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PREDICTORS FOR THE FORMATION OF DYSTHYMIC DISORDERS

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Abstract
The article analyzes the premorbid factors in the formation of dysthymic disorders, the clinical polymorphism of which is determined by mild manifestations of depressive disorders, the conditions for its formation and genesis, in which the leading role belongs to the combined influence of constitutional-biological and psychogenic factors.

Keywords: affective pathology, dysthymia, depression, premorbid factors

Introduction. Dysthymic depression is one of the most common forms of mental disorders [2, 8]. Despite the shallow level of affective pathology, dysthymia has a serious negative impact on the quality of life of the patient. This is primarily due to the protracted nature of the course of the disease and its resistance to therapy. Conducted studies of shallow protracted depressive states, which can be qualified as dysthymic depressions, have demonstrated a variety of clinical manifestations, significant differences in the conditions for their occurrence, course features, and outcomes [3, 9]. The category of dysthymic conditions, along with such classical forms as endoreactive dysthymia, included various variants of shallow, prolonged depression, collectively designated as special forms of depression [11, 13. 15].

With the development of the concept of dysthymia, prerequisites were created for studying one of the important aspects of the problem of erased depressions, namely, to clarify the role of factors that cause their protracted course [1, 16]. However, in the existing systematics of dysthymic conditions, this aspect is usually not considered.

This situation is due to the fact that the construction of a typology of dysthymia is carried out without taking into account the dynamics. Even in follow-up studies involving the study of the stereotype of the development of this disorder, the main attention is paid to the statistical indicators of “recovery”, “relapse” or “chronification”, which allows obtaining data on the average duration of dysthymia, while clinical characteristics are not specified [5]. As a result, there is a contradiction between the idea of dysthymia as a disorder, one of the distinguishing features of which is a chronic course, and the paucity of studies aimed at studying the clinical structure of dysthymic conditions in dynamics [14].

The aim of this study was to study the main clinical patterns of dysthymia (shallow prolonged depression), as well as the conditions for their occurrence, to determine the most effective therapeutic approaches for the treatment of various clinical variants of depression.

Material and research methods. The object of the study was a group of 60 patients with dysthymia treated in the clinical departments of the Republican Clinical Psychiatric Hospital. In accordance with the criteria for dysthymia, the study included patients with a history of shallow protracted depression lasting at least 2 years. The follow-up period was at least 1 year. The observations included in the study met the requirements for this diagnostic category in ICD-10: a) the presence in patients of a stable, for at least two years, or constantly recurring depressed mood; b) available intermediate periods of normal mood, not exceeding a few weeks and not accompanied by periods of hypomania; c) prolonged low mood is never severe enough to meet the criteria for moderate recurrent depressive disorder (F 33.0 or F 33.1); d) during at least some of the periods of depression, at least three depressive symptoms are present, reflecting changes in the affective, somatic or behavioral areas (decreased energy or activity, insomnia, decreased self-confidence or feelings of inferiority, difficulty concentrating, frequent tearfulness, decreased interest, feelings of hopelessness or despair, inability to cope with the responsibilities of daily life, pessimism about the future and a negative assessment of the past, social isolation).

Cases were excluded from the study when there were indications of manifest schizophrenic psychoses, diseases of the central nervous system of an organic nature, as well as patients with previously identified disorders associated with alcoholism (or drug use) in the anamnesis of patients.

The need for a thorough clinical examination of patients with a diagnosis of dysthymic disorder suggested a clinical and psychopathological analysis, as well as a somato-neurological examination of patients in a hospital.

Dysthymic disorder in the examined patients (men) was observed for a long period of time required by the conditions of selection of patients - over 2 years - 60 patients (100%), including 15 cases - over 5 years (25.0%) and over 10 years - 12 observations (20.0%). This duration of dysthymic disorder provided an opportunity to analyze its dynamics and possible outcomes (Fig 1).

