading

Please read the following articles prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from these articles topics during the discussion.

DO SOCIAL TIES AFFECT OUR HEALTH?

Cuddles, kisses, and caring conversations. These are key ingredients of our close relationships. Scientists are finding that our links to others can have powerful effects on our health. Whether with romantic partners, family, friends, neighbors, or others, social connections can influence our biology and well-being.

Wide-ranging research suggests that strong social ties are linked to a longer life. In contrast, loneliness and social isolation are linked to poorer health, depression, and increased risk of early death.

Studies have found that having a variety of social relationships may help reduce stress and heart-related risks. Such connections might improve your ability to fight off germs or give you a more positive outlook on life. Physical contact—from hand-holding to sex—can trigger release of hormones and brain chemicals that not only make us feel great but also have other biological benefits.

Marriage is one of the most-studied social bonds. “For many people, marriage is their most important relationship. And the evidence is very strong that marriage is generally good for health,” says Dr. Janice Kiecolt-Glaser, an expert on health and relationships at Ohio State University. “But if a relationship isn’t going well, it could have significant health-related consequences.”

Married couples tend to live longer and have better heart health than unmarried couples. Studies have found that when one spouse improves his or her health behaviors—such as by exercising, drinking or smoking less, or getting a flu shot—the other spouse is likely to do so, too.

When marriages are full of conflict, though, such health benefits may shrink. In NIH-funded studies, Kiecolt-Glaser and her

colleagues found that how couples behave during conflict can affect wound healing and blood levels of stress hormones. In a study of more than 40 married couples, the researchers measured changes to body chemistry over a 24-hour period both before and after spouses discussed a conflict. The troublesome topics included money, in-laws, and communication.

"We found that the quality of the discussion really mattered," Kiecolt-Glaser says. Couples who were more hostile to each other showed much larger negative changes, including big spikes in stress hormones and inflammation-related molecules. "In the more well-functioning marriages, couples might acknowledge that they disagree, or find humor in the situation, but they don't get sarcastic or roll their eyes when the other is talking," Kiecolt-Glaser says. In a related study, blister wounds healed substantially more slowly in couples who were nastier to each other than in those who were kinder and gentler during difficult discussions.

Couples with the "double-whammy" of hostile marriages and depression may also be at risk for weight problems. After eating a high-fat meal and discussing a difficult topic, these troubled couples tended to burn fewer calories than less hostile counterparts. "The metabolism in these couples was slower in ways that could account for weight gain across time," Kiecolt-Glaser says. Compared to the kinder couples, the distressed spouses had signs of more fat storage and other risks for heart disease.

The quality of a marriage—whether supportive or hostile—may be especially important to the health of older couples. Dr. Hui Liu at Michigan State University studied data on the health and sexuality of more than 2,200 older people, ages 57 to 85. Good marriage quality, she found, is linked to reduced risk of developing cardiovascular disease, while bad marriage quality is tied to increased risk, particularly in women. "The association between marriage quality and heart health becomes increasingly strong at older ages," Liu says.

Liu and colleagues are also looking at the links between late-life sexuality and health, including whether sex among the very old is beneficial or risky to heart health. "Some people assume that sex isn't important in older ages, so those ages are often overlooked in research studies related to sex," Liu says. "But our studies suggest that for many older people, sex quality and sex life are important to overall quality of life."

In one recent analysis, Liu and co-workers found that older women who reported having a satisfying sex life were at reduced risk for high blood pressure 5 years later. But the researchers also found that some older men, ages 57 to 85, were at increased risk for certain heart-related problems after 5 years if they reported having frequent (at least once a week) or extremely enjoyable sex. The reasons for these increased risks aren't clear and are still under study. Experts suggest that older men and women talk with their doctors about concerns related to sexual issues or potential health risks. <…>

Other types of relationships are important, too. These can include friends, family, neighbors, co-workers, clubs, and religious groups. Studies have found that people who have larger and more diverse types of social ties tend to live longer. They also tend to have better physical and mental health than people with fewer such relationships. Social support may be especially protective during difficult times.

Dr. Sheldon Cohen, a psychologist at Carnegie Mellon University in Pittsburgh, has been exploring the links between relationships and health for more than 3 decades. In one study, his team exposed more than 200 healthy volunteers to the common cold virus and observed them for a week in a controlled setting. "We found that the more diverse people's social networks—the more types of connections they had—the less likely they were to develop a cold after exposure to the virus," Cohen says. He and his team have since found evidence that people with more types of connections also tend to have better health behaviors (such as not smoking or drinking) and more positive emotions.

The scientists have also been exploring whether simply believing you have strong social support may help protect against the harms of stress. "Long-term conflicts with others are a potent stressor that can affect health. But we've found that its effects are buffered by perceived social support," Cohen says. "People who have high levels of conflict and low levels of social support are much more likely to get sick when exposed to a virus. But those with high conflict and high levels of social support seem protected." In addition, hugging seemed to shield against stress. People who reported having more frequent hugs were less likely to develop an infection after viral exposure.

Social ties can have mixed effects on our health. But overall, research suggests that the benefits of interactions with others can outweigh any risks. "It's generally healthy for people to try to belong

to different groups, to volunteer in different ways, and be involved with a church or involved in their neighborhood," Cohen says. "Involvement with other people across diverse situations clearly can have a very potent, very positive effect on health."

Source: *NIH: News in Health. February 2017. Pp. 1-2. https://newsinhealth.nih.gov/issue/Feb2017/Feature1*

MENTAL HEALTH: WHAT'S NORMAL, WHAT'S NOT

Understanding what's considered normal mental health can be tricky. See how feelings, thoughts and behaviors determine mental health and how to recognize if you or a loved one needs help.

What's the difference between mental health and mental illness? Sometimes the answer is clear, but often the distinction between mental health and mental illness isn't so obvious. For example, if you're afraid of giving a speech in public, does it mean you have a mental health condition or a run-of-the-mill case of nerves? Or, when does shyness become a case of social phobia?

Here's help understanding how mental health conditions are identified.

Why is it so tough to tell what's normal?

It's often difficult to distinguish normal mental health from mental illness because there's no easy test to show if something's wrong. Also, primary mental health conditions can be mimicked by physical disorders.

Mental health conditions aren't due to a physical disorder and are diagnosed and treated based on signs and symptoms, as well as on how much the condition affects your daily life. For example, a mental health condition can affect your:

- **Behavior**. Obsessive hand-washing or drinking too much alcohol might be a sign of a mental health condition.
- **Feelings**. Sometimes a mental health condition is characterized by a deep or ongoing sadness, euphoria or anger.
- **Thinking**. Delusions — fixed beliefs that aren't changeable in light of conflicting evidence — or thoughts of suicide might be symptoms of a mental health condition.

What is the Diagnostic and Statistical Manual of Mental Disorders (DSM)?

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a guide published by the American Psychiatric Association

that explains the signs and symptoms of several hundred mental health conditions.

Mental health providers use the DSM to diagnose everything from anorexia to voyeurism and, if necessary, determine appropriate treatment. Health insurance companies also use the DSM to determine coverage and benefits and to reimburse mental health providers.

How do mental health providers diagnose mental health conditions?

To determine if you have a mental health condition, a mental health provider will work with you and your loved ones to assess your symptoms, including when they began and how they've affected your life.

Your mental health provider is likely to ask about:

– **Your perceptions.** How much your signs and symptoms affect your daily activities can help determine what's normal for you. For instance, you might realize that you aren't coping well or that you don't want to do the things you used to enjoy. You might feel sad, hopeless or discouraged.

If your sadness has a specific cause, such as divorce, your feelings could be a normal, temporary reaction. However, if you have symptoms that are severe or don't go away, you could have depression. You might also need to have a physical exam to rule out any underlying health conditions.

– **Others' perceptions.** Your perceptions alone might not give you an accurate picture of your behavior, thoughts or ability to function. Other people in your life can help you understand whether your behavior is normal or healthy.

For example, if you have bipolar disorder, you might think your mood swings are just part of the normal ups and downs of life. Your thoughts and actions, however, might appear abnormal to others or cause problems at work, in relationships or in other areas of your life.

When is an evaluation or treatment needed?

Each mental health condition has its own signs and symptoms. In general, however, professional help might be needed if you experience:

– marked changes in personality, eating or sleeping patterns;
– an inability to cope with problems or daily activities;
– strange or grandiose ideas;
– excessive anxiety;

– prolonged depression or apathy;
– thinking or talking about suicide;
– substance abuse;
– extreme mood swings or excessive anger, hostility or violent behavior.

Many people who have mental health conditions consider their signs and symptoms a normal part of life or avoid treatment out of shame or fear. If you're concerned about your mental health, don't hesitate to seek advice.

Consult your family doctor or make an appointment with a counselor or psychologist. With appropriate support, you can identify mental health conditions and explore treatment options, such as medications or counseling.

***Source**: http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/mental-health/art-20044098*

1.2. Topics for discussion

Read the provided article discussing the matter of mental health.

WHAT IS MENTAL HEALTH?

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Over the course of your life, if you experience mental health problems, your thinking, mood, and behavior could be affected. Many factors contribute to mental health problems, including:

– **biological factors**, such as genes or brain chemistry;
– **life experiences**, such as trauma or abuse;
– **family history** of mental health problems.

Mental health problems are common but help is available. People with mental health problems can get better and many recover completely.

Early Warning Signs

Not sure if you or someone you know is living with mental health problems? Experiencing one or more of the following feelings or behaviors can be an early warning sign of a problem:

– eating or sleeping too much or too little;
– pulling away from people and usual activities;

– having low or no energy;
– feeling numb or like nothing matters;
– having unexplained aches and pains;
– feeling helpless or hopeless;
– smoking, drinking, or using drugs more than usual;
– feeling unusually confused, forgetful, on edge, angry, upset, worried, or scared;
– yelling or fighting with family and friends;
– experiencing severe mood swings that cause problems in relationships;
– having persistent thoughts and memories you can't get out of your head;
– hearing voices or believing things that are not true;
– thinking of harming yourself or others;
– inability to perform daily tasks like taking care of your kids or getting to work or school.

<…>

Mental Health and Wellness

Positive mental health allows people to:
– realize their full potential;
– cope with the stresses of life;
– work productively;
– make meaningful contributions to their communities.
– Ways to maintain positive mental health include:
– getting professional help if you need it;
– connecting with others;
– staying positive;
– getting physically active;
– helping others;
– getting enough sleep;
– developing coping skills.

***Source**: https://www.mentalhealth.gov/basics/what-is-mental-health*

Please answer the following questions:

– Could you find any early warning signs in your own behavior and/or state of mind?

– If no, do you know any person displaying early warning signs in their behavior?

– Could you try to determine the reasons behind these behavioral changes?

– Are these behavioral changes stable or they're caused by situational factors?

October 10th is proclaimed as World Mental Health Day: *http://www.who.int/mental_health/world-mental-health-day*. Please get familiar with World Health Organization's World Mental Health Day theme for current (or past) year and answer the following questions:

– In your opinion, why it is important to raise awareness and bring attention to specific aspects of mental health and mental illness?

– Provide arguments for this (past) year's Mental Health Day theme importance, including benefits for affected persons, mental health specialists and general population overall.

1.3. Questionnaires and psychological tests

THE HEALTH ORIENTATION SCALE (HOS)

Instructions

The items listed below refer to people's health. Please read each item carefully and decide to what extent it is characteristic of you. Give each item a rating of how much it applies to you by using the following scale:

– **0** = Not at all characteristic of me.
– **1** = Slightly characteristic of me.
– **2** = Somewhat characteristic of me.
– **3** = Moderately characteristic of me.
– **4** = Very characteristic of me.

Remember to respond to all items, even if you are not completely sure. Your answers will be kept in the strictest confidence. Also, please be honest in responding to these statements.

1. I am very aware of how healthy my body feels.
2. I sometimes wonder what others think of my physical health.
3. I feel anxious when I think about my health.
4. I feel confident about the status of my health.
5. I do things that keep me from becoming physically unhealthy.

6. I'm very motivated to be physically healthy.
7. I feel like my physical health is something that I myself am in charge of.
8. The status of my physical health is determined mostly by chance happenings.
9. I expect that my health will be excellent in the future.
10. I am in good physical health.
11. I notice immediately when my body doesn't feel healthy.
12. I'm very concerned with how others evaluate my physical health.
13. I'm worried about how healthy my body is.
14. I rarely become discouraged about my health.
15. I am motivated to keep myself from becoming physically unhealthy.
16. I'm strongly motivated to devote time and effort to my physical health.
17. My health is something that I alone am responsible for.
18. The status of my physical health is controlled by accidental happenings.
19. I believe that the future status of my physical health will be positive.
20. My body is in good physical shape.
21. I'm sensitive to internal bodily cues about my health.
22. I'm very aware of what others think of my physical health.
23. Thinking about my health leaves me with an uneasy feeling.
24. I am pleased with how well and healthy I feel.
25. I try to avoid engaging in behaviors that undermine my physical health.
26. I have a strong desire to keep myself physically healthy.
27. The status of my physical health is determined largely by what I do (and don't do).
28. Being in good physical health is just a matter of luck.
29. I do not expect to suffer health problems in the future.
30. I am a well-exercised person.
31. I know immediately when I'm not feeling in great health.
32. I'm concerned about how my physical health appears to others.
33. I usually worry about whether I am in good health.
34. I have positive feeling about my health.
35. I really want to prevent myself from getting out of shape.

36. It's really important to me that I keep myself in proper physical health.

37. What happens to my physical health is my own doing.

38. Being in excellent physical shape has little or nothing to do with luck.

39. I will probably experience a number of health problems in the future.

40. My body needs a lot of work in be in excellent physical shape.

41. I'm very aware of changes in my physical health.

42. I'm concerned about what other people think of my physical health.

43. I feel nervous when I think about the status of my physical health.

44. I feel that I have handled my health very well.

45. I am really motivated to avoid being in terrible physical shape.

46. I strive to keep myself in tip-top physical shape.

47. Being in good physical health is a matter of my own ability and effort.

48. I don't believe that chance or luck play any role in the status of my physical health.

49. I anticipate that my physical health will deteriorate in the future.

50. My physical health is in need of attention.

Scoring Instructions

The Health Orientation Scale (HOS) consists of10 health-oriented subscales, each containing five items. Reverse items (0 = 4, 1 = 3 etc.) are marked with (*):

1. **Personal Health Consciousness** (*items 1, 11, 21, 31 and 41*). The items on the Personal Health Consciousness (PHC) subscale refer to an awareness of one's health. These items were designed to measure people's tendency to think about and to reflect about their health. People who endorse these items are those who think about that status of their physical health, and who in general are reflective about the nature of the health and wellness of their body.

2. **Health Image Concern** (*items 2, 12, 22, 32 and 42*). The items on the Health Image Concern (HIC) subscale refer to an awareness of other people's reactions to one's health. More specifically, these items were designed to measure people's public concern about the image which their health (or lack thereof) projects

to others. People who endorse these items are those who are concerned about the appearance of their health to others, the impression their health makes on others, and how healthy and well others consider them to be.

3. **Health Anxiety** (*items 3, 13, 23, 33 and 43*). The items on the Health Anxiety (HA) subscale refer to anxious feelings associated with the status of one's health. More specifically, these items were designed to tap people's feelings of tension, discomfort and anxiety about their physical health. People who endorse these items are those who experience chronic anxiety as a result of thinking about their physical health.

4. **Health-Esteem and Confidence** (*items 4, 14*, 24, 34 and 44*). The items on the Health-Esteem and Confidence (HEC) subscale were designed to measure the extent to which people derive a sense of esteem from the physical status of their body, and the extent to which they feel confident about their physical health. More specifically, these items are concerned with how positive individuals feel about their physical wellness. People who endorse these items are those who feel good about the health status of their bodies; they feel positive esteem about their health and they have an air of confidence that their health is robust and durable.

5. **Motivation to Avoid Unhealthiness** (*items 5, 15, 25, 35 and 45*). The items on the Motivation to Avoid Unhealthiness (MAU) subscale refer to motivational tendency to avoid being or becoming unhealthy. More specifically, these items were designed to measure people's motivational tendency to avoid poor physical health. People who endorse these items are those who are concerned about becoming unhealthy; they are motivated to avoid behaviors and activities which undermine their physical health.

6. **Motivation for Healthiness** (*items 6, 16, 26, 36 and 46*). The items on the Motivation for Healthiness (MFH) subscale refer to the motivation to pursue positive physical health. More specifically, these items were designed to measure people's motivation to keep in excellent physical health. People who endorse these items are those who are motivated to attend to the physical health of their body, to engage in activities which promote their physical health, and to strive to maintain the wellness and integrity of their physical health.

7. **Health Internal Control** (*items 7, 17, 27, 37 and 47*). The items on the Internal Health Control (IHC) subscale refer to people's belief that their health status is determined by their own personal control. More specifically, these items were designed to measure

people's expectation that they themselves can exert an influence on their health. People who endorse these items are those who believe that they can determine whether their physical health is positive or negative.

8. **Health External Control** (*items 8, 18, 28, 38* and 48**). The items on the External Health Control (EHC) subscale refer to people's belief that their health status is determined by experiences and influences outside of their personal control. More specifically, these items were designed to measure people's expectation that their health status is largely determined by forces which they themselves can neither anticipate nor influence. People who endorse these items are those who believe that their health is not controlled by themselves, rather than their physical health is under the influence of factors external to themselves.

9. **Health Expectations** (*items 9, 19, 29, 39* and 49**). The items on the Health Expectations (HE) subscale refer to an expectation that one will continue to experience positive physical health in the future. More specifically, these items were designed to measure people's belief that their health will continue to be excellent and robust. People who endorse these items anticipate that their future physical health will continue to be good.

10. **Health Status** (*items 10, 20, 30, 40* and 50**). The items on the Health Status (HS) subscale concerns people's assessment of the physical status of their body. More specifically, these items were designed to measure the extent to which people assess their body as being in excellent and robust health. People who endorse these items believe that they are in excellent physical health.

***Source**: Snell Jr W. E., Johnson G., Lloyd P.J., Hoover W. The development and validation of the Health Orientation Scale: A measure of psychological tendencies associated with health. European Journal of Personality, 1991, 5, pp. 169-183. http://www.midss.org/content/health-orientation-scale-hos*

DEPRESSION SCALE FROM PATIENT HEALTH QUESTIONNAIRE(NINE-SYMPTOM CHECKLIST, PHQ-9)

Instructions

Over the last 2 weeks, how often have you been bothered by any of the following problems? Give each item a rating of how much it applies to you by using the following scale:

– **0** = Not at all.
– **1** = Several days.
– **2** = More than half of the days.
– **3** = Nearly every day.

1. Little interest or pleasure in doing things.
2. Feeling down, depressed, or hopeless.
3. Trouble falling or staying asleep, or sleeping too much.
4. Feeling tired or having little energy.
5. Poor appetite or overeating.
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.
7. Trouble concentrating on things, such as reading the newspaper or watching television.
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.
9. Thoughts that you would be better off dead or of hurting yourself in some way.

If you checked off ***any*** problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

– Not difficult at all
– Somewhat difficult
– Very difficult
– Extremely difficult

PHQ-9 Scores

PHQ-9 total score for the nine items ranges from 0 to 27.Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively:

– **0…4** – none or minimal depression severity
– **5…9** – mild depression severity
– **10…14** – moderate depression severity
– **15…19** – Moderately severe depression severity
– **20…27** – Severe depression severity

The final question on the PHQ-9 asks the patients to report "how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient‘s global impression of symptom-related impairment. It may be useful in decisions regarding

initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

***Source**: Kroenke K., Spitzer R.L., Williams J.B.*
The PHQ-9: validity of a brief depression severity measure
J Gen Intern Med. 2001. Vol. 16(9), pp. 606-613.
doi: 10.1046/j.1525-1497.2001.016009606.x
https://www.pcpcc.org/resource/
patient-health-questionnaire-mental-health-tools
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268

2. Psychology of stress

2.1. Preliminary and/or additional reading

Please read the following article prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from the article topic during the discussion.

THE DIFFERENT KINDS OF STRESS

Adapted from "The Stress Solution"
by Lyle H. Miller, PhD, and Alma Dell Smith, PhD.

Stress management can be complicated and confusing because there are different types of stress — **acute stress**, **episodic acute stress**, and **chronic stress** — each with its own characteristics, symptoms, duration and treatment approaches. <…>

Acute stress

Acute stress is the most common form of stress. It comes from demands and pressures of the recent past and anticipated demands and pressures of the near future. Acute stress is thrilling and exciting in small doses, but too much is exhausting. A fast run down a challenging ski slope, for example, is exhilarating early in the day. That same ski run late in the day is taxing and wearing. Skiing beyond your limits can lead to falls and broken bones. By the same token, overdoing on short-term stress can lead to psychological distress, tension headaches, upset stomach and other symptoms.

Fortunately, acute stress symptoms are recognized by most people. It's a laundry list of what has gone awry in their lives: the auto accident that crumpled the car fender, the loss of an important

contract, a deadline they're rushing to meet, their child's occasional problems at school and so on.

Because it is short term, acute stress doesn't have enough time to do the extensive damage associated with long-term stress. The most common symptoms are:

– **emotional distress** — some combination of anger or irritability, anxiety and depression, the three stress emotions;

– **muscular problems** including tension headache, back pain, jaw pain and the muscular tensions that lead to pulled muscles and tendon and ligament problems;

– **stomach**, **gut** and **bowel problems** such as heartburn, acid stomach, flatulence, diarrhea, constipation and irritable bowel syndrome;

– **transient overarousal** leads to elevation in blood pressure, rapid heartbeat, sweaty palms, heart palpitations, dizziness, migraine headaches, cold hands or feet, shortness of breath and chest pain.

Acute stress can crop up in anyone's life, and it is highly treatable and manageable.

Episodic acute stress

There are those, however, who suffer acute stress frequently, whose lives are so disordered that they are studies in chaos and crisis. They're always in a rush, but always late. If something can go wrong, it does. They take on too much, have too many irons in the fire, and can't organize the slew of self-inflicted demands and pressures clamoring for their attention. They seem perpetually in the clutches of acute stress.

It is common for people with acute stress reactions to be over aroused, short-tempered, irritable, anxious and tense. Often, they describe themselves as having "a lot of nervous energy." Always in a hurry, they tend to be abrupt, and sometimes their irritability comes across as hostility. Interpersonal relationships deteriorate rapidly when others respond with real hostility. The workplace becomes a very stressful place for them.

The cardiac prone, "Type A" personality described by cardiologists, Meter Friedman and Ray Rosenman, is similar to an extreme case of episodic acute stress. Type A's have an "excessive competitive drive, aggressiveness, impatience, and a harrying sense of time urgency." In addition there is a "free-floating, but well-rationalized form of hostility, and almost always a deep-seated insecurity." Such personality characteristics would seem to create frequent episodes of acute stress for the Type A individual. Friedman

and Rosenman found Type A's to be much more likely to develop coronary heart disease than Type B's, who show an opposite pattern of behavior.

