

Psychology of Patients with Diseases of the Nervous System

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Annotation: Psychology of patients with diseases of the nervous system. This article analyzes the impact of diseases of the nervous system on the personality and mental state of the patient. When the nervous system is disrupted, a person experiences mental changes, fear, depression, insecurity, and decreased motivation. The article highlights the patient's acceptance of the disease, his emotional reactions, and the importance of psychological support in the recovery process. It also shows the methods of psychological approach to patients with neurological diseases and the role of family, doctor, and psychologist cooperation in the rehabilitation process.

Keywords: nervous system, patient psychology, depression, stress, motivation, psychological support, neurology, rehabilitation.

Brain injuries are accompanied not only by varying degrees of neurological disorders, but also by psycho-emotional disorders. During and after brain injuries, along with neurological disorders, mental and emotional disorders are also observed. These disorders depend on the severity of the injury, its type, the patient's age, the presence of concomitant diseases, and other factors. Brain injuries often involve a concussion or a brain concussion. Most patients with brain injuries lose consciousness, and the extent of the loss depends on the severity of the injury. Usually, after the patient regains consciousness, memory impairment of varying degrees and types is observed. If the patient forgets the period before the brain injury after regaining consciousness, it is called retrograde amnesia; if memory is lost after the injury, it is called anterograde amnesia; if memory is sharply impaired both before and after the injury, it is called anterograde amnesia.

Post-traumatic Asthenia (cerebrasthenia). Cerebrasthenia is the most common syndrome observed after brain injuries. There is no clear statistical data on its incidence, since most patients with cerebrasthenia do not consult a doctor, and it is difficult to show that the patient's cerebrasthenia is directly related to the brain injury that the patient suffered. Cerebrasthenia consists of various subjective symptoms. These are irritability, irritability, irritability, impatience, mental fatigue, memory loss, sleep disorders, headaches, and other similar symptoms. In many cases, severe phobias develop after brain injuries. For example, patients injured in a car accident are afraid to go out into the street, cross pedestrian crossings, and even travel anywhere in motor vehicles, or they develop a fear of death.

Brain injuries can cause apathy. This condition, which is close to depression in terms of clinical symptoms, is sometimes difficult to correctly diagnose. Post-traumatic apathy is characterized by general numbness, lethargy, decreased interest in surrounding events and creativity in work, loss of desire, the patient abandons any work he has started or does not do it, although it is necessary. Mild specific memory disorders are observed. Post-traumatic apathy is sometimes manifested by mildly expressed vegetative and psychosomatic disorders.

Traumatic psychoses. Psychoses can be acute and chronic. Acute psychosis is usually observed in the first days of the injury and mainly in cases of brain contusion. Psychoses are especially pronounced if the frontal lobe of the brain is damaged. In these patients, computed tomography reveals signs of contusion or hematoma in the frontal region of the brain. Such patients need neurosurgical assistance.

Acute psychoses, which are observed due to damage to any part of the brain, are usually accompanied by neurological symptoms, i.e. paralysis, coordination disorders, symptoms of cranial nerve damage, etc. Disorders of higher mental functions, i.e. speech disorders, apraxia, agnosia, can also be observed. Such patients are in a serious condition and should be under the supervision of a neurosurgeon, neuropathologist or neuropsychologist.

In acute psychoses, varying degrees of mental disorders are observed, i.e. from confusion to stupor. In cases of confusion, communication with the patient is disrupted, he cannot answer questions clearly, his speech is broken and disorganized, and sometimes he talks incessantly (logorrhea). Logorrhea is mainly observed when the temporal lobe of the brain is damaged. In our observation, there was a patient who talked nonstop for 24 hours during the acute period of brain injury and was treated. After being given strong sleeping pills, he fell asleep and after waking up, he talked nonstop for several more hours. In this patient, logorrhea began to decrease on the 5th-6th day of the disease, because as the signs of brain damage decrease, logorrhea decreases. Therefore, at such times, it is necessary to prescribe all the medications that are prescribed in the acute period of the disease, not just sedatives, because, as we have already mentioned, logorrhea is a sign of local brain damage.

Korsakoff syndrome is an acute psychosis that develops after severe brain injuries, the clinical symptoms of which usually begin to appear after the patient regains consciousness. The main symptom of this syndrome is memory impairment. The patient cannot remember the events that have occurred. The patient cannot remember the days of the day, week, month, the names of the doctors (medical staff) treating him, and the place where he is lying. The patient is conscious, his communication with others is preserved, but his critical view of his condition is sharply reduced. Korsakoff syndrome lasts from several days to several months. This syndrome is especially severe in alcohol abusers. In Korsakoff syndrome, all types of memory, especially the stage of remembering, are impaired, so it is also called primary memory impairment. The duration of memory loss after brain injuries can vary, and in some cases, this period lasts for the rest of the patient's life. Even if memory recovery occurs, it may not be complete.

