



## Psychosomatic Parallelism in Cardiological Practice

Mukhamadieva N. B.

Bukhara State Medical Institute

**Summary:** The aim of the study was to study the clinical and dynamic characteristics of depressive states that occur after myocardial infarction. Psychosomatic parallelism in most protracted depressions was manifested by generalization of asthenic symptom complexes (increased general weakness, intolerance to physical exertion, lethargy, adynamia, severe daytime sleepiness combined with early insomnia) with deterioration of the somatic condition. At the same time, it was noted that with prolonged depression, there were always more or less pronounced cognitive disorders (decrease in memory for past events, limited ability to understand what is happening around, remember new information, impaired concentration).

**Keywords:** postinfarction depression, comorbidity, risk factors, pathogenetic predictors, anxious and melancholic depression.

The urgency of the problem. Mood changes (affects, emotions) permeate the entire biopsychosocial-spiritual essence of a person in a state of health and illness. However, the ICD-10 treats affective disorders using three somewhat conflicting approaches. They are included both in the framework of an organic affective disorder (F06.3) and in the framework of anxiety-adaptive disorders (F40-43), the main ones being affective disorders (F 30-39), in which psychogenic depressions of varying severity. degrees "dissolved" among the endogenous. gravity. In European and Russian psychiatry, mainly in the 20th century, the etiological division was, in particular, the classification of depression by K. Schneider into organic, endogenous and psychogenic. Like the twentieth century was a century of depression so in the twenty-first century, an even greater increase in the number of depressive states is predicted, and primarily of a psychogenic nature due to an increase in the number of not only and not very much. many natural and man-made disasters, but due to the global financial recession ("depression") social and mental terrorism, globalization, unemployment, the destruction of the institution of the family and society, personal and professional dissatisfaction, which are reflected in the ideas about the quality of life in society, country, macro- and micro-society, man himself and his understanding of happiness and fullness of life. All this leads to a discrepancy between external and internal representations in interpersonal and intrapersonal relationships, accompanied by a decrease in mood as a natural reaction of the body to biological, psychological,

Depression is often accompanied by other somatic diseases, and in such cases, diseases of two different areas - mental and somatic - exacerbate each other, sometimes leading to serious consequences. Anxiety and depression are not static states, and neither of them is dominant, although both are clearly expressed. It is only characteristic that against the background of depression, anxiety intensifies and takes on enormous proportions. Each of these conditions enhances the effect of another syndrome, and the presence of an underlying endogenous disease is a factor contributing to the emergence of anxiety and depression in patients. It is obvious that anxiety and depression are companions of endogenous mental disorders, which in one case manifest themselves dichotomously, and in the other - integratively.

Among patients with cardiovascular disease, the incidence of comorbid depression is 22-33%. In 17-27% of patients with coronary artery disease who undergo coronary angiography, depression is detected, and in patients in the post-infarction period, depression is detected in 16-45% of cases. The presence of depression in patients with cardiovascular diseases not only complicates the course and treatment of these disorders, but also reduces the life expectancy of patients. It is clear and predictable that the most pronounced emotional disorders are observed in patients who have had a myocardial infarction, since even in a satisfactory state of health, the diagnosis of myocardial infarction is associated in a person with a threat to life [7,8,9,10]. Along with anxious fears for health, gloomy thoughts about the future, depression, fear of possible disability, anxious thoughts about the well-being of the family. Without appropriate intervention, these disorders are fixed and persist for one year in 25% of survivors. According to other data, mental disorders are diagnosed in 28% of cases. In 50% of patients, an increase in neurotic features was observed (Drobizhev M.Yu., 2003, Krasnov V.N., 2001, Smulevich A.B., 2001, Dickens S.M., McGowan I., Percival S. et al., 2004, Beckers T. ., 2001).

The purpose of the study was to study the clinical and dynamic features of depressive states that occur after myocardial infarction.

