PSYCHOSOMATIC RELATIONSHIPS IN DIFFERENT AGE GROUPS IN PATIENTS WITH FACIAL DERMATOSIS

[1] Lukasheva Anastasia Vladimirovna, [2]Karshiyev Ziyadulla Hazratovich, [3]Sharapova Dilfuza Nematillayevna, [4]Shernazarov Farrukh

[1]Siberian State Medical University, Russian Federation city of Tomsk

[2]Assistant of the department of psychiatry, medical psychology and narcology, Samarkand State Medical University, Samarkand, Republic of Uzbekistan

[3]Samarkand State Medical University Clinical ordenator in the direction of psychiatry, Samarkand, Republic of Uzbekistan

[4]608 group students of Samarkand State Medical University Faculty of Medicine

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Abstract. *The pathogenesis of psychosomatic diseases is determined by their occurrence, development, course, the leading contribution to the exaserbation of psychological factors and mechanisms. Somatopsychic relationships are mediated by the influence of somatic disease on the human psyche, its reaction to the pathological process, understanding the features of symptom perception, prognosis, treatment. The relevance of research in this area is due to the complexity of the identification and evaluation of mental and somatic relationships, the ability to reliably identify certain phenomena and processes.*

Keywords: *psychosomatics, dermatosis, psychological factors, somatopsychic relationships.*

Introduction. The prevalence of skin symptoms and diseases around the world requires not only their clinical interpretation, but also the development of complex treatment models based on a personalized approach within the framework of the modern biopsychosocial concept of understanding diseases. According to WHO official data, about 22% of the world's population suffers from skin diseases. At the same time, the epidemiological values of the combination of dermatological and psychological pathology are about 30-60% [1].

Current issues-the problem of primary and secondary disorders,as well as the effect of the cause and effect. Psychosomatic mechanisms determine the appearance of skin signs as a result of internal or external psychological factors and often their combination. In such cases, the cause of the disease is in the mental sphere, which affects and is based on the violation of somatic functions [2]. The "secondary" of dermatosis can be talked about not only with stressful, traumatic events, but primarily in the identification of interpersonal contradictions and certain personal characteristics that impair the individual's ability to adapt and do not contribute to the formation of problematic-decisive behavior. At the same time, many studies consider not only psychosomatic mechanisms, but also somatopsychics, since skin diseases, especially those that cause cosmetic defects and uncomfortable sensations, contribute to the development of neuropsychiatric diseases. In this version, dermatosis is not a consequence, but the cause of the appearance and development of mental disorders [3-6]. In 2012, studies in the UK, based on an assessment of the dermatology service's work on accepted standards, found that 17% of patients with skin manifestations need psychological assistance due to experiences caused by an existing dermatological disease, 14% identified an important role of the psychological factor in exacerbating symptoms, 8%, vice versa,

the deterioration of the psycho-emotional state due to the manifestation of skin diseases and 85% showed psychosocial aspects that concern them, which are associated with skin disease [7].

In research on the ratio of biological, psychological, social components of the pathogenesis of skin diseases, hereditary predisposition, constitutional features, individual life path, environmental influences and other factors are distinguished [8].

The biological relationship between the skin and mental regulatory systems is explained by the peculiarities of development at the embryonic level, since both are formed from the same embryonic layer and develop under the influence of the same hormones and neurotransmitters [9]. The skin secretes catecholamines, cortisol mediators whose participation in a systemic, nonspecific stress response is the basis of a neurogumoral response controlled by the hypothalamus — pituitary-adrenal system [10]. Disruption of homeostatic regulatory mechanisms is often mediated by psycho-emotional stress, which develops as a result of stressors or the influence of intrapersonal experiences. The data obtained from numerous studies formed the basis of the concept of the NICES - nerve-immuno-skin-endocrinological system [11].

Related to development, regulation, physiological and humoral management, the nervous, endocrine, immune systems and the surface of the skin act as a single complex, the regulation of which is determined by the connection of the components carried out by various hormones and mediators. It is known that the basis of many mental disorders is the ratio of work disorders and neurotransmitters. Similar processes also occur in many skin diseases [12].

