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PRIORITIES OF MENTAL AND PHYSICAL HEALTH PROBLEMS IN INTERNIST'S PRACTICE

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ABSTRACT

The article presents data on mental disorders that accompany the pathology of patients in somatic clinics. The clinical classification of mental and psychosomatic disorders in general medicine, despite the polymorphism of psychopathological and somatic manifestations, is represented by fairly well-defined forms of pathology.

KEYWORDS: *Psychosomatics, Somatic Pathology, Comorbidity, Anxiety, Depression.*

INTRODUCTION

Psychosomatic diseases are a group of diseases that are manifested by bodily suffering (that is, symptoms of diseases of the internal organs), but their main cause still lies in malfunctions of the nervous system. These include a whole range of gastrointestinal disorders (functional gastric dyspepsia and irritable bowel syndrome), fibromyalgia (a specific pain syndrome in the projection of the joints), hyperventilation syndrome (a feeling of lack of oxygen and the need for frequent breathing) and much more.

Concerns about one's health often occupy a central place in the patient's life, and sometimes begin to play an all-consuming role. Patients are very worried about their health and are often unusually sensitive to the side effects of drugs (A.V. Rodionov, 2018).

Regardless of the manifestations, the essence of a psychosomatic disorder is disproportionately intense or maladaptive thoughts, feelings, or behavior of the patient in response to symptoms. Symptoms or excessive anxiety about them cause severe discomfort or disrupt the patient's daily life. In some cases, overt depression may develop **[1, 4, 5].**

In recent years, depression has become one of the most urgent problems in medicine. Anxiety and depression are the most common (primary) and normal human emotional reactions to stressful events. Often they occur together, although phenomenologically and phylogenetically they are completely different phenomena. Anxiety reflects the state of increased readiness of the body (hyper-arousal) for a quick response to possible external stress factors; depression - a state of depression, oppression, often due to the realization of the hopelessness of the situation, disappointment and loss in life. Often, depression develops a second time, after a long state of

anxiety, supported by an unresolved stressful situation, and then depression does not allow the body to cope with stress, forming a vicious circle and aggravating the condition. Such emotional reactions (affects) should be distinguished from severe pathological conditions (diseases): depression and anxiety disorders **[11, 15].** Anxiety disorders as a borderline mental pathology, as well as depression, are mostly observed in general medical practice, where they are not always recognized **[2, 3, 7, 12, 13].**

In addition, participating in the development of many somatic disorders (for example, hypertension, angina pectoris, myocardial infarction, cerebrovascular disorders, cancer, bronchial asthma, etc.), anxiety and depression significantly complicate their course and prognosis [Koenig H. G., 2011] .

Ensuring that GPs give equal priority to mental and physical health concerns and improve continuity of care can help uncover information about a patient's emotional issues. Facilitating access to psychological therapy can improve outcomes for both mental and physical health problems.

It is believed that in their normal practice the therapist encounters a patient with depression or an anxiety disorder at least once a day. According to data obtained on the American population, the risk of developing a major depressive episode during a lifetime is 17.3%, and an anxiety disorder is 24.5% [Kennedy G.J. et al., 2015], a large-scale European study - 14.4% and 16%, respectively [Hemingway H., Marmot M., 1999]. At the same time, depression is detected in almost 60% of patients with anxiety disorders.

A high prevalence of mental pathology was noted both among the contingent of polyclinic institutions and multidisciplinary hospitals, where mental disorders are mainly represented by outpatient "neurotic" forms, among which somatized anxiety-depressive disorders predominate. This situation indicates the relevance of creating an effective system of specialized care for this category of patients.

The National Institute for Health and Care Excellence (NICE) recommends that clinicians assess mood in the context of an annual review. Whether this should occur in primary or secondary care, or how mood should be assessed, is not specified.

Despite NICE guidelines promoting the annual review of RA, evidence suggests that care for patients with RA is fragmented. A recent national general practice study found that annual primary health care RA reviews focus on cardiovascular disease (CVD) and osteoporosis screening, leading to duplication of some tests while other key elements such as case detection of anxiety and depression are absent.

The NICE Guidelines for Detecting Depression in Adults with Chronic Physical Health Problems suggest that the most sensitive tools for case detection are the General Health Questionnaire (GHQ-28) and the two-part questions of the Patient Health Questionnaire (PHQ-9). . , and questions with two bases (generalized anxiety disorder scale (GAD) -2 and PHQ-2) are popular due to their ease of use **[14, 17].**

There is evidence that psychological interventions in RA are effective in managing anxiety, depression, and pain. Self-management interventions to support patients to self-manage aspects of their RA have also been found to have a positive impact on pain and well-being. Because RA is associated with an increased prevalence of anxiety and depression, and because case finding

questions are useful screening tools in other CSNs, further research is needed to identify barriers and factors that contribute to disclosure.

