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SCIENTIFIC ACHIEVEMENTS OF MODERN SOCIETY

Abstracts of I International Scientific And Practical Conference

September 11-13, 2019

LIVERPOOL
2019

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UDC 001.1
BBK 83

The 1st International scientific and practical conference "Scientific achievements of modern society" (September 11-13, 2019) Cognum Publishing House, Liverpool, United Kingdom. 2019. 320 p.

ISBN 978-92-9472-193-8

The recommended citation for this publication is:
Ivanov I. Analysis of the phaunistic composition of Ukraine // Scientific achievements of modern society. Abstracts of the 1st International scientific and practical conference. Cognum Publishing House. Liverpool, United Kingdom. 2019. Pp. 21-27.

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УДК: 616.891-02:616.441

INTERPERSONAL INTERACTION OF PATIENTS WITH NONPSYCHOTIC MENTAL DISORDERS AT RHEUMATOID ARTHRITIS

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Abstract: The study was based on examination of 160 people, 120 of them are patients with nonpsychotic mental disorders (NMD) and rheumatoid arthritis (RA), namely 55 patients with the duration of the RA disease up to 5 years (BG I), and 65 patients with the duration of the RA disease from 5 to 10 years (BG II), while other 40 persons belonging to the general population (CG). The technique of diagnosing a communicative installation by V.V. Boyko and the multidimensional scale of perception of social support of Zimet [MSPSS, D. Zimet, 1988], the Hamilton Rating Scale for Depression (HRSD), Hamilton Rating Scale for Anxiety (HRSA) and the Quality of Life Index developed by J.E. Mezzich (QLI), were used. Patients with the RA, the most often suffer from the following NMD: a depressive disorder – 35,0%, anxiety – 21,7%, emotionally labile (asthenic) – 19.2%, anxiety-phobic disorder – 11.6%, the disorder of adaptation – 12.5% of patients. The highest level of negative communicative device was found in patients BG I (46.5 ± 1.80 points). In patients BG II, the level of negative communicative installation was 39.8 ± 1.39 points ($p<0.05$).

Keywords: nonpsychotic mental disorders, rheumatoid arthritis, communicative setting, social support.

Rheumatoid arthritis is a chronic autoimmune disease with a worldwide adult prevalence of 0.2-1.2 % [1, p. 1]. The problem of the interaction between rheumatoid arthritis and mental disorders is an issue of interest according to current research [2, p. 2; 3, p. 143].

One hundred and twenty patients with a diagnosis of Rheumatoid arthritis and nonpsychotic mental disorders, who attended clinics for follow-up visits between June 2011 and November 2017, were examined in the course of this study. The patients of first basic clinical group included participants with duration of RA for 1-5 years; the second basic clinical group included those with duration of RA for 5-10 years. The third control group of comparison included 40 healthy people. The demographic features of the patients are shown in Table 1.

Table 1

Demographic features of patients

Parameters	BG I (n=55)	**%**	BG II (n=65)	**%**	CG (n=40)	**%**
Age (year)	37.9 ± 1.82		38,4±2,0		36.5 ± 1.70	
Sex						
male	9	16,4	13	20,0	7	17,5
female	46	83,6	52	80,0	33	82,5
Marital status						
Married	34	61,8	38	58,4	26	65
Single	11	20,0	7	10,8	12	30,0
Divorced	10	18,2	20	30,8	2	5,0
Educational status						
Primary school graduates	35	63,6	48	73,8	25	62,5
College graduates	5	9,1	4	6,2	12	30,0
University graduates	15	27,3	13	20,0	3	7,5
Place of residence						
City	24	43,6	25	38,5	24	60,0
Village	25	45,5	38	58,5	14	35,0
Urban village	6	10,9	2	3,1	2	5,0

For assessment we used the Hamilton Rating Scale for Depression (HRSD), Hamilton Rating Scale for Anxiety (HRSA) and the Quality of Life Index developed by J.E. Mezzich (QLI), communicative installation by V.V. Boyko and the multidimensional scale of perception of social support of Zimet [MSPSS, D. Zimet, 1988]. All patients received basic treatment, as well as antidepressants, anxiolytics, vitamin therapy and psychotherapy, depending on the form of nonpsychotic mental disorders.

