MOSCOW INTERNATIONAL ACADEMY

As a manuscript

GANICH MIKHAIL KONSTANTINOVICH

PROTECTIVE MECHANISMS PERSONALITYAND ATTITUDES TOWARDS ILLNESS IN CANCER PATIENTS

Specialization: 5.3.6. Medical psychology

THESIS
for a Candidate Degree in Psychological Sciences

Translation from Russian
Volume 1

SCIENTIFIC SUPERVISOR:
doctor of psychological Sciences, Professor
Slobodchikov Ilya Mikhaylovich

St Petersburg – 2023

CONTENTS

INTRODUCTION

Topicality of the research. The data of foreign and domestic statistics with unquestionable obviousness allow to speak, firstly, about an increasing tendency to prevalence of oncological diseases, secondly, about considerable rejuvenation of disease manifestation (Starinsky V. B. , 2012; Merabishvili V. M., 2012; Chulkova V. A., Vagaitseva M. B., Karpova E. B., Leonenkova S. A., 2015, etc.).

To date, the number of works devoted to the psychological aspects of the perception of cancer disease, the individual's living in the space of the disease course, includes many studies related to the analysis of the quality of life of cancer patients, the subjective assessment of their condition and attitude towards the disease. A number of authors indicate that the quality of life and the nature of the attitude towards the disease is closely related to the medical prognosis of the course of the disease (Ionova T. I., 1998; Montgomery S., 1999; Gerasimenko V. N., Tkhostov A. S., 2002; Kupriyanova I. E., 2000, 2012, Gnezdilov A. A. et al. V., 2007, etc.).

However, only sporadic studies have examined the relationship between subjective emotional experiences of cancer patients, a range of personality characteristics and the possibility of regulating the subjective psycho-emotional state.

The significance of patients' subjective assessment of their physical and psychological state, according to many researchers, allows us to make meaningful changes in the programs of psychogenic reactions and psychosocial factors of adaptation to oncological pathology (Semke V. Y., Guzaev A. N. N., 1991; Kupriyanova I. E., 2012; Stoyanova I. J., 2005, Gerasimenko V. N., Tkhostov A. S., 2002; Massie M. J., 2004; Novik A. A., Ionova T. I., 2002; Chulkova V. A. Karpova E. B. , 2005, 2012; Ahles et al, 2005; Levin T., Kissan W. D., 2007; Tiganov A. S., 2008; Vagaitseva M. B., 2015).

The separate direction of researches in the field of studying of psychological aspects of behaviour of oncological patients is connected with the analysis of formation of patterns of stress coping behaviour (Bakhtiyarov R. S., Gnezdilov A. V.,

1999; Temoshok L., 2000; Petticrew M. et al, 2002; Vorona O. A., 2004; Folkman S., 2004; Tarabrina N. V., 2008, 2010, 2013).

At the same time, the study of the protective mechanisms themselves, their analysis in the context of the subjective attitude towards the disease in different types of cancer, the interrelation of these elements and their manifestation as significant in the situation of a change in the worldview of the patient often remain on the periphery of scientific research.

Speaking about the formation of the attitude of a person to cancer, we can distinguish several stages in the psychological dynamics of this attitude, starting from the initial reaction to information about the possibility (reality) of the presence of a pathological process, psychological and emotional adaptation to this information, eventually to its acceptance (non-acceptance), then - living in new, crisis circumstances and adaptation to them, and then - the formation of attitude toward the disease and toward ourselves as a patient. V.A. Chulkova, E.V. Pestereva (2010, 2017), in particular, mention the interdependence of the dynamics of the disease course and prognosis of its development, the phase process in the context of the dynamics of the mental condition of the patient, considering the situation of relationship "psychologist - oncology patient".

It is important to note that, examining the dynamics of the personality's attitude to the serious disease and to himself as a subject of the disease, the conditional staging by analogy can be considered in the case of any serious diagnosis. Thus the specificity of oncological disease and, in a particular case, oncourological disease will consist in features of perception of the concrete diagnosis, not the least connected with existing steady psychological patterns of perception of this group of diseases. In fact, we are talking about the fact that the personal characteristics of the sick person, the formal and substantive characteristics of his reference groups (immediate environment), on the one hand, and the models of professional interaction with him specialists, on the other hand, form a system of significant factors of influence on his condition. The transformation of mental defense mechanisms and activation of

personal coping strategies in this connection it is appropriate to consider as a system of complex reactions, accompanying psychological dynamics of experience and change of subjective attitude to the disease and himself as a sick person and correlated with it.

Of particular relevance to the logic of this study is the possibility of correlating the phases of cancer acceptance with the dynamics of changes in psychological defences as a consequence of the type of attitude towards the disease.

The fact of disease diagnosis and even the assumption of the possibility of cancer, being a superstress, a crisis circumstance of human life (M. V. Vagaitseva, 2015; V. A. Chulkova et al., 2000), changes not only the circumstances of his real existence, but in no small measure - his attitude to himself, to his own life, forces to address the semantic categories, possibly not previously within the active attention of the individual and, in any case, not being the centre of actualization.

Under these conditions, the directed activation and realisation of defence mechanisms in relation to a range of emotional experiences (anger, guilt, aggression), including those of an existential nature (anxiety, loneliness, fear of death), resulting in the formation of an attitude towards illness, is a kind of "inner platform" on which not only do changes occur in relation to oneself and to the world around, which in turn is an element of changing the patient's world view, but a psychological resource is also formed, enabling the patient to resist the disease. Considering that the category "psychological protection" is multidimensional, within the professional contact "psychologist - cancer patient" there is an opportunity to activate and restructure different levels of protection, creating an individual model most successful for a particular personality type, in the context of coping with a particular type of experience in the course of the disease.

The very category of "existential experience" itself, which practically all researchers have noted in their work, is particularly important and significant in the structure of the patient's behaviour. The formation and maturation of these experiences, the possibility of living them, experiencing them and expressing them as freely as possible in a situation of joint directed professional activity with a specialist,

working through problematic psychological "knots" and accepting the new reality, whatever it might be, finding oneself in it, gaining psychological bearings in a situation of uncertain life perspective, filling the life space with values and meanings, finding (forming) opportunities for meaningful activity - all these tasks can be considered elements of activating the patient's behaviour. These tasks can be considered as elements of activation of the complex mechanism of coping with acute anxiety, sense of isolation and alienation, self-loathing, fears, first of all fear of death, and on this basis - as a mechanism of changing the picture of the personality's world, into which the idea of self and illness is organically built (I.M. Nikolskaya, R.M. Granovskaya, 2007, 2014).

The possibility of changing the person's world view by changing the way they feel about themselves through the analysis of their emotions not only provides a better understanding of the specifics of the person's experience of illness, but also broadens the possibilities of improving the quality and mechanisms for implementing coping strategies.

In this context, analysing the dynamics of the patient's attitude towards their illness, analysing the dynamics of changes in defence reactions and the process of changing attitudes towards illness is a research problem of particular relevance, importance and significance both in its theoretical and applied aspects.

The task of alleviating the psychological distress of the patient, finding ways to activate the system of defence reactions to complex and specific emotional experiences, directing the patient not to passively accept the situation and protect - fear, but to accept - understand (according to I. Yalom's logic) and in this connection to develop an active resistance position through awareness and increase of personal subjectivity outside the context of the dynamics and progression of the illness - this is the ideology behind this research work.

Aim of the study: to explore the relationship between defence mechanisms and types of attitudes towards illness in cancer patients.

Object of study: the system of existential experiences, defence mechanisms and

attitudes to illness as elements of the worldview of the cancer and urology patient.

Subject of the research: peculiarities of manifestation of emotional experiences, including existential nature, process of activation and realization of defense mechanisms, manifestation of types of attitude to the disease in oncourological patients with different nosologies.

Research objectives:

1. To present an analysis of the elements of a cancer patient's worldview and the factors that change it.

2. To analyse and describe theoretical and methodological approaches to the understanding of personality defence mechanisms, dynamics of their change in conditions of health and disease, taking into account the specifics of oncological diseases.

3. To analyse the scientific basis for research into types of attitudes towards illness (taking into account the specific nature of cancer), and to consider their relationship with manifestations of patients' existential experiences.

4. To explore and describe the subjective nature of existential distress and the specificity of defence mechanisms in relation to it, using cancer and urology patients as an example.

5. To explore and describe attitudes towards illness in patients with cancer and urology, taking into account the dynamics of the disease.

6. To identify and describe the relationship between activation and changes in defence mechanisms in cancer patients and types of attitudes towards the disease.

7. To test and describe methods of psychological work with oncourological patients aimed at activating coping mechanisms and modelling individual-typological defence groups.

Research hypotheses:

1. The change in the type of attitude towards the disease in the cancer patient is associated with changes in the system of defence reactions.

2. There are gender differences in the manifestations of the system of protective reactions and types of attitudes towards the disease in cancer patients with

different nosologies.

3. Changing the type of attitude to the disease and activation of subjectively significant elements of the worldview of a cancer patient in the form of positive semantic, content, emotional and image fragments forms a system of existential-resource formations, partially restoring protective mechanisms against negative manifestations of existential experiences and, consequently, activating strategies of coping behaviour.

The theoretical and methodological basis of the study was

- The provisions of V. N. Myasishchev's concept. N. Myasishchev's concept of personality as a system of relations;

- The basic assumptions of humanistic and existential psychology (JI. The main idea of the study is to develop the concept of humanistic and existential psychology (Binswanger, Buchmental, Maslow, May, Rogers, Frankl, Asmolov, Leontiev, Petrovsky, Yashchenko, etc.);

- The concept of attitude towards illness (A. E. Lichko, B. V. Iovlev and E. B. Karpova, 1983);

- M.V. Novikova-Grund's theory on the relationship between elements of the world picture and the clinical picture and dynamics of diseases of various etiologies;

- The multifactorial determinants of the development and course of cancer (J. Holland, S. Greer et al.).

- Elements of an existential approach to the study of meaningful emotional experience (I. Yalom, V. Frankl);

- The concept of stress coping (R. Lazarus).

Of particular relevance in the context of this study are the insights of I. M. Nikolska and R. M. Granovskaya on psychological protection and personality defence mechanisms as well as a number of insights and ideas of R. M. Granovskaya in the field of faith psychology.

The present study also relies on the scientific works in the field of psychological support of cancer patients of St. Petersburg scientific school of oncopsychology (D. P. Beryozkin, E. V. Demin, A. M. Belyaev, A. V. Gnezdilov, V. A. Chulkova, E. B.

Karpova, M. V. Vagaitseva et al. In the field of psychological rehabilitation (including cancer patients) within the framework of clinical psychology (N. V. Kozlova, N. E. Kupriyanova, I. J. Stoyanova, M. G. Ivashkina, M. A. Yeghikian, O. V. Lukianov, A. A. Stajpek).

Research methods and techniques:

I. Theoretical analysis and synthesis of the scientific literature.

II. An experimental study, the structure of which included:

1) a clinical interview, the purpose of which was to understand the main psychological problem areas, directly and indirectly identify personal emotional reactions, including existential reactions, to subjectivate experiences related to the fact of illness, to present the life situation in the context of the features of the illness;

2) a group of techniques to identify the content and semantic elements of existential experiences, about which, in the context of cancer, a system of protective-compensatory reactions is formed: integrative anxiety test - a complex technique to identify levels of anxiety and phobic reactions; the subjective feeling of loneliness technique; the hospital anxiety and depression scale; the fear of disease progression questionnaire;

3) a group of techniques related to the study of personality defence mechanisms: questionnaire to examine psychological defences against anxiety related to existential problems, existential scales (A. Langle-K. Orgler);

4) methods directly related to the study of types of attitudes towards illness and coping strategies: TOOL, LSI (Life Style Index), A. Haimi coping test.

Following psychological work of a psychotherapeutic nature, aimed at clarifying (working through) the patients' problematic experiences and changing elements of their current worldview, a series of repeated experimental and diagnostic procedures were carried out.

In all diagnostic and therapeutic procedures, the following were also used: participant observation, interviews, analysis of expert interviews (attending staff, clinical psychologists, relatives of patients).

Empirical background: The first group consisted of 62 patients aged 51-65 years (30 men and 32 women) with a diagnosis of renal cell cancer, evenly split between three treatment strategies.

The second group consisted of 60 patients: 30 men and 30 women between 47 and 61 years of age, diagnosed with bladder cancer, evenly distributed between the three treatment strategies.

In order to address the effectiveness of the system of psychotherapeutic (correctional) work implemented by the author during the thesis project, the need for the participation of a control group of patients was determined at the sampling stage for the research practices, which met all the parameters of the sampling frame (65 patients: 33 men and 32 women between 47 and 65 years of age, with a diagnosis and a defined medical strategy), underwent all the procedures of the research phase, but did not take part in the remedial work.

The reliability and validity of the research results are ensured by the correspondence of the material of the instrumental methods to the developed theoretical framework, and the theoretical construct to the chosen methodological approach. The reliability of the research is also ensured by the selection of scientific literature on the topic; representativeness and sample size of respondents; qualitative and quantitative processing of the experimental data and statistical significance of the obtained patterns; and the comprehensive nature of the research methods used.

The scientific novelty of the study lies in the fact that for the first time in national practice, a comprehensive analysis of the relationship between protective reactions and types of attitudes towards the disease in the context of the characteristics of oncourological diseases;

- A previously unstudied sample presents an analysis of emotional experiences, including a system of defence reactions, as elements of the worldview of the cancer patient;

- For the first time, the factors that change the elements of the worldview of a cancer

patient in the context of the activation of defence mechanisms and coping strategies were investigated;

- A comparative analysis of the manifestation of protective reactions and types of attitudes towards the disease in cancer patients with different nosologies is presented for the first time;

- For the first time, the dynamics of changes in attitudes towards the disease in relation to protective reactions were analysed, taking into account the nosological specificity of oncourological patients;

- For the first time, the gender specificity of changes in the system of personality defence mechanisms in relation to the dynamics of attitudes towards illness was investigated;

- The possibilities of psychotherapeutic approaches and techniques to restore (positively change) elements of the worldview in terms of semantic, content, emotional and image elements, in finding existential-resource formations in the reality of the disease and its perception by the patient were analysed and described within the analysis of psychological support for oncourological patients.

The elements of mental rigidity development as a protective and compensatory mechanism of personality are considered in the context of research of the world picture of the oncourological patient. The role of rigidity as a personal and behavioural variable in the regulation of the system of coping strategies is determined.

The theoretical significance of the study:

- to broaden and deepen understanding of the psychological features of the personality of oncourological patients with different nosologies, age and gender specifics of the perception of the disease; the regularities of self-concept formation and self-awareness features of oncourological patients with different prognosis of the disease course;

- a significant addition to knowledge about the structure of the motivational components of life strategies and the factors that change the view of the world of an individual with cancer and urology;

- in the development of insights into the relationship between the formation and activation of protective mechanisms and attitudes to disease in cancer patients from different nosological groups;

- gaining new knowledge about the peculiarities of development and the relationship between significant personal characteristics and perceptions of illness, using specific cancer groups as an example; gender specifics of experiencing and living through life crises, peculiarities of existential experiences; gender specifics of forming defence reactions in relation to existential experiences;

- to complement the ideas about the relationship between the elements of the picture of the world of the patient and the dynamics of the psycho-emotional state of the patient. Qualitatively new knowledge about the processes of formation of protective and compensatory mechanisms of the personality of a cancer patient was obtained.

The practical significance of the study:

- The results of the study contribute to understanding the specifics of the process of integrative psychological counselling in the situation of accompanying a cancer patient and his or her reference environment;

- The insights and knowledge about the possibilities of integrating psychological counselling with frontier areas of psychological practice in the context of working with complex clinical and psycho-psychotherapeutic problems have been expanded and supplemented in an empirical sample;

- The understanding of the regularities, structural-systemic and content-meaningful processes taking place in the process of psycho-psychotherapeutic support for cancer patients has been broadened and deepened, which in turn expands and supplements an understanding of how psychological and psychotherapeutic support for patients and their families can be made more effective within and outside the oncology hospital setting;

- Knowledge about the possibilities of activating coping strategies and modelling behavioural defence mechanisms that relate to typological and individual personality traits, the patient's perception of their illness and their attitude towards

their illness has been updated and made more concrete;

- We empirically confirmed the idea that it is possible to analyse the value and meaning components of a person's worldview as a tool for creating a system of psychological support for cancer patients, activating and stabilising coping strategies and weakening the system of formed fears (phobic reactions).

The data obtained can be used as material for counselling, psycho-corrective and psychotherapeutic work with cancer patients. On the basis of the obtained data and the tested methods and techniques it is possible to create a number of training materials of lecture and applied character with the possibility of use both in clinical psychotherapeutic practice and for the purpose of use as material for the training of students, residents, in the process of formation of programs of professional development.

The statements made for the defence:

1. The perception of the disease, subjective perception of the sick person about it and about himself as a subject of the disease, being a part of dynamics of the worldview of the sick person, essentially influences specificity of formation of system of protective reactions, mechanisms of coping behaviour and in this connection is the central factor of psychological (psychological-emotional) changes of the person, as consequence - the essential psychological factor of dynamics of disease development.

2. Protective mechanisms in cancer patients are interrelated with the types of attitudes towards the disease, while they are not related (independent) to the type of cancer, its nosology, have no significant dependence on gender and age, but their activation depends significantly on the picture of the personality's world and the dynamics of its change, due to the inclusion of the disease picture.

3. The system of activation of positive defence reactions, formation, development and strengthening of elements of coping behaviour in cancer patients is an unconditional and integral part of changing their picture of the world (changing the attitude towards the disease picture (as part of the world picture) and themselves as the subject of the disease), in this regard, directed change of the world picture

(within psychotherapy and psychocorrection) is a mechanism of activation of positive defence reactions and strengthening of coping behaviour of the patient suffering from cancer.

Structure of the thesis. The thesis consists of an introduction, two chapters, a conclusion, a bibliography, and appendices. The bibliography includes 214 sources.

CHAPTER ONE. THEORETICAL-METHODOLOGICAL FOUNDATIONS FOR THE STUDY OF PERSONALITY DEFENCE MECHANISMS AND TYPES OF ATTITUDES TOWARDS ILLNESS IN THE CONTEXT OF THE EMERGENCE AND COURSE OF ONCOLOGICAL DISEASE

1.1. Cancer as a life-changing factor

The notion that the crisis associated with a serious illness affects many structures of the personality is reflected in many studies. It is noted that the negative character of experiences complicates overcoming crises (Nikolaeva N. N., 1987; Nepomniaschaya N. I., 1998; Lebedev I. B., 2002), changes in perception of the self and the life (Gnezdilov A. V., 1977; Isaev E. I, 1998), changes in the value and motivational and semantic spheres of the personality (Asmolov A.G., 1990, Marilova T.Y., 1984, Tkhostov A.Sh., 1984, Burlachuk L.F., 1998), in the socioprofessional sphere and activity (Gerasimenko N.N., 1983, Demin E.V., 1995, A.V. Aseev, 1996).

The impact of cancer on mental functioning can be viewed from two perspectives. On the one hand, the diagnosis is traditionally regarded by many as being incurable and can in itself cause serious psychological trauma. On the other hand, having to undergo an operation, the outcome of which cannot always be accurately predicted, is extremely stressful.

Many authors (E. V. Demin, V. A. Chulkova, 1995; A. V. Aseev, 1996; N. N. Blinov, 1996) speak about "psychological crisis" of people suffering from oncological disease, which is characterized by anxiety, hopelessness, uncertainty, pessimistic estimation of future. Nikolaeva N. N. (1987) believes that a person who finds himself in a situation of severe illness, faces a breakage of stereotypes created by the previous situation of development. In the context of a severe somatic illness a new life situation arises that destroys the personality structure that was created before the illness (B. V. Zeigarnik, 1979).

The impact of the cancer crisis on the personality and its development has been studied to a greater extent in foreign psychology due to its practical orientation, with many studies examining the pathological effects of the crisis.

The problem of studying the features of the personality of cancer patients is considered by domestic authors in terms of individual aspects. Thus, the social aspect of the personality (quality of life of cancer patients as a social problem, the influence of the social sphere on the human condition, social contacts at different stages of the disease, social rehabilitation of the disabled, etc.) is studied in the works of such authors as Andreeva O. S., Antipova G. V., Barchuk A. S., Batskov S. S., Blinov N. N., Byalik M. A., Velikolug A. N., Velikolug T. I., Voytenko P. M., Gnezdilov A. V., Grishina L. P., Dementieva N. F., Demin E. V., Dregalo A. A., Dobrovolskaya T. A., Dyatchenko O. T., Zakharian A. G., Zelinskaya D. I., Ionova T. I., Isaev I. I., Kaznin Y. F., Kazakov M. S., Kaind P., Kovshar Y. A., Konishchev V. A., Kutsenko G. I., Lavrova D. I., Libman E. S., Manichas G. M., Merabishvili V. M., Morozova G. F., Nechkin B. V., Novik A. A., Puzin S. N., Stepanova E. V., Subetto A. I., Suslova M. Y., Ushakov E. V., Kholostova E. I., Khudoley V. V., Chulkova V. A., Shabashova N. Y., Shabalina N. B., Effendiev M. K. et al. The economic aspect of personal existence (economic losses of people due to illness, treatment costs, etc.) is considered in the works of the following authors: Axel E. M., Antashkova N. N., Belyaev D. G., Velikolug A. N., Velikolug T. N., Galkin E. B., Dvoerin V. V., Dyatchenko O. T., Zalyatina N. A., Kovalev G. A., Kogalenko V. Y., Manikhas G. M., Merabishvili V. M., Mikhin A. E. E., A. A. Novik, G. A. Novikov. G. A. Novikov, G. A. Orlov, N. A. Osipova, T. Pirkovskaya. N., Pozdniakov V. V., Preis V. G., Prokhorov M. B., Ryabov Yu. V., Smirnov A. I., Starinsky V. V., Hanson K. P., Chissov V. I., Shabashova N. Y, Shamshurina N. G. et al. The psychological aspect of personality in conditions of severe somatic disease (influence of disease on the psychological status of the patient and his family, relations with relatives, self-perception from norm to pathology, psychological rehabilitation) was studied by: Barchuk A.S., Belyaev D.G, Blinov N. N., Byalik M. A., Velikolug A. N., Velikolug T. I., Voitenko P. M., Volodin B. Y., Volodina L. N., Gantsev Sh. H., Gnezdilov A.

V., Demin E. V., Dergalo A. A., Zanadvorov M. S., Zotov P. B., Komiakov I. P., Kulikov E. P., Laktionova A. I., Manichas G. M., Mendelevich V. D., Moiseenko E. I., Nikolaeva V. V., Novikov G. A., Priputin A. S., E. S. Pushkova, A. G. Rakhmatulin, S. Simonton. G., Simonton S., Simonton K., Savin A. I., Slutsky A. S., Tkhostov A. S., Uryadnitskaya N. A., Usmanskii S. M., Chaklin A. V., Chernikova T. V., Chulkova V. A., Shipovnikov A. A., Shilko V. A., Yuldashev V. L. et al. The legal aspect (legal acts concerning this sphere) was described by Valentey L.V., Yurkin G. Medical aspect of personality (medical quality of life of patients with tumors of different localization, hospice care of cancer patients in order to provide quality palliative care) was considered by: Axel E.M., Barina N.N., Barchuk A.S., Volkov O.N., Gnezdilov A. V., Gotsadze D.T., Dovgalyuk A.Z., Zelenskaya T. M., Ionova T. I., Kagan A. V., Kovalev G. A., Liptuga M. E., Manichas G. M., Millionschikova V. V., Mikhnovskaya N. D., Novik A. A., Novikov G. A., Petrova G. V., Pirtskhalaishvili G. G., Plavunov N. F., Remennik L. V., Stolyarov V. I., Starinskii V. V., Trishkin V. A., Frolova A. I., Chissov V. I. et al. The problem of work optimization with oncological patients has been dealt with by: Aseev A. V., A.S. Barchuk, N.N. Blinov, V.Y. Gorbunov, N.F. Dementieva, E. Demin. V., Dyatchenko O. T., Emelyanov D. E., Komyakov I. P., Konstantinova M. M., Lazo V. V., Manikhas G. M., Merabishvili V. M., Murasheva Z. M., Priputin A. S., Hanson K. P., Tchaikovsky G. N., Chulkova V. A., Shabashova N. Ya. S. et al..

Cancer is a serious source of stress for anyone and their family. The disease is considered by some authors to be chronic due to duration, complexity of treatment, recovery period, risk to life and many other factors. Various researchers (Patterson J. M., Garwick A. W.) have identified universal problems in families with cancer, which can be divided into four groups [58]:

1. Emotional difficulties that can arise in parent-child relationships, marital dyads, extended families.

In the context of childhood and adolescence, A.J. Varga viewed these difficulties as a reaction of the family system to the stressful situation of the child's illness. It is noteworthy that the nature of stress and personal characteristics of family

members influence the intensity and duration of emotional distress [11].

2. Functional difficulties that distort different aspects of family members' lives in the following areas:

- professional achievements, career development and self-fulfilment of family members;

- opportunities for family leisure and recreation;

- allocation of roles and responsibilities.

3. Difficulties related to interaction in society. There are two sides to these difficulties. The ill person fears the reactions of those around them, given that the range of reactions can be very wide and difficult to emotionally perceive and experience. In the case of children (adolescents), relatives fear negative reactions from friends and neighbours, are ashamed of changes in the child's appearance, are concerned about the child's physical and emotional vulnerability and limit their contact. Consequently, social isolation almost inevitably occurs to some degree. It is important to understand that, regardless of age, the manifestation of the disease and its development also leads to a number of acute experiences of an existential nature - a sense of loneliness, an exacerbation of guilt, resentment, undeserved "punishment", life incompleteness, etc. It is also important to note that the very fact of the oncological disease is a conditional marker of a change in the personal and semantic structure, particularly in the direction of sudden maturation (as often occurs in the case of children and adolescents), a rethinking of life values or, conversely, the formation of a number of specific protective adaptive (defence-replacement) reactions of the infantile type.

4. Financial problems caused by functional changes in family life amid serious illness of an adult or child.

All groups of difficulties do not exist in isolation; they are interrelated and complement each other.

A review of the literature also identifies specific factors that have a major influence on the occurrence and intensity of emotional distress in cancer patients.

Firstly, the characteristics of the illness (prognosis for recovery, consequences

of illness and treatment, possible disability, pain sensations) have an impact on the emotional state of the patient and therefore on the psychological climate in the family.

Secondly, R.B. Miroshkin highlights the difficulties associated with being in hospital, namely that when a patient first enters an oncology ward, the diagnosis in most cases is very recent. Being confronted with the rules of the hospital, getting to know the new responsibilities, and worrying about the procedures involved cause considerable frustration, especially in the initial phase of treatment. Thus, in the early stages of the disease, a stay in hospital is in the vast majority of cases psychologically traumatic for patients.

Fear of being discharged after a long hospital stay is also a stressor. During a long stay in the ward, there is an adjustment to the hospital environment. Families rearrange their lives to suit their circumstances. Anxiety is exacerbated by the time of discharge, when there is an awareness of the need to re-establish their lives outside hospital.

Adult cancer patients, especially at the first stages of acceptance and awareness of the fact of their disease, often show return (child-adolescent) elements of emotional and even behavioral reactions, with the exception that, regardless of the level of acceptance of the situation by relatives and loved ones and the degree of their emotional, personal and physical inclusion in the system of adaptation to the disease of a loved one, direct transfer of the matrix of child-parent relations is impossible. In a number of cases, this is a source of additional intrapersonal conflict (crisis) for the adult who is ill: the feeling of helplessness, defencelessness, an acute desire to return to childhood, specific fears, an acute, up to painful, need to take responsibility for the reality of the situation, coming into conflict with the desire to remove this responsibility from oneself, shifting it to the "parent". The role and importance of the psychotherapist, who consciously or unconsciously takes on the role of a "protective" figure in relation to the sufferer, is particularly relevant here. A special emphasis should be placed on the experience of anger, powerlessness and an acute sense of shame about one's own weakness in the inability to cope with an existing crisis

situation, especially in adult patients with a strong personality structure.

A number of authors highlight personality traits that determine the onset and development of cancer, such as infantilism, alexithymia (inability to assess and describe one's condition), a closed emotional sphere, as well as a high level of ineffective archaic psychological defences and a lack of effective coping strategies. Thus, cancer can be associated with a personality disposition described as suppression of emotions, helplessness and depression [34].

Numerous studies have shown that the fact that patients are aware of their cancer disease leads to significant changes in personality. Among the main factors affecting the psyche of patients are: the fatal nature of the diagnosis despite advances in oncology; crippling surgery and treatment; and lack of guarantees against recurrence and metastases [34].

Several natural stages have been identified in which personality disorders in cancer patients manifest themselves: 1) diagnostic; 2) admission to hospital; 3) pre-operative; 4) post-operative; 5) discharge; 6) follow-up [15].

The first two stages are among the most important in terms of the severity of the reactions and the ability to determine their further dynamics. This is the time when the patient is first confronted directly with the suspicion of cancer or its presence. Regardless of the localization and stage of the underlying cancer process, age, gender, education, you can record the presence of emotional tension in patients, which forms the psychogenic reactions of mainly anxious-depressive and dysphoric nature. Depression of mental functions, asthenia and various kinds of psychosis, as well as suicide attempts can be observed as a result of the secondary psychological reaction [21]. The degree to which patients are informed about their illness and assess their own psychological readiness to receive the true diagnosis plays a major role in the severity of the emotional-personal reactions. Various studies have found a direct desire and need for most patients to know the true nature of their illness and the necessary details of treatment already at this stage [21]. After learning about the diagnosis, the patient goes through a series of consecutive stages characterising the specifics of the emotional and psychological response to the illness. E. Kübler-Ross

has described 5 phases of the process which the patient may go through: 1) denial and isolation (the patient refuses to accept his/her illness); 2) anger and aggression; 3) the "trading" phase (seeking treatment methods); 4) depression and estrangement; 5) humility, acceptance of the illness and building a new life strategy [15].

In the stages associated with surgery, there is a direct correlation between the degree of mutilation, defined by the site of the lesion, and the severity of the emotional disturbance. For example, patients with rectal extirpation have more severe emotional disturbances than patients with resection [15].

Speaking of the stages associated with surgery (discussed separately below), it is the group of stoma patients studied in this paper that draws particular attention. Practically all of them turn out to be psychologically unprepared both to the fact of operation and its surgical consequences, and to life with stoma. Patients who are indicated for reconstructive surgery and those who are expected to live with the stoma for a long time have both similarities and differences. All patients tend to concentrate on their problems and solve them autonomously. They are characterized by inadequate self-esteem, social maladaptation, high levels of auto-aggression, emotional instability, and rejection of intimacy with others. Those patients who are not subject to reconstructive surgery use irrational modes of psychological defence, are resentful, aggressively restless, personality-anxious, inadequate in their perception of their body, their space of activity, refuse to describe their body image, are afraid that people avoid them out of fear of infection, experience shame, reduce contact and communication [27].

Cancer, like other serious illnesses, causes anxiety, worry and fear in many patients. They worry about how the disease will go and how life-threatening it will be, because there is a common misconception among people that cancer is an incurable disease. Associated psycho-emotional distress, tension or depression can exacerbate the course of the disease. The data available in the world scientific literature about the influence of emotional deviations on cancer patients testify that not only disease course, but also social and psychological rehabilitation of a patient, his return to active full life in the family and society, decrease of the risk of recurrent

disease mostly depend on the person's attitude towards the disease, his spiritual state, will, active position, directed to the struggle with the disease [5].

The psyche of a cancer patient during the progression of the disease is much the same as that of a patient suffering from any serious physical illness. The initial period is characterised by certain features of the psyche associated with the disease process. At the time of diagnosis, mental disorders are limited to psychogenic manifestations. At the beginning it is usually fear of the diagnosis.

B. E. Peterson distinguishes four periods in the mental state of a cancer patient: pre-medical, outpatient, inpatient and the period of outpatient observation.

In the beginning, the cancer patient tries not to pay attention to his illness, he does not pay attention to it, he "runs away" from it. In the early stages of cancer, there are no patients who aggrandise their condition or who are hypochondriacally fixated on painful sensations. None of them brag about the disease, but none of them consider it a disgrace either. Suicide attempts are rare in this period (before the final diagnosis). The depressed mood does not reach a marked degree of depression, but the feeling of fullness of life is lost. Successes at work, enjoyable life events do not bring same level of joy. Attention is focused on suspicions of illness. Everything around you and your own sensation is evaluated on the basis of this suspicion. There is a certain isolation from others. The patient becomes more susceptible to indoctrination by others. Various reports of illness and an assessment of symptoms and manifestations are firmly fixed in the mind. During this period, personality traits also become more acute. Thus, in the presence of psychasthenic traits, the patient may flit from one doctor to another, sometimes despairing and sometimes hopeful. The dreamer is passive in his fate, the strong-willed person is silent, "displaces", ignores the danger of hysterics.

The initial period, during which mental health changes are clearly expressed, is followed by a "diagnostic" period, when the patient becomes aware of his or her illness in one way or another.

The pattern of mental disorders is dominated by affectivity. This period lasts for a few weeks, after which the affective feelings smooth out and the patient adapts

to the new situation.

During the diagnostic period, the psychogenic reaction rarely reaches psychotic severity. This reaction may be expressed in pathological calm, passivity, fantasising, visualising one's intrusive thoughts and fears, substituting and even as if analysing threatening perceptions.

But from this time on, the struggle of the active human personality against a looming formidable danger begins. The instinctive forces are mobilised for this struggle, efficiency, intellectual work is restructured, and attitudes to the outer and inner world are changed.

In the "advanced" phase of the disease, patients have severe internal organ damage and dysfunction. They differ from end-stage patients in that they retain the ability to maintain the necessary metabolic balance, the possibility of objective improvement recognised by doctors and no visible signs of hopelessness.

Some have undergone surgery, others are preparing for it, receive special treatment (radiation, chemotherapy), i.e. in this phase they are patients of oncological hospitals. The background of experiences is asthenic and there is some lethargy. These patients cannot tolerate even mild pain, cannot tolerate injections or infusions. Their speech, appearance, posture, and face become monotonous and repetitive.

Some authors (K.A. Skvortsov, V.A. Romasenko) note onyric states: patients lying in bed with their eyes closed see moving images and scenes in front of them. Orientation is preserved - it is a passive peculiar contemplation of reality. Sometimes there are elementary hallucinations, figures of people wrapped in blankets, rustles, mutterings, murmurs, smells of damp, leaves in the forest. Anxiety and suspicion emerge: they are treated incorrectly, medications are confused, harmful substances are given, experiments are conducted, neighbours say something unkind, hint, show with their eyes. This is revealed by careful questioning and is in the nature of delusional doubts.

In the long-term course of the disease, mental disorders can sometimes be linked to a specific localisation of the disease process. In rectal cancer, for example, after a long period without any visible disorder, feelings of fear, anxiety and, at the

same time, lethargy appear. They are usually silent and stare into space. In later periods, the patient is stamped with detachment, but usually the patient is full of hope for recovery in the back of his mind.

The period of full development of the disease is characterised by somatogenic mental changes. An astheno-depressive background of experiences comes to the fore. The active forces of the personality are used for achieving a true or symbolic exit from the illness. Suicidal attempts are generally uncommon.

Cancer psychoses are seen as onyric delirium, depression, paranoid outbursts. There are often delusional doubts, delusions, hypnagogic hallucinations, anxious-depressive concentration, drop in higher volitional functions.

The patient's inner world is characterised by faded colours. The perception of time changes and it goes faster.

The patient's personality remains intact in the terminal stage, but intellectual strenuousness and purposefulness decline. Speech changes due to exhaustion. Affects weaken. The content of the mental world is reduced, criticism weakens and internal isolation increases. The pre-mortem period in a number of patients is deprived of the experience of the fear of death. The idea of death is subjected to so-called displacement, "the illness itself is alienated".

Fear, anxiety, tension - all these phenomena certainly have an explanation if we consider the diagnosis of cancer as a psychotraumatic factor that causes psychological stress. Psychotrauma is defined as damage to a person's mental health caused by intense exposure to adverse environmental factors or by the acutely emotional, stressful effects of others on their psyche [5]. Thus, various emotional reactions - fear, anxiety, anxiety - form a single picture of emotional stress.

1.2. Theoretical and methodological aspects of research on coping behaviour in cancer situations

Attempts to study personality traits through behavioural strategies contributed to the development of the direction associated with the study of the characteristics of

coping styles with life difficulties and stressful situations (coping-strategies). One of difficulties in this direction of researches was presence of different approaches to understanding of adaptability of different types of coping-strategies, that is testified by large quantity of various classifications of strategies of coping-behaviour. Perhaps the differences in approaches to the study of coping explain the inconsistency in the results obtained. For example, some studies do not support the influence of coping strategies (coping spirit, helplessness/ hopelessness, denial, avoidance) on survival, others point to the importance of factors such as the ability to act and change, the use of self-help techniques for survival, evidence that patients whose coping style is characterised by "anxious absorption" or "helplessness" often adapt poorly compared to those who demonstrate a "combative spirit". Representatives of the domestic school of studying psychological reactions in cancer patients, single out "the degree of emotional reaction to the disease itself", "loss of control, fear of pain and injury, self-isolation and loneliness" among factors influencing the prognosis of the course of the disease. So, in particular, in the study of N.V. Tarabrina (2008) it was shown that development of stress disorders is promoted by negative underlying beliefs about the value and importance of our own self, our luck and ability to control the situation, as well as the perception of unfriendliness of the surrounding world. Post-traumatic stress reactions have been found to aggravate the course of the following research line is a good example of this: "The cancer patient has a negative impact on their immune status, which increases the risk of recurrence". The features of cancer patients' behaviour described in some foreign studies, such as "losing time before the first visit" and "suppressing dysphoric emotions", are attributed to avoidance coping by followers of this research trend. The research conducted by G. J. Eisen and including the study of avoidance coping. Eysenck's study which included training in adaptive coping behaviours in healthy subjects, confirms the role of the coping-strategies. After 13 years, 16 people died of lung cancer in the control group (made up similarly to the experimental group) and none in the experimental group (in which psychotherapy was given). Twenty-one people in the control group developed lung cancer, while 13 people in the experimental group did. Mortality from other causes

was 13 in the control group and 5 in the experimental group. These studies confirmed the preventive effectiveness of psychotherapy.

Thus, we can see a divergence of opinion among researchers on the impact of coping strategies on survival, which can also largely be attributed to methodological and theoretical difficulties.

The concept of coping comes from the English "to cope" and is translated into Russian as coping or coping behaviour, at the moment there is no unanimity among researchers concerning the use of this terminology [4, 10]. The study of coping behaviour as a new trend in psychology emerged in the 60s of the XX century. However, the origins of the study of this issue can be found in the late XIX century in the study of psychological defences by Z. Freud. The concepts of coping and psychological defences have historical connections and study parallels. What they have in common is that in both cases the concepts describe the reactions and behaviour of a person in a difficult, stressful situation.

Two main points of view can be distinguished on the distinction between these concepts: 1) the integration of these concepts; 2) the distinction between defences as unconscious, uncontrollable mechanisms of behaviour and conscious and voluntary coping behaviour.

The concept of psychological defence or protective behaviour owes its origins to Freud. Freud. The term "defence" first appeared in Freud's 1984 work “Protective Neuropsychosis” [14] to describe how the self-functions when painful thoughts and feelings arise. Sigmund Freud identified 10 defence mechanisms, one of which was described as a variant of the norm that does not lead to neurosis - sublimation. Anna Freud further developed the theory of personality defence mechanisms and added new defence mechanisms to the list (identification with the aggressor, destruction of what has been done, fantasy, intellectualisation, altruistic concession). She also discovered that a person does not use all existing defence mechanisms equally, but tends to choose only some of them, i.e. has a certain repertoire. This idea is reflected in studies of stress and coping, relating to the dispositional approach. Anna Freud developed the idea of her father, who suggested a connection between specific forms

of defence and specific illnesses in the appendices of "Inhibitions, Symptoms and Anxiety" (1926). Also of great resonance was the idea that defence mechanisms have different degrees of pathologicity, different adaptive potential.

In particular, Waylant [10] identified "mature" (sublimation, humour, anticipation, restraint) and "immature" (projection, passive aggression) defense mechanisms, as well as an intermediate class. He suggested that a person's use of "mature" defence mechanisms is associated with mental health and satisfaction in communicating with others. Based on his model, he developed a system for assessing defences, and his findings include may suggest a link between "mature" defence mechanisms and good self-regulation of the individual.

Among stress and coping researchers, various classifications of coping mechanisms based on the criteria of pathological and adaptive capacity have been created, and the adaptation criterion is now one of the traditional criteria for the classification of coping strategies.

Early studies of coping can be said to have taken place within the framework of the study of psychological defences. For example, Haan [10] developed a special observation system to assess defense mechanisms, which was based on the model of 20 "Ego Mechanisms": 10 defense mechanisms and 10 coping or coping mechanisms (sublimation, substitution, suppression). It was in the 1960s that the focus of interest shifted from defense mechanisms to coping processes. It should be noted that many authors began to refer to adaptive defence mechanisms as coping actions. This tendency to use the term "coping" in the sense of adaptive psychological defences is still observed. On the other hand, the opposite trend can be observed: within the study of coping strategies, defence mechanisms are also studied as maladaptive coping options.

The debate about the distinction between psychological defence and coping is still ongoing. However, it is possible to name the basic parameters which are distinguished by the majority of authors. Psychological defences, in contrast to coping, operate at an unconscious level. They also serve not to resolve the situation or problem itself, but rather to mask it and reduce the anxiety of the person, as well as

distort the perception of reality. Thus, defences are usually seen as maladaptive, less constructive behaviours.

Although the issue of human behaviour and reactions to difficult situations has its origins in the research and study of psychological defences, the first study of coping proper was conducted much later and this field of research was not established very long ago. The first works belong to L. Murphy [4] who investigated the ways of overcoming developmental crises in children, they had a local character. Later the phenomenon of coping began to be studied in a wider context of studying the problem of stress.

One of the necessary elements of the situation of coping is the stressor, the difficulty, the requirements of the environment to cope with. The notion of stress was introduced into science by physiologist G. Sellier [1, 8], who viewed stress as a non-specific physiological reaction of the organism in response to any requirement imposed on it. Psychology traditionally distinguishes between physiological and psychological stress, the latter reflecting a person's emotional reactions to a difficult situation. Experiencing psychological stress is influenced by many variables (significance of the situation, personal characteristics, cognitive features) and is therefore more specific and individual in nature. It does not depend directly on the characteristics of the situation. Although there are situations that are stressful for most people (high impact situations - disasters, wars, serious health conditions), the same situation will have different stress potential for different people.

There are different classifications of situations according to the type and nature of the stressor [11]. Thus, according to the type of difficulties there are, for example, financial, work, interpersonal situations, etc., according to the intensity - acute, medium, moderate, by duration - chronic and short-term, by the degree of controllability of events - controlled and uncontrolled, by the level of influence - macro- and microstressors.

K. Aldwyn [10], a student of R. Lazarus, describes three different approaches to understanding and measuring stressors. The first is the life event based approach.

According to this approach any change in life the most stressful event is a stressful one that requires adaptation and various kinds of coping with it. Trauma is the highest in terms of the severity of the impact as well as the degree of unexpectedness of the event. The second approach identifies everyday adversities and microstressors as stressors, while the third approach identifies chronic stressors that have a long-term impact on a person.

One can draw attention to a certain dynamic that existed in the type of situations that attracted researchers' attention. In the early works, the focus was mainly on life-threatening and traumatic life events, i.e. the focus was shifted towards the extreme. This was the reason why situational variables were highlighted and personality variables were not, as in this kind of situation situational variables are of paramount importance.

