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GROUNDING PSYCHOLOGICAL HELP FOR ADOLESCENTS WITH ATOPIC DERMATITIS

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Abstract. The article addresses some information about psychological problems, emotional state, personal, behavioral and family-associated patterns in adolescents with atopic dermatitis, which served a basis for differentiation of targets and measures of psychological help.

There were defined such targets of psychological interventions as follows: physical discomfort, self-perception of the appearance, poor therapy compliance, reduced mental activity, high levels of anxiety, depressive manifestations, disharmonious personal features, a destabilizing profile of coping strategies, distancing and avoidance strategies, problems in child-parent relationships, imbalanced marital relationships, affected self-acceptance, imbalanced in the internality-externality axis, high escapism.

As psychological interventions there were used some techniques of Gestalt therapy, rational therapy, art therapy, cognitive-behavioral therapy, psychological training. Family therapy was an important component of psychological help for adolescents with atopic dermatitis.

Key words: atopic dermatitis, adolescents, psychological help.

Atopic dermatitis (AD) is a serious interdisciplinary medical problem which various physicians encounter in the everyday practice. This is due to the prevalence of AD in pediatric population, characteristics of the disease course and involvement not only the skin, but other

organs and body systems [1, 2]. According to epidemiological studies, the incidence of AD ranges from 6.0 to 25.0 per 1,000 population and it tends to grow [3].

Many publications cover the problems of clinical presentation, diagnosis and treatment of AD both in adults and children, i.e. purely medical aspects of the disease. However, the steady increase in the number of patients with AD and tendency to chronicity and severity of the disease are indicative of the need for new methods and approaches to treatment.

Numerous testimonies of significant influence of psychological factors on the occurrence and course of skin diseases were the basis for the development of psychodermatology. The aspects within the competence of psychodermatology include investigation of psychological factors impact on the occurrence and course of dermatoses; identification of psychological changes associated with skin diseases and the treatment; assessment of prevalence and structure of mental disorders in dermatoses, psychopharmatherapy; revealing the psychosomatic background of dermatological diseases; development of psychological care for patients with skin diseases.

From a psychological viewpoint the skin is an organ of contact with other people (touch, pain, sexual arousal, physical violence), an indicator and reflection of the human emotional state. Dermatological diseases that lead to a change in appearance (defects, flaws) make interpersonal interaction difficult, contribute to social phobia. The feeling of own ugliness and immediate related subjective experiences are usually stronger than in surrounding people [4]. Features of clinical manifestation of the disease cause difficulties of patients' social adaptation, to great extent worsen the quality of life, social activity, reduce productivity, create difficulties in communication, personal life, and a severe course can lead to the isolation of the patient. [5].

Itching, which occurs in many skin diseases and is resistant to treatment, is an extremely unpleasant symptom and as a chronic symptom it leads to high anxiety [6].

Children likely to develop atopic dermatitis are often characterized by high sensitivity and nervousness, which is not only a source of stress for children and parents, but further increases the effects of pathological factors of the disease [7]. Psychological features of children with AD are also characterized by emphasizing characterological traits, increased emotionality, the presence of aggressive tendencies, inability to express negative emotions, affected identification [8].

Psychosomatic understanding of AD is based on the hypothesis of affected relationship with the mother in early childhood (hypecare or mother's coldness) [9].

According to numerous studies, mental disorders are reported to affect 80% of dermatological patients; there is seen the marked prevalence of depressive disorders, anxiety and hypochondry [10, 11]. AD patients experience psychopathy 8 times more often than the general population [12]. According to the taxonomy of psychodermatological disorders, on ne hand AD

refers to psychosomatic illnesses, on the other hand, being a chronic form it may cause nosogenic reactions and pathological development.

Given the above, the study and development of effective psychological care for patients with dermatological diseases is a necessary and integral part of the treatment process.

The aim of the study was to identify psychological problems, features of the emotional state, individual, behavioral and family-associated patterns in adolescents with AD and define the target and measures of medical and psychological care based on the findings.

During the study there were used diagnostic tools as follows: methods of multidimensional assessment of children anxiety [13], adolescent version of the Beck Depression Inventory (BDI) [14], Pathocharacterological Diagnostic Questionnaire (PDQ) [15], the questionnaire «Ways of Behaviour Overcoming» by R. Lazarus [16], Parental Attitude Research Instrument - RARI) [17], methods of social and psychological adaptation diagnosis by Rogers-Diamond [14].

