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YOUTH'S MENTAL HEALTH AND DEVELOPMENT OF COMMUNITY MENTAL HEALTH CARE SERVICES IN UKRAINE

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Youth's mental health in Ukraine has noticeably got worse during last ten years: the frequency of cases of anxiety disorders, social fobia, depression, PTSD, suicides and behaviour disturbance has grown. The results of epidemiological and clinical researches show that their significant reasons are the following: chronic social unstability, unexpected getting worse of economic situation of the majority of citizens, growth of frequency of family disfunctions and divorces, child abuse, family violence and neglect, absence of needed Governmental reforms in psychiatry.

One of the ways of improvement of mental health may be developing of new system of Community Mental Health Services in Ukraine. It has the most significant orientation on needs of people in the field of mental health, and it is closely connected with activity of other Community-based social and psychological programs and NGO's. The six-years' experience of activities of Youth and Family Social Psychological Support Agency of Odessa (NGO) may serve as confirmation of success of this approach in mental health. The key to its succes lies in decentralized, relatively non-hierarchical organizational structure wich allows committed and skilled multidisciplinary teams to work with youth and their families in their community. Partnerships among professionals, patients, families and community agencies result in work that is creative, productive and effective.

The development of Community Mental Health Services in Ukraine constantly meets counteraction of the State Medical Administration, their non-understanding and non-trustful attitude to NGO's in Community, Government's corruption and absence of financial support from the Government.

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ECOLOGY OF PSYCHOTHERAPY. A VIEW FROM THE PROVINCES OF RUSSIA

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In my report I would like to discuss the influence of professional activity on the quality of life of a psychotherapist in the Russian provinces.

I would also like to look at some models of psychotherapy, such as:

Healthy psychotherapist - healthy client;
Healthy psychotherapist - sick client;
Sick psychotherapist - healthy client;
Sick psychotherapist - sick client.

I would like to answer the following questions:

- How should one solve the problems of the client: either for the client, apart from the client, at the expense of the client, or together with the client?
- How can a psychotherapist work without getting burned out?
- What are the peculiarities of working with transfer and countertransfer in the Russian conditions?
- Is psychotherapy in Russia a science, an art or an occupation?
- How long should one study, for how long should one get treatment?
- Happiness and psychotherapy - is it possible?

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SYSTEMES ET NOUVELLES ORIENTATIONS SANITAIRES: REPERCUSSIONS SUR LES SERVICES ET SUR LES USAGERS

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Cette observation, préparée par les auteurs après avior attentivement analysé le territoire, a été realisée à travers le travail effectué chez des malades, leurs familles, dans l'institution et sur le territoire. L'évaluation de cette étude a amené aux réflexions sur les arguments qui suivent et qui ont leur point de départ du profil des usagers au seuil du XX° siècle et de leurs prévoiables exigences futures:

- Les réformes radicaux qu' on a eu dans la santé à cause des choix économiques et politiques et relatives conséquences.
- Le raccourcissement des séjours dans l'hôpital et les interrogations qu'il suscite; l'évaluation de la qualité des soins et la satisfaction des malades.
- L'engagement de la communauté dans la politique sanitaire et ses aspects positifs.
- L'importance de la santé et du soin des êtres humains pour le progrès général de la societé.
- L'incapacité politique de formuler des programmes en gré de donner des importants résultats futurs.
- Le changement du rôle de l'Etat à l'intérieur d'un pays avec un Système Sanitaire National; l'offre de services de bonne qualité à un coût contenu; la préparation du personnel sanitaire professionnel; le choix des Services Privés et relatives conséquences.

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VARIOUS "FACES" OF THE PLACEBO-EFFECT

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Nowdays the presence of the placebo-effect inthe therapeutic action of any pharmacological remedy including psychopharmacological ones has becom the generally accepted axiom. Every new remedy is even specifically tested. It allows to estimate its pharmacological truth effect. Although, what does the knowleadge of the placebo-effect of a psychopharmacological remedy bring tothe practice of a real psychotherapist? We are in a paradoxical situation: full and obvious but so general recognition of placebo is equal to its oblivion. In this report we consider (as an example) a well-know situation of frequent bordeline patients' perverted reaction to antidepressin medicines. Our observation permit to suppose that such inadequate reactions are connected with psychotherapist' paternal behaviour. That is, speaking Transactional Analysis language, strict "Parent" psychotherapist' position causes the protest of "Child" patient. From the psychotheraputical point of view such a reaction of bordeline patients is almost clear as his symbiotic relationships with the parents remain unresolved. The patien could return to the classical reaction on the medicine only under the conscious psychotherapist correction of his psychological position. So it is necessery to take into account not only evidences and contraevidences for various medicines but psychodinamics of the patient with a different nasology and their relations with the psysician. Whether psychoterapists want to recognize it or not psychopharmacotherapy is a from of suggestion, that is a from of psychoterapy. If we stay on the position of Transactional Analisis we'll have an opportunity to pick out three basic typs of the placebo-effect: "Parent", "Adult", "Child", depending on the doctor' ego-state.

