Central Asian Journal of Medicine

CLINICAL AND PSYCHOPATHOLOGICAL FEATURES OF THE STRUCTURE OF AFFECTIVE DISORDERS IN ELDERLY PATIENTS

Lola Sh. Shadmanova [1], Zarif Sh. Ashurov [2], Nargiza F. Yadgarova [3], Yekaterina M. Lyan[4]

1 Candidate of Medical Sciences, Associate Professor of the Department of Psychiatry and Narcology of Tashkent medical academy, Uzbekistan
E-mail: l.shadmanova.tma@gmail.com

2 Doctor of Medical Sciences, Head of the Department of Psychiatry and Narcology of Tashkent Medical Academy, Uzbekistan
E-mail: zarifjon.ashurov@gmail.com

3 PhD, Associate Professor of the Department of Psychiatry and Narcology of Tashkent Medical Academy, Uzbekistan

4 Assistant of the Department of Psychiatry and Narcology of Tashkent Medical Academy, Uzbekistan
E-mail: yekaterina.lyan@gmail.com

ABSTRACT

Last decades approaches to an assessment of an outcome of depressive distress at persons of serotinal age have undergone essential changes. Along with conservation of traditional methodology in definition of categories of an outcome of depression and their division into the congenial and unfavorable bunches (Jhingan H.P., Sagar R., 2001; Baldwin R.CandGallagley A., 2006), representation about criteria of reference of each concrete variant of an outcome to one of these categories has extended.

Key words: depression, involutionary period, suicide, anxiety, adaptation.

INTRODUCTION

The analysis of scientific literature on the problems of depression is one of the central in the field of psychiatry. This is determined, first of all, by their high prevalence in the involutionary age, the frequency of depression among other forms of mental pathology is steadily increasing with aging.

In the process of aging, age-related changes are observed in almost all neurotransmitter systems, presumably involved in the pathogenesis of depression, however, the time of appearance of these changes in the aging process and the rate

of their progression are not the same, which can determine the features of the pathogenesis of depression in different periods of late age.

Thus, many fundamentally important aspects of neurotic depression caused by adjustment disorders have not yet been resolved. Questions of typological differentiation need special research; clarification of the relationship between psychopathological manifestations, personal characteristics of patients, characteristics of traumatic factors; optimization of treatment and rehabilitation programs in accordance with the clinical and psychopathological differentiation of neurotic depression caused by adaptation disorders.

Purpose of the study: To study the clinical and psychopathological features of the structure of affective disorders in elderly patients

Materials and methods: 40 patients with depressive disorders at the age of 55-65 years were examined. The median age was 55.9 years. Among them, there were 31 women (68.8%), and 14 men (31.1%). Of the research methods used were clinical and psychopathological; experimental psychological research methods (scale for assessing depression DRALEX (2012), Hamilton psychometric scale). All patients underwent inpatient treatment at the City Clinical Psychiatric Hospital of the City Health, Department of the Khokimiyat of Tashkent.

