ATJ, 2024, №2, 117-124

AZƏRBAYCAN TİBB JURNALI
AZERBAIJAN MEDICAL JOURNAL

KƏLLƏ VƏ BOYUN DEFORMASİYASI OLAN XƏSTƏLƏRİN FƏRDİ-PSİXOLOJİ XÜSUSİYYƏTLƏRİ, PSİXOSOSİAL DEZADAPTASİYA, HƏYACANLANMA, DEPRESSİYA, STRESLƏ ƏLAQƏLİ POZUNTULAR VƏ ONLARIN KORREKSİYASI

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Xülasə. *Məqalədə kəllə və boyunda defekt və deformasiyalara görə rekonstruktiv operativ müalicə alan xəstələrdə törənən psixososial dezadaptasiya, klinik psixopatoloji və parapsixoloji dəyişikliklərin kompleks psixokorreksiya sisteminin tətbiqinin effektivliyinin analizi təqdim edilmişdir. Tədqiqatın əsasını başında və boynunda defekt və deformasiyalar olan şəxslərin fərdi-psixoloji xüsusiyyətlərinin psixi vəziyyətinin, dezadaptasiya təzahürlərinin və sosial fəaliyyətinin öyrənilməsi təşkil etmişdir. Nevrotik, streslə əlaqəli pozuntuların diaqnostikası aparılmış, onlara əsaslanmaqla psixokorreksiya sistemi hazırlanmışdır. Müəyyənləşdirilmişdir ki, baş və boynun defekt və deformasiyalarına görə rekonstruktiv operasiyalar kursu keçən pasiyentlərə tətbiq edilən psixoterapevtik tədbirlər zamanı müalicəvi təsir sistem şəkilli, mərhələli və kompleks olmalıdır. Bu zaman bir neçə psixoterapiya üsulundan istifadə edilməli, pasiyentin klinik-psixopatoloji və psixoanamnestik xüsusiyyətlərindən asılı olaraq müalicə metodları diferensiasiyalı şəkildə seçilməli, həmçinin zədələnmənin xüsusiyyəti, operativ müdaxilələrin sayı, pasiyentin şəxsi reaksiyavermə xüsusiyyəti nəzərə alınmalı, psixoterapevtik təsir maksimal şəkildə fərdiləşdirilməlidir.*

Açar sözlər: *həyacanlanma, depressiya, streslə əlaqəli pozuntular, kəllə və boyun deformasiyaları, psixokorreksiya*

Ключевые слова: *тревога, депрессия, расстройства, связанные со стрессом, психосоциальная дезадаптация, дефекты и деформации головы, психокоррекция*

Key words: *anxiety, depression, stress-related disorders, psychosocial maladjustment, head defects and deformations, psychocorrection*

INDIVIDUAL PSYCHOLOGICAL CHARACTERISTICS, PSYCHOSOCIAL DISADAPTION, ANXIETY, DEPRESSION, STRESS-RELATED DISORDERS IN PATIENTS WITH DEFECTS AND DEFORMATIONS OF THE HEAD AND NECK AND THEIR PSYCHOCORRECTION

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The article presents an analysis of the effectiveness of a comprehensive psychocorrection system applied to patients undergoing reconstructive surgery for cranial and cervical defects and deformities, focusing on the resulting psychosocial maladaptation, clinical psychopathological changes, and parapsychological alterations. The study involved 118 patients with defects and deformities of the head and neck. To achieve the goals and objectives of this study, the following methods were used: information-analytical, clinical-anamnestic, clinical-psychopathological, psychodiagnostic, psychometric and statistical methods of mathematical processing of the results.

Based on the results of our survey, both general personality traits and stereotypical response mechanisms, as well as certain differences between the examined patients, were identified. Using the data of a comprehensive examination, a program of psychotherapeutic correction was developed, taking into account the individual and group characteristics of patients.

The main principles of building a system of psychotherapy for patients with defects and deformities of the head and neck, who undergo a course of reconstructive operations, should be the systemic influence and phasing of psychotherapeutic measures, complexity, the use of several methods of psychotherapy.