Based on the study of clinical-psychopathological, patho-psychological and psychosocial features of formation of the NMD associated with the RA, has systematized the clinical and diagnostic criteria of the NMD against the background of the RA process, depending on the duration of the disease on the symptomatic, syndromic, and nosological levels. Patients with the RA, the most often suffer from the following NMD: a depressive disorder – 35,0% of patients, anxiety disorder – 21,7%, the disorder of adaptation – 12.5%, emotionally labile (asthenic) disorder – 19.2%, anxiety-phobic disorder – 11.6% (tab. 2). With the extension of the duration of the RA, increases the number of people with depression disorder (from 18.2% to 49.2%, $p<0.01$), anxiety disorder (from 16.3% to 26.1%, $p<0.05$) and decreases the number of people with anxiety-phobic disorder (from 20.0% to 4,7%, $p<0.01$), emotionally labile (asthenic) disorder (from 27.3% to 12.3%, $p <0.05$) and disorder of adaptation (from 18.2% to 7.7%, $p<0.05$).

Table 2

Nonpsychotic mental disorders of patients with rheumatoid arthritis

Parameters	Group (n=120)						p
	BG I (n=55)		BG II (n=65)		All		
		%		%		%	
Depressive disorder (F-06.3)	10	18,2	32	49,2	42	35,0	<0,01
Anxiety disorder (F-06.4)	9	16,3	17	26,1	26	21,7	<0,05
The disorder of adaptation (F-43.2)	10	18,2	5	7,7	15	12,5	<0,05
Emotionally labile (asthenic) disorder (F-06.6)	15	27,3	8	12,3	23	19,2	<0,05
Anxiety-phobic disorder (F-40.8)	11	20,0	3	4,7	14	11,6	<0,01

The quality of life means system of indicators that characterize the peculiarities of realization and satisfaction of human needs. The patients with rheumatoid arthritis and nonpsychotic mental disorders have a significant decline in quality of life based on all indicators. The general assessment of the quality of life of the examined patients in the BG I is 62,2 ± 1,33, while in the BG II examined – 57,0 ± 1,47 (5, p.49). BGI patients had low level of physical well-being (4,69 ± 0,14), public and official support (4,67 ± 0,25), psychological and emotional well-being (5,78 ± 0,25). Examining the BG II patients, minimum number of points was given for physical well-being (4,40 ± 0,18), community and services support (4,43 ± 0,19), occupational functioning (5,06 ± 0,22), psychological and emotional well-being (5,03 ± 0,23) and social and emotional support (5,28 ± 0,18). At the same time, the indicators of spiritual fulfillment, self-care and independent functioning named above, namely, the spiritual fulfillment of BG I patients (6,90 ± 0,21), BG II patients (7,16 ± 0,18), self-care and independent functioning of BGI patients (7,80 ± 0,18), of BG II patients (7,00 ± 0,19). Longer duration of the RA disease significantly weakens the general working capacity by 0,83 points $p<0,05$, self-service and independence of the patients by 0,80 points, $p<0,05$, psychological and emotional well-being by 0,75 points, $p<0,05$, interpersonal interaction at 0,91 points, $p<0,05$.

The highest level of negative communicative device was found in patients with a longer course of rheumatoid arthritis (46.5 ± 1.80 points). In patients with a disease up to 5 years, the level of negative communicative installation was 39.8 ± 1.39 points ($p<0.05$). The average values of the general ability to subjective perception of social support in patients with BG II were 52.9% ± 1.9 and were 12.8% lower than in BG I (65.7% ± 1.6) ($p<0, 05$), which indicates a significantly lower ability of patients with a longer course of RA and NMD to adequately perceive social support, which creates significant barriers for successful social and psychological adaptation of patient data.

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