акцентуациями характера больных, их внутренней картиной болезни и механизмами психологической защиты. Выявлены особенности данных параметров в зависимости от половой принадлежности больных и стажа их заболевания. Выявлены также существенные различия по ВКБ у больных с различной продолжительностью болезни: у пациентов со стажем болезни менее 5 лет значимо реже встречаются сенситивный и эгоцентричный типы ВКБ, и, наоборот, значительно чаще наблюдается эйфорический тип по сравнению с пациентами, продолжительность заболевания которых превышает 15 лет.

Ключевые слова: акцентуация характера, механизм психологической защиты, внутренняя картина болезни, хронический колит.

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mechanisms of psychological defense are revealed. The peculiarities of these parameters depending on patients' gender and their experience of the disease are shown. Significant differences were also found for internal picture of the disease (IPD) in patients with different disease duration: patients who have been diseased less than 5 years were significantly less likely to have sensitive and self-centered IPD types, and, conversely, euphoric type was observed more frequently than in patients whose disease has lasted for over 15 years.

Key words: accentuation of character, mechanism of psychological defense, internal picture of the disease, chronic colitis in remission.

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CLINICAL-PSYCHOLOGICAL REHABILITATION OF CARDIAC PATIENTS THROUGH OPTMIZATION OF THE SELF-PERCEPTION OF HEALTH

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Clinical-psychological rehabilitation with the author's "Program of clinical and psychological rehabilitation of cardiologic patients by optimizing the self-perception of health " can be used to control the quality and effectiveness of rehabilitation of patients after acute coronary syndrome. It was established that the use of such an approach contributed to the change in objective and subjective data of patients, as well as to a healthy lifestyle. Along with this, the factors of improving the quality of rehabilitation are the use of complex medical therapy, close cooperation of a multidisciplinary team consisting of a cardiologist, a physician of physical and medical rehabilitation, a psychologist, a physical therapist and a patient.

Key words: acute coronary syndrome, percutaneous coronary intervention, rehabilitation, self-perception of health.

The present study is a fragment of the research project "Non-alcoholic fatty liver disease: influence on the course of cardiovascular diseases, optimization of treatment", state registration No. 0118U004756.

The development of modern medical science suggests that over the past three decades, there has been a general tendency in Europe to reduce mortality from ischemic disease, although it remains the most common cause of death worldwide. The leading method of treatment with STEMI is percutaneous coronary intervention (PCI), according to the Percutaneous Coronary Interventions Register data during the 2017, nearly 7500 PCI were performed in patients with acute myocardial infarction with ST segment elevation (STEMI) [2, 5]. Also, current research studies show that the reduction of mortality in STEMI is provided by both through reperfusion therapy, primary percutaneous coronary intervention (PCI) and the performance of secondary prevention [8]. Secondary prophylaxis, in particular rehabilitation and recovery period after STEMI, is an integral part of effective comprehensive treatment for patients with STEMI [8, 6]. An important task at the present stage of development of rehabilitation practice is to improve and unify the procedure for the rehabilitation of patients with coronary heart disease.

The rehabilitation involves the close collaboration of the patient with the interdisciplinary team providing of the rehabilitation process, respectively it is important to control the factor of the patient's attitude towards his/her health in general and the rehabilitation procedure in particular. The reflection of a person's attitude towards his/her health has become the phenomenon of the self-perception of health(SPH), whose main function is the regulation of the individual's activities in relation to his/her behavior in support of health and the response to the disease, and that this function should be realized, the SPH should be uncontroversial [1]. The definition of the structural components of the SPH allows performing the control of rehabilitation more qualitatively. Thus, *the sensitive component of the SPH* is interpreted as an image of a body that manifests itself in the extended or limited possibilities of possession of his/her own body. *The emotional component of the SPH* – is the usual way of experiencing their own life situations, as well as responsibility for their recovery, the ability to accept emotional support for the family. *The cognitive component of the SPH* is considered as an awareness of the patient's complexity of the disease, the role of the psychological factors in the development of the disease and the acceptance of the consistent patterns of

the course, the prospects of recovery. Value-motivational component of the SPH – beliefs and internal values as stimuli for a constructive behavior strategy are the motive for recovery (the will for health, for life). The combination of efforts, actions, and specific human actions aimed at achievement of subjectively meaningful health rehabilitation goals, reflects *the behavioral component of the SPH* [3].