Introduction. Restoration of deformed tissues has always been an actual medical and social problem of mankind. It is known that even minor head injuries, and in particular the face, cause cosmetic inconvenience in patients and are the severe mental trauma [1-3].

Cosmetic defects often bring people no less suffering than pain caused by a pathological process [4, 5]. Congenital or acquired physical defects, defects of the sense organs, mutilations, actual or imagined cosmetic defects, etc. can become for a person a source of a sense of inferiority, moral suffering, and, accordingly, lead to the emergence of psychosocial maladjustment and the development of various psychopathologies, mainly of a neurotic level [6-9]. In particular, a high correlation was found between the level of personal depression and the degree of dissatisfaction with the body, between the success of self-realization and the assessment of one's own body [10, 11].

Concerns about physical appearance affect a sizeable proportion of the general population [12]. Some concerns relate to inherited characteristics, for example, body shape, facial features. In addition, during a life course, changes to outward appearance occur—some of which are desired, while others are not [13]. Throughout our lives, the majority of us strive to manipulate the way we look in some way, in order to present ourselves in the best possible light [14-16].

Suffering arising in response to the fact of the formation of pronounced cosmetic defects does not always lead to the decompensation of the protective mechanisms of the psyche. Sometimes they contribute to hypercompensation or revaluation by the victims and their relatives of generally accepted standards of beauty and value guidelines. However, in most cases, defects and deformations of the appearance, especially parts of the face, affect the personality, change the person’s character and behavior, and cause disturbances in the emotional and motivational sphere.

Today, an increasing number of patients are turning to plastic surgery. According to WHO data, the number of reconstructive surgical interventions has increased several times over the past decade. This is due both to the high availability of plastic surgery for patients, and to the significant expansion of opportunities in this industry. At the same time, in a significant part of cases, the appeal to specialists in the field of aesthetic surgery is associated with the so-called "pursuit of the ideal", the desire to meet certain standards of beauty that are imposed by television advertising, public opinion. The feeling of inferiority knocks a person out of the labor rhythm, reduces vitality and quite often leads to the decision to perform aesthetic surgery, which is not always necessary [17].

The pressures leading a person with a visible difference to seek some kind of professional help come from a variety of sources and may be driven by a combination of personal beliefs, coercion from family, peers, the media, or societal context. Interventions and provision of care in relation to disfigurement can usefully be classified as biomedical, psychosocial, or educational [18].

Premorbid "neurotic personality structure" (the presence of special personal traits within the framework of accentuations, primarily hysteroid, anxious-thoughtful and sensitive radicals) is the main prerequisite for the emergence of reactive states. Remote consequences of skull injuries, neuroinfections, physical and mental fatigue can also play an important role.In cases of formation of post-traumatic stress disorders, as a rule, the following characterological features are present: emotional instability, increased anxiety, immaturity of the personality [19].

In this case, both the very fact of the formation of the defect and caused by it the sudden change in the perception of one's body, the frustration of many life needs, and the violation of the implementation of life programs of varying degrees of expressiveness act as psychotraumatic factors. As a rule, mental disorders are mainly related to the position of the individual, and not to microsocial factors. However, it is quite difficult to objectively assess the degree of severity of mental trauma and its specific weight in the formation of a mental disorder.

A large number of defects that are considered cosmetic, for example, abnormalities of the auricles and nasal membrane, are accompanied by physical and functional disorders that additionally affect the mental state of the patient [20].

Whether present at birth, congenital or

acquired later in life, a visible disfigurement can have a profound psychological impact upon the individual concerned. Difficulties include adverse effects on body image, quality of life, and self-esteem. In addition, social encounters can present many challenges, however many individuals adapt to the demands placed upon them and appear relatively unaffected by their visible difference [21].

A cosmetic defect quite often begins to affect the patient in childhood, especially during puberty, which definitely has a negative impact on the formation of character. In such patients, the personality is formed with the predominance of shyness, indecisiveness, behavioral strategy of avoidance in conflict situations. On the background of a feeling of inferiority, ideas of relationship often develop, they begin to believe that they are constantly viewed by others, laugh at them, and this ultimately leads to a sharp limitation of social contacts, affects work capacity, harms socio-economic success [22].