The study involved 108 AD persons (67 girls and 41 boys) who constituted the main group (MG) and 48 somatically healthy adolescents (29 girls and 19 boys) as the comparison group (CG).

The overall range of psychological problems in adolescence was associated with interpersonal relationships, learning, self-expression and self-determination. However, they were the dermatosis-related difficulties that took a leading position among aforementioned issues in respondents with AD. The main disease-associated psychological problems in AD adolescents included:

1) psychological and sensory. Recurrent skin discomfort (itching, dryness, painful feelings in skin integrity damage);

2) psychological and visual. Visible symptoms (redness, weeping, lichenification) that worsened appearance;

3) therapy-conditioned. Prolonged, repetitive treatment, the need for continuous control of the physical well-being;

4) restrictive. The need to observe restrictions (food, hygiene products, clothing) in order to avoid potential recurrence-triggering factors.

An assessment of anxiety severity in girls included in the MG revealed higher values of total anxiety (5.9 ± 2.4 and 4.4 ± 2.3 points), peers-related anxiety (5.6 ± 2.5 and 4 3 ± 2,2 points), surrounding people-related anxiety (5.9 ± 2.6 and 4.8 ± 2.5 points), parents-related anxiety (6.5 ± 2.4 and 4.8 ± 2.8 points), self-expression-associated anxiety (5.6 ± 2.5 and 3.9 ± 2.2 points). There was also found out the greater reduction in mental activity associated with anxiety (7.0 ± 2.2 and 4.8 ± 2.3 points) and higher autonomic reactivity compared with girls who constituted the CG (6.9 ± 2.3 and 4.6 ± 2.7 points), $p < 0.005$.

Male AD adolescents had higher indices of total anxiety (5.8 ± 2.9 and 4.0 ± 2.2 points in the MG and CG, respectively), peers -related anxiety (5.6 ± 2.6 points in the MG and 3.9 ± 2.6 points in the CG), anxiety-related decrease in mental activity (6.2 ± 2.7 points in the MG and 4.7 ± 2.2 points in the CG) and increased autonomic reactivity (6.3 ± 2.4 and 4.2 ± 2.9 points in the MG and CG, respectively), $p < 0.005$.

There were more people with high anxiety among AD children compared with healthy interviewees. Unlike the girls from the CG, the young female from the MG showed high and/or very high levels of total anxiety (52.2 ± 5.0% and 27.6 ± 4.5%, respectively), environment-related anxiety (40.3 ± 4.9% and 20.7 ± 4.1%, respectively), anxiety caused by relationships with parents (44.8 ± 5.0% in the MG and 24.1 ± 4.3% in CG), self-expression and testing-related anxiety (23.9 ± 4.3 and 22.4 ± 4.2% in the MG; 6.9 ± 2.5 and 6.9 ± 2.5% in the CG), decreased mental activity (73.1% in the MG and 27.6% in CG) and increased autonomic reactivity (in 72.2% of the MG and 31% of the CG), $p < 0.005$.

Among boys there were found more people with high total anxiety (48.8 ± 5.0% in the MG and 21.1 ± 4.1% in the CG, $p < 0.005$) and increased autonomic reactivity (48.8 ± 5 0% and 21.1 ± 4.1%, respectively $p < 0.005$). A deeper analysis, namely common grouping of respondents with high and very high anxiety, also revealed significant differences on scale 2 (anxiety relative to peers: 56.1% in the MG and 31.6% in the CG, $p < 0.005$), scale 7 (self-expression anxiety: 58.5% and 31.6%, respectively, $p < 0.005$) and scale 9 (decreased mental activity: 53.7% in the MG and 26.4% in the CG, $p < 0.005$).

As for depression, there was found out the following. Higher levels of depressive symptoms were revealed in adolescents included in the MG, namely, 10.2 ± 6.1 points in girls and 8.7 ± 5.8 points in boys as opposed to 6.9 ± 3.8 and 5.8 ± 3.4 points in in the CG, respectively, $p < 0.005$. The level of depressive feelings among the patients with «depression» was also higher in adolescents of the MG (15.6 ± 4.8 and 14.4 ± 5.2 points in boys and girls, respectively vs 14.4 ± 5.2 and 12.3 ± 2.5 points in the CG, $p < 0.005$).