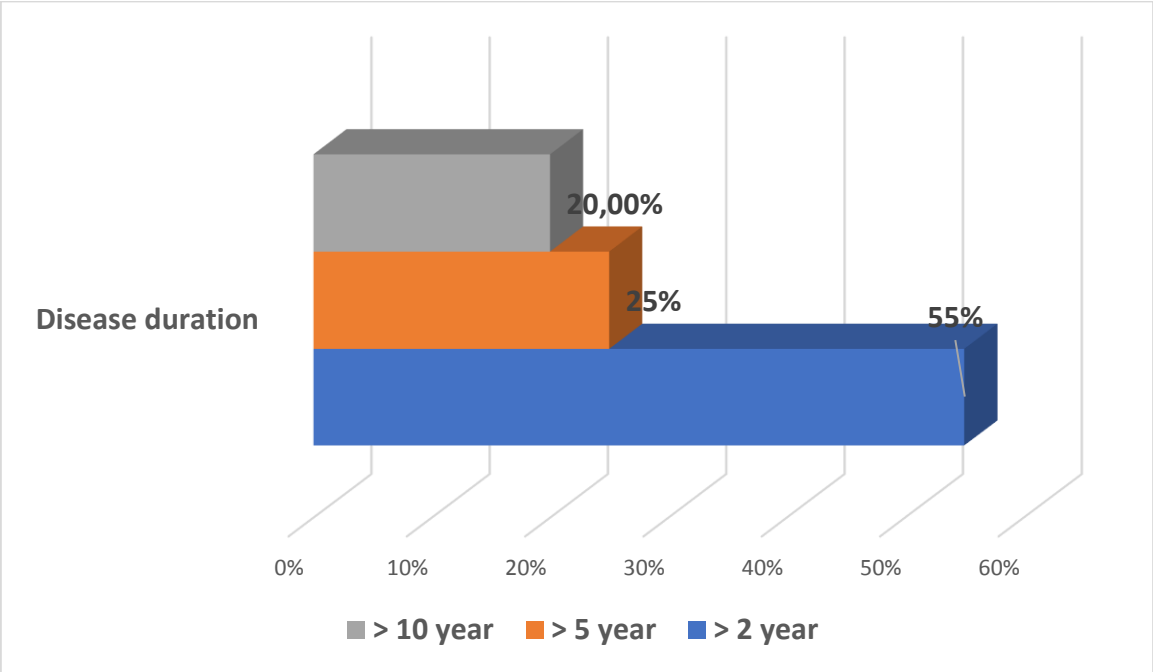

Figure 1. Duration of the disease in the examined patients

Research results. An analysis of background factors preceding the development of dysthymia revealed a psychopathologically burdened heredity in 17 (28.3%) patients, and the most common diseases of close relatives were affective disorders of various origins and alcoholism. The premorbid-personality characteristics of patients with dysthymic disorders turned out to be quite pronounced, which made it possible to attribute them to obvious character accentuations with a predominance of inhibitory traits in 16 (26.7%) and cycloid traits in 9 (15.0%). Psychosocial stressors preceding the development of dysthymia ranged from mild and moderate to catastrophic and were characterized by the magnitude of the psychosocial stressor coefficient, which tended to decrease from adynamic to thymopathic variant of dysthymia. In the studied sample of patients, the probabilistic frequency of occurrence of symptoms of dysthymia was identified according to the ICD-10 criteria, among which depressive mood was 100%. Unlike patients with major depressive disorders, where the objectification of depressive mood does not cause much difficulty, with dysthymia, the depressive affect does not appear so brightly and pronouncedly, but has a smoothed, softened, and sometimes hidden character. Appetite disorders were noted in 35 (58.3%) patients. Decreased appetite was often combined with some gastrointestinal disorders: heartburn, flatulence, constipation, diarrhea. In a number of cases, there was no sufficiently distinct decrease in appetite, but the patients spoke of a lack of pleasure from eating. Sleep disorders in patients with dysthymia were noted in 71.7% of cases (43 patients). Difficulties in falling asleep with mastering ideas or exhausting internal dialogues, nocturnal and early awakenings, superficial sleep with disturbing dreams were the most common. There was also a dream with a feeling of incessant mental work according to A.V. Wayne (1982), as well as a feeling of complete lack of sleep. Lack of energy or fatigue takes second place after depressed mood (47 people - 78.3%).