In this situation, there is an acute question of the need to create a system of psychocorrection for patients undergoing reconstructive surgery.

The aim of our research was to study the effectiveness of the use of psychocorrection of psychosocial maladjustment and mental non-psychotic pathology in patients with defects and deformities of the head and neck before and after a course of reconstructive plastic surgery.

Material and methods. The study involved 118 patients with defects and deformities of the head and neck (62 women and 56 men). The age of patients is from 22 to 56 years. Patients were initially divided into two groups according to their motives for seeking medical help.

The first group included 66 patients, or 55.93% of the total number of examinees, who had congenital or acquired defects or deformations of the head and neck, which significantly deviated from the physiological and aesthetic norm accepted in cosmetology, distorted the appearance and were clearly visible at the first look at the patient. When applying for medical cosmetology help, they motivated their desire by the need to improve their appearance, to make it conform to certain generally accepted standards in their social environment. Patients of this group underwent surgical reconstructive intervention based on absolute medical indications.

The second group consisted of 52 patients (44.07% of the total number of examinees) who had minor cosmetic defects or deformations of the head and neck, but at the same time they paid undue attention to them due to subjective factors, were not satisfied with their appearance and wished to radically improve it. The main motives for seeking help from plastic surgeons were the desire to establish interpersonal relationships and achieve success in the professional field. Patients of this group underwent surgical reconstructive intervention based on relative medical indications.

Among those examined in the first group, there were 32 women and 34 men, and among patients in the second group, this indicator was 30 and 22, respectively.

Data on the age of the examinees at the time of the study are presented in Table 1.

In the first group, among patients with distinct defects or deformations of the head and neck, young people predominated. The most numerous age group were patients aged 18-25, who were 59.09%. The second group was dominated by older people, the most numerous of which was the group of patients aged 36-50, which comprised 44.23% of all examined.

For 56 (84.85%) examinees from the first group, this request for help to plastic surgeons was the first, and 10 (15.15%) patients resorted to surgical interventions for the second time in order to eliminate defects and deformities of the face. In the second group, 29 (55.77%) patients were primary and 23 (44.23%) were repeatedly treated in this department.

Congenital defects of the head and neck were the reason for seeking medical help for 78.79% (52 people) of the patients of the first group. Of them, 15.15% were formed within the framework of

Table 1. Distribution of examinees according to age at the time of the study

Age of the examined	The first group, n = 66		The second group, n=52	
	absolute number	%	absolute number	%
18-25	39	59,09	9	17,31
26-35	20	30,30	12	23,08
36-50	7	10,61	23	44,23
after 50	0	0	8	15,38

nosologically defined congenital anomalies, and 63.64% were the result of disproportionality of development and were accompanied by acute dissatisfaction with one's own appearance. Acquired pathology, mostly of a traumatic and technogenic nature, was observed in 21.21% (14 people) of the first group examinees.

At the same time, 63.46% (33 people) of the patients of the second group had a subjective belief about the presence of cosmetic facial defects, the inconsistency of their own appearance with generally accepted social standards, which, in their opinion, is the cause of communication difficulties and social failures. Another 36.54% (19 people) of the examinees of this group decided on the necessity for surgical correction of appearance due to age-related changes in the face.

To achieve the goals and objectives of this study, the following methods were used: information-analytical, clinical-anamnestic, clinical-psychopathological, psychodiagnostic, psychometric and statistical methods of mathematical processing of the results. The clinical-psychopathological method was used on the generally accepted principles of psychiatric examination by interviewing and observation, followed by verification of the data obtained based on the ICD-10 diagnostic criteria. At the stage of involving patients in the study, an examination was carried out using the "Scale for complex assessment of the degree of psychosocial maladjustment in various areas". The Diagnostic Interview Schedule (DIS) revealed information about the causes of difficulties in psychosocial functioning in patients. In order to evaluate the effectiveness of psychocorrection, the Clinical Global Impression Scale (CGI-S) was used at the screening stage and the Clinical Global Impression – Improvement scale (CGI-I) was used to reflect the severity of the patient's condition, the degree of improvement that provided it is possible to assess the degree of psychocorrection effect.

Results and Discussion. Based on the results of our survey, both general personality traits and stereotypical response mechanisms, as well as certain differences between the examined patients, were identified.

