

Section: PPT cases

TWO "FACES" OF REPRESSED AGGRESSIVE IMPULSE AND FEELINGS. ATOPIC DERMATITIS AND HYPERTENSION'S CONFLICT DYNAMIC THROUGH THE PRISM OF POSITIVE PSYCHOSOMATIC PSYCHOTHERAPY



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Abstract

The article presents two cases with psychosomatic problems - atopic dermatitis and hypertension, which from a psychodynamic point of view are related to the suppression of aggressive impulses and feelings. From the psychodynamic point of view, atopic dermatitis is related to the peculiarities of the social situation and conflict relations in the sphere "Mother-Child." Hypertension as a way of repressive coping with events and feelings. Intrapsychic conflicts involving unacceptable desires, fantasies, and impulses hidden from consciousness.

Keywords: Positive Psychotherapy, atopic dermatitis, hypertension, psychodynamic, actual conflict, basic conflict, inner conflict

Introduction

often begins in childhood (even infancy) and can continue into adulthood (Brown & Johnson, 2018).

1.1. ATOPIC DERMATITIS:

Definition

Atopic dermatitis (AD) is a chronic inflammatory skin disease characterized by eczema, itching and dryness. The most common location of lesions in childhood is around the lips and cheeks (Smith et al., 2020). This disease

Biopsychosocial etiology and pathogenesis

AD results from complex interactions between genetic, immunological, psychological, and environmental factors (Smith et al., 2020).

Biological factors:

- genetic predisposition: mutations in the filaggrin gene (FLG) lead to a disrupted skin barrier (Brown & Johnson, 2018).

- immune dysregulation: increased T-helper cell type 2 (Th2) activity and IgE production (Smith et al., 2020).

Psychological factors

- Stress can worsen AD symptoms by increasing cortisol and other stress hormones that affect the immune system (Brown & Johnson, 2018).

Social factors

- Social support and quality of life also influence disease management (Smith et al., 2020).

Relationship with Inner Conflict

- AD is often associated with internal conflicts related to personal boundaries and identity (Brown & Johnson, 2018). Patients may manifest symptoms as a physical manifestation of internal discomfort or stress (Smith et al., 2020). The detailed Inventarization of the factors involved in the formation of the Basic conflict of the patients supports the psychotherapist's understanding of the conflict dynamics and the disease picture.

Diagnosis and clinic

The diagnosis of AD is based on the patient's clinical picture and history. Since it concerns the onset of symptoms from infancy, it is necessary to examine the overall family dynamics in which the child is raised and formed (Brown & Johnson, 2018).

The main symptoms include: - chronic itching (Smith et al., 2020), erythema (Brown & Johnson, 2018), papules and vesicles (Smith et al., 2020), lichenification (thickening of the skin) (Brown & Johnson, 2018).

A psychotherapeutic approach

Psychotherapy can help reduce stress and improve the quality of life of patients with AD (Smith et al., 2020). Approaches include: a balanced model of the patient's functioning and the entire family dynamic, helping patients to identify and change negative thought patterns (Brown & Johnson, 2018), which are the Basic conflicts and Inner conflict.

1.2. HYPERTONIA

Definition

Hypertension (high blood pressure) is when the blood pressure in the arteries is elevated for a prolonged period (Garcia et al., 2019), usually recorded on a minimum of three consecutive days, after three times of measurements in the same position. Hypertension increases the risk of cardiovascular disease, stroke, and kidney problems (Wilson & Green, 2021).

Biopsychosocial etiology and pathogenesis

Hypertension is a multifactorial disease involving genetic, physiological, psychological, and social components (Garcia et al., 2019):

Biological factors

- Genetic predisposition, is the presence of a combination of genes that mutually influence their phenotypic expression (Wilson & Green, 2021)

- Overweight and obesity (Garcia et al., 2019)
- unhealthy diet and low physical activity (Wilson & Green, 2021)

Psychological factors

- Chronic stress and anxiety can increase blood pressure by activating the sympathetic nervous system and releasing stress hormones (Garcia et al., 2019).

Social factors

- Socio-economic status and level of education also influence the risk of hypertension (Wilson & Green, 2021).

Relationship with Inner Conflict

Internal conflicts and suppressed emotions can contribute to the development of hypertension (Garcia et al., 2019). Unresolved emotional issues can lead to persistent stress that affects the cardiovascular system (Wilson & Green, 2021).