Another form of episodic acute stress comes from ceaseless worry. "Worry warts" see disaster around every corner and pessimistically forecast catastrophe in every situation. The world is a dangerous, unrewarding, punitive place where something awful is always about to happen. These "awfulizers" also tend to be over aroused and tense, but are more anxious and depressed than angry and hostile.

The symptoms of episodic acute stress are the symptoms of extended over arousal: persistent tension headaches, migraines, hypertension, chest pain and heart disease. Treating episodic acute stress requires intervention on a number of levels, generally requiring professional help, which may take many months.

Often, lifestyle and personality issues are so ingrained and habitual with these individuals that they see nothing wrong with the way they conduct their lives. They blame their woes on other people and external events. Frequently, they see their lifestyle, their patterns of interacting with others, and their ways of perceiving the world as part and parcel of who and what they are.

Sufferers can be fiercely resistant to change. Only the promise of relief from pain and discomfort of their symptoms can keep them in treatment and on track in their recovery program.

Chronic stress

While acute stress can be thrilling and exciting, chronic stress is not. This is the grinding stress that wears people away day after day, year after year. Chronic stress destroys bodies, minds and lives. It wreaks havoc through long-term attrition. It's the stress of poverty, of dysfunctional families, of being trapped in an unhappy marriage or in a despised job or career. It's the stress that the never-ending "troubles" have brought to the people of Northern Ireland, the tensions of the Middle East have brought to the Arab and Jew, and the endless ethnic rivalries that have been brought to the people of Eastern Europe and the former Soviet Union.

Chronic stress comes when a person never sees a way out of a miserable situation. It's the stress of unrelenting demands and pressures for seemingly interminable periods of time. With no hope, the individual gives up searching for solutions.

Some chronic stresses stem from traumatic, early childhood experiences that become internalized and remain forever painful and

present. Some experiences profoundly affect personality. A view of the world, or a belief system, is created that causes unending stress for the individual (e.g., the world is a threatening place, people will find out you are a pretender, and you must be perfect at all times). When personality or deep-seated convictions and beliefs must be reformulated, recovery requires active self-examination, often with professional help.

The worst aspect of chronic stress is that people get used to it. They forget it's there. People are immediately aware of acute stress because it is new; they ignore chronic stress because it is old, familiar, and sometimes, almost comfortable.

Chronic stress kills through suicide, violence, heart attack, stroke and, perhaps, even cancer. People wear down to a final, fatal breakdown. Because physical and mental resources are depleted through long-term attrition, the symptoms of chronic stress are difficult to treat and may require extended medical as well as behavioral treatment and stress management.

Source: *https://www.apa.org/helpcenter/stress-kinds.aspx*

2.2. Questionnaires and psychological tests

THE SCREEN FOR POSTTRAUMATIC STRESS SYMPTOMS (SPTSS)

Background information

The Screen for Posttraumatic Stress Symptoms (SPTSS) is a brief screen, not based on a single-reported trauma model, that may aid researchers and clinicians in identifying persons who have high levels of posttraumatic stress symptoms. Items for the SPTSS are designed to closely match the DSM-IV criteria for PTSD except that symptoms are not linked to a particular stressor. Items are written in simple, colloquial language making the instrument suitable for use with a wide variety of populations. There're several advantages of the SPTSS including its not linking the symptoms to a specific event, which allows it to be used with individuals who have experienced multiple stressful events, its focus on frequency rather than distress, which may increase its utility with individuals hesitant to report vulnerable emotions, its low reading level requirement, and the short duration required for administration.

Several versions of the SPTSS are available and inquire about the symptoms experienced over the past two or one weeks. Each version

contains 17 items and uses either a 10-point or, more often, 5-point frequency rating scale.

Instructions (original)

For each question, choose a number to tell how much that thing has happened to you in the past two weeks. Use the scale below to decide which number to put in the blank space. Put "0" if you never had the experience during the past two weeks, and put "10" if it was always happening to you or happened every day during the past two weeks. If it happens sometimes, but not every day, put in one of the numbers between "0"and "10" to show how much.

(never) 0 1 2 3 4 5 6 7 8 9 10 (always)

Instructions (modified version – one week)

For each question, choose a number to tell how much that thing has happened to you in the past week.

- **0** = not at all
- **1** = 1 or 2 times
- **2** = almost every day
- **3** = about once every day
- **4** = more than once every day

Instructions (modified version – two weeks)

For each question, choose a number to tell how much that thing has happened to you in the past two weeks.

- **0** = not at all
- **1** = 1 or 2 times
- **2** = almost every day
- **3** = about once every day
- **4** = more than once every day

1. I don't feel like doing things that I used to like doing.
2. I can't remember much about bad things that have happened to me.
3. I feel cut off and isolated from other people.
4. I try not to think about things that remind me of something bad that happened to me.
5. I feel numb: I don't feel emotions as strongly as I used to.
6. I have trouble concentrating on things or paying attention to something for a long time.

7. I have a hard time thinking about the future and believing that I'm going to live to old age.

8. I feel very irritable and lose my temper.

9. I avoid doing things or being in situations that might remind me of something terrible that happened to me in the past.

10. I am very aware of my surroundings and nervous about what's going on around me.

11. I find myself remembering bad things that happened to me over and over, even when I don't want to think about them.

12. I get startled or surprised very easily and «jump» when I hear a sudden sound.

13. I have bad dreams about terrible things that happened to me.

14. I get very upset when something reminds me of something bad that happened to me.

15. I have trouble getting to sleep or staying asleep.

16. When something reminds me of something bad that happened to me, I feel shaky, sweaty, nervous and my heart beats really fast.

17. I suddenly feel like I am back in the past, in a bad situation that I was once in, and it's like it was happening it all over again.

***Source**: Carlson E. Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. Assessment, 2001, 8, pp. 431-441.doi: 10.1177/107319110100800408*
Caspi Y., Carlson E.B., Klein E. Validation of a screening instrument for posttraumatic stress disorder in a community sample of bedouin men serving in the Israeli defense forces. Journal of Traumatic Stress, 2007, 20, pp. 517-527. doi: 10.1002/jts.20237
http://www.midss.org/content/screen-posttraumatic-stress-symptoms-sptss

PERCEIVED STRESS SCALE (PSS-14)

Background information

Potentially stressful life events are thought to increase risk for disease when one perceives that the demands these events impose tax or exceed a person's adaptive capacity. In turn, the perception of stress may influence the pathogenesis of physical disease by causing negative affective states (e.g., feelings of anxiety and depression), which then exert direct effects on physiological processes or behavioral patterns that influence disease risk. The Perceived Stress Scale (PSS) measures psychological stress associated with sex, age, education, income, employment status, and a number of other demographics. The PSS was designed for use with community

samples with at least a junior high school education. The items are easy to understand and the response alternatives are simple to grasp. Moreover the questions are quite general in nature and hence relatively free of content specific to any sub population group.

Instructions

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate your response by choosing a number representing how often you felt or thought a certain way:

- **0** = never
- **1** = almost never
- **2** = sometimes
- **3** = fairly often
- **4** = very often

Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

1. Upset because of something that happened unexpectedly?
2. Felt that you were unable to control the important things in your life?
3. Felt nervous and "stressed"?
4. Dealt successfully with day to day problems and annoyances?
5. Felt that you were effectively coping with important changes that were occurring in your life?
6. Felt confident about your ability to handle your personal problems?
7. Felt that things were going your way?
8. Found that you couldn't cope with all the things that you'd to do?
9. Been able to control irritations in your life?
10. Felt that you were on top of things?
11. Angered because of things that happened that were outside of your control?
12. Found yourself thinking about things that you have to accomplish?
13. Able to control the way you spend your time?
14. Felt difficulties were piling up so high that you could not overcome them?

Scoring

PSS-14 scores are obtained by reversing the scores on the seven positive items (1, 2, 3, 8, 11, 12, 14), e.g., 0=4, 1=3, 2=2, etc., and then summing across all 14 items. Items 4, 5, 6, 7, 9, 10, and 13 are the positively stated items.

***Source**: Cohen S., Kamarck T., Mermelstein R. A global measure of perceived stress. Journal of Health and Social Behavior, 1983, vol. 24 (4), pp. 385-396. http://www.psy.cmu.edu/~scohen/globalmeas83.pdf*
Cohen S., Williamson G.. Perceived stress in a probability sample of the United States. (in: The social psychology of health: Claremont Symposium on applied social psychology. Ed. by S. Spacapam, S. Oskamp. Newbury Park, CA: Sage, 1988.http://www.psy.cmu.edu/~scohen/Cohen%2C%20S.%20%26%20Williamson%2C%20G.%20(1988).pdf
http://www.midss.org/content/perceived-stress-scale-pss

COHEN-HOBERMAN INVENTORY OF PHYSICAL SYMPTOMS (CHIPS)

Background information

The CHIPS is a list of 33 common physical symptoms. Items were carefully selected so as to exclude symptoms of an obviously psychological nature (e.g., felt nervous or depressed). The scale does, however, include many physical symptoms that have been traditionally viewed as psychosomatic (e.g., headache, weight loss). Each item is rated for how much that problem bothered or distressed the individual during the past two weeks. Items are rated on a 5-point scale from "not at all" to "extremely".

Instruction

Select the number for each statement that best describes how much that problem has bothered or distressed you during that past two weeks including today. Mark only one number for each item. At one extreme, 0 means that you have not been bothered by the problem. At the other extreme, 4 means that the problem has been an extreme bother.

How much were you bothered by:

1. Sleep problems (can't fall asleep, wake up in middle of night or early in the morning).
2. Weight change (gain or loss of 5 lbs. or more).
3. Back pain.

4. Constipation.
5. Dizziness.
6. Diarrhea.
7. Faintness.
8. Constant fatigue.
9. Headache.
10. Migraine headache.
11. Nausea and/or vomiting.
12. Acid stomach or indigestion.
13. Stomach pain (e.g., cramps).
14. Hot or cold spells.
15. Hands trembling.
16. Heart pounding or racing.
17. Poor appetite.
18. Shortness of breath when not exercising or working hard.
19. Numbness or tingling in parts of your body.
20. Felt weak all over.
21. Pains in heart or chest.
22. Feeling low in energy.
23. Stuffy head or nose.
24. Blurred vision.
25. Muscle tension or soreness.
26. Muscle cramps.
27. Severe aches and pains.
28. Acne.
29. Bruises.
30. Nosebleed.
31. Pulled (strained) muscles.
32. Pulled (strained) ligaments.
33. Cold or cough.

To create a total score, sum the scores across the 33 items.

***Source**: Cohen S., Hoberman H.M. Positive events and social supports as buffers of life change stress. Journal of applied social psychology, 1983, 13(2), pp. 99-125. doi:10.1111/j.1559-1816.1983.tb02325.x http://www.midss.org/content/cohen-hoberman-inventory-physical-symptoms-chips*

3. Types of stress protection behavior

3.1. Preliminary and additional reading

Please read the following article prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from the article topic during the discussion.

COPING WITH TRAUMATIC EVENTS

Overview

A traumatic event is a shocking, scary, or dangerous experience that affects someone emotionally. These situations may be natural, like a tornado or earthquake. They can also be caused by other people, like a car accident, crime, or terror attack.

How individuals respond to traumatic events is an important area of research <…>. Researchers are exploring the factors that help people cope as well as the factors that increase their risk for problems following the event.

Warning Signs

There are many different responses to potentially traumatic events. Most people have intense responses immediately following, and often for several weeks or even months after, a traumatic event. These responses can include:

- feeling anxious, sad, or angry;
- trouble concentrating and sleeping;
- continually thinking about what happened.

For most people, these are normal and expected responses and generally lessen with time. Healthy ways of coping in this time period include avoiding alcohol and other drugs, spending time with loved ones and trusted friends who are supportive, trying to maintain normal routines for meals, exercise, and sleep. In general, staying active is a good way to cope with stressful feelings.

However, in some cases, the stressful thoughts and feelings after a trauma continue for a long time and interfere with everyday life. For people who continue to feel the effects of the trauma, it is important to seek professional help. Some signs that an individual may need help include:

- worrying a lot or feeling very anxious, sad, or fearful;
- crying often;
- having trouble thinking clearly;

– having frightening thoughts, reliving the experience;
– feeling angry;
– having nightmares or difficulty sleeping;
– avoiding places or people that bring back disturbing memories and responses.

Physical responses to trauma may also mean that an individual needs help. Physical symptoms may include:

– headaches;
– stomach pain and digestive issues;
– feeling tired;
– racing heart and sweating;
– being very jumpy and easily startled.

Those who already had mental health problems or who have had traumatic experiences in the past, who are faced with ongoing stress, or who lack support from friends and family may be more likely to develop stronger symptoms and need additional help. Some people turn to alcohol or other drugs to cope with their symptoms. Although substance use can temporarily cover up symptoms, it can also make life more difficult.

<…>

Source: *NIH: https://www.nimh.nih.gov/health/topics/coping-with-traumatic-events/index.shtml*

3.2. Questionnaires and psychological tests

GENERAL SELF-EFFICACY SCALE (GSE)

Background information

The construct of Perceived Self-Efficacy reflects an optimistic self-belief. This is the belief that one can perform a novel or difficult tasks, or cope with adversity – in various domains of human functioning. Perceived self-efficacy facilitates goal-setting, effort investment, persistence in face of barriers and recovery from setbacks. It can be regarded as a positive resistance resource factor. Perceived self-efficacy is an operative construct, i.e., it is related to subsequent behavior and, therefore, is relevant for clinical practice and behavior change.

The scale was created to assess a general sense of perceived self-efficacy with the aim in mind to predict coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events. Ten items are designed to tap this construct. Each item refers to

successful coping and implies an internal-stable attribution of success. The measure is suitable as an indicator of quality of life at any point in lifetime.

Instructions

Please read the following statements and choose a number representing how much each of them is applicable to you:

- **1** = not at all true
- **2** = hardly true
- **3** = moderately true
- **4** = exactly true

Sample item[1]

1. I can always manage to solve difficult problems if I try hard enough.

Scoring

Responses are made on a 4-point scale. Sum up the responses to all 10 items to yield the final composite score with a range from 10 to 40.The mean score of the scale is 29,2±4,6.

Source: *Schwarzer R., Jerusalem M. Generalized Self-Efficacy scale. (in J. Weinman, S. Wright, M. Johnston, Measures in health psychology: A user's portfolio. Causal and control beliefs. Windsor, England: NFER-NELSON. 1995. Pp. 35-37). http://userpage.fu-berlin.de/~health/selfscal.htm*

WAYS OF COPING (FOLKMAN & LAZARUS)

Background information

The Ways of Coping (Revised) is a 66-item questionnaire containing a wide range of thought sand acts that people use to deal with the internal and/or external demands of specific stressful encounters.

Usually the encounter is described by the subject in an interview or in a brief written description saying who was involved, where it took place and what happened. Sometimes a particular encounter, such as a medical treatment or an academic examination, is selected by the investigator as the focus of the questionnaire.

[1] Due to legal reasons, reproducing the full text of the scale in electronic or printed form is forbidden by copyright holders. The full text of the scale is available online from *Freie Universität Berlin*on their website (URL is provided in *Source section*)

There are two approaches to measure ways of coping, derived from studies performed on two different samples: community and college students.

Instructions

Please read each item below and indicate, by using the following rating scale, to what extent you used it in the situation you have just described.

- **0** = not used
- **1** = used somewhat
- **2** = used a quite bit
- **3** = used a great deal

1. Just concentrated on what I had to do next – the next step.
2. I tried to analyze the problem in order to understand it better.
3. Turned to work or substitute activity to take my mind off things.
4. I felt that time would make a difference – the only thing to do was to wait.
5. Bargained or compromised to get something positive from the situation.
6. I did something which I didn't think would work, but at least I was doing something.
7. Tried to get the person responsible to change his or her mind.
8. Talked to someone to find out more about the situation.
9. Criticized or lectured myself.
10. Tried not to burn my bridges, but leave things open somewhat.
11. Hoped a miracle would happen.
12. Went along with fate; sometimes I just have bad luck.
13. Went on as if nothing had happened.
14. I tried to keep my feelings to myself.
15. Looked for the silver lining, so to speak; tried to look on the bright side of things.
16. Slept more than usual.
17. I expressed anger to the person(s) who caused the problem.
18. Accepted sympathy and understanding from someone.
19. I told myself things that helped me to feel better.
20. I was inspired to do something creative.
21. Tried to forget the whole thing.
22. I got professional help.
23. Changed or grew as a person in a good way.
24. I waited to see what would happen before doing anything.

25. I apologized or did something to make up.
26. I made a plan of action and followed it.
27. I accepted the next best thing to what I wanted.
28. I let my feelings out somehow.
29. Realized I brought the problem on myself.
30. I came out of the experience better than when I went in.
31. Talked to someone who could do something concrete about the problem.
32. Got away from it for a while; tried to rest or take a vacation.
33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
34. Took a big chance or did something very risky.
35. I tried not to act too hastily or follow my first hunch.
36. Found new faith.
37. Maintained my pride and kept a stiff upper lip.
38. Rediscovered what is important in life.
39. Changed something so things would turn out all right.
40. Avoided being with people in general.
41. Didn't let it get to me; refused to think too much about it.
42. I asked a relative or friend I respected for advice.
43. Kept others from knowing how bad things were.
44. Made light of the situation; refused to get too serious about it.
45. Talked to someone about how I was feeling.
46. Stood my ground and fought for what I wanted.
47. Took it out on other people.
48. Drew on my past experiences; I was in a similar situation before.
49. I knew what had to be done, so I doubled my efforts to make things work.
50. Refused to believe that it had happened.
51. I made a promise to myself that things would be different next time.
52. Came up with a couple of different solutions to the problem.
53. Accepted it, since nothing could be done.
54. I tried to keep my feelings from interfering with other things too much.
55. Wished that I could change what had happened or how I felt.
56. I changed something about myself.
57. I daydreamed or imagined a better time or place than the one I was in.
58. Wished that the situation would go away or somehow be over with.

59. Had fantasies or wishes about how things might turn out.
60. I prayed.
61. I prepared myself for the worst.
62. I went over in my mind what I would say or do.
63. I thought about how a person I admire would handle this situation and used that as a model.
64. I tried to see things from the other person's point of view.
65. I reminded myself how much worse things could be.
66. I jogged or exercised.

Scoring (community sample)

To score the scales, sum ratings & calculate mean for each scale.

1. Confrontive coping (items 6, 7, 17, 28, 34 and 46).
2. Distancing (items 12, 13, 15, 21, 41 and 44).
3. Self-controlling (items 10, 14, 35, 43, 54, 63 and 64).
4. Seeking social support (items 8, 18, 22, 31, 42 and 45).
5. Accepting responsibility (items 9, 25, 29 and 51).
6. Escape-Avoidance (items 11, 16, 33, 40, 47, 50, 58 and 59).
7. Planful problem-solving (items 1, 26, 39, 48, 49 and 52).
8. Positive reappraisal (items 20, 23, 30, 36, 38, 56 and 60).

Scoring (college students sample)

To score the scales, sum ratings & calculate mean for each scale.

Empirically constructed scales:

1. Problem-focused coping (items 2, 26, 35, 39, 46, 48, 49, 52, 54, 62 and 64).
2. Wishful thinking (items 11, 55, 57, 58 and 59).
3. Detachment (items 4, 12, 13, 21, 24 and 53).
4. Seeking social support (items 8, 18, 28, 31, 42, 45 and 60).
5. Focusing on the positive (items 15, 20, 23 and 38).

Rationally created scales:

6. Self blame (items 9, 29 and 51).
7. Tension reduction (items 32, 33 and 66).
8. Keep to self / Self isolation (items 14, 40 and 43).

Source:*Folkman S., Lazarus R.S. If it changes it must be a process: Study of emotion and coping during three stages of a college examination. Journal of Personality and Social Psychology, 1985, 48 (1), pp. 150-170.*
Folkman S., Lazarus R.S., Gruen R.J., DeLongis A. Appraisal, coping, health status, and psychological symptoms. Journal of Personality & Social Psychology, 1986, 50 (3), pp. 571–579.
https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/uploads/tools/surveys/pdf/Ways%20of%20coping.pdf

4. Psychology of communication

4.1. Preliminary and/or additional reading

Please read the following article prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from the article topic during the discussion.

BUILDING SOCIAL BONDS:
CONNECTIONS THAT PROMOTE WELL-BEING

Strong, healthy relationships are important throughout your life. Your social ties with family members, friends, neighbors, coworkers, and others impact your mental, emotional, and even physical well-being.

"We can't underestimate the power of a relationship in helping to promote well-being," says NIH psychologist and relationship expert Dr. Valerie Maholmes. Studies have found that having a variety of social relationships may help reduce stress and heart-related risks. Strong social ties are even linked to a longer life. On the other hand, loneliness and social isolation are linked to poorer health, depression, and increased risk of early death.

As a child you learn the social skills you need to form and maintain relationships with others. But at any age you can learn ways to improve your relationships.

NIH funds research to find out what causes unhealthy relationship behavior. Researchers have created community, family, and school-based programs to help people learn to have healthier relationships. These programs also help prevent abuse and violence toward others.

What Is Healthy?

Every relationship exists on a spectrum from healthy to unhealthy to abusive. One sign of a healthy relationship is feeling good about yourself around your partner, family member, or friend. You feel safe talking about how you feel. You listen to each other. You feel valued, and you trust each other.

"It's important for people to recognize and be aware of any time where there is a situation in their relationship that doesn't feel right to them or that makes them feel less than who they are," Maholmes advises.

It's normal for people to disagree with each other. But conflicts shouldn't turn into personal attacks. In a healthy relationship, you can disagree without hurting each other and make decisions together.

"No relationship should be based on that power dynamic where someone is constantly putting the other partner down," Maholmes says.

If you grew up in a family with abuse, it may be hard as an adult to know what healthy is. Abuse may feel normal to you. There are several kinds of abuse, including physical, sexual, and verbal or emotional. Hurting with words, neglect, and withholding affection are examples of verbal or emotional abuse.

In an unhealthy or abusive relationship, your partner may blame you for feeling bad about something they did or said. They may tell you that you're too sensitive. Putting you down diminishes you and keeps them in control.

In a healthy relationship, however, if you tell your partner that something they said hurt your feelings, they feel bad for hurting you. They try not to do it again.

Abuse in an intimate relationship is called domestic or intimate partner violence. This type of violence involves a pattern of behaviors used by one person to maintain power and control over someone that they are married to, living with, or dating now or in the past. A pattern means it happens over and over.