In the rehabilitation of patients, we've used the author's "Program of psychological rehabilitation of cardiologic patients by optimization of the self-perception of health", based on the idea of optimization of SPH in patients with ischemic heart disease [11].

The purpose or the work was to study the changes in objective and subjective health indices during clinical-psychological rehabilitation of cardiological patients through the optimization of the self-perception of health of patients with ACS with ST elevation (STEMI) after percutaneous coronary interventions (PCI).

Materils and methods. We've evaluated the results of clinical-psychological rehabilitation implemented into the activity of the Ivano-Frankivsk Regional Clinical Cardiological Center, Infarction Department No. 2 and rehabilitation of 78 patients who were performed PCI. The average age in the group of patients was 61.05±1.38 years; thus men under 45 years old – 6.41%; 45-59 years: women – 7.69%, men – 30.77%; 60-74 years: women – 12.82%, men – 28.21%; 75years and more: women – 5.13%, men – 8.97%. Residents of the city – 46.2%, residents of the village – 53.9%.

The course of ACS according to the clinical-anamnestic and objective data using psychometric techniques and conversations, was evaluated. The questioning was performed during the first week after admission to the cardiological center: the data were filled in by the patients independently in the presence of a doctor or a psychologist; the same diagnosis was performed after participating in the rehabilitation program.

In the diagnostics of SPH, the author's model of the estimation of the formation of the components, representing a mutually complementary complex of clinical and psychodiagnostic methods, which basically contains the therapeutic potential and is based on the multimodal biopsychosocial approach (table 1).

Table 1

Model of estimation of the formation of SPH components

Components of SPH	Methods of diagnostics
Sensitive component	*Medico-clinical unit* – complaints, clinical signs, objective indices – blood pressure, heart rate; lipid profile, Echo-CG data, exercise tolerance based on 6-minute walking test, Borg scale "Seattle questionnaire of life quality of patients with angina pectoris" (Seattle Angina Questionnaire - SAQ), scales: - Limitation of physical activity (Physical Limitation – PL), - Stability of angina pectoris (Angina Stability – AS), - Frequency of attacks (Angina Frequency – AF), Determination of life quality (The 36-Item Short Form Health Survey - SF-36)scales: - Physical functioning (Physical Functioning - PF); - Intensity of pain (Bodily Pain - BP), - Social functioning (Social Functioning - SF). Medico-clinical unit – complaints, clinical signs, objective indices – blood pressure, heart rate; lipid profile, Echo-CG data,
Emotional component	Hospital scale for detection of anxiety and depression (Hospital Anxiety and Depression Scale – HADS); Questionnaire of patient about health condition (Patient Health Questionnaire-9- PHQ-9) Scale of the level of reactive and personal anxiety of Spielberg-Hanin. Determination of life quality (The 36-Item Short Form Health Survey - SF-36), scales: – Social functioning (Social Functioning - SF), "Role functioning conditioned by the emotional state" (Role Emotional - RE) Mental health (Mental Health – MH).
Cognitive component	"Seattle questionnaire of life quality of patients with angina pectoris" (Seattle Angina Questionnaire - SAQ) "Satisfaction with the treatment" (Treatment Satisfaction – TS0, "Attitude to the disease" (Disease Perception – DP) Determination of life quality (SF-36)scale: General health condition (General Health - GH).
Value-motivational	Determination of life quality (SF-36) : - Viability (Vitality - VT), Determination of the behavioral component – according to the SF-36:
Behavioral component	Medico-clinical unit – exercise tolerance based on 6-minute walking test, Borg scale Determination of life quality (SF-36) scales: Role functioning conditioned by physical state (Role Physical Functioning - RP), Role functioning conditioned by emotional state (Role Emotional - RE) Social functioning (Social Functioning - SF).

Interpretation of the results was performed according to the keys of each method. Statistical processing was performed using the software system Statistica (version 8.0) with the calculation of the arithmetic mean, standard deviation, taking into account the methods for determination of differences for qualitative ($\chi 2$) and quantitative (t) variables. The difference was considered reliable at the result of $p<0.05$ for each of the parameters. In optimization of SPH of patients the multimodal biopsychosocial approach and the system approach, which involves understanding of the SPH as a complex system, the links of which are closely interrelated and interdependent from each other; this approach is implemented in the "Program of psychological rehabilitation of cardiological patients by optimisation of the self-perception of health". The principle of a systematic approach to the SPH allows us to perform the formation of influence not only of its various levels and subsystems, but also the main system-forming factors of the SPH. Clinical-psychological rehabilitation of cardiological patients according to the "Program" consists of three complementary parts: medical-clinical, physical and socio-psychological. The medical-clinical part involves clinical diagnostics, non-medical and medical treatment of patients throughout the time of rehabilitation. Physical rehabilitation involves stimulation of available physical activity in order to improve the quality of life in general and tolerance to physical activity throughout the time of rehabilitation. Socio-psychological – is a psychological accompaniment of treatment and training of patients, provides diagnostic and counseling (group and individual) work with patients throughout the time of rehabilitation.