Diagnosis and clinic

The diagnosis of hypertension is made by measuring blood pressure (Garcia et al., 2019), three times a day on three consecutive days in the same position of the patient. Normal values are around 120/80 mmHg (Wilson & Green, 2021), and it is necessary to measure the blood pressure in both arms of the patient.

Symptoms of hypertension can include a gradual increase in blood pressure, as well as nonspecific symptoms: fatigue (Garcia et al.,

2019); dizziness (Wilson & Green, 2021), seasickness (Garcia et al., 2019), and blurred vision (Wilson & Green, 2021).

A psychotherapeutic Approach

Psychotherapy for those affected by hypertension includes techniques for managing stress and changing unhealthy behavioral patterns (Garcia et al., 2019), helping patients recognize and change thought and behavioral patterns that contribute to stress (Wilson & Green, 2021) – balance model and processing of conflicting contents.

Medical practice recognizes seven diseases with a proven psychosomatic connection, so-called by F. Alexander (1950), „Holy Seven Psychosomatic Diseases“, which include hypertension, thyrotoxicosis, bronchial asthma, rheumatoid arthritis, peptic ulcer, ulcerative colitis, and neurodermatitis. This designation implies that the diseases include psychological determinants and could be identified and treated by psychotherapy (Kimball, 1978).

Causes of psychosomatic diseases:

1) Chronic stress and emotional tension - quarrels with family and friends, conflicts with others, demands from superiors, chronic lack of time, constant bustle, information overload (microtraumatic events).

2) Acute psychological reaction. As a rule, it occurs in response to difficult life circumstances: the death of a loved one, loss of a job, a painful breakup (macrotraumatic events).

3) Prolonged experience of strong negative emotions - resentment, disappointment, anger, anxiety, fear, aggression.

4) Unreacted emotions - any traumatic and painful events and emotions not analyzed and responded to by a person.

5) Illness is a benefit for some of the patients, illness as a way to solve their psychological problems.

This article presents two cases with psychosomatic problems - atopic dermatitis and hypertension, which from a psychodynamic point of view are related to the suppression of aggressive impulses and feelings.

Atopic dermatitis (AD) is an inflammatory, chronic, and relapsing skin disease characterized by the presence of eczematous lesions and pruritus with implications for quality of life. Skin manifestations have a typical, age-dependent

location on the body and characteristics. Its incidence is about 2-5% in adults and 20% in children, making it one of the most common skin diseases.

Modern medicine recognizes the fact that mental imbalance is symbolically expressed through deviations in blood pressure. At the same time, attempts to establish a relationship between psychological problems and the appearance of essential hypertension are difficult without following the bio-psycho-social model. Only the unity of these factors allows understanding of the etiology of this disease (Brown & Johnson, 2018).

Case

2.1. Case vignette – “Skin as a “Geographic map” - path to the repressed need”

D., 36 years old, atopic dermatitis - chronic relapsing-remitting, exacerbated at the time of the first meeting, referred by the treating physicians - dermatologist and allergist. Developed around the age of 2 years, when the mother observed episodic recurrent erythematous-squamous eruptions mainly on the skin of the cheeks, neck, folds, abdomen, and thighs. The cause of allergy is not specified. D. is married with 2 children, a daughter aged 14 and a son aged 10. Profession - social worker.

D. is a beautiful woman, elegant, slender, stylishly dressed, well-groomed hair and nails, she has cleverly concealed her neck rash with an accessory. She is self-conscious, fussing as she enters, as if out of place (although she gives the impression of being confident and secure). She begins worriedly, "I'm coming at the insistence of my doctors. They've been telling me for a long time that I need to see a psychotherapist., and, well, I've decided" (no request).

Asked to continue, D. says, *"I've had skin problems since I was a little girl, and my parents (mostly my mother) always associated them with food, and I got used to being careful and blaming food as the cause of my condition."* Question from the therapist: "What is your explanation for them?"

- *"When I was little, I believed it was food, then there were a lot of situations that literally made me “come out of my skin”. At work, and at home., almost **everywhere, always** I feel reproached, or I have done something that others don't approve of, or I hear ("my*

favourite") *"I didn't expect that from you!" It makes me want to tear myself to pieces and hope that any of them manages to satisfy others. "I don't actually know who I am!"*

"How can we find the right words, or picture, for your suffering?"- *"Well, my skin becomes a "geographic map „whenever others are judging me and not understanding me."*

"It's like your skin is drawing the right path between the inner and outer world..."