In an unhealthy or abusive relationship, you may not be allowed to spend time with family, friends, and others in your social network. "One of the signs that's really important in relationships where there is intimate partner violence is that the partner that is being abused is slowly being isolated from family and friends and social networks," Maholmes says. "Those social networks are protective factors."

Social Ties Protect

Studies have shown that certain factors seem to protect people from forming unhealthy relationships over their lifetime. The protection starts early in life. NIH-supported research has shown that the quality of an infant's emotional bond with a parent can have long-lasting positive or negative effects on the ability to develop healthy relationships.

"The early bond has implications that go well beyond the first years of life," says Dr. Grazyna Kochanska, an NIH-funded family relationships researcher at the University of Iowa. The goal of Kochanska's research projects is to understand the long-term effects of that early bond and to help children develop along positive pathways and avoid paths toward antisocial behaviors.

A family that functions well is central to a child's development. Parents can help children learn how to listen, set appropriate

boundaries, and resolve conflicts. Parents teach children by example how to consider other people's feelings and act in ways to benefit others.

Secure emotional bonds help children and teens develop trust and self-esteem. They can then venture out of the family to form other social connections, like healthy friendships. In turn, healthy friendships reduce the risk of a child becoming emotionally distressed or engaging in antisocial behaviors.

On the other hand, having an unhealthy relationship in the family, including neglect and abuse, puts a child at risk for future unhealthy relationships.

"One caring adult can make a huge difference in the life of kids whose family structures may not be ideal or whose early life is characterized by abuse and neglect," says Dr. Jennie Noll of the Center for Healthy Children at Pennsylvania State University. "That caring adult could be an older sibling, or a parent, or someone else in the family, a teacher—the kind of people who have a large influence in communicating to the child that they matter and that they're safe, and that they have a place to go when they are needing extra support."

Healthy friendships and activities outside of the home or classroom can play protective roles during childhood, too. In fact, everyone in a community can help support the development of healthy connections. Adults can serve as good role models for children, whether the children are their own or those they choose to mentor.

Helping and Getting Help

At any age, your relationships matter. Having healthy relationships with others starts with liking yourself. Learn what makes you happy. Treat yourself well. Know that you deserve to be treated well by others.

Having an unhealthy or abusive relationship can really hurt. The connection may be good some of the time. You may love and need the person who hurts you. After being abused, you may feel you don't deserve to be in a healthy, loving relationship.

With help, you can work on your relationship. Or, sometimes in an abusive relationship, you may be advised to get out. Either way, others can help.

<…>

Source: *NIH: News in Health. April 2018. Pp. 1-2*
https://newsinhealth.nih.gov/2018/04/building-social-bonds

4.2. Questionnaires and psychological tests

INVENTORY OF SOCIALLY SUPPORTIVE BEHAVIORS (ISSB)

Background information

The Inventory of Social Supportive Behaviors (ISSB) is a 40-item self-report measure that was designed to assess how often individuals received various forms of assistance during the preceding month. The instrument conceptualizes social support as including tangible forms of assistance, such as the provision of goods and services, and intangible forms of assistance, such as guidance and expressions of esteem.

Ideas for items came from a variety of articles, but content analysis of interviews with single mothers proved to be particularly valuable source for items. Three principles guided the selection and writing of items:

– behavioral specificity was emphasized to reduce the need for subjective inferences;

– wording that would limit the applicability of items to specific populations was avoided (e.g., helped me study for an exam);

– explicit references to states of psychological adjustment were omitted (e.g., helped me feel less depressed).

Instructions

We are interested in learning about some of the ways that you feel people have helped you or tried to make life more pleasant for you over the past four weeks. Below you will find a list of activities that other people might have done for you, to you, or with you in recent weeks. Please read each item carefully and indicate how often these activities happened to you during the past four weeks.

Use the following scale to make your ratings:

– **1** = Not at all
– **2** = Once or twice
– **3** = About once a week
– **4** = Several times a week
– **5** = About every day

During the past four weeks, how often did other people do these activities for you, to you, or with you?

1. Looked after a family member when you were away.
2. Was right there with you (physically) in a stressful situation.
3. Provided you with a place where you could get away for a while.

4. Watched after your possessions when you were away (pets, plants, home, apartment, etc.).

5. Told you what she/he did in a situation that was similar to yours.

6. Did some activity with you to help you get your mind off of things.

7. Talked with you about some interests of yours.

8. Let you know that you did something well.

9. Went with you to someone who could take action.

10. Told you that you are OK just the way you are.

11. Told you that she/he would keep the things that you talk about private – just between the two of you.

12. Assisted you in setting a goal for yourself.

13. Made it clear what was expected of you.

14. Expressed esteem or respect for a competency or personal quality of yours.

15. Gave you some information on how to do something

16. Suggested some action that you should take.

17. Gave you over $25.

18. Comforted you by showing you some physical affection.

19. Gave you some information to help you understand a situation you were in.

20. Provided you with some transportation.

21. Checked back with you to see if you followed the advice you were given.

22. Gave you under $25.

23. Helped you understand why you didn't do something well.

24. Listened to you talk about your private feelings.

25. Loaned or gave you something (a physical object other than money) that you needed.

26. Agreed that what you wanted to do was right.

27. Said things that made your situation clearer and easier to understand.

28. Told you how he/she felt in a situation that was similar to you.

29. Let you know that he/she will always be around if you need assistance.

30. Expressed interest and concern in your well-being.

31. Told you that she/he feels very close to you.

32. Told you who you should see for assistance.

33. Told you what to expect in a situation that was about to happen.

34. Loaned you over $25.
35. Taught you how to do something.
36. Gave you feedback on how you were doing without saying it was good or bad.
37. Joked and kidded to try to cheer you up.
38. Provided you with a place to stay.
39. Pitched in to help you do something that needed to get done.
40. Loaned you under $25.

Scoring

The 5-point ratings of each item are summed to form a total frequency score. Alternatively, an average frequency score can be calculated. This latter method permits the calculation of a global score when there are some missing data for a few of the 40 items.

Confirmatory factor analysis of results found out four subscales:

1. Directive guidance (items 5, 12, 13, 15, 16, 19, 21, 23, 27, 28, 33, 35 and 36).
2. Tangible assistance (items 1, 3, 4, 17, 20, 22, 25, 34, 38, 39 and 40).
3. Positive social exchange (items 6, 7, 8, 26 and 37).
4. Nondirective support (items 10, 18, 29, 30 and 31).

Items 2, 9, 11, 14, 24 and 32 were dropped from factor model.

Source: *Barrera Jr M., Sandler I.M., Ramsay T.B. Preliminary development of a scale of social support: Studies on college students. American Journal of Community Psychology, 1981, 9 (4), pp. 435-446. Barrera Jr M.,Baca L.M. Recipient reactions to social support: Contributions of enacted support, conflicted support and network orientation. Journal of Social and Personal Relationships, 1990, 7 (4), pp. 541-551. http://www.midss.org/content/inventory-socially-supportive-behaviors-issb-long-and-short-form*

INTERPERSONAL SUPPORT EVALUATION LIST (ISEL)

Background information

The ISEL was designed to measure perceptions of social support among individuals in the general population, and is concerned with ways in which others affect persons' responses to stressful events. The ISEL consists of a list of 40 statements concerning the perceived availability of potential social resources. The items are counterbalanced for desirability; that is half the items are positive

statements about social relationships while the other half are negative statements. Items each fall into four 10-item subscales; tangible support, appraisal support, self-esteem support, belonging support. The shortened 12-intems variant is also used in screening.

Instructions

This scale is made up of a list of statements each of which may or may not be true about you. For each statement choose one of the answers:

- **0** = definitely false
- **1** = probably false
- **2** = probably true
- **3** = definitely true

For each statement select 3 ("definitely true") if you are sure it is true about you and 2 ("probably true") if you think it is true but are not absolutely certain. Similarly, you should check 0 ("definitely false") if you are sure the statement is false and 1 ("probably false") is you think it is false but are not absolutely certain.

1. There are several people that I trust to help solve my problems.
2. If I needed help fixing an appliance or repairing my car, there is someone who would help me.
3. Most of my friends are more interesting than I am.
4. There is someone who takes pride in my accomplishments.
5. When I feel lonely, there are several people I can talk to.
6. There is no one that I feel comfortable to talking about intimate personal problems.
7. I often meet or talk with family or friends.
8. Most people I know think highly of me.
9. If I needed a ride to the airport very early in the morning, I would have a hard time finding someone to take me.
10. I feel like I'm not always included by my circle of friends.
11. There really is no one who can give me an objective view of how I'm handling my problems.
12. There are several different people I enjoy spending time with.
13. I think that my friends feel that I'm not very good at helping them solve their problems.
14. If I were sick and needed someone (friend, family member, or acquaintance) to take me to the doctor, I would have trouble finding someone.

15. If I wanted to go on a trip for a day (e.g., to the mountains, beach, or country), I would have a hard time finding someone to go with me.

16. If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put me up.

17. I feel that there is no one I can share my most private worries and fears with.

18. If I were sick, I could easily find someone to help me with my daily chores.

19. There is someone I can turn to for advice about handling problems with my family.

20. I am as good at doing things as most other people are.

21. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.

22. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

23. If I needed an emergency loan of $100, there is someone (friend, relative, or acquaintance) I could get it from.

24. In general, people do not have much confidence in me.

25. Most people I know do not enjoy the same things that I do.

26. There is someone I could turn to for advice about making career plans or changing my job.

27. I don't often get invited to do things with others.

28. Most of my friends are more successful at making changes in their lives than I am.

29. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

30. There really is no one I can trust to give me good financial advice.

31. If I wanted to have lunch with someone, I could easily find someone to join me.

32. I am more satisfied with my life than most people are with theirs.

33. If I was stranded 10 miles from home, there is someone I could call who would come and get me.

34. No one I know would throw a birthday party for me.

35. It would be difficult to find someone who would lend me their car for a few hours.

36. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

37. I am closer to my friends than most other people are to theirs.
38. There is at least one person I know whose advice I really trust.
39. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.
40. I have a hard time keeping pace with my friends.

Scoring

The ISEL consists of a list of 40 statements concerning the perceived availability of potential social resources. The items are counterbalanced for desirability that is, half the items are positive statements about social relationships, while other half are negative statements.

The ISEL was designed to assess the perceived availability of four separate functions of social support as well as providing an overall support measure. The items which comprise the ISEL fall into four 10-item subscales: The "tangible" subscale is intended to measure perceived availability of material aid; the "appraisal" subscale, the perceived availability of someone to talk to about one's problems; the "self-esteem" subscale, the perceived availability of a positive comparison when comparing one's self to others; and the "belonging" subscale, the perceived availability of people one can do things with.

- Appraisal items: 1, 6*, 11*, 17*, 19, 22, 26, 30*, 36*, 38
- Tangible items: 2, 9*, 14*, 16, 18, 23, 29*, 33, 35*, 39*
- Self-esteem items: 3*, 4, 8, 13*, 20, 24*, 28*, 32, 37, 40*
- Belonging items: 5, 7, 10*, 12, 15*, 21, 25*, 27*, 31, 34*

Note: Reverse-coded items are marked with (*).

Subscale independence was maximized by selecting items (from a larger item pool) which were highly correlated with items in their own subscale and at the same time minimally correlated with other subscales.

Source:*Cohen S., Mermelstein R., Kamarck T., Hoberman H.M. Measuring the functional components of social support. (in: Social support: Theory, research and applications Springer, Dordrecht, 1985. Pp. 73-94).*
http://www.midss.org/content/interpersonal-support-evaluation-list-isel

5. Communication skills development

5.1. Preliminary and/or additional reading

Please read the following abstracts prior to seminar to the main background of the topic. You could also read full-text articles (available online) to get even better understanding of the topic.

Based on information acquired from these articles, you're encouraged to participate in discussion, providing facts and arguments you've found relevant to the topic of discussion.

COMMUNICATION SKILLS TRAINING FOR HEALTH CARE PROFESSIONALS WORKING WITH CANCER PATIENTS, THEIR FAMILIES AND/OR CARERS[abstract]

Background

This is the third update of a review that was originally published in the Cochrane Library in 2002, Issue 2. People with cancer, their families and carers have a high prevalence of psychological stress, which may be minimised by effective communication and support from their attending healthcare professionals (HCPs). Research suggests communication skills do not reliably improve with experience; therefore, considerable effort is dedicated to courses that may improve communication skills for HCPs involved in cancer care. A variety of communication skills training (CST) courses are in practice.We conducted this review to determine whether CST works and which types of CST, if any, are the most effective.

Objectives

To assess whether communication skills training is effective in changing behaviour of HCPs working in cancer care and in improving HCP well-being, patient health status and satisfaction.

Search methods

For this update, we searched the following electronic databases: Cochrane Central Register of Controlled Trials (CENTRAL; 2018, Issue 4), MEDLINE via Ovid, Embase via Ovid, PsycInfo and CINAHL up to May 2018. In addition, we searched the US National Library of Medicine Clinical Trial Registry and handsearched the reference lists of relevant articles and conference proceedings for additional studies.

Selection criteria

The original review was a narrative review that included randomised controlled trials (RCTs) and controlled before-and-after studies.

In updated versions, we limited our criteria to RCTs evaluating CST compared with no CST or other CST in HCPs working in cancer care. Primary outcomes were changes in HCP communication skills measured in interactions with real or simulated people with cancer or both, using objective scales. We excluded studies whose focus was communication skills in encounters related to informed consent for research.

Data collection and analysis

Two review authors independently assessed trials and extracted data to a pre-designed data collection form. We pooled data using the random-effects method. For continuous data, we used standardised mean differences (SMDs).

Main results

We included 17 RCTs conducted mainly in outpatient settings. Eleven trials compared CST with no CST intervention; three trials compared the effect of a follow-up CST intervention after initial CST training; two trials compared the effect of CST and patient coaching; and one trial compared two types of CST. The types of CST courses evaluated in these trials were diverse. Study participants included oncologists, residents, other doctors, nurses and a mixed team of HCPs. Overall, 1240 HCPs participated (612 doctors including 151 residents, 532 nurses, and 96 mixed HCPs).

Ten trials contributed data to the meta-analyses. HCPs in the intervention groups were more likely to use open questions in the postintervention interviews than the control group (SMD 0.25, 95% CI 0.02 to 0.48; P = 0.03, I^2 = 62%; 5 studies, 796 participant interviews; very low-certainty evidence); more likely to show empathy towards their patients (SMD 0.18, 95% CI 0.05 to 0.32; P = 0.008, I^2 = 0%; 6 studies, 844 participant interviews; moderate-certainty evidence), and less likely to give facts only (SMD -0.26, 95% CI -0.51 to -0.01; P = 0.05, I^2 = 68%; 5 studies, 780 participant interviews; low-certainty evidence). Evidence suggesting no difference between CST and no CST on eliciting patient concerns and providing appropriate information was of a moderate-certainty.

There was no evidence of differences in the other HCP communication skills, including clarifying and/or summarising information, and negotiation. Doctors and nurses did not perform differently for any HCP outcomes.

There were no differences between the groups with regard to HCP 'burnout' (low-certainty evidence) nor with regard to patient satisfaction or patient perception of the HCPs communication skills (very low-certainty evidence). Out of the 17 included RCTs 15 were considered to be at a low risk of overall bias.

Authors' conclusions

Various CST courses appear to be effective in improving HCP communication skills related to supportive skills and to help HCPs to be less likely to give facts only without individualising their responses to the patient's emotions or offering support. We were unable to determine whether the effects of CST are sustained over time, whether consolidation sessions are necessary, and which types of CST programs are most likely to work. We found no evidence to support a beneficial effect of CST on HCP 'burnout', the mental or physical health and satisfaction of people with cancer.

PLAIN LANGUAGE SUMMARY

Do courses aimed at improving the way healthcare professionals communicate with people who have cancer impact on their physical and mental health?

What is the aim of this review?

The aim of this Cochrane review was to find out if communication skills training (CST) for healthcare professionals working with people who have cancer has an impact on how healthcare professionals communicate and on the physical and mental health of the patients.

What types of studies did we include?

We included only randomised trials (RCTs) that evaluated the impact of CST for healthcare professionals (doctors, nurses and other allied health professionals) who work with people with cancer. We included different types of CST and evaluated its impact on healthcare professionals and their patients, through the following reported outcomes: use of open questions, elicited concerns, delivery of appropriate information, empathy demonstration, use of fact contents, healthcare professional 'burnout' and patient anxiety.

What are the main results of the review?

We found 17 RCTs comparing CST with no CST. The studies used encounters with real and simulated patients to measure the communication outcomes. The evidence on whether CST leads to an improvement of the use of open questions is very uncertain.

However, we did show that CST probably improves healthcare professional empathy and reduces the likelihood of their giving facts only without individualising their responses to the patient's emotions or offering support. CST probably does not have an effect on the ability of healthcare professionals to elicit concerns or to give appropriate information.

Evidence suggesting that CST might prevent healthcare professional 'burnout' is of low-certainty and it is very uncertain whether CST has an effect on patient anxiety.

What do they mean?

CST probably helps healthcare professionals to empathise more with their patients, and probably improves some aspects of their communication skills. These changes might lead to better patient outcomes; however, evidence on the latter is very uncertain and more research is needed.

***Source**:Moore P.M., Wilkinson S.S.M., Mercado S.R. Communication skills training for health care professionals working with cancer patients, their families and/or carers. Cochrane Database of Systematic Reviews. 2004, No. 2. doi:10.1002/14651858.CD003751.pub4 https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003751.pub4/full*

WHY DON'T PATIENTS AND PHYSICIANS TALK ABOUT END-OF-LIFE CARE?BARRIERS TO COMMUNICATION FOR PATIENTS WITH ACQUIRED IMMUNODEFICIENCY SYNDROME AND THEIR PRIMARY CARE CLINICIANS [abstract]

Background

Patients with chronic and terminal disease frequently do not talk to their physicians about end-of-life care. Interventions to improve this communication have generally been unsuccessful, suggesting that important barriers to this communication must exist.

Objectives

To determine the barriers to and facilitators of patient-clinician communication about end-of-life care and to identify barriers and

facilitators that are more common among those patients who are least likely to discuss end-of-life care: minorities and injection drug users.

Methods

We conducted a prospective study of 57 patients with advanced acquired immunodeficiency syndrome and their primary care clinicians who were recruited from university and private clinics. Barriers to and facilitators of end-of-life communication were identified from a prior qualitative study and assessed for frequency and importance and for an association with the occurrence and quality of end-of-life communication.

Results

Clinicians identified more barriers than patients. Barriers identified by patients and clinicians fell into 3 categories of potential interventions: education about end-of-life care, counseling to help address end-of-life concerns, and health care system changes to facilitate patient-clinician communication. Although none of the patient-identified barriers was associated with the occurrence of communication, 2 clinician-identified barriers were associated with less communication: "*the patient has not been very sick yet*" and "*the patient isn't ready to talk about end-of-life care*". Nonwhite patients were more likely to identify the following 2 barriers than white patients: "*I feel that if I talk about death, it could bring death closer*" and "*I don't like to talk about the care I want if I get very sick*".

Conclusions

The diversity of barriers and facilitators relevant to patients with acquired immunodeficiency syndrome and their clinicians suggests that interventions to improve communication about end-of-life care must be focused on individual needs and must involve counseling interventions and health system changes in addition to education. Clinician barriers are more common and more strongly associated with the occurrence of end-of-life communication than patient barriers, suggesting that clinicians are an important target group for improving this communication.

***Source**: Curtis J.R., Patrick D.L., Caldwell E.S., Collier A.C. Why don't patients and physicians talk about end-of-life care? Barriers to communication for patients with acquired immunodeficiency syndrome and their primary care clinicians. Arch Intern Med. 2000, 160(11), pp. 1690–1696. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/485344*

EFFICACY OF COMMUNICATION SKILLS TRAINING FOR GIVING BAD NEWS AND DISCUSSING TRANSITIONS TO PALLIATIVE CARE[abstract]

Background

Few studies have assessed the efficacy of communication skills training for postgraduate physician trainees at the level of behaviors. We designed a residential communication skills workshop (*Oncotalk*) for medical oncology fellows. The intervention design built on existing successful models by teaching specific communication tasks linked to the patient's trajectory of illness. This study evaluated the efficacy of *Oncotalk* in changing observable communication behaviors.

Methods

Oncotalk was a 4-day residential workshop emphasizing skills practice in small groups. This preintervention and postintervention cohort study involved 115 medical oncology fellows from 62 different institutions during a 3-year study. The primary outcomes were observable participant communication skills measured during standardized patient encounters before and after the workshop in giving bad news and discussing transitions to palliative care. The standardized patient encounters were audiorecorded and assessed by blinded coders using a validated coding system. Before-after comparisons were made using each participant as his or her own control.

Results

Compared with preworkshop standardized patient encounters, postworkshop encounters showed that participants acquired a mean of 5.4 bad news skills ($P < .001$) and a mean of 4.4 transitions skills ($P < .001$). Most changes in individual skills were substantial; for example, in the bad news encounter, 16% of participants used the word "*cancer*" when giving bad news before the workshop, and 54% used it after the workshop ($P< .001$). Also in the bad news encounter, blinded coders were able to identify whether a standardized patient encounter occurred before or after the workshop in 91% of the audiorecordings.

<…>

***Source**: Back A.L., Arnold R.M., Baile W.F., Fryer-Edwards K.A., Alexander S.C., Barley G.E., Tulsky J.A. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. Archives of Internal Medicine, 2007, 167(5), pp. 453-460. doi: 10.1001/archinte.167.5.453 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/769642*

5.2. Topics for discussion

Read the provided article discussing communication barriers.

PHYSICIAN COMMUNICATION: BARRIERS TO ACHIEVING SHAREDUNDERSTANDING AND SHARED DECISION MAKING WITH PATIENTS[2]

Introduction

Patient involvement in their health care is likely to reduce errors, adverse events, and nonadherence to treatment. Emphasis is being increasingly placed on developing partnerships between patients, physicians, and other health professionals. This may also reduce the economic burden of chronic disease and enhance healing and illness management. This taxonomy of behaviors has been labeled shared decision making (SDM), which prior studies have examined using qualitative and quantitative methods. SDM is appropriate in any situation where there is more than one reasonable course of action and where a single option is not readily apparent. McNutt contends that patients must decide on their own course of treatment once they understand all of the pertinent information. The physician often provides initial information about available options, ensuring that patients understand the ramifications of their choices. But, before provider and patient can engage in SDM, there must be a shared understanding of each other's frame of reference.

