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**FEATURES OF THE PSYCHO-EMOTIONAL SPHERE IN COMORBID PATHOLOGY**

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**Annotation.** The relevance of the problem of comorbidity of somatic pathology for medical science and practical healthcare is increasing every year. The article is devoted to the results of the study of the psycho-emotional sphere in comorbid pathology. The study included 68 patients, including 38 women, 30 men aged 20 to 60 years, the average age of 48.6 ± 2.1 years. Clinical-psychopathological, experimental-psychological, psychodiagnostic research methods were used in the work. Test questionnaires were used: hospital Anxiety and Depression Scale (HADS), Hamilton scale for determining anxiety (HARS), Hamilton scale for determining depression (HDRS); the FPI personality questionnaire and the TOBOL questionnaire were used to assess personality traits and types of attitude to the disease; the Dutch DQEB questionnaire was used to assess eating behavior. All participants of the study got acquainted with its goals and objectives, signed an informed consent for personal participation. The obtained data were processed statistically using the computer program "Statistica 10.0" with the use of para- and nonparametric criteria. As a result of the study, quantitative estimates of indicators for assessing the characteristics of the psychological status and eating behavior of patients with dyspepsia syndrome and in combination with metabolic syndrome were obtained. The results obtained show that the majority of patients with dyspepsia syndrome have significant changes in the state of the psycho-emotional sphere, including personality traits predisposing to neuroticism and stress response, maladaptive types of attitude to the disease, clinically manifested affective disorders, a reduced number of positive emotions, a pessimistic attitude towards the future, which limit their daily work and everyday life. activities that reduce the quality of life, what is most pronounced in patients with dyspepsia syndrome in combination with metabolic syndrome. The expediency of a comprehensive examination of patients with dyspepsia syndrome and metabolic syndrome is explained by the possibility of implementing a differentiated individual approach in the treatment of such patients, which will contribute to a qualitative increase in the effectiveness of therapeutic and preventive measures.

**Keywords:** psychoemotional sphere, eating behavior, metabolic syndrome, dyspepsia syndrome, comorbid pathology.

**Relevance.**

According to statistics, diseases of the cardiovascular system occupy the 1st, digestive organs - the 4th place in the world in terms of epidemiology, impact on disability and mortality. According to statistics, one of the most common at present are dyspepsia syndrome and metabolic syndrome (up to 40% in the population) (Lyalyukova E.A. et al., 1918; hunt P et al., 2019), including overweight or obesity, hypertension, dyslipidemia and insulin resistance

According to the WHO Commission of experts, by 2025 there will be more than 3 billion people in the world. obese patients. In the countries of the European region of the World Health Organization (WHO), 30-80% of adults and up to one third of children suffer from overweight problems. In the summary of the WHO European Commission on Obesity (2007) “The problem of obesity in the WHO European region and its solution strategy”, it is noted that the obesity epidemic in Europe is an unprecedented health problem, which is also underestimated, poorly studied and not fully understood as a state problem with significant economic consequences (Tutelyan V.A., 2019). According to the forecasts of WHO experts, by 2020 depression will occupy one of the leading places in the overall structure of morbidity. Both dyspepsia syndrome and metabolic syndrome are closely related. Each of these diseases aggravates or provokes the course of the other. Due to the complex interweaving of their symptoms, the commonality of many manifestations, a significant part of depressions is not recognized. In hospitalized cardiological patients, anxiety hypochondriac reactions are detected in 28.2%, somatized - in 3%, anxiety-phobic - in 2.9%. According to A.B. Smulevich, 67.2% of cardiac patients need psychotropic drugs (A.B. Smulevich, 2003). Of these, 19.7% need to prescribe antidepressants from the group of selective serotonin reuptake inhibitors (afobazole, citalopram, etc.). In the treatment of both dyspepsia syndrome and metabolic syndrome, unresolved problems remain (Izmailova O.V., 2018; Romanova M.M., 2010, 2012, 2021; Chernov A.V., 2021): ensuring stable and persistent remission, prolongation of the relapse-free period, reduction of temporary disability, disability, unsatisfactory quality of life of patients.

**Problem statement.**

Currently, there is a contradiction between the existing recommendations for the diagnosis and treatment of dyspepsia syndrome (Kareva E.N., 2017; Lazebnik L.B., 2018; 2017 Yange E. Ya.,), when antidepressants and anxiolytics are the drugs of choice only when therapy is ineffective. In addition, the urgency of the problem of comorbidity of somatic pathology increases every year. In practical healthcare, both general practitioners and district therapists, as well as narrow specialists, are constantly faced with a whole "bouquet" of combined pathology in a particular patient. Hence the need for a syndromic approach, the complexity of differential diagnosis at the stages of diagnostic search, and, accordingly, difficulties in the selection and selection of medicines: on the one hand, the standards of medical care, on the other hand, the risk of polypragmasia.

