МНОГОФАКТОРНАЯ ХАРАКТЕРИСТИКА ПАЦИЕНТОВ С НЕПСИХОТИЧЕСКИМИ ПСИХИЧЕСКИМИ РАССТРОЙСТВАМИ И ХРОНИЧЕСКИМ БОЛЕВЫМ СИНДРОМОМ

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Актуальность. Ряд биологических, психологических и социальных факторов, среди которых ведущим является эмоциональное состояние, определяет формирование болевого поведения у пациентов с хронической болью. Многофакторное субъективное восприятие боли и ответ на нее в виде болезненного поведения у некоторых пациентов с хроническим болевым синдромом (ХБС) препятствует процессу заживления или значительно его удлиняет.

Цель исследования заключалась в многофакторной комплексной оценке характеристик пациентов с ХБС в зависимости от наличия сопутствующих психических расстройств, в частности депрессивного эпизода (БДЭ), генерализованного тревожного расстройства (ГТР) и тревожно-депрессивного расстройства (ТДР).

Методы. Проанализированы характеристики особенностей боли у 135 пациентов с ХБС неонкологической генеза с непсихотическими психическими расстройствами с помощью The McGill Pain Questionnaire (MPQ), The West Haven-Yale Multidimensional Pain Inventory (WHYMPI), Pain Catastrophising Scale (PCS), шкалы комплексной оценки SPAASMS. .

Результаты. Формирование болевого поведения у пациентов с ХБС происходило соответственно наличию НПР, step-by-step, от сенсорной сенсибилизации к аффективному реагированию с дополнительными изменениями мотивационного компонента. На фоне аффективных изменений добавлялся поведенческий компонент, прежде всего в виде более активного потребления медицинской помощи (дополнительные лекарства и визиты к врачу), но не общей активности.

Выводы. Прерывание (или даже временное приостановление) step-by-step цепи формирования болезненного поведения путем своевременной диагностики и терапии НПР должно уменьшить социально-экономическое бремя пациентов с ХБС.

Ключевые слова: психические расстройства, синдром хронической боли, депрессия, тревожное расстройство, болевое поведение.

MULTIFACTORIAL CHARACTERISTICS OF PATIENTS WITH NON-PSYCHOTIC MENTAL DISORDERS AND CHRONIC PAIN SYNDROMES

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Relevance. A number of biological, psychological and social factors, including the prevailing emotional state of patients, determines the formation of unhealthy behaviors in patients with chronic pain. Based on multifactorial nature of subjective pain perception and response, specific pain behavior is formed in some patients with chronic pain syndrome (CPS) and interferes with the healing process or significantly extend.

Aim of the study was to assess predictors of forming pain behavior in patients with CPS, depending on the presence of comorbid psychiatric disorders such as depressive episode (MDD), generalized anxiety disorder (GAD), and anxiety-depressive disorder (ADD).

Methods. Were analyzed by multifactorial comprehensive assessment of the characteristics of 135 patients with CPS non- cancer genesis and the non-psychotic mental disorders using The McGill Pain Questionnaire (MPQ), The West Haven-Yale Multidimensional Pain Inventory (WHYMPI), Pain Catastrophising Scale (PCS), the scale integrated assessment SPAASMS.

Results. Formation of pain behavior in patients with CPS occurred respectively by the presence of non-psychotic mental disorders (MDD, GAD, ADD): from sensor sensitization to affective response with additional modifications of the motivational component. Then the behavioral component was added first as a active use of medical aid (additional drugs and visits to the doctor), but not the total activity.

Conclusions. Interrupts or even a temporary suspension of forming painful chain behavior by timely diagnosis and treatment of non-psychotic mental disorders (MDD, GAD, ADD) is to reduce the social and economic burden of patients with CPS.

Key words: mental disorders, chronic pain syndrome, depression, anxiety disorder, pain behavior.

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REHABILITATION POTENTIAL OF PERSONALITY IN PARANOID SCHIZOPHRENIA

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Key-words: personality's component, rehabilitation potential, transactional analysis, paranoid form of schizophrenia.