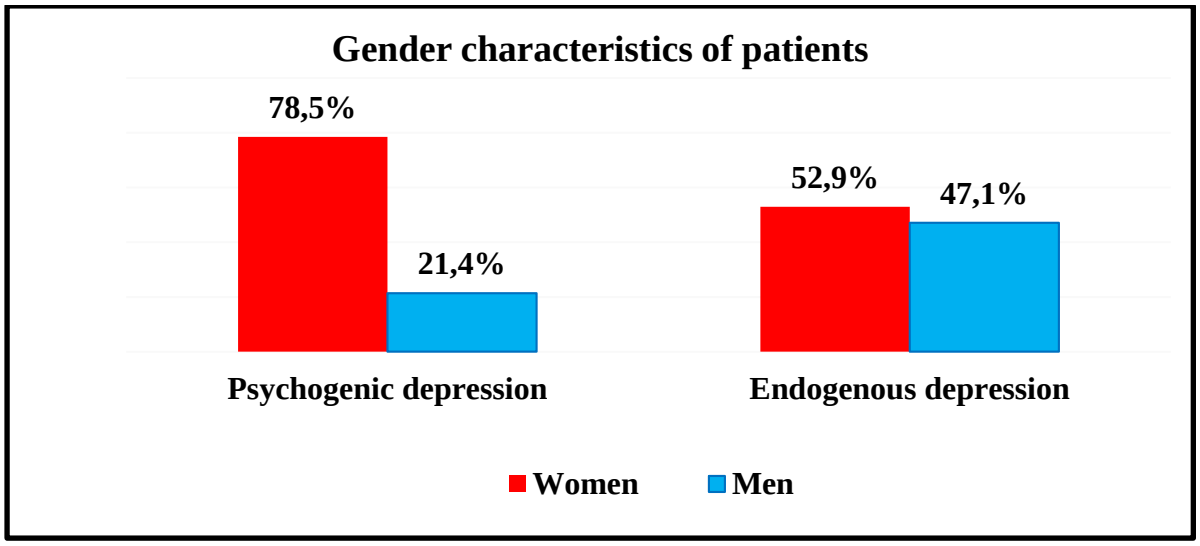

Figure 1. Distribution of patients by sex.
(P<0,05)

The main clinical criteria for the selection of patients were: the presence of a clear pathogenic relationship between affective symptoms and psychogenic disorders; the predominance of anxious and depressive manifestations in the clinical picture of mental disorders of an endogenous nature; the typical nature of the clinical picture of these disorders for the establishment of diagnostic criteria; a combination of mental disorders with concomitant somatic pathology.

Among the social factors contributing to the selection of patients were:

1. Age over 45;
2. Frequent hospitalizations in a psychiatric hospital
3. Disorders of social adjustment

The above criteria were met by the following disorders according to the International Classification of Mental Illness, 10th revision (ICD-10): (Fig. 2.)

F-31.0 (Bipolar disorder);

F-32.0 (mild depressive episode);

F-32.1 (moderate depressive episode);

F-32.3 (severe depressive episode);

F-33. (Recurrent depressive disorder);

F-43.2 (Depression due to adjustment disorder).

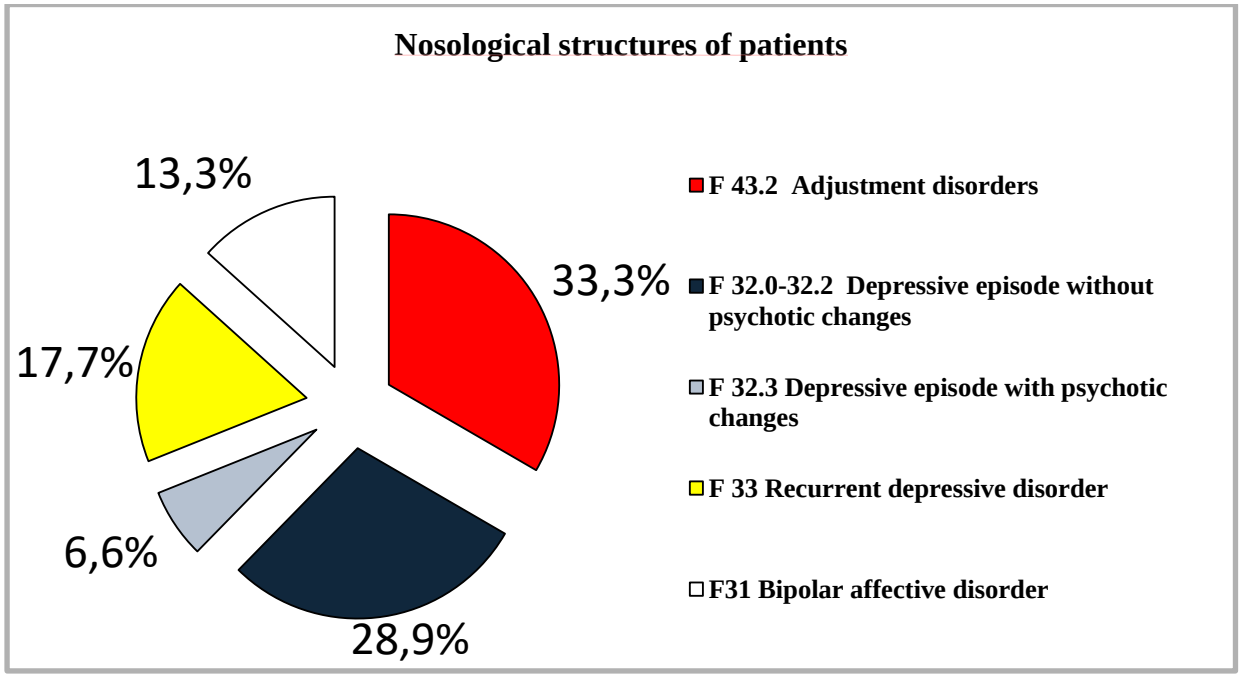

Fig. 2. Distribution of patients by nosology (P<0,05)