Pathological changes in the nervous, endocrine, immune system cause a general imbalance of coordinated work, which is expressed in a violation of the adaptive resources of the whole organism. The result is expressed by the release and increase in secretion of hormonal discordation, uncontrolled nonspecific inflammation, neurotransmitters (acetylcholine, catecholamines), neuropeptides (neurokinin a, substance P, neurotenzine) and neutrophins (neutrophins [NGF]-3,4,5, nerve growth factor), which is a pathogenetic mechanism for mental and dermatological disorders [13]. For example, the development of depression in patients with facial dermatosis enhances afferent innervation of the facial region and leads to the manifestation of somatic skin reactions [14].

In the scientific literature, it is noted that there are gender characteristics in the frequency of occurrence of skin diseases. Thus, it was found that men are more likely than women to suffer from skin diseases, but less likely to seek medical attention [15].

At the present stage of scientific research based on the principles of evidence-based medicine, the problem of determining and evaluating cause-and-effect relationships and the interaction of the skin and psyche remains [16].

Despite the complexity of detecting mental and somatic interactions and distinguishing primary pathogenetic mechanisms, many studies have reliably confirmed that skin diseases, the main effect of which depends on psychological factors, are significantly more common in pathogenesis, which determines the relevance of a comprehensive approach to the diagnosis, treatment and Prevention of these diseases [17].

Currently, there is no doubt that in the development of any psychogenic disorder, including the skin, not only the psychotraumatic phenomenon itself, but also the sensitivity and weakness of the patient's psyche, based on deep psychological mechanisms, play an important role-premorbid personality traits, interpersonal contradictions, adaptive and protective mechanisms (active

psychological protection, coping mechanisms, problem-solving behavior skills), as well as features of social activity [18, 19].

One of the frequent characteristics of Psychosomatic patients that are important in the pathogenesis of these diseases is the premorbid characteristic - alexithymia (inability to recognize and manifest emotions), which leads to difficulties in distinguishing between somatic sensations and negative emotional experiences [20]. Has been argued that moderate to severe levels of atopic dermatitis are significantly more frequent in people who are unable to confront high levels of alexithymia, anxiety, stressful, and psychotraumatic situations, further weakening such individuals and significantly lowering their quality of life.

Representatives of the dynamic direction of psychotherapy believe that, based on an analytical interpretation of the psychosomatic nature of skin diseases, it plays a role in relation to the psychological protective function of the skin, creating not only a physiological, but also a psychological barrier of the body to maintain and maintain homeostasis.barriers of personality from stressful negative influences, psychological trauma [21-23]. According to the psychoanalysis paradigm, the main cause of psychosomatic disorders should be considered an interpersonal conflict between the conscious and the unconscious, the content of which is sexual and aggressive impulses that contradict the norms of social morality. Skin diseases and forced scratches during exacerbation were seen as an expression of taboo autoagression and autoerotism. Some authors believe that the manifestation of dermatological diseases is the result of a symbolic conversion associated with sadomasochistic, voyeuristic and visual trends in individuals with hysterical manifestations [24-27].

By introducing the term" skin neurosis", offered to attribute such skin diseases to him, based on "neurotic conflicts", which in most cases manifest with anxiety and anxiety [28].

In their work, viewed the skin as an organ representing an internal need to reduce emotional stress, considered it an area to respond to aggressive effects, and noted the significant impact of various psychological conflicts on the severity of atopic dermatitis. Such relationships form a vicious circle (mediator chaos): a violation of the anxiety-depressive series, an increase in free radical oxidation and an imbalance of mediator units create a complex picture of dermatosis pathogenesis, in which it is not always possible to distinguish a primary connection [29-31].

If, as a result of the influence of psychological factors, a skin psychosomatic disease develops that changes appearance, accompanied by unpleasant symptoms (burning, itching, redness, peeling, maceration, etc.), then a violation of quality of life, a decrease in the chances of social activity, a decrease in self-esteem, a change in self-attitude becomes an additional irritating factor, which increases anxiety, skin disease [32-36]. There are prerequisites for breaking up relationships with others, building personal relationships, because dermatological diseases affect sexuality and the ability to orgasm [37].

Patients with skin diseases are more susceptible to addictive behavior, specifically alcoholism and smoking, than healthy people, as alcohol and nicotine have anxiolytic properties and reduce anxiety [38].

The purpose of the study: to study the characteristics of Psychosomatic relationships in patients of different ages with facial dermatoses.