Important changes related to the conceptualization and realization of the important role of rehabilitation in the treatment of mental illnesses take place in the world of psychiatry. These changes are related to schizophrenia spectrum disorders in particular. The modern psychiatry problem of effectiveness and safety of reduction of exacerbations in patients with schizophrenia has been appeared and still is an actual issue. Complex psychological problems in the family, related to the risk of its collapse, the growth of neurocognitive deficits, social stigma society with the «displacement» of patients and the general decline in the quality of their life are the most important issues for these patients. [1]

Actuality. Psychosocial rehabilitation measures in the form of clinic- psychological, psycho-pedagogical and psychotherapeutic conditions are the most important issues for these patients. Their goal is to achieve the patients autonomous functioning in society as the restoration of their ability to conscious control of social behavior [2]. Increasing of social adaptation and support of social patients' functioning optimal level became treatment quality evaluation criteria. Psycho-rehabilitative activities include individual and group forms of psychotherapy, psycho-educational programs, family therapy, social skills training and other forms of medical and social influence in a properly organized rehabilitative environment. Adoption of the disease and a positive attitude to therapy with strict adherence to the therapeutic regimen, increasing of stress resistance, the formation of positive motivation, improved social functioning of the patient and creation of optimal conditions for their reintegration into society are the tasks of stress management approved in clinical protocols of medical care and rehabilitation of patients with schizophrenia. Transactional analysis as a theory of the individual and systemic psychotherapy, aimed at the development and personality changes has found its place in the system of rehabilitation [5]. The problem of psychotherapy of

schizophrenic patients is relevant for modern society, which tends to socialize and to ensure an adequate standard of living of everyone. Transactional analysis has proved to be an effective method for the therapy of these patients, but lacks theoretically based and statistically validated data regarding aspects of the structure and development of the personality, characteristic behavior patterns, components of internal picture of illness in schizophrenia that are needed to improve the system of effective psychotherapy from the perspective of transactional analysis. A human becomes the subject of study and therapy with the structure of his personality, which is represented in its progressive development. A certain peculiar pattern of psychological defense mechanisms and object relations is typical for each individual. It can cause decompensating in the form of the corresponding disorder in the psycho-traumatic situation, exceeding the adaptive capacity of the individual. The value of this approach lies in its practical orientation and recommendations for therapy based on deep and subtle understanding of the unique individuality of each patient. It is based on the so-called «life script» - individual life plan, that is developed as a survival strategy and the model of which is laid in early childhood. According to Eric Byrne, the most important life decisions are made in the first 2-3 years of life, and most of the «scenarios» are assimilated up to 6 years. The main determinants of «scenarios» are «the child ego-states» of the child's parents, which are placed in his mind through the «ban» and «promises» [3, 6]. Features of therapy in Transactional analysis are orientation on changes, and not just on the achievement of insight or enlightenment. Of course, Transactional analysis causes stress in understanding the genesis of the problems, but this understanding is never seen as the ultimate goal - awareness becomes a tool for personality changes, and the change itself is made up of decision-making and active process of the changes to be brought to life [4]. The aim of the Transactional analysis is to achieve one's autonomy and independence, taking responsibility for own emotions, thoughts and actions, independent determination of one's «destiny», included in the reality of «here and now», free from psychological games interactions, that make possible safety and transparency [5].

In Transactional analysis the «ego state» is a system of thinking and feeling, accompanied by corresponding patterns of behavior and perception. There are «Parental ego state,» which includes patterns of behavior, thinking and feeling, copied from the parental figures, as they took care of us; «Child's ego state,» which includes the feelings, thoughts, behavior and especially the perception of belonging to our past, related primarily to our current desires and needs, including the need for affection or dependency; «Adult's ego state», which includes perceptions, thoughts, feelings and behaviors related to the reality «here and now», and is responsible for contact with the reality and the realization of our desires.

Relationships within families of patients with paranoid schizophrenia is represented in terms of pathological symbiosis. The concept of symbiosis by Schiff is used in this study [10, 11]. Painful relationships of patients with paranoid schizophrenia are presented here as passive behavior due to unresolved symbiotic relationship with their parents in childhood. Symbiosis, in terms of J. Schiff, is a normal stage of development of a child, which is perceived by the mother and the child as split and merge of their needs. Symbiosis occurs when two or more people act as if they form the whole person together. Using the term structure of transactional analysis, they cachet various complementary «ego states» so that together they have a complete set of «ego states», and individually do not. Symbiosis is a normal state for a child, because he does not have adequately developed «Parental» and «Adult's» ego states», so he uses the parents' «ego states», otherwise he may die. For an adult person is not normal to depend on his partner and devalue their «Parental» and «Adult's» ability, so it is a pathological symbiosis in this case. Patients with paranoid schizophrenia make their contribution to the symbiosis with their «Child's ego states» and their relatives - with their «Parental» and «contaminated Adult's ego state.» Thus, as if the whole person is forming - a patient with paranoid schizophrenia with his «child's» needs, and some of his relatives - with their «parental» and «adult's» skills, the desire to satisfy them and to care for the mentally ill. The symbiotic relationship between patients with paranoid schizophrenia and his relatives includes mutual depreciation of up to ignoring the problems, the inability to resolve them and to change something in their life (the well-known psychological defense mechanism in the form of denial - a source of anosognosia as the absence of criticism to the illness). The purpose of such relationships is the acting out of their own problems and negative emotions on the other person, and avoidance of intimacy. And codependent person needs these relations no less than patient with paranoid schizophrenia.