A significantly greater number of people with satisfactory emotional condition was found in the CG (72.4 ± 4.5% of girls and 84.2 ± 3.6% of boys, compared to the adolescents in the MG (53.7 ± 5.0 % of girls and 61.0 ± 4.9% of boys), $p < 0.005$.

The study of personal traits accentuation in adolescents showed more people with pathocharacterological features among those from the MG, namely 70.1% of girls and 75.6% of boys, compared to the CG, where the corresponding figures were 51.7% and 57.9 %, respectively, $p < 0.005$. Prevailing accentuations among girls from the MG included: asthenic-neurotic (20.9%), hysteroid (13.4%) and labile (11.9%); among boys they were: asthenic-neurotic (22.0%) and hyperthymic (17.1%). Girls from the CG showed hyperthymic (17.2%) and sensitive (13.8%) accentuation to be predominant, while in the boys it was hyperthymic (26.3%).

The number of respondents reported asthenic-neurotic and labile accentuation was higher among girls from the MG compared to the CG (20.9% in the MG vs 6.9% in the CG; 11.9% in the MG vs 0% in CG, $p< 0.005$). A larger proportion of hyperthymic type was revealed among boys of the CG (26.3%) compared to the MG (17.1%). As opposed to it, the number of asthenic-neurotic and epileptoid adolescents in the MG was higher (22.0% in the MG and 5.3% in the CG; 7.3% in the MG and 0% in the CG, $p< 0.05$).

Analysis of coping types in respondents revealed the differences between manifestation degrees in adolescents included in MG and CG. Compared to the CG, girls of the MG showed higher levels of confrontation-oriented coping (7.4 ± 4.3 points in the MG and 4.4 ± 2.8 points in the CG), distancing-oriented coping (7.6 ± 4,0 and 4.6 ± 2.6 points in the MG and GP, respectively), self-control-oriented coping (6.4 ± 3.7 points in the MG and 3.9 ± 2.5 points in CG), search for social support-oriented coping (8.4 ± 4.0 points in the MG and 5.6 ± 3.4 points in the CG), taking responsibility (6.0 ± 3.2 and 4.0 ± 2.5 points, respectively in the MG and CG) and avoidance-oriented (7.6 ± 3.8 points in the MG and 4.9 ± 3.1 points in CG), $p<0.01$, and planning of problem solution (5.0 ± 3,2 and 3.8 ± 2.5 points in the MG and CG), $p< 0.05$.

The differences seen in boys of the MG compared to those of CG included higher intensification of confrontation-oriented coping (6.9 ± 3.7 points in the MG and 5.3 ± 2.6 points in CG), distancing-oriented coping (6.1 ± 3.5 and 4.1 ± 2.9 points in the MG and CG, respectively), self-control-oriented (6.4 ± 4.5 points in the MG and 4.2 ± 2.6 points in the CG), search for social support (6.4 ± 4.0 points in the MG and 4.4 ± 2.4 points in the CG), avoidance and positive reappriasal (6.3 ± 3.8 and 5.6 ± 3.3 points in the MG and 4.4 ± 2.2 and 5.0 ± 2.2 points in the CG, respectively) with $p< 0.05$.

Some gender differences were also found in the intensity of coping strategies, namely higher expression of distancing in girls compared with boys in the MG (7.6 ± 4.0 points in girls and 6.1 ± 3.5 points in boys), search for social support (8.4 ± 4.0 and 6.4 ± 4.0 points in girls and boys, respectively) and avoidance (7.6 ± 3.8 points in girls and 6.3 ± 3.8 points in boys), while the boys of this group showed higher rates of positive reappraisal (5.6 ± 3.3 points in boys and 4.6 ± 2.8 points in girls) with $p< 0.005$. Differences in the CG were related to higher indices of problem solution planning and positive revaluation of a stressful situation in boys compared to girls (5.1 ± 2.5 and 5.0 ± 2.2 points for boys and 3.8 ± 2.5 points for girls) with $p< 0.005$.