Qualitative studies conducted in the 1990s by researchers in Great Britain and Sweden investigated shortcomings in the physician-patient relationship that inhibit shared understanding. Patients emphasized that, to achieve understanding, they must communicate with providers at the same or a similar level. However, the level of health literacy, absence of patients' feeling of empowerment, insufficient access to information, beliefs about illness, and relationship styles have all been shown to inhibit understanding. Successful consultation depends on developing a reciprocal understanding, and is crucial for patients with chronic illnesses such as obstructive pulmonary disease. Patients believe that emotional safety helps to empower them to engage in SDM. For example, positive expression of emotions by physicians toward patients has been shown to be strongly associated with shared

[2] To achieve easier readability of provided text for students, the in-text references, references list and some parts of the text were omitted. The original (unedited) version of the article could be found via links in "*Source*" section.

understanding. Patients assert that the most important factor in fostering SDM is a physician who demonstrates good interpersonal skill. On the other hand, physicians consider the ability of the patient to provide complete and accurate information as the most important factor. A trusting relationship may be the most fundamental determinant of patients' willingness to engage in SDM. Trusting relationships are more likely to succeed when developed over time and when they are in the context of a continuous relationship with the provider. For example, patients may conceal use of complementary and alternative treatment approaches to avert disapproval from their health care provider.

Taking sufficient time to discuss the ramifications of the treatment plan in a nonjudgmental way may help to minimize potential risks and facilitate optimum patient wellbeing. Physicians who spend more time with patients tend to have communication styles that result in a greater degree of SDM. In contrast, physicians having higher volumes of patients who spend less time with them tended to be less participatory. Both patients and physicians agree that time pressure is a significant barrier to shared decision making.

The authors undertook to measure specific barriers that were reported by physicians as inhibiting shared understanding and shared decision making with patients.

Methods

Survey data were collected during the fall of 2006 in the province of Manitoba, Canada. A self-report questionnaire was distributed through the provincial medical association's bimonthly newsletter to its members and by a direct mailing from the researchers to the work addresses of the physicians obtained from the public access website of the College of Physicians and Surgeons of Manitoba. Completed questionnaires were returned to the first author. We received 278 responses, 53% from the provincial medical association, and 47% from the College. The respondents' mean years of practice was 16.49 (SD = 11.05), 60% were male, and 84% were white. The mean percentage of time spent in patient care was 68% (SD = 24%); the mean number of minutes spent per patient was 19.04 (SD = 14.76). On average, the respondents reported that 58% of their patients were female (SD = 14.62), 42% were male (SD = 11.82); 63% of patients were white (SD = 23.83), 24% were Aboriginal (SD = 21.35), and 13% were from other ethnic groups (SD = 9.16). The various specialties were classified into the following groups: family medicine (n = 110), internal medicine

(n = 60), pediatric disciplines (n = 30), surgical disciplines (n = 29), residents (n = 20), psychiatry (n = 19), other (n = 10).

Part C of the Doctor-Patient Communication Needs Assessment scale (18 items) asked the participants about specific difficulties they have in communicating with patients from different cultural and socio-economic backgrounds. The participants' responses were rated on a scale of 1 to 5 with 1 being "none" and 5 "extremely serious." A principal components analysis (PCA) with varimax rotation of the 18 communication items was performed to determine whether the correlations among the items supported the factors of shared understanding and shared decision making. PCA is a form of factor analysis that is used to detect the underlying relationships among items. Linear combinations that maximize the amount of explained variance among the items are grouped together as distinct factors. As an iterative approach, the amount of variance explained by the first factor is first extracted. Then the amount of the remaining variance explained by the second factor is extracted. The number of extractions is based on the criterion of factors having eigenvalues of 1.0 or greater. To facilitate interpretation, only items that loaded 0.50 or higher on either factor with no cross-loading were retained.

Results

Table 1 shows the 18 items rank-ordered by their means. Of these items, patients not following through with treatment plans (mean = 3.29), insufficient time (mean = 3.28), difficulties getting patients to understand diagnosis (mean = 3.07), and getting patients to understand the implications of their diagnosis (mean = 3.06), were the furthest above the scale midpoint and the most serious communication barriers from the physicians' perspective. Patients using culturally based alternative therapies that the physician is unfamiliar or disagrees with (mean = 2.45), and patient does not appear to trust the physician (mean = 2.53), were the furthest below the scale midpoint and the least serious communication barriers.

Table 2 shows that the factors of shared understanding and shared decision making had eigenvalues of 5.48 and 2.93, respectively, and the percentages of variance extracted were 30.31 and 16.26, respectively. Factor 1 was comprised of five items related to shared understanding grouped into the following subcategories: patient management, presentation of symptoms, and explanation and planning. Factor 2 was comprised of nine items related to shared decision making grouped into the following subcategories: explanation and planning, cultural beliefs and practices, health

maintenance behaviors, and partnership-building behaviors. The other four items (numbers 5, 11, 14, and 16 in Table 1) did not load significantly on either factor and were not included in our analysis. The greatest individual barrier to shared understanding was the "patient presenting with too many problems" (.70). The greatest individual barrier to shared decision making was "patient does not appear to trust the physician" (.84). Overall, the patients' health maintenance and partnership-building behaviors were the greatest barriers to shared decision making (Factor 2) and higher than all of the barriers to shared understanding with the exception of one (Factor 1).

Table 1. Means of the 18 Communication Barriers

Item	Mean
1. Patient does not follow through with treatment or make lifestyle changes	3.29
2. Insufficient time	3.28
3. Difficulty getting patient to understand diagnosis	3.07
4. Difficulty getting patient to understand implications of diagnosis	3.06
5. Interpreter does not adequately translate	3.02
6. Patient presents too many problems	2.97
7. Patient history is rambling and disorganized	2.94
8. Patient does not buy into treatment plan	2.92
9. Patient provides inconsistent information	2.92
10. Patient is uninterested in self-care or health maintenance	2.92
11. Difficulty establishing rapport with patient	2.84
12. Difficulty reconciling patient's self-diagnosis with physician diagnosis	2.68
13. Patient does not want to participate in a partnership with physician's diagnosis	2.68
14. Interpreter as child of inappropriate	2.66
15. Patient' s cultural beliefs about illness interfere with diagnosis and treatment	2.66
16. Patient talks too much to interpreter	2.60
17. Patient does not trust the physician	2.53
18. Patient uses culturally based alternative therapies that physician is unfamiliar with or disagrees with	2.45

Note. Response scale for each item: "Extent of problem when communicating with patients of different cultural and/or socioeconomic backgrounds": 1 = None;2 = Slight;3 = Moderate;4 = Fairly serious;5 = Extremely serious.

Table 2. Principal Components Analysis Results

	Shared Understanding	Shared Decision Making
Patient management		
2. Insufficient time	.66	
Presentation of symptoms		
9. Patient provides inconsistent information	.56	
7. Patient history is rambling and disorganized	.67	
6. Patient presents too many problems	.70	
Explanations and planning		
3. Difficulty getting patient to understand diagnosis	.58	
12. Difficulty reconciling patient's self-diagnosis with physician diagnosis		.60
4. Difficulty getting patient to understand implications of diagnosis		.65
Cultural beliefs and practices		
15. Patient' s cultural beliefs about illness interfere with diagnosis and treatment		.69
18. Patient uses culturally based alternative therapies that physician is unfamiliar with or disagrees with		.68
Health maintenance behaviors		
1. Patient does not follow through with treatment or make lifestyle changes		.70
10. Patient is uninterested in self-care or health maintenance		.78
Partnership-building behaviors		
8. Patient does not buy into treatment plan		.72
13. Patient does not want to participate in a partnership with physician's diagnosis		.77
17. Patient does not trust the physician		.84
Eigenvalue after varimax rotation	5.48	2.93
Percentage of variance extracted after rotation	30.31	16.26

Note. Only loadings > .50 are shown.

Discussion

Although the concept of shared understanding is an integral part of the decision-making process, there is little research that addresses this area. If patients did not feel that they have been adequately informed or the physician did not feel that the patient's recall of symptoms and problems could be understood, then neither participant is likely to be motivated to participate in SDM. This may explain why "patient's history is rambling and disorganized" (.67), "patient presents too many problems" (.70), and as a follow-up, "patient does not want to participate in a partnership with physician" (.77) were highly correlated with lack of shared understanding.

Successful SDM requires that patients be able to follow through with the treatment plan once it has been established. The provider should ensure that the patient's context and life circumstances have been taken into account and that the appropriate support mechanisms are available. Our findings revealed that patients often have difficulties following through with treatment and engaging in self-care practices. This may indicate that motivation, education, and social and community support may often be inadequate. Physicians who coordinate care effectively and have continuous relationships with patients are more likely to observe chronically ill patients who follow through with their treatment, rate their care as excellent, and have greater success in managing their illness. Electronic health records and high-quality after-hours care are important factors that support patients with chronic illnesses. However, less than 50% of Canadian doctors use electronic records or coordinate care after hours.

Our findings also indicated that the greatest and most significant barrier to SDM was lack of trust in physicians. Patients will not feel comfortable speaking up and asking questions where there is mistrust. Interpersonal skills and relationship building were considered to be the most powerful facilitator for SDM, especially among ethnic minorities. A study of patients from a family practice clinic indicated that physician behaviors most strongly correlated with trust were a comforting and caring approach, a provider who demonstrates a high level of competency, and a provider who has expressive communication. Our physicians indicated that insufficient time was a barrier to shared understanding, which may lead to patients feeling that they have not been adequately informed. Patients in another study indicated that they may have themselves contributed to a shorter visit because they felt guilty for taking up too much of the doctor's time. Patients who leave the consultation with

unanswered questions and inadequate information are less inclined to participate in shared decision making.

Future studies should address the limitations of our study. In particular, since self-report bias may have occurred with our participants, it is important to also obtain the perspective of the patient. Although the structure of this study was appropriate given the research question asked, future studies utilizing patient responses could provide more insight into some of the barriers that the physicians have reported, as well as identifying others that haven't been identified here.

In summary, our study has shed light on the barriers to shared understanding and decision making at both micro and macro levels from the physicians' perspective, and has implications for efforts to improve patient participation. Our findings further suggest that a systems approach is needed to empower and involve patients in their health care decisions.

***Source**: Lovell B.L., Lee R.T., Brotheridge C.M. Physician communication: barriers to achieving shared understanding and shared decision making with patients. Journal of Participatory Medicine, 2010, 2, e12. https://participatorymedicine.org/journal/evidence/research/2010/10/13/physician-communication-barriers-to-achieving-shared-understanding-and-shared-decision-making-with-patients/*

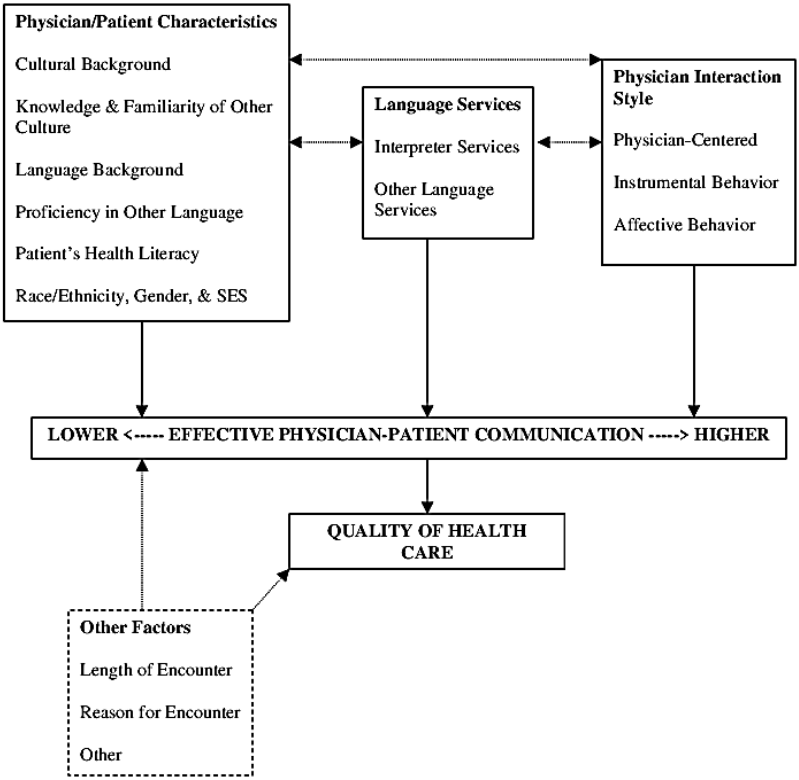
Please answer the following questions about the article:

1. Do you agree with order/rank of communication barriers mentioned in the article? Do you think that some of them should've been more or less important in everyday practice?
2. Could you provide another hypothetical factorial structure of communication barriers (for example, consisting of three factors instead of two) and/or their distribution among new factors?
3. In your opinion, is there the way to overcome communication barriers in healthcare? Are some of them inevitable?

For the model of physician-patient communication and quality of health care scheme (below) please answer the following questions:

1. Which physician/patient characteristics affect communication more than others? Does their effect have positive or negative consequences on physician-patient communication?
2. On the scheme, "quality of health care" module is shown as being influenced by communication effectiveness. Do you have any

ideas how on contrary the quality of health care could be the source of influence on communication between physician and patient?



***Source**: Lee S.M. A review of language and other communication barriers in health care. Portland: US Department of Health and Human Services, 2003. 28 p. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.583.683&rep=rep1&type=pdf*

5.3. Questionnaires and psychological tests

INTERPERSONAL COMMUNICATION SKILLS INVENTORY (ICSI)

Background

This Interpersonal Communication Skills Inventory is designed to provide individuals with some insights into their communication

strengths and potential areas for development. By answering each question candidly, an individual will receive a profile that displays their level of competence in four key communication areas. This inventory is intended to be viewed only by the individual who completes it.

Instructions

To complete this inventory, read each statement carefully and honestly assess how often the particular statement applies to you.

For instance, in Section I – question number 1, if you sometimes find it difficult to talk to other people, you would place a check mark in the "*Sometimes*" column for question number 1. And for question 2, if others often tend to finish sentences for you when you are trying to explain something; you would check the "*Usually*" column and so on until you have completed all questions in all four sections of the inventory.

SECTION I **SCORE: SECTION I TOTAL:**	**Usually**	**Sometimes**	**Seldom**
1. Is it difficult for you to talk to other people?			
2. When you are trying to explain something, do others tend to put words in your mouth, or finish your sentences for you?			
3. In conversation, do your words usually come out the way you would like?			
4. Do you find it difficult to express your ideas when they differ from the ideas of people around you?			
5. Do you assume that the other person knows what you are trying to say, and leave it to him/her to ask you questions?			
6. Do others seem interested and attentive when you are talking to them?			
7. When speaking, is it easy for you to recognize how others are reacting to what you are saying?			
8. Do you ask the other person to tell you how she/he feels about the point you are trying to make?			
9. Are you aware of how your tone of voice may affect others?			
10. In conversation, do you look to talk about things of interest to both you and the other person?			

SECTION II SCORE: SECTION II TOTAL:	Usually	Sometimes	Seldom
11. In conversation, do you tend to do more talking than the other person does?			
12. In conversation, do you ask the other person questions when you don't understand what they've said?			
13. In conversation, do you often try to figure out what the other person is going to say before they've finished talking?			
14. Do you find yourself not paying attention while in conversation with others?			
15. In conversation, can you easily tell the difference between what the person is saying and how he/she maybe feeling?			
16. After the other person is done speaking, do you clarify what you heard them say before you offer a response?			
17. In conversation, do you tend to finish sentences or supply words for the other person?			
18. In conversation, do you find yourself paying most attention to facts and details, and frequently missing the emotional tone of the speakers' voice?			
19. In conversation, do you let the other person finish talking before reacting to what she/he says?			
20. Is it difficult for you to see things from the other person's point of view?			

SECTION III SCORE: SECTION III TOTAL:	Usually	Sometimes	Seldom
21. Is it difficult to hear or accept constructive criticism from the other person?			
22. Do you refrain from saying something that you think will upset someone or make matters worse?			
23. When someone hurts your feelings, do you discuss this with him/her?			
24. In conversation, do you try to put yourself in the other person's shoes?			
25. Do you become uneasy when someone pays you a compliment?			

SECTION III	Usually	Sometimes	Seldom
26. Do you find it difficult to disagree with others because you are afraid they will get angry?			
27. Do you find it difficult to compliment or praise others?			
28. Do others remark that you always seem to think you are right?			
29. Do you find that others seem to get defensive when you disagree with their point of view?			
30. Do you help others to understand you by saying how you feel?			
SECTION IV **SCORE: SECTION IV TOTAL:**	**Usually**	**Sometimes**	**Seldom**
31. Do you have a tendency to change the subject when the other person's feelings enter into the discussion?			
32. Does it upset you a great deal when someone disagrees with you?			
33. Do you find it difficult to think clearly when you are angry with someone?			
34. When a problem arises between you and another person, can you discuss it without getting angry?			
35. Are you satisfied with the way you handle differences with others?			
36. Do you sulk for a long time when someone upsets you?			
37. Do you apologize to someone whose feelings you may have hurt?			
38. Do you admit that you're wrong when you know that you are/were wrong about something?			
39. Do you avoid or change the topic if someone is expressing his or her feelings in a conversation?			
40. When someone becomes upset, do you find it difficult to continue the conversation?			

Scoring

Go back and look over your responses to each question. In front of each question, write the appropriate score using the table below.

For example, if you answered "*Seldom*" to Question 1, you would get 3 points. Write the number 3 in front of Question 1 on the inventory. Proceed to score all other questions. Each section contains 10 questions. After scoring all questions, go back to Section 1 and put that number on the line "*Score Section 1 Total*." Proceed to total all scores for all other sections.

Question	Usually	Sometimes	Seldom	Question	Usually	Sometimes	Seldom
1	0	1	3	21	0	1	3
2	0	1	3	22	3	1	0
3	3	1	0	23	3	1	0
4	0	1	3	24	3	1	0
5	0	1	3	25	0	1	3
6	3	1	0	26	0	1	3
7	3	1	0	27	0	1	3
8	3	1	0	28	0	1	3
9	3	1	0	29	0	1	3
10	3	1	0	30	3	1	0
11	0	1	3	31	0	1	3
12	3	1	0	32	0	1	3
13	0	1	3	33	0	1	3
14	0	1	3	34	3	1	0
15	3	1	0	35	3	1	0
16	3	1	0	36	0	1	3
17	0	1	3	37	3	1	0
18	0	1	3	38	3	1	0
19	3	1	0	39	0	1	3
20	0	1	3	40	0	1	3

Score for each section as one indication of the degree to which you effectively communicate:

– Scores in the 1…15 range indicate areas of your communication skills that need improvement.

– Scores in the 16…21 range indicate areas of communication skills that need more consistent attention.

– Scores in the 22…30 range indicate areas of strength or potential strength.

***Source**: Bienvenu (Sr) M.J. An interpersonal communication inventory. Journal of communication, 1971, 21(4). Pp. 381-388. https://www.csus.edu/indiv/s/stonerm/coms5-ipcskillinventory1.pdf*

SELF-PERCEIVED COMMUNICATION COMPETENCE SCALE (SPCC)

Background

The self-perceived communication competence scale was developed to obtain information concerning how competent people feel they are in a variety of communication contexts and with a variety of types of receivers.

Since people make decisions with regard to communication (for example, whether they will even do it), it is their perception that is important, not solely that of an outside observer.

It is important that users of this measure recognize that this is NOT a measure of actual communication competence, it is a measure of PERCEIVED competence.

Instructions

Below are twelve situations in which you might need to communicate. People's abilities to communicate effectively vary a lot, and sometimes the same person is more competent to communicate in one situation than in another.

Please indicate how competent you believe you are to communicate in each of the situations described below. Indicate in the space provided to the right of each item your estimate of your competence.

Presume 0 is equal "*completely incompetent*" and 100 is equal "*competent*".

Situation	Your estimate
1. Present a talk to a group of strangers	
2. Talk with an acquaintance	
3. Talk in a large meeting of friends	
4. Talk in a small group of strangers	
5. Talk with a friend	
6. Talk in a large meeting of acquaintances	
7. Talk with a stranger	
8. Present a talk to a group of friends	
9. Talk in a small group of acquaintances	
10. Talk in a large meeting of strangers	
11. Talk in a small group of friends	
12. Present a talk to a group of acquaintances	

Scoring

To compute the subscores, add the percentages for the items indicated and divide the total by the number indicated below

Context-type subcsores:

– *Public subscore*: item 1 + item 8 + item 12; divide by 3.

– *Meeting subscore*: item 3 + item 6 + item 10; divide by 3.

– *Group subscore*: item 4 + item 9 + item 11; divide by 3.

– *Dyad (interpersonal) subscore*: item 2 + item 5 + item 7; divide by 3.

Reciever-type subcsores:

– *Strangers ubscore*: item 1 + item 4 + item 7 + item 10; divide by 4.

– *Acquaintance subscore* : item 2 + item 6 + item 9 + item 12; divide by 4.

– *Friend subscore*: item 3 + item 5 + item 8 + item 11; divide by 4.

– *Total SPCC score*: sum all the items, and then divide total by 12. Alternatively, you could sum subscores for *Stranger*, *Acquaintance*, and *Friend*, and then divide that total by 3.

Norms for SPCC scores and subscores

SPCC score / subscore	Low	Medium	High
Public subscore	0…50	51…86	87…100
Meeting subscore	0…50	51…85	86…100
Group subscore	0…60	61…90	91…100
Dyad (interpersonal) subscore	0…67	68…93	94…100
Stranger subscore	0…30	31…79	80…100
Acquaintance subscore	0…61	62…92	93…100
Friend subscore	0…75	76…99	100
Total SPCC score	0…58	59…87	88…100

Higher SPCC scores indicate higher self-perceived communication competence with basic communication contexts (public, meeting, group, dyad) and receivers (strangers, acquaintance, friend).

***Source**: McCroskey J.C., McCroskey L.L. Self-report as an approach to measuring communication competence. Communication Research Reports, 1988, 5(2). https://www.csus.edu/indiv/s/stonerm/Self-PerceivedCompetenceScale--Assignment-Directions-Rubric-ModelPaper.doc*

WILLINGNESS TO COMMUNICATE (WTC)

Background

Willingness to communicate is the most basic orientation toward communication. Almost anyone is likely to respond to a direct question, but many will not continue or initiate interaction. This scale was designed as a direct measure of the respondent's predisposition toward approaching or avoiding the initiation of communication.

Instructions

Below are twenty situations in which a person might choose to communicate or not to communicate. Presume you have completely free choice. Indicate the percentage of times you would choose to communicate in each type of situation. Indicate in the space at the right of the item what percent of the time you would choose to communicate.

Presume 0 is equal "*never*" and 100 is equal "*always*".