The form of performance – group and individual on request, duration of lessons: up to 60 minutes, frequency of classes – once a week. The program of lessons according to the "Program" included 5 meetings. Classes were cyclical. The chosen form of work allowed us to be in a conversation mode, an interactive dialogue between the treating physician, the doctor of physical and medical rehabilitation, the psychologist, the physical therapist and the patient. In case of necessity and upon request of the patient the individual work is performed [9]. Each group session is intended for optimization of the patient's SPH and is constructed so that at the same time as a result of the selected exercises, the optimization of all components of the SPH is performed through the work with one that is in the superposition at a particular lesson.

All patients received standard therapy for patients with IHD in accordance with ESC recommendations, conservative treatment with application of anti-platelet medicines (acetylsalicylic acid, thienopyridine derivatives), anticoagulants (unfractionated heparin, low molecular weight heparins), anti-ischemic therapy (beta-blockers, nitrates), statins, ACE inhibitors. The PCI consisted in coronary angiography and stenting of the infarct-dependent coronary artery.

Results of the study and their discussion. In the majority of the examined patients, there was an AHII, despite the applied medical technology and the course of IHD. There were documented 19.23% of patients with concomitant diabetes mellitus type II.

In general, we've recorded a decrease in angina attacks in most patients. Shortness of breath at the beginning of treatment was noted by 57.6% of patients, after 1 month only 23.1%. The tendency to decrease in the process of rehabilitation was fatigue, increased sweating, general weakness, and so on.

Attitude to health is an important component in preventive and rehabilitative medicine [2].

The patient's attitude to his or her health may affect the course of cardiovascular disease due to the patient's behavior. Failure to follow the recommendations of the physician in both primary and secondary prophylaxis, in particular in rehabilitation, leads to a deepening of maladaptation processes, which in turn leads to complications of the course of the disease and re-hospitalizations [2].

According to the model of the formation of the components of SPH, we've obtained the results for each of them. As a result of the implementation of the rehabilitation program in STEMI patients who had PCI in the emotional sphere (emotional component of the SPH), not only the level of anxiety and depression decreased, but also self-awareness and self-knowledge improved. We can note the development of emotional self-awareness, improvement of the ability to analyze the mood and skills to overcome the devastating effect of emotions on the cardiovascular system. There was an optimization of emotional response to the disease (table 2).

Table 2

Indices of the emotional component of SPH

	HADS		PHQ-9	Questionnaire of Spielberg-Hanin		SF-36		
	Level of anxiety	Level of depression	Level of depression	PT	OT	SF	RE	MH
At the beginning	7.96±0.52	7.91± 0.53	6.40±1.2	47.4±1.30	48.0±1.23	42.9±20	45.7±18	43.2 ±17
After the treatment	6.12±0.49*	7.45± 0.51	6.0±1.0	34.±1.28*	36.2±1.25*	69±13.1	65.5±18.2	68±20.2

Notes: Reliability of difference of indices: *<0.05

In the body (sensitive component of SPH) there was a certain dynamics of changes in blood pressure, thus at the beginning of rehabilitation, the SAP level was 138.9±2.6 mmHg, after its completion 120.5±1.0 mmHg, DAP decreased from 84.6±1.6 mmHg to 74.0±0.9 mmHg, the mean heart rate at the beginning was 110±3 beats/min, and after the treatment it was 80±1 beats/min. By evaluating the dynamics of indices of left ventricular contractility, a decrease in volumetric indices of LV EDV and ESV was noted after 1 month of optimized treatment. Such changes were accompanied by an increase in EF from 47.5±1.31% to 54.2±1.26% ($p<0.05$).

Clinical diagnosis showed a decrease in lipid metabolism, so the total level of cholesterol at the beginning of the study was 6.19±0.22 mmol/l, a month later it decreased to 4.13±0.15 mmol/l ($p<0.05$), LDL levels were 4.29±0.11 mmol/l and 2.48±0.08 mmol/l, respectively ($p<0.05$).

