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SOCIO-PSYCHOLOGICAL CHARACTERISTICS OF THE PERSONALITY OF FEMALE PATIENTS WITH ONCOLOGICAL DISEASES OF THE REPRODUCTIVE SYSTEM AND BREAST AT DIFFERENT STAGES OF DIAGNOSIS AND TREATMENT

Abstract

The issue of morbidity and treatment of oncological diseases of the female reproductive system and breasts represents an acute medical and social problem and warrants serious attention, as the number of such patients is steadily increasing. It has been established that the nature of the course of oncological disease is largely determined by the peculiarities of the patient's emotional reaction to the diagnosis (the internal picture of the disease), social support, and the specificity of the patient's relationships with their surroundings. Under the conditions of illness, an individual and unique attitude toward the disease, the new status as a patient and a sick person, is formed. Significant importance is attached to the subjective experiences of the patient, caused by a painful reaction to the disease course and the treatment process, as well as to family relationships and dynamics within the family. In this regard, the study of the main theoretical approaches to the personality of female patients with oncological diseases of the reproductive system and breast at various stages of diagnosis and treatment, both in domestic and foreign psychological literature, is considered a relevant problem for determining the content of therapy, rehabilitation, and psychological support for these patients.

Key words: oncology, psychology, rehabilitation, breast cancer.

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ДИАГНОСТИКА МЕН ЕМДЕУДІҢ ӘРТҮРЛІ КЕЗЕҢДЕРІНДЕ ҰРПАҚТЫ БОЛУ ЖҮЙЕСІ МЕН СҮТ БЕЗІНІҢ ҚАТЕРЛІ ІСІГІ БАР ӘЙЕЛДЕРДІҢ ЖЕКЕ БАСЫНЫҢ ӘЛЕУМЕТТІК-ПСИХОЛОГИЯЛЫҚ ЕРЕКШЕЛІКТЕРІ

Аңдатпа

Әйелдердің ұрпақты болу жүйесі мен сүт бездерінің онкологиялық ауруларының жиілігі мен лечения мәселесі өткір Медициналық және әлеуметтік проблема болып табылады және елеулі назар аударуды қажет етеді, өйткені мұндай науқастардың саны тұрақты түрде өсіп келеді. Қатерлі ісік ауруының сипаты көбінесе науқастың диагнозға эмоционалды реакциясының ерекшеліктерімен (аурудың ішкі көрінісі), әлеуметтік қолдауымен және пациенттің қоршаған ортамен қарым-қатынасының ерекшелігімен анықталады. Ауру жағдайында ауруға жеке және ерекше көзқарас, науқастың және науқастың жаңа мәртебесі қалыптасады. Науқастың аурудың ағымына және емдеу процесіне ауыр реакциядан туындаған субъективті тәжірибесіне, сондай-ақ отбасылық қатынастар мен отбасы ішіндегі динамикаға айтарлықтай мән беріледі. Осыған байланысты отандық және шетелдік психологиялық әдебиеттерде диагностика мен емдеудің әртүрлі кезеңдерінде репродуктивті жүйе мен сүт безінің қатерлі ісігі бар науқастардың жеке

басына негізгі теориялық тәсілдерді зерттеу терапияның мазмұнын анықтау, оңалту және әйелдерді психологиялық қолдау үшін өзекті мәселе болып саналады.

***Түйінді сөздер*:** онкология, психология, оңалту, сүт безі обыры.

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СОЦИАЛЬНО-ПСИХОЛОГИЧЕСКИЕ ОСОБЕННОСТИ ЛИЧНОСТИ ЖЕНЩИН С ОНКОЛОГИЧЕСКИМИ ЗАБОЛЕВАНИЯМИ РЕПРОДУКТИВНОЙ СИСТЕМЫ И МОЛОЧНОЙ ЖЕЛЕЗЫ НА РАЗНЫХ ЭТАПАХ ДИАГНОСТИКИ И ЛЕЧЕНИЯ