A person's own activity in coping with stress in a difficult situation is described through the concepts of coping strategies and styles. Coping strategies are understood as conscious efforts to regulate the emotional and intellectual state in order to overcome difficult situations and adapt. The choice of a particular strategy may depend both on the individual characteristics of a person (and be considered as a distinct personality trait) as well as on the situation. Coping styles are specific sets of individual coping strategies with similar characteristics. The first studies of coping focused on the two main types of coping responses proposed by Lazarus and Folkman [10, 20]: emotionally-oriented (aimed at changing one's state and attitudes) and problem-oriented coping. These two dimensions are traditionally highlighted in studies of coping behaviour and at this point in time. A third dimension, avoidance-oriented coping, has also been highlighted in some cases. These dimensions can include a set of different individual coping strategies and the two different coping strategies can be considered as a style characteristic of coping. It should also be noted that sometimes efforts to change one's state and attitudes are divided into two different coping strategies. For example, Moss and Schaeffer [11] distinguish between assessment-focused, emotion-focused and problem-focused strategies. The assessment-focused strategy refers to the individual's efforts to establish the meaning

of the situation; in a non-constructive version, it can be expressed through denial or downplaying the threat.

Various predictors of coping behaviour, factors related in one way or another to the realisation of coping, the success of adaptation, and the choice of particular strategies have been extensively researched.

All these factors can be divided into 3 large groups: 1) individual, personal; 2) situational; and 3) cultural or environmental [10].

To date, there are different perspectives on the role of personality and situational factors in studies of coping behaviour, with a predominant emphasis on one of these classes of variables, but there are studies in which the authors aim to combine both situational factors and individual characteristics in their work.

Personality or personality traits are classified as one of a class of factors that can predict coping behaviour, its success and its characteristics. They can also be considered as coping resources.

The various personality traits represent a multi-level structure [12]. At the lower level are formal-dynamic, constitutional characteristics (temperament, predispositions), at the second level are substantive qualities (traits, personality types, abilities, style characteristics of behaviour), and at the upper level are attitudinal characteristics (personality orientation, values, beliefs, attitudes). Thus, characteristics at different levels can influence and predict coping behaviour in different ways.

Among individual characteristics, gender, age, temperament, anxiety level, locus of control, character focus, as well as optimism and attitudes, are more frequently examined.

T. L. Kryukova [10] and her colleagues have conducted a number of empirical studies aimed at studying the relationship between the integral structure of personality, its individual psychological and personality traits of different levels and coping strategies. Among these variables were, in particular, anxiety and locus of control.

Anxiety levels reflect a person's sensitivity to various kinds of stress and a tendency to perceive situations as threatening. If a person experiences anxiety more often than objective circumstances require, this leads to less adaptive behaviour and exhaustion [12]. A person with high levels of anxiety will find himself or herself in stressful situations much more often, as he or she will perceive a greater range of situations as threatening.

Anxiety is often studied as a component of the neuroticism factor [10] in combination with depressiveness and a tendency towards negative affect. Empirical evidence suggests that personality anxiety is associated with the use of more emotional coping behaviours. In certain situations requiring active action, this behaviour would be maladaptive. We observed a connection between high levels of personal anxiety and the use of maladaptive coping strategies, avoidance strategies and withdrawal strategies. On the other hand, too low levels of anxiety also have a negative influence on adaptation, because then the person tends to underestimate the situation and does not take the necessary action to deal with it. Thus, we wanted to trace in his study, how the relationship between the level of personality anxiety and coping attitudes in cancer patients is mediated.

The notion of locus of control was introduced by J. Rotter [10, 15] and describes a person's perceptions of how much of his life is determined by himself or external circumstances and to what extent he can control significant events. The external pole of the scale is characterised by the attribution of causes to forces external to the individual, while the internal pole, on the contrary, is characterised by self and one's own activity. Although people are often divided into these two types, locus of control is actually a continuum of values, and most people have an intermediate locus of control [15]. Research by foreign psychologists identifies external/internal locus of control as an important predictor of coping behaviour, with the internal pole usually associated with the choice of more productive coping behaviours. Also, the general locus of control can be divided into components that determine perceived control in different types of situations. For example, J. Rotter's USC methodology, adapted by Bazhin, distinguishes between internalism in the area

of achievement and in the area of failure, in the area of family, work and interpersonal relations as well as in relation to health. T.L. Kryukova [10] and colleagues found not very high correlations between the level of subjective control in the situation of interpersonal relations and the general internalism index. This may indicate that the overall integral index of the level of subjective control can not always adequately predict the peculiarities of coping behaviour in interpersonal situations.

In our study, we also used this adaptation of the methodology to assess how attitudes towards fate relate not only to the integral indicator of internality/externality, but also to individual subscales.

Situational change refers to the specific types of difficult situations in which a person finds himself or herself. Differences in coping behaviour are considered in different situations differentiated on the basis of certain criteria (e.g. interpersonal and business), and the behaviour of a person in a certain specific situation (e.g. examination situation) is also described. Situational factors include the characteristics of a person's perception of the situation [19, 20] and the motivational sides of behaviour.

T.L. Krukova refers to environmental factors as social interactions and interpersonal relations, socio-cultural characteristics, attitudes, role positions and gender identity.

1.3. Mental defence mechanisms and the specificity of their manifestation in the situation of cancer

The study of psychological defence mechanisms was originally carried out within the framework of psychoanalysis and from positions close to psychoanalysis. The term 'defence' was first introduced by Freud in the late 19th century. Subsequently, this notion was revealed by the author in a number of other works, in which psychological defence was described as a way for the self to fight against painful and intolerable ideas and affects. Later, Z. Freud abandoned this term and

replaced it with "repression". In the appendix to his work "Inhibition, Symptoms and Anxiety," Freud returned to the old concept of defence, while defining it as "the principal definition for all the ways in which the self uses in a conflict which may lead to neurosis. The term 'displacement' was retained to denote one of the special defence methods which serves the same purpose as the other defence mechanisms, namely the guarding of the self against instinctive demands.

Further consideration of defence mechanisms is associated with the revision of psychoanalysis and the works of A. Freud and K. Horney. Freud gives the study of defense mechanisms one of the main roles in his research and in 'The Ego and Defense Mechanisms' he describes the operation of defense mechanisms whose function is to protect the self from:

a) anxiety due to an increase in instinctive tension;

b) anxiety due to threats to the "super-ego" or

c) real danger. Protection can act against both instinctive drives and affects.

K. Horney reconstructs a theory of defence without reference to Freud's 'It' (‘Id’) with its instinctive drives, in its place she puts the competing desires for safety and satisfaction. In doing so, Horney uses Freud's defence mechanisms, which she classifies under the headings of reactive formations and projections.

In 1979, R. Plutchik, H. Kellerman & H. Conte described the LSI (Life style index) technique, which was developed as a diagnostic tool to measure self-protective mechanisms. It was based on a theoretical model linking particular defence mechanisms to different affective states and diagnostic concepts. They proposed a model of 4 pairs of bipolar emotions, fear - anger, joy - sadness, acceptance - disgust and hope - surprise, which they believed to be related to distinct defence mechanisms, in turn related to certain personality traits. The expression of the latter is associated with certain diagnostic concepts that the authors have borrowed from the DSM-U classification of personality disorders. Table 1 shows the relationship between personality traits, personality disorders and defense mechanisms.

Table 1 - Suggested interrelationships of personality traits, personality disorders and defence mechanisms

Personality traits	Personality disorders	Protection mechanism
Shy	Passive-aggressive passive type	Displacement
Aggressive	Passive-aggressive aggressive type	Substitution
Sociable	Manic type	Reactive formations
Depressing	Depressive type	Compensation
Trusting	Hysteroid type	Denial
Suspicious	Paranoid type	Projection
Supervising	Obsessive-compulsive type	Intellectualisation
Uncontrolled	Psychopathic type	Regression

The authors of the questionnaire describe the main types of protection as follows:

Denial - a lack of awareness of certain events, experiences and feelings that would hurt a person when acknowledging them.

Compensation is an intensive attempt to correct or somehow make up for one's own real or imagined physical or mental disability.

Regression - a return under stress to ontogenetically earlier or less mature behaviours.

Projection is the unconscious rejection of one's own emotionally unacceptable thoughts, attitudes or desires and attributing them to others.

Intellectualisation - unconscious control of emotions and impulses through their marked dependence on a rational interpretation of the situation.

Displacement is the exclusion from consciousness of an idea or personal experience and the emotions associated with it.

Substitution is the discharge of emotions (usually emotions of anger) into objects, animals or people perceived by the individual as less dangerous than those that actually provoke anger.

This technique was used in this paper to diagnose psychological defences.

Irwin D. Yalom, one of the greatest representatives of the existential approach in psychology, in his work “Existential Psychotherapy”, described the defence mechanisms that people use to protect themselves from existential anxiety. His approach to internal conflicts and defences against them differs from the psychoanalytic approach. Whereas in terms of psychoanalysis internal conflicts occur when opposing instincts and instincts clash with the demands of the environment, in the existential approach it is a conflict resulting from the confrontation of the individual with the given conditions of existence. Irwin Yalom identifies five ultimate givens: death, freedom, isolation, loneliness, and meaninglessness. The individual's existential anxiety stems from a fear of death, emptiness, isolation, and meaninglessness, and defence mechanisms arise to overcome one of the primary existential fears. Thus, the existential approach retains the basic dynamic structure, but its content changes.

The existential approach maintains the notion of anxiety as the driving force behind psychopathology. This anxiety generates defence mechanisms which, while providing security, limit the growth and possibilities of experience. But Freud's formula begins with an impulse and Irwin Yalom's begins with an awareness of the fear of finite givenness. However, Yalom does not reject the psychodynamic scheme of the emergence of defence mechanisms but supplements it with his own. He identifies two types of defence mechanisms:

1. The conventional defence mechanisms described by Freud, Anna Freud and Sullivan that shield the individual from any anxiety, regardless of its source.

2. Specific defences that serve to protect against existential fears.

Below will be those specific defence mechanisms highlighted and described by Irwin D. Yalom. Yalom. As already noted, they protect the individual from fears associated with five existential certainties: death, freedom, isolation, meaninglessness, loneliness.

Defence mechanisms against anxiety related to death

According to Yalom, the mechanisms of defence against the fear of death are based on the negation of this existential given. The two main strongholds of the system of negation are the archaic belief in one's own exceptionalism and the unchanging belief in the ultimate saviour.

A belief in one's own exceptionalism

On a conscious level, none of us deny that in relation to the finitude of existence we are no different from anyone else. But deep down inside, we irrationally believe that death can bypass us. When a person discovers that he is suffering from a serious illness such as cancer, his first reaction is usually a form of denial. Denial helps to cope with anxiety and is at the same time a function of our deep belief in our uniqueness.

According to Yalom, the belief in one's exceptionalism is extremely useful for adaptation. It strengthens our courage, allowing us to face danger without being demoralised by the threat of our own destruction. But if we go a little further, defences become overwhelmed and maladaptive forms emerge.

Yalom described the following forms of belief in one's exceptionalism:

Compulsive heroism. A person can respond to an existential situation with heroic individuation, but this defence can become maladaptive if the person does not choose and their actions are compulsive and rigidly conditioned, as is the case with the hero of Hemingway's The Old Man and the Sea, who met death in a standard way, like the other dangers of life: went out to sea alone in search of the great fish.

Workaholism. A workaholic is an individual totally absorbed in work, who has an implicit confidence that he is advancing, progressing, evolving. His chief enemy is time, which can explode his illusory notion of a constant ascent that assures him immortality.

Narcissism. A person, in their belief in their own indestructibility, may not recognise the rights and exclusivity of another person. This is a sign of a narcissistic personality. An example would be that such people believe it is possible to offend and criticise others, but their personal criticism should not concern them.

An aggressive and controlling lifestyle. By resorting to this defence, one avoids a sense of fear and boundaries, expanding one's self and one's sphere of control. For example, there is evidence that people who choose death-related professions (military doctor, priest, undertaker) are motivated in part by the need to achieve control over death.

Depression resulting from an interrupted perpetual upward spiral. Individualistic achievements may be accompanied for some time by a mental uplift, but this is sooner or later replaced by depression. Freud called this phenomenon the "collapse from success" syndrome; clinicians have written about "success neurosis", a condition that arises in a person who is at the peak of success, to which he has long strived, when instead of euphoria he is overcome by paralysing dysphoria, often leaving no chance for further advancement. The man has achieved his goal and now he has nothing to strive for, which directly confronts him with the problem of the finitude of his own existence. Unable to cope with this burden, the individual resorts to defence in the form of depression.

When our belief in our invulnerability becomes insufficient to provide us with relief from fear, we turn to another fundamental system of denial - belief in a personal saviour.

Faith in the ultimate saviour

According to Yalom, belief in an ultimate saviour as a defence is less effective than belief in one's own exceptionalism. It imposes greater limitations on the individual. The following forms of this defence mechanism have been identified:

Self-deprecation. This form involves the exaltation of the power or person on whom the individual believes he or she is entirely dependent, at the expense of a complete belittling of one's own personality.

Fear of losing the love of the one who dominates and predetermines an individual's life. Without it, existence seems impossible.

Passivity. Since there is some force on which a person's existence is completely dependent, he sees no need to be active: he cannot change anything in his life on his

own anyway.

Dependency is self-sacrifice (masochism). This form of belief in an ultimate saviour implies a willingness to sacrifice oneself, to endure sorrows and tribulations for the sake of some power or significant other. For the person resorting to such protection, to be punished means to be protected.

An aversion to becoming an adult. A person who seeks addiction does not want to become an adult. He wants to remain a child protected by his parents from all the vicissitudes of fate.

Depression after the collapse of a belief system. People who have lived not for themselves, but for a dominant other or a dominant goal, do not survive the collapse of their idealised perceptions. The person may feel that they have sacrificed their life for false values, but they have no alternative survival strategy. In this case, he or she often develops depression.

Thus, the variants of behaviour associated with a hypertrophied belief in the ultimate saviour have been described above. Any of these variants, when accentuated, can develop into a specific clinical syndrome in the same way as hypertrophied forms of belief in one's own exceptionalism.

Protection mechanisms against anxiety related to the fear of freedom

Irwin Yalom considers those aspects of freedom that are important to everyday clinical practice: responsibility, namely the freedom of the individual to create his own life path, and will, that is, the individual's freedom to want, choose, act and change.

Avoiding responsibility

Modern man has more problems with freedom than with repressed urges. He deals with the task of choosing what he wants to do. Having made the choice, man is responsible for his actions. But we are not ready for this responsibility. The strain is too great, the anxiety needs to be defused, and we engage in a search for defenses against the freedom that is thrust upon us. Yalom identifies the following forms of defences for avoiding responsibility:

Compulsivity. In protecting himself from responsibility, he unconsciously creates a world in which he exists under the power of irresistible force. He behaves in a compulsive way that absolves him of responsibility for his own life.

Shifting responsibility. Often, we avoid personal responsibility by shifting it to someone else. A clinical example of this defence can be seen in paranoid patients who clearly delegate responsibility to other individuals and forces. They deny their own feelings and desires, invariably attributing their dysphoria and their failures to external influences.

Denial of responsibility: losing control. Losing control, being temporarily "out of your mind" is another way of resetting from their responsibility. For many people, their own potential irrationality serves as a means of tyranny over their partner.

Autonomous behaviour avoidance. This form of responsibility avoidance is when a person, knowing what they need to do, refuses to take the necessary step. He is frightened by the prospect of being 'his own father' (Yalom's expression). Here we see an amalgamation of two referent structures: the acceptance of responsibility leads to a rejection of passive faith in the ultimate saviour. These two structures help us to understand the pathologically dependent character.

Avoiding manifestation of will

A free person creates himself or herself and is responsible for this process. Experiencing desires and making decisions are constitutive elements of creation. By accessing one's desires and making a conscious decision, man, according to Yalom, manifests his will. Thus, Yalom's avoidance of the manifestation of the will is reduced to two components: disorder of desires and avoidance of decision-making.

Desire disorder

Impulsiveness without differentiating desires. Some individuals avoid their own desires by not differentiating them but acting quickly and impulsively under the influence of any one of them. They avoid having to choose between different desires, which, if experienced simultaneously, may contradict each other.

Compulsivity. This form of defence suggests that internal demands are not experienced as desires. Such a person is active, full of energy and purposeful. He is

so busy that he has no time to think about what he himself wants to do, even though he doubts that the desires and tasks he has are his own.

Avoidance of decision-making

Avoidance of denial. Decision-making is accompanied by denial, anxiety, and guilt. To mitigate the awareness and painfulness of the decision, we must erect defences against these threats: avoiding the consciousness of renunciation by distorting the alternatives, and the consciousness of anxiety and guilt by arranging for someone else to make the decision. There are several options for avoiding renunciation.

Bargaining. If the decision is difficult because one has to give up one possibility while choosing another, it becomes easier if one organises the situation in such a way that one gives up the least. For example, a woman who cannot make up her mind and permanently sever her relationship with her husband, which is already hopelessly damaged, enters a relationship with another man. As a result, she does not have to choose between her husband and loneliness, but between her husband and a loving friend, which is much easier.

The devaluation of the unchosen alternative. This is a common psychological phenomenon. A person experiencing cognitive dissonance perceives information that increases the value of the chosen alternative and decreases the value of the unchosen alternative.

Delegating a decision to someone or something. An example would be a patient who, in psychotherapy, always tries to force or persuade the therapist to make a decision for him or her.

To the extent that man is responsible for his own life, he is alone. Responsibility implies authorship, being aware of one's authorship means giving up the belief that there is another who creates and protects you. The act of self-creation is accompanied by profound loneliness. Erich Fromm believed that isolation is the primary source of anxiety, from which one also needs to protect oneself.

Mechanisms of defence against anxiety related to awareness of existential isolation

Experiencing existential isolation produces a highly discomforting subjective state. A person can take on a partial burden of isolation and courageously bear it. As for the rest the main defence of the horror of existential isolation, then, is a relationship. Thus, the main defence against the horror of existential isolation has to do with relationship.

Martin Buber argued that the individual does not exist as a separate entity. He called the two types of relationship between people 'I-You' and 'I-It'. The first relationship is entirely reciprocal, involving the full experience of the other. This relation is not mediated by anything and does not bear in itself any goal, any lust, anticipation. If a person does not relate to the other with his whole being, if he treats the other as an object and wants something in return, then he transforms the meeting "I-You" into a meeting "I-It".

Yalom describes clinical manifestations of defence mechanisms against existential loneliness, in which the individual is not close to the other and uses the other.

Existence in the perception of others. This defence is that a person needs to know that there is someone in the world who is thinking of him or her. Then he does not feel so alone.

Denial through fusion. The fear of recognising one's own isolation is overcome through denial: the person develops the illusion of fusion in detail and becomes part of another individual or group.

Compulsive sexuality. Indiscriminate sexual contact offers the lonely individual a strong but temporary respite. It is temporary because it is not real intimacy, but only a caricature of a relationship.

The other as a lifeline. This protective mechanism involves a market-based approach to relationships with people: sharing knowledge, skills, using the other person for certain purposes.

How many people are in the room. In a mature relationship, a person is connected to the other with his whole being. When he keeps a part of himself out of the relationship, to observe them or their impact on the other person, the ‘I-You’ relationship turns into an ‘I-It’ relationship. In such cases, Yalom asks the question, "How many people are in the room?"

Thus, the defences against the fear of loneliness described above are linked to a non-authentic surface relationship, which Martin Buber called the "I-It" relationship.

Defences against meaninglessness

Everyone needs meaning. The lack of meaning, values, ideals in life causes considerable suffering. However, the modern existential conception of freedom maintains that the world is random and has no meaning. That is why modern man feels very strongly the need to find meaning in a world that has no meaning.

Yalom separates cosmic meaning from earthly meaning. Cosmic meaning presupposes some kind of intention that exists outside the individual. Earthly meaning can have a secular basis, i.e. we can have a personal sense of meaning that has no relation to cosmic meaning.

Cosmic meaning

Religious tradition provides an overarching scheme of meaning. People are extremely comforted by the belief in the existence of some higher holistic plane in which each individual has a role to play. But the more the existence of something incomprehensible to man was called into question, the more difficult it became for people to perceive a cosmic scheme of meaning. But man needs to build for himself a meaning strong enough to sustain life.

Personal meaning in the absence of cosmic meaning. The existentialist philosopher Camus believed that man can only be fully realised by living with dignity in the face of absurdity. Man's indifference can only be overcome by man's proud rebellion against the existing situation. Sartre wrote that there is no absolute meaning, man is alone and must create his own meaning. For both Camus and Sartre it is important for people to realise that one must create one's own meaning and then devote oneself fully to embodying it, as does Dr. Rie, a character in Camus' novel

“The Plague”, who invariably shows courage, energy, and love for people, despite the vicissitudes of fate.

Productive defences against meaninglessness

Yalom looks at secular actions that give one a sense of meaning in life, inner satisfaction and do not need to be justified.

Altruism. Making the world a better place to live in, serving other people, participating in charity - these actions are good and right and give life meaning to many people.

Devotion to a cause. This secular action is well reflected in Karl Jaspers' words that man is what he has become because of the cause he has made his own.

Creativity. Creating something new, something marked by novelty, beauty and harmony is a good antidote to feelings of meaninglessness. Creativity in any profession and in any activity adds something of value to life.

The hedonistic solution. According to this view, the purpose of life is to live fully, to perceive life as a gift, to maintain wonder at the wonder of life, to immerse oneself in its natural rhythm and to seek pleasure in the deepest possible sense.

Self-actualisation. Another source of personal meaning is the desire to actualise oneself, to devote oneself to realising one's innate potential. Viktor Frankl raised serious objections to too much emphasis on self-actualisation. In his view, excessive preoccupation with self-expression comes into conflict with genuine life meaning. Self-actualisation that has become an end in itself often makes meaningful relationships where going beyond oneself is necessary impossible.

Pathological defences of meaninglessness

In addition to productive defences against meaninglessness, Yalom, referring to Salvador Muddy, describes the clinical manifestations of defence mechanisms against loss of meaning.

Crusaderism. This mechanism is characterised by a strong tendency to seek out spectacular and important ventures for oneself in order to immerse oneself in them. It represents reaction formation: the individual's immersion in the activity is a compulsive reaction to a feeling of meaninglessness.

Nihilism is characterised by a great tendency to discredit activities that make sense to others.

Vegetative form: the person compulsively does not seek meaning, but is deeply immersed in an experience of aimlessness and apathy.

Compulsive activity is, according to Yalom, one of the most common clinical forms of meaninglessness. This kind of manic activity is so debilitating for the individual that the problem of meaning loses its urgency.

Thus, I. Yalom identifies four groups of defence mechanisms against the anxiety associated with experiencing the existential givenness presented above.

To conclude this overview of existential defence mechanisms according to I. Yalom it is important to note that all finite givens are linked and accordingly the anxiety and fears experienced by the individual extend to all existential categories. Fear of death implies fear of loneliness, because 'no one can die with someone or instead of someone'. The fear of isolation is related to the fear of freedom because 'to the extent that one is responsible for one's own life, one is alone'. A person who has found meaning in his life transcendes death and does not feel so isolated.

1.4. Subjective perceptions of illness and types of attitudes towards illness as a factor in changing the individual's worldview

Modern medicine is characterised by the introduction of the ideas and methods of medical psychology into the clinic of somatic diseases. This process is largely due to the development of rehabilitation, one of the most important principles of which is the personal approach. In the concept of rehabilitation, the patient, along with the doctor, acts as a subject in the treatment and rehabilitation process. For this reason, the patient's personality and attitude towards their illness and treatment, as well as towards doctors and other medical staff, become essential factors in the success of their rehabilitation. In somatic diseases, as a rule, there is always, as K.K. Platonov put it, "complex circular dependence of mental and somatic in the type of circle, and in some cases, a vicious circle", with mutual transition of psychogenia into

somatogenia and vice versa. Psychopharmacological and psychotherapeutic influences on the patient's psyche "with the aim of eliminating painful symptoms and changing the attitude towards their illness, themselves and their environment" can help the patient to get out of this "vicious circle" (V. Rozhnov, S. Libich, Psychotherapy Manual, 1979).

Psycho-oncology is the science of the psychological, mental, social, and ethnic factors relevant to the development, prevention and management of cancer pathology, as well as the study of psychological and psychiatric disorders in cancer patients. The narrower term psychosocial oncology refers to the study and management of the psychological reactions of cancer patients, their families, and medical staff. Psycho-oncology is a field of interdisciplinary research and clinical practice at the interface of psychology, psychiatry, oncology, and sociology, which has emerged and developed as a subset of oncology.

Psycho-oncology deals with two psychological factors caused by an illness such as cancer: the emotional response of patients at all stages of the illness, their families, and carers (the psychosocial factor), and the psychological, behavioural and social factors that can influence morbidity and mortality due to cancer (the psychobiological factor).

Psycho-oncology studies the lifestyle of the patient, the psychological and social aspects of cancer, the effects on carcinogenesis and the course of the process, and how cancer affects the psychological health of the patient, the influence of psychological and social factors, including the patient's social interactions with medical staff and the family environment. It also looks at cognitive impairment resulting from chemotherapy and radiation therapy, as well as placebo and nocebo effects.

Psychosocial oncology is a specialty in cancer care, concerned with understanding and treating the social, psychological, emotional, spiritual, and functional aspects of cancer at all stages of the disease - the trajectory from prevention to end of life. Psychosocial oncology involves a comprehensive approach

to the individual in cancer care, where the full range of human needs that can improve or optimise the quality of life of people and their families affected by cancer are considered.

Four quality of life factors: physical health (pain, energy, ability to move, daily activities, need for help, ability to work), psychological well-being (life significance, satisfaction, ability to concentrate, appearance, emotions), social relationships (personal relationships, social support, sexual life), living environment (environmental safety, housing conditions, money, accessibility of health services, awareness, leisure activities, transport).

The main aim of psycho-oncology is to study the impact of cancer on the psyche of the patient and their loved ones and how psychological and behavioural factors influence disease progression and survival.

The study of the causes of cancer and its various courses has led to the identification of numerous risk factors and the understanding of cancer as a multifactorial disease. If not so long ago cancer was considered to be unrelated to personality and life circumstances, this process was understood as a pathological process of cell growth, proceeding fatally, then the successes of psychoneuroimmunology and psychosocial interventions contributed to the change of this view. Scientists have come to the conclusion that a certain psychogenic factor can both promote the emergence of the disease and influence its course (Simonton K., 1995; Brautigam V., 1999; Davydov M. I., 2007; Bukhtoyarov O. V., Arkhangelsky A. E., 2008). However, a definite psychogenic component has not been identified until now. The reasons that complicate the study of cancer are the wide range of possible damaging factors and the long latent process in relation to the damaging effects. In this regard, the list of risk factors today is the main way of preventive information of the population about the likelihood of cancer (Lisitsin Y. P., 1998; Zhuravleva I. V., 2006). Today it is possible to meet lists of numerous external (natural and social environment) and internal (socio-psychological) pathogenic factors that have a damaging effect on the body and contribute to the occurrence of cancer or its adverse course. According to one of them, improper diet (35-37%) and

bad habits (33-34%) are in the first place, the influence of ionizing radiation and oncovirus infections are estimated to be 9% and 5%, respectively. In addition, scientists acknowledge that the causes of a significant, if not the majority, of tumours are unknown, i.e., no apparent link with inducing agents has been established. Therefore, the search for possible mechanisms of disease development is being conducted today by specialists in various scientific fields. For example, researchers in the field of sociology of health believe that in 50% of cases health and morbidity of noncommunicable diseases are influenced by "lifestyle", and its mediating behavior is the leading in multifactorial health conditioning (Lisitsin Y. P., 1998; Oganov R. G., 2001; Zhuravleva I. V., 2006). Research data convincingly show the connection of morbidity and mortality with social characteristics, such as habits and behaviors, harmful to health (smoking, alcoholism or hypodynamia), educational level (Perre M., Lantz P.M., 2005, Zhuravleva, 2006, Nazarova I.D., 2006) as well as relationship of social position, educational level and ability to cope with stress loads (Simonton K., 1995; Hornung R., 1997; Brautigam V., 1999, Tarabrina N.V., 2005, Starodubov V.I., 2009). However, not all of the observed patterns of morbidity and mortality can be explained by unhealthy behavior and insufficient social resources, which shows the inadequacy of the monodisciplinary approach to the study of this subject. Therefore, modern research is increasingly becoming interdisciplinary. Thus, in sociology the concept of "attitude towards health" is being formed, although "attitude" is predominantly a philosophical and psychological concept (V.P. Myasishchev, 1960; I.P. Gurvich, 1999; I.V. Zhuravleva, 2006), the need to consider moral and emotional parameters when studying these processes is noted, while in psychology the studies on the impact on the emergence and course of disease are socially and psychologically influenced. Due to the results of previous years' research, an important place in psycho-oncological research has been taken by such sociological category as "quality of life" (Ionova T.I., Novik A. A., 1998; V. A. Gorbunova, V. V. Breder, 2000; I. M. Lebedenko, 2001; G. Staypek, 2003; T. A. Ahles, 2005), which highlights the factors of adaptation caused by disease, sick person, society, which made it possible to trace the relationship between physical

functioning, health state and social and psychological indicators as well as evaluate the effectiveness of applied methods of treatment and minimize necessary interventions. Thus, the efforts of specialists of different directions are aimed at finding a solution to the main problem of modern oncology - to obtain the possibility to have some influence on the malignant tumor process; however, despite significant successes in this area, the capabilities of medical professionals are limited. Therefore, among promising directions of work are researches with participation of psychologists, because psychological factors, as researches show, are those internal factors by means of which external conditions influence, and also are more accessible for correction in comparison with social conditions.

Psychotherapy for patients with somatic disorders is aimed at changing inadequate reactions to the illness, creating realistic attitudes towards treatment, restoring intrafamilial and wider social ties and thereby helping not only to improve the condition of patients, but also to prevent relapses. These psychotherapeutic goals can only be achieved if attitudes towards the disease are changed.

As a theoretical basis for medico-psychological research carried out in connection with psychotherapeutic tasks, in Russian psychology V.N. Myasishchev's concept is used according to which personality is seen as a system of attitudes. For medical psychology, one of the most important relationships in the personal structure of the patient is the attitude towards illness. Consideration of this attitude from the standpoint of V. Myasischev's concept seems to be very important. Myasischev's conceptualization seems quite constructive as it allows generalization of psychological content of such concepts as "internal picture of illness", "experience of illness", "reaction of personality to illness", "consciousness of illness" and others. (E. K. Krasnushkin, 1950; R. A. Luria, 1957; L. L. Rokhlin, 1957), within the framework of which the "personality and illness" problem is currently discussed.

In V. Myasishchev's psychological analysis involves looking at attitudes towards illness from three semantic perspectives. This view is based on the notion of three components of attitude: emotional, behavioural and cognitive. In accordance

with this, the emotional component of attitude toward illness reflects the whole spectrum of feelings caused by the illness, as well as those emotional experiences that arise in situations related to the illness. The motivational-behavioural component reflects the development of a particular strategy of behaviour in life situations in connection with the disease (accepting the "role" of the patient, actively fighting the disease, ignoring the disease, pessimistic attitudes, etc.), as well as disease-related reactions that contribute to adaptation or maladaptation to it. The cognitive component reflects knowledge about the disease, awareness of it, understanding its role and influence on the patient's life functioning, and the expected prognosis. Thus, psychological analysis of the attitude towards the disease, carried out in these semantic perspectives, allows us to describe all the main mental phenomena in the personality of the patient associated with his disease. Most authors identify at least three factors influencing the formation of attitudes towards illness: 1) premorbid features the individual; 2) the nature of the illness itself; and 3) socio-psychological factors.

Consideration of attitudes to illness from the perspective of relational psychology inherently involves analysis of all three factors mentioned above. Attitudes towards illness, like all attitudes, are individual, selective, conscious (or capable of awareness) and reflect a personal level. Like all attitudes, it is subjective-objective, meaningful and cannot be seen outside the object of the relationship, in other words, determined by the nature of the illness itself. Finally, like all attitudes, attitudes towards illness are mediated by existing in the microsocial environment meaningful to the patient and in society as a whole, notions about the disease in question, about culturally regulated norms of behaviour of the patient, about the social and socio-psychological consequences of the disease.

Attitudes towards illness, like every psychological attitude, are individual and unique. However, psychological analysis shows that a particular person's attitude, while remaining unique, can be described by relating that attitude to certain psychological types of attitudes, that is, by identifying similarities with the unique attitudes of others.

The most common trigger factors in the development of many diseases are the following psychosocial stressors: social dislocation, changes in social status, urbanisation, geographical and social mobility, unfavourable employment situations, job dissatisfaction, dramatic life events (loss of loved ones, grief, despair, depression, and hopelessness). The severity of a patient's response to psychosocial stressors depends on the importance the patient attaches to the event, his or her ability to adequately respond to and cope with the stress and his or her adaptive capacities. It has been proven that the increase in morbidity always occurs when the emotional balance of patients is altered, when patients perceive their living situation as unsatisfactory, threatening, intolerable, conflictual and are unable to cope with it.

Having cancer indicates that there are unresolved problems somewhere in the person's life that have been exacerbated or made worse by a series of stressful situations that occurred between six months and a year and a half before the onset of the disease. A typical reaction of a cancer patient to these problems and stresses is to feel helpless, to refuse to fight. This emotional reaction triggers a series of physiological processes that inhibit the body's natural defence mechanisms and create conditions conducive to the formation of atypical cells.

People have been aware of the link between cancer and the emotional state of humans for more than two thousand years. One might even say that it is the neglect of this connection that is relatively new and strange. Almost two millennia ago, in the second century AD, the Roman physician Galen pointed out that cheerful women were less likely to develop cancer than women who were often in a depressed state. In 1701 the English physician Gendron, in a treatise on the nature and causes of cancer, pointed out its relationship to life's tragedies, causing severe distress and grief.

One of the best studies examining the relationship between emotional states and cancer is described in a book by Carl G. Jung's follower Elida Evans, “Cancer Research from a Psychological Perspective”, with a foreword written by Jung himself. He felt that Evans had solved many of the mysteries of cancer, including the unpredictable course of the disease, why it sometimes returned after years in

remission, and why it was associated with the industrialisation of society.

Based on a study of 100 cancer patients, Evans concludes that shortly before the onset of the disease many of them had lost meaningful emotional ties to them. She believed that they were all of a psychological type that tended to attach themselves to a single object or role (person, job, home) rather than develop their own individuality. When these objects or roles to which they are attached are threatened or disappear, they may feel as if they are on their own, but they have no skills to cope with these situations. Cancer patients tend to put the interests of others first. Evans also believes that cancer is a symptom of unresolved issues in the patient's life. Her observations have been confirmed and refined by a number of later studies.

Based on an analysis of the psychological aspects of cancer patients' lives, Evans, followed by a number of other authors, identifies four main points:

1. The adolescence of cancer patients was marked by feelings of loneliness, abandonment, and despair. Too much closeness to other people caused them difficulty and seemed dangerous. In long-term studies, it was found that a striking feature of people who later developed cancer was their profound experience of a lack of intimacy with their parents. They rarely showed strong feelings and were usually in a bad mood. Another variant was the early loss of a significant loved one who was the object of deep affection and love;

2. In early adulthood, these patients either developed a deep, very meaningful relationship with someone, or derived great satisfaction from their work. They put all their energy into this relationship or role, it became their raison d'être, their whole life was built around it. The typical cancer patient very often cultivates an exclusive relationship with only one person, ignoring outside contacts. He willingly sacrifices himself for his parents, children, or spouse. He puts his all into this relationship and is willing to endure anything so as not to lose his partner.

3. Then the relationship or role disappeared from their lives. Reasons varied - death of a loved one, moving to a new place of residence, retirement, their child starting an independent life, etc. Continued dependence on the significant other (co-dependency, infantilism, personal immaturity). As a result, despair set in again, as if a

recent event had hurt a wound that had not healed since youth.

4. One of the main characteristics of these patients was that their despair had no outlet, they experienced it "within themselves". They were unable to express their pain, anger, or hostility. They were characterised by an inability to openly express hostile feelings, to respond to their pain. Many cancer patients find it difficult to express negative feelings. They feel the need to appear nice at all times. People around them usually think that cancer patients are unusually good people. On the surface, they may seem to be able to cope with their misfortune. They keep doing their job day by day, but they have lost the "taste" for life and the energy and meaning of it. It seems as if nothing else is holding them back in this life.

From our point of view, this approach is unacceptable, and the signs noted above are not only to a certain extent special cases, but also a kind of psychological "stamp", "cliché", which, on the one hand, of course, allows us to draw a direct connection between elements of the early life of the sick person and his present conception of the life situation and the built into this situation, moreover, to identify obvious psychological elements-predictors of the disease itself; on the other hand, the objectivity of these stamps is highly questionable; indeed, elements of the interviews and conversations of the ill participants in the present study point directly to a much broader range of biographical features, actually linked to a range of personality traits, which can be typologised with a certain degree of caution.

A number of works by domestic psychologists have investigated the "psychological profile of the cancer patient". It was found that many patients have the following traits: dominant childlike position in communication; tendency to externalize the locus of control (everything depends on external circumstances, I do not decide anything); high formality of norms in the value sphere; high threshold of perception of negative situations (long will endure; goals related to self-sacrifice); own needs they either do not perceive or ignore them (Malkina-Pykh I.G. "Psychosomatics: handbook of practical psychologist". Electronic version). It is very difficult for them to express their feelings. The presence of the dominant mother was

revealed more often in the family. Cancer patients exhibited signs which indicated frustration, emptiness, and a feeling of being separated from others by a glass wall. They complain of complete inner emptiness and parchedness.

The basis for the study of psychological reactions to cancer in Russian psychology was the concept of the internal picture of the disease (IPD) by A. R. Luria, who defined it as a "product" of the subject's own internal creative activity, which forms during any somatic suffering. The structure of the IPD is divided into: 1) sensory components; 2) emotional components; 3) intellectual component; 4) volitional component related to the patient's attitude towards his illness (motivational level), with the need to change his lifestyle and behaviour (Konecny R., Bouchal M., 1974; Luria A.R., 1977). IPD is a complex multilevel phenomenon and is shaped by a variety of factors: the nature of the illness, its severity and rate of progression, the characteristics of the individual in the period preceding the illness, etc. The influence of different levels manifests itself in the degree of emotional reaction, which is influenced by such somatic factors as the severity of the disease course, localization of the process and expected complications, side effects of treatment. V.D. Mendelevich connects the type of reaction to a certain disease with two characteristics: objective severity of the disease (determined by the criteria of lethality and probability of disability) and subjective severity of the disease (the patient's own assessment of his condition), indicating that subjective severity depends on social and institutional characteristics, which include gender, age, and profession of the individual. We know from research in the field of psycho-oncology that the course of the disease and prognosis largely depend on how the individual is able to adapt to this difficult situation. Regarding reactions related to gender, studies have shown that women tolerate pain and limitation of movement more easily than men. Related to gender is the subjective evaluation of the value of different body parts. Thus, the results of the survey of "healthy" people showed a high importance of the organs belonging to the sexual sphere in men compared to women, who did not reveal certain preferences. In terms of the influence of age on subjective perception of

illness, it is known that reactions to chronic and disabling illnesses turn out to be related to the system of values relevant to each age period. The value system of a mature person is related to the need for well-being, well-being, independence, autonomy, ability to maintain work and capacity to work. It has been noted that often inadequate response of the elderly to illness can be associated with a protest against old age, in which the fear of destroying the life pattern, loneliness is manifested. Psychological problems of the elderly are a subject of study in gerontology. However, given that cancer diseases, despite significant "rejuvenation", are still predominantly diseases of the elderly, consideration of age-specific features is necessary for planning psychological support for patients. Another factor influencing attitudes towards the disease is family history, which ranks the diseases not by objective severity, but by their significance, examples of successful or unsuccessful treatment. Having a family history of prolonged and sustained remission after cancer treatment, or even recovery, may contribute to a psychologically less severe perception of cancer than a family without such examples.

A detailed description of pathopsychological reactions in oncological diseases is given in the works of domestic researchers (Vasyanova V. V., 1996; Semke V. Ya, Guzeyev A. N., 2001; Bazhin E. F., Gnezdilov A. B., 2002; Samushiya M. A., Mustafina E. A., 2008). The reactions can be characterized both in general form (according to the strength of the reaction) and as complex pathopsychological complexes including several levels. Two extreme psychological variants of reactions to the disease are distinguished according to the degree of their expression, the type of the emotional attitude of the patient toward his illness, its manifestations and prognosis: hypernosognosia (exaggeration of the severity and danger of the disease) and hyponosognosia (underestimation of these aspects of the disease).

Studying the internal picture of the disease in this way involves taking a lot of information into account. Various classifications of IPD have been created for research purposes that allow for systematization of data. There are several classifications of IPD on various grounds: according to emotional-personal

reactions, according to levels of activity, according to personal significance, as well as descriptions of psychological reactions to illness. The most widely known is A. E. Lychko's classification of attitudes towards illness, reflected in the TOBOL technique and including 12 types of reactions (M. M. Kabanov, A. E. Lychko, V. M. Smirnov, 1983). Application of the technique in psycho-oncology showed that despite the fact that the extensive list allows a detailed description of the individual features of the attitude, the diagnosis of combinations of different types in patients complicates its practical application. The research difficulties may be related to the fact that the formation of the IPD does not occur in a single moment, but passes through a series of stages in accordance with the hierarchy of mental functions. Moreover, the new stage as if "interiorizes" the key experiences of the previous one, while remaining a full-fledged and autonomous entity with its specific modality of response. Up to now, there has been some discussion regarding the number of the considered stages. B. V. Nikolaeva singles out four: 1) direct-sensory (feelings and states conditioned by the illness); 2) emotional (immediate emotional reactions to feeling conditioned by the illness and emotional reactions to consequences of the illness in person's life); 3) intellectual (knowledge of the illness and rational assessment of the illness); 4) motivational (occurrence of new motives and restructuring of premorbid motivational structure).

The dynamics of reactions and attitudes in relation to the stages of treatment also influence the picture. The following stages are distinguished: "outpatient" (or "diagnostic"), "admission to clinic", "preoperative (pre-treatment)", "postoperative" (in operated patients), and "discharge". Researchers note the importance of personality traits in the severity and nature of reactions observed in all patients at all stages of treatment, noting that patients with a "psychasthenic personality complex" are the most sensitive, while patients with “epileptoid and hyperthyroid premorbid personality” are the most stable. In describing changes in reactions in cancer patients it is common to take as a basis five main phases, which succeeding each other. These phases are usually described as reactions to impending death: shock,

denial, aggression, depression, and reconciliation, but, according to Gnezdilov, they may reflect general patterns of psychological adaptation of the patient to an extreme situation, and the change of phases does not always follow the order in which they are usually listed; shortening or increasing the duration of certain reactions and alternating and returning phases due to the individual characteristics of the patient are possible.

According to domestic researchers, ten basic pathopsychological syndromes can be distinguished among marked psychogenic reactions in cancer patients, among which the first place in frequency in the first three periods of the disease is the anxious-depressive syndrome - more than 50% of patients. Anxiety predominated in stenotic individuals, while depressive symptoms were more common in asthenic individuals. In the follow-up phase, hypernosognosic reactions prevail in the form of prolonged depressions accompanied by ideas of their own worthlessness and uselessness.

In its most general form, the literature distinguishes three main types of reactions to the disease: the stenotic (active) position, the negative side of which is a weak ability to comply with the necessary restrictions imposed by the disease, including the doctor's recommendations; the asthenic position, where there is a tendency to pessimism and anxiety, but with a relatively easier psychological adaptation to the disease than in stenotic patients; the rational position, where there is a realistic assessment of the situation and a rational departure from frustration (Sidorov P. I., Parnikov A. B., 2000).

Thus, the response to a disease is a complex dynamic pattern, changing over time depending on the characteristics of the patient's personality, the stage of the disease, and the severity of the diagnosis. The characteristics of reactions to cancer are most often described by researchers as pathopsychological. Thus, in modern oncology clinic the researches are carried out, as a rule, within the limits of a certain localization of disease that allows to allocate features of the mental reactions connected with somatic influence (V.V. Vasjanova, 1996; M. Shafigullin. R., 2008; Samushiya M. A., Mustafina E. A., 2008) However underdeveloped problem areas

are the typology of IPD, assessment of adequacy and inadequacy of personal reaction to the disease. Some authors point out that research in these areas is hampered by the complex nature of the interplay of the disease process and the mental activity of the patient (Abramova G. S., Yudchitz Y. A., 1998).

