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Psychological Care for Cancer Patients

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ABSTRACT

This field of clinical practice research at the junction of psychology, oncology and sociology, which arose and is developing as a subsection of oncology, is the science of psychological, mental, social and ethnic factors related to the development, prevention and elimination of oncological pathology, as well as the study of psychological abnormalities and psychiatric disorders in people suffering from oncology. But let's not forget about heredity either! Heredity is the basis of the causal series and is used to understand oneself. The law of inheritance implements the consequences and actions of a person, both positive and negative. The concept has its roots, according to which all living beings are responsible for their lives - their actions and their consequences. Information about cancer disrupts a person's habitual and safe existence and fills his life with difficult experiences, the core of which is the fear of death. Psychological studies conducted both abroad and, in our country, indicate that cancer patients need psychological help.

Introduction

Study For adequate psychological assistance, it is important to determine the situation in which the patient and his family find themselves. Usually, the situation of cancer is described as stressful. Currently, a conceptual approach has been developed in the psychology of crisis and extreme situations, from the standpoint of which the situation of cancer is defined as extreme and crisis [1]. A person in an extreme situation experiences extreme stress, and in a crisis – prolonged macrostress [5]. The reason for the inheritance of mental characteristics is one of the most hotly debated topics in modern science. Our research conducted in the field of psychotechnics shows that there is a statistical increase in manifestations of psychopathology in the families of patients suffering from mental disorders. To explain this phenomenon, research in the field of psychosomatics was aimed at finding certain mechanisms through which the transmission of predisposition to the disease is carried out. Research data have shown that, based on the genetic determination of neurophysiological processes, we can only talk about some features of the activity of the nervous system and psychophysiological processes. But at the same time, there is no reason to conclude about the genetic determination of mental activity. Modern theories about the inheritance of psychological and pathological signs through the transmission of genetic information do not have reliable data on the specific mechanism of such inheritance and are in the nature of hypotheses. The area of interest goes beyond the treatment of oncology and includes the patient's lifestyle, psychological and social aspects of the disease. Studying both the effect of cancer on the patient's psychological health and the influence of psychological and social factors, including the patient's social interactions with medical staff and family environment, on carcinogenesis and the course of the oncological process. In addition, she examines cognitive impairments resulting from chemotherapy and radiation therapy, as well as the placebo effect. The motivation for writing the article was due to several circumstances. Firstly, at present, a multidisciplinary approach to the treatment of an oncological patient includes rehabilitation as an obligatory component, an essential element of which is psychological rehabilitation. Attention to the psychological problems of an oncological patient is dictated by the fact that a malignant disease can carry a threat of mental trauma. Secondly, high-tech treatment methods create the possibility of prolonging and improving the quality of life of cancer patients. Oncologists, focusing on the process and result of treatment, leave the inner world of patients out of their field of attention. This can not only negatively affect the relationship between the doctor and the patient, but also to a certain extent affect the treatment. At the same time, the quality of life has become the subject of study in other sciences: psychology and sociology. The initial period of studying the quality of life is characterized by the lack of a unified approach to both the concept itself and the research methodology. In psychology, attention was focused on the affective and cognitive structural components of the quality of life [3], the need to investigate and treat a holistic person with a unique character of experiences, freely and responsibly deciding how to act in various situations, including in a situation of illness. The evolution of medical paradigms of the twentieth century proceeded in parallel with the trends of changing the understanding of public health: the World Health Organization (WHO) expands the concept of health and defines it as a state of physical, psychological and social well-being, and not just the absence of disease. At the same time, the concept of social conditioning of health marked the beginning of the development of a new paradigm of clinical medicine – the concept of quality of life, which came into its own in the late 1990s. During this period, WHO recommends considering the quality of life as an individual correlation of a person's position in society, in the context of the culture and value systems of this society with the goals of this individual, his plans,