Patients, as a rule, complain of fatigue, weakness, weakness, unwillingness to do anything, reduced performance. Against the background of this all-consuming feeling of weakness, which is perceived by patients as a rather pronounced violation of the habitual sensation of their body, hypochondriacal fears, phobic reactions, and obsessive doubts begin to arise. Low self-esteem occurred in 61.7% of cases (37 patients) and most often related to cognitive abilities, working capacity, somatic strength and energy. Secondary ideas of guilt were noted, arising transiently in connection with the reactively experienced circumstances of life.

Violation of concentration or difficulty in making decisions was observed in 31 (51.7%) patients. Complaints were about the lack or decrease in memory, difficulty in concentrating attention, lack of volitional activity. The last of the symptoms of dysthymia according to ICD-10, a feeling of hopelessness, was noted in 40 (66.7%) patients. As a rule, the expression of hopelessness manifested itself in patients in the form of figurative sensory-colored representations. Hopelessness was also manifested in the feeling of a lack of mental resources for one or another type of activity, which often led to internal self-reproaches or feelings of failure and demoralization.

As a result of research in the development of the systematics of dysthymic states, it seemed most reasonable to distinguish between depressive states, depending on the features of their syndromic structure, into two main typological groups. Each of the groups was characterized by stable dominance in the picture of the dysthymic state of one of the most significant manifestations of the depressive syndrome, which is determined at any of the stages of the dynamics. These permanent phenomena include features of an affective disorder - the phenomenon of hypothymia with an alarming coloration of depressive manifestations, in their structure to a large extent corresponding to the de-

scription of the melancholic type of depression [4]. Another clinically outlined variant of dysthymia was a state with a predominance of a decrease in vitality and adynamia, similar to the so-called loss of vitality [10]. These symptoms were the most stable throughout the entire painful period, and their presence determined the general structure of the dysthymic disorder and the features of its dynamics.

The distinction between dysthymic states into two groups corresponds to the point of view of H. Helmhen [6] that it is these components of the depressive syndrome that make it possible to differentiate depressive states with the greatest clarity and contrast. This principle was once used to distinguish between mild depressive disorders according to the leading affect (anxious, melancholy, apathetic, undifferentiated), as well as according to the characteristics of disorders in the motor or ideator spheres (agitated, inhibited and mixed) [7, 12]. According to a similar principle, there are four main depressive syndromes (anergic, melancholic, anxious and depersonalization), the affective structure of which, according to the authors, is largely determined by the pathogenetic mechanisms of the disease state and serves as a criterion for choosing an adequate therapy. The structure of a depressive disorder was chosen as a sign coordinating the systematization of dysthymic states. It has been established that dysthymia proceeds in two main types: adynamic type and anxious type. The adynamic type is determined by the leading symptom - vital asthenia. This clinical type of dysthymia is similar to conditions previously identified as asthenic depression, exhaustion depression, adynamic depression, and anergic depression. Anxious type of dysthymia is characterized by a predominance of depressive mood with symptoms of anxiety. Within each of the two main clinical types of dysthymia, differences were determined due to the completeness and severity of the following disorder complexes: 1. somatic symptoms of dysthymia; 2. the presence and severity of symptoms of the neurotic register (hypochondriac, obsessive-phobic, senestopathic), an anxious component of dysthymia, as well as the peculiarities of psychopathic behavioral traits; 3. the presence and nature of symptoms of age-related features: - psychoorganic (memory impairment, episodes of disorientation after sleep) and cerebrovascular symptoms (headaches, dizziness, staggering, tinnitus, sensitivity to weather changes); - features of psychopathization (selfishness, rude hysterical reactions, stinginess, increased resentment, exactingness, tyranny in relation to others).