A. G. Maklakov's approach, according to which the significant characteristics include: neuro-psychological stability, personal self-esteem, which determines the degree of adequacy of perception of activity conditions and one's capabilities, sense of social support, level of personality conflict, experience of social communication, is aimed at holistic study of human resistance to stress, prediction of activity efficiency in extreme conditions and assessment of consequences of extreme factors impact on a person. The range of factors to which a person can adapt depends on the level of development of these characteristics. Based on the concept of "adaptation", A.G. Maklakov believes that optimization of the functioning of body systems and balance in the "human-environment" system is achieved through the process of adaptation, as its mechanisms ensure the possibility of organism existence in constantly changing environmental conditions.

In describing the factors that are important in adapting to the situation of cancer, researchers have attached great importance to interpersonal relationships, which refers to the social psychological level of functioning. Thus, A. V. Gnezdilov notes that resource psychosocial factors contributing to adaptive coping with the disease at all stages include a positive stereotype of interpersonal relationships formed before the disease, based on deep feelings, harmonious relations with the environment, which remain stable even after the diagnosis and treatment. The resource at diagnosis is the absence or minimal level of emotional disturbance, which is largely determined by the level of stress. At the inpatient stage, a significant factor influencing the effectiveness of the treatment carried out is the nature of the relationship established between the doctor and the patient, the activity of the patient's position, his readiness for a partnership relationship with the doctor. At the follow-up stage, the patient's inclusion in the system of social relations, as opposed to

isolation and loneliness, is essential. Working patients were shown to be less affected by depression, and to have a broader perspective of life. The return to work is also found to be an effective way of alleviating the phenomena of self-isolation and promoting a sense of confidence and optimistic outlook (A. B. Andryushchenko, 2006, A. B. Gnezdilov, 2007).

Another factor is age. It is known that neoplastic processes are slower in the elderly than in the young, when in some especially malignant forms of cancer the disease may have a rapid course. The literature also notes that the psychological reaction of young people to a cancer diagnosis is more pronounced than that of older people. However, it has also been noted that survival rates for cancer appear to be higher in the young, which may be related to a decrease in adaptive potential with age, and not only on a biological level, but also on a psychological level.

CHAPTER TWO. CHANGING EXISTENTIAL DEFENCES AND ATTITUDES TOWARDS ILLNESS AS A SYSTEM FOR ACTIVATING COPING STRATEGIES IN CANCER AND UROLOGY PATIENTS

In starting to present the results of the direct practice of this study, as well as the results of the diagnostic procedures and activities, a few important preliminary remarks should be made.

When it comes to the specific nature of complex chronic diseases, when developing conceptual approaches to the study of the disease pattern, clinical and psychological dynamics of the patient, a number of factors must obviously be taken into account, the most important of which are the age of the patient, the specificity of the disease itself, including the severity and features of the clinical picture itself (in the case of cancer, the type of lesion).

There are, however, a number of circumstances which do not invalidate this specificity, but unify it in some way. Thus, within the framework of our hypothesis and in order to justify the central idea of the study, we consciously formed a complex and heterogeneous experimental research sample, which included several clinical groups that differed in age, gender, clinical and morphological characteristics of the diseases. Our main goal was to understand the relative uniformity in the action of certain clinical and psychological mechanisms which, relatively speaking, "connect" the patient and his disease, we mean, of course, representations of oneself as a patient and representations of one's illness. Our studies develop, in particular, the findings of M.V. Novikova-Grund on the inbuilt picture of the disease in the context of the patient's picture of the world and the specificity and dynamics of this system, transforming these changes into a single "vector" – the patient's own self-management mechanisms, as well as protective-compensatory and protective-adaptive reactions, are of particular importance in this respect. In this connection it is especially important to focus attention on the mechanisms of self-regulation, on the development of prerequisites for the activation of these mechanisms in the patient

(which, in turn, is associated with his, the patient’s, personal features), on the possibilities of implementation of the mechanism of self-regulation in a situation of active course of the disease. Globalising this "sector" of research, we can assert that it is an attempt to understand the bases of the motivational system connected with overcoming of illness, desire to recover, on the one hand, and about an opportunity (and desire) of search and activation of a resource for realisation of this desire.

Obviously, when it comes to the commonplace understanding of the basics and the presence of such a desire proper, there is not a single person who would answer this question negatively, except for some individuals who perceive their own illness in the context of specific personal (value and social) experiences, such as the possibility (and need) of realising feelings of guilt and therefore punishment for this "guilt", or in the context of psychological paradigm of "unconditional submission", but even in this case, again Consequently, it is possible, with a certain degree of conditionality, to take as an axiom the fact of any person's desire to get well, especially in the situation of such a pool of diseases as oncological pathology. In this case we should speak, and actually do, only about immediate psychological expenses on activation and support of this wish, on the background of general physical well-being. We by no means rule out the fact that the result of a sharp deterioration of the general condition is a significant drop in the internal resistance to the disease, a kind of "resignation" to the situation in some cases, and acute psychological fatigue in others. It should be noted in this regard, that the very phenomenon of the cessation of the "psychological struggle" for self, the causal series, the substantive, personal, value and motivational aspects of this condition have to date been virtually unexplored, despite the fact that they are the basis for understanding the psychological mechanisms of the "prolongation" of the patient's life. The main professional task of the psychologist and psychotherapist working with the sick is the activation of this very "reserve" potential, most of which lies in the sphere of complex personal existences.

2.1. General structure and sample of the study, the background clinical interview

Stage 1 patient selection assumed a history of two clinical diagnoses: renal cell cancer and bladder cancer.

The 2nd stage of patient selection 'aligned' the sampling frame by gender and age.

Stage 3 of sampling took into account the specificity of the underlying disease and treatment strategy.

Thus, a multistage, production-based, random, stratified sample was constructed.

The first group consisted of 62 patients aged between 51 and 65 years (30 men and 32 women) diagnosed with renal cell cancer, evenly distributed between the three treatment strategies.

The second group consisted of 60 patients: 30 men and 30 women, aged 47 to 61, diagnosed with bladder cancer, evenly distributed between the three treatment strategies.

In order to address the effectiveness of the system of psychotherapeutic (correctional) work implemented by the author, at the stage of sample formation for research practices, the need was determined for a control group of patients who met all the parameters of the sampling frame (65 patients): 33 men and 32 women between the ages of 47 and 65, having a diagnosis and a definite medical strategy), underwent all the procedures of the research phase, but did not take part in the remedial work.

Table 2 – Experimental group 1: patients diagnosed with renal cell cancer (hereafter referred to as group 1), number

Treatment strategy	Age 51-65		Number of people
	Men	Women	
Surgery is indicated (operation carried out)	10	12	22
Chemotherapy is indicated	10	10	20
Radiotherapy is indicated	10	10	20
Всего	30	32	62

Table 3 – Experimental group 2: patients diagnosed with bladder cancer (hereafter Group 2), number

Treatment strategy	Age 47-61		Number of people
	Men	Women	
Surgery is indicated (operation carried out)	10	10	20
Chemotherapy is indicated	10	10	20
Radiotherapy is indicated	10	10	20
Всего	30	30	60

Table 4 – Control group: patients with urological oncological diagnosis (hereafter referred to as Group 3), number

Treatment strategy	Age 50-60		Number of people
	Men	Women	
Surgery is indicated (operation carried out)	12	13	25
Chemotherapy is indicated	12	10	22
Radiotherapy is indicated	9	9	18
Всего	33	32	65

General methodological toolkit for the study

1. Clinical (in-depth) interview.
2. The Integrative Anxiety Test (ITT).
3. The subjective feeling of loneliness methodology (MSLP (loneliness)).
4. Hospital Anxiety and Depression Scale (Hospital Anxiety Scale).

5. Fear of Disease Progression Questionnaire (FPSQ).

6. A. Langle - C. Orgler (Langle Existence Scale).

7. Life Style Index (LSI).

8. Coping Mechanisms Diagnostic Methodology (Heim Coping Mechanisms Methodology).

9. Diagnosable Types of Attitudes towards Illness (TOBOL).

Statistical analysis of links

1. The Wilcoxon t-test was used to compare measures measured in two different conditions on the same sample of patients.

2. The Kruskal-Wallis test was used to test the equality of the means of several samples.

3. The Spearman rank correlation coefficient was used to quantify the statistical study of the relationship between the variables.

Description of the results of the inception clinical interview

Clinical (in-depth) interview

The clinical interview was methodologically a variant of the in-depth interview and was conducted according to the following guide (interview guide):

1. Subjective feelings of health at the time of admission to the cancer centre.

2. Presenting a history of chronic illness.

3. Self-image: personal characteristics and characteristics, specificity of life strategies, experience of overcoming obstacles, typical reactions to stressful situations.

4. Family status and relationships: dynamics in relation to the onset of the disease.

5. Circle of closest communication - reference groups: dynamics in relation to the onset of the illness.

6. Occupational interests, professional status, experience, occupation: dynamics in relation to the onset of the disease.

7. Subjective perception of one's emotional state in the current period of life (anxieties, fears, questions).

8. Personal attitude towards the disease.

9. Degree of trust in the health care facility and health care staff.

10. A vision of life prospects and the current life situation in relation to the illness.

Description of the results obtained during the initial interview procedure

Table 5 – Subjective feelings of health at the time of admission to the oncology centre, %

Name of state	Group 1	Group 2	Group 3
The state of health can be described as excellent	0	0	0
Good state of health	8	7	8
The state of health is difficult to assess	10	12	14
The health status is rather poor	39	42	37
Poor health status	44	40	42
The overall result	100	100	100

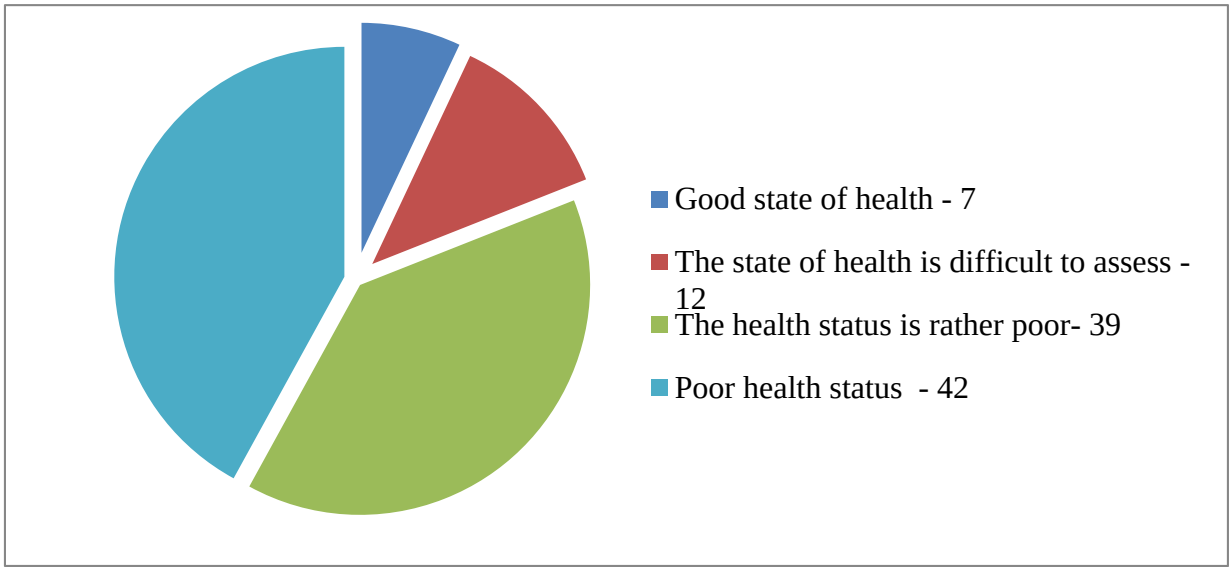

Figure 1. Health status assessment (cumulative results for the three groups), %

Thus, the predominant attitudes among patients are those indicating an unsatisfactory and poor state of health, as recorded during the interviews. The distribution of these attitudes is presented in the diagram (Figure 1).

Table 6 – Presenting a history of chronic diseases at the time of admission to the oncological dispensary, %

Row names	Group 1	Group 2	Group 3	The overall result
Have	95	97	94	95
Do not (according to them)	3	3	5	4
Difficult to answer	2	0	2	1
The overall result	100	100	100	100

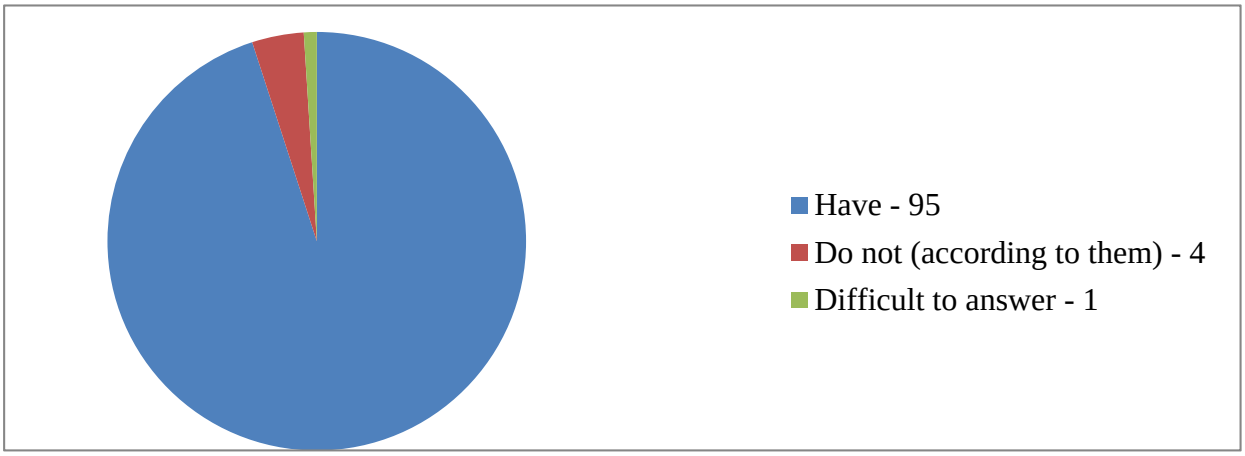

Figure 2. Perceptions of chronic disease history (cumulative results for the three groups), %

Thus, the majority of those interviewed indicated the presence of chronic diseases in their medical histories. The majority of those interviewed recalled and named them freely.

Table 7 – Patients' self-image (based on frequently encountered response options), %

Features	Group 1	Group 2	Group 3	The overall result
Active	6	3	5	5
Cheerful (positive)	5	5	8	6
Determined	3	3	5	4
Stress-resistant	2	2	2	2
Sociable	3	2	2	2
Alarming	6	7	8	7
"Loser."	2	3	8	4
Shy, shy	3	3	6	4
Executive	3	2	3	3

Other options (as expressed by patient informants): - caring; - loving; - attentive; - empathetic; - harmful; - jealous; - greedy; - demanding; -principle; - reliable; - happy.	66	70	55	64
The overall result	100	100	100	100

During the interviews, we asked informants to discuss issues related to their families: the existence of a family, the nature of family relationships, the most significant environment, etc.

Table 8 – Family status of patients, %

Family status	**Group 1**	**Group 2**	**Group 3**	**The overall result**
Married (married)	82	80	74	79
Divorced	11	10	12	11
Single (single)	2	3	5	3
Widower	5	7	9	7
The overall result	100	100	100	100

Thus, the bulk of the patients interviewed indicate their current family status regardless of the group number, which makes it possible to develop conversations in this direction in the dialogues and count on the resource help of this unit.

Table 9 – Assessment of family relationships, %

Assessing family relationships	Group 1	Group 2	Group 3	Overall result
Close and warm relationships prevail in the family	32	40	40	37
An even-handed, respectful family is prevalent, but a neutral relationship	47	38	38	41
Family members are autonomous, each living their own lives	21	22	22	21
The overall result	100	100	100	100

Thus, based on the informants' answers, three models of family relations can be distinguished: close and warm, even, and neutral, and autonomous. It should be emphasised that the proportions between the choices of these models are similar in all three groups studied. First of all, patients mentioned even and neutral relationships in their families to date. One in three was convinced that they were surrounded by loving relatives. And almost one in five in our general sample thinks that the family is not an area of understanding and acceptance for them - close people lead a very autonomous life. This is presented in the following diagram.

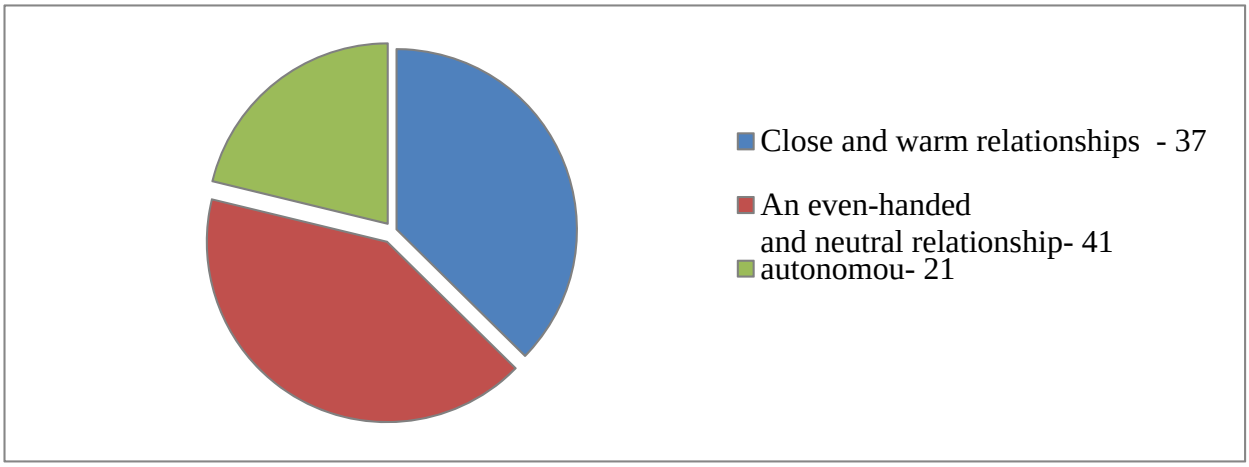

Figure 3. Perceptions of prevailing characteristics of family relationships (summary of three groups), %

Nevertheless, the family is still the environment in which the most precious people live, according to our patients' assessments. This is evident from the results

presented in the following table. And among all family statuses, children and grandchildren are the most important - a significant majority of our informants indicated them. In second place in importance and closeness are relatives, and in third place are friends. In second place in importance and closeness are relatives, and in third place are friends.

Table 10 – Features of the reference groups, %

The immediate environment, which is labelled as "people I care about in particular"	**Group 1**	**Group 2**	**Group 3**	**The overall result**
The family I live with (joint household)	27	25	29	27
Relatives	19	20	15	18
Friends	18	17	17	17
Work colleagues	13	13	14	13
Children, grandchildren	10	12	11	11
Neighbours	8	8	9	9
Other: - garden (dacha) neighbours; - pen pal; - "friend" from social media; - former classmate; - an ex-army buddy; - a buddy I used to play sports with; - son's educator; - manager (supervisor); - priest.	5	5	5	5
The overall result	100	100	100	100

In addition to the family environment, the existence and importance of which our informants talked about, their thoughts included memories of work and career, of their professional activities, although the distribution of our sample according to this attribute looks very heterogeneous. We have presented it in the following table.

Table 11 – Professional status, %

Professional activities at the moment	Group 1	Group 2	Group 3	The overall result
I am employed (have an employment contract, contract etc.)	21	40	34	32
I am a pensioner	61	50	51	54
I'm a "working pensioner"	15	7	11	11
Other: - I have a sole proprietorship, I am self-employed; - I have a disability status; - Not officially employed, but I work part-time from time to time; - I take work home with me; - working privately; - a man of "free profession"; - I do things with my grandchildren.	3	3	5	4
The overall result	100	100	100	100

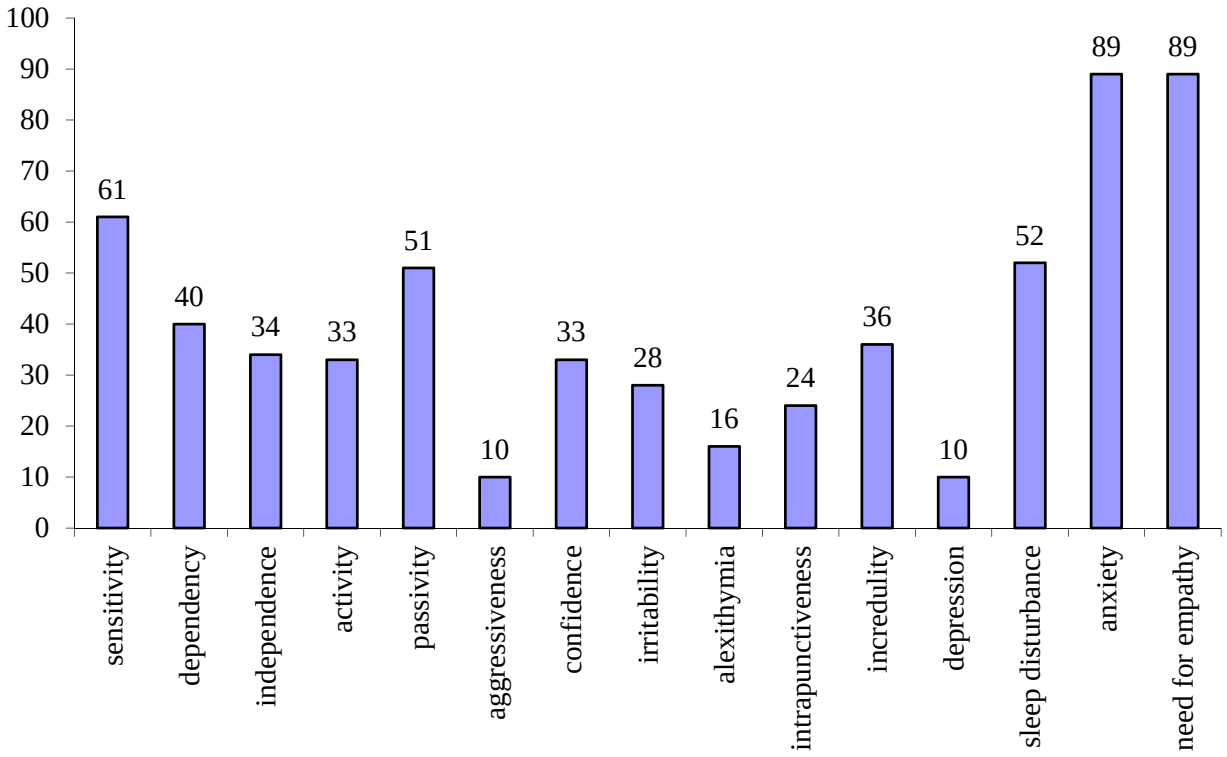

Figure 4. Subjective perception of one's emotional state in the current period of life (cumulative results of the three groups of interviews), %

In general, when describing their emotional state, our informants admitted to experiencing serious anxiety and concern, being highly sensitive and needing empathy from others. These experiences are at the top of the resulting rankings. About half of the respondents indicated that they do not want to do anything (passivity) and that they have sleep disturbances. Mistrustfulness, together with dependent orientations, could be ranked third in terms of frequency of choice on the part of interviewees.

Thus, we can conclude that during the interviews, informants noted a reduced mood background, decreased energy and mood, high anxiety and serious apprehension about future prospects. Therefore, the next thematic block of our in-depth interview was aimed at revealing the specificity of the perception of one's illness.

Table 12 – Attitudes towards the disease, %

Attitudes towards the disease	Group 1	Group 2	Group 3	Overall result
Illness as a test	37	32	29	33
Sickness as 'God's punishment'	11	15	11	12
Illness is nearing an end	16	15	20	17
The sickness of "I don't understand - why?"	18	17	15	17
Illness as a chance to get better	10	13	15	13
Illness as an inevitability	5	5	5	5
Other: - can't talk about it; - it's all a blur; - will be as it will be; - It's a shame it has to be that way; - We'll fight again; - everyone has something; - I was unlucky.	3	3	5	4
Overall result	100	100	100	100

As can be seen from the data in the table, quite a number of response options were highlighted by patients. Let us specify that these options were named by them on their own. We have resorted to the grouping method in order to group them together according to certain semantic bases. Overall, it can be emphasised that attitudes towards illness are highly ambiguous, they are still in their formative stages

and these processes do not stop at this stage of life. However, fatalistic and pessimistic attitudes currently prevail in this respect.

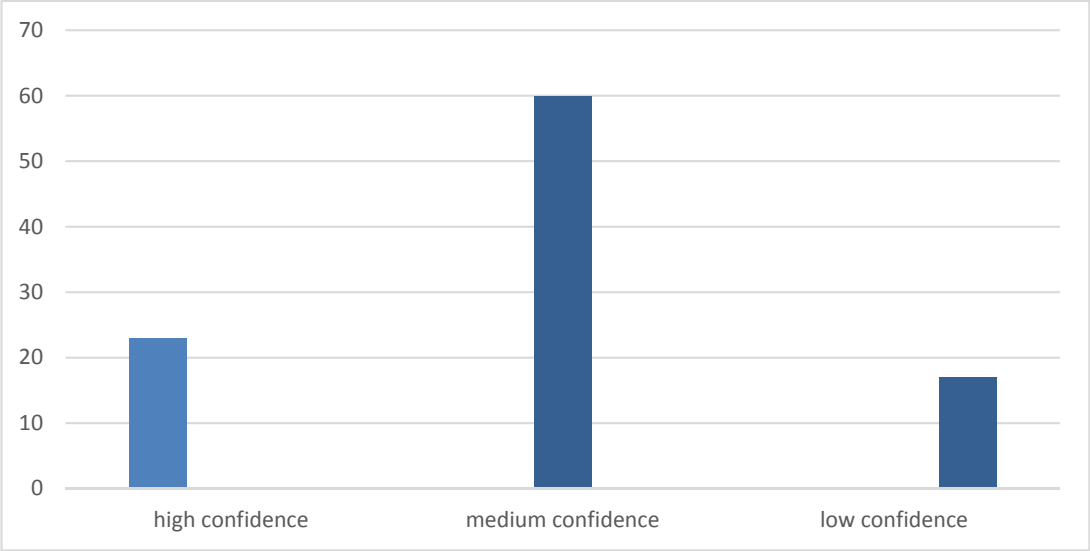

Figure 5. Level of trust in the health centre and health personnel (summary of three groups), %

When talking about the medical institution and the medical staff with whom they are currently interacting directly, our informants emphasised an average degree of trust in them. It prevailed in general across the three groups of interviewees. Only one in five interviewees felt they could trust the medicine fully and unconditionally at this stage of treatment. The share of those who expressed their doubts and distrust is 17% of all respondents interviewed.

In this regard, the next block of our interview was relevant, in which we tried to find out our informants' perceptions of their treatment prospects and future life horizons. The analysis of this block revealed the predominance of pessimistic positions in all three groups of respondents.

The distribution between the positions is presented in more detail in Table 13.

Table 13 – Vision of life prospects, %

A vision of life prospects	Group 1	Group 2	Group 3	Overall result
Positive attitude	3	5	8	5
Pessimistic stance	65	68	63	65
Undefined position	32	27	29	29
Overall result	100	100	100	100

Thus, pessimistic attitudes ("I do not expect anything good", "everything will end badly", etc.) are in the first place in terms of frequency of presence in the answers of the informants. For every third respondent the picture of the future is very vague and unclear. The share of optimists in this question is not high. The proportion between the shares of these attitudes in our sample is presented in the following diagram.

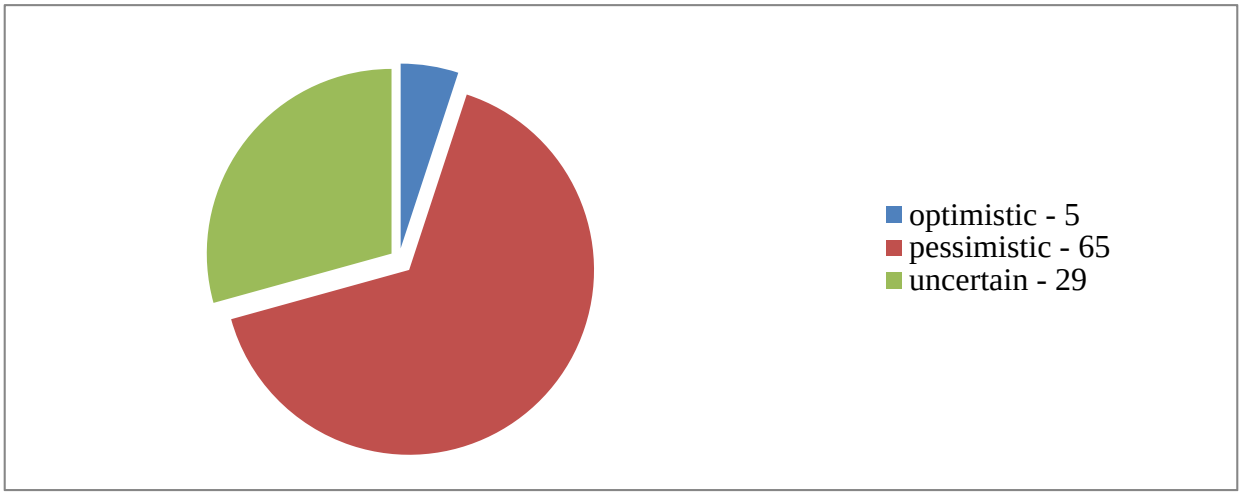

Figure 6. Perceptions of life prospects (summary characteristics of the three groups), %

Key findings from the inception clinical interview:

At the time of admission to the oncological dispensary, most of the subjects suffer from various chronic diseases (arterial hypertension, chronic bronchitis, pyelonephritis, etc.).

When describing their personality traits, half of the subjects describe

themselves as self-confident and active, stressing that they were as such before the disease, but they question these traits today.

A fairly high proportion of informant-patients (about 40% of those interviewed) described themselves as sensitive and vulnerable. They stressed the presence of serious feelings and emotional tension in stressful situations, recalling incidents from childhood and adolescence in which these feelings manifested themselves most strongly (situations of answering a blackboard, tests, exams).

Every third informant describes a range of melancholic traits.

The attitude of the subjects towards their illness varies from perceiving it as a "punishment" to accepting it as a challenge. Most of the participants, as a rule, know little about their disease, and judge its specifics mainly by the words of acquaintances and relatives. The prevailing attitude towards the disease is that of a hopeless future. Informants used the phrases: "I don't believe in a cure", "whatever happens", "no one will hire me anymore", "who will need me".

It should be noted, however, that the degree of trust in the medical staff and the medical institution was predominantly characterised by them as medium. Nevertheless, the majority of informants expressed their willingness to cooperate and comply with all appointments 'in the name of health'. About 12% of the patients interviewed had read specific literature on the topic in order to learn more about disease patterns and medical strategies. At the same time, about 7% of informants defined their position as "don't know anything and don't want to know".

The subjects complained of anxiety, fear, lethargy, and sleep disorders. The reason for their emotional state was the diagnosis of cancer. The majority of the subjects attributed their experiences to:

- with an uncertain prognosis for treatment;
- with a fear of physical pain;
- with the fear of rejection, of being alone;
- with the fear of death.

The clinical interview process identified features of emotional responses to cancer.

Analysing the results of the clinical interview, the highest scores were on the

"anxiety" scale (89% of informants reported these characteristics) and the "need for empathy" scale (89% of patients reported it). Patients in a number of cases emphasized their increased vulnerability and resentfulness (the "sensitivity" section - 61% of informants); under the pretext of disbelief in a better outcome of the disease, they reacted with passivity. 52% of the informants report a loss of energy and sleep disorders.

The opinion of others is important to more than half of the informants. Activity was reported by 20% of the interviewees. Self-confidence was reported by 10% of the interviewees. 28% of patients reported intemperance and irritability towards relatives and caregivers. 24% of the informants tended to blame themselves for their situation. 16% of patients are unable to express their feelings. Aggressiveness was reported by 11% of the informants. 10% describe themselves as being in a situation of despair.

Based on the analysis of the clinical interview results, we can conclude that cancer patients are dominated by a low mood and increased anxiety. Patients want to be understood and empathised with. Against the general background of low mood, the development of passivity, irritability, sleep disturbances, insecurity, and lack of confidence in the best outcome of the disease. There was no significant difference in these reactions between the sample groups in terms of gender, age and type of illness.

2.2. Results and interpretation of empirical procedures related to the study of defence mechanisms and types of attitudes towards illness in cancer patients with different nosologies

A direct study of protective mechanisms and types of attitudes towards illness in cancer patients with different nosologies included:

- a group of techniques to identify the content and semantic elements of existential distress, about which, in the context of cancer, a system of protective and compensatory reactions is formed: Integrative Anxiety Test - a comprehensive technique to identify levels of anxiety and phobic reactions; the subjective feeling of loneliness technique; the hospital anxiety and depression scale; the fear of disease

progression questionnaire;

- a group of techniques related to the study of personality defence mechanisms: questionnaire to examine psychological defences against anxiety related to existential problems, existential scales (A. Langle-K. Orgler);

- methods directly related to the study of attitudes to illness and coping strategies: TOOL, LSI (Life Style Index), elements of the A. Haimi coping test.

Integral Anxiety Test (ITT)

The Integrative Anxiety Test (ITT) is designed to detect the level and structure of personal and situational anxiety as an indicator of social and psychological distress in cancer patients.

A maximum anxiety level of 10, a minimum of 0, an average anxiety level (normal) of 0-3, 4-6 indicates a moderate level of anxiety, and 7-10 indicates a high level of anxiety, indicating a sustained tendency to perceive a wide range of situations as threatening.

Table 14 – First cut, %

	ST-C			**ST-L**		
	faintly pronounced	expressed by	very pronounced	rarely	often	most of the time
Group 1	16	27	57	19	37	44
Group 2	15	37	48	22	42	37
Group 3	20	29	51	15	42	43

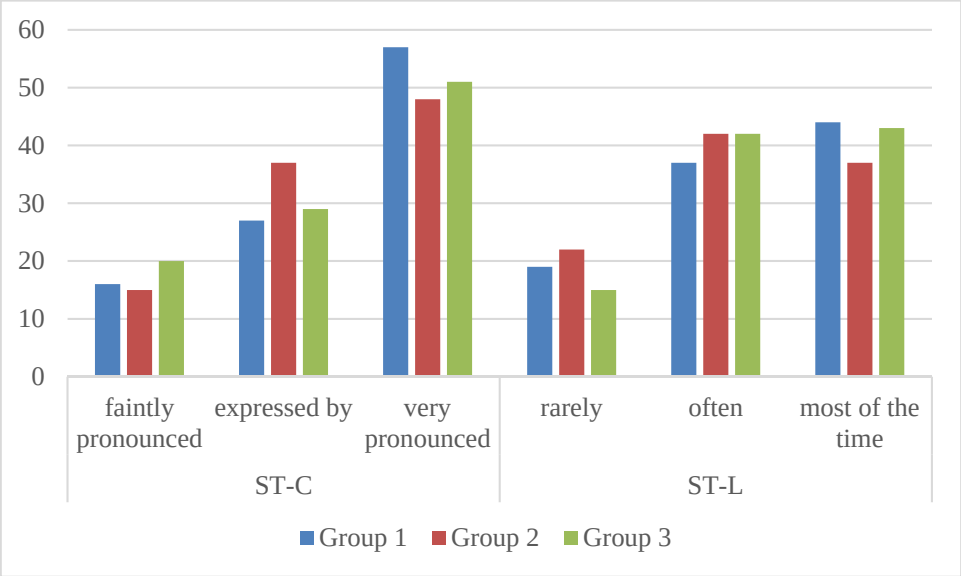

Figure 7. Distribution in groups according to the level of anxiety

Table 15 – First cut,%

	ED			AST			FOB			OP			NW		
	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails
Group 1	0	27	73	79	21	0	6	47	47	3	32	65	40	56	3
Group 2	2	30	68	73	27	0	3	38	58	2	32	67	47	53	0
Group 3	3	31	66	79	22	0	3	46	51	2	40	59	46	54	0

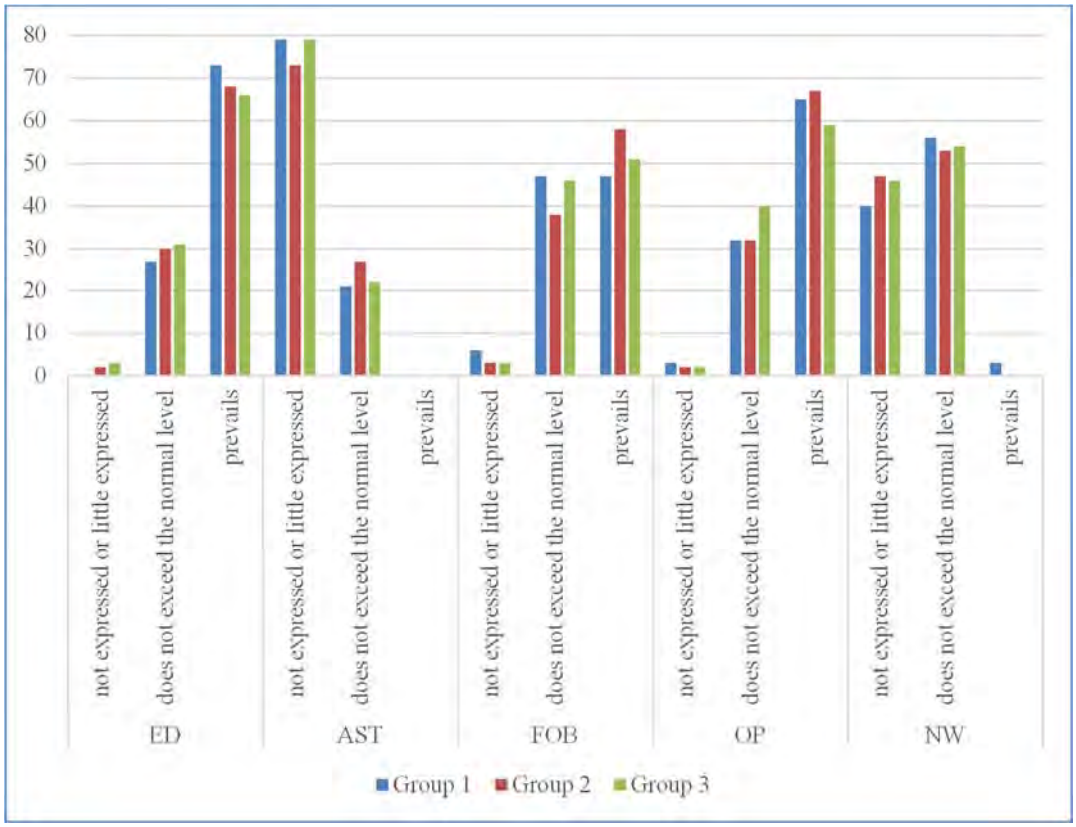

Figure 8. Correlation of anxiety level and reaction type

The subjective feeling of loneliness methodology

Table 16 – First cut, %

	High levels of loneliness	Average level of loneliness	Low levels of loneliness
Group 1	52	39	9
Group 2	52	37	12
Group 3	55	37	8

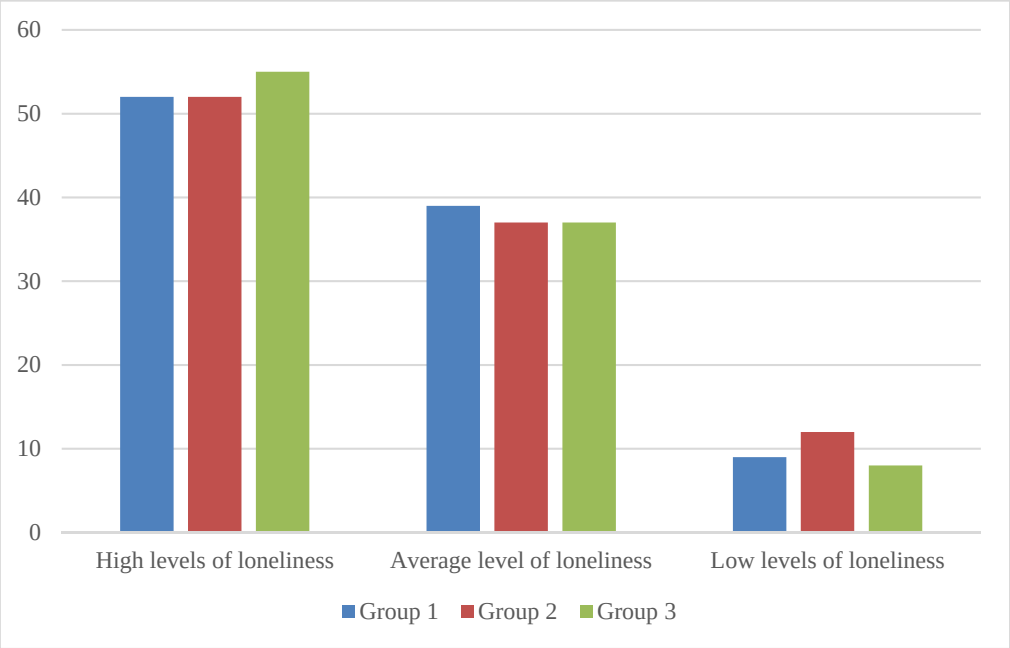

Figure 9. Distribution of levels of subjective feeling of loneliness, by group

Analyzing the results, it should be noted that situational and personality anxiety correlate with the level of regulatory flexibility (0.70, $p \leqslant 0.05$). When situational anxiety is heightened, the patient feels insecure and is unable to respond adequately to the situation. In the presence of high personality anxiety, the patient finds it difficult to adjust to a change in lifestyle, there are regulatory failures and failures in various activities. It is important to note that in the conditions of cancer treatment in the hospital the patient to some extent (according to the statements - rather high) feels danger, can not concentrate on the performed activity, it is difficult to feel confident in this situation and objectively assess what is going on around him. In connection with this observation, an additional line of enquiry arises, related to the specificity of the patient's existential conflict in connection with a stay (especially a long stay) in hospital. In this connection, a number of specific personal and behavioural characteristics need to be considered, in particular those related to changes in perceptions of the "syndrome hospitalism" and its manifestation in a particular psychotraumatic situation. This was not within the scope of the present study, but can be seen as one of the perspectives of this study.

The inverse correlation coefficient between the General Level of Self-Regulation scale and the Bass-Durkey questionnaire scales of Irritation and Verbal

Aggression was 0.68 and 0.72, respectively, p⩽0.05. Thus, we can say that the lower the level of self-regulation in these patients with oncopathology, the higher their readiness to display negative feelings at the slightest arousal both through form (yelling, screaming) and content of verbal responses (cursing, threatening).

Correlations between anxious (0.75 and 0.71, p⩽0.05), neurasthenic (0.69 and 0.70, p⩽0.05), melancholic (0.60 and 0.62, p⩽0.05), apathetic (0.53 and 0.51, p⩽0.05) types of attitudes towards illness and situational and personality anxiety were revealed. These indices indicate that, at this point, situational influences actualize the constitutional personality trait of anxiety, transforming it into a state of anxiety. Excessive anxiety is accompanied by disturbances in the social adaptation of patients with these types of attitudes.

Because of the need to understand the meaning content of the existential characteristics highlighted and manifested by the patients, it was possible to conduct a factor analysis, highlighting the significant factors, which in fact can be described as meaning-containing variables, elements of the world picture, on the basis of which the formative part of the experiment will be conducted.