Situation	Your estimate
1. Talk with a service station attendant	
2. Talk with a physician	
3. Present a talk to a group of strangers	
4. Talk with an acquaintance while standing in line	
5. Talk with a salesperson in a store	
6. Talk in a large meeting of friends	
7. Talk with a police officer	
8. Talk in a small group of strangers.	
9. Talk with a friend while standing in line	
10. Talk with a waiter/waitress in a restaurant	
11. Talk in a large meeting of acquaintances	
12. Talk with a stranger while standing in line	
13. Talk with a secretary	
14. Present a talk to a group of friends	
15. Talk in a small group of acquaintances.	
16. Talk with a garbage collector	
17. Talk in a large meeting of strangers	
18. Talk with a spouse (or girl/boyfriend)	
19. Talk in a small group of friends	
20. Present a talk to a group of acquaintances	

Scoring

To compute the subscores, add the percentages for the items indicated and divide the total by the number indicated below

Context-type subcsores:

– *Group discussion subscore*: sum scores for items 8, 15 and 19; divide by 3.

– *Meetings subscore*: sum scores for items 6, 11 and 17; divide by 3.

– *Interpersonal conversations subscore*: sum scores for items 4, 9 and 12; divide by 3.

– *Public speaking subscore*: sum scores for items 3, 14 and 20; divide by 3.

Reciever-type subcsores:

– *Stranger subscore*: sum scores for items 3, 8, 12 and 17; divide by 4.

– *Acquaintance subscore*: sum scores for items 4, 11, 15 and 20; divide by 4.

– *Friend subscore*: sum scores for items 6, 9, 14 and 19; divide by 4.

– *Total WTC score*: sum subscores for *Stranger*, *Acquaintance*, and *Friend*, and then divide that total by 3.

Norms for WTC scores and subscores

SPCC score / subscore	Low	Medium	High
Group discussion subscore	0…56	57…89	90…100
Meetings subscore	0…38	39…80	81…100
Interpersonal conversations subscore	0…63	64…94	95…100
Public Speaking subscore	0…32	33…78	79…100
Stranger subscore	0…17	18…63	64…100
Acquaintance subscore	0…56	57…92	93…100
Friend subscore	0…70	71…99	100
Total WTC score	0…51	52…82	83…100

***Source**: McCroskey J.C. Reliability and validity of the willingness to communicate scale. Communication Quarterly, 1992, 40. Pp. 16-25.*
http://www.jamescmccroskey.com/measures/WTC.htm
http://www.midss.org/content/willingness-communicate-wtc

6. Psychology of conflict

6.1. Preliminary and/or additional reading

Please read the following abstracts prior to seminar to the main background of the topic. You could also read full-text articles (available online) to get even better understanding of the topic.

Based on information acquired from these articles, you're encouraged to participate in discussion, providing facts and arguments you've found relevant to the topic of discussion.

TYPES OF CONFLICTS AND CONFLICT MANAGEMENT AMONG HUNGARIAN HEALTHCARE WORKERS [abstract]

Introduction

Efficient communication, conflict management and cooperation are the key factors of a successful patient care.

Aim

This study is part of an international comparative research. The aim of this study is to unfold conflicts among healthcare workers.

Method

73 healthcare workers were interviewed using a standardized interview protocol. The in-person interviews used the critical incident method. 30 interviews (15 doctors, 15 nurses) were analysed with the Atlas .ti 7 content analysis software. The sources, types, effects of conflicts and conflict management strategies were investigated.

Results

The content analysis unfolded the specificities of conflicts in healthcare based on personal experiences. Organizational hierarchy was a substantial source of conflict, especially among physicians, which originates from implicit rules. As a result of the avoiding conflict management the conflicts remain partly unresolved which has negative individual and group effect.

<…>

***Source**: Csupor É., Kuna Á., Pintér J.N., Kaló Z., Csabai M. Types of conflicts and conflict management among Hungarian healthcare workers. Orv Hetil. 2017, 158(16), pp. 625-633. doi: 10.1556/650.2017.30736. http://www.akademiai.com/doi/full/10.1556/650.2017.30736*

ROLE OF EMOTIONAL INTELLIGENCE IN CONFLICT MANAGEMENT STRATEGIES OF NURSES [abstract]

Purpose

This study analyzes the emotional intelligence levels and conflict management strategies of nurses and the association between them.

Methods

This cross-sectional, descriptive study was conducted with 277 nurses in a stratified random sample from a university hospital in Turkey. The data were collected from nurses who gave their informed consent to participate using a personal information form, the Rahim Organizational Conflict Inventory-II and Bar-On's Emotional Quotient Inventory (EQ-I). Data were assessed by descriptive statistics, t tests, and Pearson correlation analyses, using SPSS software.

Results

The levels of the nurses' strategies were as follows: avoiding (M = 2.98), dominating (M = 2.76), and obliging (M = 2.71) were medium; compromising (M = 1.99) and integration (M = 1.96) were low. The levels of the emotional intelligence of nurses (mean = 2.75) were medium on a 5-point scale. Integration (r = .168), obliging (r = .25), dominating (r = .18), and compromising (r = .33), which are conflict management strategies, were positively correlated with scores of emotional intelligence, and avoiding (r = -.25) was negatively correlated with scores of emotional intelligence ($p < .05$).

Conclusions

The study determined that nurses' emotional intelligence affects conflict management strategies. To use effective strategies in conflict management, nurses must develop emotional intelligence. Training programs on conflict management and emotional intelligence are needed to improve effective conflict management in healthcare facilities.

***Source**: Başoğul C., Özgür G. Role of emotional intelligence in conflict management strategies of nurses. Asian Nurs Res (Korean Soc Nurs Sci). 2016, 10(3), pp. 228-233. doi: 10.1016/j.anr.2016.07.002 https://www.ncbi.nlm.nih.gov/pubmed/27692253*

6.2. Topics for discussion

Read the provided article discussing psychological and professional aftermaths of organizational conflict in healthcare.

DYSFUNCTIONAL EFFECTS OF A CONFLICT IN A HEALTHCARE ORGANIZATION[3]

Introduction

Workplace conflicts in healthcare settings are very common now as a result of the continuous changes and transformations occurring in modern healthcare organizations and the vigorous interaction between the medical professionals.

Most often these conflicts result as a consequence of the contradictions caused by the discrepancy gap of information, interests, norms of conduct, and human values.

A conflict may be functional under certain circumstances, but, as many studies have demonstrated, it can still have a negative impact on the teamwork and potentially can affect the entire hospital organization.

Aim

The aim of this study was to survey the opinions of medical professionals on the potential destructive effects of conflict on them at work.

Materials and methods

The study was conducted at four regional referral hospitals for the regions of Plovdiv, Asenovgrad and Kardzhali.

Using direct individual survey we studied the opinions of 279 medical employees between December2011 and February 2012. A specially designed questionnaire was prepared for the study based on the relevant reference literature we surveyed before the study. The questionnaire covered five basic domains: socio-demographic characteristics of respondents; satisfaction of medical professionals of the organization and conditions of work environment; causes and frequency of conflicts in medical work teams; impact of conflict on medical professionals and the quality of healthcare provided; skills of medical professionals to deal with conflicts.

[3] To achieve easier readability of provided text for students, the in-text references, references list and some parts of the text were omitted. The original (unedited) version of the article could be found via links in "*Source*" section.

The questionnaire was pilot tested and validated on a sub-sample of 30 medical professionals. The set of questions we used addressed the negative effects and consequences of conflict on healthcare professionals as direct or indirect participants. The data were analyzed using descriptive statistics and on parametric analysis at a significance level for the null hypothesis $p < 0.05$. The statistical analysis was performed using SPSS v. 16.

Results

The characteristics of respondents are presented in Table 1.

It is noteworthy that 84.1% of healthcare workers indicated that conflict was a negative time wasting phenomenon at work. Only 15.3% of the respondents were unanimously of the opinion that conflicts could also have a positive influence.

As to the negative consequences of conflicts we found that most of the medical specialists (55.17 ± 3.08%) rated diminished work satisfaction as the most significant negative outcome.

Table 1. Socio-demographic and work-related characteristics of respondents

Variables		n	% + Sp
Sex	Men	37	13.2 ± 2.03
	Women	242	86.74 ± 2.03
Type of employees	Physicians	74	26.52 ± 2.64
	Nurses	173	62.01 ± 2.91
	Other medical professionals	32	11.47 ± 1.91
	Hospital management staff	50	17.92 ± 2.30
	Full time employees	229	82.08 ± 2.30
Age (years)	< 30	26	9.5 ± 1.76
	31…40	80	29.2 ± 2.72
	41…50	81	29.6 ± 2.73
	> 50	87	31.8 ± 2.78
	mean ± SEM	279	44.23 ± 0.64
Length of service (years)	< 10	43	16.2 ± 2.21
	11…20	87	32.8 ± 2.81
	21…30	67	25.3 ± 2.60
	> 30	68	25.7 ± 2.62
	mean ± SEM	279	21.54 ± 0.66

Workplace conflicts lead in some cases to disruption of relationships between members of the organization. A great number of medical workers (40.0 ± 3.04%) associated the negative consequences of conflicts with exchange of personal insults and offenses.

Some respondents (35.25 ± 2.96%) rated the disruption of cooperation in the team as a dysfunctional effect resulting from the conflict.

These problems are not the only negative results from conflicts at work. We also found some consequences related to administration. According to 10.38 ± 1.89% of respondents some of their colleagues quit work because of a conflict at work while 6.54 ± 1.53% of them report of obstructions that prevent them from making innovations. Some of the participants in the conflict were transferred to other wards (2.31 ± 0.93%), or were fi red (2.69 ± 1.0%) or were refused the opportunity of having a continuing post-graduation education (1.54%).

Of some interest are the responses to the question addressing the consequences induced by direct involvement of an employee in a conflict.

The relationships in a conflict are closely associated with the generated negative emotional reactions. Most of the healthcare workers (54.6 ± 3.9%) reported that they walked away of a conflict situation feeling angry, frustrated or aggressive.

Many respondents (72.47%) reported that their mood changed negatively as a result of the conflict which exerted a disruptive effect on their presence of mind, working capacity and communicative skills.

The results show that 57.8 ± 3.61% of the surveyed respondents experienced an increase of the psychological stress, which quite often was concomitant with insomnia and other neuro-psychological disorders. The data obtained are strongly correlated with the age of the employees. Older employees(over 51 years of age) were more vulnerable with respect to the negative stress effect of conflict as opposed to the ones aged no more than 30 years, $p < 0.05$ ($\chi^2 = 18.73$).

We should also take into account the effect, not particularly a favourable effect, of increase of tension associated with increase of anxiety and stomach pains in 36.37% of the respondents.

It is disturbing that conflict causes 58.1% of the respondents to feel exhausted (burnt-out), and 63.8% to be demotivated. Analyzing the effect the main characteristics of the respondents have on their opinions, we found that they correlated with only the employment status and position of respondents (Table 1). Quite a large percentage

of full time employees (41.9%) were demotivated in conflicts, while their management officers reported rather a low percentage (24.1%) that were demotivated $p < 0.05$ ($\chi^2 = 9.68$).

Discussion

A conflict in a healthcare organization is an open opposition event resulting from mutually exclusive interests and positions. The hypothesis of the dysfunctional effect of conflict on the healthcare teams and on the activity of the organization as a whole has been investigated in a number of studies. Conflict has been, on the other hand, considered in a number of studies to be a necessary incentive for functional development of the work teams. Taking into consideration the complexity of the social phenomenon in question the researchers emphasize the fact that the consequences of a conflict differ depending on the outcome of the conflict.

Analysis of the results of this study confirms the fact that a conflict affects negatively the sense of work satisfaction of the employees. In such a context, work dissatisfaction can be a sign for the emergence of social tension.

The studies investigating work satisfaction of physicians and nurses have found a direct correlation between work satisfaction and its quality. Medical professionals that are dissatisfied with their work have a higher risk of committing professional errors and this directly influences the quality of the healthcare service. On the other hand, inadequate work satisfaction has been found to be associated with an increased number of mental ill-health cases among medical professionals.

Presence of conflicting relationships between the members of the team creates unpleasant experiences, leading to negative attitudes and behaviour.

The results of the survey show that in quite a great number of cases (40%) the opponents in a conflict respond with verbal aggression expressed in personal insults and attacks. The dysfunctional consequences from the verbal aggression between medical specialists are poor working relations, work dissatisfaction, reduced feeling of well-being, as well as lack of trust and feeling of support on the working place.

Information is retrieved during a conflict obtained in the clash of the different opinions and decisions. The disrupted communication in such a situation acts as a conflict catalyst hindering the understanding of an individual employee of the situation or of the viewpoints of the others. Specialists in the field suggest that inadequate communication obstructs the effective resolution of conflicts.

The negative character of the conflict at onset prevents the opposing parties from cooperating with one another, erects artificial barriers to mutual understanding and fuels the desire to keep the conflict alive. The communication and collaboration failures among medical professionals result in turn to accidents in the healthcare provision to patients.

The conflict outcomes have a negative impact on the qualified staff turnover.

The present study found relatively small percentage of employees that quit the job (10.38%). It should be noted here that this information was not obtained from those that quit the job as a result of a conflict, which makes it quite likely that this percentage could be greater.

The destructive impact of conflict becomes quite evident in the medical professionals implicated directly in the conflict.

<…>

Most of the employees (54.6%) walked away from the conflict feeling angry, frustrated or overtly aggressive. The fact that there is discrepancy in the perceptions, values and beliefs, triggers a number of emotional and affective processes which generate emotional states of anger, aggression, resentment, criticism and subsequent frustration. Emotions are an integral part of the conflict dynamics – they determine the way people respond to certain situations. When conflicts are not discussed effectively, emotions escalate. On the other hand, when the way a conflict is resolved does not satisfy the participants in the conflict, it affects the professional relations and the teamwork efficiency providing quality care to the patient.

Analysis of the results in the present study shows that mood changes negatively with clearly manifested animosity and instability in most of the medical employees (72.47%). Anger and the accompanying conflict-related negative emotions cause the attitudes and the cognition of other people to change.

Most of the medical professionals (57.8%) reported that conflict appears to be a workplace stressor, a finding that is consistent with the results of other researchers. Being a major source of stress conflict has an impact on the employees' well-being and performance and on the team health.

The intense excitement and greater stress, as well as the interpersonal tension and distrust do not allow the individual to focus on the problems and be ready to generate ideas and implement the adequate solutions of these problems. Research has shown that continuous exposure to stressors may have negative outcomes for the

medical professional – these can manifest themselves as psychosomatic complains, mental strain, burnout syndrome and sleeping disorders. All these influence the quality of healthcare and the satisfaction of the patients.

Conflict relationships demotivate 63.8% of the medical professionals while performing their professional duties. This finding is consistent with the results of other researchers regarding the negative impact of conflict on the motivation of employees.

Work motivation determines the quantity and quality of the performance of a hospital employee; it is an important factor for a healthcare organization to function efficaciously. Reduced motivation as a result of tension and stress weakens the concentration of the medical professionals on their job performance.

Thus the negative impact of conflicts on the motivation of employees will affect the optimal functioning of the team and the entire hospital.

The differences we found in analyzing the results for the two categories of employees – management and regular employee – suggest that healthcare managers have inadequate information about the factors that demotivate employees to perform their professional duties. Therefore it is necessary that the motivation profile of medical professionals be studied regularly so that the factors having a negative effect on motivation can be effectively eliminated.

The contradictions that arise in a conflict destroy both personal and professional interrelations leading inevitably to creation of poor work environment; they also generate expenses with respect to time, energy, increase of stress and decrease of efficiency.

Conclusions

1. Generally, the conflicts at work have a negative impact on the work satisfaction and motivation of medical professionals during performance of their hospital duties.

2. Analysis shows that the conflict outcomes affect negatively the relations and collaboration of medical employees and impede efficient team work.

3. The conflict's dysfunctional consequences affect directly the emotional and health state of medical employees.

4. We differentiated the major negative responses of medical professionals involved in a conflict – these can be used to develop effective methods for conflict management.

5. A conflict has an impact on the work efficiency as medical employees divert their attention away from their job to the conflict situation.

Given the considerable destructive effect of conflicts on the individual employee, our findings highlight the necessity of intervening in the work process to prevent their generation at work or reduce their harmful effects on medical professionals and the healthcare organization.

***Source**: Raykova E.L., Semerjieva M.A., Yordanov G.Y., Cherkezov T.D. Dysfunctional effects of a conflict in a healthcare organization. Folia Medica, 2015, 57(2), pp. 133-137. doi:10.1515/folmed-2015-0032 https://content.sciendo.com/view/journals/folmed/57/2/article-p133.xml*

Please answer the following questions on the above article:

1. Which factors could be considered direct and indirect catalyst of interpersonal conflict and/or as facilitator of hostile behaviour?
2. How do interpersonal conflicts tend to generalize into overall decrease of medical care quality?
3. Name the main psychological, psychosomatic and somatic outcomes for healthcare specialist engaged in conflict.
4. The article is mostly about professional conflict outcome. In your opinion, how dysfunctional communication with patients, their family members or caregivers, which finally led to acute conflict situation, could affect healthcare professionals?

Regression model is the outcome of statistical procedure known as regression analysis, aimed to determine the set of the most influential factors and the ways of their influence on source variable. It is usually represented as formula which ties together one *independent variable* (in this case – intensiveness of work-family conflict) with one or more *dependent variables (factors)*. Each of those factors in the model has their own coefficients representing the direction of influence (positive values for the same-way and negative for different-way changes of both independent and dependent variables) and significance of influence compared to all other factors (the more absolute value of coefficient, the more the influence).

For the regression model of work factors, family factors, and personal factors affecting work-family conflict among healthcare professionals in Thailand (below) please answer the following questions:

1. Ignore the constant, second set of number in parentheses and the absolute value of the coefficients, and focus on their sign

(positive or negative). Could you explain why each of the factors either increase or decrease intensiveness of the conflict?

2. Ignore the constant and second set of number in parentheses. For each set of the factors (work, family, personal), could you explain why specific ones are the most influential while others are not? (*Tip: the most significant are marked with stars*)

You're encouraged to read full text of the article (available online via link in "*Source*" section) to get the proper context for this model and get familiar with study's results and conclusions.

Regression results

Variables	**Work-family conflict**
Independent variables	
Constant	2.409 (2.705)**
Work Factors	
Workloads	0.259 (2.836)**
Work flexibility	-0.162 (-2.083)*
Job autonomy	-0.106 (-1.157)
Job security	-0.156 (-1.617)
Reward and revenue	0.006 (0.074)
Manager and colleague support	-0.024 (-0.224)
Family Factors	
Spouse support	0.098 (1.081)
Family role conflict	0.375 (3.689)**
Number of children and dependents	0.037 (0.879)
Respondent as financial supporter	0.040 (0.158)
Respondent and spouse as financial supporters	0.031 (0.137)
Spouse employment	0.150 (0.730)
Personal Factors	
Male	-0.057 (-0.378)
Age	-0.013 (-1.567)
Doctor and dentist	-0.002 (-0.008)
Professional nurse	-0.251 (-1.104)
Nurse	-0.049 (-0.235)
Pharmacist and technical staff	0.126 (0.428)
Assistant Doctor and public healthcare staff	-0.113 (-0.534)

Variables	Work-family conflict
Marital status	-0.007 (-0.021)
Monthly income less than ฿ 20,000	-0.250 (-0.761)
Monthly income during ฿ 20,000 – 50,000	-0.016 (-0.057)

*Note. **p < 0.01; *p < 0.05.*

***Source**: Rittippant N., Tongkong J., Thamma-Apiroam S., Mingariyamark S. Work–family conflict: An investigation of healthcare professionals in Thailand. Internafional Proceedings of Economic Development & Research. 2011, 8, pp. 64-8. http://www.ipedr.com/vol8/13-S00022.pdf*

6.3. Questionnaires and psychological tests

THOMAS-KILMANN CONFLICT MODE INSTRUMENT

Background

The TKI is designed to measure a person's behavior in conflict situations. "Conflict situations" are those in which the concerns of two people appear to be incompatible. In such situations, we can describe an individual's behavior along two dimensions: *assertiveness*, the extent to which the person attempts to satisfy his own concerns, and *cooperativeness*, the extent to which the person attempts to satisfy the other person's concerns. These two basic dimensions of behavior define five different modes for responding to conflict situations: *competing*, *accommodating*, *avoiding*, *collaborating* and *compromising*. None of us can be characterized as having a single style of dealing with conflict. But certain people use some modes better than others and, therefore, tend to rely on those modes more heavily than others—whether because of temperament or practice.

Instructions

Imagine a conflict scenario that you have experienced and answer the prompts with that scenario in mind. For each prompt, choose the statement (either a or b) that best describes how you would respond. You may find that neither of the statements matches what you would do. In that case, select the option that most closely reflects how you would respond. It is important to note that there are no right and wrong answers.

– 1A. There are times when I let others take responsibility for solving the problem.

– 1B. Rather than negotiate the things on which we disagree, I try to stress those things upon which we both agree.

– 2A. I try to find a compromise solution.

– 2B. I attempt to deal with all of his/her and my concerns.

– 3A. I am usually firm in pursuing my goals.

– 3B. I might try to soothe the other's feelings and preserve our relationship.

– 4A. I try to find a compromise solution.

– 4B. I sometimes sacrifice my own wishes for the wishes of the other person.

– 5A. I consistently seek the other's help in working out a solution.

– 5B. I try to do what is necessary to avoid useless tensions.

– 6A. I try to avoid creating unpleasantness for myself.

– 6B. I try to win my position.

– 7A. I try to postpone the issue until I have had some time to think it over.

– 7B. I give up some points in exchange for others.

– 8A. I am usually firm in pursuing my goals.

– 8B. I attempt to get all concerns and issues immediately out in the open.

– 9A. I feel that differences are not always worth worrying about.

– 9B. I make some effort to get my way.

– 10A. I am firm in pursuing my goals.

– 10B. I try to find a compromise solution.

– 11A. I attempt to get all concerns and issues immediately out in the open.

– 11B. I might try to soothe the other's feelings and preserve our relationship.

– 12A. I sometimes avoid taking positions, which would create controversy.

– 12B. I will let him/her have some of his/her positions if he/she lets me have some of mine.

– 13A. I propose a middle ground.

– 13B. I press to get my points made.

– 14A. I tell the other person my ideas and ask for his/hers.

– 14B. I try to show him the logic and benefits of my position.

– 15A. I might try to soothe the other's feelings and preserve our relationship.

– 15B. I try to do what is necessary to avoid tensions.

– 16A. I try not to hurt other's feelings.

– 16B. I try to convince the other person of the merits of my position.

– 17A. I am usually firm in pursuing my goals.

– 17B. I try to do what is necessary to avoid useless tensions.

– 18A. If it makes the other person happy, I might let them maintain their views.