The study did not include patients whose depressive disorder was combined with chronic alcoholism, drug addiction, mental disorders caused by organic damage to the central nervous system.

All patients were divided into 2 groups:

1st group - 28 (62.2%) patients with psychogenic depression

2nd group - 17 (37.8%) patients with endogenous depression

Research results

In the structure of the revealed depressions, psychogenic disorders predominated - 62.2%. Depression in most cases was formed in connection with acute or chronic traumatic situations, which is a characteristic feature in the

development of depressive disorders in the involutionary age. A feature of the dynamics of depressive disorders was their protracted course.

Endogenous depression was detected in 37.8% of patients. Based on the ICD-10 criteria, the following diagnostic groups were identified:

- Adaptation disorder (F 43) - 15 people (33.3%).
- Mild to moderate depressive episode (F32.0-F32.2) -13 people (28.8%).
- Depressive episode of severe degree (F32.3) -3 people (6.6%)
- Recurrent depressive disorder (F 33) - 8 people (17.7%)
- Bipolar affective disorder (F 31) - 6 people (13.3%)

Psychogenic depressions prevailed in patients in the border department, while in the closed department, on the contrary, a greater proportion was made by patients with endogenous depressive disorders.

When comparing depressive disorders in borderline and closed wards, significantly more pronounced depression was found in patients with closed wards, mainly, as mentioned above, due to the predominance of endogenous depressions with a large number of somatic disorders. According to the Hamilton scale, these patients had significantly more pronounced depressive symptoms, the mean score was 30.2 ($p < 0.5$), and the indicators of mental and somatic anxiety did not differ from those in patients in the border department ($p > 0.05$) , were respectively 20.4.

The predominance of depression of the lungs and moderate severity -20.4 points on the Hamilton scale - was noted in the patients of the border department. The study in patients revealed a significant excess of indicators of somatic, obsessive-compulsive, depressive, anxious, paranoid scales, as well as an additional scale of depression ($p < 0.05$).

A high somatic score reflects distress arising from a feeling of bodily dysfunction. In a specific case, this is associated with both the presence of disorders of the affective circle and the presence and manifestation of real somatic diseases.

High numbers of the obsessive-compulsive scale are mainly due to positive answers to questions such as repetitive unpleasant, obsessive thoughts, memory problems, the need to do everything very slowly to avoid mistakes. These phenomena in most patients are due to anxiety and depression itself, and in a number of patients - also organic symptoms.

The anxiety scale included an increase in both "mental" and "somatic" anxiety indicators. The high indicator of the paranoid scale did not reflect the paranoid mood of the patients itself, but testified to the characteristics characteristic of the involutionary age and the feeling that “others are to blame for almost all troubles (the outwardly blaming nature of the response)”, that “most people cannot be

trusted", "others underestimate them successes "(lack of attention, lack of demand). Such characteristic reactions of people of involutionary age can be explained by increased sensitivity.

The category of psychogenic depressions included patients with diagnoses of "adjustment disorder", "depressive episode", since in both cases it was not about depression of the endogenous circle, and the similarity of the clinical picture and course of these several diagnostic groups was revealed:

The group "Adjustment disorder" (F43) consisted of patients who survived the loss of close relatives (6 people), looked after seriously ill patients (4 people), or had long-standing intractable situations, often associated with litigation - issues of division, inheritance of property (5 people). Often after the death of one of the spouses, patients completely cut off contact with relatives or former acquaintances, said that they were not needed by anyone, they developed a long-term conflict situation with children. These patients complained of sleep disturbance, anxiety during the day, tearfulness, fear of loneliness, a pessimistic outlook on the future, and absorption in thoughts of traumatic content was noted. In isolated cases, hysteroform disorders (visual and tactile elementary illusions of perception) were observed, accompanied by fear of insanity and increased anxiety. Often, in connection with complex everyday problems (for example, litigation or illness of relatives), patients showed adequate activity, were rather stern, but after the resolution of the conflict they developed depressive disorders. In such cases, the so-called "depression of exhaustion" was diagnosed, described at the time by R. Kleprin (1957).