In the structure of stress overcoming behavior, among adolescent girls of the MG there was seen a greater number of respondents with high intensity distancing (14.9 ± 3.6% in the MG and 0% in the CG), search for social support (22.4 ± 4.2% in the MG and 6.9 ± 2.5% in the CG) and avoidance (16.4 ± 3.7% and 0%, respectively, in the MG and CG), $p< 0.005$. There was also found a greater proportion of girls with middle intensity distancing and seeking social support in the MG (49.3 ± 5.0% and 49.3 ± 5.0% in the MG and 27.6 ± 4.5% and 31.0 ± 4.6% in the CG),

besides a large proportion of respondents of the MG were revealed by self-control (52.2 ± 5.0% in the MG and 31.0 ± 4.6% in the CG), p< 0.05.

According to the findings, in the structure of coping strategies there were seen more male respondents with highintensity distancing in the MG (4.9 ± 2.2% in the MG vs 0% in the CG), seeking social support and avoidance (7.3 ± 2. 6% and 9.8 ± 3.0% in the MG vs 0% in the CG, respectively), with middle intensity seeking social support (51.2 ± 5.0% in the MG and 26.3 ± 4.4 % in the CG), p< 0.05.

Based on intrapsychological and behavioral characteristics there were identified psychological associations – psychotypes as follows: constructive-social, constructive-internal, passive-social, passive-avoiding and destructive-social. Constructive-social and constructive-internal types were classified as psychostabilizing, passive-avoiding and destructive-social - as destabilizing, while passive-social took an intermediate position. In the MG, there was a fewer number of both male and female respondents of a constructive-social type (19.4 ± 4.0% of girls and 17.1 ± 3.8% of boys in the MG vs 51.7 ± 5.0% of girls and 47.4 ± 5.0% of boys in the CG, p< 0.05). Among girls of the MG there were also more respondents of an avoiding-passive type compared to their peers from the GP (34.3 ± 4.7% in the MG vs 13.8 ± 3.4% in the CG, p< 0.05). Having summarized the results, there was found that in the MG the proportion of stabilizing patterns accounted for 29.9 ± 4.6% for the girls and 31.7 ± 4.7% for the boys. Intermediate patterns were seen in 26.9 ± 4.4% and 29.3 ± 4.5% of girls and boys, respectively; destabilizing patterns were revealed in 43.3 ± 5.0% and 39.0 ± 4.9% of girls and boys, respectively. In the CG the values were as follows: stabilizing patterns were found in 65.5 ± 4.8% of girls and 63.2 ± 4.8% of boys, intermediate patterns were seen in 17.2 ± 3.8% of girls and 15.8 ± 3. 6% of boys, destabilizing patterns were revealed in 17.2 ± 3.8% and 21.1 ± 4.1% of girls and boys, respectively.

In the child-parent relationships of adolescent girls with AD compared to the healthy peers, there was found affected optimality of the emotional contact manifested by lower levels of partnership (11.0 ± 3.2 points and 12.1 ± 1.8 points in girls from the MG and CG, respectively) and equality of parents (10.8 ± 2.5 and 11.8 ± 2.6 points, respectively); there was also revealed excessive emotional distance as a result of mother's irritability (11.7 ± 3.0 points and 10.7 ± 2.1 in girls from the MG and CG, respectively) and mother's avoidance of contact (11.9 ± 2.8 points and 9.3 ± 1.5 points in girls from the MG and CG, respectively), excessive concentration due to enhanced care (11.9 ± 3.0 points and 10.5 ± 2.3 points in girls from the MG and CG, respectively), inhibition of willful harassment (11.6 ± 3.2 points and 9.7 ± 2.2 points in respondents from the MG and CG, respectively), expressions of aggression and sexuality (11.6 ± 2.9 and 12.2 ± 2.9 points in the MG and 9.8 ± 2.2 and 10.0 ± 2.2 points in the CG), exclusion of extrafamilial influences (11.9 ± 2.5 points in girls from the MG and 10.8 ± 1.7

points in the CG) and excessive interference of parents in the personal world (12,1± 3.2 points and 9.8 ± 2.0 points in girls from the MG and CG, respectively), p< 0.05.