opportunities and the degree of general disorder: "Quality of life is the degree to which individuals or groups of people perceive that their needs are being met, and the opportunities necessary to achieve well–being and self-realization are provided" [5]. Thus, we can say that the quality of life is a set of parameters reflecting the measurement of the course of life with an assessment of physical condition, psychological well–being, social relations and functional abilities during the development of the disease and its treatment. One of the fundamental principles of the concept of quality of life in medicine is the postulate that in order to assess the state of basic human functions, a universal criterion is needed, including the characteristics of at least four components of well-being: physical, psychological, social and spiritual. This criterion is considered as a meaningful content of the concept of "quality of life". Today, it is human well-being, bringing patients' lives closer to the level of practically healthy people, that is one of the main goals of treatment. Oncology is no exception in this regard. The question of not only "how long the patient lived", but also "how he lived these years", is increasingly occupying a place in scientific publications of recent years. The change of approaches to medical care is a worldwide modern trend: the medical model, which aims only at eliminating the disease and restoring the functioning of the human body, is gradually being replaced by a model focused on a psychosocial approach. Such a concept requires not only the restoration of the biological function of the body, but also the normalization of its psychological and social functioning. But even then, it was noted that the quality of life is an integrative concept [2]. It reads as follows: "quality of life is the adequacy of the psychosomatic state of an individual to his social status" quality of life is "satisfaction from psychosocial and other forms of activity in conditions of limitations associated with the disease" [5] The study of health-related quality of life in oncology plays an important role both in research and in clinical practice. The methodology of quality-of-life research allows us to accurately describe a complex system of multifaceted and diverse disorders that occur with cancer patients during the development of the disease and its treatment. In relation to oncological practice, the concept of quality of life research has wide possibilities for use and allows you to: • optimize the standardization of treatment methods; • to carry out the examination of new treatment methods based on international criteria adopted in most developed countries; • improve the quality of examination of new medicines; • provide full-fledged individual monitoring of the patient's condition with an assessment of early and long-term treatment results; • Develop predictive models for various forms of cancer; • Evaluate the effectiveness of prevention programs [3]. The lack of timely psychological help can lead to psychopathological changes in the patient's personality. Attention to the quality of life in oncology highlights the assessment of patients of their condition and their life in a situation of illness and treatment, which are accompanied by mental experiences of the patient. In this regard, the subjective nature of the quality of life cannot be assessed without taking into account the psychological parameters of the patient's personality [4].

A study was conducted in SIC in order to establish a link between the quality of life and socio-psychological characteristics and peculiarities of attitude to diagnosis in patients with oncological pathology. Using the clinical and psychological method (clinical conversation, observation), the content side of patients' experiences was studied. The experimental psychological method was aimed at identifying the features of the psychosocial aspect of the quality of life of patients (EORTC QLQ - C30) and showed the following results: • The quality of life of cancer patients does not depend on the diagnosis. • The quality of life depends on the stage of treatment. At the "pre-surgery" stage, regardless of whether they underwent preoperative therapy or not, the indicators on the scales of role-playing were unexpected: the patient is experiencing mental suffering. Naturally, he seeks to avoid them.

Thus, the patient is unconsciously psychologically protected from suffering. But when the unconscious psychological protection ceases to work, the patient can be said to be "forced" to cope with suffering, and for this it is necessary to be with them for some time of his life, to be in them. And, of course, the quality of life at this point may decrease. But it is suffering that pushes a person to change, and only by passing "through them" is the patient able to restore mental balance, disturbed by the news of the disease, and adapt to a changed life situation. • Patients who noted that their family relationships due to the disease "became better and stronger" had a higher quality of life compared to those whose family relationships "did not change": significant differences were found on the symptomatic scales of "fatigue" • The relationship between the quality of life and the ability of an oncological patient to find the subjective cause of her disease has been revealed. Patients who were able to relate their life story to what is happening now have higher indicators on the "physical functioning" scale, compared with those who perceived the disease as "something external", A special aspect of improving the quality of life is psychosocial support. The situation of the disease and all subsequent changes in the patient's lifestyle unfold many intrapersonal conflicts, thus being a "field" of psychological traumatization and actualization of existing and not experienced mental traumas. The experiences caused by the disease situation can outwardly be expressed in the form of psychogenic reactions: deterioration of the emotional status (depression, anxiety) leads to limited social contacts. Psychogenic reactions are ambivalent for the quality of life, being a form of mental adaptation and a factor of social maladaptation at the same time. The degree of severity of psychogenic reactions may differ not only in different patients, but also vary in the same patient at certain stages of diagnosis, treatment and rehabilitation. Social maladjustment can manifest itself in refusal of treatment, non-compliance with the regime, change of priorities to the detriment of health and life expectancy. Of course, the current situation significantly reduces the quality of life of an oncological patient, and psychological rehabilitation aimed at complex adaptation (mental and social) in order to develop positive motivation for treatment is of great importance for the success of treatment [6] A significant role in improving the quality of life of an oncological patient is played by a significant environment – the family. The patient's willingness to continue treatment, his attitude, and assessment of his capabilities also largely depend on relatives. The feeling of helplessness, the inability to help a loved one, "forces" relatives to psychologically distance themselves from the cancer patient, they may experience hard-to-hide anger from a sense of powerlessness and lack of control over the situation. As a rule, the reason for such reactions is a feeling of guilt and a feeling of helplessness. In such cases, the relatives themselves need the individual help of a psychotherapist or a medical/clinical psychologist. There are a number of theories focused on improving the quality of life, on which psychological assistance algorithms are based. The most common theory, the Discretion Theory, comes from the subject's perception of the gap between the expected and actual effect of treatment. The possibility of improving the patient's quality of life appears when the gap is reduced with effective treatment of the disease, adequate correction of symptoms, social support for the patient and a change in the patient's attitude to the disease and treatment. Life is truly of high quality when there is not a big gap between the ideal and reality; life loses its quality when there is a big gap between the ideal (hopes, ambitions, dreams) and the real (reality: here and now). Thus, in order to improve the psychosocial aspect of the quality of life of an oncological patient, it is necessary to reduce the gap between ideals (adjusted expectations) and opportunities (improving the quality of life at present). It follows from the above that the quality of life can be improved if the patient adequately evaluates his capabilities and adjusts expectations. This is very important to take into