– 18B. I will let the other person have some of their positions if they let me have some of mine.

– 19A. I attempt to get all concerns and issues immediately out in the open.

– 19B. I try to postpone the issue until I have had some time to think it over.

– 20A. I attempt to immediately work through our differences.

– 20B. I try to find a fair combination of gains and losses for both of us.

– 21A. In approaching negotiations, I try to be considerate of the other person's wishes.

– 21B. I always lean toward a direct discussion of the problem.

– 22A. I try to find a position that is intermediate between his/her and mine.

– 22B. I assert my wishes.

– 23A. I am very often concerned with satisfying all our wishes.

– 23B. There are times when I let others take responsibility for solving the problem.

– 24A. If the other's position seems very important to him/her, I would try to meet his/her wishes.

– 24B. I try to get him to settle for a compromise.

– 25A. I try to show him the logic and benefits of my position.

– 25B. In approaching negotiations, I try to be considerate of the other person's wishes.

– 26A. I propose a middle ground.

– 26B. I am nearly always concerned with satisfying all our wishes.

– 27A. I sometimes avoid taking positions that would create controversy.

– 27B. If it makes the other person happy, I might let him maintain their views.

– 28A. I am usually firm in pursuing my goals.

– 28B. I usually seek the other's help in working out a solution.

– 29A. I propose a middle ground.

– 29B. I feel that differences are not always worth worrying about.

– 30A. I try not to hurt the other's feelings.

– 30B. I always share the problem with the other person so that we can work it out.

Scoring

Count the number of matching answers for each of the five strategies and determine the strategy(-ies) with maximal sum of matches:

– *Competing strategy:*

2a, 6b, 8a, 9b, 10a, 13b, 14b, 16b, 17a, 22b, 25a, 28a

– *Accommodating strategy:*

1b, 2b, 4b, 11b, 15a, 16a, 18a, 21a, 24a, 25b, 27b, 30a

– *Avoiding strategy:*

1a, 3b, 5b, 6a, 7a, 9a, 12a, 15b, 17b, 19b, 23b, 27a, 29b

– *Collaborating strategy:*

3a, 5a, 8b, 11a, 14a, 19a, 20a, 21b, 23a, 26b, 28b, 30b

– *Compromising strategy:*

4a, 7b, 10b, 12b, 13a, 18b, 20b, 22a, 24b, 26a, 29a

Competing strategy (assertive uncooperative style)

An individual pursues his own concerns at the other person's expense. This is a power-oriented mode in which you use whatever power seems appropriate to win your own position—your ability to argue, your rank, or economic sanctions. Competing means "standing up for your rights," defending a position which you believe is correct, or simply trying to win.

Strengths: they are often passionate about their views and dedicated to pursuing their convictions. They are also good at making quick decisions, and tend not to waste time, which is especially helpful in the time of crisis.

Weakness: sometimes wind up with unequal relationships with others and can hurt or overlook one's feelings with their decision-making style.

Accommodating strategy (unassertive cooperative style)

The complete opposite of competing. When accommodating, the individual neglects his own concerns to satisfy the concerns of the

other person; there is an element of self-sacrifice in this mode. Accommodating might take the form of selfless generosity or charity, obeying another person's order when you would prefer not to, or yielding to another's point of view.

Strengths: they are adept at placating people in uncomfortable situations and often gain appreciation from others involved in a conflict.

Weaknesses: they may build up resentment from denying their own needs. It also may be difficult for those who want to get to the root of the problem to work with one who tend to focus on making others happy.

Avoiding strategy (unassertive uncooperative style)

The person neither pursues his own concerns nor those of the other individual. Thus he does not deal with the conflict. Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a threatening situation.

Strengths: they are often admired for having a calming, quiet presence in the face of crisis.

Weaknesses: sometimes keep their feelings bottled up and then aren't able to meet their own needs. That causes frustrating buildup of emotions.

Collaborating strategy (assertive cooperative style)

The complete opposite of avoiding. Collaborating involves an attempt to work with others to find some solution that fully satisfies their concerns. It means digging into an issue to pinpoint the underlying needs and wants of the two individuals. Collaborating between two persons might take the form of exploring a disagreement to learn from each other's insights or trying to find a creative solution to an interpersonal problem.

Strengths: they tend to welcome differences, build high-levels of trust and mutual understanding in relationships. There is also the potential to learn from creative problem solving.

Weaknesses: when time is a factor, it is difficult to spend the energy and time needed to process the way problem solvers tend do. There is also the potential for burnout from over-processing.

Compromising strategy (semi-assertive semi-cooperative style)

The objective is to find some expedient, mutually acceptable solution that partially satisfies both parties. It falls intermediate between competing and accommodating. Compromising gives up more than competing but less than accommodating. Likewise, it

addresses an issue more directly than avoiding, but does not explore it in as much depth as collaborating. In some situations, compromising might mean splitting the difference between the two positions, exchanging concessions, or seeking a quick middle-ground solution.

Strengths: they tend to think about what they are willing to give up and what they are willing to hold on to, and try to focus on this give and take for all parties. It can be done quickly when both parties are engaged.

Weaknesses: sometimes neither party really winds up with what he/she wants. It can also be viewed as a Band-Aid approach that doesn't really get to the root of a conflict.

***Source**: Kilmann R.H., Thomas K.W. Developing a forced-choice measure of conflict-handling behavior: The"MODE" instrument. Educational and psychological measurement. 1977, 37(2), pp. 309-25. Thomas K.W. Thomas-Kilmann Conflict Mode. TKI Profile and Interpretive Report. 2008, pp. 1-11. https://pmi-ob.org/document-repository/attendance-rosters/273-thomas-kilman-conflict-mode-instrument/file https://www.usip.org/sites/default/files/2017-02/Conflict%20Styles%20Assessment_0_0.pdf*

7. Emotional burnout prevention

7.1. Preliminary and/or additional reading

Please read the following articles' abstracts prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from these articles topics during the discussion. The full-text versions could be accessed by link in "*Sourse*" section.

PREVALENCE OF AND FACTORS ASSOCIATED WITH BURNOUT AMONG HEALTH CARE PROFESSIONALS IN ARAB COUNTRIES: A SYSTEMATIC REVIEW

Background

Burnout among healthcare professionals is one of the key challenges affecting health care practice and quality of care. This systematic review aims to (1) estimate the prevalence of burnout among health care professionals (HCP) in Arab countries; and (2) explore individual and work-related factors associated with burnout in this population.

Methods

Multiple electronic databases were searched for studies published in English or Arabic from January 1980 to November 2014 assessing burnout (using the Maslach Burnout Inventory; MBI) amongst health care professionals (HCP) in Arab countries.

Results

Nineteen studies (N = 4108; 49.3% females) conducted on HCP in Bahrain, Egypt, Jordan, Lebanon, Palestine, Saudi Arabia and Yemen were included in this review. There was a wide range of prevalence estimates for the three MBI subscales, high Emotional Exhaustion (20.0–81.0%), high Depersonalization (9.2–80.0%), and low Personal Accomplishment (13.3–85.8%). Gender, nationality, service duration, working hours, and shift patterns were all significantly associated with burnout.

Conclusions

Within the constraints of the study and the range of quality papers available, our review revealed moderate-to-high estimates of self-reported burnout among HCP in Arab countries that are similar to prevalence estimates in non-Arabic speaking westernized developed countries. In order to develop culturally appropriate interventions, further research using longitudinal designs is needed to confirm the risk factors for burnout in specific HCP settings and specialties in Arab countries.

Keywords

Arab world; compassion fatigue; depersonalization; emotional exhaustion; health personal; Maslach burnout inventory; occupational health; personal accomplishment; professional burnout; wellbeing.

Source: *Elbarazi I., Loney T., Yousef S., Elias A. Prevalence of and factors associated with burnout among health care professionals in Arab countries: a systematic review. BMC Health Serv Res. 2017 Jul 17; 17(1), p. 491 doi: 10.1186/s12913-017-2319-8 https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2319-8*

PERSONALITY, ORGANIZATIONAL STRESS, AND ATTITUDES TOWARD WORK AS PROSPECTIVE PREDICTORS OF PROFESSIONAL BURNOUT IN HOSPITAL NURSES

Aim

To examine to what extent personality traits (extraversion, agreeableness, conscientiousness, neuroticism, and openness),

organizational stress, and attitudes toward work and interactions between personality and either organizational stress or attitudes toward work prospectively predict 3 components of burnout.

Methods

The study was carried out on 118 hospital nurses. Data were analyzed by a set of hierarchical regression analyses, in which personality traits, measures of organizational stress, and attitudes toward work, as well as interactions between personality and either organizational stress or attitudes toward work were included as predictors, while 3 indices of burnout were measured 4 years later as criteria variables.

Results

Personality traits proved to be significant but weak prospective predictors of burnout and as a group predicted only reduced professional efficacy ($R^2 = 0.10$), with agreeableness being a single negative predictor. Organizational stress was positive, affective-normative commitment negative predictor, while continuance commitment was not related to any dimension of burnout. We found interactions between neuroticism as well as conscientiousness and organizational stress, measured as role conflict and work overload, on reduced professional efficacy ($\beta_{NRCWO} = -0.30$; $ßc_{RCWO} = -0.26$). We also found interactions between neuroticism and affective normative commitment ($\beta = 0.24$) and between openness and continuance commitment on reduced professional efficacy ($\beta = -0.23$), as well as interactions between conscientiousness and continuance commitment on exhaustion.

Conclusion

Although contextual variables were strong prospective predictors and personality traits weak predictors of burnout, the results suggested the importance of the interaction between personality and contextual variables in predicting burnout.

Source: *Hudek-Knezević J., Kalebić Maglica B., Krapić N. Personality, organizational stress, and attitudes toward work as prospective predictors of professional burnout in hospital nurses. Croatian medical journal, 2011, 52(4), pp. 538-49. doi: 10.3325/cmj.2011.52.538 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160701*

IDENTIFYING THE DOMINANT PERSONALITY PROFILES IN MEDICAL STUDENTS: IMPLICATIONS FOR THEIR WELL-BEING AND RESILIENCE

Purpose

There is a high prevalence of stress, depression, and burn-out in medical students. Medical students differ widely in personality traits, self-perceptions, and values that may have an impact on their well-being. This study aimed to investigate variability in their personality profiles in relation to their potential for well-being and resilience.

Method

Participants were 808 medical students from The University of Queensland. An online questionnaire collected socio-demographics and the Temperament and Character Inventory to assess personality traits. Latent profile analyses identified students' trait profiles.

Results

Two distinct personality profiles were identified. Profile 1 ("Resilient") characterized 60% of the sample and was distinguished by low Harm Avoidance combined with very high Persistence, Self-Directedness and Cooperativeness compared to Profile 2 ("Conscientious"). Both Profiles had average levels of Reward Dependence and Novelty Seeking and low levels of Self-Transcendence. Profiles did not differ by age, gender, or country of birth, but rural background students were more likely to have Profile 1. While both Profiles indicate mature and healthy personalities, the combination of traits in Profile 1 is more strongly indicative of well-being and resilience.

Conclusions

Finding two distinct profiles of personality highlights the importance of considering combinations of traits and how they may interact with medical students' potential for well-being. Although both profiles of students show healthy personalities, many may lack the resilience to maintain well-being over years of medical training. Programs that develop character and personality self-awareness would enhance their well-being and prepare them to promote the health of their patients.

Source: *Eley D.S., Leung J., Hong B.A., Cloninger K.M., Cloninger C.R. Identifying the Dominant Personality Profiles in Medical Students: Implications for Their Well-Being and Resilience. PLoS one, 2016, 11(8), e0160028. doi:10.1371/journal.pone.0160028 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4975484*

7.2. Topics for discussion[4]

Read the provided article discussing the matter of professional burnout & professional stress assessment among medical students.

USING A PERSONALITY INVENTORY TO IDENTIFY RISK OF DISTRESS AND BURNOUT AMONG EARLY STAGE MEDICAL STUDENTS

Background

Physician self-care is an important foundation for quality patient interactions and outcomes, and yet studies suggest that not enough attention is paid to physician well-being, which may be shaped early in medical training. Distress and burnout among medical students are well reported in literature, with studies documenting a prevalence of 20%–50%, including common stressors (e.g., examinations, finances, and relationships). Student physicians' distress and burnout may predict adverse future health status and practice performance. Medical schools now offer programs to improve or maintain student well-being. Strategies to better identify students at risk of distress and burnout are needed for successful outcomes. Administering separate instruments to assess distress and burnout at intervals is not practical given the heavy student burden of evaluations, examinations, and the risk of survey fatigue. Using an instrument, that is, already being deployed in the curriculum is a potential solution to address these obstacles.

The Myers-Briggs Type Indicator (MBTI) is often administered in medical schools as a self-assessment tool to teach about communication and teamwork and for career guidance. Different versions of the MBTI with varying item numbers have been developed. A free online abridged version is available. Studies suggest that exploring MBTI preferences may help ascertain vulnerability and response to stress. According to a study by Davidson et al., medical school performance has been linked to individual personality traits. The study notes that unlike extraverted medical students, those with a preference for introversion performs well academically during their 1st year of training, but experience more stress and score lower on interpersonal behavioral assessments later in training. A report on medical residents found that

[4] To achieve easier readability of provided text for students, the in-text references, references list and some parts of the texts were omitted. The original (unedited) version of each article could be found via links in "*Source*" section.

introversion and other MBTI preferences of sensing, thinking, and judging were associated with higher burnout scores. In this study, extraversion, intuition, feeling, and perception were noted to be associated with greater social interactions, creative responses, and appreciation of external viewpoints and understanding, respectively. Studies exploring self-identified MBTI preferences, distress, and burnout levels among early stage (1st year) medical students are lacking.

We therefore conducted a survey study among 1st year medical students to examine the purported link between MBTI preferences and distress and burnout scores. We hypothesized that the prevalence of distress and burnout in our sample would mirror that reported (20%–50%) in literature. Our second hypothesis was that students with preferences for extraversion, intuition, feeling, or perceiving on the MBTI would score lower in distress and burnout measures than their dichotomous counterparts.

Methods

This is a cross-sectional survey study of one class of 185 1st year medical students at an urban California medical school. Participants were students in a Professionalism course who had already completed their MBTI personal preference online as part of a session on team-building. During a second session, 1 month later, they were invited to complete and submit an anonymous paper-and-pencil survey comprising two instruments: the general well-being schedule (GWB) and Maslach Burnout Inventory-Student Survey (MBI-SS). Survey administration was timed so as not to coincide with any external stressor such as examinations. Students scored themselves on the measures and were given information resources to self-manage high stress levels. The study received the Institutional Review Board approval.

Instruments. We selected the MBTI because of its utility in the context of relating effectively to others with different MBTI preferences and for building effective teams. It is a valid and reliable instrument (test-retest reliability 0.85) that has been used with medical students and healthcare professionals. The MBTI explores four dichotomies of personal preferences: extraversion-introversion, sensing-intuition, thinking-feeling, and judging-perceiving. Dichotomy one, extraversion-introversion, refers to personal sources of energy; extraverts draw energy from social interactions in contrast to introverts who reflect on experiences and concepts. Dichotomy two, sensing-intuition, signifies how one receives information;

sensing types prefer facts and data while intuitive types focus on possibilities and theoretical knowledge. Dichotomy three, thinking-feeling, focuses on how decisions are made; thinkers make decisions based on logic, whereas feelers consider other people, personal information, and values. Dichotomy four, judging-perceiving, indicates coping with the outside world; judgers favor structure and organization compared to perceivers, who opt for choices and flexibility. We elected the online version of the MBTI for our study for its ease of administration.

We chose the validated GWB as a measure of current distress in medical students. The 18-item GWB measures subjective wellness using six subscales of emotions (anxiety, depression, positive well-being, self-control, vitality, and general health) experienced within the past month. Total GWB scores range from 0 to 110, with values of 0–60 indicating severe distress, 61–72 moderate distress, and 73–110 reflecting positive well-being. Depression and anxiety are reverse scored. The GWB has a high test-retest reliability (0.68–0.85) and internal consistency coefficient (0.91 for men and 0.95 for women).

We chose the widely used MBI-SS to assess three dimensions of burnout (exhaustion, cynicism, and decreased professional efficacy). Responses for each of the 15 survey items range from 0 (never) to 6 (every day), with low scores on professional efficacy and high scores on both exhaustion and cynicism suggesting overall burnout. Burnout levels are scored as low, moderate, and high. The MBI-SS has shown good validity and reliability (0.74–0.81 emotional exhaustion, 0.59–0.86 cynicism, and 0.67–0.79 professional efficacy) among medical students.

Data collection and analyses. We collected completed anonymous paper survey responses with self-reported MBTI preferences, and entered the data into Excel. We used descriptive statistics to report demographics and prevalence. We tested quality of the data using reliability and effect sizes. We performed parametric tests based on our adequate sample size and balanced gender distribution. Using one-way MANOVAs (Hotelling's Trace), we examined the differences of MBTI personal preferences (i.e., independent variables) with distress, burnout, and related aspects (i.e., dependent variables) as measured by GWB and MBI-SS scales and subscales, respectively. In addition, we conducted two-tailed Pearson correlation and multiple regressions to assess the relation between distress and burnout variables. Alpha <0.05 was considered to be statistically significant for all tests. We used IBM SPSS Statistics for Windows version 22.0 for data analyses.

Results

All 185 students completed the three instruments (100% response rate). Students took an average of 15 min to complete the GWB and MBI-SS in class.

Demographics and participant MBTI preferences. Ninety-two (52.3%) of the students were male. Age range was 18 to over 30; 148 (83.1%) were 22–25-year-old. Seventy-six (43.7%) students self-identified mainly as Asian and 58 (33.3%) non-Hispanic white/Caucasian. More students reported a preference for intuition over sensing and judgment over perception while the other two paired preferences were evenly distributed. Introversion (vs. extraversion) was favored by 94 (51.9%), intuition (vs. sensing) 122 (68.5%), feeling (vs. thinking) 89 (50.3%), and judgment (vs. perception) 150 (83.3%). Table 1 shows student demographic and MBTI personal preferences.

Characteristics	Responses, *n* (%)
Gender	
Male	92 (52.3)
Female	84 (47.7)
Age group	
18-21 years old	3 (1.7)
22-25 years old	148 (83.1)
26-29 years old	23 (12.9)
30 years old or more	4 (2.2)
Race/ethnicity	
Hispanic/Latino	9 (5.2)
Non-Hispanic white/ Caucasian	58 (33.3)
Black/African-American	6 (3.4)
Asian	76 (43.7)
Other	25 (14.4)
MBTI personal preferences	
Extraversion	87 (48.1)
Introversion	94 (51.9)
Sensing	56 (31.5)
Intuition	122 (68.5)
Thinking	88 (49.7)
Feeling	89 (50.3)
Judging	150 (83.3)
Perceiving	30 (16.7)

The values do not add up to 185 due to missing information. MBTI=Myers-Briggs Type Indicator

Prevalence of distress (General Well-Being) and burnout (Maslach Burnout Inventory-Student Survey). Overall, positive

well-being was reported by 101 (54.6%) students, with 84 (45.4%) reporting overall distress (GWB). Of the 84 (45.4%) who reported distress, 47 (25.4%) noted moderate distress and 37 (20.0%) severe distress. For the MBI-SS, 21 (11.5%) of the respondents had high-level scores on all three dimensions of burnout (i.e., exhaustion, cynicism, and decreased professional efficacy), 6 (3.3%) moderate-level scores, 6 (3.3%) low-level scores, and 149 (81.9%) had variable scores in each burnout dimension. Examination of the MBI-SS subscales showed that 118 (64.8%) experienced high-level exhaustion, 76 (41.8%) cynicism, and 38 (20.9%) decreased professional efficacy. The prevalence of moderate-level exhaustion, cynicism, and decreased professional efficacy was 48 (26.4%), 73 (40.1%), and 42 (23.1%), respectively. The prevalence of low-level exhaustion was 16 (8.8%), cynicism 33 (18.1%), and decreased professional efficacy 102 (56.0%).

Differences between distress, burnout, and MBTI personal preferences. We conducted one-way MANOVAs to assess if there were MBTI differences between distress and burnout based on the linear combinations of the six GWB subscales and the three MBI-SS subscales, respectively. We found a statistically significant difference between extraversion-introversion preferences and scores on the GWB scale (Hotelling's Trace = 0.087, F {6, 174} =2.52, $P < 0.05$, $\eta^2 = 0.08$). Of the six GWB subscales, depression (F {1, 179} =10.4, $P < 0.01$, $\eta^2 = 0.06$), positive well-being (F {1, 179} =4.58, $P < 0.05$, $\eta^2 = 0.03$), and self-control (F {1, 179} =4.57, $P < 0.05$, $\eta^2 = 0.03$) were statistically significantly different for extraversion and introversion. Lower depression scores were found with extraversion (mean (M) =15.6; standard deviation [SD] =2.83) compared to introversion (M = 14.1; SD = 3.49). In addition, higher scores on positive well-being and self-control were shown with extraversion (M = 10.1; SD = 2.41 and M = 12.0; SD = 2.36) than introversion (M = 9.33; SD = 2.52 and M = 11.2; SD = 2.71). We found a statistically significant difference between extraversion-introversion preference and MBI-SS scores (Hotelling's Trace = 0.079, F {3, 174} =4.58, $P < 0.01$, $\eta^2 = 0.07$). Univariate analysis showed that professional efficacy (F {1, 176} =11.8, $P < 0.01$, $\eta^2 = 0.06$) contributed statistical significance toward distinguishing extraversion from introversion. Greater professional efficacy scores were reported with extraversion (M = 28.8; SD = 4.44) than introversion (M = 26.2; SD = 5.54) preference. With respect to the other MBTI preferences, there was a statistically significant difference between thinking-feeling and GWB scores (Hotelling's Trace = 0.102, F {6, 170} =2.89, $P < 0.05$, $\eta^2 = 0.09$).

Vitality (F {1, 175} =6.59, P < 0.05, $\eta^2 = 0.04$) was statistically significantly different for thinking and feeling; higher vitality scores were noted in feeling (M = 12.0; SD = 3.27) than thinking (M = 10.7; SD = 3.44) preference. We found no other statistically significant difference between MBTI personal preference and distress and burnout scores as reflected by the GWB or MBI-SS scales and subscales.

Relation between distress and burnout constructs. We performed Pearson correlation to examine the relation between distress and burnout as measured by GWB and MBI-SS scales. A high sum score on the GWB, which suggests greater well-being, was negatively associated with MBI-SS's exhaustion (P< 0.01) and cynicism (P< 0.01) and positively correlated with professional efficacy (P< 0.01). High scores on all six GWB subscales were negatively related with exhaustion (P< 0.01) and cynicism (P< 0.05) and positively correlated with professional efficacy (P< 0.01). With multiple regression analyses, GWB subscales accounted for 38% of the variance in exhaustion, 19% cynicism, and 17% professional efficacy. The significance found in both constructs suggests that the GWB subscales are unique predictors of all three MBI-SS dimensions. Table 2 shows the correlation coefficients and multiple regressions for both distress and burnout.