By the nature of the leading symptoms in this group of patients, anxiety-depressive (20%) and asthenic-depressive syndromes (40%) and somatized (40%) can be distinguished. A feature of the course of depressive disorders in this case was protracted depressive reactions, which could last in patients for several years, and the patients could not cope with their condition on their own.

1) The group "Depressive episode" (F 32) (13 people) consisted of patients in whom it was not possible to find any objectively significant traumatic experiences that caused the appearance of a depressive episode, but insignificant events could cause a negative reaction, which was explained by the peculiarities of the "soil" and the meaning of "small psychogenies" (Zhislin S.G., 1956).

The subjects of this group showed a decrease in mood for no apparent reason, a feeling of irritation at situations that had not been previously paid any attention, anxiety during the day, increased conflict, the patients became grumpy, uncompromising, hypochondriacal ideas were expressed.

Despite the similarity with the onset of senile dementia, the core of the personality in such patients remained intact, and this condition, according to the observation of relatives, lasted for years. Such manifestations give every reason to talk about the so-called “senile depression”.

A feature of endogenous depression in elderly patients was a rather polymorphic picture of psychopathological disorders. In the structure of depressive disorders, both anxious depression (38.5%) and asthenic (38.5%) syndromes were observed, in isolated cases they had hypochondriac fixation (7.6%) accompanied by fear of insanity and increased anxiety.

Conversion disorders (15.3%) were revealed in 2 patients from this group, which also appeared as a reaction to a traumatic situation. The fact that all the examined patients had some sort of somatic disease allows us to speak about the formation of an internal picture of the disease associated with somatic ill-being. Therefore, the symptoms of the affective circle (weakness, anxiety, sleep disturbance, various unpleasant sensations) were often regarded by them as an exacerbation of the current somatic illness.