The patient's reaction surprised her: *"So, I haven't really looked at it in this way..."*

D.'s Actual Situation could be described with the sentence: *"I – My Self always following everyone (Them), in service to everyone!"*

Actual Conflict: *"I want armor instead of skin! I want to be untouched by the judgments of others, to be my My Self, but I can't, I don't know how!"*

In the area of Body/senses processes conflict: trying to be "thick skinned" and simultaneously "everything gets under her skin". In the area of Activity/Achievement: no personal criterion for success, others' criterion (mostly vague) is determinant. In the Contact's area: ambivalence - I need others / I am afraid of others (localization of conflict). In the Fantasy/Future' area: the constant expectation of negative evaluations

D. is the older of two sisters (3 years difference), she got her first rashes during the parents' decision to have a second child, the disease picture developed during the mother's pregnancy with her sister (mother and father live with the mother's parents). The family messages to her date from around that time: „Be careful what you do, the baby won't want you for a sister! “; „Behave yourself! „You of all children are the only one who acts like a monkey! Look at the others!"

D. described her mother this way: *"She didn't know what she wanted from me. To this day, I don't know exactly what I should do to make her happy. I was never prepared enough, and I couldn't predict how she would react. She punished me for nothing, literally nothing. She wanted things from me, and I didn't know how to do them. The thing I remember the most was her leaving me with a pile of laundry and telling me to iron it, I had never touched an iron before then, I only knew what it was, and what it was for, I was 6 - 7 years old. I remember sitting down on the ground and on the carpet, I started trying to iron things, I burnt my inner thighs badly, it hurt a lot, and it itched around the burn. She saw what*

I was doing and beat me up because ironing on the ground isn't the right way., her words, "Who does that?!!!" (accompanying the spanking) The stupid ones do that! Are you stupid?!"

She describes her father as quiet, patient, and tolerant. *"It was as if we both understood each other without words! I later realized that he was working a lot, as if not to be at home. I missed him, even though my sister was "daddy's girl", I knew and believed that I was his favorite. My grandparents (mother's parents) never accepted me! To them, I was one of "those - the others" (my father's side of the family), when our parents weren't around, they took my sister with them, and I was locked up upstairs in the house. The only place I felt comfortable was when I was playing sports. There I won a series of first places and medals, but I had to stop because, as my mother said: "an athlete does not feed a house". She thought that sports interfered with all my other duties.*

Only when I blindly followed "what others would say" and the family received an evaluation of my behavior from the outside: "she is polite and well mannered, she backed down, she is not selfish," only then did they leave me alone (especially my mother).

I have grown accustomed to sentences like: "Be careful what others would say!"; "Be careful not to give us a red face!"; "Not you! Others are important!"

In the area of "I" - D. doesn't know who she is but she knows very well who the others are. The attitude she receives from the mother is ambivalent - D. is either already big (should be able to ...) or small (can't do anything). The father is a "silent support" and a model: "if he is silent and tolerates, then I can, too" (the father has hypertension, diabetes and micro stroke).

The grandparents (mother's parents) - rejecting and cold, the others (father's parents), supposedly, supportive, but expect her to glorify them and grow up educated and cultured.

The sister - "the favourite child of the dynasty".

The Basic Conflict is localized in the area of "I", in content: love; unity (integrity) - diligence; obedience; courtesy.

Within D.'s personality traits are: nonassertiveness (toward others); yielding; altruism; modesty; consistency; sense of duty; deliberation of one's own actions; striving for achievement; anxiety, vulnerability, depressive experiences. In shared experiences there is a

sense of loss of control over what is happening, frustration and anger, and unsuccessful attempts to suppress this, resulting in depressive experiences taking over and skin reacting (symptoms exacerbated).

From the psychodynamic point of view, atopic dermatitis is related to the peculiarities of the social situation and conflict relations in the sphere "Mother-Child": pathological symbiosis, lack of boundaries between self and non-self, or lack of symbiosis, a rigid boundary between self and non-self; lack of separation and individuation, and containerization of the child's emotions; unreasonably high demands and expectations by parents on the child. Disturbances in a social situation form psychological characteristics such as: lack of boundaries between self and non-self; fear of losing a significant person; division of the structure of the self into two parts - ideal self and rejected (wounded) self. (N. Peseschkian, 2003; S. Ledentsova, A. Ledentsova, 2020; E. Maguire, 2012, etc.).