In patients with medical indications for surgery (I group), at the onset of the reactive state, neurasthenic symptoms predominated, which manifested themselves as irritability, a tendency to dysphoria, and, sometimes, alcoholism. These symptoms somewhat concealed a gloomy mood, deep inner tension, and hypochondriacal doubts. There was a sharpening of perception of unpleasant aspects of life, sleep disturbances. Over time, in some patients, hypochondriacal unrest acquired confidence in the incurability and was supplemented by obsessive thoughts of a tragic content. Depressive manifestations, anxiety-phobic symptoms with agitation, obsessive ideas were frequent (the fate of a lonely disabled person was drawn, life seemed “ended”). Anxiety was especially intensified in the evening, which led to persistent insomnia.

The overwhelming majority of patients who applied for medical help for cosmetic reasons had a high social status (II group), lived in good material and living conditions, but quite often noted dissatisfaction in the sexual sphere. Sexual issues, as a rule, dominated in the clinical picture of anxiety and depressive symptoms, characteristic of most patients in this group. Their most common personality traits were isolation, communication difficulties, imbalance, tension, suspicion, suggestibility, impulsiveness, guilt. The significant prevalence of mental disorders in their environment can be justified by the fact that for them appearance, attractiveness in most cases were very significant for themselves. It is no coincidence that in the presence of a physical defect, even the very contact with others became a psychotraumatic factor for them.

Analysis of psychodiagnostic studies showed the following. In the patients of the I group, the personal attitude towards their own appearance in all cases was was expressed negatively, that is, the examinees recognized the surgical correction of appearance as the only means to get out of the crisis situation associated with the non-compliance of their own appearance with socially acceptable standards. Persons with acquired facial defects and deformities perceived their own appearance most negatively.

The overall self-assessment of social and personal significance in the first group examined was low in 50 (75.76%) cases, average in 15 (22.73%) and only 1 (1.51%) patient rated his social and personal status highly.

When determining the leading sphere of the I group patients’ activity, it was established that in 52 (78.79%) persons it had a personal and family orientation, in 3 (4.55%) – social and professional, and in 11 (16.66%) of the examined it had mixed character. In 2 (3.03%) patients, the communication sphere had the character of wide connections, in 9 (13.64%) it

was limited to family and professional communication, in 39 (59.09%) it was family-restricted and in 16 (24.24%) of persons was determined by selective contacts.

The examination of the II group patients showed that 32 (61.54%) of them had a generally positive attitude to their own appearance, considering surgery only as an additional means of improving it, 7 (13.46%) were completely negative, considering surgery as the only way out of a crisis situations, 2 (3.85%) – neutrally and 11 (21.15%) persons – ambivalently. When studying the general self-assessment of social and personal significance in the II group patients, it was found that in 9 (17.30%) cases it was low, in 15 (28.85%) – average, and in 28 (53.85%) – high.

According to the results of the assessment of the degree of psychosocial maladjustment using the "Scale for complex assessment of the degree of psychosocial maladjustment in various areas" it was established that in the first group, which included 66 persons, violations prevailed in the socio-economic, socio-professional and socio-informational spheres of psychosocial functioning, where the indicator exceeded 20 points and corresponded to the signs of maladaptation. 44 (66.67%) patients of this group were diagnosed with neurotic, stress-related and somatoform disorders, in particular, 11 people with mixed anxiety and depressive disorder (F41.2), 4 people with obsessive-compulsive disorder (F42), 8 people – adjustment disorders (F43.2), neurasthenia (F48.0) – 5 people, hypochondriacal disorder (F45.2) – 6, somatoform autonomic dysfunctions (F45.38) – 3, phobic disorders (F40.2) – 7.

In the second group, numbering 52 persons, in whom indicators of more than 20 points were found on at least one of the scales, which corresponded to the signs of maladjustment, violations prevailed in the interpersonal, family and parental spheres. The clinical picture in this group is mainly represented by mixed anxiety and depressive disorder (F41.2) – 9 people, with a predominance of sexual complaints.