In terms of transactional analysis, playing roles in symbiosis is a «psychological game», which is a close substitute for unhealthy families. «Psychological games» are the series of repetitive, stereotyped, and saturated unconscious negative emotional experiences of a patient's relationship with their micro social environment, with a characteristic change of «psychological roles.» Switching between the roles of «Chaser», when there is a worsening of the disease, and the «Victim» when he «pays» for his behavior after returning to the criticism endured is typical for the patient with paranoid schizophrenia. The alternation of roles is also typical for the inner circle of the patient. It is the role of «Victims» when relatives are literally victims of his relative in his psychotic state, «Chaser» as they pour out all the anger, all suffering from the experience of this period, and «Saviour», when, in spite of everything, they continue to live with such a person, thinking that without them he will be «completely lost», or that this is their marital or parental duty. These relationships with typical switching between roles are called «dramatic triangle.» They are characterized by a high emotional intensity and constant switching between psychological states of alternating various negative emotions of anger and rage, or guilt and pity, hopelessness and despair. They also lack clear boundaries, direct statements (intimacy), often a manipulative behavior takes place [3,6].

The object of the study was to determine the structure of rehabilitation potential of the personality of the patient with paranoid schizophrenia.

The subject of the study were the factors forming the inner picture of disease of the patient with paranoid schizophrenia.

The purpose of the study was to determine the rehabilitation potential of the personality of the patient with paranoid schizophrenia.

The tasks of the study were to develop a set of diagnostics instruments to determine the features of the structure of personality and explore the factors shaping the internal picture of the disease in the form of paranoid schizophrenia.

Materials and methods

Theoretical analysis of the current state of the investigated problems, clinic-anamnestic method, questionnaire for the definition of «structural ego states» by Julia Hey, questionnaire of «drivers» by Mary Cox, questionnaire of «personality adaptations» by Joines, the questionnaire for the definition of «moments of crisis» by Jean Isily Clark, a statistical analysis of the data.

Results and discussion

This study presents a clinical case of the patient with paranoid schizophrenia, in terms of Transactional analysis, on the part of the relationships that the patient and his family are building with each other.

Patient R., 32 years old, suffers from paranoid schizophrenia with episodic remitting type of flow.

According to the results of the test method for the determination of «structural ego states» by Julia Hey, patient is dominated by «the Parental ego state.» This result can be explained in such a way, that the person, who has developed a schizoid type of protection and proper personality structure, experienced significantly dominant influence from his parental figures and formed a strong internal introject as the basis of the «Parental ego state», and the development of the «Child's ego state» was braked to meet the requirements of his parenteral figures [5, 7, 8]. The inclusion of these introjects into his personality structure was a necessary condition for «survival» in their environment. This hypothesis can be confirmed by the data, obtained during the clinical interview, when the patient noted to be exposed to physical and moral violence in the families in his childhood. The negative manifestation of attention, that was called «strokes» by Bern, are the reflection of the negative «Parental ego state» of his parenteral figures and, therefore, form a negative parental introject. Thus, this patient is determined by contamination of the «Parental ego state» and slow downed «Child's ego-state.» The result is a tendency to criticize himself with «Parental ego states» and use the security mechanism of «escape» in response to his «Child's ego states.» The more he «escapes», the more «Parental ego state» criticizes him. Thus, a person stucks in his negative feelings. Such a structure is formed at an early oral stage, when basic needs were not satisfied [6].

