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Mental and Emotional Disorders of Patients with Oncological Diseases

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Annotation: Oncological diseases increase the mental and emotional state of patients. Fighting with such diseases creates a unique problem and many consequences. Patients may experience emotional and psychological changes related to themselves, their life indicators, and the way they live their changed lives. It is also important for cancer patients to receive the treatments and medical care they receive. It is very important to maintain relationships with patients and to support them well, understand their problem, and provide emotional and spiritual support regarding their life directions.

Keywords: oncological diseases, psycho-oncology, mental rehabilitation.

INTRODUCTION

Mental illness in people with cancer is in many ways typical of any severe physical suffering, but no disease carries such a heavy burden of stress as cancer. Despite the dramatic advances in modern oncology, for many, this word is still synonymous with doom. The fight against mental illness is not only the responsibility of the doctor, but also of his family and friends. If the specialist tells him the right ways, the patient himself can do a lot.

Psycho-oncology is a broad approach to cancer therapy that addresses the emotional, social, and spiritual suffering that often accompanies cancer. The development of psycho-oncology began in the second half of the 20th century, which reflects the increased interest in studying the psychological reactions of cancer patients at all stages of their illness.

MAIN PART

Today, psycho-oncology has become an accepted part of cancer care, with psycho-oncology departments established in most major cancer centers in Canada, the United States, and many Western European countries. A major clinical challenge for the oncologist is to distinguish expected and temporary cancer-related distress from extreme, disabling conditions that require psychiatric intervention. One-third of cancer patients experience distress requiring assessment and treatment, and the most common psychiatric comorbidities are depression, anxiety disorders, and adjustment disorders. Psychiatrists should be involved in the multidisciplinary treatment team working with cancer patients. Further research is needed to determine the effectiveness of various psychological and psychopharmacological interventions in psycho-oncology and palliative medicine. Mental health issues should be incorporated into the training of health care

professionals in all fields of medicine, psychology, and social work to meet the needs of cancer patients. [1]

The role of chronic stress (mental disorders) in generalizing the cancer process in patients with a history of psychogenic illness.

a) psychoemotional disorders (anxiety, depression) as a result of chronic stress in cancer patients with psychogenic disease history are accompanied by permanent damage to body tissues and compensatory systemic activation of sanogenetic processes to restore damaged tissues. The processes of restoration of this system are inevitably accompanied by systemic suppression of anti-tumor immunity, paving the way for the generalization of the cancer process;

b) Stable elimination of psychoemotional disturbances in cancer patients restores the natural systemic activity of the antitumor immune system and helps to localize the cancer process. [2]

Advances in the field of clinical oncology, improving immediate and long-term results of treatment of patients with malignant tumors, increasing their life expectancy have not solved many rehabilitation issues affecting the quality of life of cancer patients. Neuropsychiatric disorders that occur in the stages of special and palliative treatment of cancer patients complicate the process of diagnosis and therapy and negatively affect the manifestations and results of the tumor process. Cancer patients who undergo appropriate, timely psychopharmacological and psychotherapeutic treatment are characterized by better and faster psychosocial adaptation to their disease and new living conditions. In this regard, the task of introducing and conducting complex treatment and rehabilitation programs for patients in oncology departments, including psychopharmacotherapy and psychotherapy, taking into account the stage of treatment: special (surgery, chemotherapy, radiation) or palliative, remains relevant to this day.

For cancer patients with neuropsychiatric disorders, 4 complex treatment and rehabilitation programs, including psychopharmacotherapy and various types of psychotherapy, were developed and implemented. The first three programs are specially designed for cancer patients at the stage of treatment. They were aimed at eliminating neuropsychic diseases, actively developing an attitude to "life" and mobilizing the reserve potential of patients' mental functions.

At this stage, the main importance for patients was given to various group psychotherapeutic methods (relaxation and visualization according to K. Simonton and S. Simonton, 2001; self-training, breathing exercises, content processing, etc.). Among the psychopharmacological drugs, mainly drugs with anxiolytic and antidepressant effects were used. Medicinal plants, exercise therapy and massage were also prescribed as part of these programs.

The fourth program is intended for incurable cancer patients in the stage of palliative treatment, and is mainly aimed at providing drug therapy to alleviate psychopathological symptoms, reduce pain, eating disorders, metabolic disorders, and intoxication. When using psychotherapy of a personal nature, an attitude has been formed to implement and continue palliative treatment and to activate mental functions of patients. [3-8]

At all stages of treatment, certain psychogenic reactions are observed in any patient, which vary in clinical appearance and severity.

