PSYCHOVEGETATIVE CHANGES IN PATIENTS WHO EXPERIENCE TENSION HEADACHES

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Relevance: according to the World Health Organization, headaches are ranked 3rd among diseases that cause incapacity for work. In different countries of the world, this disease occurs in up to 50% of the adult population, with 1.7-4% of the adult population suffering from chronic headaches. Globally, the incidence of neurological diseases has increased over the past 25 years due to an increase in the population and an increase in the duration of life. Tension headaches are the most common neurological disorder and are estimated to suffer from 1.5 billion populations worldwide. According to data given by various authors, the prevalence of tension headaches is 20.6% to 78% indicative. The chronic form of headache is assessed as a long-term condition leading to patient dezadaptation compared to the episodic form. According to the World Health Organization, three-quarters of the population between the ages of 18 and 65 have had at least one headache attack in the last year, while chronic headaches are observed in 2-3% of the population. The desired pain syndrome is known to be accompanied by Psychovegetative disorders. For this reason, a number of scientific studies are underway to establish effective methods of preventing and treating psychovegetic changes and postural disorders in primary forms of headaches on a global scale.

Patients experience a high incidence of skin redness, sweating, finger cooling, rapid heart rate, and respiratory failure from major vegetative changes. The patient was examined for the purpose of bakholizing the vegetative system, the number of yux, AQB, thermometry, the kerdo index was evaluated. In patients with Group 1, YuQS was 77.83±1.08, sab 109.86±1.16, dab 71.81±0.77, and body kharorat was 36.61±0.01 degrees. In 2-Guruh patients, YuQS was 74.84±1.55, sab 110.89±1.58, dab 72.67±1.07, and body kharorat was 36.65±0.02 degrees. When the Kerdo index results were analyzed, SZBO was estimated to be 48 (66.66%) sympathicotonic, 20 (27.77%) vagotonic, and 4(5.57%) eytonia of existing 1st group patients. Patients have been found to have increased sympathetic nerve tone ($p<0.05$).

The 2nd cohort patients with frequent tension headaches were found to be 23(51.11)% sympathicotonic, 14 (31.11%)% parasympathicotonic, and

8(17.78%) eytonia. Changes in the vegetative system of patients indicated the need for the study of their psychoemotional state.

Considering the observation of anxiety in patients with tension headaches, the HADS scale of anxiety and depression assessment has been used in both groups of patients. Anxiety levels in 1-group patients were 27.78±5.28% pre-treatment normative indicators, subclinical anxiety 33.33±5.56%, high clinically expressed anxiety 38.89±5.75%. When depression levels were assessed, non-depressive states were 26.39±5.19%, subclinical depression was 25±5.1%, and high clinically expressed depression was 48.61±5.89%.

Anxiety levels in 2-group patients were 24.44±6.41% before treatment, subclinical anxiety 35.56±7.14%, high clinically expressed anxiety 40±7.3%. When depression levels were assessed, non-depressive states were 37.78±7.23%, subclinical depression was 22.22±6.2%, and high clinically expressed depression was 40±7.3%.

Thus, no significant statistical discrepancy has been found in research groups in anxiety and depression level indicators. The presence of high percentage indicators of anxiety and depression in patients required correction. The correlation between pain fluency and psychoemotional disorder has been studied.

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