For D., the disease comes as a result of an underlying deficit in the following areas of stabilized experience (OPD-2, 2008):

- Dependency - Autonomy, lacks symbiotic relatedness, rejection and neglect are visible. She struggles for autonomy by enclosing herself (from age 2) "in her own skin" and at the same time "transferring to her own skin" the responsibility to chart through the "geographical map" the path to the repressed need to belong, to be connected, to be part of the whole.
- Self-esteem - D. has withdrawn her narcissistic claims towards the world and others, her inflated expectations of herself, ambivalent reactions to her activity and orientation to external evaluation of productivity, success, achievements make her vulnerable and prone to self-depreciation and guilt.
- Identity - Chronic lack of sense of self (who I am) and connection (what I belong to).

The narcissistically functioning mother tends to divide her children into the "beloved," and the other "torn off piece" (which is how D. feels). the "scapegoat." In the case of D.'s narcissistically-functioning family, the sister, the "beloved" is chosen as an extension of the mother by the extended family members and all love and care is projected upon her and she is showered with attention and praise by her parents and the mother's parents. In relation to her father's parents, D. is projected upon to be a source of pride and joy, whose successes signify the family name, but without receiving love and attention. D. is again „cut out of the whole piece,“ as her failures are continually vocalized rather than being downplayed or erased. Thus, the narcissistic distortion is not erased (H. Kohut, 2003; K. McBride, 2019).

According to them, D.'s being a "torn-off piece" is the cause of all the situations shaming the family. She is like a "target" for family anger and a "trash can" for blame. In varying degrees, overtly or covertly, she is systematically belittled and shamed (a child who is made into a scapegoat may be punished even for having done something good and successful because it threatens the mother's (family's) narcissistic belief that the child is completely bad). In D.'s case, she was expected to have quit the sport immediately after achieving success, under the pretext that it was interfering with her grades in school and her future, as she would need to earn a living.

Inner Conflict – D. is functioning in the "arena" of a struggle between two tendencies - the inner (wounded) child's needs for affection, acceptance, attention, and certainty (wholeness), and the inner critic's directives (the internalized expectations of the significant figures of childhood) manifested in inflated and unrealistic demands on the self. D. lives under the pressures of "I must" and "I have to" which do not come from her own needs but are the expectations of others. Everything D. does and aims to succeed in is in the hope of meeting the family's requirements/expectations in order to receive love at least once, i.e. to be part of the whole – accepted. fig. 1.