Analysis of the features of psychosocial maladjustment in the studied contingent made it possible to obtain the following results. The average indicators of psychosocial maladjustment in certain areas of psychosocial functioning according to a scale for complex assessment of the degree of psychosocial maladjustment in various areas are shown in the Table 2.

Thus, the differences between patients in I and II groups were established, which affect both the patient's behavior and his response stereotypes in various situations. It was shown that non-psychotic mental pathology with signs of psychosocial maladjustment was present for patients who had congenital or acquired defects or deformations of the head and neck and deviated significantly from the physiological and aesthetic norm. Patients with minor cosmetic defects or deformations of the head and neck, but with excessive fixation on them, had pronounced signs of psychosocial maladjustment in various areas and of varying degrees of severity. Based on the received data and using the data of a comprehensive examination, a program of psychocorrection was developed, taking into account the individual and group characteristics of patients. Psychotherapeutic correction in both

Table 2. Average indicators of the degree of psychosocial maladjustment according to the scale for complex assessment of the degree of psychosocial maladjustment in various areas in patients with defects and deformities of the head and neck

Spheres of psychosocial maladjustment	Average indicators, M±m (points)		p
	I group	II group	
Socio-economic maladjustment	54,48±2,77	23,69±8,56	<0,01
Social and information maladjustment	43,38±2,71	31,59±8,55	<0,01
Social and professional maladjustment	52,88±2,61	12,36±6,58	<0,01
Interpersonal maladjustment	13,04±2,68	71,31±7,46	<0,01
Family maladjustment	14,79±2,56	67,80±8,13	<0,01
Parental maladjustment	14,27±3,13	46,24±8,06	<0,01

groups of patients began before reconstructive surgery and ended after it. The basis of psycho-corrective measures was a comprehensive program aimed at various personal and behavioral aspects that were involved in the formation of an inadequate response to the presence of cosmetic defects. The system of psychotherapeutic correction was based on a didactic approach, which provides phasing of influence, the connection of each subsequent session with the previous one, the availability of information for the patient, and the correspond-dence of tasks to the patient's capabilities. At the same time, in the process of psycho-therapeutic influence, we identified three stages: sedative-adaptive, therapeutic-corrective and prophylactic-fixing.

At the first stage, which, as a rule, consisted of 1-2 individual sessions, individual psycho-therapeutic sessions were conducted, during which, first of all, emotional contact with the patient was established, an adequate attitude to psychotherapy was formed, trust in the doctor was carried out, the phenomena of psychosocial maladjustment and acute neurotic symptoms were deactualized.

The therapeutic-corrective stage consisted of 2-3 individual sessions and included the achievement of positive dynamics in the patient's emotional state, awareness of the connection between factors and manifestations of neurotic disorders with personality and behavioral characteristics, conflicts, and unresolved emotional problems. An important task was to correct the scale of experience due to a defect or deformation, its social signi-ficance, the restructuring of the patient's perso-nality, the system of his relations. The central problem of this stage of psychotherapeutic correction was the formation of self-confidence, adaptation to the perception of one's appearance.

Of the methods focused on the personality, we used rational psychotherapy in individual and group forms. The most common methods for correcting the psycho-emotional state are behavioral and cognitive psychotherapy. Of the methods of suggestive psychotherapy, indirect suggestion, autosuggestion by Coue, autogenic training were used both before and after surgery.

The third, postoperative stage was mainly carried out in a group (4-6 persons each) form and included mainly the refinement of mental self-regulation skills using rational psycho-therapy, correction of life values, attitudes towards one's "I" and the environment, readap-tation to macro- and microsocial environment. Classes lasted 60-80 minutes 2-3 times a week.

In psychotherapeutic groups, we used training of confident behavior and social skills. Patients received homework: they were asked to write down everything they did every day, felt, what problems they encountered. These self-reports were reviewed before the sessions and made it possible to obtain the necessary information about the effectiveness and its appropriateness.

For three months after plastic surgery, 56 (84.85%) patients of the first group showed a weakening of internal tension, anxiety, and dysphoric manifestations leveled off. Hypo-chondriacal excitements lost their expres-siveness, but were sometimes maintained due to postoperative asthenia and pain syndrome. In general, due to the carried out psychothe-rapeutic correction in these patients, it was possible to achieve a state of mental com-pensation.