The most common with different symptoms are:

- anxiety,
- fear,
- bad mood (up to the level of clear melancholy),
- asthenia (characterized by weakness, increased fatigue, emotional instability, sleep disorders, tears),

- hypochondria (hypochondria differs from depression, because here the cause of depressed mood is only his illness, and the patient pays full attention to it),
- apathy,
- dysphoria (sad, gloomy, angry, angry mood prevails, manifestations of anger and aggression are rare).

At the same time, a person requires maximum care and participation from loved ones. The most characteristic symptoms of this stage are anxiety and depression. This condition is characterized by severe anxiety, a sense of hopelessness about existence, and thoughts of impending death. These events can be combined with fatigue and inability to perform physical or mental activities. A person complains of headache, fatigue, insomnia or sleepiness. Some patients have obsessive, painful thoughts about death, their own funeral, etc. They constantly search, but cannot find their own hypothesis for the occurrence of the disease; they spend their entire previous life in their memories and doubt the correctness of the diagnosis. Such patients need special care and participation of their relatives and their treatment requires a lot of effort from the doctor.

Anxiety and fear often prevail in patients who were previously characterized by high vital activity. For passive people, depression comes to the fore.

There is a category of patients who always find specific "problems" in the body, which cause vague sensations and misjudge them as symptoms of rapid spread of the tumor throughout the body. Patients who were previously characterized by anxious suspicion are prone to this type of deviation

Apathetic and asthenic syndromes deserve special attention. Patients are characterized by lethargy, apathy, loss of interest in their fate, including the duration of hospitalization and the nature of treatment. They should be prescribed general strengthening and stimulating psychopharmacotherapy. In this case, it is necessary to consult a psychiatrist or psychotherapist.

After hospitalization, the severity of mental illness usually decreases (though not always). This is due to the fact that the psychological protection system is finally being activated: "Now I am under the supervision of qualified doctors in a special hospital, they will do everything to help me." Constant strengthening of such relations is the most important psychotherapeutic task, which must be solved by the attending physician and the relatives of the patient.

Conversations with the attending physician, examinations and active conducting of various studies play a special role. In a word, everything that gives the patient the impression of an active and complete study of his condition. Frequent visits to family and friends, their encouraging conversations ("You are a great doctor, we are lucky!", "You look better", etc.) are also very important. If the patient is left to fend for himself, it will worsen his condition. Every minute that is not devoted to the patient seems to him an unforgivable waste of time.

Anxiety and depressive symptoms may still be present. But his character is changing. Now the anxiety is related to the desire to get treatment as soon as possible, the person is afraid of missing time. The need for psychopharmacotherapy, as a rule, disappears at this stage. Psychotherapeutic methods come to the fore. At this stage, it is recommended to work with a psychologist or psychotherapist.

Possible manifestations of aggression. Patients are in a sad and angry mood and often require a change of treating physician. Often the edge of anger is directed at relatives, and they should be treated with tolerance.

It is customary to reject dates. In the treatment of these diseases, sedatives should be used. Psychotherapy is best aimed at reducing the negative activity of patients by changing the object of attention. The patient can be advised to keep a self-monitoring diary, bring interesting books, videos, etc.

Apathetic disorders almost double at this stage. This is indicative of ongoing fatigue in such patients. The use of antidepressants is recommended, but psychotherapy is indicated only when an increase in the patient's activity is achieved. In case of severe apathy, it is useless.

In the pre-operative (pre-treatment) stage, unfortunately, the intensity of most psychogenic diseases increases again. Apparently, with the news of a long-awaited operation, some patients have a negative attitude towards it. Refusal of surgical treatment, there are thoughts about "other" methods of treatment that have not been adequately implemented. Such an experience is often worsened by contact with other patients who have undergone surgery, for whom such treatment almost did not help.

What is characteristic of this period is the revival of superstitions, increased attention to dreams and omens. Such experiences should not be suppressed by persuasion. However, at this stage, treatment with traditional methods, turning to sorcerers and healers should not be allowed.