In a survey of the patient's investigation dominant functional «ego states» of «Controlling Parent» and «Adaptive Child» have been identified. The «ego-state of Caring Parent» has not been defined. These data correlate with the results, obtained in the determination of the dominant structural «ego state». Any structural «ego state» can manifest in any functional «ego states», resulting in the regression of «Parental ego state» appearing in functional «ego states» of «Adaptive Child» and the «Controlling Parent» in the structure of the dominant personality [8]. Functional «ego-state» of «Adaptive Child» directly reflects the structure and provides adaptive behavior. As the patient was subjected to violence in the childhood, the decision as a «survival strategy» at the time was appropriate, and this form of behavior was an opportunity to adapt to the environment in order to preserve his life. But the dominance of «ego-state» of the «Adaptive Child» in the present time is no longer relevant and leads to social maladjustment of the patient. Functional «ego-state» of the»Controlling Parent» directly reflects the parents' introject. The aim of the «Controlling Parent» is the domination, criticism and depreciation of others [5, 6]. The patient incorporated the characteristics of his real parents and formed tight introjects. The absence of the «ego-state» of the «Caring Parent» can be explained by the fact, that the patient did not get enough care and support from his parents, and therefore has not formed a positive introject of the «Caring Parent».

According to the results of the clinical conversation, the patient's typical «life position» was identified as «I-, You-». The patient was subjected to the certain psycho-traumatic situation throughout his life, which was perceived by him as a strong threat from the outside world. This result corresponds to the described hypothesis and shows the position of the basic distrust to the outside world.

The typical «door contact» for the patient, according to Paul Ware [6], has been determined as «passive behavior.» «Passive behavior as an escape from the real interaction» is the main way for such people to respond to the world around them. The resource here is the realization of his «escape» through action, resulting in the restoration in contact with the inner emotional sphere, from which the patient is dissociated. Passive behavior is a manifestation of the dissociation process - internal alienation from unpleasant emotions. The patient puts in his conduct most of their energy. In order to establish the contacts, necessary is to act with him, because the patient does not feel safe enough to demonstrate his needs and feelings. To exit from the typical state of the patient is necessary to involve his process of thinking, but instead of thinking about his real needs and their satisfaction, he is inclined to dream and a lot of fantasy to replace reality. Pondering for him is an internal process, which he practically does not externalize. It is necessary to give positive support to the patient for him to begin externalizing his thinking process and approaching reality [10, 11].

According to the test method of determining the leading «drivers» by Mary Cox, the leading «drivers» (behavioral patterns) were identified in the following ratio: «rejoice others» (38%), «be strong» (39%), «be perfect» (10 %), «try» (9%) and «rush» (4%). Thus, the leading «drivers» are «be strong», «rejoice others» and «be perfect.» According to the results, a behavior pattern «be strong» can be determined to play a significant role in the formation of the internal picture of the disease. It is evident with overly cautious behavior of alienation from the own feelings, confidence in the own strength and endurance. This «driver» operates after dissociation of the personality and provides an opportunity not to get in touch with the own feelings, which seem to be threatening and destructive. In order to unconsciously «please» his parents, the patient tries to «be strong», with no needs and equating the concept of «to be resilient» and «to be good.» The «driver» «rejoice others» is a manifestation of a functional «ego-state» of «Adaptive Child» and provides the behavior of the adaptation [8]. Thus, undergoing psycho-traumatic influence from parental figures, the patient

realizes his old screenwriting solution to adapt and to avoid additional negative incentives.

During the methodology to determine the «moments of crisis» by Jean Isily Clark patient was determined to «stuck» in the first stage of development. The main task for the age from 0 to 6 months is to «to be». «Prohibitions», that a child can receive at this stage, are:«do not exist», «do not feel», «do not have needs», «do not be healthy» and «do not be close» [10]. Getting the psycho-traumatic injury by the patient at an early stage of development causes symptoms at all levels of operation. It is characterized by a basic mistrust, dissociated from his own experiences, disorientation in his own feelings and self-awareness. Two main frustrated needs are in the heart of these experiences – to feel safety and to be in close contact. The patient is afraid to let anything out of hand and to be «unprepared». This fear arises in early childhood, when a child can't defend himself from something unexpectedly happened in reality. Thus, the decision of the patient's early childhood was to control himself, others and to keep others at a safe distance.

The patient was found «scenario ban» «do not be close.» Since he experienced negative manifestations of attention, ignorance and the failure to be taken by the parents in his childhood, the child took an early decision «to stay emotionally away from people to avoid negative feelings of abandonment, loneliness and despair.» Also, the patient was found «ban» «do not feel your feelings.» This «scenario solution» is closely linked to the decision «not to be close» and an internal protection from pain. The discovered «ban» «do not think» is formed from the previous «bricks»: as the patient is dissociated from the signals of his body - sensations and feelings, his thoughts are based on his own fantasies, not on facts. This «ban» appears excessive fantasizing, inability to analyze data about the world and inability to distinguish his fantasies from reality. Discovered «ban» «don't be healthy» patient realized, felling ill with schizophrenia.