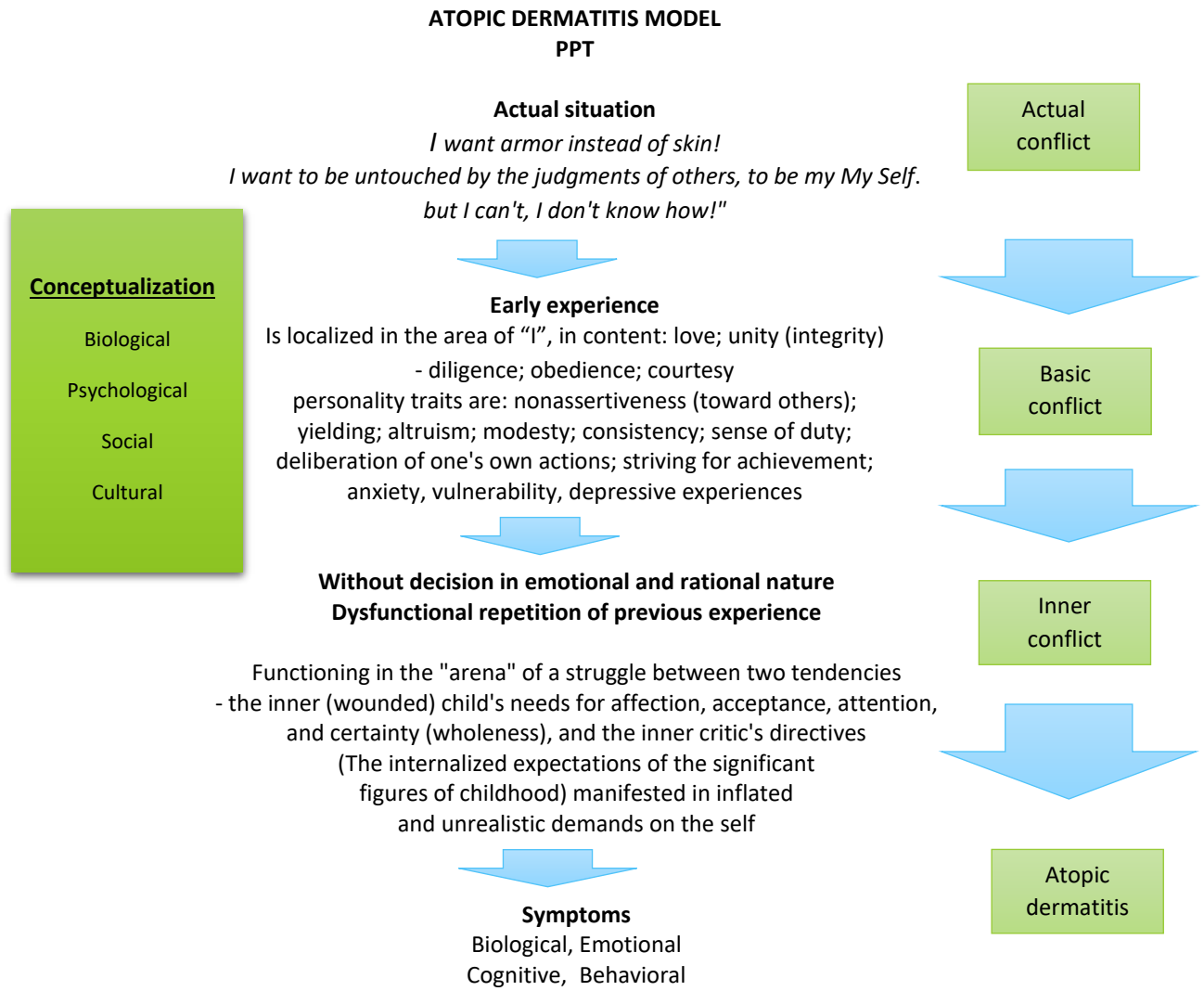


Figure 1. Atopic dermatitis – psychosomatic conceptualization

2.2. Case vignette Hypertension

N., 51 years old, with high blood pressure for 5 years, anxiety, fear, insomnia, complete the picture of symptoms. Officially divorced for 3 yrs., relationship breakdown 7 yrs. ago.

Has a daughter 28 yrs old (not yet married, last year at university). Profession - physics teacher. Referred by family doctor. Request: *"I want my anxiety to go away!"* N. is a large but not fat woman, speaks tightly, sharply and loudly. She enters confidently and sits down on the couch. Her first words are: *"I am rarely ill, but when it happens, I can get very ill!"* *"How long will it take you to make me calm again and for this anxious thing inside me to disappear?"* At this moment, high blood pressure and fear are not a problem within the psychotherapist's competence - they are medical, she adds: *"although the doctor told me the blood pressure was from nerves."*

N., linked her symptoms to a surprise inspection by the education inspectorate, following a complaint by a parent. The complaint was not against her personally but against the school administration. The problem as it related to her had nothing to do with her teaching abilities but had been about omissions and inaccuracies in documentation. She described the situation as: *"the blood pooled in my head, it would literally explode, my legs and arms would go limp, my stomach would churn."* Prompted to share other situations where "the blood rushed to her head as if to prepare her for what was coming" - **blood pressure as ability to cope with unexpected (increased) demands.** The patient shared a series of conflict situations - with the school principal, with a colleague and with a parent of a student, she was able to see the "common pattern" in all these situations - suppression of her own feelings, high self-

control, yielding in situations that implied protecting her own authority and competence. Excessive compliance with what is expected of others and over-politeness. She spontaneously exclaimed, *"It seems I want to blow myself up! - this continual suppression of myself, the constant feeling that I am in an insignificant and unimportant position...I have a right to resentment..."* At this time, N. did not connect the family situation with the symptoms.

N's **Actual Situation** – when difficulties arise, she more often chooses adjustment and swallowing and less often (almost never) competitiveness, assertion (irrational strategies of behavior).

