ALCOHOL DEPENDENCE AND MANIFESTATION OF AUTOAGRESSIVE BEHAVIOR IN PATIENTS OF DIFFERENT TYPES

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Abstract. *In patients with different types of personality, alcohol addiction psychotherapy should be carried out taking into account the leading manifestations of autoagressive behavior. As psychotherapeutic goals, it is necessary to choose negative parental messages that the patient received in childhood and influenced the formation of his personality. The most persistent therapeutic remissions are performed in patients with a hysterical and anxious personality type, while the least resistant ones are in patients with dissocial, narcissistic and paranoid personality types.*

Keywords: *alcohol addiction, autoagressivism, psychotherapy, personality, remission.*

Introduction. The spread of alcohol dependence continues at a consistently high level. The mortality rate for causes directly or indirectly related to alcohol abuse remains consistently high. Thus, according to official statistics, about 12% of all deaths in our country are related to alcohol consumption [1-4]. At the same time, the results of preventive and therapeutic work with alcohol-dependent patients are not always satisfactory [5].

In this regard, scientific research aimed at studying the features of the etiology and pathogenesis of Alcohol Dependence in various categories of patients, as well as the development of therapeutic approaches to this nosological unit, remains relevant. Alcohol abuse can usually be seen as one of the manifestations of non-suicidal autoagressive behavior [6-9]. In turn, autoagression is more common in alcohol-dependent patients than in non-drug people [10]. Self-destruction in people with alcohol addiction is a classic form of suicide (suicide, parasuicides, self-harm, suicidal thoughts and tendencies) and forms of suicide (self-destruction in family relationships, in the professional sphere, somatic autoagression, dangerous and antisocial behavior) [11-14]. At the same time, both alcohol dependence and autoagression are closely related to the individual characteristics of patients. The result is a chain consisting of alcohol addiction, autoagressive behavior, and personality traits. At the same time, each connection of the chain is affected and determines the characteristics of others. In connection with the above, we conducted a clinical and instrumental study of the characteristics of personal pathology and autoagressive behavior in people with alcohol dependence in order to improve psychotherapeutic care [15-19].

Autoagressive behavior is a serious medical and social problem of modern society. Threatening growth of completed suicide in the world [20-23]. For a long time, autoagressive behavior included phenomena such as suicide, parasuicides, suicidal thoughts [24]. At the same time, non-suicidal self-harm, on the contrary, concerned situational or unconditional autodestruction "without autoagressive grounds" [25].

According to modern concepts, autoagressive behavior includes any actions in the physical, psychosocial or spiritual sphere that are consciously and unconsciously aimed at self-harm [26-30] or abandonment of active life, civil obligations, duties, unwillingness to solve personal and social issues; activities that are manifested at the ideator, affective and behavioral levels, aimed at self-harm in the physical, mental, social and spiritual spheres of intentional (conscious or unconscious). Thus, autoagressive behaviors include suicidal behaviors, as well as behaviors associated with a complex of potential death factors: drug use, alcohol use, risk Drive, etc. [31-34].

Today, literature data on the ratio of the frequency of suicide attempts between women and men seem quite contradictory. Thus, it has been shown that the rate of suicide attempts among women in our country exceeds the corresponding figure for Men [4]. The rate of suicide attempts among women is higher than that of men, and in most countries in Europe, except Finland. Among adolescents, girls also try to commit suicide more often than boys. At the same time, various authors have accurate data on the ratio of the frequency of suicide attempts by men and women. Women attempt suicide more often than men, on average 2-3 times. Among those who try to commit suicide while intoxicated, men prevail, and among sober suicides, women [35-39].

Recently, there have been fundamental changes in the understanding of suicide behavior, which began to be seen as a continuous process, based on behavioral predisposition [40].

Within the framework of this model, 4 groups of factors of the emergence and development of the suicide process are distinguished: biological – mental disorders (especially depressive and drug disorders) and hereditary weight for suicide.

The presence of clinical-mental disorders, among them depressive disorders, personality disorders and schizophrenia, has a high risk of suicide; low detection of mental disorders in the population; the presence of developmental disorders in childhood; alcohol abuse; substance use, chronic somatic diseases, especially the presence of cardiovascular, digestive and respiratory systems.