Hospital Anxiety and Depression Scale

Table 17 – First cut, %

	Anxiety			**Depression**		
	as normal	above normal	high	as normal	above normal	high
Group 1	36	27	37	32	34	34
Group 2	61	17	22	58	20	22
Group 3	45	28	28	46	23	31

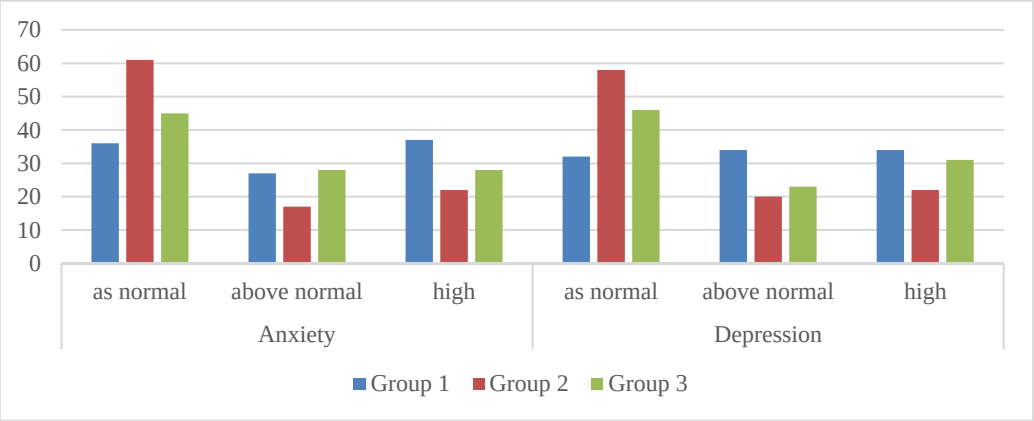

Figure 10. Distribution of normativity of anxiety and depression by group

Fear of Disease Progression Questionnaire (FPSQ)

Table 18 – First cut, %

	General level of fear of disease progression			Emotional responses			Family fears			Fear of loss of autonomy		
	High	Medium	Low	high	Medium	low	High	Medium	Low	high	Medium	Low
Group 1	53	44	3	52	45	3	45	55	0	27	73	0
Group 2	58	40	2	55	43	2	48	48	3	20	80	0
Group 3	58	40	2	54	45	2	51	49	0	22	79	0

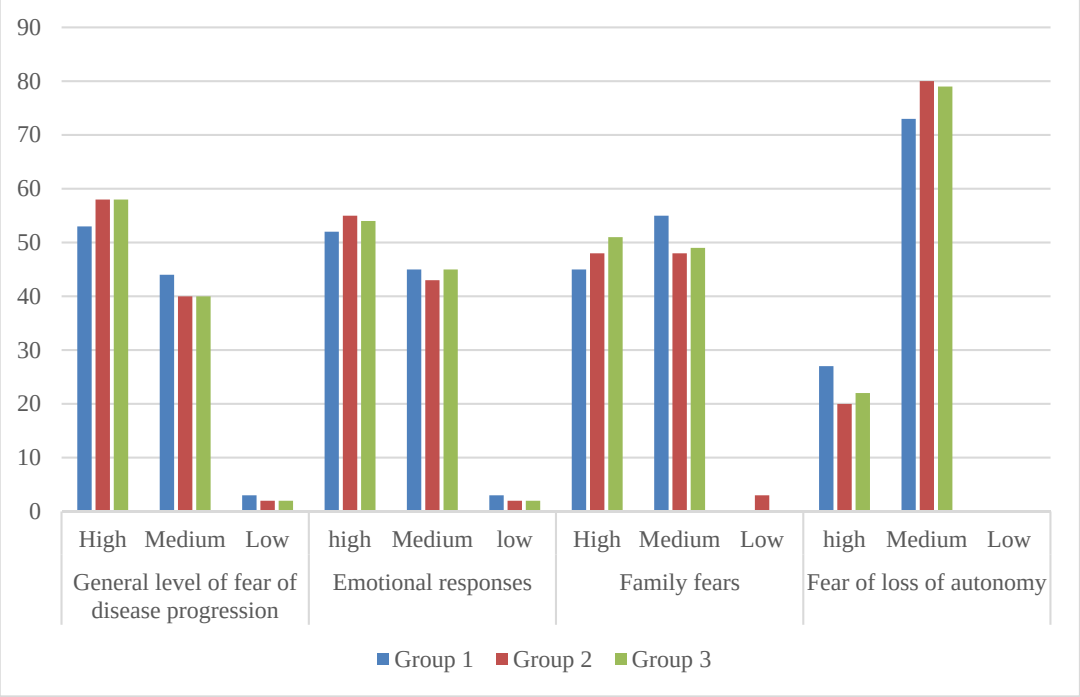

Figure 11. Distribution of intensity and types of fears by group

A. Langle's Existence Scale - C. Orgler (Langle Existence Scale)

At the same time, we note clear differences in the expression profile of the average values of existential defences in the two groups studied. Thus, in the first group of patients diagnosed with renal cell cancer, only two groups of defences exceed a 50% level of expression. These, as noted above, are the productive defences against meaninglessness and the defences against fear of loneliness. In the second group (patients diagnosed with bladder cancer), however, five groups of defenses are already "tense": defenses against fear of death ("belief in one's own exclusivity" and "belief in the ultimate savior"), defenses against fear of freedom ("avoidance of manifestation of will"), defenses against fear of solitude, and productive defenses against senselessness. It should be noted that bladder cancer patients have a greater degree of tension of existential defences, as well as a greater variety of fears relating to almost all aspects of their existence.

In studying the dynamics and specifics of the existential experiences of cancer patients, we can focus on another phenomenon that correlates with the "traumatic

freedom" we mentioned earlier: the interruption of the formation of the existential-value matrix. In fact, the picture of the world of a cancer patient, changing due to traumatic circumstances, from the moment of diagnosis begins to take shape according to the trauma-replacement type, i.e. the attitude towards the disease and the perception of oneself as "conditionally complete" are built into it initially, at the level of meaningful value and meaningful variables. But in the same connection, a peculiar "thirst for life" is also activated in a large percentage of cases; in fact, we can speak of a peculiar compensatory process, using A. Langle's terminology, - the desire to realise the fulfilment of life.

Table 19 – First cut, %

Group	Self-steering (SD)			Self-transcendence (ST)			Freedom (F)			Responsibility (V)		
	high	Medium	low	High	Medium	Low	high	Medium	low	high	Medium	low
Group 1	0	29	71	3	42	55	0	31	69	0	27	73
Group 2	0	32	68	2	47	52	0	35	65	2	32	67
Group 3	0	35	65	2	42	57	0	42	59	0	35	65

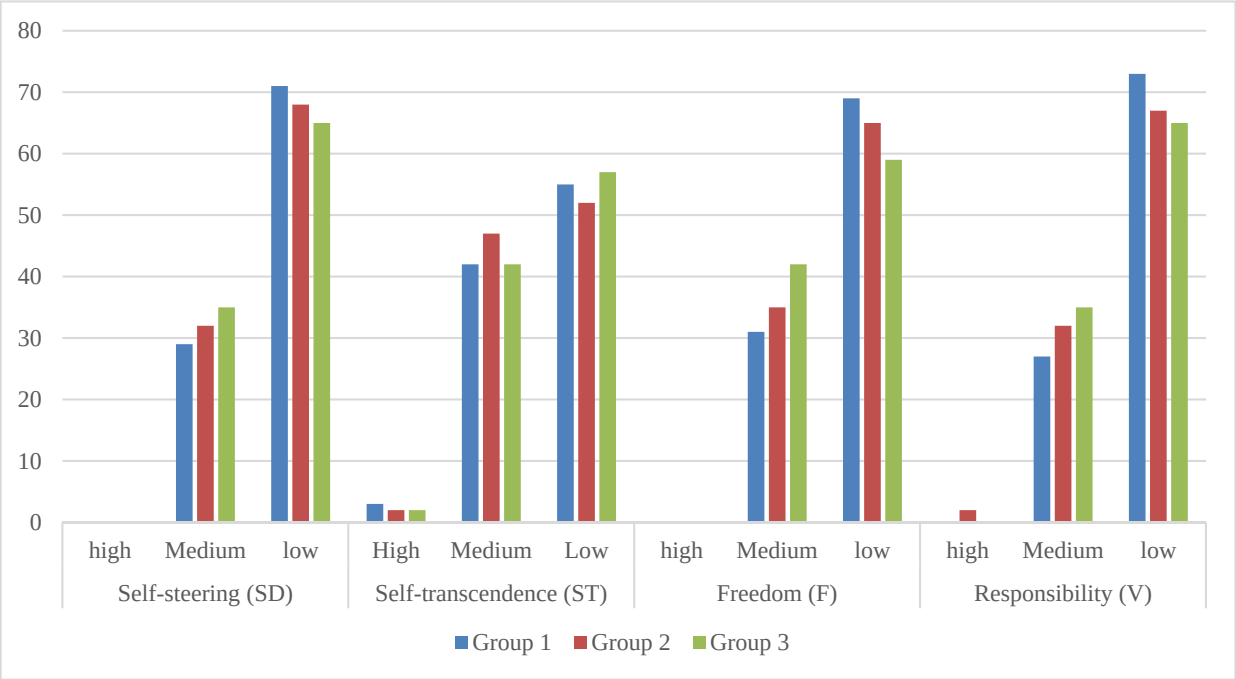

Figure 12: Distribution of intensity of expression and types of existential reactions

According to the results of this technique, we can see that the majority of subjects had a high level of existential fulfilment of life, which characterises an adult. In general, most subjects had an average level on the main scales (SD, F, V), with only the ST scale falling out of this average level. From which we can conclude that the subjects assessed themselves as inclined to accept themselves in a particular situation. In fact, we are talking about an activated capacity for feeling, experiencing a value attitude towards the world, and striving to understand the existential significance of what is happening.

Life Style Index (LSI)

Table 20 – First cut, %

Group	Denial	Displacement	Regression	Compensation	Projection	Substitution	Intellectualisation	Reactive formations
Group 1	13	24	11	7	5	8	8	24
Group 2	17	33	3	7	13	7	8	12
Group 3	15	22	8	9	8	6	6	26

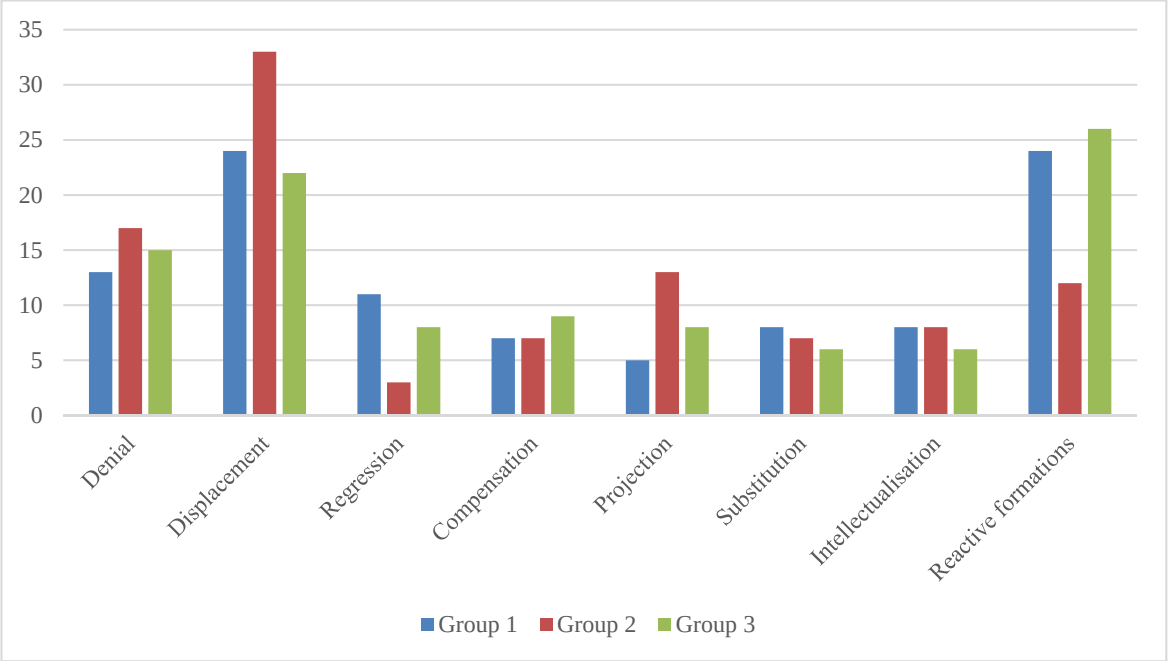

Figure 13: Distribution of severity and types of LSI by group

Coping Mechanism Diagnostic Technique (Heim Methodology Coping Mechanisms)

According to Hymie's theory and methodology, we distinguish between adaptive and non-adaptive coping strategies in the cognitive component. Adaptive coping strategies include behaviours aimed at analyzing difficulties and possible

ways out of them, increasing self-esteem and self-control, a deeper awareness of one's own worth as a person, and belief in one's own resources in overcoming difficult situations. Non-adaptive coping strategies include passive forms of behaviour with refusal to overcome difficulties due to lack of confidence in one's own strength and intellectual resources, with deliberate underestimation of adversity.

In the behavioural component, a higher proportion of 27 respondents show relatively adaptive coping mechanisms of behaviour. Following that, 26 show adaptive coping strategies, and only 3 are identified as maladaptive coping behaviours. Relatively adaptive coping-mechanisms of behavior are characterized by aspiration to a temporary withdrawal from the decision of problems by means of immersion in favourite business, fulfillment of desires. Adaptive coping strategies demonstrate a person's behaviour in which he/she engages in cooperation with significant (more experienced) people, seeking support in the immediate social environment. Non-adaptive coping mechanisms refer to behaviour that involves avoiding thoughts of adversity, refusing to solve problems, being passive and secluded.

In the emotional component, the majority of the respondents (11 people) demonstrate maladaptive coping mechanisms of behaviour. Relatively adaptive were revealed in 3 respondents, adaptive - in 2. Non-adaptive variants of behavior are characterized by the depressed emotional state, the state of hopelessness, resignation, anger and laying the blame on themselves and others. Relatively adaptive coping strategies aim either to relieve tension or to transfer responsibility for resolving difficulties to others. Adaptive coping strategies are characterised by an emotional state with active resentment and protest towards difficulties and confidence that there is a way out in any, even the most difficult, situation.

Table 21 – Adaptive coping behaviours. First cut-off, number of

	Problem analysis	Maintaining self-control	Setting your own value	Protest	Optimism	Cooperation	Address	Altruism
Group 1	0	0	6	5	8	13	0	0
Group 2	0	0	8	8	0	5	2	2
Group 3	0	0	12	6	0	8	0	0

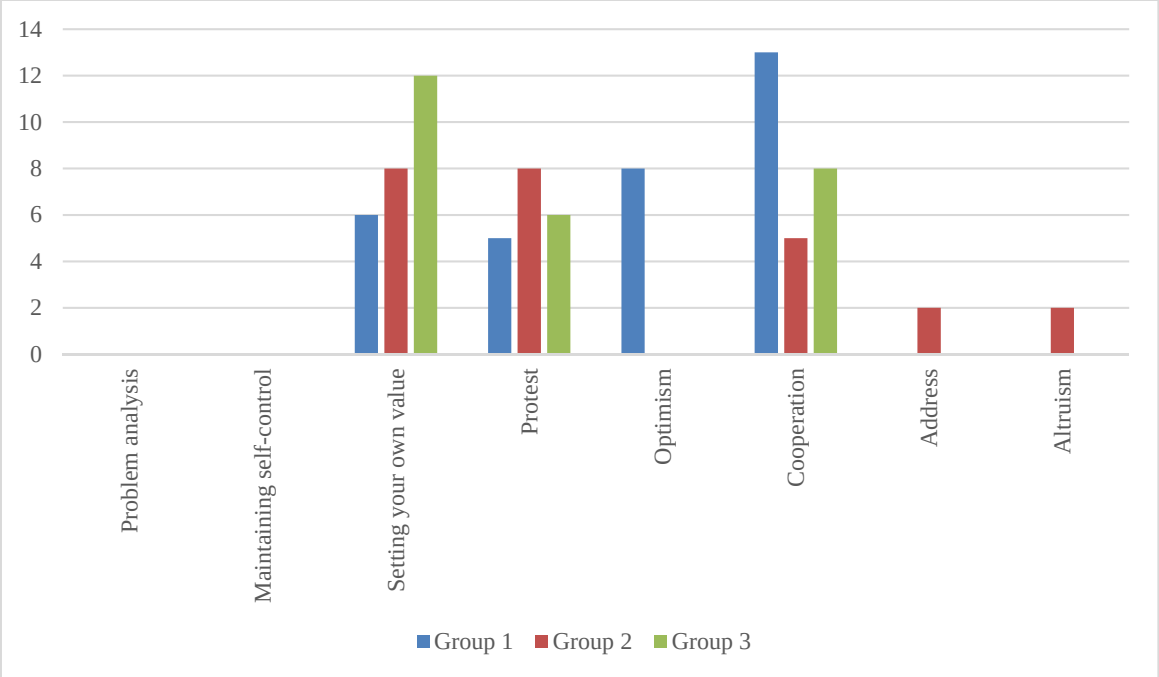

Figure 14: Distribution of intensity of adaptive strategies

Table 22 – Non-adaptive coping behaviours. First cut-off, number of

Group	Humility	Confusion	Dissimulation	Ignoring	Suppression of emotion	Obedience	Self-incrimination	Aggressiveness	Active avoidance	Retreat
Group 1	3	17	3	5	0	0	0	5	5	10
Group 2	0	0	12	5	0	0	3	0	5	5
Group 3	12	3	2	2	0	0	0	5	6	8

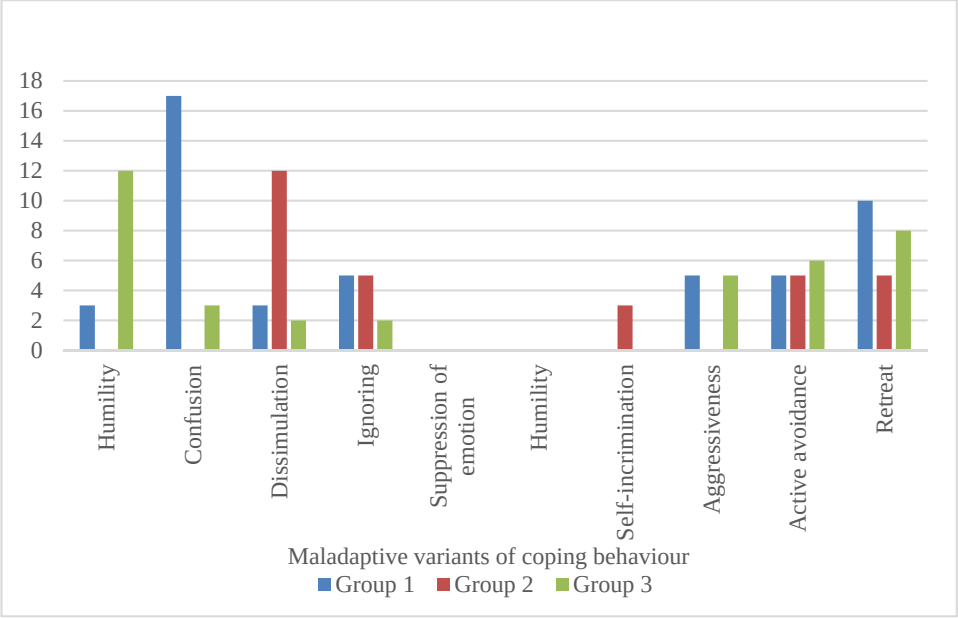

Figure 15. Distribution of intensity of maladaptive strategies

Table 23 – Relatively adaptive coping behaviours, number of

Group	Relativity	Giving meaning	Religiousness	Emotional release	Passive cooperation	Compensation	A diversion	Constructive activity
Group 1	21	0	0	15	0	0	0	0
Group 2	20	0	0	22	3	0	0	0
Group 3	22	0	0	8	8	0	0	0

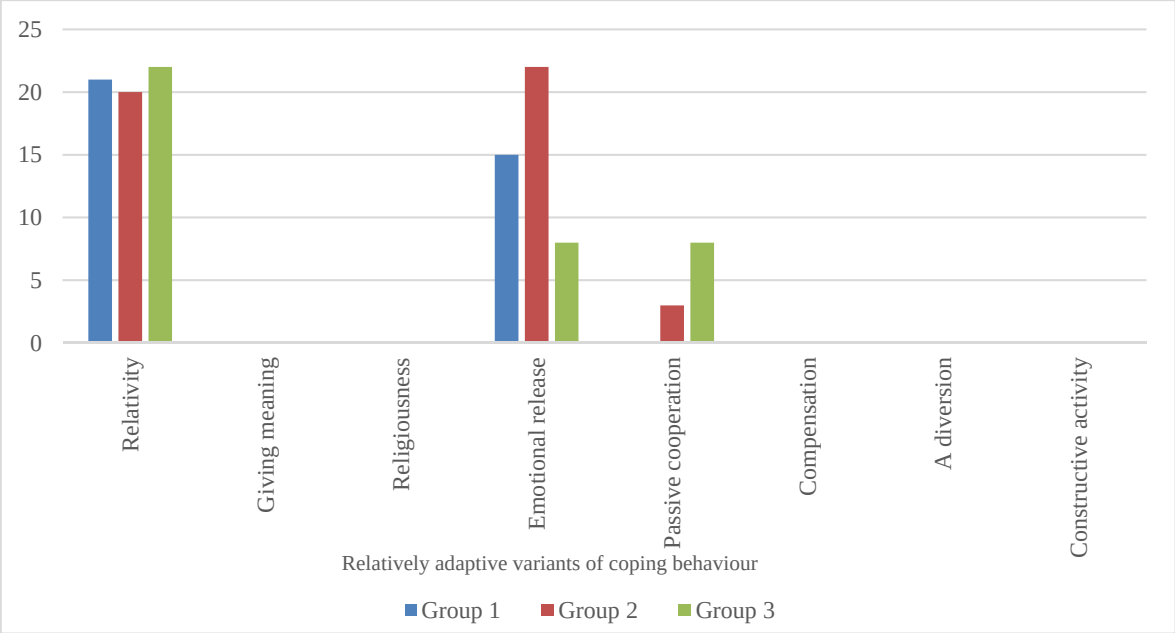

Figure 16. Distribution of expression of relatively adaptive strategies

Diagnosable types of attitudes towards illness (TOBOL)

Table 24 – Types of attitudes towards illness, First cut

	Harmonious (D)	Ergopathic (R)	Anosognostic (H)	Anxious (T)	Anxiety-neurasthenic	Hypochondriac (I)	Neurasthenic (N)	Melancholic (M)	Melancholic and hypochondriac	Apathetic (A)	Anosognosic-apathic	Sensitive (C)	Egocentric (E)	Paranoid (P)	Dysphoric (D)
Group 1	0	10	5	21	7	13	3	5	3	5	5	15	5	0	5
Group 2	0	8	7	20	13	13	3	5	0	5	0	12	5	3	3
Group 3	0	12	6	22	0	8	3	3	15	5	0	14	5	3	5

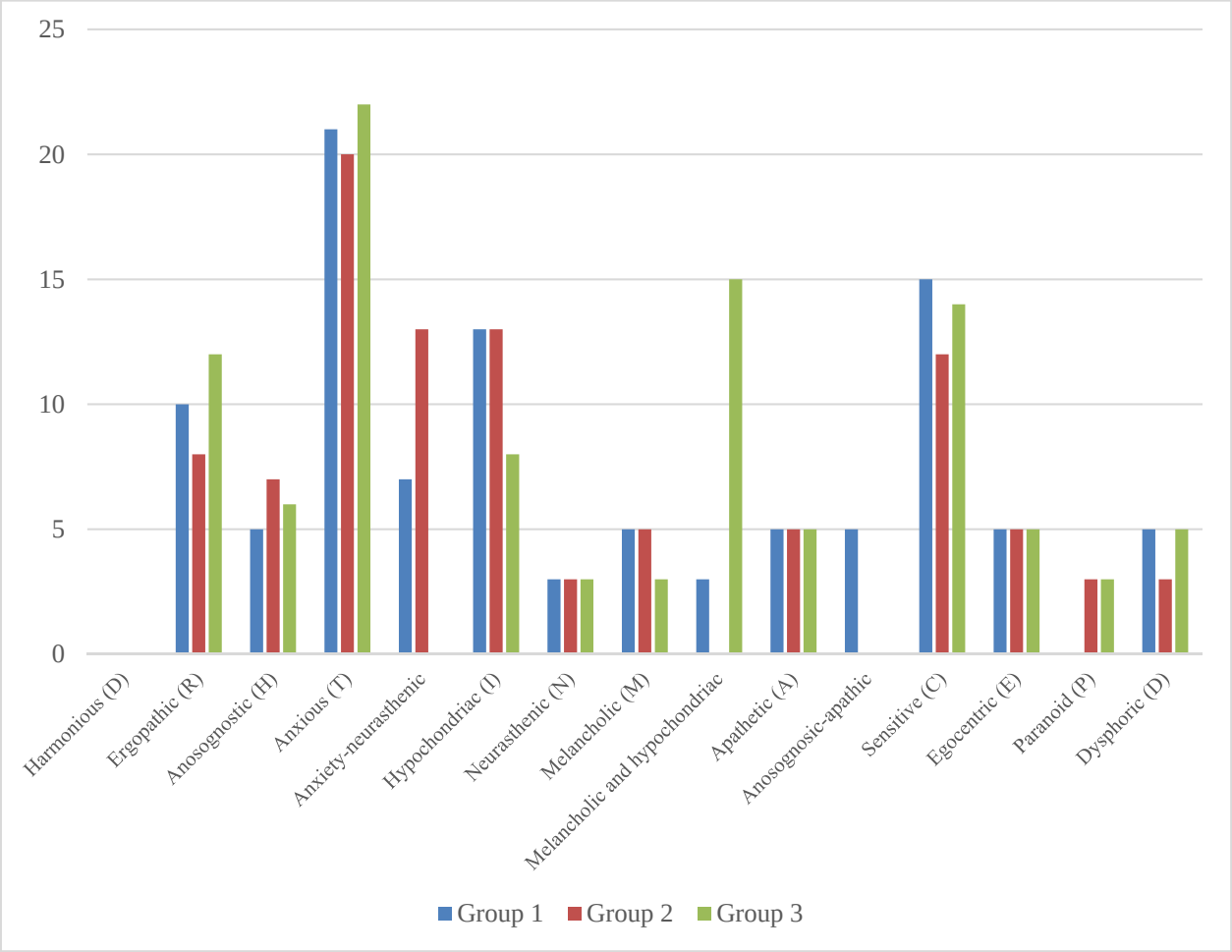

Figure 17: Distribution of the representation of attitudes towards illness

The internal picture of disease (IPD) as a "product" of the subject's own inner creative activity is formed in its more or less developed forms in any somatic suffering, from single episodes of pain and discomfort to gross manifestations of somatic pathology (in severe chronic diseases). The study of the essence of this process is the most important condition for the successful study of personality and its changes in cancer patients.

The study of IPD makes it possible to consider to a considerable extent the entire complex process of self-knowledge of a sick person, to reveal the means used by a person to implement this cognitive process. At the same time, the study of IPD opens up the possibility of understanding the special ways and techniques of overcoming, mastering one's own behaviour used by a person in a difficult life situation. In this way, an analysis of the inner picture of the illness opens up the possibility of gaining insight into the compensatory potential of the individual.

Disease as a pathological process in the body is involved in two ways in the construction of the internal picture of illness:

1. Local and general bodily sensations give rise to a sensory level of disease pattern reflection. The degree of involvement of the biological factor in establishing the internal disease picture is determined by the severity of the clinical manifestations, asthenia, and pain sensations.

2 The illness creates a difficult psychological situation for the patient. This situation involves many different things: procedures and medication, communication with doctors, and the restructuring of relationships with loved ones and colleagues at work.

These and some other things affect a patient's own assessment of their illness and shape their final attitude towards their illness.

The scientific literature uses a large number of terms to describe the subjective side of diseases, which have been introduced by different authors but are often used in very similar ways. E. The subjective side of illness is described by K. Krasnushkin in the term "illness consciousness", R. A. Luria calls it "the internal picture of illness", and E. A. Shevalev refers to it as "the experience of illness". A. Shevalev calls it "experience of illness". The German internist Goldscheider wrote of an "autoplastic disease picture", distinguishing two interacting sides: sensory (sensual) and intellectual (reasoning, interpretative) [19].

The growing knowledge of the mental side of illness in domestic medical theory and practice has led to the emergence of many different conceptual frameworks that reveal the structure of the inner world of the ill person.

Most current psychological studies of the internal picture of disease [19] identify several interrelated aspects (levels) in its structure for different nosological forms:

1. the pain side of the illness (sensory level, sensory level) - the localisation of pain and other unpleasant feelings, their intensity, etc.

2. the emotional side of the illness relates to different kinds of emotional reactions to individual aspects, symptoms, the illness as a whole and its

consequences.

3. the intellectual side of the illness (rational-informational level) relates to the patient's perceptions and knowledge of the illness, thinking about its causes and consequences.

4. the volitional side of the illness (motivational level) is related to a certain attitude of the patient towards his/her illness, the need to change behaviour and lifestyle, and the actualisation of activities to regain and maintain health.

On the basis of these sides, the patient develops a model of the disease, i.e. an idea of its etiopathogenesis, clinic, treatment and prognosis, which determines the "scale of experience" (Libich S.S., Berezin T.B.) and behaviour in general [7].

The distance between the true state of health and the "disease model" can be both exaggerated and downplayed, even to the point of denying the disease itself (see Fig. 18).

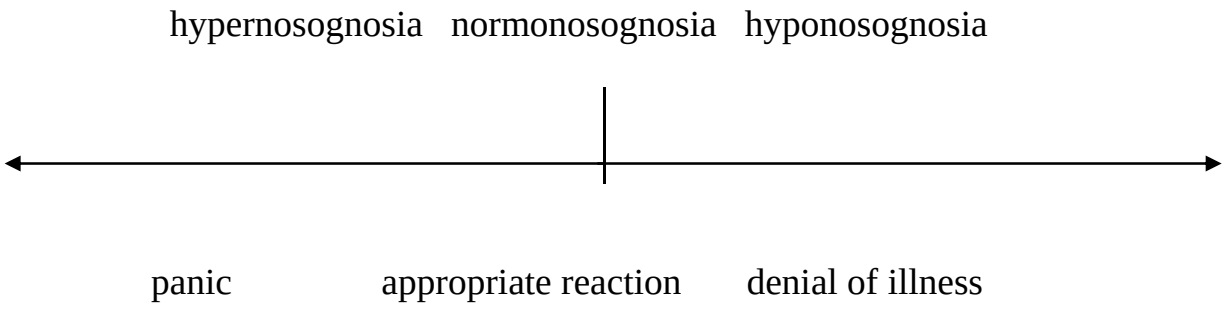

Figure 18. Scale of the experience of illness

In an appropriate type of response (normonosognosia), patients correctly assess their condition and prospects, and their assessment coincides with that of the doctor.

With hypernosognosia patients tend to overestimate the significance of individual symptoms and of the illness in general, while with hyponosognosia patients tend to underestimate them [4].

Three main reactions to the illness can be distinguished: stenic, asthenic and rational.

1. When the patient takes an active stance towards examination and treatment, it is referred to as a stenotic reaction to the illness. There is, however, a negative

side to this behaviour, as the patient may be poorly able to fulfil the necessary restrictions of the lifestyle imposed by the illness.

2. In asthenic reactions to the disease, patients tend to be pessimistic and hypochondriacal, but they are relatively easier to deal with than patients with a stenotic reaction, adjusting psychologically to the illness.

3. In the rational response there is a realistic assessment of the situation and a rational withdrawal from frustration [4].

A number of authors (N.I. Reinwald, 1969; A.D. Stepanov, 1975; L.N. Lezhepekova, P.Y. Yakubov, 1977) describe types of attitude towards an illness, having in mind the character of interaction developing between a doctor and a patient.

Types of personality response to illness (Yakubov B. A.,1982):

A co-operative reaction. This reaction is characteristic of those with advanced intelligence. From the first days of the illness, they become like "assistants" to the doctor, demonstrating not just obedience, but also a rare punctuality, attention, and friendliness. They trust their doctor implicitly and are grateful for his help.

A calm reaction. This reaction is characteristic of persons with stable emotional and volitional processes. They are punctual, react adequately to all the doctor's instructions and carry out the therapeutic measures accurately. They are not just calm, but even appear to be "solid" and "sedate" and easily come into contact with the medical staff. They may sometimes be unaware of their illness, which prevents the doctor from identifying the influence of the psyche on the illness.

An unconscious reaction. Such reactions, while pathologically based, in some cases act as a psychological defence, and this form of defence should not always be eliminated, especially in severe illnesses with an adverse outcome.

Trace reactions. Patients are at the mercy of prejudice, tendentiousness. They're suspicious. Distrustful. Difficult to make contact with the attending physician and do not take his or her instructions and advice seriously. They often have conflicts with the medical staff. Despite their mental health, they sometimes exhibit what is known as "double-directedness".

Panic reaction. Patients are fearful, easily suggestible, often inconsistent, treated simultaneously in different institutions, as if checking one doctor with another. Often, they are treated by witch doctors. Their actions are inadequate, erroneous and characterised by affective instability.

A destructive reaction. Patients behave inadequately, carelessly, ignoring all the instructions of the treating physician. Such persons are unwilling to change their usual lifestyle and occupational load. This is accompanied by a refusal to take medication or to undergo inpatient treatment. The consequences of such reactions are often unfavourable (4).

In N. D. Lakosina and G. K. Ushakov's (1976) typology of reaction, as a criterion taken as a basis for classification of types, the system of needs that are frustrated by the disease is distinguished: vital, socio-professional, ethical, or related to intimate life [19]. Other authors (Burne D.G., 1982) believe that the reaction to the disease is largely conditioned by the prognosis of the disease [18].

In any case, the individual develops a set of adaptation techniques in order to cope with the changed well-being and various manifestations of the illness. E. A. Shevalev (1936) and Sh. V. Kerbikov (1971) define them as adaptation reactions, which can be both compensatory (artificial restriction of contacts, subconscious masking of symptoms, conscious change of the daily regime, nature of work, etc.), and pseudocompensatory (denial and ignoring the disease). In other words, the sick person, on the basis of his or her conception of the disease, changes his or her usual way of life and work activities in a certain way, and in this respect a wide variety of somatic illnesses can create the same life circumstances for a person.

P. Barker (1946) identifies 5 types of attitudes toward illness: discomfort avoidance with autism (characteristic of patients with low intelligence), substitution with finding new means of achieving life goals (persons of high intelligence), ignoring behaviour with displacement of recognition of defect (in persons of average intelligence but high educational level), compensatory behaviour (tendencies toward aggressive transfer of inadequate experiences to others etc.), neurotic responses.

The content of the internal picture of illness reflects not only the situation in life (the illness situation), but also the premorbid personality, character and temperament of the patient. The premorbid features of personality can largely explain the preference of patients for certain forms of response to the disease.

Pathological forms of reaction to an illness (experience of an illness) are described by researchers in psychiatric terms and concepts: depressive, phobic, hysterical, hypochondriacal, euphoric-anisognostic and other variants (E. A. Shevalev,1936; L. L. Rokhlin, 1971; V. V. Kovalev, 1972). In this aspect, the classification of the types of attitude towards the disease proposed by A. E. E. Lichko and N. Ivanov (1980).

Type of attitude towards illness (A. E. Lichko, N. Y. Ivanov, 1980):

1. Harmonic - a correct, sober assessment of the condition, not wanting to burden others with the burdens of self-care.

2. Ergopathic - "walking away from illness into work", the desire to maintain capacity for work.

3. Anisognostic - actively rejecting the thought of illness, "it will get better".

4. Anxious - incessant worry and mistrust. Believing in omens and rituals.

5. Hypochondriacal - extreme concentration on and exaggeration of subjective sensations, fear of side-effects of medication, procedures.

6. Neurasthenic - 'irritable weakness' behaviour. Impatience and outbursts of irritation towards the first person you see (especially in pain), followed by tears and remorse.

7. Melancholic - disbelief in recovery, discouragement over illness, depressed mood (suicidal threat).

8. Apathetic - complete indifference to one's fate, passive submission to procedures and treatment.

9. Sensitive - sensitive to interpersonal relationships, full of fears of being shunned by others because of illness, fear of becoming a burden to loved ones.

10. Egocentric - "retreating into illness", showing off suffering, demanding special treatment for oneself.

11. Paranoia - belief that the illness is the result of someone else's intent and that complications in treatment are the result of the negligence of medical staff.

12. Dysphoric - mood dominated by a gloomy, angry mood, envy, and hatred of the healthy. Outbursts of anger with a demand from loved ones to please them in everything [4].

There are also classifications of types of reactions to illness, which take into account the social consequences of the illness. According to Lipovsky (1983), psychosocial reactions to illness consist of reactions to information about the illness, emotional reactions (such as anxiety, grief, depression, shame, guilt) and coping reactions.

Reactions to information about the illness depend on the "meaning of the illness" for the patient:

1) illness is a threat or challenge, and the type of response is counteraction, anxiety, withdrawal or struggle (sometimes paranoid);

2) illness - bereavement, and the corresponding types of reactions - depression or hypochondria, confusion, grief, trying to get attention, disruption of regime;

3) illness is a gain or deliverance and the types of reactions in this case are indifference, cheerfulness, disruption, hostility towards the doctor;

4) illness is a punishment and there are reactions such as oppression, shame and anger.

Coping reactions are differentiated by the predominance of cognitive components (downplaying the personal significance of the illness or paying close attention to all its manifestations) or behavioural components (active resistance or capitulation and attempts to "escape" from the illness) [30].

In addition to the fact that illnesses occur at different episodes in a person's life (I would like to say that they always occur at the wrong time), they also have a temporal characteristic, i.e. they have a temporal dimension.

The following stages can therefore be observed in the person's experiences and attitudes towards their illness:

1. Pre-medical phase - lasts until communication with a doctor, the first signs

of illness appear and the person is faced with the decision to seek medical help.

2. The breakdown phase is the transition to a stage in the illness where the patient becomes isolated from work and often from family when hospitalised. He is uncertain about the nature and prognosis of his illness and is full of doubts and worries.

3. Adaptation phase, when the feeling of tension and hopelessness diminishes, as the acute symptoms of the illness gradually diminish, and the patient has already adapted to the fact of the illness.

4. Surrender phase - the patient is reconciled to their fate, makes no active effort to seek "new" treatments and understands the limitations of medicine in curing them completely. He becomes indifferent or negatively moody.

5. The phase in which compensatory coping mechanisms are formed, the attitude to gain some material or other benefit from the illness (rent attitude) (15).

According to our data, Group 1 patients (diagnosed with renal cell cancer) have an "ergopathic" attitude towards illness. At the same time, they are also characterised by "harmonious" and "sensitive" types of attitude towards the disease. With these indicators, patients are most characterized by an over-responsive, sometimes obsessive, stenotic attitude to work, which in some cases is even more pronounced than before the disease. A selective attitude towards examination and treatment, primarily due to the desire to continue working despite the severity of the illness. Patients in this group want at all costs to maintain their professional status and to be able to continue to work actively in their former capacity. Interestingly, both patients in the first and second groups of retirement age either continue to work or actively switch to household chores. They do not underestimate the severity of their illness, but they do not exaggerate it either. They do not oppose the treatment. They fear becoming a burden to their loved ones and try to do everything they can to prevent this from happening (this was also often expressed by patients). If they understand the unfavourable prognosis of the disease, they switch their interests to those areas of life that will remain available to the patient and focus on their own

affairs and the care of their loved ones. At the same time, they are sometimes overly sensitive and vulnerable, which is probably due to their worries that people around them will pity them, consider them inferior, or treat them with disdain or apprehension, spreading unfavourable rumours about the cause and nature of the illness and even avoiding contact with the sick person.

Patients diagnosed with bladder cancer are also most characterised by the "ergopathic" type of attitude towards the disease. To a lesser extent, they are characterised by "harmonious" and "sensitive" attitudes towards illness.

Compared to the first group of patients, they are also to a large extent characterised by a hypochondriacal attitude towards their illness. Analysis of the results showed that they are ambivalent about their illness. In their preoccupation with their work, they exaggerate actual illness and fictional illness and suffering. They are characterised by exaggeration of discomfort about the side-effects of medication and diagnostic procedures. They reveal a combination of a desire for treatment and disbelief in success, a constant demand for thorough examinations by reputable specialists and a fear of the harms and painfulness of the procedures.

2.3. Changing attitudes towards meaningful elements in the worldview of the cancer patient as the basis of a psychotherapeutic model for activating coping behaviour

Psychological factors play a significant role in the etiopathogenesis of tumour diseases, so the importance of psychotherapy in the complex of measures to increase the nonspecific resistance of the organism is recognised by many researchers.

According to V. E. Rozhnov and A. K. Matsanov (1979), in some cases in patients with tumour pathology psychotherapy is only used to create a favourable psychological environment, with individual and group psychotherapeutic conversations with patients; in other cases, a wide arsenal of psychotherapeutic methods can be directed towards treatment and rehabilitation tasks, the content of which is determined by the stage of the disease, its severity and prognosis.

During cancer prevention, autogenic training and behavioural psychotherapy methods can be used. In the initial diagnostic period, when patients are anxious and fearful, rational psychotherapy is appropriate, aimed at calming the patient, activating him, forming a more adaptive attitude to the disease and treatment. In severe cases, hypnotherapy is recommended. Rational psychotherapy and self-involvement techniques aimed at eliminating fear and instilling confidence in the success of treatment are also considered appropriate during the difficult experience of cancer patients before surgery.

In the post-operative period, psychotherapeutic tasks are determined by the patient's condition and further treatment. With patients receiving radiation therapy, psychotherapeutic measures aimed at correcting the emotional state and eliminating the side effects of treatment are carried out individually and in a group. In addition to those mentioned above, techniques such as "psychotherapeutic mirror", "therapeutic perspective" and "anonymous discussion" are used. In advanced stages of these illnesses, psychotherapy techniques are used to alleviate pain, improve sleep and include an empathic, empathetic attitude towards the patient as an important component, as well as an inspiration of hope.

Knowledge of the mental state of cancer patients (Gerasimenko V. N. et al., 1983; Gnezdilov A. V., 1995; Biktimirov T.Z., Modnikov S. P., 1999) before and after the surgery, peculiarities of their "internal picture of illness", psychological defense mechanisms, process of "isolation syndrome" formation let us use some elements of person-oriented group psychotherapy in the treatment of these patients as well as in psychoprophylactic work with them.

Vachon and Lyall (Vachon M.L., Lyall W.A., 1976), summarising their many years of experience of working with patients with cancer, point to one-hour daily group sessions as a form of psychotherapy, in which group members provide mutual moral support, share their own experiences of adjusting to their illness and finding alternative ways of overcoming emotional tension and problems caused by the illness. Attempts of group psychotherapy even with hopelessly ill patients with metastatic carcinoma have been described (Yalom I. D., Greaves C., 1977). Psychotherapy was carried out daily for 90 minutes in a group of 6-7 patients. The authors believe that this form of work is an effective means of supporting the patients and enabling them to cope with stress by improving their adaptation to the emotional disorders that accompany the disease. The open confrontation with death allows the patient to orientate not to the past or the future, but to the present - to "life" rather than "death"; the fear of being humiliated, of getting into a difficult situation goes away, as "cancer cures neuroses". The complexity of the role of the psychotherapist is emphasised, the need to integrate into the situation of the dying patient, the ability not to separate the patients from themselves - not to separate the concepts of "I" and "You".

Support groups for patients and their families, and early psychiatric care, notes Peterson (1981), can significantly reduce the risk of severe and uncorrectable psychological and psychopathological reactions to cancer.

Eysenck (Eysenck H. J., 1993) has also convincingly confirmed the role of psychotherapy in oncology. The research was based on the coping mechanisms of the patients and included individual and group forms of behavioural psychotherapy and coping training. We followed up 100 people; they were healthy people who had been diagnosed with either lung cancer or coronary heart disease in a psychosocial study.

