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PSYCHOLOGICALASPECTS OF ALIMENTARY OBESITY (literature review)

Abstract. The article analyzes domestic and foreign studies on a role of psychological factors in the for- mation of alimentary obesity. The authors systematized the psychological features of obese individuals. The special role of emotions in the personal profile of patients with obesity is noted. Difficulty in expression (alexithy-mia) and the regulation of emotions such as anger, depression, disappointment, resentment, guilt leading to the for-mation of a substitute eating behavior. The main problems in the treatment of obesity are not only the inability to lose weight, but also the inability to maintain the achieved results of weight reduction, failures, the gradual return a body weight to the baseline. The possible psychological causes are a violation of the ability to prolong systhematic efforts, the inadequacy long-term life planning, the underdevelopment of a new image of oneself, an inadequate sense of pleasure from new sensations from a thin body. Psychological correction of psychogenic overeat-ing should include an educational component: informing the patient about the causes and features of the course of the disease, the risks of the formation of complications and secondary disorders, learning basic terminology. The modern methods of the disadaptive eating behavior psychological correction include cognitive-behavioral therapy, correction emotional imbalance, correction the old and

development of the new eating behavior, training in strategies aimed at retention of results, Gestalt therapy, art therapy.

Key words: obesity, eating disorders, psychogenic overeating, binge eating, emotions, psychological correction of obesity.

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ПСИХОЛОГИЧЕСКИЕ АСПЕКТЫ АЛИМАНТИЧЕСКОГО ОЖИРЕНИЯ (обзор литературы)

Аннотация. В статье анализируются отечественные и зарубежные исследования роли психологических факторов в формировании алиментарного ожирения. Авторы систематизировали психологические особенности лиц с ожирением. Отмечается особая роль эмоций в личностном профиле пациентов с ожирением. Трудности в выражении (алекситимия) и регуляции таких эмоций, как гнев, депрессия, разочарование, обида, вина, приводят к формированию замещающего пищевого поведения. Основные проблемы в лечении ожирения заключаются не только в неспособности похудеть, но и в неспособности поддерживать достигнутые результаты снижения веса, неудачах, постепенном возвращении массы тела к исходному уровню. Возможные психологические причины включают нарушение способности к длительным синтетическим усилиям, неадекватность долгосрочного планирования жизни, недоразвитие нового образа себя, недостаточное чувство удовольствия от новых ощущений, связанных с худым телом. Психологическая коррекция психогенного переедания должна включать образовательный компонент: информирование пациента о

причинах и особенностях течения заболевания, рисках формирования осложнений и вторичных расстройств, изучение базовой терминологии. Современные методы психологической коррекции дезадаптивного пищевого поведения включают когнитивно-поведенческую терапию, коррекцию эмоционального дисбаланса, коррекцию старого и развитие нового пищевого поведения, обучение стратегиям, направленным на сохранение результатов, гештальт-терапию, арт-терапию.

Ключевые слова: ожирение, расстройства пищевого поведения, психогенное переедание, компульсивное переедание, эмоции, психологическая коррекция ожирения.

The relationship between psychological status and excess body weight is currently being widely studied. The literature notes the significant role of psychological factors in the emergence, development, and maintenance of maladaptive forms of eating behavior. According to ICD-10, eating disorders leading to obesity include *psychogenic overeating* (PO) (heading *F* 50.4 reactive obesity, hyperphagic reaction to stress.

Active hyperphagia (AH): International Classification of Diseases (10th revision) "Mental and Behavioral Disorders", adapted for the Russian Federation), which has no analogues in *the DSM-5.* According to the proposed definition, PP is a reaction to distress, leading to the consumption of excess food to relieve emotional discomfort and, as a consequence, to obesity [7].

Psychogenic overeating corresponds to an emotional type of eating behavior, which occurs in approximately 60% of individuals with obesity and overweight. According to psychosomatic model put forward by *HL Kaplan, HS Kaplan,* in patients with psychogenic overeating stimulus to eating becomes not hunger, but emotional discomfort [8]. This means that a person does not eat because he experiences a physiological need for energy and nutrients, but also because he is irritated, anxious, feels guilty, ashamed, sad, tired, and sometimes even joy.

According to the "masking" hypothesis proposed by *J. Polivy and C. P. Herman* (1999), in some cases the substitution mechanism allows overweight individuals to replace difficulties in their lives with overeating. The patient considers excess weight to be the cause of distress and their main problem, although in fact, obesity – is merely a consequence of disharmony in other areas of his life. In this case, overeating occurs unconsciously, and the incessant attempts to lose excess weight serve as an excuse not to engage in his own life and ignore real problems [6].

