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SYNDROMOLOGY OF DYSTHYMIC DISORDERS, DEFINITION OF THERAPEUTIC APPROACHES

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ABSTRACT

This article discusses the results of a study of the main clinical patterns of dysthymia, as well as the conditions for their occurrence, the determination of the most effective therapeutic approaches for the treatment of various clinical variants of depression, taking into account the syndromic structure of dysthymia and the characteristics of the somatic state of patients.

Keywords: affective pathology, dysthymia, depression, therapeutic approaches.

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.

Research results. 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 (obligate) 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 description 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.

The choice of therapy was determined by the severity, clinical and psychopathological features of dysthymia, and the general condition of the patients. With the predominance of hypothymia, antidepressants with a balanced effect were more often used (venlafaxine at the beginning at a dosage of 37.5 mg with a further increase to 150 mg per day). With adynamic depression of dysthymia - antidepressants with activating properties (fluoxetine) in combination with drugs with a nootropic effect. In the presence of polymorphic symptoms in the structure of dysthymia, combined therapy with antidepressants, atypical antipsychotics (risperidone, quetiapine) and tranquilizers was used. Due to the high resistance of patients to therapy, general restorative therapy with antidepressants in combination with antipsychotics, mood stabilizers and nootropics was used as methods of overcoming resistance. The greatest difficulties in the course of treatment usually arose when adynamic dysthymia dominated the clinical picture. In combination with antidepressants with activating properties, drugs were used that reduce the asthenic component and have a nootropic effect (cerebrolysin 10.0 intravenously by drip, lucetam by intravenous drip with subsequent administration in capsules). The relationship between the therapeutic effect and the general somatic condition of patients was noted. In this regard, along with psychotropic therapy, the patients underwent restorative therapy (vitamin therapy, exercise therapy, physiotherapy). Depending on the somatic condition, symptomatic treatment was carried out with the appointment of cardiovascular drugs that normalize cerebral circulation (cavinton, trental, stugeron), activate energy metabolism and improve brain function (cerebrolysin, actovegin). Thanks to the follow-up examination of all patients, it was revealed that the periods of good condition in these cases ranged from 1-2 days to 1-2 months (34 observations - 56.7%). Complete reduction of symptoms was observed only in 4 (6.7%) patients. At the same time, after the disappearance of depressive symptoms, they did not show distinct disorders in the mental sphere, again returning to their usual way of life, led a fairly active lifestyle. The condition of some patients was characterized by signs of personality change of varying severity - increased

anxiety, mood instability, hypochondria, increased fatigue, egocentrism and grumbling (15 observations - 25.0%). In some cases, signs of strengthening of psychoorganic disorders were determined (7 observations - 11.7%). In connection with the presence of residual manifestations, patients were recommended to carry out maintenance therapy even after discharge from the hospital. Psychotherapy in combination with drug treatment was an obligatory component of the treatment process and was carried out throughout the entire course of treatment. Basically, rational psychotherapy was used - individual and corrective.

Conclusion. Thus, psychopharmacological treatment of dysthymic conditions should be carried out in accordance with modern principles of depression therapy, but with the obligatory consideration of both the syndromic structure of dysthymia and the characteristics of the somatic state of patients. The widespread use of cardiovascular drugs that normalize cerebral circulation, drugs that activate energy metabolism and improve brain function has been shown.

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