

Emotion of Depression Clinical Manifestations in Gender Differences

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Annotation: The variety of stressful effects in modern conditions is accompanied by an increase in the number of affective disorders and especially psychogenic depression. Their high prevalence is associated not only with socio-economic transformations in modern society, but also with the pathomorphosis of psychogenic disorders, the peculiarity of which is a non-psychotic level with a predominance of asthenic and somato-vegetative symptoms [1, 12].

Keywords: psychogenic depression, stress, asthenic and somatovegetative symptoms, psychotherapy

INTRODUCTION

The dynamics of psychogenic depressions is often characterized by a prolonged, socially maladaptive course with a complicated clinical picture and the formation of

pharmacological resistance [7]. Despite the psychogenic nature of depressions, which determines the leading significance of stressful events in the etiology of the pathology and under consideration, the pathoforming influence of such biological factors as monoamine metabolism disorders, as well as gender and age on the development and course of the disease is not excluded [3, 4, 14, 16, 18]. Gender differences play an important role in differentiating the clinical manifestations of depression. At the same time, under – accounting of the sex composition of the studied groups can lead to contradictory results and conclusions in studies conducted using the same methodology, depending on whether men or women prevailed in this sample [4, 5]. Studies on the epidemiology of depression are dominated by data indicating a high prevalence of depression among women, which is associated not only with the peculiarities of biology (primarily hormonal), but also with socio-psychological or gender roles that determine the stress accessibility of women, as a result, in particular, of the weakness of protective psychological structures [2, 13, 15, 17]. Nevertheless, a number of authors point out that a part of "male depressions" is "hidden" from population studies, in particular, the data of N. Singleton et al. [9], in which the ratio of depressive episodes and disorders among men and women is set as 0.8:1.0. Women's depression may be caused by less active treatment of men with depressive symptoms for medical help, which is associated with a certain gender stereotype of "dominant masculinity" ("real men never cry") [9]. This is confirmed by the high suicide-related mortality rate, which is higher among women and men than among women [5]. Thus, the pathogenesis of psychogenic depressions is the biopsychosocial concept of psychiatry, which implies a comprehensive treatment of depressive patients, including pharmacotherapy, taking into account gender and / or gender differences [1, 2, 4]. The aim of the work is to determine the clinical features and approaches in the treatment of psychogenic depression, taking into account the gender factor.

Material and methods: The study was conducted on the basis of the Department of neuroses and psychotherapy of the Bukhara Regional Clinical Psychiatric Hospital. The necessary criteria for selection and inclusion in the study were: the presence of non-psychopathological depression in the structure of the psychopathological which developed in connection with a psychotraumatic situation; the presence of psychotraumatic circumstances in the experience with the dependence of clinical phenomena on their intensity and the improvement of the patient's condition during the resolution of the psychotrauma or its deactivation, as a result of therapy. The study included 60 patients, including 30 men (mean age 43.2 ± 12.8 years) and 30 women (mean age 43.3 ± 10.2 years). All patients were examined in the RA station before and after complex therapy (average bed-day 48.2 ± 5.8), including psychopharmacotherapy, group and individual psychotherapy, and sociotherapy measures. Patients with psychotic depression, neurotic depression of endogenous and somatogenic origin, neurosis-like disorders within the framework of organic CNS damage and low- progressive schizophrenia, as well as persons with personality disorders in the stage of decompensation were excluded. According to the diagnostic criteria of ICD-10, the studied patients corresponded to the following categories: F43. 20-10 men (33.4%) and 12 women (40%) – prolonged depressive reactions and conditions; F34. 1-4 men (13.3%), 8 women (26.7%) – chronic depressive disorders. conditions (dysthymia); F32. 0, F32. 1, F32.2 – 12 men (40%), 8 women (26.7%) - mild,

moderate and severe depressive episodes without psychotic symptoms of severity; F41. 2 – 4 men (13.3%), 2 (6.6%) women – mixed anxiety and depressive disorder. In addition to the clinical and psychopathological method, the following methods were used in the study. To objectify clinical data: the questionnaire on the severity of psychopathological symptoms SCL-90-R, developed by L. R. Derogatis, adapted in Russia by N. V. Tarabrina [9], which consists of 90 statements that determine the current symptomatic status. To study the features of coping behavior: questionnaire E. Heim (1988), which allows us to determine the modality of 26 variants of coping in the behavioral, emotional, and cognitive spheres of varying degrees of adaptability.

Statistical data processing was performed in the STATISTICA 7.0 system for Windows. Nonparametric criteria were used to test about the significance of differences: U-Mann-Whitney test for independent samples, W-Wilcoxon matched pair test for dependent samples. Results with a confidence level not lower than 95% ($p < 0.05$) were considered significant.

