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A New Approach to Psychoemotional Disorders and Personality Traits in Duodenal Malignancies

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Abstract: According to the results of epidemiological studies, somatogenic, psychogenic or mental disorders occur in almost half of tumor patients. Such combined forms of diseases require a comprehensive approach to diagnosis and treatment with the participation of an oncologist, a psychiatrist, and a psychotherapist. In practice, the advice of a psychiatrist in an oncology clinic is aimed at providing emergency care to patients with specific mental disorders - it is aimed at preventing somatogenic, reactive effects. Borderline disorders are often underdiagnosed and require individual attention.

Keywords: Psychoemotional, carcinogenic, panic-depressive.

Introduction: The psychoemotional sphere of a person is the most sensitive mechanism that first responds to any exogenous or endogenous influence. The existence of psychoemotional and psychovegetative relationships in somatic, including oncological pathology is a proven fact [1]. As a branch of psychology, psycho-oncology appeared more than 30 years ago, but the importance of studying the psychoemotional field of cancer is still not universally accepted [2]. CurrentlyhafliThere are extreme views on the nature of the tumor. One of them completely ignores the psychological ELR aspect of tumor formation, development and patient survival (traditional view), considers carcinogenesis as a multi-step process, which is directly influenced by the environment and lifestyle. is the result of the secret. , genetic, hormonal and immunological factors and their combination [3], and up to 90% of the responsibility for the occurrence of cancer falls on chemical carcinogens [4]. ignores [5]. Some studies show that positive and negative emotions, anxiety, stress, There is a certain relationship between the control of the patient's condition and especially the presence of depression symptoms and long-term survival [6; 7]. Such facts require further study. The relevance of the study is to show once again that there are additional important indicators of long-term survival of cancer patients. Until now, we believe that they are the psycho-emotional state of the patient and related to his personality traits, in particular his attitude towards illness, alexithymia and depression.

The purpose of the study: A study of psycho-emotional status and personality characteristics of cancer patients in relation to their long-term survival.

Research methods. The study was conducted in 2021-2022. During these years, the patient with a malignant tumor was under the supervision of the oncologist of the Bukhara district of the Bukhara region. 136 of them underwent additional psychological examination with their consent (2020-2022) no later than 1 month after the diagnosis of cancer. The examined group consisted of 60 men and 76 women aged 34 to 60 years, newly diagnosed with breast, stomach, colon and rectal, lung cancer in clinical group IIb. diagnosed. Psychosocial stress indicators are the Rider scale, reactive and personal anxiety (Spielberger-Khanin self-assessment scale), depression level (CES-D questionnaire), R. Cattell's Multifaceted Personality Survey (16PF) was assessed for individual-personality traits.

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questionnaire) and the patient's attitude to the disease and treatment was determined. After the diagnosis, all patients underwent special treatment at the regional oncology dispensary and other medical institutions of the region. Two years later (2022-2023) we compared initial psychological characteristics, dividing these patients into groups of survivors (52 people) and those who died (84 people).

Results. When comparing the initial psychological characteristics of those who lived more than 5 years (group 1) and those who died (group 2), it was found that the level of psychosocial stress according to the Reader scale was the same at the time of diagnosis. , so we can assume that the patients were equal in terms of stress level (Table 1).

The scale includes all potentially stressful aspects of life: work, family, interpersonal relationships, self-assessment of individual personal qualities, assessment of one's well-being, activity. The scale allows to assess not only the actual level of psychosocial stress , but gives an idea about the perception of stressors by the personality of the subject. According to our data, there was only a statistically insignificant trend towards a higher level of stress in group 2 patients.

Table 1. Level of psychosocial stress in two groups of cancer patients

Statements	Group 1 survivors N=52	Group 2 Deceased N=84
1. Maybe I'm a nervous person	2.1 + 0.27	2, 3 + 0.31
2. I worry a lot about my work.	1.8 + 0.25	2.0 + 0.18
3. I often feel nervous tension	3.1 + 0.22	3.2 + 0.21
4. My daily routine causes a lot of stress.	3.3 + 0.31	3.4 + 0.28
5. Communicating with people, I often feel nervous tension.	2.6 + 0.26	2.8 + 0.31
6. By the end of the day, I am completely exhausted, physically and mentally.	2.7±0.28	2.9±0.30
7. There are often tensions in my family.	3.1 + 0.22	3.2 + 0.21

The results of determining the types of reaction to the disease using LOBI showed that in the first group of patients only 17 people (32.6%) had a reaction to the disease that disturbed social adaptation. Together with anxious or obsessive, or anxious-obsessive, euphoric-anosognosic, sensitive-ergopathic types, a sensitive reaction type to the disease was determined.