Social, including macrosocial (social problems in society, financial and economic crises, risk of loss or loss of work, severe financial situation, private entrepreneurship, trade, as well as professional employment in finance; forced change of place of work) and microsocial (incomplete parental family, pathologists-parental upbringing in the parent family, conflict relationships in their own family, absence or loss of their own family, loneliness, childlessness, narrowing or loss of social ties) factors.

Autoagressive and autistic-depressive types of response to personal psychological-stress, absence or priority of high personal needs, egocentrism, impulsivity, persistence behavioral stereotypes, high levels of anxiety; avoidance behaviors [41-45].

Currently, the main symptoms of non-suicidal autoagressive behavior include:

1) the sign of" cliché " or the fatal repetition of tragic or traumatic events in individual life;

2) partial conscious personal dependence (attraction) with a sense of coercion in uncomfortable situations, understanding the abnormality of what is happening, dealing with violence (as if out of desire) in autoagressive situations;

3) the basis for obtaining problems in the form of any interpersonal benefit; on the motivational side, it can be the behavior of the victim, masochistic or pseudoriganism (if the rental benefit does not exceed psychological, moral or physical harm);

4) in the form of family heredity to obtain a clearly defined parental program of abnormal death by the recipient [46-48].

According to modern concepts, the main forms of behavior associated with non-suicidal (isomorphic) autoagressive phenomena often include: excessive enthusiasm for dangerous sports, a tendency to unreasonable risk, excessive smoking, alcoholism and drug addiction, nozophilia, many cases of self-treatment, asceticism, insufficient decrease in search activity in adverse situations [49].

The purpose of this study is: study of the features of the manifestation of alcohol dependence and autoagressive behavior in different patients

Materials and methods. From 2020 to 2023, we conducted a clinical examination of 190 men seeking outpatient anonymous Narcological assistance with a narcologist-psychiatrist for the treatment of alcohol addiction.

The main criteria for joining the study were: male sex and the identification of alcohol addiction syndrome in the patient (F10.2). The study did not include: patients with signs of organic damage to the central nervous system, patients with acute psychotic disorders, patients with severe forms of somatic diseases. The diagnosis of alcohol addiction syndrome was made using the criteria described in ICD-10. For the diagnosis of personality disorders, the ICD-10 criteria, anamnestic data provided by the patient and his relatives, as well as information from medical documents indicating the diagnosis of previously identified personality disorders were used. In childhood, a proposed questionnaire was used to identify negative parental messages received by the patient. The age of patients in the study group is from 21 to 64 years (average age is 37±9,4).

Quantitative and qualitative indicators were used for statistical processing of the material, the reliability of the research results according to the student's method was calculated. Achieving a $p<0,05$ significance level was considered reliable. A factor and correlation analysis was performed using the four-pole table method. Statistical analysis of the data was carried out using the Microsoft Excel 2010 program and the SPSS 17.0 statistical package.

Results and their discussion. In 33,2% of patients who seek anonymous outpatient drug care to treat alcohol addiction, symptoms of personality disorders can be identified. Typically, alcoholic addicts undergoing outpatient treatment identify emotionally resistant (22,1%), dissocial (16,8%), and paranoid (10,6%) personality types, less frequently – narcissistic (7,9%), avoidance (7,3%), anancastic (6,3%), schizoid (5,8%). and hysterical (4,5%) species.

In patients with comorbid personality disorder, alcoholics are different from those in patients with previous formation, a high progressive course, frequent contact with a periodic form of Alcohol Abuse, high tolerance to alcohol with frequent toxic overdose, paroxysmal disorders during the period of removal and with alcoholic psychoses with a hidden and pronounced characteristic emphasis.

In alcohol-dependent patients, in combination with personality disorders, different manifestations of autoagressive behavior are statistically significantly more frequent. Suicidal

manifestations of autoagressive behavior (suicidal thoughts, attempts, self-harm) are most characteristic for patients of an emotionally unstable personality type; non – suicidal manifestations of autoagressive behavior, such as anti-social and dangerous behavior-for dissocial patients; autoagression associated with professional relationship disorders is for narcissistic and family relationship disorders are for paranoid patients.