According to the criteria of the definition of «personality adaptations», the prevailing «personality adaptations» were identified as «schizoid» and «paranoid». For the «schizoid» is a typical contamination of the «Parental ego state». The typical functional «ego-state» is the «ego-state» of «Adaptive Child.» The characteristic «life position» is «I-, You-». The tone is generally flat and monotonous, facial expressions and gestures are poor. Basic needs are to recognize and satisfy his needs and feelings. For this adaptation characteristic position is the avoidance of solutions. The typical «bans» are «do not be healthy,» «do not be close,» «do not feel» and «do not think», that correspond to the survey. «The doors of contact» with the «schizoid» are carried out through behavior. «Parents contamination», the exclusion of the «Child's ego state», leading functional «ego-state» of «Controlling Parent», «life position» - «I -, You -» are characteristic for the «paranoid personal adaptation». Basic needs are trust and a sense of security. Basic «bans» are «do not feel», «do not be close» and «do not trust». The leading «drivers» are «be perfect» and «be strong». These characteristics coincide with the findings. «Door contact» for «paranoid» is thinking - awareness of thoughts, which leads to the realization of feelings and then to change of the behavior [9].

Thus, from the viewpoint of Transactional analysis, schizophrenic disorders can be considered as a protective reaction. This structure allows the individual to dissociate the «unbearable» part of his own experience and «to separate» it from him. Therefore, the patient unconsciously does not trust anyone (including his analyzers and thinking, based on real facts), and «is forced» to build such understanding of reality that would satisfy his frustrated need for close contact with a significant figure (secure patterns of attachment), since the adoption of the fact, that he was rejected by family and significant awareness of his despair about this is devastating for him. Thus, for the patient real way to change his life situation is to exclude access to his «child's» needs out of the absorption symbiotic relationship, to work in the direction of bigger autonomy through confrontation and awareness of his passive behavior with respect to his own needs.

Findings

1. Schizophrenic disorders may be considered as a protective reaction.The «ego states» of «Controlling Parent» and «Adaptive Child» dominate in patient with paranoid schizophrenia.

2. No introject of the «ego state» of the «Caring Parent» is a consequence of lack of care and support by parenteral figures in childhood.

3. The prevalence of «life position» «I -, You -» is a reflection of a basic distrust to the outside world, impairment of self and others.

4. The leading «driver» «be strong» operates personality's functioning after dissociation. 5. The co-dominating «drivers» «rejoice others» and the «driver» «be strong» are formed as a result of the psycho-traumatic impact of the «Controlling Parent's ego state» of the patient's parenteral figures and are functional manifestations of the «Adaptive Child ego-state»

6. Getting the psycho-traumatic injury by the patient at an early stage of the development of personality causes symptoms on all levels of its functioning.

7. The typical «scenario prohibitions» of the patient are «do not be close», «do not feel», «do not think» and «do not be healthy».

8. The characteristic «personality adaptations» of the patient are «schizoid» and «paranoid». 9. Adequately selected and individually metered rehabilitation activities on initial stages of schizophrenia are the indicator of the success of the received assistance and determine the level of the quality of a patient's life and his social adaptation. 10. The purpose of psychotherapy in the treatment of patients with paranoid schizophrenia is to access the exclusion of their «child's» needs as the way out of absorption symbiotic relationship, to work in the direction of greater autonomy through confrontation and awareness of patient's passive behavior with respect to his own needs. 11. The obtained results can be used to diagnose internal picture of illness of the patients with paranoid schizophrenia, as well as for therapy to maintain remission phase and to improve the quality of life of the patients.

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РЕАБІЛІТАЦІЙНИЙ ПОТЕНЦІАЛ ОСОБИСТОСТІ ПРИ ПАРАНОЇДНІЙ ШИЗОФРЕНІЇ

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В даній статті представлений клінічний випадок хворого на параноїдну шизофренію з точки зору транзактного аналізу. Метою даного дослідження було визначення реабілітаційного потенціалу особистості пацієнта з параноїдною формою шизофренії залежно від впливу оточуючих психосоціальних факторів за допомогою опитувальника для визначення «структурних его-станів» Julia Hey, опитувальника «драйверів» Mary Cox, опитувальника «особистісних адаптацій» Джойнса, анкети для визначення «кризових моментів розвитку» Jean Isily Clark. Результати дослідження дозволили встановити, що розлади при шизофренії можуть бути розглянуті як захисна реакція. Отримані результати можуть бути використані для діагностики внутрішньої картини хвороби при параноїдній формі шизофренії, а також для проведення психотерапії з метою підтримання фази ремісії та покращення якості життя пацієнтів.