In adolescent boys emotional contact with parents was characterized by lower levels of verbalization (10.6 ± 1.9 points and 11.6 ± 1.9 points in boys from the MG and GP, respectively) and the impulse to activity (11.0 ± 1.9 points and 12.1 ± 2.5 points in boys from the MG and GP, respectively); there was emotional distance from the mother as a result of her irritability (11.4 ± 2.8 points and 9,9 ± 1 3 points in respondents from the MG and CG, respectively), severity (11.5 ± 1.9 and 10.5 ± 1.9 points in boys from the MG and GP, respectively) or avoidance of contact (11.5 ± 2.2 points and 9.5 ± 1.1 points in boys from the MG and GP, respectively), p< 0.05. There were also found out some signs of excessive concentration on the adolescent as will expression control (11.2 ± 1.9 points in the MG and 9.3 ± 2.1 points in CG), inhibition of aggressive and sexual impulses (11.4 ± 2.3 and 11.9 ± 3.0 points in boys from the MG and 9.3 ± 2.3 and 9.3 ± 2.1 points in those from the CG), expressed interference in the internal world of the child (11.4 ± 2.4 points and 9. 5 ± 1.6 points in the MG and CG, respectively) combined with the fear to offend the child (11.2 ± 2.4 points in respondents of the main group and 10.4 ± 0.6 points in the comparison group), p< 0.05.

AD adolescents' mothers experienced a sense of dependence on family (11.6 ± 2.2 and 11.2 ± 1.9 points in mothers of girls and boys, respectively), lack of independence (11.0 ± 2.2 and 11.0 ± 2.0 points), self-sacrifice (11.4 ± 2.3 and 11.2 ± 1.6 points), they complained of the husband's self-removal from family responsibilities (11.7 ± 2.8 and 11.3 ± 2. 3 points) or the women held a dominant role (11.6 ± 2.8 and 11.8 ± 2.7 points), family conflicts were frequent (11.9 ± 2.9 and 11.6 ± 2.2 points), p< 0.05.

There were identified the types of child-parent relationships in families of adolescents with AD as follows: partnership, care-restrictive, demanding-distancing and contrasting. There were defined the following types of marital relations: harmonious, mother-dependent, mother-dominant and parent-authoritarian. Partnership and harmonious types were the most favorable for family psychological functions, care-dependent and parent-dominant types took the second position, demanding-distancing and mother-dependent types had an average potential, while the contrasting and parent-authoritarian types showed the lowest psychoresource opportunity. In the MG, there was a greater number of demanding-distancing families (28.4 ± 4.5% of girls and 29.3 ± 4.5% of boys respectively vs 6.9 ± 2.5% and 5.3 ± 2. 2% in the CG) but a fewer number of families with a partnership type of children-parents relationship compared with families of somatically healthy adolescents (29.9 ± 4.6% and 29.3 ± 4.5% of young female and young male in the main group vs 65.5 ± 4.8% and 68.4 ± 4.6% in the comparison group, respectively), p< 0.05. Some differences were also seen in the marital relations of the studied families. Among girls of the main group, a greater proportion of families was characterized by mother-dependent

type of marital relations (41.8 ± 4.9% in the MG vs 24.1 ± 4.3% in the CG) and mother-dominant (26.9 ± 4. 4% in the main group and 6.9 ± 2.5% in the comparison group for girls vs 31.7 ± 4.7% in the MG and 0% in CG for boys), while a harmonic type was predominant in healthy children (28.4 ± 4.5% and 26.8 ± 4.4% of girls and boys in the main group vs 65.5 ± 4.8% and 63.2 ± 4.8% in the comparison group, respectively), $p< 0.05$.

Assessment of psychosocial adaptation was carried out on separate scales forming diagnostic dyads and according to integrated values. In an "adaptability-disadaptability" dyad there were found higher levels of adaptability in girls of the CG (102.1 ± 30.9 points in the MG and 116.7 ± 31.6 points in the CG) and disadaptability in boys of the MG (67.6 ± 19.6 points in the MG and 57.1±14.0 in the CG). There was also found that in boys with AD adaptability value was higher compared to girls with AD (102.1 ± 30.9 and 119.1 ± 29.4 points respectively) $p<0.05$.

Regarding a diagnostic dyad "acceptance or rejection of the self", there were recorded lower levels of acceptance in girls (31.1 ± 9.8 points in the MG and 36.2 ± 8.8 points in the CG) and higher levels of rejection in respondents of both genders in the main group as opposed to the comparison group (21.7 ± 4.8 points in girls and 20.4 ± 4.1 points in boys of the MG vs 19.7 ± 3.8 points and 18.2 ± 3.4 points in the CG, respectively), $p<0.05$. Having compared the results of respondents from the MG, it was found that boys showed higher levels of self-acceptance compared with girls, $p<0.05$.