Аннотация

Вопрос заболеваемости и лечения онкологических заболеваний женской репродуктивной системы и молочных желез представляет собой острую медицинскую и социальную проблему и требует серьезного внимания, поскольку число таких пациенток неуклонно растет. Установлено, что характер течения онкологического заболевания во многом определяется особенностями эмоциональной реакции пациента на диагноз (внутренней картиной заболевания), социальной поддержкой и спецификой взаимоотношений пациента со своим окружением. В условиях болезни формируется индивидуальное и неповторимое отношение к болезни, новый статус пациента и больной личности. Значительное значение придается субъективным переживаниям пациента, вызванным болезненной реакцией на течение заболевания и процесс лечения, а также семейным отношениям и динамике внутри семьи. В связи с этим изучение основных теоретических подходов к личности пациенток с онкологическими заболеваниями репродуктивной системы и молочной железы на различных этапах диагностики и лечения, как в отечественной, так и в зарубежной психологической литературе, считается актуальной проблемой для определения содержания терапии, реабилитации и психологической поддержки женщин.

Ключевые слова: онкология, психология, реабилитация, рак молочной железы.

INTRODUCTION. Oncological diseases of the reproductive system and breast occupy one of the leading places among the causes of death in women, having not only a physiological, but also a profound psychological impact. Diagnosis and treatment of these diseases are accompanied by pronounced emotional experiences such as fear, anxiety, depression and impaired self-esteem. At each stage, from diagnosis to completion of therapy, a woman faces various socio—psychological difficulties related to the perception of her own body, the threat of loss of fertility and a change in social status. These features require special attention from psychologists, medical professionals, and loved ones. Studying the socio-psychological characteristics of women's personalities during such periods is important for creating effective support and rehabilitation programs aimed at maintaining the quality of life and adapting to new conditions.

Malignant neoplasms of the reproductive system and breast cancer represent not only a serious medical issue but also a significant psychological challenge for women, affecting the most sensitive aspects of their identity, self-esteem, and social roles. The experience of a life-threatening illness, loss of control over one’s body, reproductive function, and femininity leads to a complex set of emotional and personality reactions, which require thorough interdisciplinary investigation.

Particular importance is attached to the study of the socio-psychological characteristics of women facing an oncological diagnosis in the context of different stages of the disease — from the moment of initial diagnosis through treatment, remission, or transition to palliative care. These stages are marked not only by different medical characteristics but also by qualitatively distinct emotional states, levels of anxiety, coping strategies, and cognitive processing of information about the illness.

Contemporary research shows that such variables as resilience, basic beliefs about the world, locus of control, learned helplessness, and subjective quality of life vary significantly depending on the stage of the disease and the prognosis. Women passing through various phases of the oncological process demonstrate different patterns of psychological adaptation — ranging from active involvement in treatment and help-seeking behavior to passive avoidance, depression, or the development of paradoxically positive beliefs. At the same time, their social roles, interpersonal relationships, self-perception, and views of the future undergo substantial transformations.

Identifying the specific features of psychological functioning at each stage makes it possible not only to gain a deeper understanding of patients' inner experiences but also to develop more effective models of psychosocial support aimed at maintaining quality of life, restoring a sense of personal significance, and strengthening adaptive resources.

The present study aims to analyze the socio-psychological characteristics of the personality of women with oncological diseases of the reproductive system and breast cancer at various stages of diagnosis and treatment, in order to identify the factors that contribute to or hinder their successful adaptation to the illness and its consequences.

MATERIALS AND METHODS. The analysis of scientific articles on such databases as PubMed, Google Scholar, Cyberleninka, Scopus was carried out. 35 articles were selected, 22 of them were used as reference materials. 13 articles were not included due to loss of relevance and outdated data.

RESULTS AND DISCUSSION. The key objective of the conducted literature review is the need for a comprehensive examination of the psychological functions of patients with breast cancer at various stages of the disease. On the one hand, psychological characteristics of women diagnosed with oncological diseases of the breast and reproductive system may act as factors potentially influencing the course of the illness. The course of the disease is understood as the progression of the tumor and the clinical manifestations over time, including the effects of medical treatment. In the present study, this aspect is considered through the lens of disease outcomes—favorable (remission) or unfavorable (tumor progression)—depending on the individual psychological characteristics of the patient [1].