account when interacting with an oncological patient and his relatives. At the same time, taking into account this aspect of quality of life can lead to certain psychological difficulties associated with the acceptance of the disease by cancer patients, for the resolution of which it is necessary to involve medical/clinical psychologists. In addition, the correction of timely recognized psychologically conditioned reactions in cancer patients and their family members, along with other forms of therapy in an oncological clinic, increases adaptability and thereby improves the quality of life of the patient.

Conclusion

The main goal of the entire system of medical and psychological care in oncology is to restore and/or preserve the quality of life. Within this definition, survival, i.e., life itself, is the first goal. Other biological outcomes of the disease and the treatment process – the tumor's response to treatment, duration of effect, toxicity, etc. – are secondary. Understanding the insufficiency of assessing only the biological effects of the malignant process on the patient highlighted the restoration of quality of life as a new goal of treatment. The quality of life of an oncological patient is a dynamic condition, a function that changes over time, therefore it should be evaluated over a certain period as a changing parameter depending on the type and course of the disease, the treatment process and the medical care system.

Rehabilitation of an oncological patient is understood not only as the elimination of the disease itself (this is the prerogative of treatment) and the restoration of physical functions of the body, but also as the most acceptable restoration of a person's ability to live in a familiar environment, which is impossible without addressing the personality of a sick person. The basic principles of rehabilitation of a cancer patient: • Doctor-patient partnership; • the versatility of efforts, impacts and activities aimed at different areas of the patient's life; • the unity of biological and psychosocial methods of influence; stepwise (step-by-step appointment of rehabilitation measures taking into account the dynamics of the functional and psychoemotional state of the patient) [3]. The increasing interest in rehabilitation in recent years can most likely be explained by the awareness of the medical community of the fact that the quality of life of an oncological patient can be influenced not only by the choice of the type of treatment, but also by the implementation of rehabilitation measures. In addition, the psychological rehabilitation of an oncological patient begins already at the diagnostic stage, when the patient is directly confronted with the traumatic situation of the disease. Psychological rehabilitation is an integral part of the rehabilitation of an oncological patient, it is aimed at adapting him to the situation of the disease and contributes to improving the quality of life of the patient. The development of the concept of quality of life was facilitated by the biopsychological model of medicine proposed in 1980 by American researchers, the purpose of which was to take into account the psychosocial aspects of the disease. The most accurate concept of quality of life as a key factor in the interaction between a doctor and a patient is characterized by the well-known principle: "it is necessary to treat not the disease, but the patient," formulated by the famous ancient physician Hippocrates.

Clinical Conversation

A clinical conversation is conducted in the form of an informal interview or a semi-structured conversation. Depending on the objectives of the study, the range of issues to be discussed is determined, but the duration and content of the conversation are not regulated in advance, which creates the opportunity for patients to freely present their problems.

Psychological rehabilitation - psychological assistance to them should be aimed at helping patients cope with the psychological consequences caused by oncological diseases and adapt to the situation of the disease. The psychological adaptation of the patient to the

disease consists in the ability to live in the conditions of the disease and accept all the changes that it makes or can make in life. In a situation of cancer, a person comes into contact with the extremity of his own life, and this causes him super-strong painful experiences: the picture of the world of a sick person is destroyed, his whole being refuses to believe that the former life will no longer be. And he defends himself from this devastating catastrophic information as best he can, using unconscious psychological defense mechanisms.

Psychological protection is a manifestation of unconscious mental activity, which was formed in the process of personality development [2]. Psychological protection arises as soon as there is a danger of illness, it exists both during and after treatment, preventing the development of psychological and physiological disorders. Due to psychological protection, information about the disease is not allowed into the consciousness of a sick person at all (for example, the displacement of information about the disease from the conscious sphere into the unconscious; denial of the malignant nature of the disease; regression is a return to earlier, infantile personal reactions, manifested in a demonstration of helplessness and dependence), and if traumatic information is allowed, then it is interpreted as if in a "painless" way for a person (rationalization is an explanation of information about the disease in such a way that it becomes acceptable: "The disease is severe, but detected in time"; intellectualization – control over emotions due to the predominance of reasoning about them instead of direct experience). Psychological protection acts as a buffer to ease emotional tension, reduce anxiety and fear in the patient, but, having gained a foothold, it prevents the development of new information and, consequently, the processing of the traumatic situation of the disease.