The patients were divided into 50 pairs of people of the same sex and age. One of the pairs was then randomly assigned to a psychotherapy group, while the others were not given psychotherapy sessions. After 13 years, 16 people died of lung cancer in the control group and none in the experimental group (in which psychotherapy was given). Twenty-one people in the control group developed lung cancer, while 13 people in the experimental group did. Mortality from other causes was 13 in the control group and 5 in the experimental group. The research confirmed the effectiveness of psychotherapy as a preventive measure. The possibility of prolonging the life of incurable cancer patients by means of psychotherapeutic methods was also considered. Twenty-four such patients were divided into pairs. One patient in the pair received behavioural psychotherapy, while the other patient received only conventional treatment. The mean life expectancy (since follow-up) was more than 5 years in the former and more than 3 years in the latter. Similar results were obtained in behavioral therapy of women in the terminal stage of breast cancer (Biktimirov T.Z., 1999; Chulkova V.A., 1999). According to the authors, physiological processes in the body are under a pronounced influence of psychological influences (in stressful situations, in particular, cortisol content in the blood rises, which has a negative impact on the activity of the immune system).

The special working conditions in an oncology clinic require special training for doctors and nurses. Wise (1977) describes a group work experience in the form of a workshop for doctors and nurses. The focus was on the feelings of concern and anxiety that arise when working with cancer patients; techniques for dealing with the dying; and the group's understanding that they are working in a complex area of medicine. Wise emphasises the effectiveness of the form of training used. One of the important features of working with the most common causes of such patients in psychotherapy are dealing with the fear of death (most often imminent and in representations - excruciating), the fear of pain and the thoughts of an impossible future. A particularly pronounced fear may stem from the imminence of a risky surgical intervention, which is often intensified by the psychotherapist's anxiety about helplessness in the face of the fatal prognosis. In the hospital, the patient is attended

by the attending physician, nurses, counsellors, social workers, and others at the same time, and yet he feels alone. In order to face the approaching death with dignity or with relative peace of mind, the patient needs relatives and doctors that he can trust. Talks should not be given (even in whispers) at the dying person's bedside, the content of which is not always sufficiently clear, which may increase their anxiety and uncertainty about the safe outcome of the illness.

One of the common mistakes in dealing with the dying or terminally ill is the conscious or unconscious desire of others to avoid unnecessary contact with them. In these cases, it is worth taking a holistic approach to work with the patient and, if possible, to provide therapy also with relatives or close associates of the dying person.

The therapist themselves may identify with the patient, with the terminally ill person and their relatives, and the question of prognosis constantly raised by the patient is perceived by the professional as a confrontation with them or a challenge to their own powerlessness and death.

Without proper support, the terminal patient may exclude the possibility of treatment for themselves and stop attending specialists, which in the vast majority of cases affects the work of medical staff and their emotional state.

There are special features in dealing with terminal patients:

1. The significance and power of fear of illness. Patients imagine their illness to be dangerous for their loved ones and believe that it can be transmitted to them. This perception of illness can manifest itself in the avoidance of loved ones and relatives. This leads to social isolation and stigmatisation, which naturally reduces the effectiveness of specialist care.

2. Another problem is the desire on the part of doctors and medical staff to necessarily cure the patient, to relieve him or her of anxiety and suffering. This manifests itself in increased pressure on the patient and harms the relationship between the patient and the medical staff. It is more often the "being there" for the patient, being close and willing to help, rather than the treatment itself, that is of paramount importance.

The way in which the terminal patient is informed of his diagnosis is of great importance to him. Sincerity in conversations with the patient is a fundamental law of terminal psychotherapy. This applies not only to the medical staff dealing with the dying person, but also to relatives, attendants, and clergymen.

The diagnosis is made honestly and without concealment, but the patient's personality and possible reactions are also taken into account. Particular attention must be paid to what the patient really wants to know and what matters most to them. If possible, it is the attending physician who communicates the diagnosis. At the same time as the diagnosis is communicated, a therapeutic perspective should be formed in the patient's mind, therapeutic suggestions should be made or encouraging findings from the examination should be emphasised in the conversation with the patient. In this way, the doctor promises the patient that he will not be left alone with the illness and supports his sense of worth.

The doctor as an accompanying partner eases the patient's way through rejection, hope and hopelessness. These feelings are often suddenly changed in the patient's mindset, but they can also coexist, causing uncertainty and forcing them to search for direction.

The effectiveness of terminal psychotherapy largely depends on the skilful use of family support by the therapist (in the course of the therapy). The psychotherapist also needs to understand the significance of suffering for the patient and his relatives, the systemic mechanisms that are in place before and especially during the illness and after the possible death of the patient.

Sometimes relatives may ask the doctor not to tell the patient about the diagnosis, which can lead to different levels of awareness among family members and subsequently affect relationships. Lack of information does not change the nature of the diagnosis and the patient feels alienated and isolated without understanding the reason for this condition. It is therefore important that all family members are fully informed. This way, the patient can count on the mobilisation of family resources and the opening up of relationships. In addition, this situation is more comfortable for

work in psychotherapy, both individual and group, both personal and family.

The following measures are recommended in the context of working with the terminally ill person:

1) develop positive transference and create a stable relationship with the therapist;

2) make the therapist as accessible as possible to the patient, rigid boundaries are not very appropriate;

3) take every opportunity to express feelings in the patient (aggression, anxiety, guilt, etc.);

4) psychological support as a complementary factor to a somatic therapy programme;

5) use the patient's beliefs and beliefs to improve their well-being.

Modern organisational forms for terminal psychotherapy are palliative care facilities, hospices, specialised units, or centres for the treatment of AIDS patients, gerontology departments in general hospitals and psychiatric hospitals. Terminal psychotherapy is carried out on an inpatient or outpatient basis. In the latter case, other professionals (e.g. a nurse or social worker) can also be involved in working with the patient.

In modern approaches (e.g. Eriksonian hypnosis, short-term positive psychotherapy), short-termism is an important principle in preventing the patient from developing a "psychotherapeutic defect or addiction"; it also prevents to a certain extent "running away to psychotherapy" and shifting responsibility for one's life onto the psychotherapist. Most short-term methods are directive and imply that the therapist acts as a teacher, coach, helper, who helps the patient to solve his problems by himself.

The concept of "short-term psychotherapy" cannot be considered outside of a specific conceptual framework: from short-term psychodynamic psychotherapy over a period of several months to one-off psychotherapy in behavioural psychotherapy or short-term positive psychotherapy. In either case, significant (on average 10-fold) time constraints are implied compared to similar "classical" forms of psychotherapy.

On average, in short-term therapy, 4-8 to 16-18 sessions are devoted to the treatment of one problem.

One fairly popular short-term method in Russia is short-term positive psychotherapy, centred on activating one's own resources. As with any theory, short-term positive psychotherapy can be divided into its sources and principles. Sources include attitudes, systemic and strategic family psychotherapy and psychoanalysis.

Basic principles:

1) Reliance only on the positive things in the patient's life, their resources;

2) Using only positive reinforcement with the patient and their loved ones;

3) A positivist (in the philosophical sense) approach.

The search for resources can be oriented towards the past ("What has helped you to overcome similar problems in the past? How have your relatives and acquaintances solved such problems?"), the present ("What is helping you to solve the problem now, even temporarily?") and the future ("Who or what could help you to solve the problem?").

Recognising the one-sidedness and illusory nature of this worldview, positive psychotherapists emphasise the equally one-sided but "black" worldview that characterises the vast majority of patients and consider the task of psychotherapy to be the formation of a more dialectical worldview, expanding it to include "light" vision and hope. The use of only positive reinforcements in work with the patient allows him to liberate and activate his positive memories, his intuition and ability to fantasise constructively, to make available his subjective conception of health, an illness which patients are usually ashamed to present to the psychotherapist on account of its "unscientific and naive" nature. The positivist approach to psychotherapy, the fundamental giving of the leading role to the experience and intuition of the patient, his relatives and psychotherapists, the conscious overcoming of the rigid framework of any psychotherapeutic conceptions allow positive psychotherapists to resolve the stereotype of a step-by-step therapeutic interaction with the patient (symptom diagnosis - setting of a syndrome and/or nosological diagnosis - creation of a model of psychotherapeutic intervention - psychotherapeutic

measures proper with the evaluation of the patient's condition). The patient's cognitive level of care should be analysed and psychotherapeutic interventions modelled on the negative feedback on the primary intervention, only if cognitive techniques are ineffective.

A course of psychotherapy is an average of 3-4 sessions with the therapists' orientation on the desirability and possibility of psychotherapy of a single conversation. The duration of a session is usually more than one hour, the first session often more than two hours. The time between sessions varies from a few days to a few months. Such psychotherapy is often carried out by several psychotherapists. The patient may come alone, but relatives or acquaintances are welcome to attend.

The main theoretical tenets of short-term positive psychotherapy are several important tenets:

1. The causes of each person's problems lie in the past, but in their own experience there are also resources for solving these problems. "Every patient knows the solution to their problem even if they think they don't know it" (Erikson).

2. The analysis of the causes of the problem is accompanied by self-blaming by the patient and blaming their relatives, which is not conducive to psychotherapeutic cooperation. Therefore, it is more constructive to identify and activate the patient's resources for solving the problem.

3. The framework of any psychotherapeutic concept is always narrower than the individual characteristics and experiences of particular patients. The concept adopted may impose unrealistic and ineffective solutions due to dogmatic belief and logical "beauty". Intuitive experience anchors and prompts only effective solutions.

4. One is not free to free oneself from all illnesses and problems, but one does have the opportunity to change the "black" vision of one's life and the world to a more dialectical world view. This contributes to overcoming problems. Confrontation, "fighting" the problem in most cases is ineffective; acceptance of the problem is the way to a compromise solution.

The term "short-term" in relation to psychodynamic psychotherapy was proposed in the 50-60s of the last century by representatives of the psychoanalytic

psychodynamic movement. The term "short-term psychotherapy" was coined in the 1950s and 1960s by representatives of the psychoanalytic psychodynamic movement.

Although Freud's own course of psychoanalysis was relatively short (3 to 6 months), and some of his closest disciples purposely limited psychotherapy to 10 to 12 sessions, only the historical necessity of the post-World War II period and the quantitative and qualitative (due to the poor and protected sections of society) expansion of demand for psychotherapeutic help forced orthodox psychoanalysts to abandon their positions. Radical psychotherapy for only a few years and the acceptability of short-term forms of psychotherapy became the subject of debate and research.

Despite the differences in the psychotherapeutic positions of the proponents of short-term psychodynamic psychotherapy, it is possible to identify common principles concerning goals, patient selection, phases, and techniques.

1. Short-term psychodynamic psychotherapy is considered to be purposefully limited to 1-40 sessions (the most common variant is 10-12) with a frequency of meetings with the patient approximately once a week.

2. The goal of short-term psychodynamic psychotherapy is behavioural change in the focused area of conflict, as opposed to the orthodox psychodynamic psychotherapy's attitude of personal development through the total overcoming of a complex of basal conflicts.

3. Accordingly, the guiding strategic principle of short-term psychodynamic psychotherapy is the isolation and processing of a focal conflict, in most cases of an oedipal nature (rivalry, problems of winning-loss, etc.). Markers of this focal conflict are the patient's references to early trauma associated with it, recurrent stereotypes of traumatic experiences, an association of this conflict with a single transference figure (paternal or maternal) and with manifestations of blocking (inhibiting) some aspects of the patient's activity. An indirect indicator of adequate choice of focal conflict is the affective response of the patient to a trial interpretation of it.

4. Requirements for the therapist's role position: ability to make an affective contact with the patient, combined with a "good-hearted lack of concern", active in

contact and interpretation (in contrast to the "neutral mirror" position of the orthodox psychodynamic psychotherapist).

5. Specific requirements for the patient. Indications: presence of focal conflict of oedipal nature or loss of a loved object, high motivation, experience of at least one meaningful relationship, ability to reflect on feelings and a constructive response to trial interpretation. Contraindications: severe depression, psychotic disorders (paranoid and/or narcissistic nature), tendencies for pathological processing of experiences (suicidal or substance abuse behaviour). An indirect contraindication is the patient's predominant use of projection and denial mechanisms. Short-term psychodynamic psychotherapy is much more effective than long-term psychotherapy, focuses on the patient's own ability to summarise and use the material learned in psychotherapy.

6. Phases of short-term psychodynamic psychotherapy. The first, qualifying phase aims at diagnosing the motivation and strength of the patient's self and highlighting the focal conflict (1-2 first sessions), concluding a psychotherapeutic contract. The second phase is devoted to processing the focal conflict. The final, third, separation phase aims at the resolution of the transference and a rather directive conclusion of the psychotherapy. It is debated whether or not to give the patient a precise date for the end of the psychotherapy, but it is thought that this technical approach is preferable for the novice psychotherapist, because it avoids the experience of guilt and the feeling that he is "leaving the patient". Naturally, the patient still has the option of seeing the therapist again when problems arise. But even if a second course is planned, a break is useful to test the insights gained with practice.

7. In addition to the usual reconstructive techniques of cognitive and identification learning in psychodynamic psychotherapy, specific modifications of these are used. The leading technical principle of "chair instead of couch" means that the psychodynamic psychotherapist focuses on the patient's sense of shame instead of the guilt exploited in orthodox psychodynamic psychotherapy. The analysis of defence and resistance in short-term psychodynamic psychotherapy centres on the

therapist's chosen focal conflict, and the interpretations of transference are limited to one significant person from the past who is connected to this conflict.

8. The leading psychotherapeutic principle of short-term psychodynamic psychotherapy is the processing of the focal conflict that causes blockages in significant life domains – the patient is able to experience a return of energy and activity which can be used to solve life's problems.

Positive psychotherapy according to N. and X. Pezeshkian is the author's name for the psychotherapeutic concept developed since 1972 by N. Pezeshkian and X. Pezeshkian. Pezeshkian draws attention to the origins of the term positive psychotherapy from the Latin positum - "occurring, really existing", rather than from positivum - "positive", thus emphasizing the need to work on both positive and negative aspects of the problem and the patient's life, expanding the dialectic view of the world. This terminological clarification allows the name "reality psychotherapy" or "common sense psychotherapy" to be used as synonyms for this type of positive psychotherapy.

Positive psychotherapy, according to the authors, is based on 3 principles - hope, balance (harmonisation) and counselling - which correspond to 3 stages of work with the patient, both during an individual session and throughout the entire psychotherapy course (an average of 10 sessions of 1-2 hours).

In the hopeful phase of the work, the principle of hope is used:

1) a positive interpretation of the patient's problem (e.g. anorexia nervosa - showing the ability to tolerate limitations, empathising with world hunger, etc.)

2) a transcultural approach - broadening the patient's understanding of the problem by introducing them to different (often directly opposite) responses and attitudes in other cultures (for example, differences in attitudes towards food and fasting in Eastern and Western cultures);

3) parables and anecdotes with a psychotherapeutic radical (the authors identify 9 psychotherapeutic functions of a parable: mediation between doctor and patient, problem-solving model, involving the patient's culture, etc.)

The harmonisation phase of the work uses the distribution of energy into the 4

main spheres of life - bodily, mental, socio-communicative and spiritual.

Bodily - eating, sleeping, sex, bodily contact, taking care of appearance, exercise, experiencing pain and bodily comfort - discomfort.

Mental - satisfying cognitive need and curiosity, professional achievement.

Social and communicative - human communication.

Spiritual - worldview and religious experiences, fantasies about the future, supra-personal ("civic") experiences and actions.

In the ideal, harmonious model, 25% of life energy is allocated to each sphere. The real distribution of energy is revealed by an unformalised test; an imbalance is noted when discussing it together and allocating 10 significant events over the last 4 years of life to the 4 spheres of life. An imbalance in the corporal sphere carries the risk of somatic and psychosomatic illness, in the mental sphere aggressive distress reactions and perfectionism, in the communicative sphere loneliness and depression, and in the spiritual sphere anxiety and psychotic disorders. If imbalances (less than 10% or more than 50%) in any sphere are detected, possibilities for harmonisation, redistribution of the other 3 spheres are first considered with the client and only then measures for balancing the most problematic sphere are purposefully discussed, if necessary. This is achieved through direct, concrete, and simple prescriptions for changing the patient's lifestyle and by planning for the future with all 4 areas of life in mind.

At the harmonisation stage, the patient's actual and basal conflicts are identified and worked through. The actual conflict is triggered by external events (e.g. job change, death of loved ones, etc.) and micro-traumas in significant interpersonal relationships with insufficient capacity to overcome these problems. The authors distinguish between primary (love, hope, trust) and secondary abilities (politeness, honesty, obedience, thrift, punctuality, etc.). A typical basal conflict is between "honesty and politeness". Fairness contributes to socially conditioned behaviour, aggression, parasympathicotonia and anxiety; dominant fairness leads to sympathicotonia and aggression. These "triggers" cause functional disturbances and, in the presence of "zones of least resistance", somatic or mental disorders. At the

conceptual level it is about harmonising "right hemispheric" manifestations and objects (love - intuition - body - search for meaning) and "left hemispheric" aspects (knowledge - time - search for meaning).

The religious and attitudinal aspect of psychotherapy plays an essential role. The authors note that in no other field are religion and meaning so clearly displaced as in psychology, medicine, and psychotherapy. Meanwhile, faith, religion and worldview can be considered as a common system of attitudes (basic concept) that shapes attitudes and modes of behaviour. Thus, religious attitudes can serve as basic information about attitudes towards sexuality (sexual prohibitions and norms, customs of sexual behaviour), about upbringing (role of parents, authoritarian upbringing, anti-authoritarian tendencies, son or daughter preference), about profession (restrictions on professional opportunities, motivations underlying professional activity, e.g. service to humanity, striving for self-fulfilment, work as a life goal, work as social commission, work as a burden or avoidance of real tasks), partnership (equality between men and women, a world view of partnership as a means of raising children, as a unit of society, as a union for pleasure, as a joint process), social contact (prescribed social relations, for example between Indian castes or social groupings, strata and classes; religiously prescribed communication situations such as joint prayers, common festivals, choral singing, meditation or work, demands of social asceticism.

The authors do not oppose their psychotherapeutic system to other concepts; they use psychodynamic and behavioural techniques when necessary, emphasising the importance of their own concept in forming a rapport with the patient and the psychotherapeutic goals (balance) available to them. Unlike other positive-oriented contemporary methods, positive psychotherapy according to N. Pezeshkian and X. Pezeshkian does not fixate only on positive aspects, but consistently works through both positive and negative aspects (from positive aspects of the problem to negatively coloured conflicts and then on to realistic working through perspectives).

Cognitive-behavioural psychotherapy is based on the extensive use of techniques to assess inadequate aspects of thinking, perceptions, rules by which the

individual reacts to external events, translating them from external to internal. The main points of cognitive-behavioural psychotherapy are as follows:

1. Many behavioural problems are the result of gaps in training and education.

2 There is a reciprocal relationship between the behaviour and the environment.

3. From the perspective of learning theory, incidental experience leaves a more meaningful mark on the individual than the traditional behaviourist model of stimulus-response.

4. Behaviour modelling is both a learning and a psychotherapeutic process. The cognitive aspect is crucial in the learning process. Disadaptive behaviour can be changed through personal self-learning techniques that activate cognitive structures.

It is thought that behaviour can be changed already by observing it. Each task can be performed by one way of learning or a combination of four: reactive, or classical, operant, observational, and cognitive.

Cognitive learning includes self-monitoring, self-monitoring, contracting, working in a patient rule system. A great deal of attention is paid to learning goals. Until one goal is achieved, one should not move with psychotherapeutic techniques to another. It is important to work only on solutions and commitments which are verbalised through "I want" and not "would like". It is better to define and formulate problems in terms the patient can understand, you can also outline the barrier he/she wants to overcome, e.g: "I want to overcome the fear of talking to strangers".

The most interesting ones can then be chosen together with him or her. Psychotherapeutic contracts are made in the form of a written record of the expected changes on the part of the patient. As far as possible, a discreet and convenient method of recording any changes that occur in the course of psychotherapy is chosen. A great deal of importance is attached to homework: specific exercises from the self-assertion training programme and self-instructions are carried out. Functional behavioural training often does not guarantee that the patient will try to use the newly acquired ways behaviour also in the natural environment. When talking to the child, they should be introduced to the system of rules for problematic behaviour, starting

with a list of them. It is desirable to find out who made the rule and for what purpose (parents are often the source), if there is no conflict between the rules. If the cognitive components of behavior are the subject of psychotherapeutic intervention, then by the end of each session, it is recommended to modify the already made list of rules on the basis of the experience gained during the session. In doing so, obsolete rules can be eliminated. Patients are advised to reread them 2-3 times a day for a certain amount of time, dividing them into acceptable (+) and unacceptable (-). The aim of the exercise is to restructure negative rules into positive ones. Following the principle of retraining, the patient cognitively codes and applies the rules outside the psychotherapeutic session on a daily basis. The implementation of the plans is clearly hindered by fixed rules and a lack of willingness to change, which is essentially a psychological defence. At every psychotherapeutic session, it is necessary to summarise the results and outline further steps. If the problem has been solved, it is necessary to analyse what has contributed to this success in order to consolidate it.

Most authors who use this method recommend the following techniques in the session. Meichenbaum suggests that a patient's inability to cope with stress arises from a lack of specific skills - relaxation, cognitive self-beliefs, and experience with stressful influences. Practically, anxiety can be reduced by teaching the patient to relax and by changing attitudes to anxious thoughts and feelings. The anxiety-provoking situation is reproduced in the safe environment of the psychotherapeutic session, and then transferred to a real stressful environment. Using small doses of stress to develop resilience is similar to inoculating against disease and creating immunity. One of Meichenbaum's methodology is self-instructional training. Here is one of the variations:

1) Preparing to face stress: "I will be able to develop a plan to cope with it";

2) Reacting during stress: "As long as I can stay calm, I am in control of events";

3) Coping with stress: "Agitation prevents me from perceiving the situation";

4) Reflection of experience: "It turned out not to be as scary as I thought it

would be.

Bandura, attaching great importance to observational learning, recommends the following techniques for psychotherapy sessions:

1. Training in alternative self-descriptions of stressful situations. This is done in a state of relaxation, where the patient is asked to describe the stressful situation aloud with their eyes closed. In contrast to the implosion method, self-instruction training or deepening relaxation should not be avoided by increasing the level of anxiety.

2. The therapist prepares an alternative solution to the problems.

3. Sampling of experiences carried out by the patient.

4. Discussing the results achieved and recording them in writing in the patient diary

5. Memorising aloud an alternative dialogue suggested by the therapist.

6. Applying the "stop" technique. The point of this technique is that the therapist says "stop" in a loud voice, presenting a red traffic light when anxiety is heightened. The patient is then asked to recreate a picture that evokes positive emotions. The patient is taught to say the word "stop" subvocally.

Mahoney focuses on drawing up an individual programme of psychotherapeutic training. He sees personal problems as scientific problems. Training in coping with stressful and conflict situations takes place through defining the problem, setting research goals and objectives, collecting data, interpreting them, selecting hypothetical possibilities for problem solving, experimenting, analysing the results, revising or replacing the hypothesis. This method is indicated for patients who have poor problem-solving skills. The essence of the treatment is self-observation, making inferences and acquiring the skill to control the situation.

Ellis, in his rational-emotional psychotherapy, suggested that positive emotions, such as feelings of love or elation, are often linked to or result from an internal belief expressed in the phrase "This is good for me", while negative emotions, such as anger or depression, are linked to a belief expressed in the phrase "This is bad for me". He also confirmed that the emotional response to a situation

reflects the 'label' that is 'attached' to it (such as whether it is dangerous or pleasant), even when the 'label' is not true. To achieve happiness, according to Ellis, it is necessary to rationally formulate goals and choose adequate means. We bring two distinctive types of cognitions to any situation: beliefs and assumptions. Here is a list of the most typical irrational beliefs that a patient needs to overcome:

1) there is a rigid need to be loved or approved by everyone in a meaningful environment;

2) everyone should be competent in all areas of knowledge;

3) most people are mean and corrupt and despicable;

4) disaster will occur if events take a different path from what man has programmed;

5) human misfortunes are caused by external forces and people have little ability to control them;

6) if there is a danger, it should not be overcome;

7) it is easier to avoid certain difficulties in life than to face them and be responsible for them;

8) in this world, the weak depend on the strong;

9) a person's past history should influence their immediate behaviour "now";

10) you should not worry about other people's problems;

11) it is necessary to solve all problems correctly, clearly and perfectly, and if this is not done, disaster will occur;

12) if someone is not in control of their emotions, they cannot be helped.

Cognitive-behavioural psychotherapy, including its short-term version, is proposed to be carried out in the following sequence: antecedents - belief - consequence - discussion - effect. Discussion involves 3 levels: cognitive, emotional, and behavioural.

In any form of cognitive-behavioural psychotherapy, the task of the psychotherapist is diagnostic-learning, involving the patient as much as possible in all stages of analysis, planning and decision-making. The patient needs to understand what is going on in the psychotherapeutic training. Only in this way can they

participate optimally in the search for goals and make the right decisions about the stages of change.

Tasks and methods of psychological (psychotherapeutic) interaction in the situation of the need to change negative elements of the world picture and activate coping behaviour of the cancer patient:

In the cognitive component, the tasks are aimed at:

- getting rid of the fear of illness;
- the expansion of the boundaries of the idea of normality to include more than just health;
- a positive attitude, triggering internal resources.

In the emotional component, the following stands out:

- being aware of your emotions, responding to them;
- the aim is to reduce and prevent negative emotional feelings and their manifestations;
- harmonisation of emotional state as a potential for overcoming destructive personal change and personal growth;

Behaviourally:

- the development of new behavioural patterns;
- developing skills to cope with stress;
- an orientation to finding a way out of critical situations or to changing attitudes to them.

The result of our experimental-corrective work related to changes in attitudes to illness as part of the picture of the world and to oneself as the subject of these changes was a dynamic change in a number of characteristics that were the focus of this study, in particular the level and specificity of manifestation of anxiety, experience of loneliness, manifestation of existential defences and their quality, specificity and substantive characteristics of coping strategies.

An integrated system of psychological and psychotherapeutic support

As the basis (trigger) for the changes that occurred in the structure of defence mechanisms and attitudes towards illness in the previously mentioned groups of

patients was the system of a comparative analysis of the methods of the pilot study should be preceded by a substantive presentation of it.

Before presenting the psychological work carried out with oncourological patients, it should be noted that we fully share the ideas formed and tested by a number of domestic researchers and, in particular, by representatives of the St. Petersburg school of medical psychologists working in the field of support for patients with cancer suffering. First of all, we are talking about the fact that experiencing situations related to cancer, regardless of nosology, is a systemic phenomenon that affects and changes the way of life and, as a consequence, the emotional and semantic space of not only the person affected, but, to some extent, also his or her social surroundings. In this connection, the system of providing psychological help and support can be considered only and exclusively as a system of complex psychological and psychotherapeutic support, which includes as its component parts three interconnected blocks: 1) communication and interaction directly with the patient, 2) communication and interaction with the immediate social surrounding and the circle of people whom the patient defines as a reference group, 3) communication and interaction with the medical staff.

In connection to the goals of this study, the system of psychological and psychotherapeutic work that we implemented was based on methods and techniques related to self-image (image of self - past - present - future, image of one's world, possibilities of changing it in the context of subjective efforts); work with feelings - nature, spectrum, depth of experience; related work with experience and expression of feelings - guilt and shame; work with unlived and unreacted emotions in particular, the work with anxiety and aggression (social aggression, auto-aggression); work with existential states - loneliness, fears, alienation.

Taking into account that, from our point of view (based on theoretical research by foreign and domestic authors), coping with illness is directly connected with the characteristics of a person's meaning formations, an important component of the therapy sessions is directed meaning-forming therapy (research and restoration of the integral system of personal meanings, acting as the basic components of a person's

world picture). The stage of work with the formation of psychological pillars of positive defences included elements of visualisation in relation to the stressful situation itself, an investigation of resource formations and the possibility of manifesting strong personality traits, the separation of the subconscious, observation of oneself from the height of past experience at the moment of maximum functioning of strong personality traits; controlling the image of the stressful situation (reducing and increasing its volume, changing brightness, etc.).

The tasks of shaping the support system included, inter alia:

1) reduced levels of depressive symptoms, frequent anxiety and high levels of neuroticism;

2) reducing mental burnout and emotional distress;

3) promoting the activation of personal resource states, in particular

4) training in self-regulation skills and techniques

5) forming an attitude to preserve and strengthen the existing psychophysical and psycho-emotional resource, searching for new resource formations.

In presenting the system of psychological sessions, two important points need to be made. Firstly, the development of reflection and reflexivity, even seen not as a reference personality characteristic of the patient, but as part of a mechanism for psycho-emotional acceptance of the situation and the self, is not always appropriate and correct; in the context of the situation, this characteristic can be a factor in the neuroticisation and negativisation of experiences.

Secondly, we noted that a significant psychological obstacle to psychotherapeutic work is mental rigidity, but presented not as a system-wide personality trait, but as an artificial, formed defensive strategy in the context of psychological (psycho-emotional) encapsulation, closing the personality within its own boundaries. In this connection, at the first stage of organizing the interaction with a cancer patient it is necessary to develop special strategies for overcoming this reaction, but without excessively shifting the spectrum of reactions towards flexibilism, because in this case there is an obvious problem with the patient's psychological independence, the formation of responsible and internally emotional-

mature, "mature", behavior.

It is important to emphasise that the overall background and super-task of the entire system of psychological and psychotherapeutic support is to reduce the level of subjective feelings of loneliness, alienation and isolation in connection with the illness, as well as reducing the level of manifestation of subjective fears and the transformation of fearful content into resource categories.

2.4. Results and interpretation of the follow-up (post-correction) study

2.4.1 Description of the results obtained in the secondary interviewing procedure

Conducting a secondary interview with a single guide was dictated by the task of studying the dynamics of the patients' subjective perceptions of themselves as a person, their illness, their general picture of the world and their place in it, which were within the scope of the psychotherapy unit's interests. Of course, the in-depth interview method is not designed to quantify this kind of dynamic processes, since it is descriptive and interpretative in nature. However, the researcher is able to identify the directions of such changes in the course of interviews with patients already at this stage of the search activity.

Dynamic changes were recorded in several thematic sections of the secondary interview: assessment of health status, perceptions of self and emotional state, perceptions of family relationships, attitudes towards medical staff and the institution, and attitudes towards the disease.

First of all, we were interested in the dynamic changes in measures of subjective assessments of health.

Table 25 – Subjective feelings of health status after psychotherapeutic work, %

Name of state	Group 1	Group 2	Group 3	Overall result
The state of health can be described as excellent	0	0	0	0
Good state of health	8	7	8	8
The state of health is difficult to assess	15	14	13	14
The health status is rather poor	46	46	38	43
Poor health status	31	32	41	35
Overall result	100	100	100	100

Comparison of the data in Table 5 (p. 64) and Table 25 shows that while the predominance of the position indicating an unsatisfactory and poor state of health recorded during the primary interview remains, after psychotherapeutic work in Group 1 and Group 2 patients there is an increase in the share of responses "I find it difficult to assess my state" and a decrease in the share of responses assessing my state of health as definitely "poor". An increase in the proportion of responses was observed in the position "unsatisfactory state of health".

It should be noted that changes between the proportions of responses in assessing one's health status are not observed in the control group at repeated interviews, but remain virtually unchanged in proportion to the primary interviews.

The distribution of these positions, based on the results of the secondary interview, is shown in the following figure.

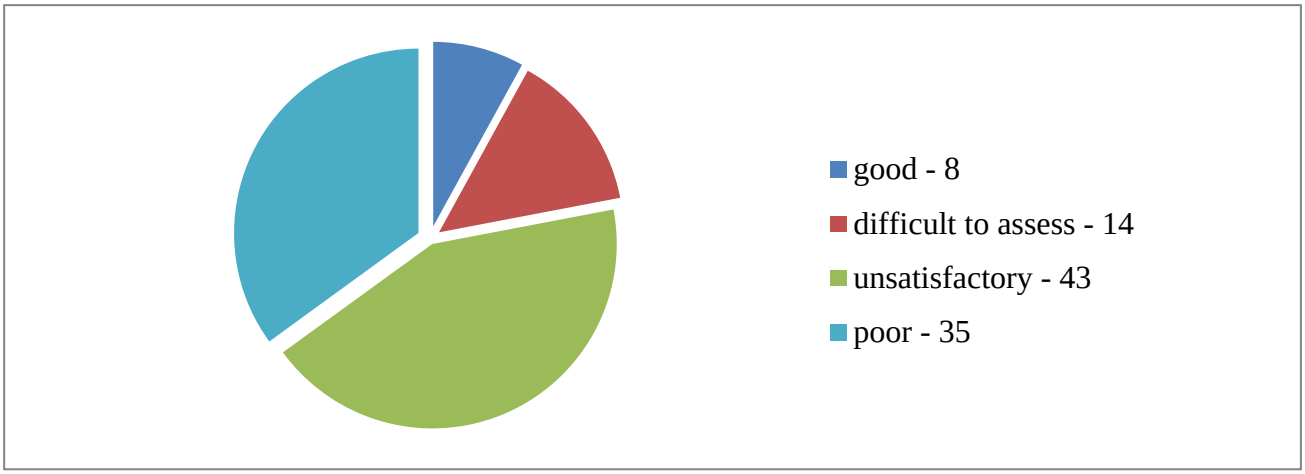

Figure 19: Assessment of health status after psychotherapeutic work (cumulative results for the three groups), %

Table 26 - Assessment of family relationships, %

Evaluation	Group 1	Group 2	Group 3	The overall result
Close and warm relationships prevail in the family	37	41	40	39
An even, respectful but neutral relationship prevails in the family	47	38	38	41
Family members are autonomous, each living their own lives	15	21	22	20
The overall result	100	100	100	100

A comparison of the interview results in Table 9 (p. 67) and Table 26 shows a slight trend in the direction of increasing the proportion of those who chose the 'close and warm family relationship' model with a simultaneous decrease in the proportion of those who chose the autonomous family relationship model. Moreover, we observe similar trends only in the first two groups, which suggests a positive impact of the psychotherapeutic support factor organised with them in the course of the research project. The results of the control group survey remained unchanged.

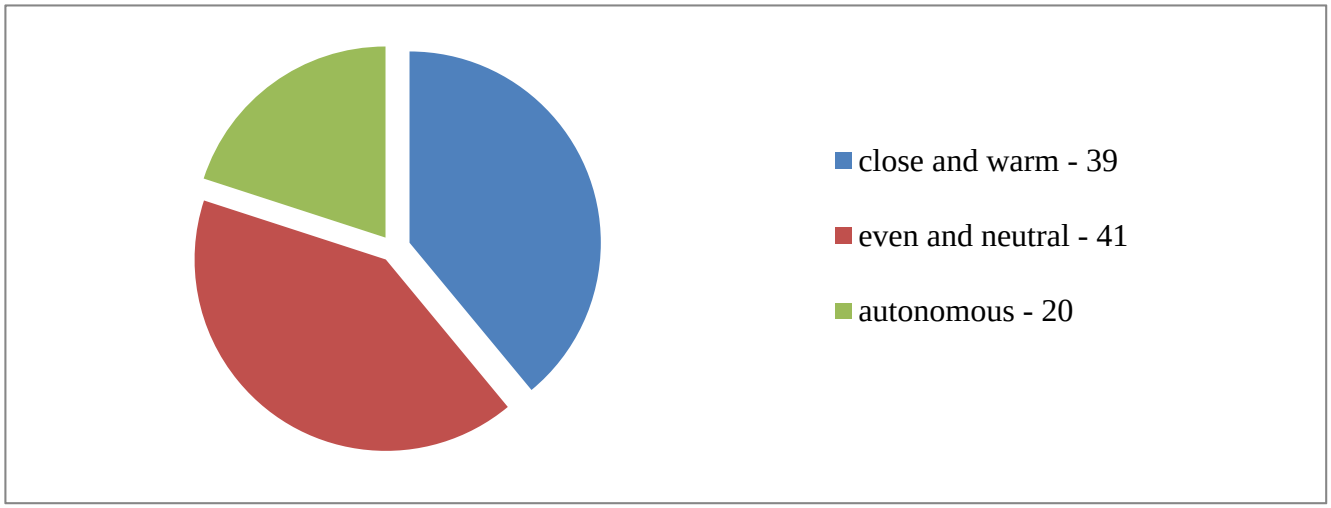

Figure 20: Perceptions of predominant characteristics of family relationships after repeated interviews (summary characteristics of three groups), %

Indeed, family remains for them the environment in which the most precious people live, according to our patients' reassessments. It can become a resource of vitality and optimism, hope and help.

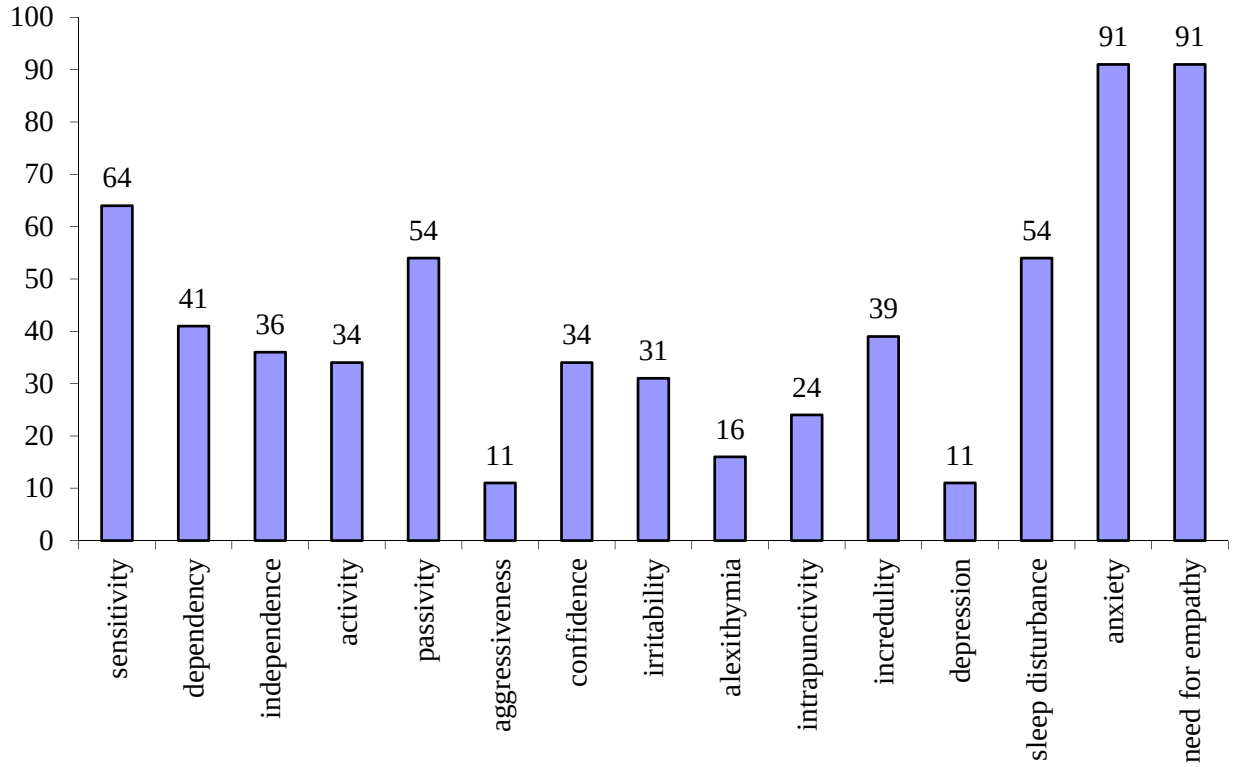

Figure 21: Subjective perception of their emotional state after participation in psychotherapy (summary of Group 1 and Group 2 interviews, %)

In describing the results of the initial interview, we concluded that the

informants had a decreased mood background, low energy and mood, high anxiety and serious fears about future prospects. A follow-up interview confirmed these trends.

However, a comparison of the indicators that we were able to present in the form of scales (from sensitivity to need for empathy) during the two interview series shows a slight change in the responses of our informants towards a decrease in the intensity of their statements on criteria such as sensitivity, dependence, aggressiveness, irritability, anxiety and need for empathy. These changes are small in quantitative terms (calculations can only be made on the basis of the percentages of responses), but they were recorded in the interview. They said that they "worry less for no reason", "I don't lose my temper over nothing", "I want to get stronger", etc.

Let us turn to the specifics of the perception of their illness, which also showed a number of dynamic changes in the perceptions of our informants after participation in psychocorrectional work.

Table 27 - Attitudes towards the disease, %

Thesis	**Group 1**	**Group 2**	**Group 3**	**The overall result**
Sickness as a test	41	35	30	35
Sickness is like 'God's punishment'	7	7	10	8
Illness is a close call	10	9	18	12
Sickness - "I don't understand - why?"	17	14	16	16
Illness is a chance to get better	10	8	10	9
Sickness as an inevitability	3	4	5	4
Other	12	23	11	15
The overall result	100	100	100	100

It should be emphasised that attitudes towards illness remain the most painful topic in the interview process. It is dynamic. Patients find it difficult to formulate their ideas on the subject and find it difficult to articulate them. Fatalistic and pessimistic attitudes continue to prevail.

However, we were able to register a slight trend in Group 1, Group 2 and Group 3. Thus, the shares of those who saw their illness as a test increased in Group 1 and Group 2, while the shares of those who saw the illness as a punishment and a sign of an imminent end decreased slightly, as the comparison of the results of Table 12 (p. 70) and Table 27 shows.

These changes are seen only in those groups with whom the medical psychologist's psychotherapeutic work has been carried out, which allows to suggest that the latter has a positive impact on the process of accepting one's situation as a cancer patient.

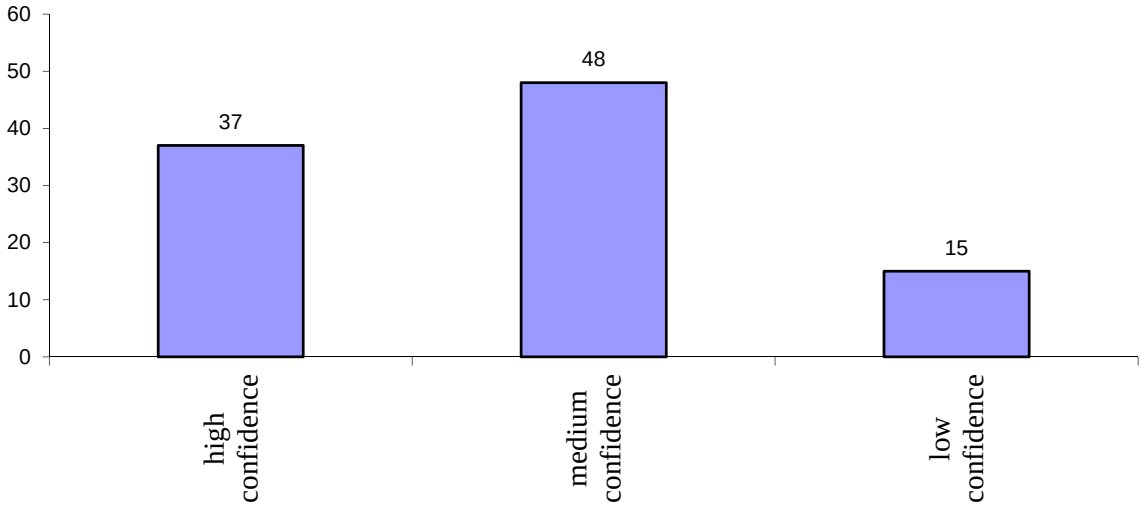

Figure 22. Level of trust in the health care facility and health care staff after psychotherapeutic work (Group 1 and Group 2 combined), %

As we have shown above, when speaking about the medical institution and the medical staff with whom our informants interact, in the first interview they emphasised an average degree of trust in them. This prevailed across the three groups of interviewees. This trend continued after processing the results of the second

interview. What draws attention, however, is the fact that after the psychotherapeutic work conducted in Group 1 and Group 2, the level of high trust increased at the expense of the proportion of medium trust, while the proportion of those who identified "low trust" as the most appropriate to describe their attitude remained the same. In the control group, the proportion of trust in the healthcare institution remained unchanged at the second interview.