The literature examines various factors that contribute to the development of psychogenic overeating. The role of family upbringing and the nature of relationships in the parental family are described. During their development, children experience a lack of attention, care, and emotional warmth.

from parents and begins to perceive food as the only way to give oneself pleasure, praise, pity, take care of one's own personality and express love [1, 2]. E.I. Getmanchuk identifies four stages of PP development. At the first stage, primary anxiety-depressive disorders develop as a result of psychotraumatic factors. At the second stage, there is an attempt to compensate and mask these emotional disorders through a hyperphagic reaction.

third - secondary anxiety-depressive disorders develop as a reaction to weight gain. The last stage is characterized by increased anxiety about excess weight.

food consumption and loss of the compensatory capacity of hyperphagia.

DSM-V classifies *compulsive* eating disorder as an eating disorder leading to obesity.

Binge -eating (BE). The main clinical manifestations of this disorder, according to According to the American Psychiatric Association (2013), short, repetitive

episodes of overeating, accompanied by accelerated food intake with a possible lack of feeling hunger, loss of control and a feeling of unpleasant fullness in the stomach upon completion.

According to the analysis of sources of electronic databases *Pubmed, PsychINFO* and *Embase,* in modern The study of psychological aspects of KO is widely represented in foreign literature. A large number experimental studies are devoted to the study of the cause-and-effect relationships between emotions and KO [25]. It has been established that excessive food consumption occurs mainly in solitude due to a feeling of shame in front of others and subsequently leads to a feeling of disgust towards themselves, guilt

[14]. *Emotions in the personality profile of patients prone to obesity.* Studies show that in the majority of patients (from 67 to 79%), CO is comorbid with mood swings and high anxiety level [25]. As a result of the examination of 279 women with eating disorders

[5], eating disorder of the emotiogenic type was detected in 32% of the examined subjects. During the interview, they reported that anxiety, irritability, bad mood, disappointment, resentment, loneliness, and boredom served as stimuli for eating. The most pronounced decrease in mood was observed immediately before eating. The experience of melancholy was revealed in the structure of this disorder. A connection was established between depressive symptoms, acute experience of melancholy, and KO, and it was shown that higher

Depression levels are associated with more severe CR [14].

Furthermore, food cravings leading to KO were associated with lower mood levels,

well-being and a higher level of stress than food cravings that did not lead to KO.

Along with the experience of melancholy, emotions such as anger, frustration, and anxiety play a significant role in KO

accounting for 95% of the moods preceding an episode of KO. In a number of studies

The significant role of anger in KO is noted. It has been shown that anger and disappointment can precede an episode of KO more often than melancholy and sadness [27].

In the development of CO, it is important to note the role of emotions arising as a result of interpersonal relationships: feelings of guilt, irritation, anger, rage, inadequacy, helplessness, discouragement, disappointment, jealousy. Studying a wide range of emotions in CO, *A. Zeeck et al.* [27] found that most episodes

The KOs were driven by anger, frustration, and feelings of suffering or loneliness.

However, in a recent meta-analysis*S. Evers et al.* [15]

I.G. Malkina-Pykh (2010), A.V. Sidorov (2012) highlight such psychological characteristics of patients as a tendency to categorical, dichotomous thinking, perfectionism, and a violation satisfaction with body image, excessive impulsivity and alexithymia [4, 6].

Psychological strategies for regulating emotions in eating disorders.

Emotional regulation is a person's ability to effectively experience, express, and manage emotions. emotions triggered by everyday events. People unconsciously use emotion regulation strategies to cope with difficult situations throughout the day.

regulate their emotions, have the ability to differentiate, as well as soften and modify own emotional states [12].

Most theoretical models of eating disorders *are* based on the idea that overweight people are unable to regulate their emotions, so turning to food serves as an attempt to avoid or alleviate emotional stress. For example, it is suggested that the inability to adequately cope with emotional states *(mood intolerance)* may be the underlying psychological process that determines eating disorders. A peculiar intolerance of emotions affects all intense emotional states.

states, including positive (e.g., excitement) and negative (e.g., depression, anger, anxiety). In people with eating disorders, binge eating is most often serves as an attempt to regulate these emotions.

A number of studies have examined the causal relationship between regulatory strategies emotions and overeating in OC. It was found that the most frequently used strategies for regulating maladaptive emotions in people with OC are emotion suppression and rumination.