The spectrum of messages from negative parents, which affects the formation of behavioral characteristics of an individual, is interconnected with its type. For individuals with hidden accents of a character, as well as for its anankastic type, the presence of a negative parental message "do not be a child" is most characteristic; for a type of paranoid personality-"do not believe"; schizoid - "do not be close", "do not belong"; for emotionally unstable - "do not live", "Do Not Grow", "do not be healthy", "do not think"; for dissocial - "do not live", "do not feel","do not think; for narcissistic - "do not be yourself"," do not be close"," do not feel"," do not believe"; for anxious - "do not grow"," do not be significant","do not belong".

Autoagression of patients with a narcissistic personality type is manifested in the professional field. For example, they explain the lack of work by the fact that they cannot find an option "worthy" of their personality. Therefore, contracts are concluded with narcissistic patients, who, even if the patient underestimates himself, encourage them to work and continue activities. Emphasizing the importance and specificity of narcissistic patients, it is possible to form a good therapeutic alliance, and then be invited to psychotherapeutic work aimed at long-term, personal changes.

Lack of trust, suspicion and pathological jealousy help to destroy family relationships in paranoid individuals. When working with such patients, the specialist is designed to provide an environment of reception and safety, as well as to give the patient enough time to build confidence. The doctor should avoid phrases that contain criticism, as well as sentences that can be interpreted in a double way.

The patient should be persuaded to double-check their assumptions, such as questioning the fact of the husband/wife's infidelity. It is also possible to achieve changes in their behavior in the family by encouraging the paranoid to express their emotions, inviting them to long-term therapy with a focus on family problems.

We could evaluate the results of psychotherapeutic work using the approach described above according to the existing catamnestic data of 106 patients (84 patients gave up therapy after passing one of its stages – their catamnesis is unknown). The average duration of therapeutic remission of Alcohol Dependence in the studied sample was 13,88±6,94 months. At the same time, in patients with personality disorder, the duration of remission (1 gy) was lower than statistically significant ($p<0,05$) (11,78±6,29 months)), compared to patients in the other two groups (2 and 3 gy), which confirms previously obtained data. In all three groups, the most violations of therapeutic remission occurred within 12-24 months after the start of therapy. At the same time, impaired remission of Alcohol Dependence in patients with personal pathology occurred more frequently in the first 6 months of statistically reliable ($p<0,05$) therapy.

In patients with anxiety (avoidance), anankastic, schizoid and hysterical personality type, the best results of therapy were achieved, more than 60% of them restarted alcohol abuse within 2 years of the start of treatment, and 25% of them achieved remission for more than 2 years. Significantly less remissions could be achieved when working with dissocial and narcissistic

patients – in 62,5%, the recovery of alcoholism occurred more often in the first year of therapy, in narcissistic patients – in the first half of treatment, and in dissocial patients-in the second.
Among patients who refuse psychotherapeutic help at one of its stages, it is often manifested by patients with emotionally unstable, dissocial, narcissistic and paranoid personality types, especially at the level of personality disorder. In our opinion, the greatest difficulty in working with such patients is associated with difficulties in forming a psychotherapeutic alliance between the patient and the doctor.

Conclusions. In patients with different types of personality, alcohol addiction psychotherapy should be carried out taking into account the leading manifestations of autoagressive behavior. As psychotherapeutic goals, it is necessary to choose negative parental messages that the patient received in childhood and influenced the formation of his personality. With a combination of alcohol dependence and comorbid personality disorder, the duration of therapeutic remissions is less than in patients with a latent and clear character. The most persistent therapeutic remissions are performed in patients with a hysterical and anxious personality type, while the least resistant ones are in patients with dissocial, narcissistic and paranoid personality types.

This study found a strong correlation between alcohol dependence, autoagressive behavior, and the individual characteristics of the patient. The presence of this type of relationship leads to the need for psychotherapeutic treatment of alcohol addiction to include methods aimed at neutralizing pathological desire for alcohol, correcting autoagressive behavior patterns, as well as performing work aimed at the patient's personality. At the same time, the greatest difficulties are observed during psychotherapeutic work with patients with characteristics of emotionally unstable, dissocial, narcissistic and paranoid personality types, especially during its functioning at the level of personality disorders. During the psychotherapy of such patients, the main actions should be directed to the formation of a therapeutic alliance with the formation of a long-term relationship of trust between the doctor and the patient.

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