On the other hand, the specifics of the illness at different stages—for instance, during remission or in stage IV—may contribute to the manifestation of particular psychological traits, which can be interpreted as personal adaptive resources in response to the cancer diagnosis. These psychological features also influence patients' subjective evaluation of their quality of life, particularly in those with breast and reproductive system cancers [2].

An analysis of one study involving a sample of 186 Russian women diagnosed with stage I–III breast cancer revealed a statistically significant positive correlation between quality-of-life indicators and variables such as core beliefs, resilience, and locus of control across various areas of life [3].

The psychological parameters associated with the course of oncological illness in this study include cognitive traits (e.g., locus of control, core beliefs, life orientations, and resilience), systemic personality characteristics (such as the degree of personal helplessness), behavioral strategies (coping behavior), and prognostic indicators potentially linked to life expectancy (such as overall quality of life and subjective age). It is assumed that this set of psychological variables offers a comprehensive representation of an individual's adaptive potential in coping with a life-threatening medical condition[4].

An analysis of literary sources concerning the socio-psychological characteristics of female patients with endometrial cancer (EC) and breast cancer (BC) at various stages of diagnosis and treatment has been conducted.

According to data obtained in a study led by S. Sanjida, the highest levels of anxiety among women diagnosed with endometrial cancer were observed prior to surgical intervention: 16% of participants exhibited clinically significant anxiety, while an additional 19% demonstrated subclinical levels. Subsequently, during the course of treatment, anxiety levels gradually declined. Six months post-surgery, anxiety disorders persisted in only a minority of patients—approximately 11% with clinically significant anxiety and 10% with subclinical symptoms [5]. Mean anxiety scores decreased from 6.6 to

3.6 points. Conversely, depressive symptoms peaked one week after surgery, declining from 3.6 to 2.1 points over a six-month period. Three years following diagnosis, depressive symptoms were still present in 15% of endometrial cancer patients—more than twice the rate observed in the control group. Research also indicates that during the first year after diagnosis, the risk of being prescribed antidepressants was twice as high as in healthy women and remained elevated for up to five years. These statistics underscore the high vulnerability of the psychoemotional state in women with gynecologic malignancies, including the impact on their sexual and emotional well-being [6].

The removal of reproductive organs due to malignant neoplasms in women of reproductive age is often accompanied by consequences affecting body image, self-confidence, and intimate relationships. For instance, in a domestic study employing the Female Sexual Function Index (FSFI), all patients reported difficulties in their intimate lives within the first week after surgery. These difficulties were attributed to both preoperative stress and the immediate physiological and psychological effects of the intervention[7]. The findings are consistent with international data, which report that sexual dysfunction following gynecologic oncology surgery ranges from 61% to 97%. Moreover, more than half of surveyed women did not resume sexual activity after treatment. In a study conducted by N. Gao and colleagues, nearly 90% of patients reported deterioration in sexual function, including painful intercourse. Similar conclusions were drawn in a publication by V. Karataşlı, where the incidence of such disorders reached 94.5%, and the average sexual function score was low (16.7 ± 8.5 points). The participants' mean age was 56 years, with follow-up durations ranging from one year to two decades post-surgery [8].

Our results align with global literature, confirming the high prevalence of psychoemotional disorders among endometrial cancer patients. Our therapeutic approach to managing anxiety and depression was based on the need for a comprehensive strategy, as these conditions constitute major obstacles to patients' social reintegration and return to normal life. The outcomes of our study are consistent with both international and national data indicating that one of the most effective methods for addressing psychoemotional disturbances is a combination of group and individual psychotherapy sessions [10].