During the same period, 33 (63.46%) anxiety-phobic symptoms were significantly deactivated in patients of the second group. When using psychotherapy before plastic surgery 14 (26.92%) patients refused surgery in the second group. This once again testifies in favor of the fact that the change in appearance in the vast majority of cases is clearly overestimated as a means of solving life's problems. If a person is happy, if his inner life is harmonious, then he is least of all concerned with how he looks. A change in appearance does not entail a change in personality, and plastic surgery does not eliminate psychological problems.

By results of the research, it was established that in the first group of patients, according to the CGI-I scale, there were very much improved in the mental state – 44 (66.67%) persons, much improved in the state – in 19 (28.78%) persons, minimally improved in the state – in 3 (4.55%) persons, worsening of the state was not noted.

In the second group, the results according to this scale were as follows: very much improved – 28 (53.84%) persons, much improved – 22 (42.31%) persons, minimally improved – 2 (3.85%) persons, no changes or worsening of the condition were not noted.

Conclusion. In the modern world, when the social rhythm of life tends to constantly accelerate, the possibilities of reconstructive surgery technologies are rapidly increasing, and the number of patients who seek help from plastic surgery is also increasing, which is not always advisable, since optimally carried out psychocorrection in many cases can be solve existing problems without surgery. Mostly, the desire to eliminate any cosmetic defect is, first of all, the desire to change something in personal life, solve psychological problems, and improve interpersonal issues, overcome the phenomenon of maladaptation. But at the same time, one should not ignore patients who have significant damage to their appearance and are undergoing a course of reconstructive surgery. In such cases, psychotherapeutic correction can significantly improve the psycho-emotional state of patients, readjust them in society, develop self-confidence, and solve interpersonal and sexual problems.

To correct the psycho-emotional state, patients with defects and deformities of the head and neck were treated with rational psychotherapy, autogenic training, behavioral psychotherapy in accordance with the predominance of one or another psychopathological syndrome, the features of the clinical picture, the number of performed plastic surgeries and their effectiveness, the premorbid state of the personality.

The main principles of building a system of psychotherapy for patients with defects and deformities of the head and neck, who undergo a course of reconstructive operations, should be the systemic influence and phasing of psychotherapeutic measures, complexity, the use of several methods of psychotherapy, differentiated selection of methods depending on the clinical-psychopathological and psychoanamnestic characteristics of the patient, as well as the characteristics of damage, the number of surgical interventions, personal response, as well as the maximum individualization of psychotherapeutic influence.

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ИНДИВИДУАЛЬНО-ПСИХОЛОГИЧЕСКИЕ ОСОБЕННОСТИ, ПСИХОСОЦИАЛЬНАЯ ДЕЗАДАПТАЦИЯ, ТРЕВОГА, ДЕПРЕССИЯ, РАССТРОЙСТВА, СВЯЗАННЫЕ СО СТРЕСОМ У ПАЦИЕНТОВ С ДЕФЕКТАМИ И ДЕФОРМАЦИЯМИ ГОЛОВЫ И ШЕИ И ИХ ПСИХОКОРРЕКЦИЯ

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Резюме. Представлен анализ эффективности применения системы комплексной психокоррекции психосоциальной дезадаптации, клинико-психопатологических и патопсихологических особенностей пациентов с дефектами и деформациями головы и шеи, которые проходят курс реконструктивных операций. В основу данного исследования положены индивидуально-психологические особенности лиц с дефектами и деформациями головы и шеи, исследование их психологических особенностей, проявлений дезадаптации и социального функционирования. Диагностированы невротические, связанные со стрессом расстройства, особенности которых положены в основу разработанной системы психокоррекции. Установлено, что для пациентов с дефектами и деформациями головы и шеи, которые проходят курс реконструктивных операций должны быть системность влияния и этапность психотерапевтических мероприятий, комплексность, использование нескольких методик психотерапии, дифференцированный подбор методик в зависимости от клинико-психопатологических и психоанамнестических особенностей пациента, а также особенностей повреждения, количества оперативных вмешательств, личностного реагирования, а также максимальная индивидуализация психотерапевтического влияния.