Continuous interaction of psychological, biological and social factors with each other and an increase in the probability of stabilization of painful disorders, a steady increase in dyspepsia syndrome, hypertension and obesity in the population, unsatisfactory treatment results: an increase in complications, prolonged and subclinical forms with a continuously recurring course, an increase in cases of temporary and persistent disability, unsatisfactory quality of life determine the relevance of the present research. The need for simultaneous assessment of somatic and neuropsychiatric manifestations of the disease, the state of adaptive regulatory systems and their correction and improvement of the quality of life of patients with dyspepsia syndrome in combination with metabolic syndrome dictate the demands of practical healthcare (Romanova M.M., 2014). All these factors require clarification and addition of standard approaches to the examination and development of tactics for the management of such patients. The study and evaluation of the features of the psycho-emotional sphere and eating behavior of patients with functional and organic dyspepsia syndrome and in combination with metabolic syndrome seem relevant to us. .

**Methods and materials.**

We observed 68 patients with dyspepsia syndrome (36 women and 30 men) aged 20 to 60 years (mean age 48.6±2.1) with dyspepsia syndrome. The control (1st) group consisted of 16 practically healthy patients. The criteria for inclusion in the study were: age - 20 - 65 years; the presence of dyspepsia syndrome; the absence of mental, infectious diseases and diseases in the decompensation stage. All patients were divided into two groups: the 2nd - with dyspepsia syndrome (24), the 3rd - with dyspepsia syndrome and metabolic syndrome (44). The two groups were comparable in gender, age, duration and severity of dyspepsia syndrome. All patients underwent a general clinical examination according to the "Standards for the Diagnosis and Treatment of diseases of the digestive system", including clinical, biochemical and instrumental research methods to verify the diagnosis. Clinical-psychopathological, experimental-psychological, psychodiagnostic research methods were used in the work. To assess the symptoms of anxiety and depression, test questionnaires were used: hospital Anxiety and Depression Scale (HADS), Hamilton Scale for determining anxiety (HARS), Hamilton Scale for determining depression (HDRS). When interpreting the data, the total score on all questions was taken into account, which determined the severity of the disorders: 0-7, 0-6 and 0-8 points (respectively on the above scales) – the absence of symptoms of anxiety and depression; 8-10, 7-15 and 8-20 (respectively) - subclinically expressed signs of anxiety and depression; >11, > 16, > 20 (respectively) - clinically expressed anxiety and depression. To assess personal characteristics and types of attitude to the disease, the personal questionnaire FPI (Krylov A.A., 1990) and TOBOL were used. The Dutch DQEB questionnaire was used to assess eating behavior, and questionnaires No. 1 and No. 2 were used to assess eating habits.2. All participants of the study got acquainted with its goals and objectives, signed an informed consent for personal participation. The obtained data were processed statistically using the computer program "Statistica 10.0" with the use of para- and nonparametric criteria (p<0.05).

**The results of the study.**

The results of the questionnaire on two scales for assessing anxiety and depression as competing are analyzed. According to the Hamilton scale of anxiety - 14.8± 2.8 and 15.25± 2.8, respectively, according to the Hamilton scale of depression – in the 2nd group 15.0± 2.8 and in the 3rd - 15.5 ±1.2, according to the hospital scale of anxiety and depression, the average score in the 2nd group was 15.1 ± 1.5, in 3rd - 18.5±1.8. Thus, comparable data were obtained on two scales, the differences are unreliable. Each of the studied groups was heterogeneous in the degree of severity of anxiety-depressive disorders. Statistical processing of the data obtained on the hospital scale of anxiety and depression revealed that 34% of patients in group 2 and 54.3% in group 3 had clinically expressed anxiety and depression; 48.1% and 35.5% (respectively) had indicators from 8 to 10 points, which corresponds to subclinically expressed signs of anxiety and depression; 17.9% and 10.2% of respondents (respectively) scored from 0 to 7 points, which indicates the absence of anxiety and depression. The same trend (more than half of the patients in group 3 had clinically pronounced signs of anxiety and depression) was observed when analyzing the data separately on the scales of anxiety and depression. It was found that with an increase in BMI, the degree of severity of affective disorders increases and the differences are significantly significant (p" 0.05). Thus, in group 3, in patients with dyspepsia syndrome in combination with metabolic syndrome, affective disorders, violations of personal characteristics and types of attitudes were more significant.