Ключові слова: особистісна складова, реабілітаційний потенціал, транзактний аналіз, параноїдна форма шизофренії.

РЕАБИЛИТАЦИОННЫЙ ПОТЕНЦИАЛ ЛИЧНОСТИ ПРИ ПАРАНОИДНОЙ ШИЗОФРЕНИИ

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В данной статье представлен клинический случай больного параноидной шизофренией с точки зрения транзактного анализа. Целью данного исследования было определение реабилитационного потенциала личности больного параноидной формой шизофрении в зависимости от окружающих его психосоциальных факторов с помощью опросника для определения «структурных эго-состояний» Julia Hey, опросника «драйверов» Mary Cox, опросника «личностных адаптаций» Джойнса, анкеты для определения «кризисных моментов развития» Jean Isily Clark. Результаты исследования позволили установить, что расстройства при шизофрении могут быть рассмотрены как защитная реакция. Полученные результаты могут быть использованы для диагностики внутренней картины болезни при параноидной форме шизофрении, а также для проведения психотерапии с целью поддержания фазы ремиссии и улучшения качества жизни пациентов.

Ключевые слова: личностная составляющая, реабилитационный потенциал, транзактный анализ, параноидная форма шизофрении.

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ОСОБЛИВОСТІ ПЕРЕВАЖАЮЧОЇ ПЕРЦЕПТИВНОЇ МОДАЛЬНОСТІ ТА ФУНКЦІОНАЛЬНОЇ ПІВКУЛЬОВОЇ АСИМЕТРІЇ У ХВОРИХ З ПСИХОТИЧНИМИ, НЕПСИХОТИЧНИМИ, ДЕФЕКТНО-ОРГАНІЧНИМИ РОЗЛАДАМИ ТА В ОСІБ, ЩО ПЕРЕБУВАЮТЬ ПІД ДІЄЮ СТРЕСОГЕННИХ ЧИННИКІВ

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Ключові слова: переважаюча модальність сприйняття, функціональна півкульова асиметрія мозку, деменція.

Проведені дослідження відображають особливості переважаючої модальності сприйняття, особливості півкульової асиметрії мозку у пацієнтів з психотичними, непсихотичними та дефектно-органічними розладами, та у осіб, які перебувають під дією гострого та хронічного стресового чинника.

Актуальність. Організація всього психічного життя людини, в основі якого лежать базові психічні функції, пов'язана з безпосереднім відображенням сигналів, що надходять із зовнішнього світу. Перцептивний образ є цілісним відображенням предмета у всіх його просторово-часових і модальних характеристиках (Л.М. Веккер, 1974, 1976, 1981, 1998).

Дані нейропсихології вказують на те, що в корі представлені первинні (сенсорні) і вторинні (перцептивні) зони тільки трьох модальностей – окципітальна (зорова), темпоральна (слухова) і постцентральна (соматосенсорна, кінестетична). Тільки ці три конвекситальні ділянки формують третинні (парієтальні) зони, забезпечуючи репрезентативний рівень когнітивних процесів (Васильева Н.В.).

Дослідження І.М. Сєченова, І.П. Павлова, П.К Анохіна, Л.С. Виготського, А.Р. Лурія довели, що будь-яка дія людини здійснюється складною функціональною системою, що розвивається і змінюється протягом життя.

Біологічний розвиток організму в онтогенезі підкоряється суворим закономірностям на всіх його стадіях. У кожної психічної функції і функціональної ланки є своя програма розвитку. Знання схем розвитку сприяє більш чіткій констатації поділу випадків органічної або функціональної недостатності мозку, варіантів його несформованості, тобто диференційованому підходу до відхилень від норми (дизонтогенезу).

Е. Кречмер сформулював дві основні закономірності:

при розвитку вищих ступенів мозку нижчі не відходятьвбік і не зникають, а «працюють у загальному союзі, як підлеглі інстанції під управлінням вищих»;

функції переходять знизу доверху, внаслідок чого встановлюється складна залежність між нижчим рівнем організації мозку і вищим.