We can note the acceptance and understanding of the meaning of physical comfort or discomfort, understanding of symptoms of the disease and changes in the dynamics of symptoms during rehabilitation, which contributed to a positive attitude towards medical treatment and increased responsibility. The symptom was evaluated by the patient as the ability to get information on the dynamics of the disease, fear of the symptom decreased, and, accordingly, the abilities to have control of the body were expanded. Due to the trust in the body's sensations in the present, there is a construction of a prospect of recovery and the possibility of the body in the future with the acceptance of age-related opportunities and the impact of concomitant diseases. Particularly important is the acceptance of the optimum of physical capabilities that can be achieved during and after the treatment and rehabilitation (table 3).

Table 3

Indices for assessement of the sensitive component of SPH

	SAQ			SF-36		
	PL	AS	AF	PF	BP	SF
At the beginning	43±4	44±8	37±6	40.4±13.4	42.3±14.1	42.9±20.0
After the treatment	56±5	52±8	50±5*	69±12.1	70.2±20.2*	69±13.4

Notes: Reliability of difference of indices: *<0.05

Improvement of the range of knowledge of the patient (cognitive component of SPH) concerning the ways to support and improve health is an important factor in the increase of the responsibility for the treatment and rehabilitation. During the implementation of the program, the patients received a range of knowledge about all the components of the SPH, which enables them to be competent in the health. It is important to get reliable knowledge about the individual peculiarities of the disease. The improvement of self-knowledge, awareness and comprehension of vital decisions affecting health have been fixed. In general, the expansion of cognitive resources, development of the ability to identify successful strategies for health improvement (table 4).

Table 4

Indices for assessement of the cognitive, value-motivational, behavioral components of SPH in patients with STEMI, who were performed PCI

Indices for assessement of the cognitive component			
	SAQ		SF-36
	TS	DP	GH
At the beginning of treatment	77±4	45±5	43.3±14.4
After the treatment	87±4	70±5*	67±18.2*
Indices for assessement of the value-motivational component			
SF-36			
	VT	RE	SF
At the beginning of treatment	38.8±17.7	45.71±18.5	42.9±22.4
After the treatment	66.9±24.1*	65.5±23.0	69±13.1*
Indices for assessement of the behavioral component			
SAQ SF-36			
	PF	RP	VT
At the beginning of treatment	40.4±13.0	40.3±12.4	38.8±17.2
After the treatment	68±15.2	69±13.2	66.9±24.4

Notes: Reliability of difference of indices: *<0.05

The perceived need for cardiovascular behavior change has been evaluated by other researchers. Researchers say patients identify a particular lifestyle change as the most important to improve their health, most have indicated their intention to improve their physical health next year, and almost all planned changes are known to modify cardiac risk, arguing the value of the result selected [13]. The motivation of the patient plays a leading role in keeping the medical appointments and new rules of healthy lifestyle. The analysis of the results of optimization of the value-motivational component of SPH indicates about the increasing responsibility for the health and awareness of his/her own significance for making vital decisions. The expansion of life perspectives of the patient, finding new life goals, faith in the result of rehabilitation, change in the system of values and a proactive position regarding the implementation of health value.

Studies that examined the impact of patients' attitudes on health on health recovery showed that patients considered the main cause of their illness - behavioral risk factors. They then indicate psychological, biological and environmental factors, respectively. Patients at the rehabilitation stage considered psychological problems as the second important factor in the development of the disease. At the same time, many patients were unaware of the cause of their illness [4].

Optimization of SPH contributed to the increase of tolerance to physical activity of the patient (Behavioral component) According to the test with a 6-minute walk, an increase in SAP and heart rate, reduction of angina attacks, which contributed to an increase in load volume (the walked distance was – 415.3±10.7 m). When calculating the integrated score according to the Borg scale, a lower average score of shortness of breath was observed, angina pectoris, and fatigue after loading.

The result of clinical-psychological rehabilitation is the setting for a healthy lifestyle, the search, awareness and implementation of behavior that favors health promotion. During the participation in the "Program", we observe the formation of a behavior strategy aimed at restoration and maintenance of health. The formed establishment of the extension of the area of responsibility in actions aimed at health, is very important. Patients themselves indicated an increase in vital activity and expansion of spheres of awareness of their strengths, disclosure of internal resources. Especially valuable is timely and qualitative performance of medical appointments, physiotherapeutic rehabilitation exercises.