For a long time, the issue of sexual adaptation in women after oncogynecologic treatment remained outside the focus of clinicians. Only in recent years has there been a surge of interest in this area, as reflected in scientific literature and international clinical guidelines. There is now growing emphasis on the importance of timely diagnosis and a comprehensive approach to addressing sexual difficulties that arise in women following treatment for gynecologic cancers. However, in practice, many patients continue to face a lack of appropriate support[11]. Key barriers include personal factors such as embarrassment or discomfort, as well as systemic issues like lack of information and insufficient training of medical personnel in this field. As a result, intimate problems often go unaddressed, which can negatively affect women's psychoemotional health and significantly reduce overall quality of life. All these qualities are important factors in determining the socio-psychological characteristics of cancer patients [12].

According to Russian studies, the disease of BC creates a crisis situation for the individual, leading to a change in the patient's life position. In the preoperative period, the predominant motives are the preservation of health and survival, as well as "completion of affairs and securing the future of their children." After surgery, the focus shifts to issues of social survival. Such patients may develop a sense of lost femininity, which, in turn, leads to feelings of inferiority and inadequacy [13]. Patients experience fear of possible social isolation and family breakdown. Women who have undergone mastectomy often exaggerate the cosmetic consequences of the surgery and emphasize the perceived change in the attitude of those around them [14].

Although existing literature highlights differences in the psychosocial perception of a breast cancer diagnosis across different stages of a woman's life, there remains a limited number of studies directly comparing the psychosocial experiences of younger and older patients. In particular, one reviewed study focused solely on a single age group without providing comparative data across age categories.

Available evidence suggests that younger women diagnosed with breast cancer are at greater risk for anxiety and depressive disorders compared to their older counterparts. Furthermore, they tend to express more concern regarding career prospects and financial stability. Young patients also tend to report lower quality of life, which may be attributed to decreased emotional well-being, pronounced cancer-specific challenges, depressive symptoms, and intrusive thoughts [15].

In contrast, older women more frequently face somatic complications that negatively impact survival rates, regardless of chemotherapy treatment. Overall, older breast cancer survivors demonstrate better mental health and subjective quality of life compared to younger patients; however, their physical condition and health-related quality of life are often poorer due to the presence of comorbidities. Low income is another significant risk factor for psychosocial distress, particularly relevant for older women, who are more likely to be on fixed financial resources. Nevertheless, the literature points to a higher degree of psychosocial adaptation among older women with breast cancer. This may be associated with their broader life experience, including prior interaction with the healthcare system, exposure to cancer diagnoses in others, and fewer competing life demands. These factors are thought to contribute to more effective coping mechanisms and adjustment to illness among older women.

In studies of early-stage adjustment to a breast cancer diagnosis, identity-related concerns have been found to play a key role. The illness represents a threat to one's self-coherence, and the integration of the cancer experience requires the reconstruction of one’s self-image and the formation of a revised personal narrative, a process described in the literature as “meaning-making”. However, differences in identity formation and meaning-making processes between younger and older women in the context of cancer remain underexplored. It is known that, for younger women, the diagnosis is often a shocking experience that raises existential concerns about mortality, whereas older women are more likely to perceive the illness as part of the natural aging process.

The topic of body image occupies a central place in breast cancer research. Body image disturbance is frequently associated with physical changes such as alopecia, breast disfigurement, and weight fluctuations. Data indicate that younger women are more likely to seek restoration of their physical appearance following mastectomy, including undergoing reconstructive surgery. However, significantly less is known about body image perceptions among older patients. Some findings suggest that body dissatisfaction may even be greater among older women, possibly due to persistent limitations in physical functioning[16].

The diagnosis and treatment of breast cancer affect not only the patient herself but also her family system. This includes changes in marital, parental, and intergenerational relationships. Partners tend to reorganize family roles and compensate for increased household responsibilities, particularly during active treatment. The emotional well-being of children is influenced by the nature of their interactions with their mother, with positive involvement being associated with improved family climate. Conversely, maternal mood disturbances and marital tension may adversely affect children. Parents of women diagnosed with breast cancer also experience emotional challenges, as they must come to terms with their daughters' serious illness.

In the course of a comparative analysis conducted by Russian researchers, statistically significant differences were identified between women in remission and those diagnosed with stage IV breast cancer across several psychological indicators. Notable distinctions were found in the levels of basic beliefs, perceived quality of life, personal helplessness, locus of control, and resilience[17].