Materials and methods. 70 patients aged 14 to 66 (average age 29.3±1.4 years) were treated on an outpatient basis by a dermatologist due to various facial dermatoses. All patients were advised by a dermatologist and psychiatrist. 34 patients were diagnosed with adult acne, 24

adolescent acne, 12 rosacea and rosacea (perioral) dermatitis. The severity of skin disease ranged from mild (11.4%) to acute (7.1%). Moderate to severe skin disease rates are presented in 45.7% and 35.7% of cases, respectively. The patients examined were divided into 2 groups according to age: the first group of patients under 24 years of age and the second group of patients aged 25 and older based on the separation of age/adult forms of skin pathology by a dermatologist. The assessment of psychopathological symptoms was carried out using psychometric scales: the hospital anxiety and depression scale (HADS), the Hamilton anxiety and depression scale (both-A and-D), and the SCL-90 psychopathological symptomatology survey. Quantitative assessment of Psychosomatic relationships was carried out using Pearson and Spearman correlation coefficients.

Results and discussions. Mental disorders according to the ICD-10 criteria were diagnosed in 44% of patients and mostly fell under the category F4 "neurotic, stress-related and somatoform disorders". In such cases, the next age will most likely determine the severity of depressive experiences and depression. This is shown by the average positive correlation between the age of patients and the incidence of hads depression and the overall SCL-90 index (r=0.335, p<0.01 and R=0.362, p<0.01, respectively).

The findings suggest that the severity of skin lesions determines the severity of response anxiety reactions, which is confirmed by the severity of skin disease with both-a (rs \ U003D 0.284, p<0.05) and SCL-90 somatization and the presence of a direct relationship with signal subschales (rs \ u003d 0.315, p<0.01 and rs \ u003d 0.344, p< 0.01 respectively).

Psychosomatic relationships in comparison groups differed in structure. Thus, in the older age group, more accurate relationships were established between the age of patients and the indicators of hads depression, the general index of SCL-90 (r \ u003d 0.426, p<0.05 and R \ u003d 0.425, p<0.05, respectively) than in the general group.

A direct relationship was found between the age of the patients and the HAM-D indicators (r=0.400, p<0.05). The severity of the disease in the adult group was positively correlated with paranoia of SCL-90 (R=0.336, p<0.05).

No correlation between age indicators and severity of psychopathological symptoms has been reported in the comparison group, but a clear correlation between severity of skin diseases and HAM-a indicators has been found (rs=0.483, p<0.01). Positive relationships have also been found between the severity of dermatological pathology and a number of SCL-90 subcalls: somatization (rs \ u003d 0.489, p<0.01), obsessions (rs \ u003d 0.337, p<0.05), anxiety (rs \ u003d 0.392, p<0.05), paranoia (rs \ u003d 0.338, p<0.05), and the overall measurement index (Rs=0.456, p<0.01).

Such differences in Psychosomatic relationships depending on the age of patients allow us to draw conclusions about the peculiarities of the pathomorphosis of mental disorders in such patients. Based on the data obtained, it can be assumed that mental pathology in facial dermatosis in young patients is mainly represented by acute anxiety reactions, and its severity depends on the severity of skin damage.

The correlation between patient age and HAM-D rates varies over time as the structure of mental disorders changes with prolonged depressive symptoms, worsens moderately with age, and does not depend on the severity of skin lesions.

In the age group, SCL-90 somatization indicators were positively correlated with hads and HAM-a signal indicators (r=0.539, p<0.01 and R=0.348, p<0.05). In the larger group, a

relationship between the values of the SCL-90 somatization index and the levels of depression and anxiety in terms of hads has been noted ($r=0.459$, $p<0.01$ and $R=0.420$, $p<0.05$). This difference, with age, can be associated with the fact that in such patients, as a rule, gradual somatization of anxiety and depressive disorders, manifested by a number of specific skin symptoms, occurs.

Conclusions. Thus, a significant level of mental illness has been reported in patients with facial dermatosis, mainly represented by neurotic disorders of the anxiety spectrum. In patients with facial dermatosis, the structure of Psychosomatic relationships undergoes certain changes with age. Thus, young patients are characterized by a greater parallel with the severity of skin disease and the severity of anxiety disorders.

At the same time, it is characteristic that the severity of depressive disorders for elderly patients does not directly depend on the severity of dermatosis. The data obtained can be used to develop the "goals" of complex therapy, depending on the age of the patients and the structure of the existing diseases.

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