Conclusion

Clinical-psychological rehabilitation of cardiac patients through optimization of the self-perception of health is accessible and effective. Such rehabilitation can be performed with the help of "Program". The formed mutual complementary complex of clinical and psychodiagnostic methods, implemented in the model of evaluation of the formation of components of SPH, is the basis for control of the quality and efficiency of cardiological patient rehabilitation.

As a result of the multidisciplinary approach application in the clinical-psychological rehabilitation of cardiological patients, there have been positive changes in both objective and subjective indices of health. We believe that the main factors in the improvement of the quality of rehabilitation are the use of complex medical therapy, close cooperation of the multidisciplinary team consisting of a consulting physician, a doctor of physical and medical rehabilitation, a psychologist, a physical therapist and a patient.

Realization of such tasks of rehabilitation as increase of trust in a body; development of understanding of bodily sensations; development of the reflection of the internal emotional states and experiences of the patient; formation of a responsible attitude towards health; awareness of health as a basic value; the inclusion of health into the structure of vital claims; creating a motivation for a healthy lifestyle is possible due to the influence of the main psychosocial factors.

Psychosocial factors of the program are: proactive position in the field of health; system of value-based beliefs and health orientations; emotional-motivational competence; the ability to program their actions and behavior; assessment and correction of ways to achieve a result in the restoration and preservation of health.

Prospects for further research are as follows: development of an individual profile of a cardiologic patient taking into account the self-perception of health with the possibility of application at different stages of medical and psychological suppot.

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Реферати

КЛІНІКО-ПСИХОЛОГІЧНА РЕАБІЛІТАЦІЯ КАРДІОЛОГІЧНИХ ХВОРИХ ЧЕРЕЗ ОПТИМІЗАЦІЮ ВНУТРІШНЬОЇ КАРТИНИ ЗДОРОВ'Я

Нестерак Р.В., Гасюк М.Б.

Важливим завданням реабілітаційної медицини є удосконалення та уніфікація процедури реабілітації хворих на ішемічну хворобу серця. Відображенням ставлення людини до свого здоров'я став феномен внутрішньої картини здоров'я (ВКЗ), основною її функцією є регуляція діяльності індивіда у відношенні його поведінки, спрямованої на підтримку здоров'я і протидія хворобі. Клініко-психологічна реабілітація за допомогою авторської «Програми клініко-психологічної реабілітації кардіологічних хворих шляхом оптимізації внутрішньої картини здоров'я» може застосовуватись для контролю якості та ефективності реабілітації хворих після гострого коронарного синдрому. Застосування такого підходу сприяло зміні об'єктивних та суб'єктивних даних хворих, а також налаштуванню на здоровий спосіб життя. Чинниками підвищення якості реабілітації є застосування комплексної медикаментозної терапії, тісної співпраці мультидисциплінарної команди у складі кардіолога, лікаря фізичної та медичної реабілітації, психолога, фізичного терапевта і пацієнта.

Ключові слова: гострий коронарний синдром, черезшкірне коронарне втручання, реабілітація, внутрішня картина здоров'я.

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КЛИНИКО-ПСИХОЛОГИЧЕСКАЯ РЕАБИЛИТАЦИЯ КАРДИОЛОГИЧЕСКИХ БОЛЬНЫХ ЧЕРЕЗ ОПТИМИЗАЦИЮ ВНУТРЕННЕЙ КАРТИНЫ ЗДОРОВЬЯ

Нестерак Р.В., Гасюк М.Б.

Важной задачей реабилитационной медицины является совершенствование и унификация процедуры реабилитации больных ишемической болезнью сердца. Отражением отношение человека к своему здоровью стал феномен внутренней картины здоровья (ВКЗ), основной ее функцией является регуляция деятельности индивида в отношении его поведения, направленного на поддержание здоровья и противодействие болезни. Клинико-психологическая реабилитация с помощью авторской «Программы клинико-психологической реабилитации кардиологических больных путем оптимизации внутренней картины здоровья» может применяться для контроля качества и эффективности реабилитации больных после острого коронарного синдрома. Применение такого подхода способствовало изменению объективных и субъективных данных больных, а также настройке на здоровый образ жизни. Факторами повышения качества реабилитации является применение комплексной медикаментозной терапии, тесного сотрудничества мультидисциплинарной команды в составе кардиолога, врача физической и медицинской реабилитации, психолога, физического терапевта и пациента.

Ключевые слова: острый коронарный синдром, чрескожное коронарное вмешательство, реабилитация, внутренняя картина здоровья.

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