A dyad of "acceptance or rejection of the others" was characterized by higher levels of acceptance in girls of the CG (19.3 ± 6.8 points in the MG and 22.7 ± 4.7 points in the CG) and greater rejection in boys compared with girls of the MG (17.0 ± 5.1 points in girls vs 22.9 ± 7.1 points in boys) $p<0.05$.

There were found lower values of emotional comfort in boys (27.6 ± 6.0 points in the MG and 31.3 ± 7.0 points in CG), but higher levels of emotional discomfort in the MG respondents of both genders (21.1 ± 6.4 points for girls and 23.6 ± 8.0 points for boys in the MG vs 18.3 ± 5.3 and 19.8 ± 2.7 points in the CG, respectively), $p<0.05$.

Boys and girls from the MG tended to have higher levels of external control (23.5 ± 4.9 points in girls and 24.8 ± 5.2 points in boys of the MG vs 20.4 ± 5.8 and 21.8 ± 4.1 points in the CG), $p<0.05$. Boys from the MG compared to girls showed higher internal control (27.7 ± 11.8 points in girls and 35.2 ± 10.4 points in boys), $p<0.05$.

In a "domination-subordination" dyad, boys of the MG had lower levels of dominance than those of the CG (10.2 ± 3.5 points in the MG and 12.1 ± 3.1 points in the CG); girls of the MG had higher values of subordination in comparison with the CG (20.1 ± 5.0 and 18.0 ± 4.5 points), $p< 0.05$. By comparison of the data inside the studied groups there was revealed higher

expression of dominance in boys compared with girls in the CG (10.0 ± 1.5 and 12.1 ± 3.1 points), $p < 0.05$.

Escapism (problems avoiding) was greater in respondents of the MG (13.4 ± 5.1 points in girls and 13.3 ± 4.7 points in boys from the MG and 11.3 ± 3.9 points in girls and 10.8 ± 2.5 in boys from the CG), $p < 0.05$.

There were revealed some differences of integrated values in the MG and CG. Both girls and boys of the MG showed lower adaptability than the CG (60.8 ± 8.2% of girls and 63.7 ± 7.6% of boys from the MG vs 65.7 ± 6.4% and 68.2 ± 3.7% from the CG, respectively), lower self-acceptance (46.7 ± 10.4% of girls and 53.1 ± 6.3% of boys from the MG vs 53.2 ± 8.2% and 57,8 ± 6,2% in the CG), decreased emotional comfort (54.5 ± 11.3% of girls and 54.5 ± 9.4% of boys, and in the MG vs 60.9 ± 9.4% and 60.7 ± 6.5 % in the CG), internality (44.5 ± 11.0% and 49.8 ± 8.3% - in the MG vs 51.9 ± 10.5% and 52.9 ± 8.3% - in the CG), lower desire to dominate (48.7 ± 8.6% of girls and 50.3 ± 11.4% of boys from the MG vs 52.9 ± 5.9% and 57.7 ± 6.2% of respondents from the CG).

Gender features were as follows: girls with AD showed better acceptance of other people compared with boys (56.9 ± 10.4% and 51.4 ± 10.7%), they were more oriented to the assessment of the environment (44.5 ± 11.0% and 49.8 ± 8.3%). AD boys compared with somatically healthy ones had a lower level of desire for domination (50.3 ± 11.4% and 57.7 ± 6.2%).

Having systematized the data, we have identified preventive (psychostabilizing) and destructive (destabilizing) factors in the genesis of AD psychological maladjustment of adolescents with AD (Table. 1).