GWB Variables	Correlation coefficients		
	Exhaustion	Cynicism	Professional efficacy
GWB sum score	−0.56*	−0.42*	0.38*
Anxiety	−0.57*	−0.32*	0.25*
Depression	−0.35*	−0.38*	0.31*
Positive well-being	−0.37*	−0.39*	0.39*
Self-control	−0.41*	−0.38*	0.37*
Vitality	−0.57*	−0.39*	0.28*
General health	−0.33*	−0.17**	0.24*

GWB Variables	Exhaustion			Cynicism			Professional efficacy		
	B	SEB	β	*B*	SEB	β	*B*	SEB	β
Anxiety	−0.47	0.12	−0.35*	0.06	0.13	0.04	0.13	0.12	−0.11
Depression	0.25	0.19	0.14	−0.04	0.20	−0.02	0.23	0.19	−0.14
Positive well-being	−0.18	0.22	−0.08	−0.41	0.23	−0.19	0.72	0.22	0.35*
Self-control	0.06	0.23	0.03	−0.46	0.24	−0.21	0.56	0.23	0.28**
Vitality	−0.60	0.14	−0.35*	−0.35	0.15	−0.22**	0.10	0.14	0.07
General health	−0.07	0.13	−0.04	0.12	0.14	0.08	0.12	0.13	0.08
F (df)	19.2 (6)*			8.28 (6)*			7.29 (6)*		
Adjusted R^2	0.38			0.19			0.17		

*P <0.01, **P <0.05. GWB=General Well-Being, SEB=Standard Error of B

Discussion

In this exploratory survey study, our first hypothesis was met–we confirmed a high rate of distress and burnout among 1st year medical students, comparable to what has been described (20%–50%) in literature. Moderate and severe distress was reported by 45.4% of students. Over 10% of our students reported high burnout scores as defined by the components of exhaustion, cynicism, and decreased professional efficacy.

We partially met our second hypothesis that students with extraversion, intuition, feeling, or perceiving preferences on the MBTI compared with their counterparts would score lower in distress (GWB) and burnout (MBI) measures. Students with a preference for extraversion had lower scores for depression and greater scores for positive well-being, self-control, and professional efficacy compared with students with a preference for introversion. In addition, we found higher vitality scores among students with feeling preference compared with thinking preference. Other studies (on medical students, medical residents, and general population) have reported lower stress and burnout scores and greater well-being with extraversion preference, and less depersonalization with feeling preference. This may be partially explained by the greater social coping mechanisms and acceptance of external viewpoints associated with extraversion and feeling preferences, respectively. We found no other significant differences between the other MBTI preferences and the GWB and MBI-SS scales and subscales. Understanding the relation between MBTI preferences and vulnerability to distress and burnout can help educators build balanced and functional teams. Being a part of functional teams over functioning as individuals is a preference expressed by millennials. One intervention for educators to consider is to cultivate peer support through introversion-extraversion pairings when tailoring assignments and constructing student teams, both for classrooms and for peer support and mentoring.

Our study has several strengths. The measures we chose have been widely used in other studies on medical students and health professionals. We addressed the link between the MBTI and distress and burnout at an early stage of training, which has not been previously reported. We selected robust statistical analysis methods for our sample, which permitted clear interpretation. We had a 100% response and a brief interval between administration of MBTI and GWB and MBI-SS scales. The study has some limitations. Generalizability may be limited because it was conducted at a single

institution. The prevalence of distress and burnout may fluctuate across the academic year and for different levels of training, and we cannot project the differences we found to other years or stages of training. Although there may be some recall bias for the GWB (for past month's experiences), we expected no more than that seen in a general population. One theoretical limitation is that the MBTI, which is often used in different teamwork settings to understand trait dichotomies, is a dynamic and complex instrument. Student responses may be influenced by environmental factors and the tendency to select perceived socially desirable responses. Because it is considered to be a personality "type" instrument and not an analytic tool, it cannot be used to design specific stress management strategies.

Conclusion

Our findings regarding MBTI preferences and distress and burnout among early stage medical students offer a potential for an additional function for the MBTI. Administering the MBTI early in medical training may help students self-assess their potential risk for distress and burnout. Once students self-identify their risk, stress management interventions may be offered earlier. We suggest larger multi-institutional studies to confirm our observations, including surveying students at different developmental stages. We conclude that use of the MBTI may be extended beyond the context of team building and career counseling to include early identification of distress and burnout risk.

<…>

Source: *Bughi S.A., Lie D.A., Zia S.K., Rosenthal J. Using a personality inventory to identify risk of distress and burnout among early stage medical students. Educ. Health, 2017, 30, pp. 26-30. doi: 10.4103/1357-6283.210499 http://www.educationforhealth.net/text.asp?2017/30/1/26/210499*

Please answer the following questions on the above article:

1. According to article, how severe the problem of distress and emotional burnout among medical students?

2. The Myers-Briggs Typology is criticized by some psychologists due to low reliability and psychometric validity. Nevertheless, what's your opinion on personality traits as measurement of burnout & distress risk?

HEALTH BEHAVIORS AND PERSONALITY IN BURNOUT: A THIRD DIMENSION

In a former article, Cecil and colleagues addressed a phenomenon with pronounced presence across all healthcare educational and training strata, highlighting its particular relevance to medical students. Specifically, their study provides an informative perspective on burnout and its potential association with health behaviors in a sample of undergraduate medical students. While attempting to identify potential predictors, physical activity was found to be the most predictive of burnout component scores across all investigated lifestyle and health-behavior variables, with increased physical activity being significantly associated with high personal achievement (PA) and low emotional exhaustion (EE) scores. Of note, it was concluded that making healthier lifestyle choices should be encouraged in early college life to prevent the development of burnout. One important question, however, should be raised here: Is unhealthy lifestyle a true precipitator of burnout or a mere reflector of one's susceptibility towards this persistent negative mental state?

Plausibility and methodological limitations

With an observational, cross-sectional design, there is a limited capacity to establish a cause-and-effect relationship. Certainly, existing evidence indicates the potential contribution of physical activity to the improvement of mental health. Therefore, the ability of physical activity to augment burnout reduction efforts may be deemed plausible. Additionally, health behaviors' predictive capacity of burnout – as suggested by Cecil et al.'s work – may imply a causative relationship and may accordingly propose modifications of health behaviors as possible interventions to prevent burnout. Although this could be true, it should be noted that conclusions drawn from the cited study are bound to restrictions resulting from the inability to establish temporal precedence, lack of study-sample control, and absence of objective measurements of the addressed predictors (e.g., self-reported vs. measured physical activity).

The opposing premise

In its essence, burnout results from the accumulation of emotional disturbances, perception of low self-capacity, and maladaptation – all of which are elicited by stressors and subsequently culminate in suboptimal functioning. This can initiate a

cycle of continuous emotional disturbance that fosters further deterioration of functionality and performance. Such a suboptimal mental state may affect rational decision-making and drive behavior toward unhealthy acts such as smoking, drinking, and inactivity. In fact, burnout has been implicated in extremes of health-destructive behaviors, such as drug abuse and suicide, even when depressive symptoms are controlled for. Repercussions of the psychological distress of burnout may well extend beyond health behaviors to erode the student's professional behavior, leading to dishonesty, lack of empathy, and deranged ethical attitudes. Accordingly, it can be argued that disturbed health behaviors may be a result, rather than a cause, of burnout. Given the possibility of the existence of undesirable health behaviors as a cause and/or a consequence of burnout, are we facing a paradox?

The missing perspective

It seems that a third dimension to this issue exists (Fig. 1). Burnout, in a sense an adjustment disorder, is the product of the interaction between external stimuli and internal capabilities (or perceptions thereof); whether it be stress from academic challenges, self-set goals and expectations, learning climate, institutional culture, extracurricular demands, personal-life events, financial debt, discrimination, etc.; shaping the outcomes of such outer–inner interactions lies fundamentally in one's personality, which functions as the recipient and coordinator of the human inner mental systems that utilize opportunities and cope with difficulties encountered in life (Fig. 2).

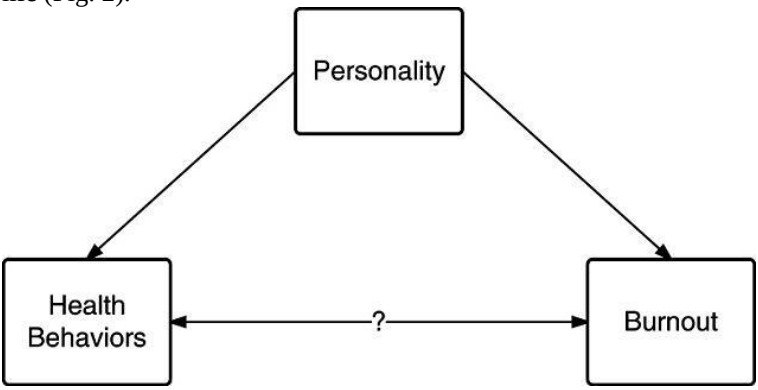


Fig. 1

A basic schematic representation of the relationship between personality, burnout, and health behaviors. Notice that the three criteria of a confounding effect of personality on the relationship between health behaviors and burnout are applicable: 1) personality is a risk factor for burnout, independent of the putative risk factor (health behaviors), 2) personality is associated with putative risk factor (health behaviors), and 3) personality is not in the causal pathway between health behaviors and burnout.

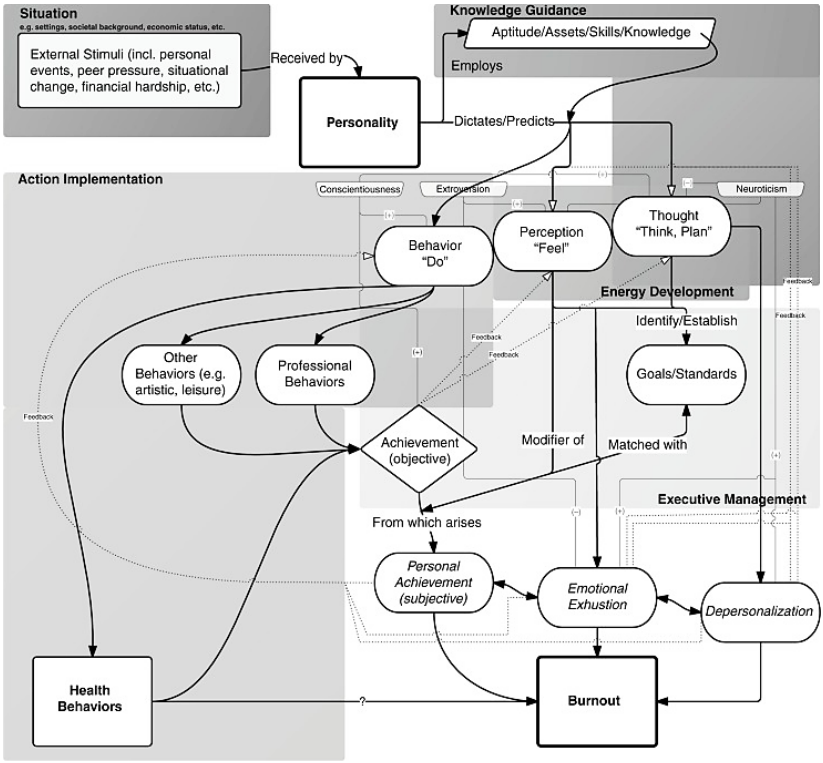


Fig. 2

Personality-burnout model: A more detailed schematic representation of the interplay between personality, health behaviors, and burnout. Personality, by definition, would incorporate elements that are predictive of behaviors (including health-oriented behaviors). Should health behaviors independently be predictive of burnout, one can appreciate how personality, through a more

comprehensive incorporation of predictive elements would represent a better prediction model of burnout. The background boxes (in shades of gray) indicate the functional areas of Mayer's Personality Systems Framework that correspond to each of the model's components that are contained within these boxes. Three constructs of the Big Five Personality Trait Model (conscientiousness, extroversion, and neuroticism) are shown to exemplify how such background personality traits could positively (+) or negatively (−) influence the various parts of the pathway between external stimuli and burnout.

Personality's effect in theory and context

Although no universally-accepted definition of personality exists, a particularly informative description of personality, which incorporates a common theme across the different views of personality in the literature, is that of Larsen and Buss:

"Personality is the set of psychological traits and mechanisms within the individual that are organized and relatively enduring and that influence his or her interactions with, and adaptations to, the intrapsychic, physical, and social environments."

In reality, applying a 'psychobehavioral trait check' to medical students can identify two opposing but mind-enlightening clusters of attributes: self-discipline, poise, dutifulness, proactivity, patience, and orderliness on one side and inattentiveness, impulsivity, negligence, passivism, and disorganization on the other. Possession of the first group of attributes allows one's knowledge, assets, and aptitude to be employed in the achievement of success in academia and maintenance thereof (Fig. 2). Similar to the prerequisites of academic success, one's ability to initiate and sustain healthy behavior (e.g., daily exercise) requires comparable determination, discipline, and patience – all of which are largely dictated by personality traits; the chances of a self-disciplined student, for example, to comply with the norms of desired health behaviors are arguably much greater than those of impulsive, unconcerned, and undisciplined counterparts.

Besides, the way perceptions of potential obstacles are composed, a key determinant of which is personality, can—in itself—empower a student with (or alternatively deprive the student of) the psychological grounds required to overcome encountered hindrances, regardless of their nature or the context in which they occur. Hardiness, a personality quality, for example, would be expected to protect against burnout. It delivers its protective effects

by leading perceptions toward viewing stressors as challenges rather than threats, resulting in the resolution of a potential psychological disturbance. Therefore, taking a holistic view of the topic, one can understand the hypothetical basis of personality's influence on the accomplishment and sustainability of success in academic as well as lifestyle matters.

The existing evidence

In addition to the conceivable theoretical foundation, the current body of evidence suggests the involvement of personality in both health behaviors and burnout. A 4.5-year longitudinal follow up of a representative sample of around 2000 Black and White US adolescents found certain personality factors to be related to risky health behaviors (such as alcohol consumption, tobacco use, and violence) and educational underachievement. Another 6-year, multicenter, admission-to-graduation longitudinal follow-up of medical students identified certain personality traits (e.g., neuroticism) as significant risk factors for experiencing high levels of stress. Reports have also suggested the persistence of personality's effect on burnout beyond medical school. A 12-year longitudinal study of UK medical graduates identified personality as a significant determinant of stress perception and eventual burnout. Likewise, McCranie et al. showed a clear correlation between the scores of maladaptive personality traits (i.e., "low self-esteem, feelings of inadequacy, dysphoria and obsessive worry, passivity, social anxiety, and withdrawal from others") and high levels of burnout.

Therefore, personality, broadly defined, does exert influence on burnout. Of note, this influence seems to remain applicable when examined under various theoretical frameworks of personality. In their meta-analysis that included several chief personality constructs (e.g., core-self-evaluation, affectivity, proactivity, and the Five-Factor Model), Alarcon et al. showed the consistent relatedness of personality to the three components of burnout: EE, PA, and depersonalization. Similarly, using constructs from Cloninger's psychobiological model, primary evidence supports the existence of personality's influence on burnout – a link which may well be embedded within basic coding blueprints of the human brain.

On the other hand, health behaviors seem to be less involved in burnout. A study evaluating the effect of an incentivizing exercise program at Mayo Clinic on physical activity and burnout found no significant difference in burnout levels between participants and non-participants despite the significant increase in meeting the U.S.

Department of Health and Human Services' recommendations for physical activity and exercise in the participants' cohort. This could be explained by the fact that physical activity, although may temporarily improve mental health and the perceived quality of life, does not address the underlying evoking factor (i.e., stressor) and accordingly plays a limited role in stress relief. In fact, on the contrary to what was believed about the positive effect of exercise on mental health, recent systematic reviews and meta-analyses have shown the effect size to be consistently small in rigorous study designs, with larger effects only seen in methodologically weaker reports. Given the involvement of personality in burnout and health behaviors, along with the limited impact of physical activity on burnout, personality may well be a confounder in the observed association between health behaviors and burnout (Fig. 1).

Conclusion

With that in mind, recognizing personality's influence on health-oriented behaviors on the one hand, and its contribution to burnout on the other hand, may aid in identifying the scaffold around which our conceptual understanding of burnout can be constructed (Fig. 2). The existing evidence indicates personality's contribution to the likelihood of success in ordinary lifestyle and professional matters; those who are capable of facing challenges of sustaining healthy behaviors are likely to confront academic difficulties with the needed resoluteness and resilience, and thus, are somewhat less likely to experience burnout. This favors the hypothesis that health behaviors' predictive capacity of burnout lies within its reflection of personality rather than a direct causality. Therefore, adjusting for potential confounding variables such as personality traits may be needed in the identification of the effect of health behaviors per se on the occurrence and development of burnout.

<…>

Source: *Health behaviors and personality in burnout:a third dimension. Med Educ. Online. 2015; 20:28187. Published 2015 Sep 11. doi:10.3402/meo.v20.28187 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4568184*

Please answer the following questions on the above article:

1. Provide summary for relationship between burnout and health behaviors (Fig. 1) based upon facts listed in the article.

2. In personality burnout model (Fig. 2), which elements could and couldn't be studied with psychological assessment tools (such as questionnaires and self-report scales)?

3. The Myers-Briggs Typology is criticized by some psychologists due to low reliability and psychometric validity. Nevertheless, what's your opinion on Myers-Briggs and Big Five personality traits as possible components of personality-burnout model?

7.3. Questionnaires and psychological tests

PSYCHOMETRIC EVALUATION OF SINGLE ITEM MEASURE FOR EMOTIONAL BURNOUT ASSESSMENT

Background information

The most common measure of burnout is the well-validated Maslach Burnout Inventory (MBI). However, the MBI is proprietary and carries licensing fees, posing challenges to routine or repeated assessment.

Non-proprietary, single-item burnout measure

1. Overall, based on your definition of burnout, how would you rate your level of burnout?

– **1** = I enjoy my work. I have no symptoms of burnout.

– **2** = Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.

– **3** = I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.

– **4** = The symptoms of burnout that I'm experiencing won't go away. I think about frustration at work a lot.

– **5** = I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.

Scoring: This item often is dichotomized as ≤2 (no symptoms of burnout) vs. ≥3 (1 or more symptoms of burnout).

Single item from MBI "Emotional Exhaustion" subscale

1. I feel burned out from my work.

– **0** = Never

– **1** = A few times a year or less

– **2** = Once a month or less

– **3** = A few times a month

– **4** = Once a week

– **5** = A few times a week
– **6** = Every day

Scoring: score ≥4 is defined as high level of burnout.

Source: *Dolan E.D., Mohr D., Lempa M., Joos S., Fihn S.D., Nelson K.M., Helfrich C.D. Using a single item to measure burnout in primary care staff: a psychometric evaluation. J Gen Intern Med. 2014; 30(5), pp. 582-587. doi: 10.1007/s11606-014-3112-6 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4395610*

8. Personality of a medical professional

8.1. Preliminary and additional reading

Please read the following article's abstracts prior to seminar to get better understanding of the topic. You're encouraged to provide facts and arguments from the article topic during the discussion. The full-text version could be accessed by link in "*Sourse*" section.

PERSONALITY TRAITS AND CAREER CHOICES AMONG PHYSICIANS IN FINLAND: EMPLOYMENT SECTOR, CLINICAL PATIENT CONTACT, SPECIALTY AND CHANGE OF SPECIALTY

Background

Personality influences an individual's adaptation to a specific job or organization. Little is known about personality trait differences between medical career and specialty choices after graduating from medical school when actually practicing different medical specialties. Moreover, whether personality traits contribute to important career choices such as choosing to work in the private or public sector or with clinical patient contact, as well as change of specialty, have remained largely unexplored. In a nationally representative sample of Finnish physicians (N = 2837) we examined how personality traits are associated with medical career choices after graduating from medical school, in terms of employment sector, patient contact, medical specialty and change of specialty.

Methods

Personality was assessed using the shortened version of the Big Five Inventory (S-BFI). An analysis of covariance with post-hoc

tests for pairwise comparisons was conducted, adjusted for gender and age with confounders (employment sector, clinical patient contact and medical specialty).

Results

Higher openness was associated with working in the private sector, specializing in psychiatry, changing specialty and not practicing with patients. Lower openness was associated with a high amount of patient contact and specializing in general practice as well as ophthalmology and otorhinolaryngology. Higher conscientiousness was associated with a high amount of patient contact and specializing in surgery and other internal medicine specialties. Lower conscientiousness was associated with specializing in psychiatry and hospital service specialties. Higher agreeableness was associated with working in the private sector and specializing in general practice and occupational health. Lower agreeableness and neuroticism were associated with specializing in surgery. Higher extraversion was associated with specializing in pediatrics and change of specialty. Lower extraversion was associated with not practicing with patients.

Conclusions

The results showed distinctive personality traits to be associated with physicians' career and specialty choices after medical school independent of known confounding factors. Openness was the most consistent personality trait associated with physicians' career choices in terms of employment sector, amount of clinical patient contact, specialty choice and change of specialty. Personality-conscious medical career counseling and career guidance during and after medical education might enhance the person-job fit among physicians.

Keywords

Medical career; medical specialty; personality traits; person-job fit; career counseling; medical education.

Source:*Mullola S., Hakulinen C., Presseau J., Gimeno Ruiz de Porras D., Jokela M., Hintsa T., Elovainio M. Personality traits and career choices among physicians in Finland: employment sector, clinical patient contact, specialty and change of specialty. BMC Medical Education, 2018, 18(1), 52. doi:10.1186/s12909-018-1155-9 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5870817*

8.2. Topics for discussion[5]

Read the provided article discussing the matter of professional burnout & professional stress assessment among medical students.

STRUCTURAL-PHENOMENOLOGICAL FEATURES OF THE INTERNAL PICTURE OF DOCTORS' ILLNESSES[6]

The vocational activities of doctors and their social status do not ensure their health (Cui, Jeter, Yang, Montague, & Eagleman, 2007; Garelick et al., 2007; Gual, 2000; Gwen, 2005; Helliwell, 2007). Falling ill, doctors don't identify themselves with ordinary patients as they have a deep knowledge of medicine; they themselves diagnose their pathological conditions, prescribe treatments, and make prognoses for the outcome of the disease. Doctors as patients are part of the professional community, which always supports them and is loyal to them. So the problem of the internal picture of doctors' illnesses is both a research and a practical problem. A study of the problem provides an understanding of its outcome: a healthy doctor is healthy medicine! In this regard the purpose of our research was to study the phenomenological features of the internal picture of doctors' illnesses using the structural approach.