Adaptation to the disease - in general and oncological, in particular, determines the attitude to the disease. The attitude to the disease is an integrative personal characteristic of a person in a disease situation, which is formed during the disease and treatment and consists of various elements [3]. One of these elements of the relationship to the disease is the internal picture of the disease. The inner picture of the disease is called "everything that the patient experiences and experiences, the whole mass of his sensations, not only local painful ones, but also his general well–being, self-observation, his ideas about his illness, about its causes, everything that is associated for the patient with coming to the doctor - all that huge inner world a patient who consists of very complex combinations of perception and sensation, emotions, affects, conflicts, mental experiences and traumas" [3]. Thus, the internal picture of the disease represents various facets of the subjective side of the disease and consists of the following components in cancer patients [5]:

The sensual (bodily) component - is represented in the form of sensations of physical discomfort and distress, pain and their intensity. The disease forces a person to focus on the symptoms of trouble coming from the body, while resentment towards their body may arise ("My body betrayed me" – patient S.). Thus, breast cancer patients in 80% of cases admit that they did not take care of their body before the disease: they did not pay attention to those "signals" fatigue, discomfort that "came" from their body. It should be noted that concern about the state of one's body in a disease situation (especially at the beginning of the disease) is a "discovery" of one's physicality for a person and is a natural reaction. In the absence of information available to the patient about the disease and the predictability of the course of the disease, the patient's concern about the state of his body can become entrenched and turn into hypochondriac reactions, when any physical symptoms, especially pain, are perceived as life-threatening.

The cognitive component includes ideas and knowledge about the disease, the patient's thoughts, and his understanding of the disease. Based on 70 information received from various sources, including the media, the Internet, and

communication with other people, the patient's intellectual assessment of his disease occurs either as dangerous or not dangerous. Oncology for humans is one of the most complex, incomprehensible, mysterious and uncertain diseases. This fear often leads to the fact that people do not want to know anything about this disease and unconsciously defend themselves against it with the help of "denial" and "repression". The distorted view of cancer that can be observed in modern society contributes to this. However, most cancer patients want to know information about the disease in order to control their lives. There is some contradiction between the "desire to know" the truth about the disease and the "fear of knowing" the truth about it, which is resolved in such a way that the patient "wants to know" only "favorable" information for himself. The cognitive component is related to the information that the patient receives about the disease from the doctor. The patient's lack of adequate information, the inability to discuss issues related to his condition and treatment, increase the patient's anxiety, up to an increase in the symptoms of the disease and contributes to an unfavorable prognosis.

The emotional component includes the emotional reactions of the patient, which can cause both individual symptoms and the disease as a whole, as well as its consequences, including possible changes in family and social status. The specifics and intensity of emotional experiences caused by the disease depend on the degree of significance of the relationships that the disease affects. The emotional component of the internal picture of the cancer patient's disease includes, first of all, the fear of death, pain, as well as other negative emotions: anxiety, anxiety, resentment, anger, guilt and shame, emotional states of aggression and depression. These emotions and emotional states arise in response to an intellectual assessment of the disease. The doctor informs the patient about the diagnosis, refers to his cognitive assessment of the event and directly affects the emotional reactions of the patient.

The emotional component of the relationship to the disease is closely related to the somatic state. Thus, emotions are one of the factors in the holistic process of disease pathogenesis. Anxiety and depression of the patient, often concomitant with cancer, are an indicator of mental pain and always increase physical pain. The motivational component manifests itself through the unconscious of a person and in his conscious behavior aimed at recovery, getting rid of suffering, restoring physical and mental health or not contributing to it. It is expressed in the form of hope and patience of the patient while waiting for both a positive result of treatment and in the case of a negative manifestation of the disease and treatment. Often, the verbal motives for recovery and overcoming the disease do not correspond to the real attitudes of the patient. The motivational component plays a leading role in the entire internal picture of the disease, since this component determines how the patient will build his life in the context of his disease. Thus, the internal picture of the disease is a tool for creating and mastering the space of the disease in which a sick person exists. The disease space is that part of a patient's life that affects the course of his life in other areas and often determines the quality of his life. The internal picture of the disease has a certain stability and at the same time variability, clarifying and expanding the patient's own idea of the disease. Why does the patient need to explore the space of the disease? Firstly, the uncertainty that arises from the moment the disease is detected causes anxiety, which can increase. The patient tries to reduce uncertainty by explaining his illness in one way or another, which leads, accordingly, to a decrease in anxiety. Secondly, awareness of the disease, which consists not only in information about the disease, but also about treatment, and possible complications, and what the patient himself can do for his own treatment, to a certain extent creates a sense of control over the situation. Finally, mastering the space of the disease allows you to accept it and reformulate the idea of the world and yourself, which corresponds to successful adaptation.

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