Traumatic psychoses In some types of psychosis, emotional disorders prevail over mental disorders. For example, an unreasonable elevation of mood, that is, euphoria, is not manifested in various forms, they talk a lot, they like to talk in detail about past injuries, how they survived, they are carefree. Usually, euphoria is characteristic of chronic psychoses. Sometimes a person who was previously generous and selfless becomes selfish and cruel after a brain injury.

Severe brain injuries, especially open injuries, are accompanied by seizures or severe vegetative paroxysms. Posttraumatic epilepsy usually develops several years after a brain injury. Jacksonian seizures, tonic-clonic seizures, and absence seizures, which develop with loss of consciousness, are especially common. Seizures, which are often accompanied by loss of consciousness, gradually become more frequent, and the patient begins to change his behavior pathologically.

Patients with traumatic brain injuries develop the phenomenon of “seen before” or “never seen before”. When patients appear in a place they have never been to before, everything seems familiar, or when they go to a place they have visited before and seen several times, everything seems unfamiliar, and everything and events seem unfamiliar. The mechanisms of this phenomenon have not been fully studied. Mental retardation also develops after traumatic brain injuries. According to statistics, this condition is observed in 5% of patients with injuries and is associated with damage to the forehead and temporal areas. In order to prevent mental disorders observed in traumatic brain injuries, it is necessary, first of all, to properly treat patients in the acute period of the disease. As is known, in the acute period of traumatic brain injuries, patients are admitted to neurosurgery or neurotraumatology departments. Sometimes patients are discharged from the hospital within 4-5 days. Upon discharge from the hospital, they should immediately be monitored by a neurologist, and in cases where mental disorders are detected, they should be monitored and treated by a psychiatrist.

Epilepsy is one of the most common diseases of the nervous system and has become a major medical and social problem. Epilepsy is a chronic disease of the brain accompanied by seizures, which are

manifested by motor, sensory, vegetative and mental disorders. The prevalence of epilepsy among the population is 7-10 per 1000 people. Since the disease has many etiologies, it can occur at different ages, but 75% of epilepsy begins before the age of 20. The incidence is almost the same in men and women. According to experts, at least 30% of patients with epilepsy have mental disorders. The etiology and clinical manifestations of epilepsy in most cases depend on the patient's age. For example, the cause of seizures observed in early childhood is hypoxia during the fetal and neonatal periods, viral infections.

Auras are also called heralds of epilepsy. A few hours before the onset of seizures, and sometimes a day or two before, the patient loses sleep, becomes anxious, becomes irritable, has swellings in some parts of the face or body, the corners of the lips begin to tremble. Usually, after these signs, a grand mal seizure begins. It is good that auras appear before a seizure. Because at such times, the patient takes himself to a safe place, his parents or he does not leave the house, if he has been in dangerous places, he moves to safe places, etc. Grand mal seizures without aura are life-threatening and are often accompanied by brain and body injuries. Because the patient does not know when the seizures are coming and cannot take himself to safe places.

Mental disorders in epilepsy

In epilepsy, patients experience mental disorders accompanied by varying degrees of behavioral changes. Unlike other mental disorders, in epilepsy, the patient's personality changes are characterized by their own uniqueness, as a result of which the term "epileptic behavior" has appeared in medical practice. Such patients are very stubborn, stubborn, impatient, easily offended, easily change their mood, get involved in trivial matters, quickly quarrel, talk nonsense and are irritable. Of course, these symptoms can be expressed in different degrees in a patient, and their severity depends on how often epileptic seizures are observed, the type of epilepsy and the patient's treatment. A patient who was in a good mood can suddenly change and begin to insult loved ones with harsh words. This happens when he cannot find something, when someone from outside interferes in his work and points out his mistakes, when he expresses an opinion that contradicts his opinion, etc. At such times, the patient quickly starts quarreling and fighting, sometimes a quarrel that has arisen over something trivial can rise to the level of affection and the patient can cause physical harm to himself or others. Therefore, doctors treating such patients should refer them to a psychiatrist. Therefore, a patient with epilepsy, which is accompanied by a sharp change in behavior, should be under the supervision of a psychiatrist and treated there.

Conclusion:

Nervous system diseases profoundly change not only the physical functioning of the body, but also the mental state of a person. Such patients experience psychological reactions such as fear, distrust, depression, irritability, and loss of interest in life. The patient's mental state is of great importance in the process of accepting, adapting to, and treating the disease.

Therefore, a psychological approach to the treatment of nervous system diseases is as important as medical procedures. Communication with the patient, providing emotional support, increasing motivation, and creating a positive mood accelerate the recovery process.

In conclusion, proper assessment of the psychological state of patients with nervous system diseases, providing them with individual psychological support, and establishing cooperation between the family and medical staff are integral parts of effective treatment.

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