"mental chewing gum" [14, 25]. When a person uses suppression as a regulation strategy

When emotions are suppressed, the outward expression of emotions decreases, but the emotion remains unexpressed. This strategy may be effective in the short term, but is likely ineffective in the long term. Ultimately, the person becomes fixated on their emotions rather than regulating them. Thinking in the “mental gum” type leads to indecision and inaction, which interferes with effective problem solving [25, 26].

in the form of a psychological experiment, which limits the possibility of transferring the obtained results to real life. An example of an attempt to overcome these limitations is the research

EMA *(ecological momentary assessment)* project [17].

Methods of psychological correction of eating disorders leading to obesity.

The main problems in the treatment of obesity are not only the inability to lose weight, but also the inability of patients to maintain the achieved weight loss results, relapses, gradual

return of body weight to baseline values. Possible psychological causes are: impaired ability to sustain longterm systematic efforts, insufficient long-term life planning, lack of formation of a new self-image, insufficient sense of pleasure from the new sensations of a slimmer body.

The most common methods of psychological correction include: - cognitive behavioral therapy; - correction of psychoemotional imbalance; - correction of old

and development of new eating behavior (habit correction); - teaching strategies aimed at maintaining results; - Gestalt therapy;

The use of a cognitive-behavioral approach to correcting eating disorders aimed at increasing the patient's motivation for treatment, establishing trusting relationships with therapist, concluding a psychotherapeutic contract. The patient, together with the psychotherapist, assesses his psychological readiness for change, analyzes the secondary benefits of excess weight, advantages and disadvantages of transitioning to a new lifestyle. Primary issues are being worked through weight loss goals. Among the primary goals most often noted are the desire to improve appearance, increase selfconfidence, and harmonize relationships with others. In motivational The techniques “For and Against Changes” and “Looking into the Future” have proven themselves particularly well in this phase [3]. Psychological correction of psychogenic overeating must necessarily include an educational component: informing the patient about the causes and characteristics of the course of this disease, the risks of developing complications and secondary disorders, the biopsychosocial concept of disorders, teaching the basic terminology (alimentary obesity, psychogenic overeating, body mass index, etc.)

Methods that correct the flow of reflexive (conscious) processes include “prohibition” training, which consists
of developing a “stop signal” reflex in response to a need
overeating, as well as training “working memory”, which involves developing the ability to retain in the mind “the goal is to lose weight”, which is especially important for self-control when tempted to overeat [19].

Psychological correction aimed at changing automatic (unconscious) processes is based on training
“attention shift”, as well as training “associations” [24], which consist of shifting the focus of attention from food to another object, developing a reaction of avoiding food [11].

An essential component of the psychotherapeutic process is the correction of alexithymia: the patient is
taught to separate physical hunger and emotional discomfort, for which it is suggested keep an emotional diary, which allows you to understand the relationship between your psychological state and the emerging feeling of hunger. The target of cognitive correction is the tendency towards perfectionism and dichotomous thinking of patients (for example, the technique "Reasonableness Exploration" thoughts") [3].

An important integrative part of therapy is shifting the patient's focus of attention with a decrease in
weight loss to other areas of life and preparing it for the stage of maintaining the achieved results.

[9, 16]. According to the literature, cognitive training programs that can be used in real-life situations, such as at work and at home, are much more effective [18, 22].

In this regard, programs using portable electronic devices seem promising. throne devices and the Internet [10].

Conclusion: Thus, a significant role in the onset and maintenance of uncontrolled
Psychological factors, primarily negative emotions and inadequate emotional regulation strategies, play a role in food intake leading to obesity
[14]. The most significant are experiences of anger and sadness, as well as negative emotions associated with interpersonal relationships (disappointment, pain, or loneliness). People prone to obesity are characterized by alexithymia; they poorly differentiate between feelings of hunger and emotional discomfort.

high levels of family anxiety, and depressive symptoms are often observed. Problems associated with obesity and its negative consequences can lead to psychological and social maladaptation. Therefore, the development of psychological methods aimed at correction of various aspects of maladaptive eating behavior. To achieve long-term psychotherapeutic effect, it is necessary

to conduct a comprehensive diagnosis of psychological patient characteristics, emotion regulation strategies, determine the type of eating disorder that can lead to the accumulation of excess weight and complicate the process of losing it.

Based on the obtained psychodiagnostic data, a strategy for psychological correction is developed. Effective treatment of psychogenic overeating should be carried out over a long period of time, integrating various methods with psychological correction, combining individual and group forms.

work, bringing the acquired psychological skills as close as possible to the patient's real life, which

will help the patient not only lose weight, but also maintain the results achieved.

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