SADNESS AND LOSS REACTIONS AS A RISK OF FORMING A RELATIONSHIP TOGETHER

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Abstract. *Modern research confirms the importance of the experience of loss for increased mortality, including cardiovascular disease, especially in the first year after the death of loved ones. Individuals with severe losses often seek medical attention. Somatization cases associated with grief experiences are common among health care patients, which are perceived as somatic disorders and treated without success.*

Keywords: *pathological somatized grief reaction, comorbid, somatization, somatic diseases, pseudosomatics.*

Introduction. It is noted that the grief reaction can occur mainly in the form of somatic complaints and in patients with a previous history of somatoform disorders. There are descriptions of patients with hypochondria, in which an increase in the intensity of pseudosomatic complaints was noted against the background of the loss of loved ones [1]. The formation of somatoform disorders or physical dysfunctions as a result of a complex grief response is more frequent than the pictures of melancholy, mania or obsessive disorders [2].

There is a great interest among local researchers of the last decade in the study of the structure of loss, the possibility of dividing the grief reaction into a separate diagnostic category is being discussed [3, 4]. Prioritizing the study of mainly affective disorders that develop after loss, the authors highlight the deterioration of the somatic functioning of individuals who identify the grief reaction. A number of researchers [5-7] consider grief reactions within the concept of posttraumatic stress disorder (PTSD). Thus, indicates that the death of loved ones is the second most common cause of the appearance of PTSD (in 25% of cases) (after combat actions) [8]. In addition, according to the author, a significant share of this disease is somatoform symptoms. In general, the modern literature emphasizes the relationship between the history of psychological trauma, post-traumatic stress disorder and the number of somatic complaints of patients in the primary network [9-11]. Individuals with a traumatic history and patients with posttraumatic stress disorder are more commonly seen in Primary Care [12]. In this contingent, the risk of developing not only comorbid psychopathological, but also somatic diseases increased [13]. For example, a grief reaction can determine the clinical picture of arterial hypertension [14]. Lists cardiovascular disease as the leading cause of death in the first 6 months after loss (2/3 of all causes of death) [15].

Therefore, reactions that begin with the loss of loved ones are accompanied by a wide range of psychopathological diseases, which include the risk of manifestation of Affective (anxiety and depressive), somatoform diseases, PTSD symptoms and somatic dysfunctions [16-19]. Despite the

obvious interest in studying grief reactions in the psychiatric literature of recent years, the problem of the relationship between loss and the emergence of pseudosomatic and somatic diseases has not been sufficiently covered [20-25].

The data obtained show that a contingent of women with an adequate level of Education (Secondary and higher education) and personal information will be more prone to developing a pathological somatized reaction to grief emphasis, mainly C and B clusters [26-29].

In addition, the prepositional role of the Pre - and involutional age period in the formation of a pathological somatization reaction of grief can be noted. At the same time, the influence of the age factor, not counting cases associated with the predominance of the affective register (depressive-somatoform variant), is less associated with the male sex, since other clinical variants of the pathological somatized grief reaction in men (dysthymic-conversion and anxiety-somatoform), as a rule, are formed at a relatively young age [30-34]. At the same time, it is legal to propose a more significant contribution to the influence of the constitutional-genetic background and the current situation. This is confirmed by data on the pathology of personality and the frequency of alcoholism among first-degree relatives. Male alcoholism is closely related to the anxiety-somatoform variant of the pathological somatized grief response and, to a lesser extent, to the depressive – somatoform. Patients with dysthymic conversion and anxiety-somatoform variants have been found to have high rates of neurotic disorders in childhood [35-37]. In the pre-Real state period, a tendency to give a clear psychogenic response to the death of loved ones, with a homonic personal appearance, is more common in the history of patients with a dysthymic conversion option [38].