In 27 people (51.9%), harmonic and in 8 people (15.4%) mixed types were identified. In group 2, a consistent type of reaction to the disease was not found. At the same time, in 68 (81%) patients of the second group, a disorder of social adjustment due to the disease was noted. In them, the type of neurasthenic response to the disease combined with obsessive, anxious, egocentric and hypochondriac predominated, which, depending on the course of the disease, "doctor-patient" and " characterized by the change of social relations "patient-relative". disease. In 17 people (19%), the type of reaction to the disease in this group was not determined. According to the Spielberger-Hanin scale, all patients of group 2, when registered by an oncologist, showed high scores of personal anxiety - 65.3 + 2, 18 points and in most cases the level of situational anxiety increased - 42.6 + 1.66 points, which is a lot. natural. In group 1, these values were 48.3 + 1.76 points for personal anxiety and 40.3 + 1.38 for situational anxiety ($p < 0.05$). had more positive results. Mild level (up to 19 points on CES-D) was found in 36 people (69.2%), depressive disorder in 12 people (23.1%) and severe depression in 4 people (7.7%). In group 2, respectively, mild depression - 19 people (22.6%), moderate - 42 people (50.0%) and severe - 23 people (27.4%). It should be noted that our patients the depressive state detected by the oncologist was not a reactive form, as it develops over a period of time and is taken into account in the CES-D questionnaire. According to the results of using the

Cattell personality questionnaire (Fig. 1), the values of factors describing the alexithymic radical increased in patients of group 2, i.e. A, F, G, I, M, Q3, which defines their limited ability to realize their feelings and communicate them, allows them to be characterized as alexithymics, in which unreacted feelings are closed at the somatic level.They were characterized by anhedonia to a greater extent than in group 1, i.e. inability to enjoy life, sadness and pessimism of the character, low energy level, desire to avoid changes, stiffness of relationships. A clear feeling of guilt in patients of group 2 confirmed the presence of autoaggression in them.

Anxiety and depressive disorders were found in both groups of patients. In surviving patients, these disturbances were often situational in nature, while in the deceased they were personal. For them, depression was not so much related to the situation as the situation was "invoked" to explain the depressive state. We consider this difference between the personality characteristics of patients with different survival periods to be important and suggest that anxiety-depressive personality disorder should be considered as a predictor of poor efficacy of anticancer treatment. Reactive panic-depressive disorder, in our opinion, is not important for the prognosis. This statement is also confirmed by the analysis of the factors of blocks B, M, Q1, which describe the cognitive style. it shows that in the first group, before the operation, the cognitive elements of anxiety were more actualized before the operation, and in the second group. In the group, the anxiety-depressive state has the character of a comorbid disease, probably pathogenetically related to the main disease. All patients observed during the course of the disease revealed 2 to 4 psychological crises related to the knowledge and development of oncological pathology. The first crisis was related to a cancer diagnosis. The patient experiences stress when determining the diagnosis of this disease. The reaction to stress can be different, it is closely related to personal characteristics and the socio-psychological situation in which the patient is located. This is sadness, rejection reaction, diseases, anxiety and suspicious situations, the desire for secondary benefits (rejection of work, social contacts, etc.) - or mobilization, the desire to "accept" the disease, adapt to it and maintain social status. The second crisis is associated with the passage of specific antitumor therapy: surgery, chemotherapy, radiation therapy, which in some cases leads to complete or partial disability of the patient, changes in appearance, appearance of the injury, treatment lead to the need to change the method. life This psychological crisis and related stress also depend on personal characteristics, availability of social support. An acute relapse is more stressful than a gradual deterioration. Changes in the psychological state may be more obvious than during the first psychological crisis, which also depends on personal characteristics. Often there is a violation of awareness of the disease, a "blockade of emotions". The fourth psychological crisis is associated with the realization of the futility of treatment, approaching death and occurs shortly before death. During the development of an oncological disease psychogenic, somatogenic and personal factors closely influence and exchange. There are 3 variants of psychosomatic cycles: mainly psychogenic (first crisis), mainly somatogenic (second crisis), psychogenic-somatogenic (third and fourth crisis). Psychogenic and somatogenic work alternately as cause or effect. The presence of a depressive state aggravates the course of the main disease, significantly worsens the prognosis. In our opinion, depression oncological pathology is not a comorbid disease, but a condition that has common pathogenetic mechanisms with the main disease. The presence of depression reduces "psychosomatic immunity" [9; 10]. The hypothesis is that conscious and unconscious conflicts have a negative effect on the immune system through psychoneuroimmunomodulation mechanisms that contribute to cancer development. According to Burnet's theory of immunological surveillance, cancer cells that are constantly forming in the body are no longer destroyed by the immune system.

Summary.

In oncopathology, the study of the psycho-emotional state and personal characteristics of cancer patients, psychogenic-somatogenic relationships, is interesting not only theoretically, but also practically, because it shows the direction of developing new psychological rehabilitation programs that improve cancer. quality of life of patients, analysis of psychological personality characteristics of cancer patients and timely psychocorrection improves survival prognosis. According to our observations, the stress experienced by a patient when diagnosed with cancer is so damaging to the

psyche that it needs to be repaired. On the other hand, obviouslybenign tumorPsychogenic factors play an important role in the emergence and development of

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