Of particular interest is the finding that both groups demonstrated high scores on the basic belief scales “Benevolence of the World” and “Luck.” This suggests the presence of a stable worldview among patients, characterized by a perception of the environment as safe and a belief in one’s own capacity to overcome life’s challenges. However, women with stage IV breast cancer exhibited significantly higher scores on the “Luck” scale compared to those in remission. This may be interpreted as a specific psychological adaptation mechanism to advanced illness. A persistent belief in luck and the safety of the world may enable terminally ill patients to mobilize internal psychological resources in response to a limited therapeutic outlook.

This phenomenon may be explained by the nature of disease perception at stage IV, which is typically more predictable, with patients being well-informed about treatment options and prognosis. Such awareness likely contributes to the development of specific positive beliefs aimed at maintaining psychological stability. As noted by Padun and Kotelnikova (2012), referencing the studies of Tedeschi and Calhoun (1996), successful coping with traumatic experiences may lead to the strengthening of positive beliefs beyond pre-trauma levels.

For women in remission, elevated assessments of luck may be associated with the temporary stabilization of the disease and the emergence of hope for a favorable outcome.

Additionally, the analysis revealed significant intergroup differences in two components of quality of life: role functioning due to physical health (RP) and role functioning due to emotional health (RE). In both domains, patients with stage IV breast cancer exhibited below-average scores, indicating substantial limitations in daily functioning as a result of both somatic and emotional distress. These findings underscore the importance of a comprehensive approach to psychological support for cancer patients at advanced stages, with emphasis on restoring a sense of personal control, enhancing resilience, and facilitating adaptation to altered life circumstances.

A study of the level of trust among patients with breast cancer was conducted by Russian researchers at the Central Clinical Hospital No. 2 named after N.A. Semashko of JSC "Russian Railways." The "Trust in Physicians" questionnaire, developed by A.J. Mitchell (2007) and adapted for the domestic context by N.A. Sirota and D.V. Moskovchenko (2012), was used as the research method. Despite a substantial body of research on treatment compliance among breast cancer patients, the psychological and social factors influencing adherence remain insufficiently explored. It is crucial to consider individual personality traits of women facing cancer diagnoses, as well as the broader social context of their lives [18].

According to Robert’s concept, high quality of life is determined by an individual’s subjective perception and includes mental well-being and a sense of social responsibility. These factors form the psychological structure of personality: the ability to experience joy, cognitive complexity, a sense of autonomy and efficacy, self-awareness, adequate self-esteem, ease in establishing interpersonal relationships, ethical orientation, and the pursuit of productivity and self-actualization. All of these characteristics play a key role in defining the psychosocial profiles of oncology patients.

Russian studies indicate that a breast cancer diagnosis constitutes a crisis that drastically alters patients’ outlook on life. In the preoperative period, motives related to survival, health preservation, and completion of meaningful life goals (e.g., securing their children’s futures) predominate. After surgery, the focus shifts toward issues of social adaptation. Patients frequently experience a loss of femininity, accompanied by feelings of deficiency and inadequacy. Fears of social isolation, family disruption, and exaggerated concerns about cosmetic consequences and altered social perception often arise.

A study of trust levels among breast cancer patients conducted at the Central Clinical Hospital No. 2 named after N.A. Semashko (Russian Railways), using the “Trust in Physicians” questionnaire (A.J. Mitchell, adapted by N.A. Sirota and D.V. Moskovchenko), revealed a generally high level of trust in medical personnel. However, certain situations triggered a sharp decline in trust. Even minor incidents, such as nuances in communication with physicians, changes in physical condition, or intrafamily conflicts, were significant triggers. This heightened sensitivity can lead to non-adherence or even complete rejection of treatment due to changes in cognitive evaluation of the disease [19].

For oncology patients, constructive cognitive acceptance of illness is a critical factor in adaptation. It involves perceiving the diagnosis as a challenge, accepting limitations, and believing in one’s ability to cope with treatment outcomes. Conversely, patients unable to accept their illness are prone to marked emotional distress. Studies confirm a connection between feelings of helplessness and reduced survival. Acceptance of illness as a form of cognitive processing helps alleviate psychoemotional tension and strengthens personal adaptive resources.