Actual Conflict: *"I want to be significant (authority), knowledgeable (competence), but I can't find confirmation of it!"*

N. uses the Body area to "store" her anxiety, a closed circle from which she can neither escape nor use to attack and/or defend herself. In the Activity area: the yielding, overly polite behavior accumulates the build-up of tension. In this connection, ambition confronts feelings of inferiority and stimulates the emergence of aggressive impulses, which the yielding, overly polite behavior stops, and this vicious circle continues indefinitely. Because N. represses herself, she sees herself as less successful in her professional activities, and by virtue of these reasons she tends to succumb to situations involving competition and rivalry with others, which in turn stimulates envy and hostility toward the more successful (those who assert themselves and those who do not succumb to competition). In the area of Contacts: outwardly decisive, confident and reserved, but not calm. She is committed to achieving so that there is nothing to talk about. Lots of unreacted emotions, high social control and self-control. In Fantasy/meaning: depressive experiences and unrealized need for power, need for aggression that she cannot manifest, too much wandering and searching for answers "where and how".

Actual Conflict – localized in Activity/Achievement Area, reworking in Body Area – the body "absorbs" the force and pressure of unreacted emotions. In content described, by persistence, perseverance, diligence, ambition, reliability.

N. is the older of two children, she has a sister 5 years younger. Her parents are a teacher and a military man. N. describes the relationship between the parents as lacking tenderness,

control and discipline prevails, demanding and firm tone of upbringing, imposing the will of the parents, numerous prohibitions and demands of the type: "be careful", "tighten up", "there is no "cannot" - there is "do not want". She knows herself to be a "student baby" - she was unplanned, unlike her sister but she finds no difference in the treatment of the two, with one difference - she is the first and thus she must become a person of status and authority with a respected profession. The mother did not allow expressive behaviour, otherwise: "what will people say, "She is a teacher, and she has not educated her own child, so how will she educate other people's children." The mother most often punished N. with silence.

The father brought her up harshly - in a military way, crying was forbidden, as were yelling and showing emotions (no matter what). She learned early to contain and control her emotions, to keep quiet, to be patient and obedient - she paid a high price for fear of losing her parents' love. She remembers situations in which she and her sister would stand hugging each other all night in an attempt to help each other (rocking each other) to silence sobbing and crying. She remembers her teenage years as filled with sadness and despair, only lessons and work, no gatherings with peers and friends.

She was happy to go to another city as a student, but her daily life was still boring and grey, and she did not dare to get together with colleagues, lest they influence her badly. At the age of 22 she met her husband, after a year they lived together, after another year or so they got married (her parents said she could because she had graduated successfully), the next year her daughter was born (at the age of 25). She describes their marriage as complicated after the birth of their daughter; the relationship became first neutral, then cool and distant. She claims that cooling comes from him, and she continues to love him. The symptoms started around that time - anxiety, fear, insomnia, listlessness, palpitations, sharp, short, stabbing pains in various places.

After she recognized his first romantic relationship with another woman, she reacted with sudden, severe, stabbing pain, like an "electric shock" to the back of her head and neck. Following a consultation, she was diagnosed with Occipital Neuralgia of the greater occipital nerve C2. (She was then 36.) He ended the relationship and her pain disappeared. A

relatively neutral period follows in which she tries to fix her marriage. When she was 44 her husband entered into a second relationship, subsequently moved out, then filed for divorce. The patient describes this period as the worst nightmare of her life – “She., the teacher with an unfaithful husband who left and then replaced her! How will she look others in the eye? How will she be able to educate in values from now on!”

N. describes this period in the following way: “I lost the thirst for life, I stopped smiling and fear settled in me. I felt like a hunted animal. I started getting high blood pressure, in fact I kept getting high blood pressure. I tried to fight these feelings, to banish the thoughts that I was sick, but I only became more convinced that I was already a wreck. I didn't want to read anymore, much less watch TV, walking became a forced, aimless wandering around the parks, and it became simply impossible not to think about my blood pressure. It was my first thought when I woke up and my last before falling asleep. I didn't want to live anymore. And then the crisis happened. I woke up in the night, fear literally beating inside me. I woke up my daughter, she hugged me tightly and pressed me to her. We lay there until the morning, I was shaking, trying to convince myself that there was nothing to be afraid of, but the fear remained, it would not obey me...”

The **basic Conflict** is localized in the “You” area, in content: love – obedience.