Table 1

Psychostabilizing and destabilizing factors in the genesis of psychological maladjustment of adolescents with AD

PARAMETER	PSYCHOSTABILIZING FACTORS	PSYCHODESTABILIZING FACTORS
Anxiety	Low, middle	High
Background mood	No depressive manifestations	Depressive manifestations
Personal features	Hyperthymic type	Asthenic-neurotic, hysteroid, labile, epileptoid types of accentuations
Coping strategies	The positive reappraisal, social support, self-control, acceptance of responsibility, planning of problem solution	Distancing, avoiding, confrontation
Intrapsychological and behavioral psychotype	Constructive-social, constructive-internal	Passive-avoiding, destructive-social, passive-social
Children-parents relationships	Partnership	Care-restrictive, demanding-distancing and contrasting

Type of marital relations in the family	Harmonious	Mother-dependent, mother-dominant and parent-authoritarian
Psychosocial adaptation	High adaptability, self-acceptance, emotional comfort, internality	Disadaptability, self-rejection, emotional discomfort, externality

Based on the research findings there were defined the targets and goal of psychological interventions (Table. 2).

Table 2

Targets and ways to achieve them in the implementation of medical and psychological assistance to adolescents with AD

Psychological targets	Interventions goal Purpose
1	2
Physical discomfort (pain, itching)	Learning of relaxation and self-regulation of the mental state techniques Reducing emotional reactions to physical discomfort Mental self-control improving
Self-perception of the appearance (skin blemishes)	Self-discovery of the inner world Building a hierarchy of values based on internal qualities, knowledge, skills, capacity, as opposed to the external defect Formation of harmonious self-image
Poor treatment complianc (violations of the regime)	Internal motivation for treatment Discussion and elimination of the psychological problems related to affected compliance
Exhaustion, decreased mental activity	Reduced impact of stress and psychological factors, increased action psychostabilizing ones
High levels of anxiety associated with peers and environment	Self-esteem work Improving communication skills and skills Resolving interpersonal psychological problems
High anxiety caused by self-expression, self-assessment	Normalization of self-esteem Promoting of self-determination and self-identification
Depressive manifestations	Normalization of background mood by searching destabilizing sources
Disharmonious pathocharacterological features	Normalization of the personal profile through the recognition of the presence, role and influence of character features on choice of behaviour or emotional response to life situations

	Self-regulation of the mental state
Destabilizing profile of coping strategies	Detection and correction of the "excesses" in coping profiles Expanding the repertoire of coping strategies choice Study to select of the most appropriate ways of stress overcoming behavior
Stress –overcoming behavior with the leading strategies of distancing and avoiding	Conscious choice of avoiding and distancing strategies Expanding the stress-overcoming behavior selection repertoire
Affected optimality of emotional contact with parents	Harmonizing of children-parents relations Building partnership, equal relations Decrease in codependency Parents' psycheducation on age, psychological and physical characteristics of adolescence, issues of sexuality, aggression, autonomy
Excessive emotional distance from parents	
Excessive focus on the child	

1	2
Imbalanced marital relationship	Normalization of marital interaction
High disadaptability	Eliminating or reducing the impact of psychological personal and interpersonal factors that affect adaptation
Affected self-acceptance	Facilitation of self-discovery Formation of realistic positive personal self-image Search for personal potential and its fulfillment
Imbalanced internality-exterternality axis	Focusing on self-assessment by internal standards Restoring the balance between inner world and environment
High escapism	Mastering effective and appropriate to the situation ways to overcome problems

Targets of psychological interventions were identified as follows: physical discomfort, self-perception of the appearance, poor therapy compliance, exhaustion and reduced mental activity, high anxiety associated with peers and the environment, high anxiety due to self-expression, self-esteem, depressive manifestations, disharmonious pathocharacterological features, a destabilizing profile of coping strategies, stress-overcoming behavior with leading strategies of distancing and avoidance, affected optimality of emotional contact with parents, excessive emotional distance from parents or excessive concentration on the child, imbalanced marital relationships, high disadaptability, affected self-acceptance, an imbalanced internality-externality axis, high escapism.

To solve psychological problems there was developed an individual psychological intervention plan for each teenager. It was based on the features of the emotional state, intrapsychological and behavior patterns, children-parents relationship and intrafamilial specifics; it also took into account psychosocial aspects. All power of psychodiagnostic and psychological interventions was aimed at elimination of psychopathogenic factors and strengthening psychosanogenic factors.

The forms of medical and psychological measures implementation included:

•individual psychological counseling for adolescents;

• psychological correction;

• psychosocial training;

• family therapy.

We used Gestalt therapy techniques , rational therapy, art therapy, cognitive-behavioral psycotherapy, social and psychological training. Family therapy was an important component of psychological assistance to adolescents with AD.

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