Our study and analysis of the scientific literature showed no common understanding of the concept of the internal picture of a disease; existing definitions include "consciousness of disease" (Luria, 1977), "attitude to disease" (Tkhostov, 2002, p. 287), and "personal meaning of illness" (Myasishchev, 1995). Scientific interest in the internal picture of a disease is focused mainly on studying it from the standpoint of the phenomenological somatopsychic approach (Bukharov & Golubev, 2008; Danhauer et al., 2013; Koehler et al., 2011; Nissim et al., 2013; Orlova, 2010; Shtrahova, 2008; Yozwiak, Settles, & Steffens, 2011).

Nikolaev's approach (1976, pp. 95–98) provides a theoretical and methodological foundation for the study of the internal picture of a disease. In this approach, the internal picture of a disease has four levels: (1) the level of direct sensory reflection of the disease (caused by feelings and states); (2) the emotional level (immediate emotional

[5] To achieve easier readability of provided text for students, the references list and some parts of the texts were omitted. The original (unedited) version of the article could be found via links in "*Source*" section.

[6] Distributed underCC BY-NC 4.0 license (Creative Commons Attribution-NonCommercial 4.0 International).

reactions to illness caused by feelings and emotional responses to the consequences of the disease in a person's life); (3) the intellectual level (knowledge about the disease and a rational assessment of it); (4) the motivational level (the emergence of new motifs and reorganization of the premorbid motivational structure). The personal meaning of an illness is based on the integral characteristics in the system of the internal picture of the disease, including the levels (Cui et al., 2007) and the relationship between the individual system of the internal picture of the disease (Luria, 1977, pp. 37–52) (which is positive, negative, or conflictual and is aimed at changing behavior and ways of living) and a quantitative value (Shtrahova, 2008).

The *object of the study* was the internal picture of doctors' illnesses.

The *subject of the research* was the structural and phenomenological features of the internal picture of doctors' illnesses.

The *hypothesis of the study* was that the structure of the internal picture of doc-tors' illnesses is characterized by complexity and high awareness of health as a value leading to a wholesome lifestyle. When a doctor becomes ill the structure of the internal picture of the illness changes stereotyped representations about the disease at the cognitive level. In addition, distancing on an emotional level and ignoring manifestations of the disease at the behavioral level occur. The personal meaning of the doctor's own disease comes to have a conflictual character.

Method

Participants. Research was carried with the informed consent of the participants. The total number of participants was 132. The experimental group consisted of 66 sick doctors, differentiated according to the stages of their careers (Zavalishina, 2005). The first stage is vocational training (students). The second stage is professional adaptation (interns). The third stage is full professionalization (doctors). The control group consisted of 66 subjects who did not have any medical education. All the control subjects were hospitalized with chronic diseases during the study period. We graded and distributed the subjects in the experimental and control groups according to an analysis of their medical records and clinical interviews, and we grouped them according to gender (male and female), age (21 to 55 years), and nosology of the disease,

which, in equal proportions, was gastrointestinal, cardiovascular, and endocrinological (see Table 1).

Table 1. Characteristics of the total sample of subjects (N = 132)

Groups		Social and demographic characteristics		Nosology of the disease		
		Sex, m/f	age, $X_{med.} \pm \sigma_x$	Gastro-entero-logical	Cardio-vascular	Endocrino-logical
Doctors	1	12/12	22.05±0.91	8	8	8
	2	12/12	24.29±1.42	8	8	8
	3	9/9	44.03±10.33	6	6	6
Patients		33/33	39.80±10.15	22	22	22

Note. 1 — stage of vocational training (students), 2 — stage of professional adaptation (interns), 3 — stage full professionalization (doctors).

Instruments and measuring procedures

The research was carried out using clinical interviews and the archival method (analysis of medical records). The diagnostic instruments included: "Questionnaire related to health" (R. Berezovsky), "Repertory grid technique" (J. Kelly), "Question-naire on time perspective" (F. Zimbardo in A. Syrtseva's adaptation), "Timeline settings" (J. Nuttin), "Scale of psychological well-being" (K. Riff in T.D. Shevelenkova and P.P. Fesenko's adaptation), "Questionnaire of sociopsychological attitudes of a person in need of a motivational sphere" (O.F. Potemkinoy), "Lifeline technique" (autobiographical version) (J.F. Schoots). The statistical methods of research included quantitative and qualitative methods: descriptive statistics and comparative criteria (Mann-Whitney U test, F-distribution), multidimensional (factor analysis by the principal component with the Kaiser varimax rotation criterion, Karpov's (1998) structural analysis). Statistical processing was carried out with the use of "Statistica 11.0" software.

Procedure

Structural-phenomenological assessment of the internal picture of a doctor's own disease was carried out at the following levels of analysis: individual elements, generalized criteria, and integral criteria. The level of individual elements combines the properties, states, qualities, and relations of the individual. The level of generalized criteria combines the set of individual, private indicators

in a comprehensive index. The level of integral criteria combines the basic elements in the common space of the subjective manifestations of the internal picture of the disease, given the general emotional background (the balance of positive and negative states), health, and integrated assessment of the status of the individual.

We used comparative analysis (the Mann-Whitney U test and the F-distribution) for the estimation of the internal picture of the doctors' and patients' illnesses at the level of individual elements. The cognitive component consisted of awareness and competence in the field of health. The behavioral component consisted of conformity of actions and behavior to the requirements of a healthy lifestyle. The value-motivational component was characterized by the high importance of health in the individual's hierarchy of values. The emotional component, which dominated in the structure of the internal picture, was characterized by a high level of anxiety in relation to health.

Results and discussion

Sick doctors, compared with patients in the control group, were characterized by negative feelings regarding future life events with personal meaning (see Table 2). The sick doctors also had a high level of psychological well-being. We identified significantly higher values of the indicators "autonomy", "management of the environment", "personal growth", "purpose in life", and "self-acceptance". The average values of "psychological well-being" in sick doctors was significantly lower than the attitude of those in the control group, and this result testified to an insufficient level of pleasant and confident attitudes.

As can be seen in Table 2 specificity of the time perspective of the internal picture of a doctor's illness showed valid significant differences for the "negative past", "hedonistic present", "fatalistic present", and "future". For the sick doctors compared with the control-group patients past events were unpleasant and caused disgust in a greater degree. The sick doctors were focused on the satisfaction of vital needs. They were not confident in their ability to affect both present and future events.

As can also be seen in Table 2, the level of personal meaning of a doctor's internal picture was characterized by the presence of valid, significant sociopsychological factors: "result orientation", "altruism orientation", and "power (authority) orientation". The altruistic orientation in the sick doctors indicated their maturity. At the same time these people, who are ready to work very much to the detriment

of themselves, need special care because of their altruism. They are usually powerful, reliable, and able to reach good results in their activities in spite of vanity, noise, and interferences.

*Table 2. Mean values and significant differences of the internal picture of illness(experimental and control groups) (Mann-Whitney U test, $p \leq 0.05$; U*emp. ≤ Ukr.)*

<…>

We used the statistical F-distribution for estimation of the internal pictures of the sick doctors and control-group patients to get the frequency distribution of cognitive constructs ($p \leq 0.01$). The frequency of the occurrence of simple constructs was 17.53% in the sick doctors and 20.10% in the control group. The frequency of the occurrence of complex constructs was 21.30% in the sick doctors and 7.10% in the control group. The data obtained provide evidence of the cognitive complexity of personal constructs of the internal picture of a doctor's illness.

To identify the general criteria of the internal picture in the experimental and the control groups, we used the procedures of varimax rotation of the interrelationships of these variables: attitude toward the disease, meaning of the disease, mounting and the semantic component, time perspective, and Karpov's structural analysis (Karpov, 1998).

The sick doctors had a five-factor structure of the internal picture of illness, in which the first factor was the system factor, with 20.4% of the total variance. This factor consisted of the following variables: "negative past" (0.765), "positive past" (0.795), "autonomy" (0.841), "personal growth" (0.816), "sphere of disease" (0.862) with the largest positive loads, and "money orientation" (-0.706) with a negative load. We interpreted the total factor as "negative past and disease, isolation in interpersonal attitudes, domination, independence, aspiration to self-realization".

The following four generalized variables of the internal picture of the doctors' illnesses can be characterized by four generalized parameters: "time perspective" (14.9%), "high awareness in sphere of own health and altruistic values" (14.0%), "money orientation" (13.0%), "optimum uneasiness concerning own health and negative past" (10.1%). The revealed factors explain 72.4 % of the total variance.

The procedure of secondary factorization of the variables of the internal picture of the doctors' illnesses revealed the following integrative characteristics (see Figure 1): "negative past and disease,

isolation in interpersonal attitudes, domination, independence, aspiration to self-realization" (27.3%), "time perspective" (20.9%), "high awareness of own health and altruistic values" (17.4%), "optimal anxiety con-cerning own health" (10.4%). The identified factors determined 76.0% of the total variance.

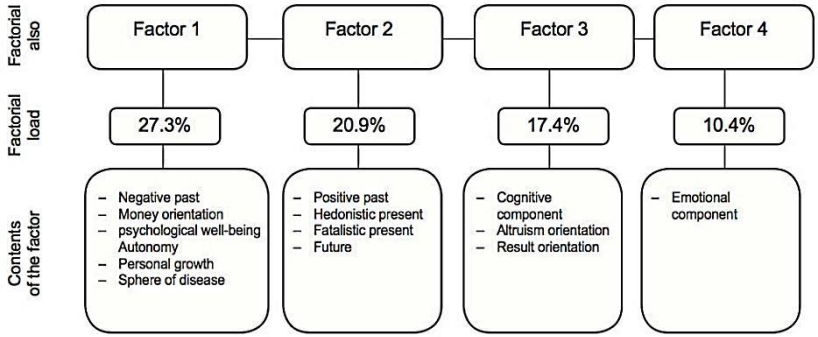


Figure 1. Factorial loadings after varimax rotation of the variables of the experimental group's internal pictures (secondary factorization); maximal factorial loadings > 0.7

We called the first factor "negative past and disease, isolation in interpersonal relationships, domination, independence, desire for self-realization". Thus, the sick doctors perceived the events of the past as unpleasant and were focused on obtaining life's pleasures. They had a limited number of relationships with other people and had difficulty expressing openness, warmth, and concern for others. They experienced frustration in the establishment of interpersonal relationships and showed unwillingness to comprise. They manifested themselves as autonomic and independent, ready to control their behavior, and they evaluated themselves according to their personal criteria. They perceived themselves as "growing" and self-realizing people, open to new experience, and having the desire and ability to realize their own potential. They did not differentiate negative life events and diseases.

We called the second factor "time perspective"; it expressed the degree of acceptance of one's own past, in which every experience was regarded as contributing to development.

We called the third factor "high awareness of own health and altruistic values"; this factor reflected the degree of awareness of one's own health and one's competence in dealing with it.

We called the fourth factor “optimal anxiety concerning own health”; this factor was characterized as the ability to enjoy one’s own health and to be pleased with it.

The next stage of the research was the factor analysis of the internal-picture structure in the control group. Five integrative indicators were identified: “psychological well-being” (19.9%), “time perspective” (16.1%), “altruism, freedom, work” (14.1%), “negative past” (9.8%), “high importance of health in the individual hierarchy of values” (7.0%). These factors explained 66.9% of the total variance.

The following integral components of the internal-picture structure in the control group explained 79.8% of the total variance: “psychological well-being” (31.5%), “time perspective” (24.5%), “egoism, authority, money” (14.7%), and “positive past” (9.1%) (see Figure 2).

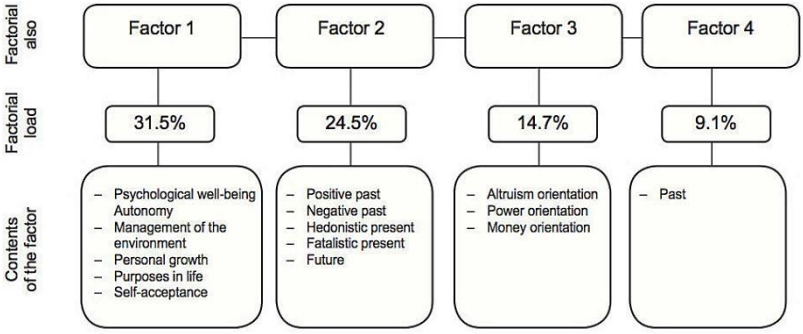


Figure 2. Factorial loadings after varimax rotation of the variables of the control group’s internal pictures (secondary factorization); maximal factorial loadings > 0.7

We called the first factor “psychological well-being” (31.5%). It was characterized as having satisfactory, confidant relationships with others, along with empathy, affection, and intimacy. It also meant understanding that human relationships are built on mutual concessions, autonomy, independence, self-regulation of one’s own behavior, and self-assessment according to one’s own criteria. This factor revealed an orientation to power and competence in managing the environment. It also was characterized by openness to new experiences as well as by having a sense of potential realization, a goal in life and sense of self-direction, a positive attitude toward

oneself, and knowledge and acceptance of various opinions, including positive and negative assessments of past events.

We called the second factor "time perspective" (24.5%); this factor represented an adequate and realistic perception of one's own disease, including the recognition of one's past experience. The indicators "hedonistic and fatalistic present" and "orientation to the future" were significantly lower in the control group than in the experimental group.

The third factor —"egoism, authority, money" (14.7%) — characterized a certain degree of "rational egoism" and the presence of orientations toward power and money.

The fourth factor, "positive past" (9.1%), reflected a positive mental attitude toward past events. This factor indicated the high importance of health in an individual's hierarchy of values and the motivation to maintain and improve health.

Study of the structural organization of the internal picture of doctors' illnesses according to the criteria of professional stages was performed using Karpov's structural analysis (Karpov, 1998) and a system of structural indices: index of coherent structures (ICS), index of divergent structures (IdS), and overall organizational structure (ITS).

The ICS was determined to be a function of positive significant relationships in the structure and measures of significance. The IdS was determined to be a function of the number and significance of negative communications in the structure. The IOS was defined as the difference in "weights" of positive and negative com-munications. These communications, significant at 0.99 and 0.95, were taken into account in the study.

Table 3. The integration measure of the structure of the internal picture of diseases in the experimental and the control groups

Group / Integration measure of the internal picture of an illness	Experimental: Professionalism stages			Control
	1	2	3	
ICS	36	64	98	108
IDS	18	40	6	8
IOS	18	24	92	100

Note. 1 — stage of vocational training (students), 2 — stage of professional adaptation (interns), 3 — stage of full professionalization (doctors); ICS — index of coherent structures; IdS — index of diver-gent structures; IOS — index of overall organizational structure.

The structural organization of the internal picture of doctors' illnesses was determined differentially according to the criteria of professional stages—vocational training, professional adaptation, and full professionalization. The highest integration measure of the structure of the internal picture of doctors' illnesses was identified at the final professional stage, doctor (IOS = 92) (see Table 3).

Study of the homogeneity and the heterogeneity of the internal-picture structure of doctors' illnesses at various stages of professionalization were carried out using the method χ^2. The results testified to the qualitative heterogeneity of the struc-ture because of the absence of statistical significance in the correlations between the ranks of the structures at various stages of professionalization: at vocational training–professional adaptation: $R = 0.87$ at $p = 0.33$; at professional adaptation– full professionalization: $R = 0.50$ at $p = 0.67$. However, the structure of the internal picture of illness in the experimental and the control groups was homogeneous because of the presence of statistical significance in the correlations between the ranks of the structures: $R = 1.00$.

Thus, the high integrity and uniformity of the structure of the internal picture of doctors' illnesses compared with the structure in patients (without the cognitive and emotional components) indicates stereotyping of perception and the conflictual nature of its personal meaning of the disease, which appeared at the behavioral level when doctors ignored symptoms of their disease.

Conclusion

The following structural and phenomenological features of the internal picture of doctors' illnesses were identified in the study: the prevalence of some anxiety in the doctors and high awareness of their health, along with their altruistic orientation, willingness to work despite difficulties, and ability to achieve high results in different activities. The structural features of the doctors' image of their own illnesses on the cognitive level were the following: qualitative heterogeneity during in-service activities, a high degree of structural integration of the image during in-service activities, and stereotyped perceptions of the disease. The emotional level revealed the emotional distance between a doctors and their patients, and the behavioral level revealed their ignoring symptoms of the disease. For the purpose of the psychoprevention of diseases, the structural-phenomenological features of the forma-tion of the internal picture of a doctor's illness as specific to the circumstances of its origin should be included in the special courses on medical psychology at

the stages of vocational training (students) and professional adaptation (interns), as well as in the "psychology in practical medicine" project for doctors.

References

<…>

Source: *Lazarenko V.A., Nikishina V.B., Molchanova L.N., Nedurueva T.V. Structural-phenomenological features of the internal picture of doctors' illnesses. Psychology in Russia: State of the Art, 2016, 9(2), pp. 4-14. doi: 10.11621/pir.2016.0201 http://psychologyinrussia.com/volumes/?article=5205*

Please answer the following questions on the above article:

3. Name the most significant features of the doctors' image of their own diseases on the cognitive and emotional level.
4. Do you consider doctors' altruistic orientation as positive or negative factor concerning their mental health?
5. Provide a few recommendations for preventive work with doctors based on results described in the article.

8.3. Questionnaires and psychological tests

PATIENT SAFETY CLIMATE IN HEALTHCARE ORGANIZATIONS (PSCHO)

Background information

The PSCHO assesses safety culture in healthcare organizations. It is comprised of subscales that assess different aspects of safety climate. These subscales are grouped into such categories as: hospital contributions to safety climate, work unit contributions to safety climate, interpersonal contributions to safety climate, and other aspects of safety climate. The hospital contributions to safety climate are composed of the senior managers' engagement, organizational resources for safety, and overall emphasis on patient safety subscales. The work unit contributions to safety is composed of the unit managers' support, unit safety norms, unit recognition and support for safety efforts, collective learning, psychological safety, and problem responsiveness subscales. The interpersonal contributions to safety climate are composed of the fear of shame and fear of blame and punishment subscales. Finally, the other aspects of safety climate section examine the provision of safe care.

Instructions

This set of statements relates to your experiences regarding patient safety in your unit and at your facility as of today, unless otherwise noted.

For each of the following statements choose one of the answers:

- **1** = strongly disagree
- **2** = disagree
- **3** = neither agree nor disagree
- **4** = agree
- **5** = strongly agree
- **X** = not applicable

Some statements refer to "my unit." Physicians and other care providers who are not unit-based should respond to these statements based on their experiences in their service, such as medicine or surgery. All others should respond to these statements based on their experiences in the work unit where they spend the majority of their time, such as ICU.

Definition: Patient Safety – Activities to avoid, prevent, or correct adverse patient outcomes which may result from the delivery of healthcare.

1. I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care
2. My unit emphasizes patient safety procedures and goals to new hires in their first 6 months of work
3. In my unit, disregarding policy and procedures is rare
4. Patient safety decisions are made at the proper level by the most qualified people
5. Senior management provides a climate that promotes patient safety
6. Reporting a patient safety problem will not result in negative repercussions for the person reporting it
7. In my unit, anyone who intentionally violates standard procedures or safety rules is swiftly corrected
8. Senior management has a clear picture of the risk associated with patient care
9. My unit takes the time to identify and assess risks to ensure patient safety
10. Asking for help is a sign of incompetence
11. Senior management has a good idea of the kinds of mistakes that actually occur in this facility

12. My unit does a good job managing risks to ensure patient safety
13. If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it
14. My unit recognizes individual safety achievement through rewards and incentives
15. Telling others about my mistakes is embarrassing
16. It is hard for doctors or nurses to hide serious mistakes
17. Good communication flow exists up the chain of command regarding patient safety issues
18. I am less effective at work when I am fatigued
19. Senior management considers patient safety when program changes are discussed
20. Personal problems can adversely affect my performance
21. I will suffer negative consequences if I report a patient safety problem
22. Compared with other facilities in the area, this facility cares more about the quality of patient care it provides
23. I have learned how to do my own job better by learning about mistakes made by my coworkers
24. My unit follows a specific process to review performance against defined training goals
25. In the last year, I have witnessed a coworker do something that appeared to me to be unsafe for the patient
26. If people find out that I made a mistake, I will be disciplined
27. Individuals in my unit are willing to report behavior that is unsafe for patient care
28. I am asked to cut corners to get the job done
29. Loss of experienced personnel has negatively affected my ability to provide high-quality patient care
30. I have enough time to complete patient care tasks safely
31. Clinicians who make serious mistakes are usually punished
32. In my unit, there is significant peer pressure to discourage unsafe patient care
33. I have never witnessed a coworker do something that appeared to me to be unsafe patient care
34. In the last year, I have done something that was not safe for the patient (R)
35. I am rewarded for taking quick action to identify a serious mistake
36. I have made significant errors in my work that I attribute to my own fatigue

37. My unit provides training on teamwork in order to improve patient care performance and safety

38. Overall, the level of patient safety at this facility is improving

Scoring

Exploratory factor analysis discovered seven main factors. Reverse items (1 = 5, 2 = 4 etc.) are marked with (*):

– Factor 1 (hospital-wide safety-related issues): items 1, 4, 5, 6, 8, 11, 17, 19, 22, 28*, 29, 30 and 38.

There're also three subscales related to safety culture overall:

1.1 Senior managers' engagement: items 4, 5, 6, 8, 11, 17 and 19;

1.2 Organizational resources for safety: items 1, 29 and 30;

1.3 Overall emphasis on safety: items 22, 28* and 38.

– Factor 2 (unit-level norms related to safety): items 2, 3, 7, 9, 12, 27 and 32.

– Factor 3 (alignment of rewards, recognition, and training with the goal of patient safety): items 14, 24, 35 and 37.

– Factor 4 (personal feelings that might deter behavior): items 10*, 13*, 15*, 21* and 36*.

– Factor 5 (coworkers or own unsafe practices): items 25*, 33 and 34*.

– Factor 6 (self-awareness of factors that could affect their performance): items 18, 20 and 23.

– Factor 7 (likelihood punishment related to mistakes and patient care errors): items 26 and 31.

Item 16 is left orphaned, as its content appeared already to be adequately represented by the other items.

Source: *Singer S., Meterko M., Baker L., Gaba D., Falwell A., Rosen A. Workforce perceptions of hospital safety culture: development and validation of the patient safety climate in healthcare organizations survey. Health Services Research, 2007, 42(5), pp. 1999-2021. doi: 10.1111/j.1475-6773.2007.00706.x https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2254575/ http://www.midss.org/content/patient-safety-climate-healthcare-organizations-pscho*

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