From the psychodynamic point of view (OPD-2, 2008):

- Individuation – Dependency -
- Suppression of the aggressive impulse with a tendency toward defensive behavior, along with rigid adaptability and superficial submissive accommodation, points to a closeness/distance conflict. A need for closeness and symbiotic closeness (dependency) and the drive for independence and distance.

The occurrence of N.'s symptoms is a result of many factors: an upbringing in a rigid and dysfunctional family; a deficit of parental attention, tenderness and patience; the formation of perfectionism, an irrational attitude to justice (“if I love my husband, why did he leave me? ”); the emotional missing of the father (he is

a distant, unreachable, cold and punishing figure); resentment and anger towards the mother, who constantly does not support and protect her daughter, and not only that, but also additionally suppresses her desires. N.'s parental family is an example to all relatives and friends. Throughout her life, N. has focused on external (imposed on her) stereotypes of prestige and success; she tries to maintain the same image (prosperous, successful) for her family, even after her husband begins romantic relationships. Her illness helps her avoid the shame of what her internal self wants and external standards forbid.

Inner Conflict: N. has been trained to follow requirements, to be executive and to obey in order to feel that she deserves love, she does not know what to do if there are no instructions. Going to university and working as a teacher are by instruction. Getting married, having a child are enforced stereotypes of norm and success (by instruction she should have the same family as her parents' example). For the relationship with her husband she has no instruction, there are emotions, and emotions are forbidden and punished. omissions and inaccuracies giving him her fidelity and devotion (obedience) as enough. The husband “reads” this as coldness and rejection and seeks tenderness in other women. N. in turn becomes even more immersed in the depressive experiences of her fantasy and exhaustively seeks instructions for “what and how”, all this blocking out her aggressive impulses. fig.2.

The idea of the psychosomatic approach is the process of finding out and investigating. “The psychosomatic approach is quite akin to good detective work. The work of the investigator is to accumulate the data, the pieces of the puzzle, until they fit together in a way that gives a satisfactory picture, a solution to the problem. This is in contradistinction to the idea that the same “psychosomatic” formula can be applied to every individual with the same problem. Each patient with a problem in which a psychosomatic approach is used becomes essentially a unique study in the factors and their relationships affecting that patient's illness” (C. Kimball, 1978, p. 688).

Positive psychotherapy in psychosomatics includes an additional view of the interconnectedness of life areas and their influence on the patient's condition.