One of the tasks of recent research in the field of somatopsychiatry is to create an effective method for predicting anxiety and depressive disorders both at an early stage of the post-infarction period and later, and, as a result, preventing the development of complications, a more comprehensive assessment of dynamic changes in the level of depression during therapy, and consequently, the effectiveness of therapy, as well as predicting the possible recurrence of the course of depressive disorders in the future, in addition, as a result of the implementation of this method, it was possible to judge the outcome of myocardial infarction.

Psychosomatic concepts in somatic clinics not only attract more and more attention of researchers, but also find practical application, are associated with a number of organizational measures. First of all, we are talking about creating models for optimizing specialized (psychiatric) care for patients with pathology of internal organs. Of paramount importance is the organization of consultative psychiatric care that meets modern requirements, the training of psychiatrists specializing in the field of psychosomatics, as well as the development of educational programs in clinical psychiatry and psychopharmacological therapy for cardiologists, cardiac surgeons and other specialists. Difficulties in organizing qualified medical care for patients with mental disorders in general somatic institutions are associated with the limited professional contacts between doctors of somatic institutions and specialists from psychiatric clinics and dispensaries, as well as the negative, distrustful attitude towards psychiatry among the population, associated primarily with the fear of stigmatization [Lyusov V.A., Volov N.A., 2010] **[5, 6].**

There are relationships between depressive disorders and coronary artery disease. In particular, the presence of depression significantly impairs compliance with cardiovascular disease therapy, reduces the quality of life and social adaptation, affects the course of the disease in the post-infarction period, and leads to earlier and increased mortality [Glassman A., Shapiro P., 1998]. In medical practice, comorbidity of depressive disorders and coronary artery disease are not uncommon. Patients with depressive disorders have a high risk of developing CHD and, conversely, patients with CHD have an increased risk of developing depressive disorders. Unfortunately, the pathogenetic patterns of the relationship between depression and coronary artery disease have not been sufficiently studied **[1, 3, 8, 9].**

These ratios can be described as a kind of "reciprocal": mild and moderate depression, especially the initial stages of a developing depressive episode, are accompanied by an increase in the risk of such life-threatening complications of a vascular disease as a hypertensive crisis, myocardial infarction, and stroke. With deep depressions with a typical, classic triad of affective, somatovegetative and motivational-volitional manifestations, the risk of developing these complications is reduced. This is well known in psychiatry. It is to such combinations of mental and somatic pathology that the concept of “psychosomatic balancing” introduced by French researchers is particularly applicable. The essence of psychosomatic balancing lies in the fact that the severity of one disease implies a decrease in the severity of the clinical manifestations of another. For example, an increase in the severity of depression smooth out the manifestations of hypertension, reduces the likelihood of a sharp increase in blood pressure, and, on the contrary, gross dyscirculatory disorders can reduce the severity of a depressive mood shift and related

experiences. At the same time, at the stages of depressive syndrome reduction, the risk of these complications of a somatic (vascular) disease may increase again, which requires special attention to the patient's somatic condition upon completion of active therapy for depression. These complex relationships between depression and vascular pathology seem to reflect regular changes in physiological reactivity inherent in the dynamics of depression **[10, 14].**

Significantly different manifestations of reactivity in its various forms - emotional, vegetative, immunological, neurophysiological - are characteristic of different stages of depression. Thus, the initial stages of the development of depression are accompanied by a general increase in reactivity from the emotional (hypothymic pole) and vegetative instability, including fluctuations in blood pressure, increased sensitivity to various external influences. On the contrary, the development of a pronounced depressive syndrome is accompanied by a decrease in reactivity - blocking or smoothing out reactions to external influences of a psychological and biological nature: a relatively stable structure of depression is formed, "closed" to external influences. At the stages of the reverse development of depression, i.e. reduction of its main manifestations, signs of emotional and vegetative instability, state fluctuations and its dependence on external influences are again found. These are both prognostically positive signs of an emerging recovery and signs of staged reactivity labilization, fraught with the risk of complications in the presence of vascular pathology. These features of depression must be taken into account in order to develop consistent therapeutic tactics **[11, 12].**

The data obtained as a result of recent studies allow us to improve treatment and rehabilitation measures for patients with somatic pathology, with depressive disorders, which will help optimize the provision of assistance by psychiatrists, cardiologists, as well as the prevention of mental disorders in this category of patients.

Integration in the work of doctors of various fields is possible using the theoretical and practical results of various studies in the field of somatopsychiatry and psychosomatics. The development of educational programs in clinical psychiatry and psychopharmacological therapy contributes to a better and more targeted monitoring of the clinical picture, the course of the disease, an adequate selection of systematic supportive therapy through the implementation of continuity in solving clinical and social issues in the management of patients with pathology of internal organs. General practitioners should give equal attention to mental and physical health issues in order to facilitate identification of suffering. Allowing time during individual visits and encouraging follow-up with the same GP to support continuity of care can be an integral part of disclosing mental health issues.

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