Fig. 3 Clinical features of depressed patients

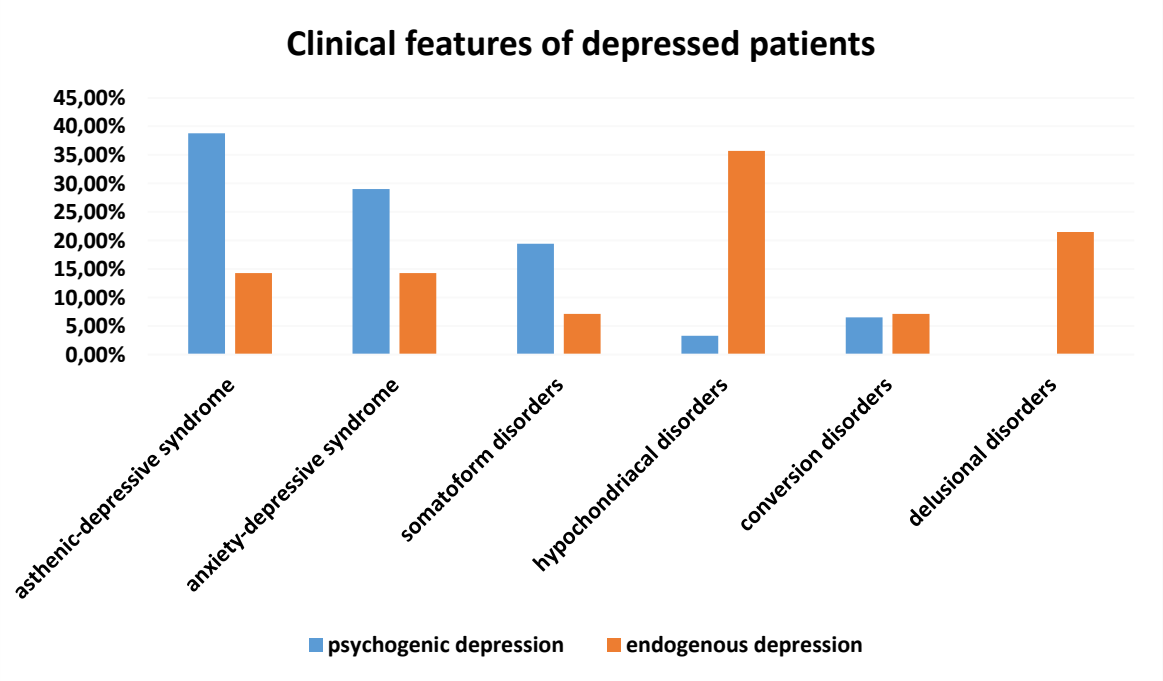

Рис 3. Clinical features of depressive patients of psychogenic and endogenous etiology.

The comparative group of patients suffering from affective disorders of an endogenous nature was, in turn, divided into the following 2 groups.

The group of patients with recurrent depressive disorder (F 33) consisted of 9 patients presenting somatic complaints (11.1%), such as headaches, a feeling of

heaviness in the epigastric region, extremities, dizziness, persistent loss of appetite, in addition, they had weakness, feeling impotence, melancholy with mild lethargy, ideas of self-blame (11.1%), hypochondriacalism (33.3%).

A characteristic feature of these patients was fixation on their own health, for example, after the death of a spouse from cancer, patients began an active search for a tumor in themselves, they believed that they could "become infected" with the same form of cancer. Diurnal mood swings, decreased activity, anxiety, and hypochondriacal fears were revealed.

In patients with bipolar disorder (F31), depression was observed that completely mimics somatic pathology. The examined patients were diagnosed with hypertension with a crisis course, prolonged dizziness, disabling patients.

Often such patients left work, were afraid to leave the house, and were treated for a long time and unsuccessfully with nootropic and antihypertensive drugs. With gastroenterological "masks" of depression, a sharp weight loss, lack of appetite, pain along the intestines, instability of the stool, lethargy, lack of activity, carcinophobia were found.

In all cases, when it was about the equivalents of the depressive syndrome, the patients were characterized by persistent hyperthymia in premorbid and the manifestation of depressive disorders at the age of 50 years and older. In anamnestic study of patients with endogenous circular depressions, a change in the nature of depressive phases with increasing age was noted, a decrease in light gaps was observed, atypical variants of depression appeared with some persistent pseudosomatic symptoms.

Separate attention should be paid to the first manifesting endogenous depressions, the proportion of which among all depressions in patients of involutional age is significantly high. In these cases, the diagnosis of endogenous depression was made taking into account the premorbid pattern, as well as the characteristics of the current depressive episode, such as the melancholy component of affect, lethargy, and ideas of self-blame.

A characteristic feature of these patients was the lack of fixation at the age itself. Often, with the onset of a depressive syndrome, an exacerbation of the current chronic somatic disease or the manifestation of a new disease was observed. At the same time, it was impossible to regard depression as a reaction to the deterioration of the somatic state, i.e. nosogeny, since these two processes, as a rule, started almost simultaneously.

Sometimes depression preceded the deterioration of the somatic state, which made it possible to speak of depressions, manifesting on the pathogenetic basis of the impact of somatic harm. When diagnosing somatized depressions (3 people), in

2 cases, maneuvering depressions were observed, when somatic disorders came to the fore, completely masking depressive disorders. However, in the presence of a large number of somatic complaints, quite pronounced symptoms of the psychopathological circle were revealed, which were not actively presented.

All patients were fixed on their own somatic health, which explained the decrease in mood and activity. In these cases, the leading was a melancholy or anxious affect (33.3%). A careful analysis of the anamnestic data made it possible to assert that these patients in the past suffered masked depressions, and the complaints related to a different functional system of the body. So, one of the patients had gastroenterological "masks" with irritable bowel syndrome, then she was treated for a long time for "sympatho-adrenal crises", as well as gynecological pains of unknown origin. During the examination, individual somatic dysfunctions were interpreted by internists at the level of somatic disease, but the lack of effect of the therapy and the spontaneous recovery from the disease state cast doubt on the correctness of the diagnosis. The severity of depressive disorders was mild and moderate. In premorbid, in some patients, the features of sthenism and increased working capacity prevailed; the patients themselves described themselves as active, “cheerful” people, while the first depressive episode occurred only in old age, often also provoked by a psycho-traumatic situation. Most of the patients had never seen a psychiatrist before, although they described delineated depressive and hypomanic episodes during their life.