The importance of the semantics of true psychogeny is evident in the identified differences between groups of patients with different clinical variants of pathological somatized distress response [39]. Clinical groups with approximately equal quantitative ratio as the object of the child's loss were significantly different from the loss of the spouse (most patients with depressive-somatoform variant), as well as with the parent and sibling, which was often observed in groups with anxious-somatoform and dysthymicoconversion variants [40]. Also, death as a result of suicide determined only affective options with a pathological somatized reaction of grief, and the cooling of relations before the death of a loved one predetermined the formation of a dysthymic-conversion option with a pathological somatized reaction of grief to a greater extent. With a pathological grief reaction, the identified features of the clinic and the differential importance of pathogenetic effects help to optimize the diagnosis, therapy and Prevention of these conditions [41].

The purpose of the study: is to identify and analyze the phenomena of joint relationships and transformations formed by the development of an incongruous state; to identify possible ways of solving the grief and loss reaction and to predict them.

Materials and methods. A permanent sample of patients with grief and loss reactions diagnosed with adaptation disorder (F43.20-43.28 on ICD - 10) was conducted at the clinical psychiatric hospital. In total, 110 patients were registered, of whom 48 were women and 62 were men. Research methods: clinocatamnestic research, premorbid background study, clinical-dynamic psychiatric examination, statistical analysis.

As there are currently no specific diagnostic criteria for the loss response, the cases studied have been diagnosed as "adaptation disorder (F43.2)", "mood affective disorder (F32, F33, f34)", "posttraumatic stress disorder (F43.1)". In addition, symptoms of somatoform (F45), conversion-

dissociative (F44.4–F44.7) and psychosomatic disorders were identified in all cases, which were defined as subsyndromal or comorbid depending on severity. Cases of chronic somatic diseases and organic brain failure were excluded from the study.

The main method of research was clinical. Clinical scales (Hamilton – anxiety and depression, Toronto alexithymic scale – TAS) and questionnaires (assessment of the effects of Horowitz's traumatic events, somatized disorders – SOMS, Spielberger–Hanin's personal and situational anxiety) have been used to qualitatively and quantitatively account for clinical manifestations., Smol, TORZ). Statistical processing of the material was carried out using the statistics program for Windows 6.0.

Results and their discussion. In recent years, the detection of borderline mental disorders, including conditions associated with adaptation disorders, which include grief and loss reactions, remains consistently high. Modern realities, determined by external and internal socio-economic, socio-moral, political paradigms, as well as the catastrophic restructuring of the system of personal adaptation in the event of loss, do not raise doubts about their impact on the mental foundation of a person. Demoralization can increase the formation of complex psychosomatic comorbid bonds in soil where Extinction is suffering, or the formation of negative soil to renew them when they are present in the past. This condition is seen as a difficulty in checking the initial condition, changing its clinical and dynamic characteristics, control problems for individuals with psychogenic diseases, as a result of which it worsens the prognosis and reduces the likelihood of a positive exit from the grief and loss reaction. This study examined the characteristics of the combined interaction of grief and loss reactions with other mental disorders within the aggravating factor of primary nosological unit resolution.

Each of the 4 stages of pathological grief has different clinical and dynamic indicators, which goes beyond the ICD-10 classifier, which in the clinic only determines depressive, anxious, behavioral responses, as well as their combinations. We managed to show that such differentiation is more characteristic of the first stage of grief (stage of emotional shock).

At the same time, by the end of this period, the manifestation of more subtle and specific pathological structures formed by the active functioning of the mechanisms of personal protection has already been observed: psychosomatic and conversion manifestations, personal shifts; as well as the dependence of the stage 1 clinic on the premorbid characteristics of the individual and the relevance of these presentable manifestations are determined.

In Stage 2 of grief (acute stage of grief), against the background of universal signs of response to a stress factor-depression, aggression, anxiety-an increase and stabilization of the manifestation of other syndromic units is noted (obsessive-compulsive inclusions-27,3%, psychosomatic manifestations-20,9%, phobias – 20,0%, addictive behavior-14,5%), which ultimately creates conditions for the sharp formation of comorbid relationships.