**Materials and research methods.** A study was conducted with 341 patients diagnosed with acute myocardial infarction. Patients are divided into 2 groups. The first, main, included 233 patients with acute myocardial infarction, who subsequently developed depressive disorders, confirmed clinically and using diagnostic scales; the second group consisted of 108 patients who also suffered an acute myocardial infarction, but subsequently did not suffer from depressive symptoms. Clinical and dynamic monitoring of patients in the postinfarction period was carried out with control over the condition in a month, three months, six months, 12 months after myocardial infarction. To identify the presence of symptoms of depression, the method of clinical observation was used (from the first hours after the patient was admitted to the hospital with a diagnosis of acute myocardial infarction), and during the survey, the Hamilton and Montgomery-Asberg scales were used. first three days of hospitalization. If no depressive symptoms were detected on the first day after an ischemic attack, then for diagnostic purposes the scales were used in a hospital daily until clinically significant symptoms of depression of any severity were detected, after discharge from the hospital - three months. six months, 12 months after the heart attack. myocardium (MI); after establishing the presence of a depressive disorder, the use of scales was carried out in the above terms. Patients were not included in the main group if symptoms of depression were not detected within 3 months after an ischemic attack. If no depressive symptoms were detected on the first day after an ischemic attack, then for diagnostic purposes the scales were used in a hospital daily until clinically significant symptoms of depression of any severity were detected, after discharge from the hospital - three months. six months, 12 months after the heart attack. myocardium (MI); after establishing the presence of a depressive disorder, the use of scales was carried out in the above terms. Patients were not included in the main group if symptoms of depression were not detected within 3 months after an ischemic attack. If no depressive symptoms were detected on the first day after an ischemic attack, then for diagnostic purposes the scales were used in a hospital daily until clinically significant symptoms of depression of any severity were detected, after discharge from the hospital - three months. six months, 12 months after the heart attack. myocardium (MI); after establishing the presence of a depressive disorder, the use of scales was carried out in the above terms. Patients were not included in the main group if symptoms of depression were not detected within 3 months after an ischemic attack. 12 months after a heart attack. myocardium (MI); after establishing the presence of a depressive disorder, the use of scales was carried out in the above terms. Patients were not included in the main group if symptoms of depression were not detected within 3 months after an ischemic attack. 12 months after a heart attack. myocardium (MI); after establishing the presence of a depressive disorder, the use of scales was carried out in the above terms. Patients were not included in the main group if symptoms of depression were not detected within 3 months after an ischemic attack.

According to the ICD-10, a clinically significant depressive disorder consists of the following symptoms: the main ones - a) a decrease in mood compared to the patient's normal norm, which occurs almost daily and most of the day, and also regardless of the situation; b) decrease (loss) of interests and the ability to enjoy activities that are usually associated with positive emotions; c) decreased activity, increased (pronounced) fatigue and decreased energy; and additionally - a) sleep disorders of any type; b) change in appetite (decrease or increase) with corresponding changes in body weight; c) recurring thoughts of death, suicide, or self-harm; d) a gloomy and pessimistic vision of the future; e) ideas of guilt and self-abasement; e) decreased self-esteem and a sense of self-doubt; g) decreased concentration, inability to concentrate, reduced ability to think, indecision or hesitation in making decisions. Mild depression (F 32.0 according to ICD-10) is characterized by the presence of two main and two additional symptoms. Moderate depression (F 32.1 according to ICD-10) is characterized by the presence of two main and three to four additional symptoms. Severe depression (F 32.2 or F 32.3 according to ICD-10) is characterized by the presence of three main, four or more additional symptoms, some of which are significant.

**Research results.** Among patients with MI with DM in the first days after MI, more than half (51.1%) reported a persistent decrease in mood more often than other symptoms, that is, these patients showed an affective component of depression, and an ideational component of depression, which manifested itself in one or another degree of delay in thinking was in 27.5% of patients, motor delay (motor component) was detected in 21.5% of the observed. In patients with almost the same frequency, an anxious and melancholic type of affect was noted (47.0% and 41.2%, respectively), a dysphoric type of affect was detected in 11.8% of cases, which is 4 times less anxious and 3.5 times. Less than melancholic.

In accordance with the objectives of the study, the patient's condition was analyzed one month, three, six and twelve months after myocardial infarction. The same analysis was carried out in patients of the control group. It turned out that 1 month after myocardial infarction, only in the control group there were no depressive disorders, and the patients of the main group had depressive syndromes. Clinically, 43.8% of patients had asthenic depression, 32.2% of DS were classified as anxious depression, 13.7% melancholic, 10.3% dysphoric depression. The clinical vector of DS is noticeably changing towards an increase in asthenic and a decrease in melancholic and anxious depressions, which is obviously associated with an improvement in the somatic condition of patients and, as a result, with a more adequate attitude towards them. condition and illness.

In the main group, there is a noticeable decrease in symptoms in patients with melancholic and dysphoric depression, but an increase in the number of patients with anxiety-depressive conditions. Interestingly, 18 patients (16.7%) with anxiety depression appeared in the control group 3 months after myocardial infarction. Such a change occurred due to the need for certain restrictions in the patient's life: compliance with the work and rest regimen and the therapy regimen, the rejection of the usual lifestyle and bad habits (smoking, alcohol), excessive care from relatives who are unusual for the patient, reassessment of one's social roles. It is necessary to pay attention to this group of patients, whose clinical manifestations of depression were: insomnia, superficial sleep, fear of recurrent myocardial infarction, constant ideas of self-accusation of misbehavior, led to myocardial infarction, episodes of vegetative paroxysms with severe palpitations, a feeling of lack of air, unpleasant sensations in the heart, which patients mistook for another MI, called an ambulance, believed that they were examined by incompetent specialists, argued with doctors and relatives. However, according to the Hamilton and Montgomery-Asberg scales, these DS were classified as mild depression, which required additional psychotherapeutic interventions in the form of convincing patients that there were no MI symptoms and sleep correction. that they were examined by incompetent specialists, argued with doctors and relatives. However, according to the Hamilton and Montgomery-Asberg scales, these DS were classified as mild depression, which required additional psychotherapeutic interventions in the form of convincing patients that there were no MI symptoms and sleep correction. that they were examined by incompetent specialists, argued with doctors and relatives. However, according to the Hamilton and Montgomery-Asberg scales, these DS