The next block of the follow-up interview, in which we tried to explore whether there was a dynamic in our informants' perceptions after psychotherapy, concerned treatment perspectives and future life plans. During the analysis of this block, the predominance of pessimistic attitudes in all three groups of respondents. However, in Group 1 and Group 2 there was a clear decrease in the proportion of those who chose pessimistic definitions in their vision of life prospects. A slight increase in the proportion of optimists among these same respondents should also be noted, as well as an increase in the proportion who are currently undecided about their life position designation.

The proportions between these positions in the control group remained unchanged (compare Table 13, p. 72, and Table 28).

Table 28 - Vision of life prospects, %

The vision of life perspectives	Group 1	Group 2	Group 3	The overall result
Positive attitude	7	7	5	6
Pessimistic stance	59	57	60	59
Undecided position	34	36	35	35
The overall result	100	100	100	100

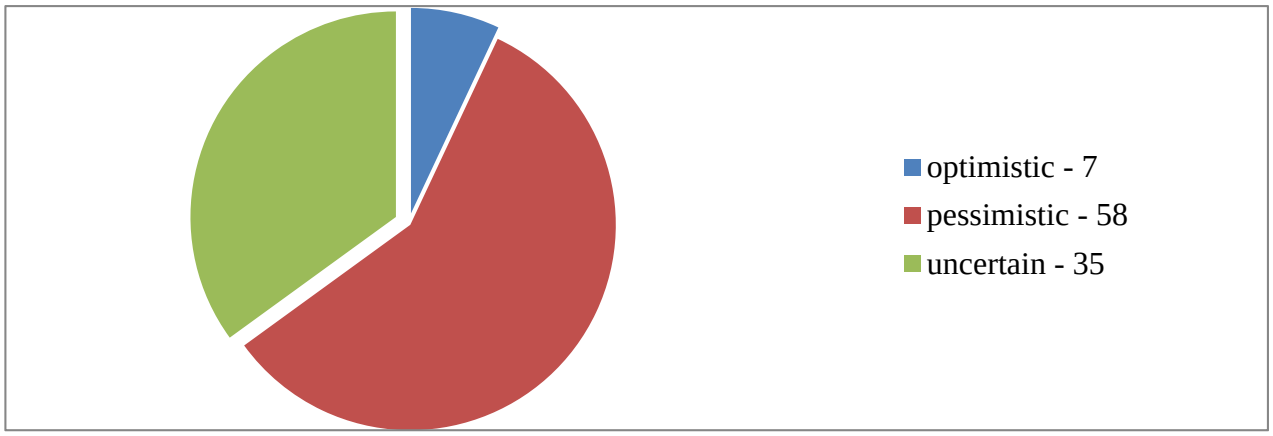

Figure 23. Perceptions of life prospects (composite characteristics of Group 1 and Group 2), %

Key findings from the secondary interview in the final research phase

Based on the analysis of the results of the initial clinical interview at the start of treatment in the oncology dispensary, we can conclude that the cancer patients had a dominant low mood background and increased anxiety. Patients wanted their understood and sympathised. In the general background of low mood, passivity, irritability, sleep disturbances, insecurity and disbelief in a better outcome of the disease developed. We did not find significant differences in these reactions between the sample groups in terms of gender, age and type of illness, as we have already mentioned.

It should be noted that the main dynamic changes that occurred in the perceptions of the patients who participated in the follow-up clinical interview, we were able to record in several thematic sections: these are the assessment of health status, perceptions of self and their emotional state, perceptions of family relationships, attitudes towards health personnel and the institution, and attitudes towards the disease:

1) There has been an increase in the proportion of responses "I find it difficult to assess my condition" and a decrease in the proportion of responses assessing my health condition as clearly "poor";

2) There was a slight trend towards an increase in the share of those who chose the "close and warm family relationship" model, with a simultaneous decrease in the share of those who chose the autonomous family relationship model;

3) There were slight changes in the responses of our informants in the direction of a decrease in the intensity of their statements on criteria such as sensitivity, dependence, aggressiveness, irritability, anxiety and need for empathy.

4) Found that the proportion of those who saw their illness as a test increased in Group 1 and Group 2, while the proportion of those who saw the illness as a punishment and an indication of an imminent end decreased slightly;

5) After the psychotherapeutic work, Group 1 and Group 2 have increased the level of high trust at the expense of a proportion of medium trust while maintaining the proportion of those who identified "low trust" as the most appropriate to describe their attitude;

6) In Groups 1 and 2, there was a clear decrease in the proportion who chose pessimistic definitions of life prospects; there was a slight increase in the proportion of optimists among these same respondents, as well as an increase in the proportion who are currently undecided about their life position, indicating that patients continue to work internally in this direction.

2.4.2 Description of the results obtained in repeated empirical procedures related to the study of defence mechanisms and types of attitudes towards illness in cancer patients with different nosologies

Integral Anxiety Test (ITT)

Table 29 – Second slice, %

	ST-C			ST-L		
	faintly pronounced	expressed by	very pronounced	rarely	often	most of the time
Group 1	20	41	39	22	42	36
Group 2	23	41	36	25	52	23
Group 3	13	43	43	17	43	40

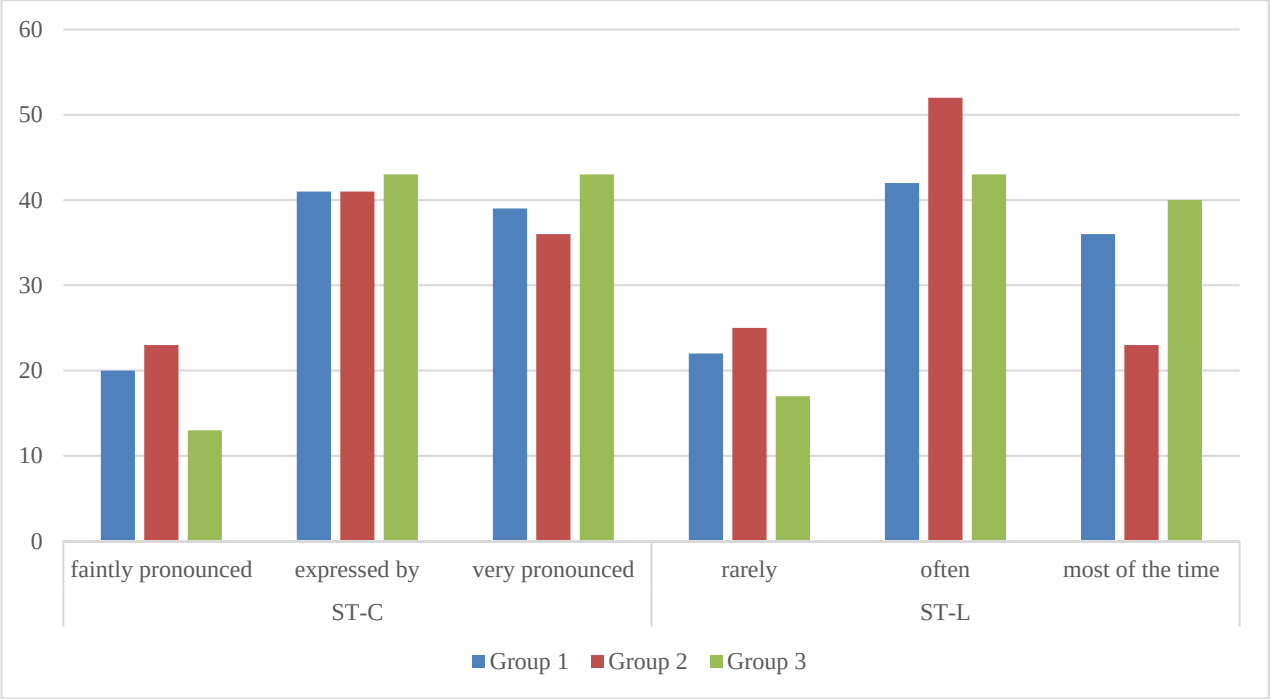

Figure 24. Distribution of anxiety intensity by group

Table 30 – Second slice,%

	ED			AST			FOB			OP			NW		
	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails	not expressed or little expressed	does not exceed the normal level	prevails
Group 1	3	63	34	68	32	0	5	54	41	5	53	43	17	63	20
Group 2	5	63	32	75	25	0	2	59	39	4	46	50	21	54	25
Group 3	3	42	55	73	27	0	3	47	50	3	42	55	50	47	3

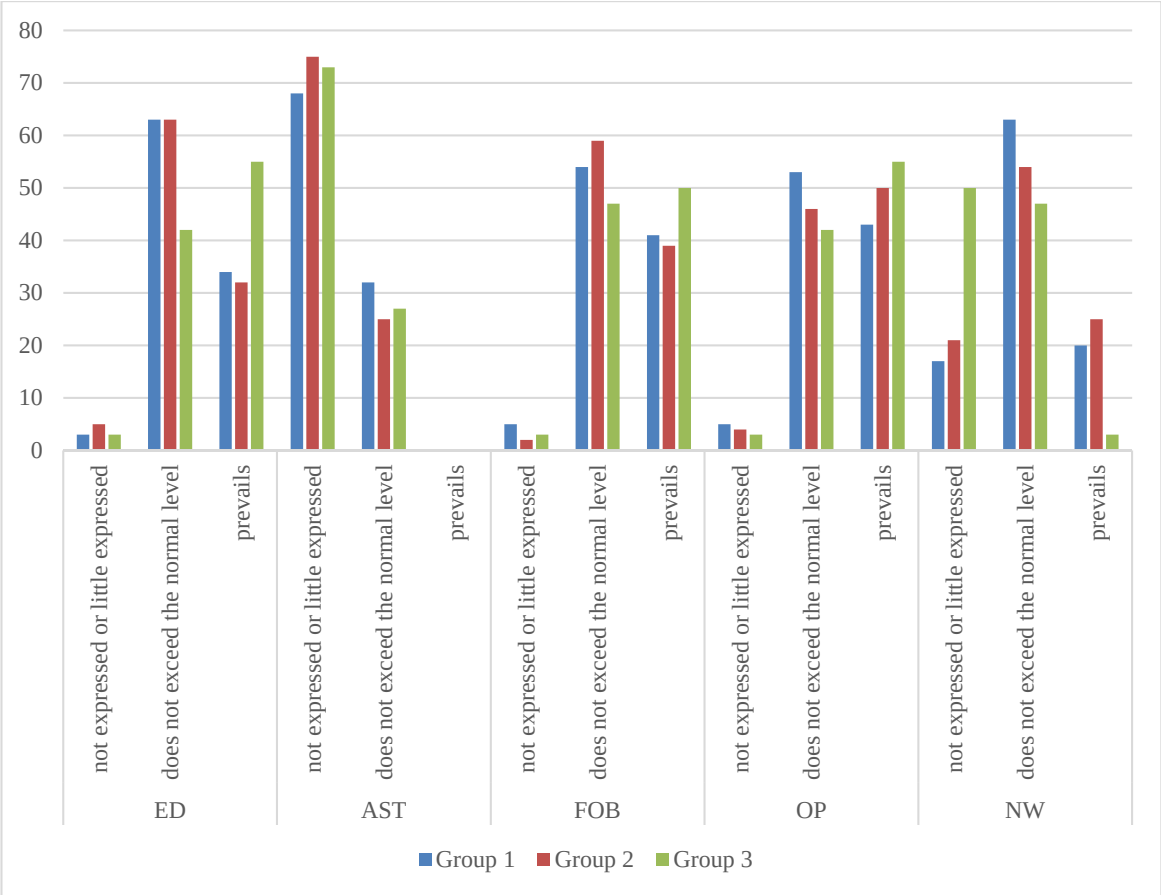

Figure 25. Distribution of anxiety severity by group in relation to defensive reactions

Table 31 – First cut - Second cut comparison, %

	ST			LT		
	faintly pronounced	expressed by	very pronounced	rarely	often	most of the time
Group 1, 1st slice	16	27	57	19	37	44
Group 1, 2nd slice	20	41	39	22	42	36
Group 2, 1st slice	15	37	48	22	42	37
Group 2, 2nd slice	23	41	36	25	52	23
Group 3, 1st slice	20	29	51	15	42	43
Group 3, 2nd slice	13	43	43	17	43	40

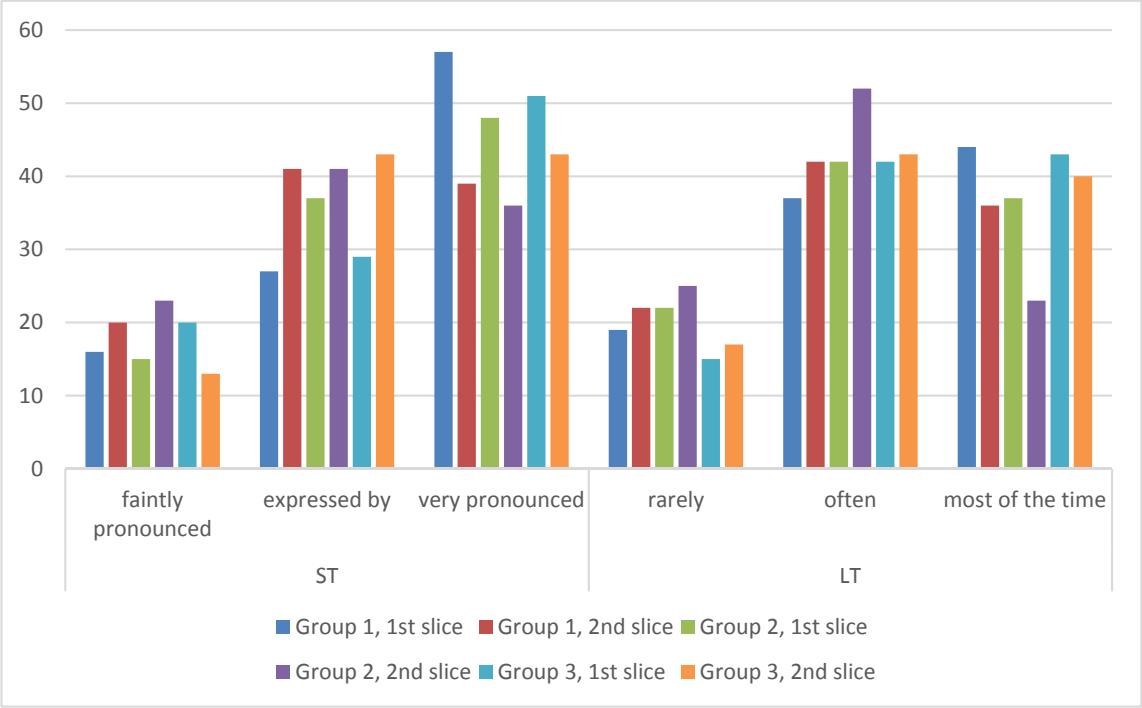

Figure 26: Summary of Comparative Anxiety Severity Characteristics by Group

The distribution of levels of expression on the Irritation scale has changed, with only 1 respondent still showing a very high level, but 3 people have improved scores and now show an average level that was not previously diagnosed in any subjects on

this scale. All participants showed a significant improvement on the Verbal Aggression scale compared to the initial diagnosis. Now 4 had an average level of expression on the scale and 2 had an elevated level. The biggest improvement here was on the guilt scale. Previously, expression levels up to high were diagnosed, while after the correction, all subjects were diagnosed with a low level of expression. Respondents have an average level on the Aggressiveness and Hostility scales.

The majority of respondents had no fundamental change in terms of personality anxiety, as it is a constitutional trait that accounts for the tendency to perceive threat in a wide range of situations. This requires longer and deeper therapy. The improvement of the situational anxiety scores was in line with our goals and here we were able to achieve visible goals. Only 1 respondent continues to exhibit a high level of anxiety, while the rest either maintained this (optimal) level or improved from high to moderate. This can be explained both by natural adaptation to hospital conditions in some respondents and by the fact that they have undergone a programme to develop an effective self-regulation system.

The subjective feeling of loneliness method (MSLP)

Table 32 - Second slice, %

	High levels of loneliness	**Average level of loneliness**	**Low levels of loneliness**
Group 1	32	52	16
Group 2	34	48	18
Group 3	53	38	8

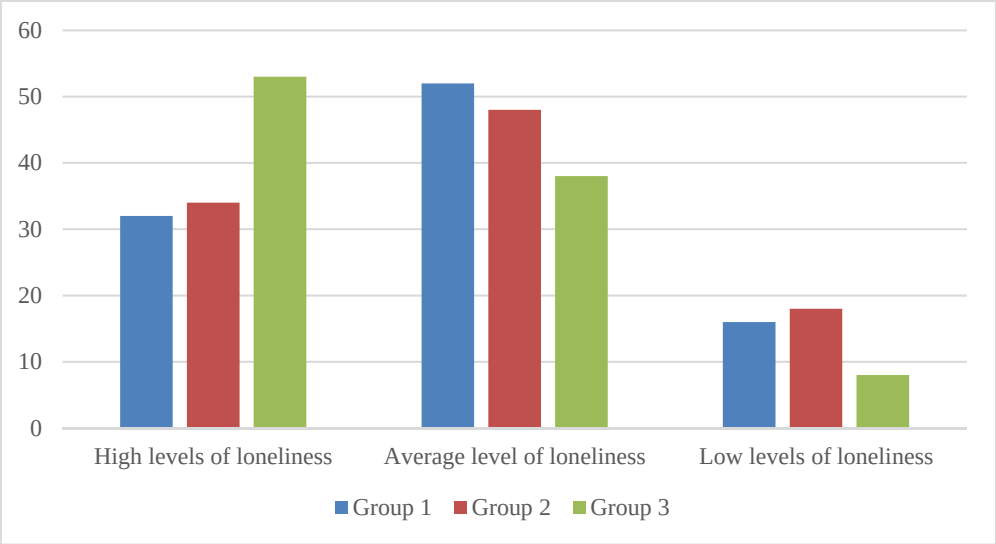

Figure 27: Distribution of intensities of the experience of loneliness

Table 33 – First cut - Second cut comparison, %

	High levels of loneliness	Average level of loneliness	Low levels of loneliness
Group 1, 1st slice	52	39	9
Group 1, 2nd slice	32	52	16
Group 2, 1st slice	52	37	12
Group 2, 2nd slice	34	48	18
Group 3, 1st slice	55	37	8
Group 3, 2nd slice	53	38	8

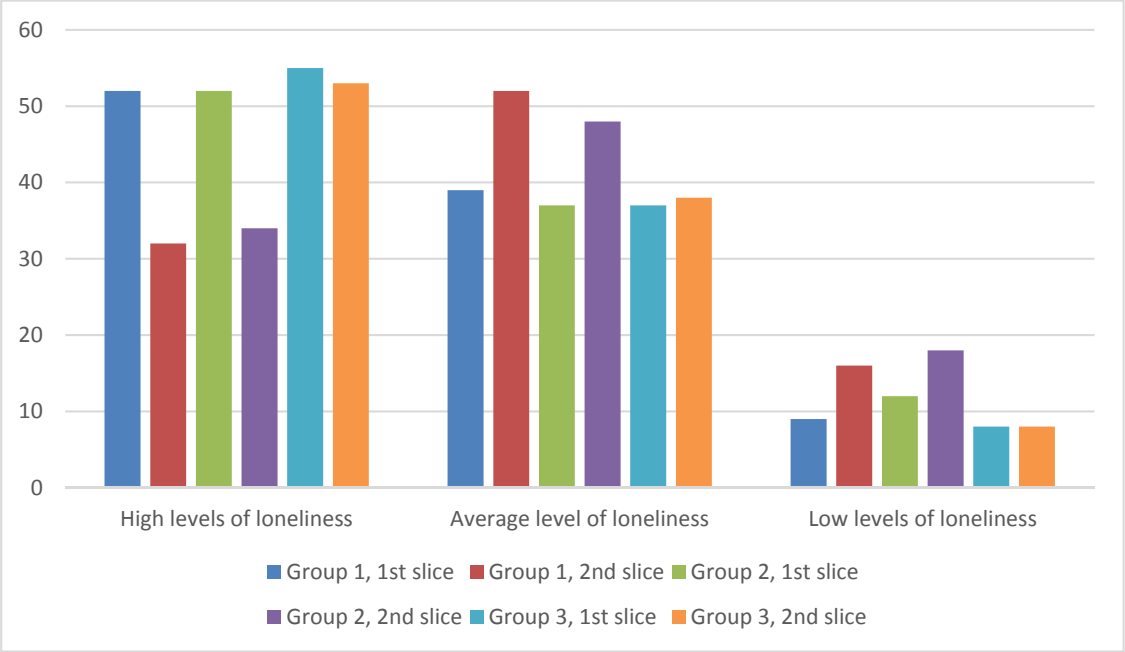

Figure 28. Summary comparative presentation of the experience of loneliness by group.

In the context of considering loneliness experience of cancer patients we can speak about our own dynamics of loneliness experience in cancer patients (the following is confirmed by the content of interviews with cancer patients, the results of clinical interview analysis): the first stage - recognition of the diagnosis and until the period of awareness and acceptance of the diagnosis - loneliness experience has the character of acute state in the form of alienation, instant isolation from social community ("leper syndrome"), then - as the awareness and acceptance of the situation, in the course of the period of the diagnosis, the loneliness experience takes on the character of unconditional background process. Loneliness becomes an unconditional background process, on the plane or, more precisely, in the space of which a number of existential variables related to the activation or passivisation of coping strategies and defence mechanisms will be formed.

In relation to the situation in question, another crucial feature needs to be highlighted: the experience of loneliness itself, as one of the most global existential experiences in the context of the "split" of the world, generates a special experience as the initial confusion is overcome and fear and anxiety are brought under control,

which in the context of trying to overcome the conflict consisting of the awareness of the incurability of illness on one hand, the need (but not always the desire) to live in a situation of severe chronic illness, accepting the reality of the situation as an element of present existence, a certain fait accompli, and, on the other hand, the acute lack of acceptance, the lack of acceptance, the protest against the "injustice of fate" and the hope for a "miracle" activate a special state of existential nature, which we have called "traumatic freedom". This is a particular manifestation of a phenomenon which is in principle coupled with a crisis situation of an irresistible nature. A detailed study of this phenomenon is neither possible nor necessary within the scope of the present study, but at the same time, this line of research can and should be seen as promising, in the context of understanding the underlying psychological mechanisms of activating resistance to the destructive process, "primal chaos", which is the inevitable primary outcome of any critical situation.

Hospital Anxiety and Depression Scale

Table 34 – Second slice, %

	Anxiety			Depression		
	as normal	above normal	high	as normal	above normal	high
Group 1	61	17	22	58	20	22
Group 2	64	18	18	57	23	20
Group 3	42	30	28	57	17	27

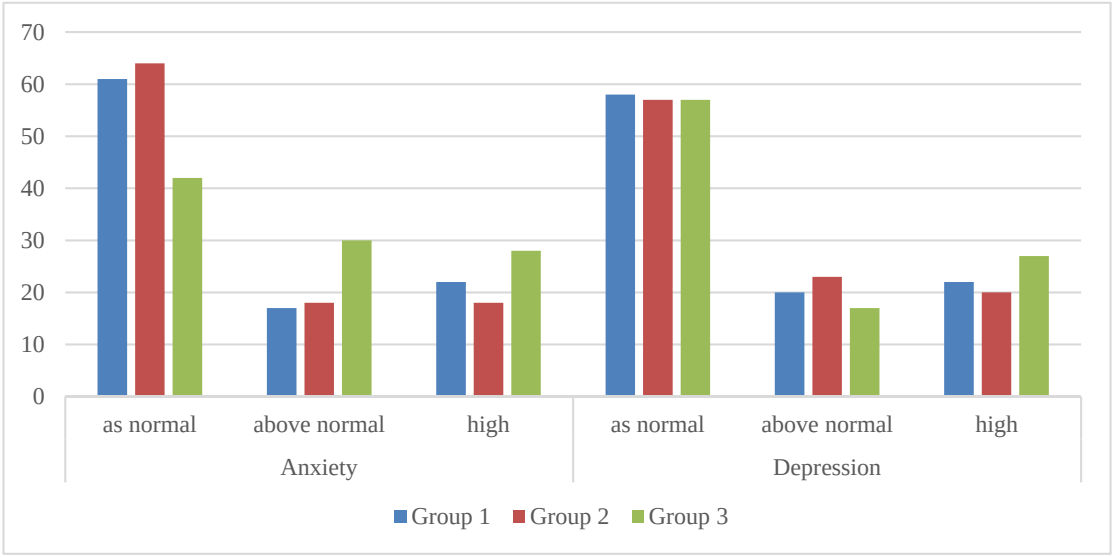

Figure 29. Representation of anxiety and depression experiences by group

Table 35 – First cut - Second cut comparison, %

	Anxiety			Depression		
	as normal	above normal	high	as normal	above normal	high
Group 1, 1st slice	36	27	37	32	34	34
Group 1, 2nd slice	61	17	22	58	20	22
Group 2, 1st slice	42	25	33	37	30	33
Group 2, 2nd slice	64	18	18	57	23	20
Group 3, 1st slice	45	28	28	46	23	31
Group 3, 2nd slice	42	30	28	57	17	27

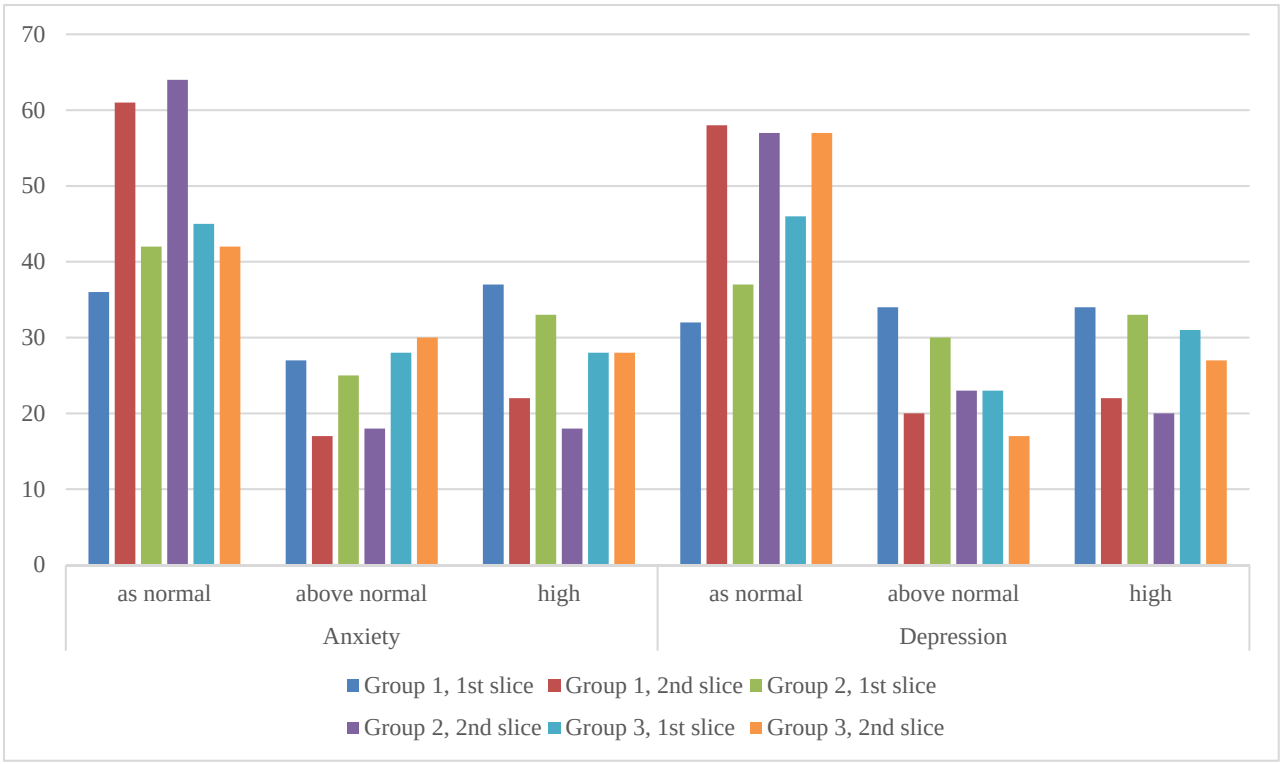

Figure 30. Summary comparative representation of anxiety and depression experiences by group

Fear of Disease Progression Questionnaire (FPSQ)

Table 36 – Second slice, %

	General level of fear of disease progression			Emotional responses			Family fears			Fear of loss of autonomy		
	high	Medium	low	High	Medium	Low	high	Medium	low	high	Medium	low
Group 1	44	39	17	34	46	20	31	53	17	15	85	0
Group 2	45	36	20	39	45	16	30	55	14	13	88	0
Group 3	58	42	0	55	43	2	50	47	3	20	80	0

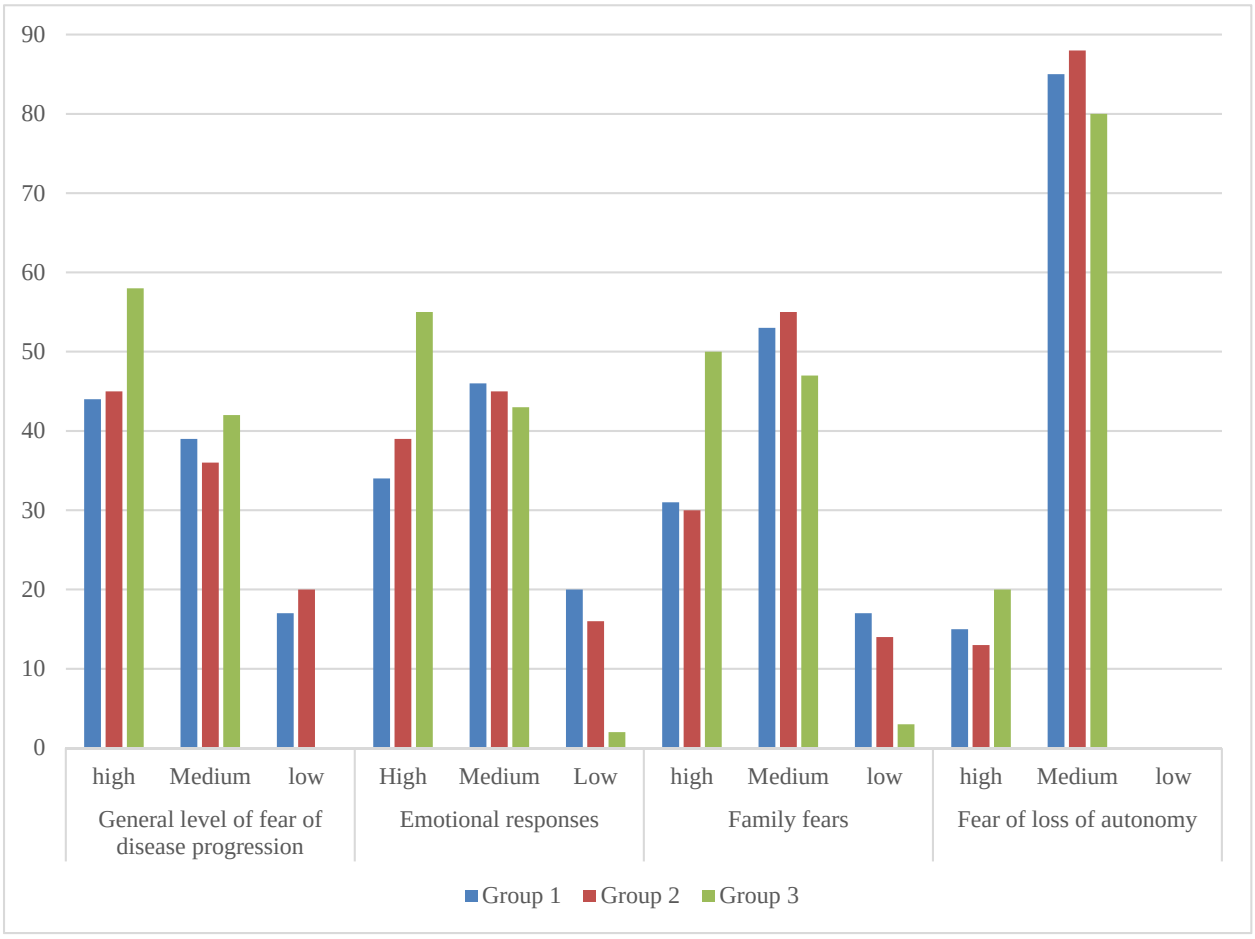

Figure 31. Representation of fears by group

Table 37 – First cut - Second cut comparison, %

	General level of fear of disease progression			Emotional responses			Family fears			Fear of loss of autonomy		
	high	Medium	low	High	Medium	Low	high	Medium	low	high	Medium	low
Group 1, 1st slice	53	44	3	52	45	3	45	55	0	27	73	0
Group 1, 2nd slice	44	39	17	34	46	20	31	53	17	15	85	0
Group 2, 1st slice	58	40	2	55	43	2	48	48	3	20	80	0
Group 2, 2nd slice	45	36	20	39	45	16	30	55	14	13	88	0
Group 3, 1st slice	58	40	2	54	45	2	51	49	0	22	79	0
Group 3, 2nd slice	58	42	0	55	43	2	50	47	3	20	80	0

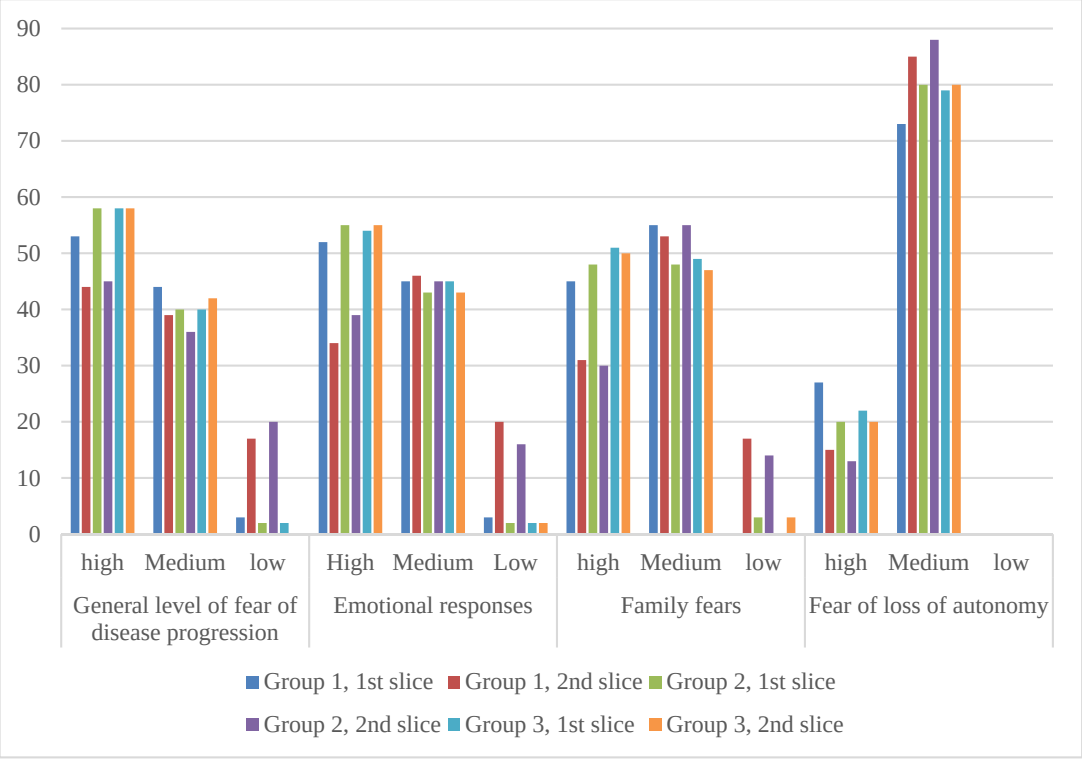

Figure 32. Consolidated comparative representation of fears by group

A.Langle - K. Orgler existential scale (Langle Existence Scale)

Table 38 – Second slice, %

	Self-steering (SD)			Self-transcendence (ST)			Freedom (F)			Responsibility (V)		
	high	Medium	low	High	Medium	Low	high	Medium	low	high	Medium	low
Group 1	10	46	44	14	58	29	0	53	48	10	51	39
Group 2	13	48	39	14	57	29	0	54	46	14	43	43
Group 3	3	42	55	2	45	53	0	45	55	3	35	62

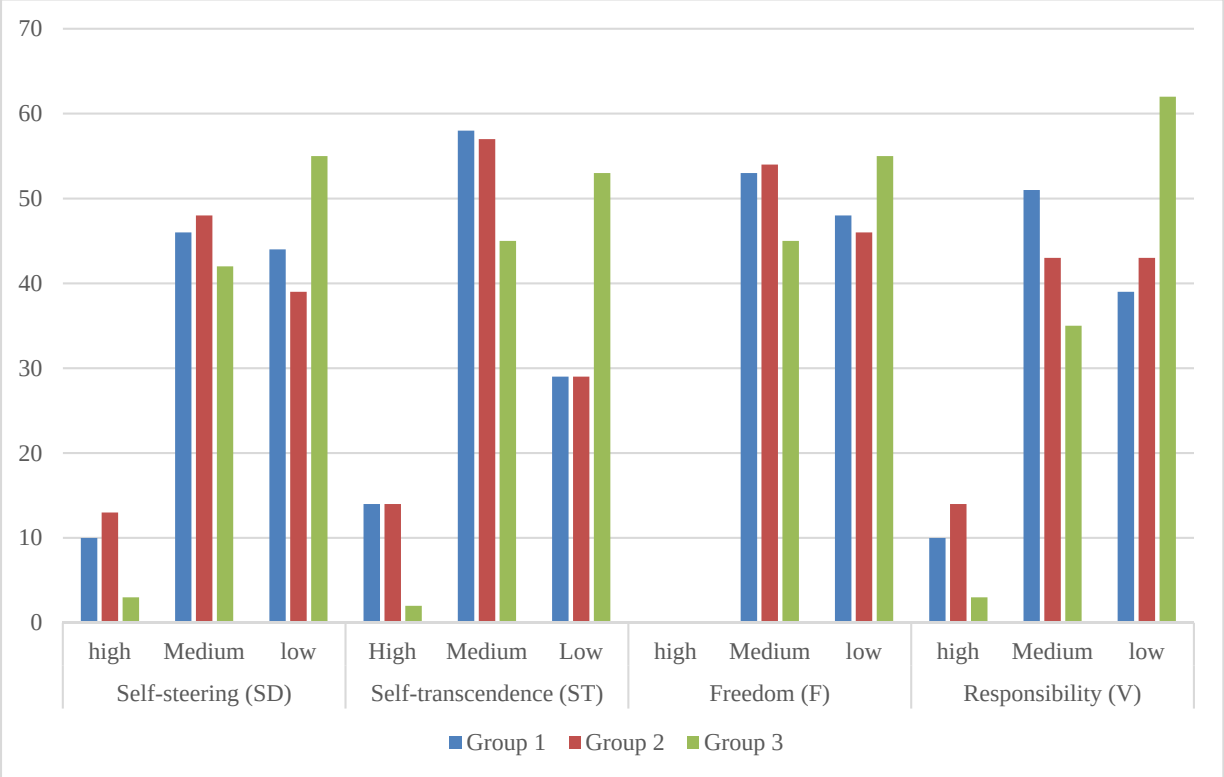

Figure 33. Representation of expression of existential types by group

Table 39 – First cut - Second cut comparison, %

	Self-steering (SD)			**Self-transcendence (ST)**			**Freedom (F)**			**Responsibility (V)**		
	high	Medium	low	High	Medium	Low	high	Medium	low	high	Medium	low
Group 1, 1st cut	0	29	71	3	42	55	0	31	69	0	27	73
Group 1, 2nd slice	10	46	44	14	58	29	0	53	48	10	51	39
Group 2, 1st slice	0	32	68	2	47	52	0	35	65	2	32	67
Group 2, 2nd slice	13	48	39	14	57	29	0	54	46	14	43	43
Group 3, 1st slice	0	35	65	2	42	57	0	42	59	0	35	65
Group 3, 2nd slice	3	42	55	2	45	53	0	45	55	3	35	62

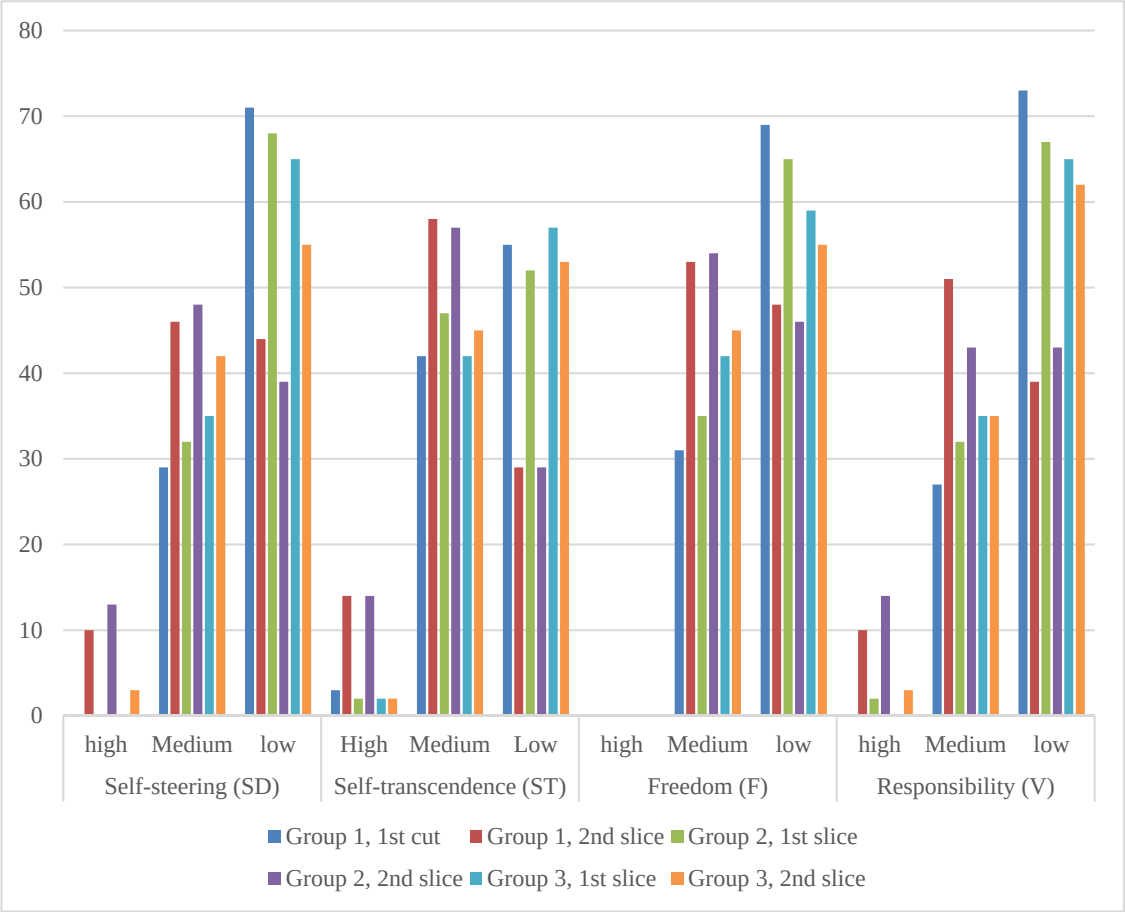

Figure 34. Summary comparative representation of the expression of existential types by group

Life Style Index (LSI) methodology

Table 40 – Second slice, %

	Denial	Displacement	Regression	Compensation	Projection	Substitution	Intellectualisation	Reactive formations
Group 1	7	15	9	14	14	12	15	15
Group 2	9	9	2	25	30	2	18	5
Group 3	18	22	8	10	7	5	5	25

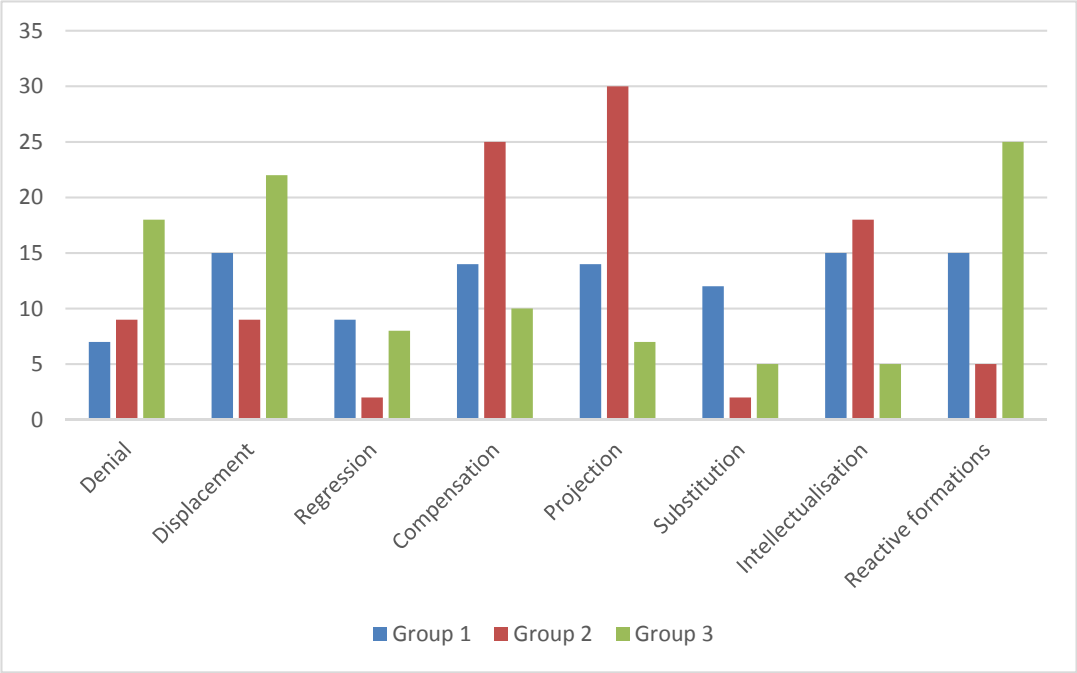

Figure 35. Representation of intensity of life style types by group

The results of the LSI methodology suggest that, overall, there was a decrease in the intensity of defence mechanisms for both groups (22-45%), while the level of defensive projections increased (17-59%).