The results of statistical processing of the data obtained once again showed the dependence of the severity of depressive disorders on age. Thus, positive correlations of age with the data of the Hamilton scale were revealed, which indicates an increase in the severity of mental pathology with increasing age.

Positive correlations of age with mental anxiety according to the Hamilton scale and negative correlations with somatic anxiety may indicate that mental anxiety predominates over somatic anxiety with age, when the severity of somatic symptoms is more a manifestation of real-life somatic diseases, exacerbated by depression. This is confirmed by the positive correlations of somatic manifestations with the data of the Hamilton scale.

The identification of a large number of elderly patients with depressive disorders confirms the results of previous studies that indicate an insufficient diagnosis of affective disorders. The failure to detect depression is due to the following reasons:

1) a combination of affective disorder and somatic illness;
2) lack of expression of depression;
3) features of age-related mental changes;

4) excessive psychologization of depressive complaints.

Conclusions

Thus, the syndromology of the phenomenon under study seems to us natural and psychopathologically justified. This is an affective pathology represented in our study by depressive states of psychogenic and endogenous genesis.

Anxiety-depressive syndrome with a characteristic clinical picture was detected in patients with initial signs of cerebral atherosclerosis and a history of hypertension.

In the future, obvious depressive symptoms were added in the form of hypothymia, slow thinking with ideas of self-deprecation, of low value and inconsistency, and a decrease in motor activity.

Severe anxious depression had significant therapeutic stability, variability of traits within the anxiety-depressive continuum in different patients, and a tendency towards an increase in "classic" depressive traits and a decrease in the anxiety coloration of the state over time.

REFERENCES

1. Avedisova A.S. Modern classification of antidepressants: opportunities to improve efficacy and safety. Psychiatry and psychopharmacotherapy. 2000.

2. Volel BA-Involutionary hysteria in the framework of the dynamics of personality disorders: // Zhurn. neurol. and psychiatry them. // - M., 2005.

3. Gorinov VV - Personality disorders in mature and old age: on the problem of the outcomes of personal pathology (analytical review): // Russian psychiatric journal //.- Moscow, 2009

4. Drobizhev M.Yu. Syrkin A.JI. Ivanov S.V., Pecherskaya M.B. Paroxetine in the treatment of depression in general hospital patients. Journal. Psychiatry and psychopharmacotherapy (journal for psychiatrists and general practitioners). 2000

5. Drobizhev M.Yu., Syrkin A.L., Poltavskaya M.G. et al. Treatment with tianeptine (coaxil) of anxiety depression in patients with ischemic heart disease. Journal. neuropathol. and a psychiatrist. 2000,

6. Dubnitskaya E.B. On the issue of adequate therapy for protracted reactive depression (introduction to the problem). Psychiatry and psychopharmacotherapy (journal for psychiatrists and general practitioners). 2000

7. Ermolaeva M. Practical psychology of old age. - M .: Publishing house EKSMO-Press, 2002.

8. Ivanets N.N., Tyuvina N.A., Balabanova V.V., Prupis O.V. The effectiveness of tianeptine (coaxil) in depressive disorders of the neurotic

(subpsychotic) level. Psychiatry and psychopharmacotherapy. Volume 3, No. 5, 2001

9. Semke V.Ya. Psychogenies of modern society. - Tomsk: Publishing house of Tomsk University, 2003.

10. Siranchiev M.A. Shallow lingering depression of late age (late dysthymia). Diss. Cand. medical sciences. M., 2002.

11. Smulevich A.B. Depression in general medicine. -S. Petersburg. 2001 year

12. Smulevich A.B. Dysthymia. // Depression in general medical practice., M., 2000.

13. Semke V.Ya. Psychogenies of modern society. - Tomsk: Publishing house of Tomsk University, 2003.

14. Siranchiev M.A. Shallow lingering depression of late age (late dysthymia). Diss. Cand. medical sciences. M., 2002.

15. Smulevich A.B. Depression in general medicine. -S. Petersburg. 2001 year

16. Smulevich A.B. Dysthymia. // Depression in general medical practice., M., 2000.