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Six months after myocardial infarction, the number of patients without DR increased significantly. It turned out that with a significant decrease in the number of patients with anxiety and asthenic depression, patients appeared with a hypochondriacal variant of DS, which is characterized by a constant search for symptoms of myocardial infarction, frequent measurement of pulse and blood pressure, visits to cardiologists and doctors. therapists, with frequent changes of doctors and distrust of consultations. In addition, these patients have changed attitudes towards others; they demanded the attention of their loved ones and tried to show everyone how seriously ill they were, they practically stopped working and were passive about family problems. In the control group, the number of patients with anxious depression decreased by more than 2 times.

A somewhat different picture is observed a year after MI. Among the examined patients, 7.3% of the main group and 0.9% of the control group had symptoms of depression. Anxious and hypochondriacal depressions were noted among DM in the main group. The severity of depression was characterized as mild. Awareness of the presence of a serious illness, the fear of a recurrence of myocardial infarction, the inability to internally change the attitude towards the transferred, the lack of objective information about the disease and its consequences create the basis for maintaining an internal psychological imbalance that disrupts the patient's emotional reaction, as a result of which depressive disorders persist. It is obvious that this group of patients requires the close attention of cardiologists and psychiatrists with the development of a plan for psycho-corrective influence.

**Discussions.** In long-term depression, the severity of affective disorders is more often directly correlated with the severity of the physical condition. If not so long depressive episodes were largely due to "one's own vision of the disease", then the severity of their symptoms depended on the conversation with the doctor and the information received from him, the degree of awareness of his diagnosis, and possible complications. , and little depended on the most general somatic status. Then, the course of prolonged depression in patients worsened with a deterioration in the cardiological and general somatic condition of the patients. Psychosomatic parallelism in most protracted depressions was manifested by generalization of asthenic symptom complexes (increased general weakness, intolerance to physical exertion, lethargy, weakness, pronounced daytime sleepiness combined with early insomnia) with deterioration of the somatic condition. At the same time, it was noted that with prolonged depression, there were always more or less pronounced cognitive disorders (decrease in memory for past events, limited ability to understand what is happening around, remember new information, impaired concentration).

In the foreground, with shorter depressive episodes, depression, a pessimistic perception of the disease, an overestimation of its consequences, anxious fears of a second attack of angina pectoris, fear of death, imminent disability were manifested.

Increased self-observation with registration of the slightest changes in well-being was combined with a mass of complaints, sometimes without sufficient somatic justification. A significant place among other components of the depressive disorder was occupied by hysterical (lump in the throat, tremor, numbness of the extremities in the form of "gloves"), somatovegetative (tachycardia, shortness of breath, insomnia) and asthenic (increased exhaustion, decreased activity, complaints of weakness, loss of activity) symptom complexes ... The reverse development of such depressions coincided with a period of stabilization of the manifestations of a somatic disease, when the danger of death was minimized, motor activity began to recover, and the level of anxiety decreased.

The above suggests that the duration of the depressive episode after acute myocardial infarction may indicate the origin of this symptom complex. So, depressive episodes lasting up to six months can be attributed to nosogens, that is, conditions that are a reaction of the psyche to a traumatic situation, in our case, a serious somatic disease. Depressive episodes with a protracted course, probably with a high degree of certainty, can be attributed to somatogenesis, that is, conditions pathophysiologically associated with severe pathology of the internal organs, i.e. In patients with more severe forms of cardiac pathology, a decrease in depression occurs at a slow pace.



## Conclusions.

1. The vast majority of patients with acute myocardial infarction experience a depressive episode of moderate (moderate) severity at initial diagnosis (71.6% on the Hamilton scale and 72.7% on the Montgomery-Asberg scale);
2. The detection of symptoms of depression within a year after MI even in patients of the control group dictates the need to study the complex of factors that led to the formation of depressive disorders in patients with MI.
3. Postinfarction depressive episodes lasting up to six months can be attributed to nosogens; depressive episodes of post-infarction genesis with a protracted course can probably be attributed to somatogenies with a high degree of certainty.

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