An analysis of the dominant types of psychological defence showed that, for Group 2 respondents, the main defences were "reactive formation", "denial" and "projection", while "intellectualisation" and "displacement" were less common.

This analysis showed no significant differences in the use of psychological defences between the groups of patients diagnosed with renal cell cancer and those diagnosed with bladder cancer.

The analysis of the results showed that respondents expressing a high degree of anxiety about their illness were characterised by the greatest number of psychological defences.

For example, the more pronounced the "compensation" defence mechanism, the more anxious and melancholic the attitude towards illness and the less paranoid the attitude towards illness.

The protective mechanism "regression" is related to melancholic, sensitivist and anxious attitudes towards illness, and the protective mechanism "reactive formations" is related to anxious attitudes towards illness and thus to the disposition of mania.

An analysis of the results showed the greatest number of statistically significant relationships for the paranoia type of attitude toward illness. The higher the score on this scale, the weaker the EHMs such as defences against loneliness, avoidance of manifestations of will, and belief in an ultimate saviour.

Respondents with a harmonious attitude towards illness are not characterised by responsibility avoidance. The scores on these scales have a negative statistically significant relationship.

However, respondents characterised by responsibility avoidance tend to have an apathetic attitude towards illness.

The egocentric type of attitude towards illness was also found to be highly correlated with pathological defences against meaninglessness.

Table 41 – First cut - Second cut comparison, %

	Denial	**Displacement**	**Regression**	**Compensation**	**Projection**	**Substitution**	**Intellectualisation**	**Reactive formations**
Group 1, 1st slice	13	24	11	7	5	8	8	24
Group 1, 2nd slice	7	15	9	14	14	12	15	15
Group 2, 1st slice	17	33	3	7	13	7	8	12
Group 2, 2nd slice	9	9	2	25	30	2	18	5
Group 3, 1st slice	15	22	8	9	8	6	6	26
Group 3, 2nd slice	18	22	8	10	7	5	5	25

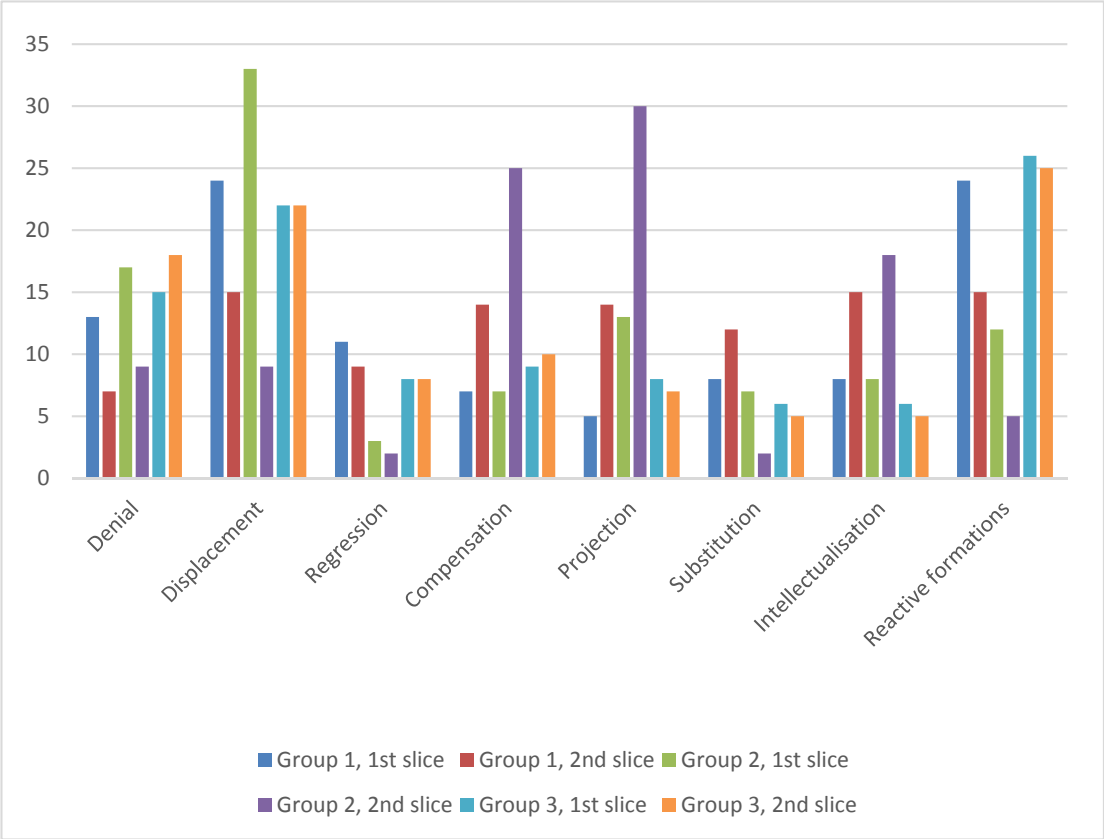

Figure 36. Summary comparative representation of life style type choices by groups

A study of coping strategies

Table 42 – Adaptive coping behaviours. Second cut-off, number of

	Problem analysis	Maintaining self-control	Setting your own value	Protest	Optimism	Cooperation	Address	Altruism
Group 1	2	22	12	10	14	7	0	0
Group 2	4	4	14	16	4	9	0	0
Group 3	0	3	13	7	2	8	2	2

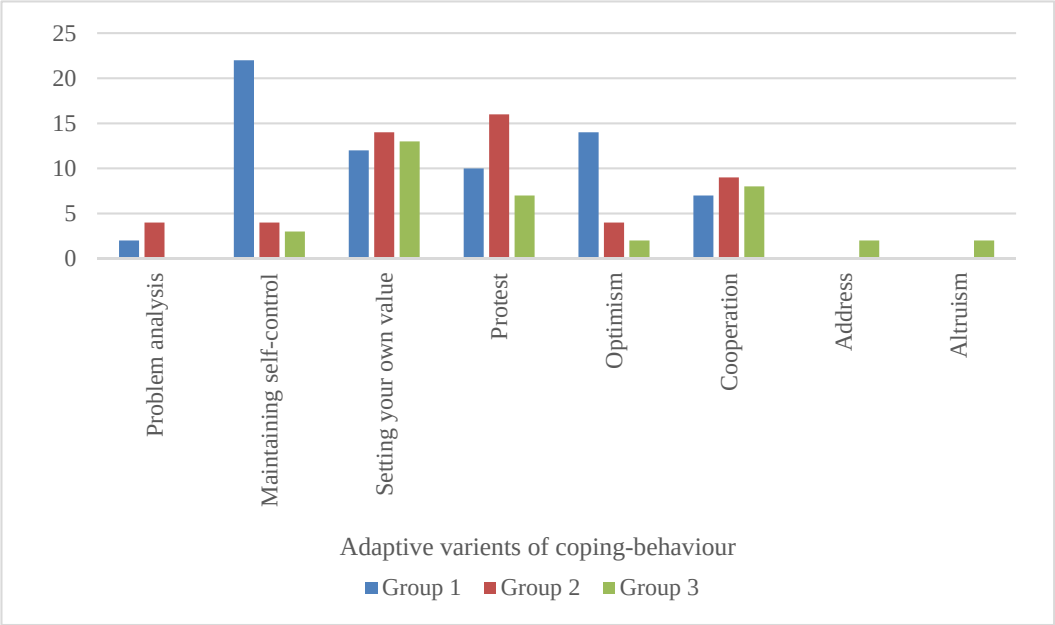

Figure 37. Representation of the distribution of adaptive copping strategies

Table 43 – Non-adaptive coping behaviours. Second cut-off, number of

	Humility	Confusion	Dissimulation	Ignoring	Suppression of emotion	Obedience	Self-incrimination	Aggressiveness	Active avoidance	Retreat
Group 1	3	0	3	5	2	2	2	0	2	5
Group 2	0	0	14	5	0	0	0	0	5	4
Group 3	12	3	0	0	0	0	0	0	8	10

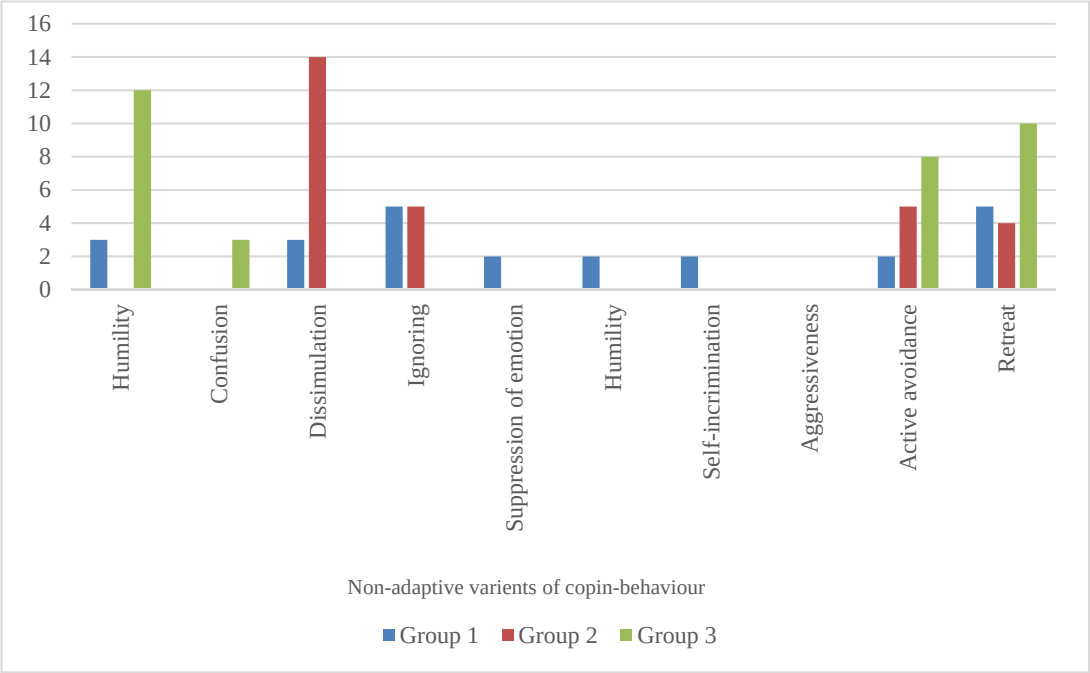

Figure 38. Representation of expression of maladaptive coping strategies

Table 44 – Relatively adaptive coping behaviours. Second cut-off, the number of

	Relativity	Giving meaning	Religiousness	Emotional release	Passive cooperation	Compensation	A diversion	Constructive activity
Group 1	15	0	0	7	2	2	2	2
Group 2	13	0	0	14	0	0	0	0
Group 3	20	0	0	7	3	0	0	0

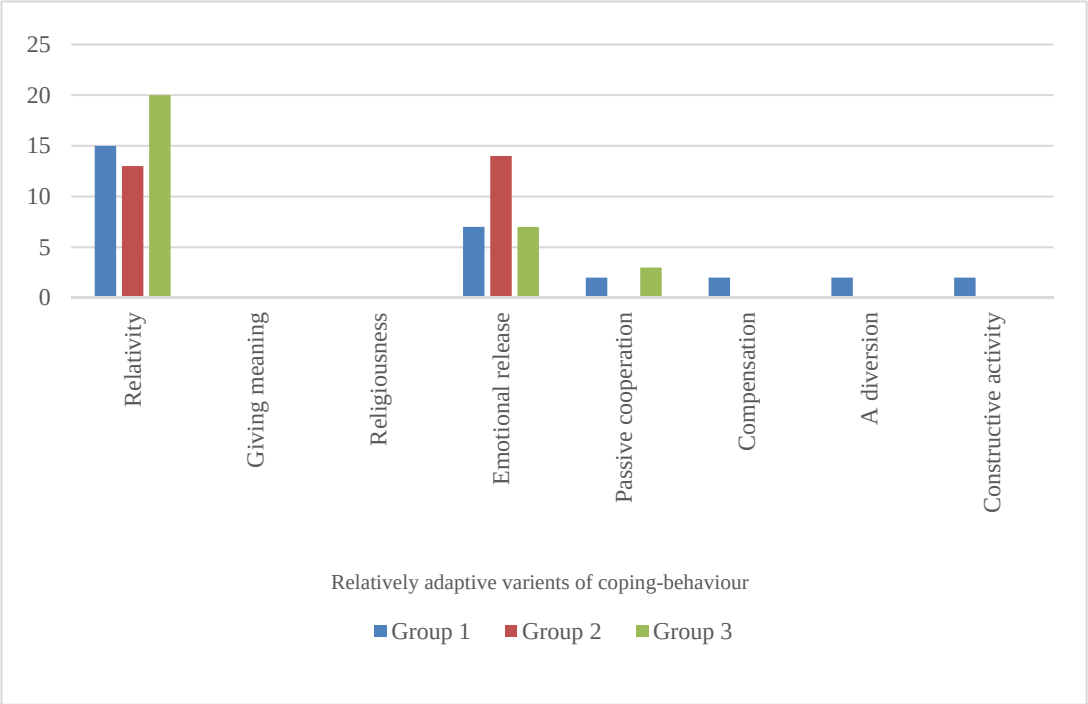

Figure 39. Representation of expression of relatively adaptive copping strategies

First cut - Second cut comparison

Table 45 – Adaptive coping behaviours, number of

	Problem analysis	Maintaining self-control	Setting your own value	Protest	Optimism	Cooperation	Address	Altruism
Group 1, 1st slice	0	0	6	5	8	13	0	0
Group 1, 2nd slice	2	22	12	10	14	7	0	0
Group 2, 1st slice	0	0	8	8	0	5	2	2
Group 2, 2nd slice	4	4	14	16	4	9	0	0
Group 3, 1st slice	0	0	12	6	0	8	0	0
Group 3, 2nd slice	0	3	13	7	2	8	2	2

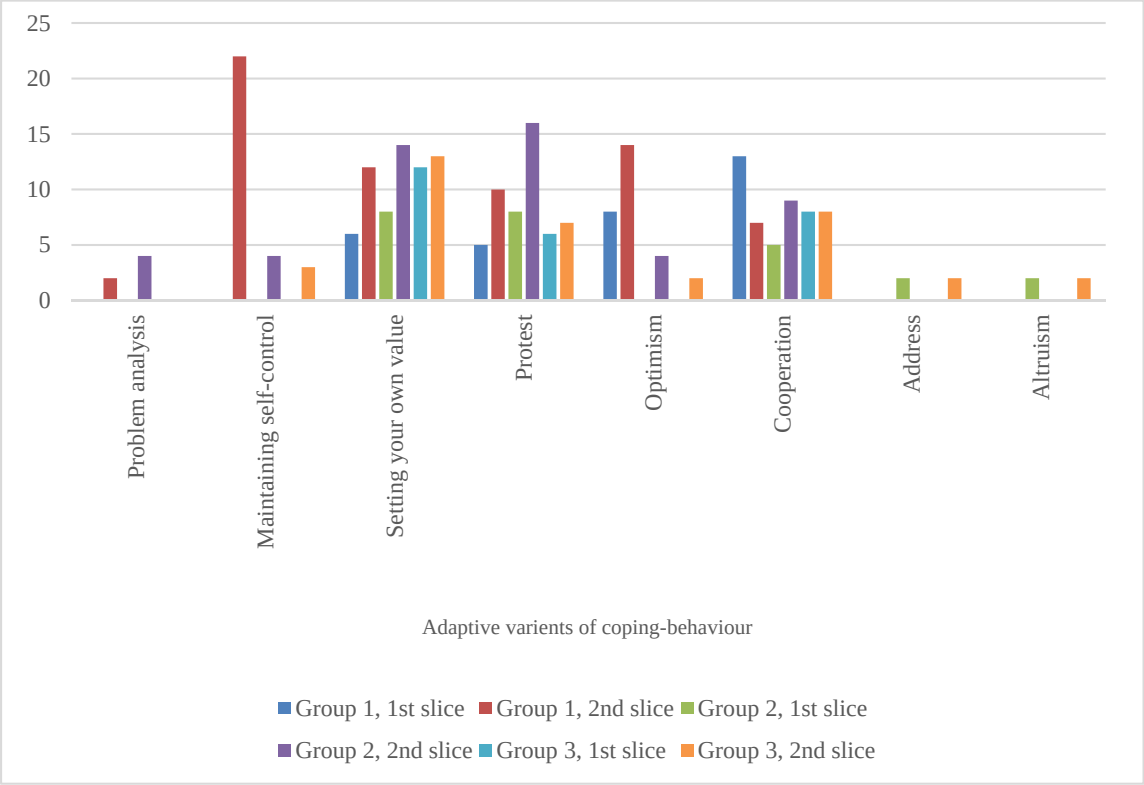

Figure 40. Comparative representation of the expression of adaptive coping strategies

Table 46 – Non-adaptive coping behaviours, number

	Humility	Confusion	Dissimulation	Ignoring	Suppression of emotion	Obedience	Self-incrimination	Aggressiveness	Active avoidance	Retreat
Group 1, 1st slice	3	17	3	5	0	0	0	5	5	10
Group 1, 2nd slice	3	0	3	5	2	2	2	0	2	5
Group 2, 1st slice	0	0	12	5	0	0	3	0	5	5
Group 2, 2nd slice	0	0	14	5	0	0	0	0	5	4
Group 3, 1st slice	12	3	2	2	0	0	0	5	6	8
Group 3, 2nd slice	12	3	0	0	0	0	0	0	8	10

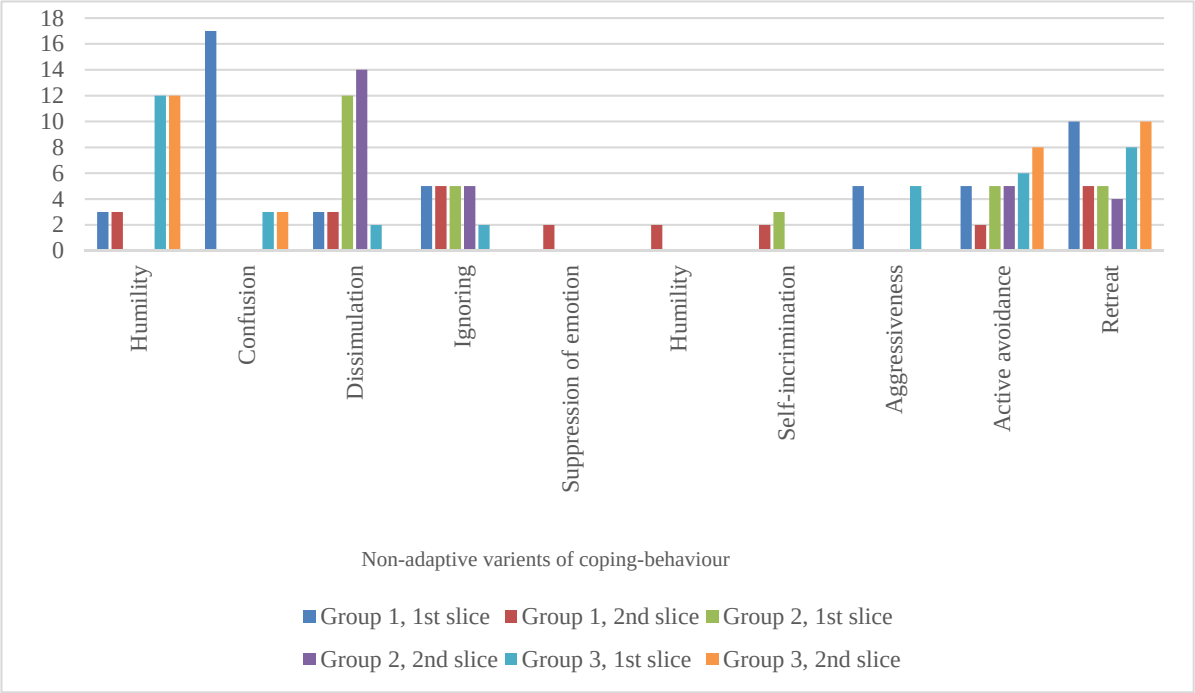

Figure 41. Comparative representation of the distribution of the expression of maladaptive coping strategies

Table 47 – Relatively adaptive coping behaviours, number of

	Relativity	Giving meaning	Religiousness	Emotional release	Passive cooperation	Compensation	A diversion	Constructive activity
Group 1, 1st slice	21	0	0	15	0	0	0	0
Group 1, 2nd slice	15	0	0	7	2	2	2	2
Group 2, 1st slice	20	0	0	22	3	0	0	0
Group 2, 2nd slice	13	0	0	14	0	0	0	0
Group 3, 1st slice	22	0	0	8	8	0	0	0
Group 3, 2nd slice	20	0	0	7	3	0	0	0

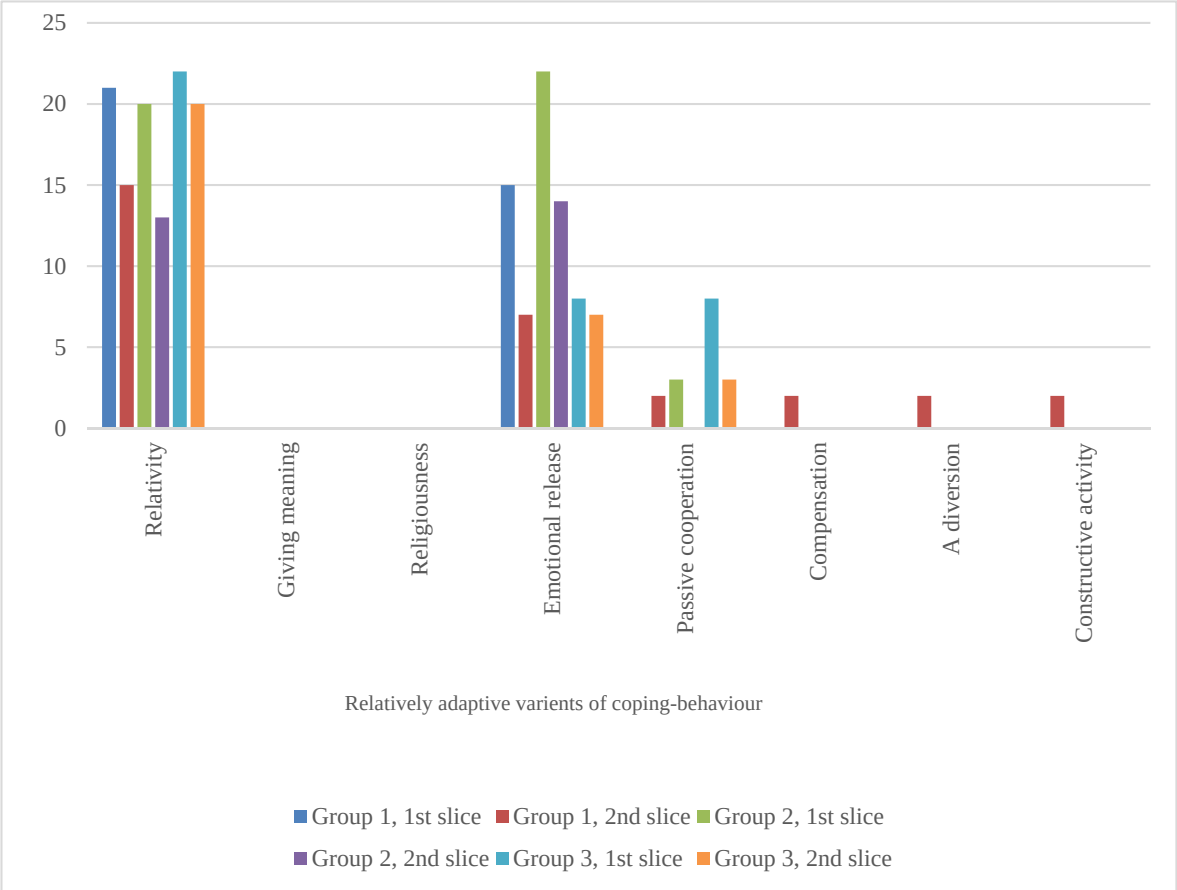

Figure 42. Comparative representation of the distribution of expression of relatively adaptive copping strategies

The analysis of the results showed that respondents in the first group (with a diagnosis of renal cell cancer) have the most pronounced protective mechanisms related to the productive defence against meaninglessness. Everyone needs a meaning. The lack of meaning, values, ideals in life causes considerable suffering. However, the modern existential concept of freedom maintains that the world is random and has no meaning. Respondents feel very keenly the need to find meaning in a world that has no meaning. Also, the data from this methodology show that respondents in this group are extremely comforted by the belief in the existence of some higher holistic plane in which each individual has a role to play. For them, it is necessary to construct a meaning for themselves that is strong enough to sustain life. At the same time, paradoxically and absurdly, the subjects simultaneously deny the existence of a higher power, so that the defense mechanism is built as a person's proud rebellion against the existing situation. It should also be noted that in the group

of existential defences classified as productive defences against meaninglessness (for the first group of cancer patients), the expression of this type of defence is as follows:

1. Altruism (67.14286 %). Making the world a better place to live, serving other people, participating in charity - these actions are good and right and give life meaning to many people.

2. Devotion to the cause (65.71429 %). This secular action is well reflected in Karl Jaspers' words that man is what he has become because of the cause he has made his own.

3. Creativity (70%). Creating something new, something marked by novelty, beauty and harmony is a good antidote to feelings of meaninglessness. Creativity in any profession and in any activity adds something of value to life.

4. The hedonistic solution (65.71429 %). According to this view, the purpose of life is to live fully, to perceive life as a gift, to maintain wonder at the wonder of life, to immerse oneself in its natural rhythm and to seek pleasure in the deepest possible sense.

Patients in the group diagnosed with renal cell cancer are also the most characterised by defence mechanisms related to productive defence against meaninglessness.

At the same time, they are also characterised by defences against loneliness, above all "denial through fusion" (84%), which is not characteristic of patients diagnosed with renal cell cancer (Group 1). The fear of recognising one's own isolation is overcome through denial: the individual develops the illusion of fusion in detail and becomes part of another individual or group.

Experiencing existential isolation generates a highly discomforting subjective state. He can take on a partial burden of isolation and courageously bear it. As for the rest, one tries to give up one's separateness and enter into a relationship with another - either the same person or a divine essence. Thus, the main defence against the horror of existential isolation has to do with relationships. But with this defence mechanism,

one is not close to the other, but rather uses him or her.

Diagnosable types of attitudes towards illness (TOBOL)

Table 48 – Second cut-off (number)

	Harmonious (D)	Ergopathic (R)	Anosognostic (H)	Anxious (T)	Anxiety-neurasthenic	Hypochondriac (I)	Neurasthenic (N)	Melancholic (M)	Melancholic and hypochondriac	Apathetic (A)	Anosognosic-apathic	Sensitive (C)	Egocentric (E)	Paranoid (P)	Dysphoric (D)
Group 1	5	17	15	15	3	7	3	3	3	5	2	19	2	0	0
Group 2	9	18	16	12	9	9	4	5	0	4	0	14	0	0	0
Group 3	3	20	7	20	0	7	3	3	12	3	0	18	3	0	0

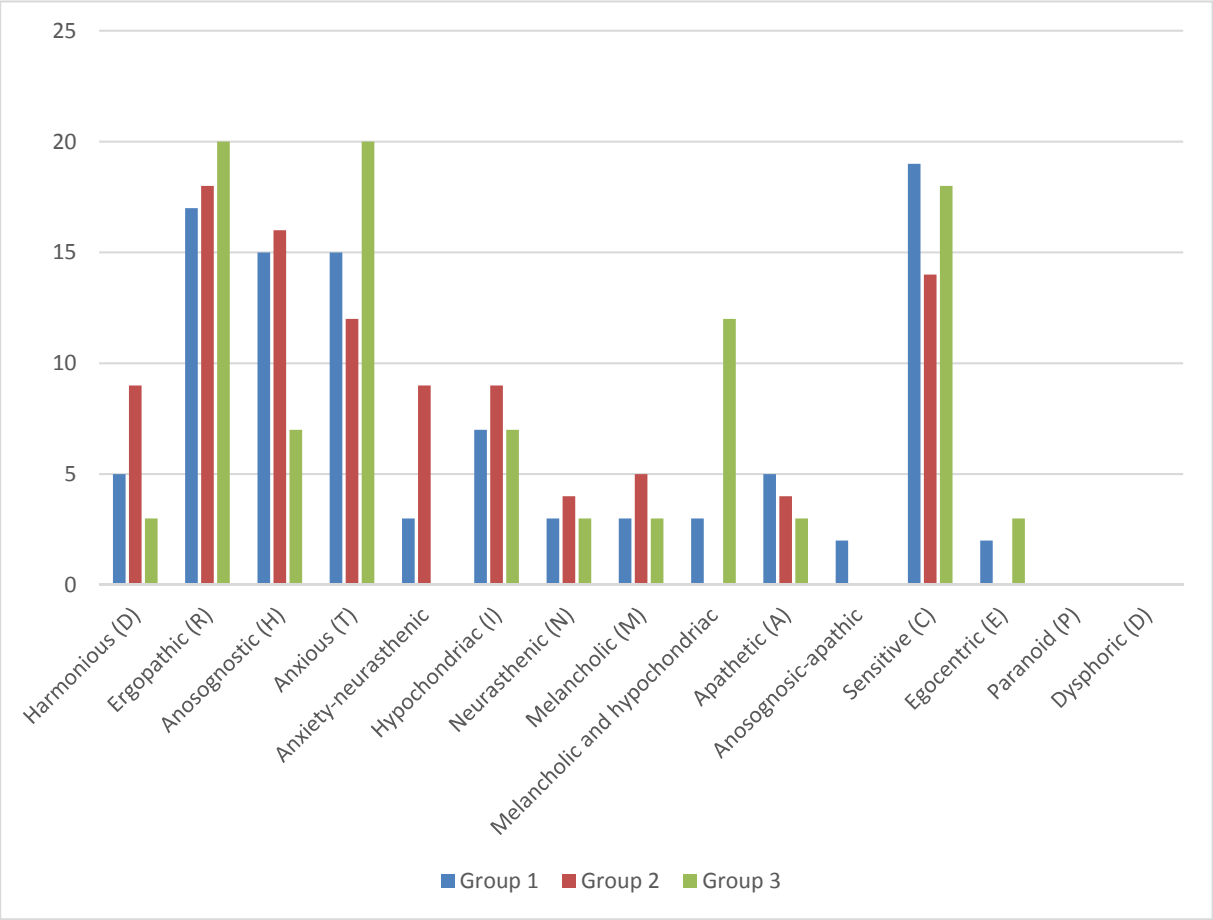

Figure 43. Representation of the severity of attitudes towards illness

Table 49 – First cut - Second cut comparison

	Harmonious (D)	Ergopathic (R)	Anosognostic (H)	Anxious (T)	Anxiety-neurasthenic	Hypochondriac (I)	Neurasthenic (N)	Melancholic (M)	Melancholic and hypochondriac	Apathetic (A)	Anosognosic-apathic	Sensitive (C)	Egocentric (E)	Paranoid (P)	Dysphoric (D)
Group 1, 1st slice	0	10	5	21	7	13	3	5	3	5	5	15	5	0	5
Group 1, 2nd cut	5	17	15	15	3	7	3	3	3	5	2	19	2	0	0
Group 2, 1st slice	0	8	7	20	13	13	3	5	0	5	0	12	5	3	3
Group 2, 2nd slice	9	18	16	12	9	9	4	5	0	4	0	14	0	0	0
Group 3, 1st slice	0	12	6	22	0	8	3	3	15	5	0	14	5	3	5
Group 3, 2nd slice	3	20	7	20	0	7	3	3	12	3	0	18	3	0	0

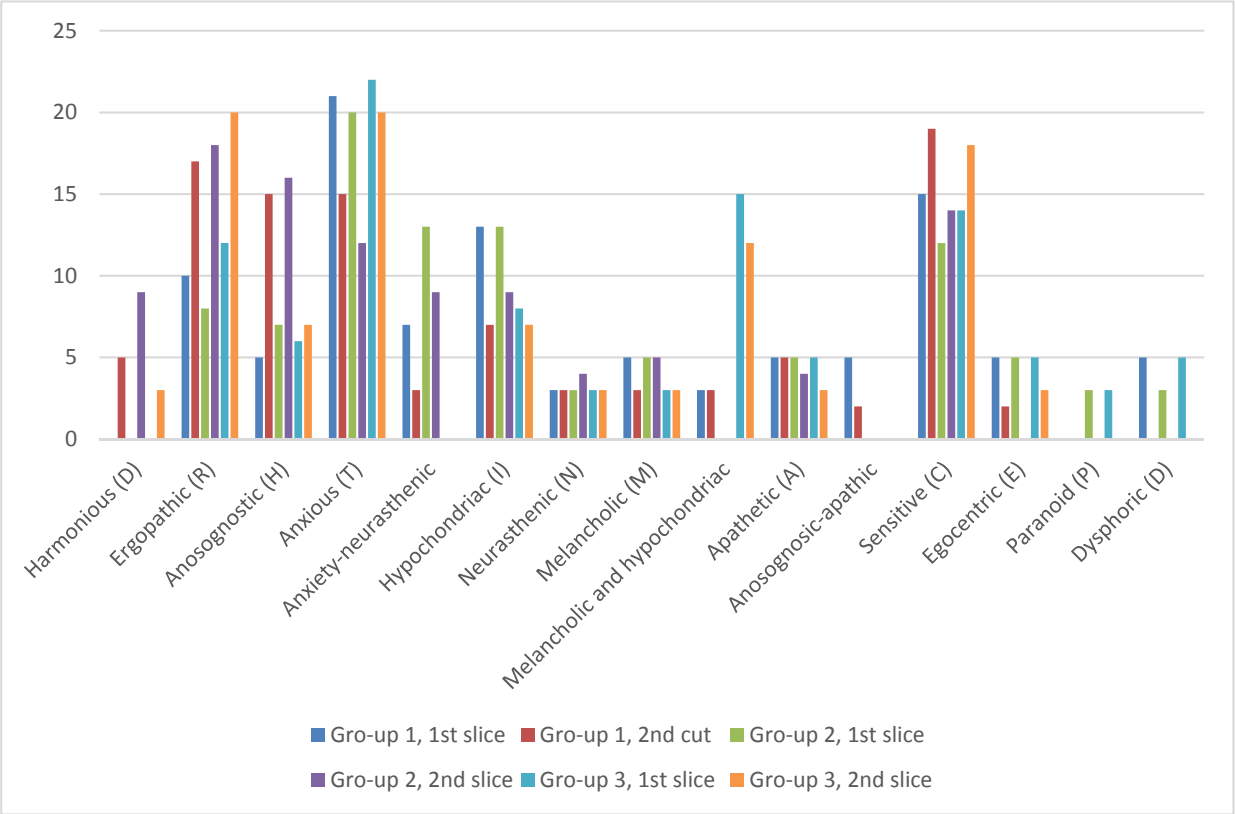

Figure 44. Comparative representation of the severity of attitudes towards illness

During re-examination using "TOBOL" method the following results were got: respondents mainly showed the following attitude types, which were characterized by intrapsychic orientation of personal reaction to the disease: anxious (15 people), melancholic-pochondriacic (9 people), neurasthenic (8 people), apathetic (12 people), anxious-neurasthenic (8 people), which caused disorders of social adaptation in patients with these types of reactions. The emotional and affective sphere of relations in these patients manifests itself in maladaptive behaviour: reactions such as irritable weakness, anxious, depressed, depressed state, "withdrawal" into illness, refusal from fighting, etc. In 11 people the sensitizing type of the attitude to the disease is diagnosed, which is characterized by the interpsychic orientation of the personal reaction to the disease, which also causes violations of the social adaptation of the patients. Also in 9 respondents the anosognostic type of the attitude to the disease at which reduction of criticism to the condition, underestimation of "importance" of the disease up to its full displacement, sometimes manifested by behavioral violations of

the mode of life recommended by the doctor, denial at times the fact of the disease is characteristic is revealed. However, pronounced phenomena of mental maladaptation are no longer present in these patients.

2 respondents showed a steady improvement in their attitude towards the disease. After the interventions, they were diagnosed with a harmonious type of attitude towards illness instead of an anxious one. They learned how to deal with their anxious attitude towards illness with the help of relaxation techniques, and also changed their inner attitudes. Block IV of the psychologically corrective programme was especially beneficial for them. The rest of the participants, unfortunately, did not show such lasting improvements in their attitude towards the disease. Two respondents were still diagnosed with an anxious attitude towards the disease; they may need longer and deeper therapy. Also, 1 person was diagnosed with a diffuse type of attitude towards the disease, although previously they had been anxious-neurasthenic. Anosognosia was again found in 1 participant.

Student's t-test for paired (dependent) samples was used to compare mean values for test and retest results. The results of the retest on methods statistically differ from earlier received $p \leqslant 0,01$ and $p \leqslant 0,05$ on methods "TOBOL", "Diagnostics of coping mechanisms". This indicates that the respondents who underwent correction showed a significant change in the system of psychological self-regulation in the cognitive, emotional and behavioural spheres. Also retest results are statistically different from those previously obtained in the ITT and Hospital Depression Scale at the $p \leqslant 0.05$ significance level. Thus, after completing the programme, respondents demonstrate a harmonisation of their emotional state.

Summing up the preliminary results we can state: the empirical research carried out has shown that in both groups the "ergopathic" (stenotic) type of attitude towards the disease prevails. Subjects with this type of attitude towards illness are most characterised by an overdependent, often overdimensional, obsessive attitude towards work which develops and at times becomes more pronounced than it was before the illness. Such patients are characterised by a selective attitude towards examination

and treatment, driven primarily by the desire, despite the severity of the disease, to continue working, working and maintaining an active life position.

It has been found that the hypochondriacal type of attitude towards illness is characteristic only of patients diagnosed with bladder cancer. They are more likely to demand advice from doctors in high positions. They exaggerate their painful feelings. They want more attention.

The analysis also showed that both groups of respondents have similar protective mechanisms. They are almost independent of the nosology of the disease. Consequently, the patients diagnosed with bladder cancer and renal cell cancer have similar dispositions and show similar emotions towards the disease. Based on the results obtained, it can be stated that both groups are characterized by a structure of defence mechanisms which includes "reactive formations", "intellectualization", "rationalization" and "displacement". The findings indicate a narrowing of the spectrum of adaptive responses to the disease, manifested predominantly in the form of a hypersocialised style of behaviour with "going to work", and a kind of "lopsided" response to a problematic and frustrating illness situation. The individual prevents the expression of unpleasant or unacceptable thoughts, feelings, or actions by exaggerating the development of opposing impulses. In other words, it is as if inner impulses are being transformed into subjectively understood opposites. For example, pity or caring can be seen as reactive formations in relation to unconscious callousness, cruelty, or emotional indifference.

The data obtained showed that the respondents are full of energy, their aim is to participate in all kinds of activities and projects. They are characterised by a good attitude towards people, friendliness, sociability, and hypertrophied sociality; the predominant emotion is joy; the innate need for an excess of pleasant stimuli is hedonism. The defence mechanism is reactive formation (reaction formation); its purpose is only to control behaviour. The super-ego suppresses the attraction of pleasurable stimuli, especially objects to which attraction is socially disapproved.

The analysis of the data also allows us to characterise patients as insufficiently aware,

denying frustrating and disturbing circumstances that are obvious to others. They tend to reject and reject their own emotionally unacceptable thoughts and prevent them by developing attitudes that are opposite to these desires, reducing the significance to themselves of the causes that caused the psychotraumatic situation.

Another peculiarity of the group of respondents diagnosed with bladder cancer that we managed to identify was that they were more characterized by such existential defence mechanism as "belief in one's own exceptionalism". This type of existential defence is a productive defence against the fear of death, so we can argue that the fear of death is stronger in patients diagnosed with bladder cancer, than in patients diagnosed with renal cell cancer. This is also evidenced by the fact that in patients diagnosed with bladder cancer, the average intensity of the second type of defence against fear of death, the "belief in the ultimate saviour" defence, exceeds 50%. These patients are more likely to constantly tell doctors and others about their experiences and feelings. They tend to exaggerate their suffering and embellish unpleasant experiences with diagnostic and treatment procedures. On the one hand, they express a great desire to be treated, to undergo all the procedures, but they also have doubts about the success of the treatment.

The analysis of the results showed that all respondents had the most pronounced defence mechanisms related to the productive defence against meaninglessness. Everyone needs meaning. The lack of meaning, values and ideals in life causes considerable suffering. However, the modern existential concept of freedom maintains that the world is random and has no meaning in it. Respondents feel very keenly the need to find meaning in a world that has no meaning. Also, the data from this methodology show that respondents in this group are extremely comforted by the belief in the existence of some higher holistic plane in which each individual has a role to play. For them, it is necessary to construct a meaning for themselves that is strong enough to sustain life. At the same time, paradoxically and absurdly, the subjects simultaneously deny the existence of a higher power, so that the defense mechanism is constructed as a proud rebellion of the individual against the existing

situation.

At the same time, we should note clear differences in the expression profile of the average values of existential defences in the two groups studied. Thus, in first group of patients diagnosed with renal cell cancer, only two groups of defences exceeded the 50 per cent level of expression. These are, as noted above, productive defences against meaninglessness and defences against the fear of loneliness. In the second group (diagnosed with bladder cancer), however, five groups of defenses were already "tense": defenses against fear of death ("belief in own exclusivity" and "belief in the ultimate savior"), defenses against fear of freedom ("avoidance of manifestation of will"), defenses against fear of loneliness, and productive defenses against meaninglessness. It should be noted that respondents diagnosed with bladder cancer have a greater degree of existential defences, as well as a greater variety of fears relating to almost all aspects of their existence.

