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Features of the formation of attitudes towards the disease in patients

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Abstract. The purpose of this article is to reveal specific psychological and psychosomatic changes in patients with tuberculosis and the factors that affect them. The factors influencing the formation of patient's loyalty to treatment, the patient's personality and the mechanism of psychological influence during psycho-preventive work with the patient are analyzed.

Key words: dysfunction, internal picture of the disease, representation of the disease, stress, adherence to treatment.

Illness is a condition that is not only a set of objectively observable symptoms but also a manifestation of complex inner feelings and desires. Studying the psychology of a patient is of great practical importance. This is because a patient may experience emotional dysfunction and an increase in harmful behaviors, which can affect the treatment process and lead to a deterioration in the patient's quality of life.

Dysfunction (from Greek *dis* – difficulty, disorder, hopelessness, and Latin *function* – to perform, execute, act) is a concept that describes the type of relationship when the consequences of a phenomenon, action, or process are inconsistent.

In patients with pulmonary tuberculosis, psychological and psychosomatic changes lead to the manifestation of unusual characteristics in interpersonal relationships, actions, or thought processes. This condition is often associated with their internal cognitive thinking processes, the manifestation of their illness, the attitudes of those around them, and, of course, the difficulties of a long-term treatment process. In medicine, there are various perspectives on analyzing a patient's illness and the factors that contribute to it. In Russian psychology, the greatest focus is placed on the internal picture of the illness (R.A. Luria, V.V. Nikolaev, A.V. Kvasenko, Yu.G. Zubarev, A.Sh. Fostov), whereas in foreign psychology, this issue is analyzed within the framework of social theory (K. Herzlich). In the theory of cognitive representation, the representation (prototypes) of illness and ideas about health are examined [1].

Illness representation is a process related to how a patient perceives their illness, including its reinterpretation, initial emotional reactions at the time of diagnosis, and the subsequent modification of information due to various influences. For example, when patients first hear their diagnosis, they may experience distress. They actively participate in the processes related to their illness, reassessing their thoughts based on the attention from those around them, their attitudes toward the illness and treatment, and their overall experience. For tuberculosis patients, emotional support, accurate information about medication adherence, and confidence in the treatability of the disease help develop resilience and commitment to treatment. Similarly, for oncology patients, correct information about painless chemotherapy and its positive effects can shape a more optimistic perception. According to V.E. Kagan, the concept of the internal picture of illness is defined as *"our knowledge about health for ourselves"* (1993). He believes that for a patient to overcome illness, they must perceive health based on their individual characteristics. The most crucial aspect of illness is the quality of health. He also emphasizes that the internal picture of illness can manifest in a patient's behavior.

R.A. Luria, in his study of the internal representation of illness, discussed a patient's unique emotions, thought patterns, and overall condition, emphasizing that a person's intellectual and emotional levels also play a role in this process. Psychologists have examined this phenomenon and concluded that such changes do not occur spontaneously (Nikolaeva, 1987). A.V. Kvasenko and Yu.G. Zubarev introduced the term "somatonoagnosia" to describe these changes. They identified that different types of somatonoagnosia manifest differently depending on the patient's age and individual characteristics during illness[2].

Somatonoagnosia is a psychological characteristic of somatic health that determines an individual's attitude toward their health and shapes their perception of illness and related circumstances. The development of somatonoagnosia is influenced by a person's biological, psychological, and socio-psychological traits, which play a decisive role. Personal characteristics can either facilitate or hinder a patient's rehabilitation and adaptation to illness.

The biological level of somatonoagnosia involves analyzing the physiological indicators of the body's reaction to illness. These include:

-the strength, mobility, and balance of the nervous system

-the developmental features of the musculoskeletal system

-the specific characteristics of sensory functions [3]

These biological factors contribute to how a person perceives and copes with their illness. The psychological level is related to cognitive mental processes, mental characteristics, conditions, emotions, and, of course, the patient's willpower. Cognitive processes are the main regulators of a patient's behavior, while mental characteristics determine the quality and quantity of the reaction to illness and play a role in forming personal attitudes. Emotional states, in turn, are the foundation for the development of psychological processes and mental traits, manifesting in a person’s optimism or depression.

The socio-psychological level allows for the analysis of a person’s interactions with others and society as a whole. This level involves the active process of shaping social needs, interests, motives, and relationships. The essence of personal socialization is the formation of the inner world of an individual, developing a system of social relations and a general system of behavior in relation to the surrounding reality. In patients with tuberculosis, the main cause of the increased manifestation of depression is the variety of perspectives on the illness, a high level of self-doubt, communication barriers, and sometimes the adverse effects of medications they are taking. For these patients, a lack of adherence to treatment is often evident, with the following factors also influencing this:

A lack of interest in treatment or the presence of other priorities

A lack of desire to change lifestyle (long-term hospitalization)

A desire to overcome the illness independently without a doctor

Feeling well during treatment and considering themselves as healed

Fear of taking medications for tuberculosis or adverse reactions to previous tuberculosis medications

A desire to hide the illness from others

"Fatigue" from long-term treatment

These factors all play a significant role in shaping the patient’s behavior and attitude toward their illness and treatment [4]. At times, the lack of adherence to treatment may be due to the patient's psychological characteristics related to their illness:

Isolation, oppression, and depression associated with the feeling of being overwhelmed by the illness, leading to avoidance of others

Refusal to fight the illness, surrendering to it

Psychological disorders and depression related to the adverse effects of tuberculosis medications

Barriers to forming treatment adherence, which are significant contributors to the patient's "maladapted" behavior and decreased adherence to treatment, include:

A rapid improvement in condition with the start of treatment, and the disappearance of symptoms (leading to a false sense of recovery)

Stigmatization and personal stigmatization

Disorganization and poor memory among patients

Mental health deterioration

These personal characteristics complicate the patient's communication and relationships with others, potentially leading to additional stress, conflicts, and disruptions to an already weakened psychological adaptation system. Psychological disturbances are especially prevalent among first-time patients and those with chronic illnesses, as well as among men and women[5].

Unemployment or the loss of a job due to illness, social vulnerability, and a decrease in financial well-being lead to a decline in the patient's quality of life. In such cases, alongside material difficulties, patients may experience psychological depression and loss of self-confidence, which may cause them to refuse treatment or discontinue it, weakening their sense of responsibility toward their treatment. Some chronic tuberculosis patients attempt to avoid the problem by immersing themselves in work. In these situations, increased anxiety, heightened sensitivity to events related to themselves, and feelings of fear of new things and new people may occur.

Additionally, patients may develop a need for excessive attention toward themselves as a way to compensate for what they have lost due to their illness. This can lead to disruptions in their relationships with medical personnel.

In conclusion, it can be said that when conducting psychological rehabilitation for tuberculosis patients, it is essential to consider their psychological and psychosomatic changes, as well as social conditions. Key areas of focus include:

-accurate diagnosis of the patient’s social-psychological status;

-helping the patient prepare for the diagnosis and assist in developing constructive behavior;

-preventing inadequate acceptance of the illness and implementing proper correction methods for problematic situations;

-diagnosing difficulties that may arise in doctor-patient relationships and organizing seminars or group support activities;

-correcting emotional disturbances such as fear, stress, and depressive states in the patient;

-developing self-help skills in the patient;

-identifying and addressing factors hindering adherence to medications;

-conducting psychological educational work with the patient's family members, guiding them toward appropriate solutions for problematic situations.

These steps are crucial to improving the psychological well-being and treatment adherence of tuberculosis patients.

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