determines the need for further endocrinological examination to justify differentiated tactics for the management of patients.

Grinko N.V.

PSYCHOLOGICAL PECULIARITIES OF PERSONS WITH ORTHOREXIA NERVOSA

S. M. Savenko Department of Nervous Diseases, Psychiatry and Medical Psychology
Higher State Educational Establishment of Ukraine
«Bukovinian State Medical University»

It is good to eat healthy food. We are encouraged to do so by major medical associations, personal physicians, celebrities, schools, employers, the media and even the US government. However, there is a variety of recommendations available regarding what healthy diet means, and some of these are stricter than others. Some people in their quest to be as healthy as possible begin to choose increasingly restricted diets and develop an obsessive, perfectionistic relationship with eating the right foods. This may go so far as to become psychologically and even physically unhealthy. In other words, it can result in eating disorder.

This unhealthy relationship with healthy foods is referred to as orthorexia nervosa from the Greek orthos, meaning “correct or right” and orexia, meaning “appetite.” While orthorexia nervosa is not listed in the DSM-V (the Diagnostic and Statistical Manual used by mental health practitioners to diagnose mental health problems), it is the subject of growing academic research and has become an accepted diagnosis in the mental health community.

A person with orthorexia nervosa has become so fixed on eating healthy food that this one goal begins to squeeze out and diminish other important dimensions of life. Thinking about what to eat replaces relationships, friendships, career goals, hobbies and most other pleasures of being alive. In extreme cases, the obsession with restricting one’s diet can lead to dangerous malnutrition, a truly ironic consequence of what began as a search for improved health. The objective of our study was to study the psychological characteristics of persons with orthorexia for further development medical and psychological support.

The study included 100 respondents: 50 women and 50 men. Participants completed the ORTO-15 (Institute of Food Sciences, University of Rome "La Sapienza", Minnesota Multiprofile Personality Questionnaire (MMPI-2) and a questionnaire on socio-demographic characteristics.

Of the 100 surveyed respondents (among women and men) 15% had orthorexia and 15% had a borderline state. Among men (50 respondents), orthorexia (20%) is more often than the borderline (16%). Women (50 respondents) have a reverse trend: border status (14%), orthorexia - (10%). That is, men are more vulnerable to orthorexia. The profile of personality with orthorexia nervosa (together women and men) is characterized by high rates of schizoid (80%), psychoasthenia (67%), hypomania (20%), hypochondria (7%) and psychopathy (7%).

Further studies are needed to explore the relationship between body image and a strong preoccupation with healthy eating in different populations, including samples that include people who are overweight and/or have an eating disorder, and to investigate relationships more broadly between orthorexia tendencies and other factors such as perfectionism, self-esteem and self-control (which are frequently cited in the literature as the personality traits associated with orthorexia nervosa).

Herasymiuk I.G.

QUALITY OF LIFE OF PATIENTS WITH RECURRENT DEPRESSIVE DISORDER

S. M. Savenko Department of Nervous Diseases, Psychiatry and Medical Psychology
Higher State Educational Establishment of Ukraine
«Bukovinian State Medical University»

There is a recognized third conceptualization of well-being, which is quality of life (QoL). Cooke et al. (2016) note that QoL is often used interchangeably with life satisfaction and subjective well-being in research. In this respect, the QoL conceptualization of well-being may be broader and more comprehensive than both hedonic and eudaimonic conceptualizations. QoL can encompass

physical, psychological, and social domains of functioning and has been employed frequently in medical contexts (Lent, 2004).

Much research has focused on QoL in relation to recurrent depressive disorder (RDD). Although a lack of consensus over the definitions of well-being and QoL has been reported in RDD literature, the two have been found to be closely related. Morton et al. (2017) found the concepts of functioning, health, subjective experience, and well-being to be related to QoL in RDD, in a thematic analysis of 275 papers. Research on QoL has allowed examination of physical, emotional, social, occupational, and spiritual well-being.

RDD can have significant adverse effects on QoL. In a qualitative study that explored a patient-centred perspective of the impact of RDD on QoL, 52 interviews with patients, caregivers, and healthcare professionals identified several themes to be central to QoL: routine, independence, stigma and disclosure, identity, social support, and spirituality. Participants reported that RDD had an immense negative impact on their QoL. The areas most impacted were noted to be education, vocation, financial functioning, and social and intimate relationships.

Hence, the QoL construct involves a highly subjective perception of personal well-being and functionality. Most clinical research has traditionally focused on symptom ratings as a measure of outcomes. However, the QoL construct has been proposed to be a measure of clinical change that is also complementary to traditionally used clinical tools. In a large study comparing 108 participants who had been 16 diagnosed with RDD to a 1,200 control participant group recruited from the general public, RDD was found to be associated with lower scores on the mental and physical measures of QoL. This association between RDD and lowered levels of well-being was prevalent, irrespective of mood state.

However, we should note that low mental quality of life was related to the early age of onset of the illness and depressive symptoms.

Pashkovskyy V.M.

COMORBIDITY IN NEUROLOGICAL AND MENTAL DISORDERS

S. M. Savenko Department of Nervous Diseases, Psychiatry and Medical Psychology
Higher State Educational Establishment of Ukraine
«Bukovinian State Medical University»

Medical care has traditionally been dominated by a separation between disciplines catering to physiological symptoms versus those catering to psychological symptoms. Emerging research points to psychiatric comorbidity in the primary care setting and in specialized services, especially with chronic conditions like cardiovascular disease and diabetes. Among psychiatric comorbidities, depression and anxiety disorders are the most prevalent and have been found to hinder treatment response, increasing disability and reducing functional outcome. Given the shared etiological processes between neurological disorders and psychiatric disorders, reports of 50% prevalence rates of depression and anxiety among neurology patients are not surprising. Despite ample evidence on comorbidity, the provision of psychiatric intervention for such patients remains lacking.

Several epidemiological studies have attempted to quantify psychiatric comorbidity in primary care and specialized services. The 52% of those with cardiovascular disease displayed symptoms of depression and anxiety, with 30% meeting the diagnostic criteria for depression. Similarly, a Belgian cross-sectional survey of primary care practices in the country revealed that although 5.4% of the 2,316 patients surveyed reported psychiatric complaints, 42.5% had an unreported psychiatric comorbidity. Mood and anxiety disorders were the most prevalent. Complications from diabetes are most prevalent in the presence of psychiatric disorders, and mortality rates increase in individuals with myocardial infarction if they also suffer from anxiety. Among 300 neurology patients surveyed in the UK, 47% met the criteria for a Diagnostic and Statistical Manual of Disorders, Fourth Edition (DSM-IV) diagnosis of depression and anxiety. In a Canadian community sample, individuals diagnosed with epilepsy were more likely to experience anxiety symptoms and had higher rates of suicidal ideation and those with migraine were more likely to experience major depressive disorder, bipolar disorder, panic disorder, and social phobia.