After the operation, the severity of all negative experiences decreases again. For many patients, surgery provides temporary psychological relief. But the patient's relatives may face post-operative fatigue, because he carelessly and indifferently repeats "there is no energy to be happy about the successful results of the operation." Often in earlier stages. Symptoms of anxiety and depression are rarely observed after surgery. During the discharge phase, people usually feel a sense of relief when they finally go home after all the shocks. Therefore, it is not surprising that euphoric manifestations are so common nowadays that they rarely require special treatment. However, even during this period, the negative experiences of patients are fully presented. Patients may lose confidence in their future. They are worried about whether they will be able to work again, how their family will receive them. The most painful thoughts are about the lack of complete recovery and radical treatment. Patients are harmed by registering in an oncology clinic, as well as warning doctors about repeated courses of therapy. Information about these events should be presented in the most gentle way. The meaning of explaining such prescriptions should have a psychotherapeutic orientation. Returning home - this stage is characterized by a much higher effectiveness of psychotherapy than psychopharmacological treatment. Relatives may face the patient's desire to isolate himself. Attitudes to the previously loved pastime are changing. Attempts by loved ones to provoke the patient in some way often end in nothing. Interest in family affairs disappears. In the experiences of patients, not only the presence of cancer, but also its consequences - disability, loss of attractiveness in women, and depressing notes related to impotence in men are constantly heard. Experiences related to the sphere of intimate life are especially painful. However, this can be overcome in families where relationships are based on deep, intimate feelings. [9]

The characteristics of mental reactions in the preoperative and early postoperative periods determine the presence and severity of subsequent mental disorders, depending on many factors, including age, social status, personality characteristics, intellectual level, family relationships, waiting time for surgery, surgery information about the practice. Results of treatment of other patients. [10, 11, 12, 13-15] According to epidemiological studies, mental disorders develop in cancer patients in 70-80% of cases. [16-18] In the case of deterioration of health, vegetative-vascular diseases and restriction of normal social activities, patients experience depression, emotional lability, constant anxiety, previously uncharacteristic aggression, fear for their health. and comes from the lack of it. [19-25] In the dynamics of ICD in cancer patients at different stages of treatment, there is an increase in anxiety from suppressing thoughts about the disease at the diagnostic stage, to the emergence of fear of death and a depressive reaction at stages, and later, depending on the outcome of treatment, the mood improves. shrinks or decreases [26].

Mental disorders are also observed in patients with oncological diseases of other localizations, and according to a number of foreign researchers, women with lung, liver, pancreas, head and neck cancer are more likely than patients with reproductive system cancer. the more specific mental illnesses develop. [27-28]. Among local studies, there is no information similar to the above on the relationship between localization and severity of mental disorders, although there

are many studies devoted to this topic. For example, I.V. Grigoryev and S.A. Igumnov thyroid cancer patients have a predominant type of anxious response to the disease; changes also occur in cognitive processes. T.I. Grushina reports on the development of anxiety and depressive disorders in patients operated on for gastric cancer, and also describes a syndrome characteristic of these patients.

The pathological emotional state of patients affects the course of the disease at all stages, complicates the preoperative period, slows down the postoperative recovery of functional disorders, and increases the risk of postoperative complications. Developing psychopathological conditions often do not tend to decrease on their own; on the contrary, their increase is observed, and therefore the need for psychological correction and rehabilitation arises [29, 30, 31]. Currently, the importance and effectiveness of psychotherapy (PT) for cancer patients is generally recognized, but uniform standards for its implementation have not yet been developed. rational, cognitive-behavioral, existential, integrative, group PT, progressive muscle relaxation, self-training, hypnosis, symbol drama, active imagination techniques, psychosynthesis, gestalt therapy, transactional analysis, psychodrama, psychoanalysis. [32]

CONCLUSION

1. In order to reduce or stop the severity of neuropsychic diseases in cancer patients in the stages of special and palliative treatment, it is necessary to carry out complex treatment and rehabilitation programs, including psychopharmacotherapy and psychotherapy.
2. Application of comprehensive treatment and rehabilitation programs should be carried out individually, taking into account the clinical structure of neuropsychiatric diseases and the stage of treatment: special or palliative.
3. In order to improve the quality of care for cancer patients, it is necessary to involve psychiatrists and psychotherapists in their treatment and to include modern psychopharmacological and psychotherapeutic approaches in the training programs of doctors engaged in special and palliative treatment (oncologist, therapist). [33]

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