In one study, the most prevalent cognition among patients was “acceptance of illness” (16.62 ± 4.55), compared to “perceived benefits” (14.84 ± 3.88) and “helplessness” (13.78 ± 3.47). This suggests

a predominance of an adaptive coping style and a desire to overcome disease-related challenges. Meanwhile, worldview shifts that emerged during illness played a secondary role, and cognitions related to loss of control were less pronounced.

An analysis of anxiety among female patients with breast cancer undergoing chemotherapy demonstrated that a subclinical level of anxiety prevailed (8.42 ± 3.22). No reliably expressed symptoms of anxiety were identified in 36% of patients, while in 52% the level of anxiety corresponded to subclinical values. Clinically significant anxiety was observed in 10% of those surveyed. Depression with clinical manifestations was also identified in 10% of patients, while subclinical depression was noted in 22% (see Fig. 1) [20].

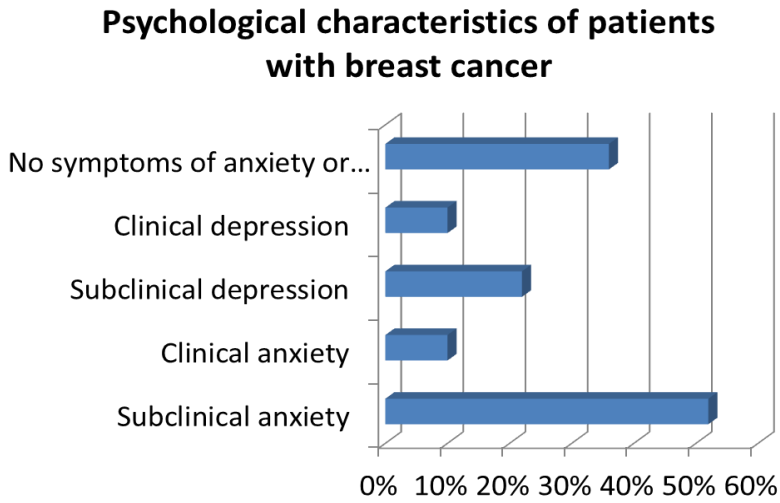

Figure 1. Psychological characteristics of patients with breast cancer

An investigation into anxiety levels among patients undergoing chemotherapy showed a predominance of subclinical anxiety (8.42 ± 3.22). Anxiety symptoms were absent in 36% of patients, subclinical in 52%, and clinically significant in 10%. Comparable results were observed for depression: 10% of patients experienced clinical depression and 22% had subclinical symptoms.

Higher levels of depression were noted in patients with pronounced “helplessness” cognition. This supports the notion that subclinical anxiety can have a mobilizing effect and promote treatment adherence. According to V.M. Yaltonsky (2010), anxiety in response to illness can stimulate behavioral activity and adherence to therapy. In contrast, depression and a focus on helplessness and distress often lead to non-compliance.

Fear of disease progression is one of the primary stressors in breast cancer. Research shows that 40% of patients experience high levels of fear of recurrence, while 60% report only moderate levels.

Long-term observations, such as a 20-year study by C. Burgess, have shown that stress may negatively impact life expectancy. However, an analysis of data from 359 cancer patients by E. Raimbault did not find a direct correlation between psychosocial factors and survival or time to recurrence. In contrast, studies by K.W. Pettingale and colleagues demonstrated that psychological responses to diagnosis—such as denial of hopelessness and manifestation of a “fighting spirit”—directly correlated with higher survival rates and the absence of recurrence.

Anxiety disorders, including specific phobias, are frequently observed in oncology patients. A particularly notable concern is the fear associated with chemotherapy-induced nausea and vomiting (CINV). These responses often develop through mechanisms similar to those of classical phobias and can significantly worsen the patient's overall emotional state.