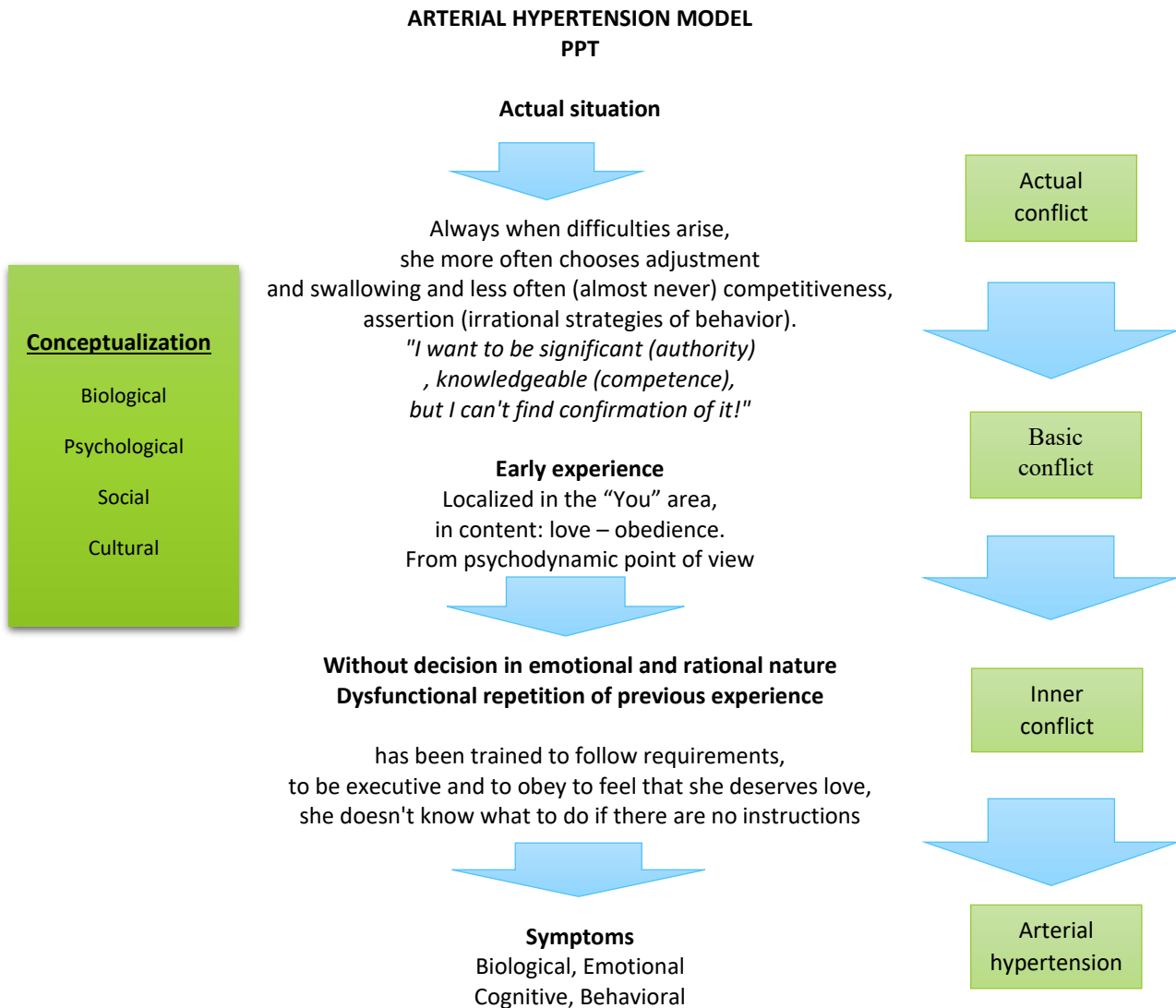


Figure 2. Arterial hypertension – psychosomatic conceptualization

Discussion

Psychosomatic connection

Atopic dermatitis (AD) is a classic example of a psychosomatic disorder in which mental and social factors play an important role in the etiology and development of the disease. Although underlying biological factors such as genetic predisposition and immunological dysregulation are essential, psychological and social aspects should not be overlooked. Stress is an important factor that can worsen the symptoms of AD. The link between stress and the immune system is well documented, as stress can increase the production of cortisol, which in turn can suppress the immune system and

disrupt the skin's barrier function (Smith et al., 2020). Patients with AD often experience chronic pruritus, which leads to constant discomfort and insomnia, creating a vicious cycle of stress and symptom exacerbation (Brown & Johnson, 2018). Social factors also play a role, with a lack of social support and negative perceptions of appearance can lead to increased anxiety and depression. Positive Psychotherapy can help patients cope with these psychological challenges by improving their quality of life and reducing AD symptoms (Smith et al., 2020).

Hypertension also demonstrates the strong relationship between psychosocial factors and physical health. High blood pressure is linked to several biological factors such as genetics, obesity and an unhealthy lifestyle, but psychosocial stressors are just as important.

Chronic stress can activate the sympathetic nervous system and increase the production of stress hormones such as adrenaline and norepinephrine, which lead to constriction of blood vessels and an increase in blood pressure (Garcia et al., 2019). Additionally, stress can promote unhealthy behavioral patterns such as smoking, excessive alcohol consumption, and poor nutrition, which further contribute to the development of hypertension (Wilson & Green, 2021). Psychotherapeutic interventions in the Positive Psychotherapy modality can be effective in reducing stress and improving blood pressure control (Garcia et al., 2019). These interventions not only reduce stress but also help patients adopt a healthier lifestyle, which is essential for long-term hypertension control (Wilson & Green, 2021).

Conclusions

Atopic dermatitis and hypertension are two examples of diseases in which the psychosomatic relationship plays an essential role in the etiology and pathogenesis. Biological, psychological, and social factors are closely related, each contributing to an individual's overall health. Understanding these interrelationships is key to developing effective therapeutic strategies that include not only medical treatment but also psychotherapeutic interventions. The study of the psychosomatic aspects of diseases such as AD and hypertension emphasizes the importance of a holistic approach to health that takes into account all aspects of the patient's life. Psychotherapy, stress management, and social support are important components of overall treatment that can significantly improve the quality of life and health outcomes for patients.

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