For Stage 3 of the reaction (stage of disorder and frustration), a decrease in the appearance and intensity of all clinical indicators is characteristic, but at the same time individual psychopathological manifestations-personal deviations (13,8%) and psychosomatic diseases (19,1%) are stabilized, which are in addition to the universal components of the psychogenic reaction. able to determine the basis for the formation of combined pathologies and their effect on the picture of grief.

Stage 4 (reorganization stage) of the loss reaction we will consider as a basis for updating existing or first manifested mental disorders, and therefore the presence of comorbid bonds found

in 75,4% of cases in the study will be of serious importance in predicting the outcome of grief reactions. In a combined relationship, the dominant pathology was Personality Disorder (30,0%), addiction disorder (21,8%), dissociative and somatoform disorders (12,7% each). Against the background of the pathological reaction of loss, we noted the decompensation of 26,7% of existing mental disorders (especially personal ones; 60,0%), as well as the formation of other psychopathological structures (in 27,2% of cases), with a predominance of Affective and personal pathology.

Studying age differences, it was found that the most characteristic ($p<0,05$) of the loss experience for young adults combines with nosologies such as personality disorder and Addiction Disorder. The middle-aged studied ($p<0,05$) recorded an equal distribution between personality disorder, addiction disorder, and a formed depressive episode (endogenous depression). Among elderly patients ($p<0,01$), a depressive episode as well as addiction and psycho-organic disorders and anxiety-phobic disorders have been found to be more frequent.

We found that only every 11 of the sample were intact, viz does not detect any combined pathology. At the same time, the duration of the 1st period and the overall reaction in intact patients is 2 times less than in patients with comorbid pathology ($p<0.01$). For a small group with combined mental pathology, the frequency of occurrence of this stretch corresponds to 34,1% and 30,1%, respectively (in an intact subgroup, this distribution is defined as 10,0% and 0,0%).

For patients with previously existing mental pathology compared to a small group of intact patients, the likelihood of the occurrence of other mental disorders was significantly determined. If for the first subgroup such a phenomenon is characteristic of 40,2%, for the second only 10,0% ($p<0,05$). In more than half of the cases in a small group with mental pathology, the resolution of the malfunctioning reaction is considered dysfunctional (56,1%). In a small group of undisturbed patients, dysfunctional resolution is significantly less common – in 10,0% of cases ($p<0,01$).

Taking into account the identification of significant prevalence among combined disorders of individual deviations, it is important to consider their personal impact on the picture of pathological grief. We have identified an important probability of additional joint relationships of loss reaction structure + personal deviations. For personality disorders-we first identified an emotionally unstable and Schizoid-the probability was 48,5%. The results of the study allow us to talk about trends in prolonging the transition from the grief and loss reaction, in the design of which there is a personality disorder ($p<0,01$; compared to those without personality disorders). This is also indicated by an increase in therapeutic measures (up to 57,6% of cases with specific personality disorders) and a negative prognosis of the outcome of the grief and loss reaction (up to 54,5%).

Conclusions. Thus, we were able to identify the following characteristics of comorbid relationships that occur in grief and loss reactions:

1. Comorbid pathology in grief and loss reactions is very common (in 75,4% of cases);

2. The formation of comorbidity begins at the end of the first stage of grief (the beginning of psychosomatic and conversion manifestations, personal shifts), manifests itself in the second stage (obsessive-compulsive, psychosomatic and phobic disorders), stabilizes in the third stage (personal and psychosomatic disorders) and determines the solution of the reaction in the last stage in connection with the identification of identified personal, addictive, dissociative, somatoforms. and endogenous Affective Disorders;

3. The presence of comorbid pathology contributes its destructive contribution to the possibility of a positive solution to the reaction: the severity and mixing of signs of a general clinical picture, increasing the time of grief, strengthening and changing therapeutic interventions associated with the organization of new nosological units.

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