Among the disorders resulting from psychological trauma or chronic stress, post-traumatic stress disorder (PTSD) and its subsyndromal forms are of particular relevance. These conditions affect a significant proportion of cancer patients, including long-term survivors who have been in remission for five years or more. When analyzing PTSD in the context of oncology, it is important to consider that

stressors are often prolonged rather than acute, which challenges the adequacy of conventional PTSD diagnostic criteria, typically based on acute, time-limited trauma exposure, in capturing the clinical reality of cancer-related PTSD[21].

Adjustment disorders represent one of the most prevalent psychiatric conditions in oncology. They reflect the emotional and behavioral responses to multiple stressors associated with the disease and its treatment. These disorders frequently involve overlapping anxiety and depressive symptoms. However, the diagnosis of adjustment disorders is often complicated by low specificity of diagnostic criteria, difficulty in distinguishing pathological responses from normative distress, and ambiguity regarding symptom duration.

Somatic symptom disorders and somatization phenomena play a crucial role in the psychological well-being of oncology patients, particularly in the long term. Patients' perception and interpretation of bodily sensations significantly influence their general well-being, levels of anxiety, and health-related behaviors. Somatic complaints such as pain may be exacerbated by anticipatory anxiety and dysfunctional beliefs, leading to increased disability, reduced treatment adherence, poorer prognosis, and diagnostic confusion—especially in differentiating depression from somatoform disorders.

Neurocognitive disorders associated with cancer and its treatment encompass a wide spectrum, ranging from mild cognitive impairment to severe delirium. These conditions may result from the neurotoxic effects of chemotherapy or radiation therapy, particularly when the central nervous system is involved. Deficits in memory, attention, concentration, learning ability, numerical processing, and spatial perception occur in patients with both brain metastases and primary brain tumors. Additional manifestations may include personality changes, speech impairments, and higher-order cognitive deficits, such as aphasia, alexia, agnosia, and apraxia.

Delirium deserves particular attention as one of the most common acute neurocognitive disturbances in terminal cancer patients, with reported prevalence ranging from 10% to 80%, depending on disease stage. The hypoactive subtype is especially frequent and often underrecognized, despite its profound impact on quality of life and the necessity for specialized care.

Beyond these described disorders, several clinical states do not always conform to traditional diagnostic frameworks but exert a significant impact on the patient's mental health. These include existential distress, demoralization, health anxiety, irritability, and diagnosis denial. For example, demoralization, characterized by feelings of helplessness, loss of meaning in life, and inability to cope, is associated with high levels of suffering, reduced physical activity, restricted interpersonal relationships, and an increase in suicidal ideation. Such conditions require a comprehensive and nuanced approach within the scope of psycho-oncological care.

Sexual dysfunctions are also highly prevalent among cancer patients, affecting both men and women. In women treated for gynecological cancers, common issues include decreased libido, arousal difficulties, orgasmic disorders, vaginismus, and dyspareunia. Among men treated for prostate or testicular cancers, the most frequent problems are erectile dysfunction, anxiety, reduced sexual desire, and ejaculatory disorders. These dysfunctions may stem from physiological consequences of treatment (e.g., surgery, hormonal imbalance, stoma placement) as well as psychological factors, including body image disturbances, anxiety, and distress related to the loss of bodily control [22].

The psychological characteristics of women with oncological diseases of the reproductive system and breast have a significant impact not only on their self-perception but also on the quality of family relationships. Emotional instability, heightened anxiety and depression, fear of losing femininity and reproductive function can lead to emotional withdrawal from partners, reduced sexual activity, and communication difficulties. Many women experience guilt toward their loved ones and avoid open conversations, which further deepens emotional distance. On the other hand, family support can be a crucial resource for adaptation and psychological recovery. Thus, the nature of family interactions largely depends on the patient's ability to express emotions, accept help, and maintain trust in relationships. These aspects should be taken into account when developing psychological support and intervention programs.

CONCLUSIONS. The identified psychological characteristics of the personalities of female patients with oncological diseases of the reproductive system and breast, at various stages of diagnosis and treatment, have defined the content of therapy, rehabilitation, and psychological support aimed at the socialization and return of patients to a fulfilling life.

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