When analyzing the results of the questionnaire according to the FPI questionnaire, it was found that the severity of some indicators differed from the average values: in group 2 patients, a high level of personal neuroticism was revealed (scale 1), the presence of signs characteristic of psychopathological depressive response (scale 3), a decrease in the need for communication (scale 5), as well as predisposition to stress response to ordinary life situations, proceeding according to the passive-defensive type (scale 8), and in group 3 patients, in addition, a high level of emotional lability (scale 11) of shyness (scale 8) was noted. At the same time, in both the 2nd and 3rd groups of patients, the severity of most personal characteristics - spontaneous and reactive aggressiveness, irritability, balance, extraversion - introversion did not go beyond the average standard estimates.

According to the analysis of the TOBOL questionnaire data, in both groups 2 and 3, neurasthenic and hypochondriacal types of attitude to the disease were most common. Egocentric and anxious types were also widely represented in group 3. Next in frequency of occurrence were ergopathic, obsessive-phobic, apathetic and sensitive types. Paranoid, harmonious and melancholic types of attitude to the disease were less widely represented. The most rare were euphoric and anosognosic types of attitude to the disease.

In the study of the type of eating disorder (PP), it was found that 34% and 26% of patients in groups 2 and 3 (respectively) had external eating behavior. They showed an increased reaction to external stimuli, such as a set table, food advertising, etc. This type of PP is characterized by the fact that people eat regardless of when they last took food, they always eat when they see food, when food is available. Emotionogenic eating behavior was observed in 28% and 68% of the examined patients from groups 2 and 3. This type of PP is characterized by a hyperphagic reaction to stress and emotional overeating, with it, the stimulus to eating is not hunger, but emotional discomfort. Finally, 38% of the 2nd group and only 6% of the 3rd group of examined patients had a restrictive type of PP.

As for the study of eating habits, the ratio of fat and vegetable food intake indicated excessive consumption of fatty foods and insufficient consumption of vegetable among all examined patients of both group 2 and group 3. Moreover, with an increase in BMI, this coefficient increased.

More than half of the patients (57%) noted the presence of pain of a constant degree of severity. The rest of the patients noted the dynamics of pain sensations during the day. Moreover, 53% rated the pain as moderate, 22% as severe, 20% as mild, and 5% of the examined patients had very severe pain.

**Discussion of the results.**

During the correlation analysis, correlations of moderate severity were revealed among various groups of patients. There are a number of correlations between individual symptoms of anxiety and depression and overall scores in the studied groups according to the HADS and HARS questionnaires, between the quality of pain and patients' complaints about mental state (k = 0.64-0.72), between the intensity and quality of pain, complaints and types of attitude to the disease in patients, in a number of cases are reliable (p<0.05).

The results obtained show that the majority of patients with dyspepsia syndrome have significant changes in the state of the psycho-emotional sphere, including personality traits predisposing to neuroticism and stress response, maladaptive types of attitude to the disease, clinically manifested affective disorders, a reduced number of positive emotions, a pessimistic attitude towards the future, which limit their daily work and everyday life. activities that reduce the quality of life, which is most pronounced in patients of group 3, in whom dyspepsia syndrome was combined with abdominal obesity. The data obtained indicate the presence of a predominantly restrictive type of eating behavior in patients with dyspepsia syndrome and the predominance of an external and emotionogenic type in patients with dyspepsia syndrome in combination with metabolic syndrome.

**Conclusion.**

Summarizing the results of the study, it can be stated that as a result of the study, quantitative estimates of indicators for assessing the characteristics of the psychological status and eating behavior of patients with dyspepsia syndrome and in combination with metabolic syndrome were obtained. It was found that the most pronounced changes in the studied characteristics are present in patients with dyspepsia syndrome in combination with metabolic syndrome. It was found that correlations were revealed between individual indicators. In accordance with the data obtained, it is concluded that such patients need to correct the corresponding characteristics by developing a comprehensive differentiated therapy. The obtained data suggest the presence of significant mutual influences of changes in the psycho-emotional sphere, psychosomatic and clinical features of patients with dyspepsia syndrome and in combination with metabolic syndrome, which requires further study and search for ways of correction. Thus, the expediency of a comprehensive examination of patients with dyspepsia syndrome and metabolic syndrome is explained by the possibility of implementing a differentiated individual approach in the treatment of such patients, which will contribute to a qualitative increase in the effectiveness of therapeutic and preventive measures.

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