At the same time, all of the patients studied were characterised by defences against loneliness. At the same time, only in patients diagnosed with bladder cancer did the intensity of this type of defence exceed a 50% level of severity. First of all, it concerns such a protective mechanism against the fear of loneliness (isolation) as "denial through fusion" (84 %), which is not characteristic of patients diagnosed with renal cell cancer (Group 1). The fear of recognising one's own isolation is overcome through denial: the individual develops the illusion of fusion in detail and becomes part of another individual or group. The experience of existential isolation produces a highly discomforting subjective state. He can take on a partial burden of isolation and courageously bear it. As for the rest, the person tries to give up his or her separateness and enter into a relationship with another - either the same person or a divine essence. Thus, the main defence against the horror of existential isolation has to do with relationships.

In our study, we found statistically significant differences between male and female samples in the types of attitudes towards illness. Based on the results of the study, it can be said that women are more characterised by denial of illness and its

consequences. They are less adequate in their assessment of what is happening and less critical of what is happening to them occurs. At the same time, male respondents demand a great deal of care from their loved ones, although they are rather lethargic about all procedures and have little interest in them. They accept their illness and flaunt all symptoms and sensations, while showing a loss of interest in life.

The study found that defence mechanisms (both life style indexes and existential defences) are related to the type of attitude towards the illness. For example, in the harmonious type, patients are characterised by taking responsibility for the treatment process and the course of the illness. If the patient displays a paranoia disposition, it is not characteristic of them to believe in an ultimate saviour, but to exercise willpower in the course of the illness. Those patients who avoid responsibility, who have a high apathetic attitude towards the disease, are indifferent to their fate and to the treatment process.

This study did not find any connection between the type of attitude towards the disease and age. Cancer patients of different age groups are characterised by similar types of attitude towards the disease and defence mechanisms, which most likely indicates that not only the types of attitude towards the disease, but also the types of psychological defences studied are formed under the influence of the disease state.

CONCLUSION

The fact of being diagnosed with the disease and even the assumption of the possibility of having cancer, being a superstress, a crisis circumstance in a person's life, changes not only the circumstances of his real existence, but to no small extent his attitude to himself, to his own life, makes him turn to the categories of meaning that may not have previously been in the sphere of active attention of the individual and, at any rate, were not the focus of actualisation.

In these conditions the directed activation and realization of protective mechanisms in relation to a number of emotional experiences (anger, guilt, aggression), including existential nature (anxiety, loneliness, fear of death), as a consequence, the formation of the attitude to the disease is a kind of "internal platform", on which not only the changes of attitude to himself and to the outside world occur, which in turn, are the elements of the patient's worldview, but also forms a psychological resource that allows the patient to resist the disease Taking into account that the category "psychological defense" is multidimensional, within the professional contact "psychologist - oncological patient" there is an opportunity to activate and restructure different levels of protections, creating an individual model, the most successful for a particular personality type, in the context of coping with a particular type of experience in the course of the disease.

Studying the problems related to the understanding of psychological defences in the context of oncourological diseases of different nosologies, their interrelation with the types of attitude towards the disease, we have identified a picture of various intrapersonal components, somehow related to the studied system, ultimately it is about the formed basic attitude and elements of self-perception as meaningful elements of the world picture, self-perception and psychological flexibility in terms of readiness for changes in the self-perception in connection with illness. The possibility of changing the person's world view by changing their attitudes, based on the analysis of their emotions, not only allows for a better understanding of the specifics of the person's experience of illness, but also broadens the understanding of

the possibilities of improving the quality and mechanisms of implementation of coping strategies.

Thus, the research carried out allows us to draw the following main conclusions:

1. Defence mechanisms (both life style indices and existential defences) are related to the type of attitude towards the illness. For example, a harmonious attitude is characterised by patients taking responsibility for the treatment process and the course of the illness.

2. When identifying the type of attitude towards the disease in patients in the two nosological groups - with the diagnosis of renal cell cancer and bladder cancer - significant differences were found only in the severity of the hypochondriacal type of attitude towards the disease, which is more characteristic of patients with the diagnosis of bladder cancer. In the rest of the characteristics, the severity of the types of attitude towards the disease in the two nosological groups is fundamentally similar.

3. When considering the expression of existential defences as one of the underlying factors influencing the course of the disease, we found significant differences in the expression of a type of defence against fear of death, such as "belief in one's own exceptionalism", which is significantly more intense in patients diagnosed with bladder cancer.

4. In situations in which paranoid dispositions are detected in patients, there is a loss of faith in the "ultimate saviour". The patient manifests his or her own will in the course of the illness, which directly affects the attitude towards the self and the illness, and can be seen as one of the psychological mechanisms of resistance to the illness.

5. Based on the findings of the study, it can be argued that women are more characterised by denial of illness and its consequences, they are less adequate in their assessment of what is happening and less critical in their evaluation of real events and changes of a psychological and psychophysiological nature.

6. Men suffering from cancer are characterised by greater anxiety and emotional sensitivity and demand for attention, emotional support and care. In this

case, there is a specific existential conflict between conditional "acceptance" of their illness and hyper-emphasis on symptoms and sensations and a simultaneous reduction of interest in life; in some cases, it may be a question of self-esteem, both in the personal and in the life-meaningful context.

7. In the process of analysis of cancer patients' picture of the world, the picture of the disease built into it, as well as the peculiarities of manifestation of protective reactions, elements of mental rigidity not connected with gender, age and nosology type were revealed. We assume that this trait could be one of the "trigger" characteristics of the process of psychological defense formation from accepting the disease, embedding it into the picture of the world, not being at the same time a part of the compensatory-replacement reactions system.

8. Among the psychological and psychotherapeutic methods that are the most effective when working with severe cancer patients, the art therapy techniques can be named, in particular, drawing and music therapy. Their usage in combination with working through meaningful situations, fragments of cancer patient's life path is connected with fixed positive changes of a number of psycho-emotional reactions, anxiety level reduction, overcoming the fear of death; elements of autobiographical analysis as a method of changing attitude towards oneself, the technique retrospective analysis of the value and meaning components of life as an activator of the system for accepting real situations, changing attitudes towards oneself, activating elements of resilience, and harmonising the type of attitude towards illness.

9. When considering the situation of psychological and psychotherapeutic work with oncology patients, it is necessary to talk about the formation of a system of complex psychological and psychotherapeutic support, which as subjects, besides the patient himself, may include his family members, as well as medical personnel directly related to the management of the patient. The content objectives of the system of comprehensive support are not only related directly to psychotherapeutic activities, but also to the organisation of a psychological atmosphere that promotes the activation of resilience mechanisms and the activation of psychological personal resources.

10. The results of theoretical and empirical analysis of the problem of attitude towards the disease and the prevalence of protective mechanisms in cancer patients with different nosologies allow us to conclude that in a broad psychological context, psychological protection is triggered in one way or another when negative, psychotraumatic experiences occur and largely determines the behavior of the individual, eliminating mental discomfort and anxiety.

At the end of this study, it is necessary to outline the prospects for its development, and therefore, given our experience of interacting with cancer patients, it is necessary to share a number of observations that go somewhat beyond the scope of posed tasks, but, as we believe, have serious scientific potential. We assume that if one of the hypotheses of the development of oncological disease (and oncourological disease in this case is no exception) puts emphasis on mental causality as a kind of trigger mechanism of the disease, then, in this regard, it is necessary to talk about the "internal duality" of the patient. In other words, we are talking about the following phenomenon – oncological disease, in its essence is not a necrotizing field, but a pathologizing super-life – in connection with the active growth of distorted cells, and this process itself is associated with an active, but repressed dynamics of transformation, (in fact, deformation), of a number of specific elements of the "I - concepts" (Self–image). The indicated state of destruction or transformation of Self–elements is conditionally autonomous and occurs not in the "field" of the psyche itself, but in the body, and the "volume" and "quality" of the displaced "product" correlate with the severity of the disease and the intensity of its course. Thus, in cases when the patient shows passivity and lack of full-fledged reactions to significant elements of the picture of his own world (significant life events and circumstances), this significance and intensity is transferred to the area of the unconscious as the repressed "content" of the life process. After a certain time, when there is no free "resource" left in the zone of conscious attitude to certain fragments of living life events, the activity of attitude to one's own life is leveled, compensation begins to occur at the expense of the actual physical resource - health. In fact, from our point of view, the historical passivity of the subject is "played out" and modeled by him in his

own body. Activation of the protective mechanisms of the psyche, in this regard, is a consequence of this systemic reaction and the very process of the activity of psychological defenses is designed to compensate and reduce the internal tension caused by unconscious conflict.

BIBLIOGRAPHY

1. Ababkov V. A. Adaptation to stress. Fundamentals of theory, diagnostics, therapy / V.A. Ababkov. - M. : Perre; SPb. : Speech, 2004. — 166 p.
2. Abelev G. I. I. What is a tumour / Soros Educational Journal. № 10, 1997. Published in: journal "Nature" 2.12.2000 [electronic resource] URL address
3. Abramov V. V. Higher nervous activity and immunity / V. V. Abramov,T. Я. Abramov, T.Y., D.N. Egorov. - Novosibirsk : Siberian Branch of Russian Academy of Medical Sciences, 2001. — 123 p.
4. Abramova G.S. Psychology in Medicine: Textbook / G.S. Abramova, Y.A. Yudchits. - M. : LPA "Chair-M", 1998. — 272 p.
5. Abulkhanova-Slavskaya K. A. On the subject of mental activity. - Moscow : Nauka, 1973. — 287 p.
6. Adler A. The practice and theory of individual psychology: Lectures on introduction to psychotherapy for doctors, psychologists and teachers. — Moscow, 1992., 243 p.
7. Alexander F. Psychosomatic medicine. - Moscow, 2000., 210 p.
8. Alexander F., Selesnik S. Man and his soul: cognition and healing from antiquity to the present day. - Moscow, 1995, 313 p.
9. Ananyev V. A. Fundamentals of health psychology. Book 1. Conceptual foundations of the psychology of health / V.A. Anan'ev. — SPb. : Speech, 2006. — 384 p.
10. Andreeva G. M. The place of interpersonal perception in the system of perceptual processes and the peculiarities of its content // Interpersonal perception in a group.— M., 1981., 142 p.

11. Andreeva G. M. Psychology of social cognition. - M. : Aspect Press, 2000. 290 p.

12. Andreeva G. M. Social psychology. — M., 2005. 345 p.

13. Andryushchenko A.B. Basic principles of rehabilitation of oncology patients / A.V. Andryushchenko // Journal of clinical psychooncology. Vyp 1 (9), 2006. pp. 32-44

14. Anokhin, P. K. Biology and neurophysiology of the conditioned reflex. - M: Medicine, 1968. — 546 p.

15. Anokhin P. K. Fundamental Problems of General Theory of Functional Systems: Selected Works / Edited by F.V. Konstantinov, B.F. Lomov, V.B. Shvyrko; USSR Academy of Sciences, Institute of Psychology. -M.: Nauka, 1978. — 399 p.

16. Antropov Y. F. Psychosomatic disorders. Moscow, 2001., 190 p.

17. Y. D. Apresyan. D. Apresyan. Deixis in Lexis and Grammar and the naive model of the world // Y. D. Apresyan Selected Works. T. 2. - Moscow, 1995., 410 p.

18. Apresyan Y. D. D. The Image of Man According to Language Data: An Attempt at Systemic Research // Problems of Linguistics - 1995. № 1., P. 32-49.

19. Arutyunova N. D. Language and the human world. - Moscow, 1999., 716 p.

20. Asmolov A. G., Marilova T. Y. The role of social position change in the restructuring of the motivational and semantic sphere in cancer patients // Journal of Neuropathology and Psychiatry. C. C. Korsakov. - Moscow: Media-Sfera, 1985, № 12. — 1846-1851 p.

21. Bazhin E. F. F., Gnezdilov A. B. Psychopharmacological and psychocorrectional aspects of rehabilitation of oncological patients // Jour. klin. psychoonkol. 2002, ¹ 3 [electronic resource] http://www. ru/jcpo/jcpo-n3.html

22. Basov, M. Y. General fundamentals of paedology. - M.-L.: State Publishing House, 1928. — 744 p.

23. Baturin K. A. A. Neurotic disorders in patients with chronic diseases . Moscow, 2003. 412 p.

24. Bauman W., Perrey M. Clinical Psychology. - St. Petersburg, 2002. 822 p.

25. Bakhtiyarov R.Sh. Morbidity of malignant neoplasms and mortality of older age groups of St.Petersburg population / R.Sh. Bakhtiyarov, O.T. Diatchenko, V.M. Merabishvili, N.Y. Shabashova, II.G. Shashkova // Clinical Gerontology, 2001. — №7. — pp. 45-51.

26. Belinskaya E. P. P. Coping as a socio-psychological problem // Psychological Research (electronic edition). 2008, № 2., pp. 45-56.

27. Boldova E. G. G. Cancer patient and study of human mental reserves / E.G. Boldova // Psychiatric Endocrinology. Reserves of human psyche in norm and pathology. Theses of the reports of the Soviet-American symposium. 5-10 September 1988. Moscow, pp. 5-19.

28. Boyarintsev V. P. P. Problems of Psychology and Psychophysiology of Activity and Self-regulation of a Person. - Moscow: Logos, 2007. — 219 p.

29. Bratus B. S. Anomalies of personality. - Moscow, 1998. 542 p.

30. Breslav G. M. Psychology of emotions. - M.: Meaning, 2004., 411 p.

31. Brautigam V. Psychosomatic medicine: Short tutorial / V. Brautigam, P. Christian, M. Rad - M.: GEOTAR MEDICINE, 1999. — 376p.

32. Brushlinsky A. V. Problems of subject psychology. -Moscow: Institute of Psychology RAS, 1994. — 209 p.

33. Buber M. I and You // Two Images of Faith. - Moscow: Respublika, 1995. — 392 p.

34. Bukhtoyarov O. V., Arkhangelsky A.E. Psychogenic cofactor of carcinogenesis: possibilities of hypnotherapy application. - SPb. : Aletheia, 2008. — 264 p.

35. Bialik M. A., Moiseenko E. E., Nikolaeva V.V., Uryadnitskaya N. A. Features of psychological adaptation and treatment of children with oncopathology // Materials of the first All-Russian conference with international participation "Social and psychological problems of childhood oncology". - Moscow: GlaxoWelcome, 1997 — pp. 97-99.

36. Whitehead M. Counselling a person in grief: A model of help // The Psychology of Maturation and Ageing. - M.: Social Sciences, 2016. - № 1 (17). — pp. 12-21.

37. Walewski O. Я. Psychology of the New Era: Book 1. - Odessa, 2005. 201 pp.

38. Varga A. Y. Systemic family psychotherapy // Journal of Practical Psychology and Psychoanalysis. M. Institute of Practical Psychology and Psychoanalysis. — 2010 г. — № 2. — pp. 132-157.

39. Vasilyuk F. E. Psychology of Experience. - Moscow: Moscow State University Press, 1984. 158 p.

40. Wasserman L. I. , Eryshev O. F. Psychological diagnostics of the life style index (handbook for doctors and psychologists). - SPb. Saint-Petersburg Scientific Research Institute. V. M. Bekhterev, 1998., 78 p.

41. Vodopyanova N. E., Starchenkova E. C. Burnout Syndrome: Diagnosis and Prevention.
— 2nd ed. amended and supplemented — Saint-Petersburg: Peter, 2008. — 336 p.

42. Volkan, W., Zintl, E. Living After Loss: The Psychology of Grief. - Moscow : Cogito-Centre, 2014. — 160 p.

43. Vorotnikov Y. L. "Linguistic picture of the world": interpretation of the concept. - Moscow, 2005., 272 p.

44. Vygotsky, L.S. Collected Works: in 6 vols. / Vygotsky, L.S. Vygotsky's Collected Works: 6 vols. - M. : Pedagogica, 1982-1984. — 369 p.

45. Vygotsky L. S. Collected Works: in 6 vols. Vygotsky L.S. Collected Works: 6 Volumes / Ed. by Zaporozhets A.V. / Vol. 3: Problems of Mental Development. / Ed. by A. M. Matyushkin. - M. : Pedagogica, 1982-1984 — 369 p.

46. Vysotsky A. I. Age dynamics of volitional activity of schoolchildren // Problems of psychology of volitional activity of personality and collective. - Ryazan : Ryazan State Pedagogical Institute. S. A. Esenin, 1984. — 122 p.

47. Gak V. G. The space of thought (experience of systematisation of words of the mental field). // Logical analysis of language. Mental Actions. - Moscow: Nauka, 1993.,374 p.

48. Gak V. G. Fate and wisdom. // The concept of fate in the context of different cultures. - Moscow: Nauka, 1994. — 286 p.

49. Ganich M.K. Theoretical concepts of psychological factors affecting the occurrence and course of cancer. / "Scientific Review" — 2016 — No. 4. — 132-157 p.

50. Ganich M.K. Empirical research of types of attitude to the disease and protective mechanisms of cancer patients. // "Successes of modern science" — 2016 — № 8 — 89 -95 p.

51. Ganich M.K. Factors influencing the occurrence and course of oncological diseases.// "Successes of modern science and education"-2016 — No. 8 — 101 -114 p.

52. Ganich M.K. Protective mechanisms and types of attitude to the disease in the picture of the world of cancer patients // National Health — 2022 —№2 — 76-78 p.

53. Gerasimenko V.N., Tkhostov A.Sh. Psychological and deontological aspects of rehabilitation of oncological patients / V.N. Gerasimenko, A.Sh. Tkhostov // Journal of clinical psychooncology. - Vol. 2, 2002. http://www. ru/jcpo-n2.html

54. Gerasimenko V.N., Tkhostov A.Sh. Psychological and deontological aspects of rehabilitation of cancer patients / B. N. Gerasimenko, A. Sh. Tkhostov // Journal of Clinical Psycho-oncology. - Vol. 2, 2002. — pp. 43-60.

55. Gerasimenko V. N. Rehabilitation of cancer patients. — Moscow: Medicine, 1988. — 271 p.

56. Gnezdilov A. B. Some aspects of the development of palliative care in Russia / A. B. Gnezdilov // Psychosocial rehabilitation and quality of life. Collection of scientific works by the V.M. Bekhterev Research Institute. — SPb. : SPbSRI V.M. Bekhterev, 2001. pp. 3-18.

57. Gnezdilov A. V., Gubachev Y. M. Terminal states and palliative care. - St. Petersburg: Gedeon Richter Chemical Works, 2015. — 462 p.

58. Groisman A.L. Medical psychology. Moscow, 1995., 359 p.

59. Danilenko V. P. Linguistic picture of the world in L. Weisgerber's concept // http://www.islu.ru/danilenko/index1.htm

60. Danilenko V. P. Linguistic picture of the world in the concept of Sepir-Whorf // http://www.islu.ru/danilenko/index1.htm

61. Danilova N. N., Krylova A. L. Physiology of Higher Nervous Activity. — R-n/d : Phoenix, 2005. — 478 p.

62. Dashieva B. V. Image of the world in the cultures of the Russians, Buryats and English // Language Consciousness: Formation and Functioning. — M., 1998.

63. Derisheva N. V. Peculiarities of patients with somatoform disorders experiencing their existence in the world. M.. 2001 (on the rights of the manuscript). , 78 p.

64. Dobryakov I. V., Zashchirinskaya O. V. Family Psychology and the Sick Child. Textbook: A reader. — SPb.: Rech, 2007. — 400 p.

65. Drobizhev M.Y. Nosogenic reactions. Historical aspects of the problem / M. Drobizhev // Journal of Clinical Psycho-oncology. - Vol. 2, 2002. http://www.ru/jcpo-n2.html.

66. Dubrova V. P., Egorov K. N. Ethico-psychological aspects of the work of a general practitioner with oncology patients // Medical News. — Minsk: YupokomInfoMed, 2003. — № 2. — 3-11 p.

67. Durnov L.A., Boychenko E.I., Glekov I. V. Clinical lectures in oncology. Ч. 1: textbook / edited by L.A. Durnov. - M.: MIA, 2013. — 270 p.

68. Durnov L. A. Handbook of paediatric oncology. - Moscow: Miklosh, 2003. — 504 p.

69. Zairatyan O. Kaktursky L. Diseases generated by doctor // Meditsinskaya gazeta. 2008. № 54.

70. Zaridze D.G. Epidemiology and etiology of malignant neoplasms / D.G. Zaridze // Carcinogenesis. — M.: Medicine, 2004. — pp. 29-85.

71. Ivannikov V. A. Psychological mechanisms of volitional regulation. — SPb. Peter, 2015. — 204 p.

72. Ivanov C. B. Peculiarities of the internal picture of the disease in cancer patients // Journal of Clinical Psycho-oncology. Vol 1 (9), 2006.

73. Kagan V. E. The internal picture of health - a term or a concept// Voprosy psychologii. 1993. №1., p. 19-26

74. Kalina N. F. Fundamentals of psychoanalysis. Moscow, 2001., 260 p.

75. Kalinauskas I. N. Picture of the World as Self-Relation // Method of Qualitative Structures: Picture of the World and the XXI Century. Materials of international scientific-practical conference. - St.Petersburg: MAI, 1997. p.43-55.

76. Camus A. Selected Works. Minsk: Nar. Asveta, 1989. 400 pp.

77. Karaulov Y. N. Language consciousness as a process (theoretical background of one experiment) / Y. N. Karaulov // Slovo. Jubilee collection dedicated to the 70th anniversary of Prof. I. Chervenkov, Sofia, 2001. 513 p.

78. Karvasarsky B.D. Neuroses. A Guide for Doctors, 2nd ed. revised and supplemented / B.D.Karvasarsky. - M.: Medicine, 1990,

79. Kitaev-Smyk L.A. Psychology of Stress. - Moscow : Nauka, 1983. 370 p.

80. Klimova S. V., Mikaelian L. L., Farikh E. N., Fisun E. The main directions of psychological assistance to families with children suffering from cancer in inpatient settings // Journal of Practical Psychologist. — Moscow: Social Sciences, 2013. — № 2. — 87-102p.

81. Klochk, V. E. Self-regulation of thinking and its formation: textbook. — Karaganda: Karaganda State University, 1987. — 179 p.

82. Klubova E. B. Methods of medical psychology in the diagnosis of psychological defence mechanisms // Theory and practice of medical psychology and psychotherapy. T. 133 (a). SPb.: The St. Petersburg Research Institute named after M. Bekhterev. V. M. Bekhterev, 1994. pp. 77-82.

83. Key ideas of the Russian language picture of the world / Anna A. Zaliznyak, I. B. Levontina, A. D. Shmelev. — M. : Yaz. of Slavic Culture, 2005.

84. Kübler-Ross E. On death and dying / E. Kübler-Ross. - Kiev: Sofia, 2001. — 320 p.

85. Kobozeva I. M. Linguistic Semantics: Textbook. M.: Editorial URSS, 2000. 700 p.

86. Kolshansky G. V. Objective picture of the world in cognition and language. — Moscow: Nauka, 1990.

87. Konopkin O. A. A., Stepansky V. I. Self-regulation of activity under conditions of temporal uncertainty of executive signals // Voprosy psychologii. - Moscow: Vopr psychikh. 1972, No 4. — 100-123 p.

88. Konstantinova T. V. Communicative interaction in the "doctor-patient" dyad // Vestnik Samara State University - Natural Science Series. 2006. №6., с.43-54

89. Kočiūnas R. Psychological counselling and group psychotherapy. Textbook. - Academic Project, 2008. 454 p.

90. Craig G. Developmental Psychology. - SPb. Peter, 2002. - 992 p.

91. Kryukova T. L. Psychology of coping behaviour: Monograph. - Kostroma: Studio Operative Polygraph "Avantitul", 2004., 356 p.

92. KSCT - Concise Dictionary of Cognitive Terms / Edited by E.S. Kubryakova, Moscow, 1996. 600 p.

93. Leontiev A. A. Language consciousness and the image of the world // Language and consciousness: paradoxical reality. M., 1993.

94. Leontiev A. N. N. Activity. Consciousness. Personality. 1977,375 p.

95. Lichko A. E. The medical and psychological examination of somatic patients // Journal of Neuropathology and Psychiatry. C. C. Korsakov. 1980. № 8., pp.54-72.

96. Lichko A. E. E., Ivanov N. Y. Methodology for determining the type of attitude to illness // Journal of Neuropathology and Psychiatry. 1980. № 8., pp.135-160.

97. Lichko A. E. E. Psychopathies and Character Accentuations in Adolescents. SPb.: Rech, 2015. — 256 p.

98. Luria R. A. The internal picture of the disease and iatrogenic diseases. M., 1977., 390 p.

99. Luban-Plozza B.,Peldinger W.,Kreger F. Psychosomatic patient at the doctor's office. -SPb: V.M. Bekhterev Research Institute, 1994 — 245 p.

100. Maklakov A. G. Personal adaptation potential: its mobilization and forecasting in extreme conditions. Psychological Journal. 2001, T.22, № 1. pp. 16-24.

101. Malkina-Pykh I. G. Psychosomatics. - Moscow: Eksmo, 2008. — 1024 p.

102. Manukhina N. M. Social maladaptation of patients with somatic diseases as an object of psychological correction // Journal of Practical Psychology and Psychoanalysis. 2003. № 3., p.45-59.

103. Mendeleevich V. D. Clinical (Medical) Psychology. M., 2005.

104. Miroshkin R.B., Fisun E. The psychological problems of families with children who have had cancer in remission and methods of working with them. // In: Journal of Practical Psychology and Psychoanalysis, Moscow, 2014. — № 1., p.50-68

105. Miroshkin R.B., Fisun E. V., Filippova N. E. Psychological rehabilitation of families with children who have undergone oncological disease. // Journal of Practical Psychology and Psychoanalysis. - Moscow, 2013. — № 3.

106. Mikhailov A. N. Rotenberg V. S. Peculiarities of psychological protection in norm and in somatic diseases // Problems of Psychology, 1990, No. 5. C. 107-125.

107. Mikhailov B.V., Serdyuk A.I., Fedoseyev V.A. Psychotherapy in General Medicine: A Clinical Manual. Kharkov, 2002., 1250 p.

108. Mikhailova S.N., Moiseenko E.I., Surina I.A., Yasonov A. V., et al. Social adaptation of young people with childhood cancer // Materials of the first All-Russian conference with international participation "Social and psychological problems of childhood oncology". - Moscow: GlaxoWelcome, 1997 — 85-86 pp.

109. Mikhailovsky V. N. N. The scientific picture of the world: architectonics, models, informatization , St. Petersburg, 1993.

110. Mikhailovsky V. N. N., Svetov Y. N. Worldview and the Modern Scientific Picture of the World. - Moscow: Znanie, 1987.

111. Moiseenko E.I., Pisarenko N.A., Zeitlin G.Y. Psychological adaptation of a family with a child with cancer in remission. // Materials of the First All-Russian Conference with The International Committee of Social and Psychological Problems of Paediatric Oncology. - Moscow: GlaxoWelcome, 1997 —pp. 112-115.

112. Morosanova V. I. Psychology of self-regulation in the 21st century / Ed. by V. I. Morosanova. I. Morosanova. - Moscow: Nestor-Istoriya, 2016. — 468 p.

113. Muzdybaev K. Strategies for Coping with Life's Challenges: A Theoretical Analysis // Sociology and Social Anthropology. 1998. T. 1, N 2. p.70-88.

114. Miagkova E. Y. Emotional load of a word: experience of psycholinguistic research. Voronezh. 1990.,600 p.

115. Myasischev V. N. Problems of personality in psychology and medicine. Topical Questions of Medical Psychology. L, 1974. pp.20-33.

116. Myasischev V. N. The Psychology of Relationships. Moscow, 1995. 290 p.

117. Nartova-Bochaver S. K. Differential Psychology. - Moscow: Izhitsa, 2002., 380 p.

118. The image of homo sapiens in the Russian language picture of the world: Monograph. Omsk, 2003., 420 p.

119. Nikolaeva V. V. The impact of chronic illness on the psyche / V. Nikolaeva. - Moscow: Moscow State University Press, 1987. — 167 p.

120. Nikolaeva V. V., Arina G. A. From traditional psychosomatics to bodily psychology // Vestnik MSU. 1996. № 14., pp. 39-47

121. Nikolaeva V. V. The impact of chronic illness on the psyche. - Moscow: Moscow State University, 1987 — 166 p.

122. Nichols, M., Schwartz, R. Family therapy. Concepts and methods.— M.: Eksmo, 2014. — 960 p.

123. Image-associative and pragmastical potential of the semantic categories space", "subject", "object", "instrument", Omsk, 2004. 512 p.

124. Ovcharenko S.I., Tkhostov A.Sh., Drobizhev M.Y., Ischenko E.N., Bevz I.A. Features of the course of bronchial asthma and the structure of the internal picture of the disease. // Pulmonology. 1997. № 3., pp.22-40

125. Oudshoorn D. N. The family of a sick child. // Family Psychology and the Sick Child. Textbook. Textbook. - St. Petersburg: Rech, 2007. — 400p.

126. Pavlov I. P. Selected Essays. — Moscow : Eksmo, 2015. — 736 p.

127. Perret M. Prevention, preservation and promotion of health: systematics and general aspects / M. Perret / Clinical Psychology / Edited by M. Perret, W. Baumann, 2nd International Edition. — SPb. Peter, 2002. — 1312 p.

128. Petriuk P. T., Yakushchenko I. A. Psychosomatic disorders: issues of definition and classification // Bulletin of the Association of Psychiatrists of Ukraine. 2003 №3., pp. 60-73

129. Pogosova K. O. The picture of the world and its types. M., 2002. 300 c.

130. Popova I. Positive dynamics of population health: behavioural models (according to longitudinal survey)/ [electronic resource] Sociology of medicine, 2006, № I., pp. 45-59.

131. Posokhova S. T. Psychology of an Adaptable Person: Monograph. SPb., 2001 — 240 p.

132. Postovalova V.I. Picture of the world in human life // The role of human factor in language: Language and picture of the world. — M.,1988. pp. 90-128.

133. Postovalova V. I. Fate as a key word of culture and its interpretation by A. F. Losev (a fragment of the typology of worldviews) // The concept of fate in the context of different cultures. - Moscow: Nauka, 1994. - pp. 204-214.

134. Postovalova M. V. Picture of the world in human life // Role of human factor in language: Language and picture of the world. Moscow, 1999. pp.70-85.

135. Psychiatry, psychosomatics, psychotherapy / Edited by K. P. Kisker, G. Freiber, G. K. Rose, E. Wolf. Moscow, 1999. 330 p.

136. Pushkina T. P. Medical psychology. Novosibirsk, 1996., 480 p.

137. Ravich R. D., Victorovich T. D., Kiseleva E. Y., Artemenko G. N. You are not alone. - St. Petersburg: Topprint, 2014. — 156 p.

138. Rtischeva O. V. Ontological and gnoseological aspects of linguistic picture of the world. Kemerovo, 2006, 22 p.

139. Rudnev Y. A. Linguistic picture of the world. Moscow, 1997., 290 p.

140. Rusina N. A. Emotions and stress in cancer. // World of Psychology: Scientific and Methodological Journal. - M. : MPSU, 2013. - № 4. — pp. 152-160.

141. Sullivan G. S. Interpersonal theory in psychiatry. Moscow, 1999., 400 p.

142. Samushin M. A. Nosogenias (psychogenic reactions) in women with malignant tumors of reproductive system organs / M. A. Samushin, E. A. Mustafina // Mental disorders in general medicine/ volume 02/ №3/ 2007. pp. 51-65.

143. Sandomirsky M. Psychosomatics and body psychotherapy. A Practical Guide. M., 2007., 320 p.

144. Semyonov, I. M. Reflexion in Organizing Creative Thinking and Selfdevelopment // Voprosy psychologii. — Moscow: Vopr. psikh. 1980. — № 2. — 45-62 p.

145. Serebrennikov G. A. The role of the human factor in language. Language and the picture of the world. Moscow, 1988. 510 p.

146. Sivashinsky M. S. Psycho-oncology literature review / M. S. Sivashinsky // Journal of Clinical Psycho-oncology. Vol. 1 (7), 2005. pp. 67-74.

147. Sidorov P.I. Psychosomatic medicine / P.I. Sidorov, A.G. Solovyov, I.A. Novikova. - M., 2006. 568 p.

148. Sidorova V. Yu. The Four Tasks of Grief. // Journal of Practical Psychology and Psychoanalysis, Moscow, 2001. - №1-2., pp. 56-67.

149. Slobodchikov I. M. Theoretical and methodological foundations for the study of the phenomenon of loneliness of the individual, Doctor of Psychology dissertation, Moscow, 2006.

150. Sokolova E.T. Psychological aspects of somatic diseases / E.T. Sokolova, N.M. Manuhina // Psychological journal. - 2000, 21, № 1.- pp.143-154.

151. Sozhenkin V. V. Psychological bases of medical activity. Textbook. - Moscow: The Planet of Children, 1997., 266 p.

152. Stepin V. S. C. The Picture of the World and Its Functions in Scientific Research. - Kiev, 1983. 340 p.

153. Tarabrina N. V. Psychology of post-traumatic stress: an integrative approach: dissertation... doctor of psychology / N. V. Tarabrina. - St. Petersburg, *2008. 42 p.*

154. Telia V. N. Metaphorisation and its role in creating a linguistic picture of the world // The role of the human factor in language: Language and picture of the world / B.A. Serebrennikov, E.S. Kubryakova, V.I. 1998, pp.80-92.

155. Tepperwein K. Psychosomatics, attitudes and health. Moscow, 2004., 210 p.

156. Tikhonov A. P. Personality and interpersonal relations: A psychological study of the socionic approach. Moscow, 2000. 365 p.

157. Tikhonravov Y. V. Existential Psychology. Moscow, 1998. 300 p.

158. Tkacheva V. V. Technologies of psychological help to the families of children with developmental disabilities: Textbook / V. V. Tkacheva. - M.: AST, 2007. - 318 p.

159. Thompson T. L. A psychoanalytic approach to the psychosomatic boundary // Journal of Practical Psychology and Psychotherapy. 2003. №1., pp..43-58.

160. Tkhostov A. Sh. Personal reactions of men and women to oncological diseases / A. Sh. Tkhostov, A. N. Molodetskikh, K. Papyrin // Journal of Neurology and Psychiatry. C. C. Korsakov. - 1981. - vol. 2, №2, - pp.160-178.

161. Tkhostov A. Sh. Psychological analysis of personality changes in some oncological diseases: Ph. Candidate of Psychological Sciences. Alexander Shamilevich Tkhostov. M., 1980. - 18 p.

162. Tkhostov A.Sh., Shpazhnikova A. V., Gerasimenko V.N. Prospects of psychosomatic research and rehabilitation in paediatric oncology // VI Congress of oncologists of the Ukrainian SSR. - Kiev: Zdorov'ya, 1980. – pp. 93-96.

163. Tkhostov A. Sh. Disease awareness in cancer patients // Journal of Neuropathology and Psychiatry. C. C. Korsakov. - M.: Media-Sfera, 1985 - N 12. – pp. 183-198.

164. Uryadnitskaya N. A. A. Psychological self-regulation in children with oncological pathology: abstract of the dissertation ... D. in Psychology. - Moscow: Moscow State University, 1998 - 20 p.

165. Ufimtseva N. V. Linguistic consciousness and image of the world of the Slavs // Linguistic consciousness and image of the world. - Moscow, 2000. pp.178-211.

166. Feigenberg I. M. Brain, psyche, health / I.M. Feigenberg. - M., 1972, 115 p.

167. Fisun E. A systemic approach in psychological work with cancer patients and their families. // Journal of Practical Psychology and Psychoanalysis, Moscow,
2014. — № 3., pp. 34-45.

168. Freud A. The psychology of the self and defence mechanisms. - Moscow: Pedagogica-Press, 1993. 290 p.

169. Freud A. Ego and defense mechanisms // A. Freud The theory and practice of child psychoanalysis. M.: OOO April Press; ZAO EXMO-Press, 1999. Volume 1. P. 115-245.

170. Freud Z. A study of hysteria. Spb., 2005. 280 p.

171. Heidegger M. Time and Being. M., 1993., 310 p.

172. Heidegger M. Time for a picture of the world. The New Technocratic Wave in the West. M., 1986., 350 p.

173. Hvorostin D. V. The philosophical meaning of the hypothesis of linguistic relativity by Edward Sepir and Benjamin Whorf, 2004., 145 p.

174. Holmogorova A. B., Garanyan N. G. Emotional disorders and contemporary culture (examples of somatoform, anxiety and Depressive disorders // Moscow Psychotherapeutic Journal, no.2, 1999, pp. 45-61.

175. Horney K. The neurotic personality of our time. Moscow, 1993. 275 p.

176. Hjell L., Ziegler D. Theories of Personality. - St. Petersburg: Peter, 2005. 712 p.

177. Chakalova E. P. Linguistic representation of the national picture of the world in an artistic text, autoref, Krasnodar, 2006. — p. 6.

178. Chissov V.I. Long-term results of treatment of patients with gastric cancer after combined and extended operations / V.I. Chissov, L.A. Vashakmadze, A.V. Butenko // Russian Journal of Oncology : a scientific and practical journal. - 2000. - N 1 . pp. 10-18.

179. Chulkova V.A., Moiseenko V.M. Psychological problems in oncology // Practical Oncology. - SPb.: TOMM Center, 2015 - №3. – pp. 151-157.

180. Shafigullin M. R. R. Nosogenic reactions in patients with malignant neoplasms of the stomach (Clinic, psychosomatic relations, therapy): dissertation...kand. medical sciences / M. R. Shafigullin. - M. , 2008.

181. Shatz I. K. Psychological support for a seriously ill child. Monograph. - SPb.: Rech, 2013. - 192 p.

182. Shmelev A. D. D. The Metaphor of Fate: Predestination or Freedom? // The Notion of Fate in the Context of Different Cultures. - Moscow: Nauka, 1994. - pp. 227-231.

183. Shustov D. I. Textbook of Medical Psychology (Psychotherapy in Medical Practice). Ryazan, 1996. 314 p.

184. Einstein A. Collected Works of Science in 4 vols: Volume IV. - Moscow : Nauka, 1967. - pp. 39-40.

185. Elkonin D. B. Age and individual characteristics of adolescents/Psychology of the Adolescent. Chrestomathy. // Comp. I. I. Frolov. - M. : Russian Pedagogic Agency, 1997. – pp. 286-312.

186. Yalom I. Existential Psychotherapy. / Class, 2015, 576 p.

187. Aspinwall L. G., Taylor S. E. A stitch in time: self-regulation and proactive coping // Psychological Bulletin, 1997. №121, pp. 417-436.

188. Brissette I., Scheier M. F., Carver C. S. The role of optimism and social network development, coping and psychological adjustment during a life transition // Journal of personality and social psychology. 2002. № 82. P. 102-111.

189. Garwick A. W. Levels of meaning in family stress theory. // Family Process. - Research Support, U.S. Gov't, Non-P.H.S., 1994. - № 33(3). – pp. 287-304.

190. Lazarus R. S. Emotions and Interpersonal Relationships: Toward a Person-Centered Conceptualisation of Emotions and Coping // Journal of Personality, February, 2006. - P. 9-46.

191. Lazarus R. S., DeLongis A. Psychological Stress and Coping in Aging. // American Psychologist. March, 1983. - P. 245-254.

192. Lazarus R. S., Folkman S. Transactional theory and research on emotions and coping. European J. of Personality, 1987, no. 1, P. 141-169.

193. Lipowski Z. J. Psychosocial reactions to physical illness // Can. Med. Assoc. J. - Ottawa: CMA, 1983. - №128 (9). - 1069-1072 p.

194. Miller B. D., Wood B. L. Emotions and family in childhood Asthma: Psychobiological Mechanisms and Pathways of effect // Asthma: Social and Psychological Factors and Psychosomatic. Dallas, 2003.

195. Opolski M., Wilson I. Asthma and depression: a pragmatic review of the literature and recommendations for future research // Clin Pract Epidemol ment Health. 2005 №1.

196. Plutchik R. Emotion: theory, research and experience. American Press, 1980.

197. Placer J. Clinical utility of a Multiprobe FISH assay in voided urine specimens for detection of bladder cancer and its recurrences compared with urinary cytology. // Eur. Urol. — 2002. — 42. — P. 547-552.

198. Pectasides D., Pectasides M., Nikolaou M. et al. Adjuvant and neoadjuvant chemotherapy in muscle invasive bladder cancer: literature review. //Eur. Urol .-2005.-48(1). — P. 60-67.

199. Ratliff T.L., Hudson M.A., Catalona W.J. Strategy for improving therapy of superficial bladder cancer. //World.J.Urol.-1991.-9.-P. 95.

200. Ratliff T.L., Ritchey J.K., Yaun J.J. Role of CD4 and CD8 lymphocytes in the antitumor activity of BCG. // J.Urol.- 1993.-150.-P.1018-1023.

201. Rapp D.E., CTconnor R.C., Katz, Steinberg G.D. Neobladder vaginal fistura after cystectomy and arthotopic neobladder constriction. //Br. J. Urol. Jnt.- 2004.-94(7).— p 1092-1095; discussion. 1095.

202. Rogerson, J.W. Intravesical bacille Calmette-Guerin in the treatment of superficial transitional cell carcinoma of the bladder. //Br. J. Urol.- 1994. -3. P. 655-658.

203. Ro J.V., Staerkel G.A., Ayala A.G. Cytologic and histologic features of superficial bladder cancer. Urol. Clin North Amer. 1992; - Vol. 19. -P. 435 - 449.

204. Sarosdy M.F., Lowe B.A., Schellhammer P.F. Bropirimine immunotherapy of bladder CIS: positive phase II results of an oral interferon inducer. (Abstract) //Proc Annu Meet Am Soc Clin Oncol. — 1994. — 13. — P. 719.

205. Sarosdy M.F., Lowe B.A., Schellhammer P.F. Oral bropirimine immunotherapy of carcinoma in situ of the bladder: results of a phase II trial .// Urology . — 1996. — 48. — P. 21-27.

206. Soloway M.S., Sofer M., Vaidya A. Contemporary management of stage T1 transitional cell carcinoma of the bladder. // J. Urol.-2002. -167(4). -P. 573-583.

207. Stein J.P., Lieskovsky, Groshen S. Radical cystectomy in the treatment of invasive bladder cancer: long-term results in 1054 patients. //J. Clin. Oncol. 2001. — 19(3). — P. 666-675.

208. Sternberg C.N., Pansadoro V., Calabro F. Neoadjuvant chemotherapy and bladder preservation in locally advanced transitional cell carcinoma of the bladder. //Ann. Oncol. — 1999. — 11. — P. 1301-1305.

209. Studer U.E., Stenal A., Manson W., Mills R. Bladder placement and urinary diversion//Eur. Urol. — 2000. — 38. — P.1-11.

210. Thurman S. A., De Weese T. L. Multimodality therapy for the treatment of muscle-invasive bladder cancer. Semin. //Urol. Oncol. - 2000. — 18 (4). — P. 313-322.

211. Traynelis C.L. Lamm D.L. Current status of intravesical therapy for bladder cancer //Urology Annual Vol 8, Stephen N. Rous (Ed.). W.W. Norton Company. — 1994 — P. 113-143.

212. Walker M.C., Masstera J.R., Parris, C.N. Intravesical chemotherapy in vitro studies on the relationship between dose and cytotoxicity. //Urol Res. 1996; 14. — P. 137-140.

213. Wientjes M.G., Badalament R.A., Wang R.C., Hassan F., Au J.L.Penetration of Mitomycin C in human bladder .//Cancer Res. — 1993.53. — P. 3314-3320.

214. Zietman A. L., Shipley W. U., Kaufman D. S. Organ-conserving approaches to muscle-invasive bladder cancer: future alternatives to radical cystectomy. // Ann. Med.-2000. — 32(l). — P. 34-42