Adynamic dysthymia was observed by us in 20 (33.3%) patients, it was distinguished by the predominance of manifestations of vital asthenia. The clinical picture of states of this type is characterized by depression, combined with a feeling of general impotence, lethargy, loss of energy. Constant weakness, loss of strength make it necessary to stay in bed. Patients look gloomy, gloomy, they are distinguished by mimic poverty, a downcast, gloomy look. They speak little and note that it is difficult for them to concentrate, to gather their thoughts. At the same time, they feel uncertainty, indecision, depression, fixed on their own impotence. Any action requires great effort from patients. Patients do not seek to talk, do not feel any desire, note that much has become meaningless for them, do not believe in recovery.

Conclusion. Thus, clinical-psychopathological and follow-up study of dysthymia showed that it has an independent clinical significance in terms of the regularity of its manifestation and outcomes, which do not significantly reduce social and labor adaptation, but worsen the "quality of life" of patients. The clinical polymorphism of dysthymia is determined by mild manifestations of depressive disorders, the conditions for its formation and genesis, in which the leading role belongs to the combined influence of constitutional-biological and psychogenic factors.

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ADAPTATION POTENTIAL AND DESCRIPTORS OF RESILIENCE IN FAMILIES, WHERE A PATIENT WITH ENDOGENOUS MENTAL DISORDER LIVES

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Abstract

Family members of a mentally ill person have to deal with reality, which is being constantly changed by the dynamics of patient`s mental disorder. Family burden associated with living with patient who has been diagnosed with endogenous mental disorder, as well as necessity for providing care for the patient, inevitably lead to psychosocial stress and emotional overstrain, which, according to the principle of feedback, negatively affects condition of the patient. Family members of patients with endogenous mental disorders (schizophrenia, affective disorders), face challenging family situation, that demands maximum personality adaptation resources and resilience in order to reach successful coping of the family and resocialization of the patient.

The aim of this study was to analyze some descriptors of resilience in reference relatives of patients with endogenous mental disorders in context of their psychosocial functioning. 168 relatives of patients with paranoid schizophrenia and 75 relatives of patients with affective disorders (bipolar disorder, recurrent depressive disorder) were included into study. Control group was represented by 55 mentally healthy individuals.

Coping behavior and communicative coping resources were estimated with the use of psychological testing tools.

Study of coping behavior indicators revealed following patterns: family members of patients with paranoid schizophrenia and affective disorders are likely to use maladaptive and relatively adaptive coping strategies, that might be a sign of exhaustion of their adaptation personality potential. Revealed tendencies in levels of communication coping resources should be taken into consideration, while implementing complex system of psychological support for families of patients with schizophrenia and affective disorders.

Keywords: endogenous mental disorder, family burden, adaptation potential, coping strategies, coping resources, resilience.

Resilience refers to both the process and the outcome of successfully adapting to difficult or challenging life experiences (APA, 2021). It's having cognitive, emotional, and behavioral flexibility in order to adjust to both internal and external demands. A number of factors contribute to how well people can adapt to stress, predominant among them are subjective perception, quality of communication resources, specific coping strategies. Psychological research proves that the resources and skills associated with more positive adaptation and greater resilience can be cultivated and practiced (11, p. 15)

Family interaction with a mentally ill family member and providing necessary family caregiving are connected with significant psychosocial stress for family members [10, p. 180]. Due to the lack of training, insufficient information about the disease and changes of family homeostasis, caused by mental state of a patient, other family members often experience the so-called family burden. Family burden includes objective negative effects of living and interacting with a mentally ill patient (decrease of health and quality of life of family members, disruption of family life, uncomfortable changes of daily routine, increased financial expenses) and subjective effects (feelings of grief, isolation, loss, anxiety, anger, guilt and frustration) [8, p. 1,3]. Together, objective and subjective effects threaten physical, psychological, economical and emotional well-being of family caregivers [7, p. 114].

Providing family support and care to patients is a challenging task, which might occur disturbing and affecting health and quality of life of family caregivers [4, p. 32]. This makes the problem of effective family adaptation more and more urgent. According to existing data, providing relatives of patients with schizo-