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Each of tham we also coud devide into subtypes, depending on what patient' ego-state influence is directed. The discription of doctor's psychological influence on the patient wich has been received as a result of this approach we could provoke such a biological reaction of patient' organism wich we need. Otherwise we'll come from time to time across toxic-placebo when psychological mechanisms could level or pervert varios pharmacological medical effects.

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TREATMENT OF PREMENSTRUAL DYSPHORIC DISORDER WITH FLUOXETINE DURING THE LUTEAL PHASE

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Pre-menstrual dysphoric disorder (PMDD) occurs one week before menses (in luteal phase) with depressed mood, anxiety, irritability, lethargy, sleep disturbances that seriously interfere with personal lifestyle. The study was randomised, double-blind placebo controlled trial of fluoxetine efficacy in the treatment of PMDD, when is given only during the luteal phase of the menstrual cycle. 25 individuals between the ages of 25–40 (mean = 29.5) with regular menstrual cycles were selected in two moth screening period based on their complaints-accordingly DSM IV research diagnostic criteria for PMDD. Women with a current history of major depressive disorder, dysthymic disorder or other concurrent mental disorder were excluded from investigation. Study lasted four months, and all individuals completed study. Women were randomly distributed to fluoxetine (n = 14) and placebo (n = 11) group. Mean daily fluoxetine dose was 20 mg pd. The efficacy of applied medication was assessed by Clinical Global Impression Scale (CGI), Hamilton Rating Scale for Depression (HAM-D) and daily reports using the Calendar of Pre-menstrual Experience (COPE). The result showed that a significantly better response was occurs in the fluoxetine group, with 72.6% of individuals rated as treatment responders (CGI), compared with 24.8% in the placebo group. The mean (+/– SD) on HAM-D after the treatment for fluoxetine was 8.83 +/– 4.96 and for placebo group 12.51 +/– 5.96.

These results recommended fluoxetine as the most successful drug choice to date for women with PMDD.

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PSYCHOPHARMACOLOGICAL THERAPY AND PREGNANCY – PROBLEMS AND RECOMMENDATIONS

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Treatment with psychotropic medication in pregnancy indicates special concerns for the handling of this therapy. Beside the advantages and disadvantages to the pregnant woman, the risks of the medication, or an otherwise insufficiently treated disease, for both the embryo or fetus and the pregnant woman, must be carefully thought of. The aim of our survey is to point out problems of this treatment and to give recommendations for clinical practice. Physiological changes during pregnancy and the potential teratogenity of the psychotropic drugs dependent on the time of intake are described, concentrating on neuroleptics, antidepressant drugs and mood stabilizers in detail.

Finally, some recommendations for the use of psychotropic drugs in pregnancy including non-medication-therapy alternatives are suggested.

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WHO ATTENDS AND WHO DOESN'T KEEP THEIR APPOINTMENTS IN THE PRIVATE PSYCHIATRIC PRACTICE

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Psychiatry is probably one of the medical specialties where private practice carries a major weight. However, in spite of the important role played by the private practice of psychiatry as assistance model, it is surprising the scarcity of publications concerning this topic. At the present time, private psychiatry is the great unknown and the darkness that encloses this practice could be explained as a consequence of, between others, three main reasons: the resistance of the psychiatrist to reveal his real annual income to the taxman, his reluctance to expose his own clinical skills to the scrutiny of the others, and the absence of a research attitude in this setting. Another added difficulty is the fact that since each private psychiatrist sees relatively few patients, it is difficult for anyone to accumulate a large enough sample for study. Moreover, data from public psychiatry cannot be generalized to private practice, as the investment in time and money required to gain access to private treatment constitutes in itself a selection bias. We study a sample of 1604 patients which constituted the total number of patients that had attended a particular private practice. All the patients had been treated by the same psychiatrist over a period spanning 20 years. Of the 1604 patients, 651 were male and 953 female, with a mean age of 40.65 ± 16.3 years. The majority of the patients had a basic educational level, with only a minority having a university degree. Fifty three percent were married, followed by the single ones (31.8%). From the diagnostic point of view we found a 46.6% of neurotic disorders and 25.6% of affective disorders, with substance abuse and schizophrenia being next in frequency. The mean number of consultation per patient was 4.13 ± 6.96 with a 42% of the sample having attended only once. The mean follow-up time per patient was of 13 ± 3.2 months. 38.5% of all patients was discharged by the psychiatrist while 43.4% ceased to attend for unknown reasons and 10.8% was still attending.

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COUNTERTRANSFERENCE IN PSYCHOTHERAPY OF YOUNG PEOPLE WITH SUICIDAL BEHAVIOUR

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During the suicidal crisis, a young boy or a young girl may become carriers of therapeutist's feelings, phantasies, conceptions and prejudices about suicide and death. Unconscious feelings (increased anxiety, fear, depression, aggression, and others), as well as the therapeutist's concenptions and philosophical point of view, are involved in the psychoterapeutical process and may present difficulty of countertransference in psychotherapy. In this paper, the variability of countertransference in the psychotherapy of thia category of patients is emphasized. The cause of such hesitations of transference are characteristic of young people personality in the developmental period as well as of the therapist's and othrs. The author considers that adequate education and supervision help the therapeutist to control this negative contertransference. In case that the therapeutist cannot control the negative countertransference, the suicidal crisis becomes deeper.

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