Research results and discussion

In the structure of psychogenic depressions in men, in comparison with women, a significant prevalence of the severity of anxiety-specific symptoms in combination with manifestations of hostility-dysphoria was found. The leading stressors in men were industrial (dismissal due to staff reduction) and nosogenic (suspected myocardial infarction) psychogenies, to a lesser extent family-related (loss of loved ones or divorce). Patients experienced repeated unpleasant, persistent thoughts about the psychotraumatic events that had occurred, with a sudden invasion of negative memories, imaginative representations, and repeated nightmares. The situation of job loss with a "dramatic" presentation of the "collapse of life achievements", the inability to provide material support for the family led to severe anxiety with a somatovegetative symptom complex and the manifestation of the disease with "pseudo-infarction masks" with an ambulance call (14 patients) and stationing in the cardiology department (8 patients). After excluding the diagnosis of "infarction" and establishing vegetative-vascular dystonia of the cardiac type, patients were referred for consultation with a psychotherapist and then to the department of neuroses. A sufficiently long period of lack of adequate treatment for anxiety led to a deepening of affect with the formation of anxiety depression and restrictive behavior (anxiety-related depression), which was objectified by the data of the SCL-90-R questionnaire at admission. Another part of young people (16 patients) in a stressful situation reacted at the initial stages of the disease with the appearance of neurasthenic symptoms, which was facilitated by industrial psychogenies with increased workload at work along with a reduction in wages and social incentives (leave with preferential rest). In the clinical picture, this was manifested by an increased intensity of PR and performance of work with overreaction, especially in contact with loved ones, outbursts of irritability, and verbal aggression. Patients had disturbed sleep, along with a feeling of constant fatigue, heaviness in the head and persistent headache. Often, patients resorted to alcohol intake to relieve tension, which led to a decrease in somatovegetative phenomena with anxiety. Close relatives or work colleagues most often insisted on contacting a psychotherapist. This variant of the development of psychogenia in men at the time was represented by anxiety-dysphoric depression with neurasthenic

symptoms. Men's coping behavior was characterized by equal representation of adaptive and adaptive variants in all three spheres, with greater maladaptivity in the emotional sphere. The leading strategy for coping with a stressful situation in the behavioral sphere was "retreat" (0.40), which implies isolation, passivity, and avoidance of active actions in overcoming difficulties (maladaptive coping). In the cognitive sphere, leading coping was "confusion" (0.30) with a sense of loss of cognitive control over the situation. The emotional sphere in men was characterized by the greatest expression of maladaptive variants of coping (average: adaptive – 0.30; maladaptive – 0.57). In the emotional sphere, along with the leading adaptive coping performance of "optimism" (0.27), maladaptive variants were identified – "suppression of emotions" (0.27) and "submission" (0.20).

In contrast to men, the leading stressors in women were family and household factors associated with long-term instability of family relations with frequent alcoholism of the husband or his infidelities, as well as living alone (without a husband) with children and/or their parents, low financial security, which created stress. Among production factors, work with low wages and high psychoemotional load prevailed (in particular, teachers and medical workers). The clinical expression of stressful situations was the formation of anxiety-dynamic or dysthymic variants of psychogenic depression. Upon admission, women were more likely to complain of a feeling of "chronic fatigue", joylessness, and low physical and psychosocial activity. In the emotional plan, there was no pessimistic assessment of the past, present and future, and the complaints most emphasized discrepancies in all spheres of life. Subjectively, depressive affect was perceived as "punishment for aimlessly wasted years of marriage", which was also manifested by separate endogenous symptoms in the form of vitality with sleep disorders, super-valuable ideas of self-defense (primarily in relation to insufficient parenting), which, nevertheless, were unstable. Verbalization of ideas of self-blame was accompanied by dramatization of affect with a clear search for social support. It should be noted that most women have signs of emotionogenic eating behavior with a preference for sweets in the diet as a "symbolic jamming problem" and a shift in food intake in the evening or before bedtime. Emotionogenic eating behavior resulted in overweight, which was anamnestic associated with depression (27 patients). Just as in men, the clinical picture of psychogenic depression in women was represented by a somato vegetative symptom complex, which had differences. It was manifested by unstable blood pressure with a tendency to hypotension, feelings of weakness in the legs and arms, dizziness when changing body position, severe sweating, gastrointestinal symptoms, sensations of a lump in the throat, a feeling of lack of air at the height of anxiety.

These features of the clinic of psychogenic depression in women and men are reflected in the syndromic configuration according to the SCL-90-R questionnaire (Figure, tab. 1) with higher and not reaching statistical indicators of depression (2.14 – women; 1.97 – men) and somatization (1.77 – women and 1.65 – men) than in men (not reaching statistical reliability).

Coping behavior of women, as well as men, was characterized by a noticeable pathoprotective content (Table 2). The greatest adaptability to the structure of coping in women was established in the behavioral sphere (adaptive variants – 0.53, non – adaptive –

0.37). Along with the leading adaptive strategies - "retreat" (0.27) and "active avoidance" (0.10) – women resorted more often than men to adaptive options совладания for coping with stress through seeking help (0.37) and cooperation (0.13). The cognitive sphere is represented by differentiation of the coping structure (on average, 0.40 and 0.43, respectively). Here, the more frequent use of non-adaptive coping – "confusion" (0.23) and "ignoring" (0.10) – is combined with adaptive coping - "problem analysis" (0.20) and "self-value setting" (0.13). Just as in men, the greatest adaptability in the structure of coping in women is established in the emotional sphere (on average, adaptive-0.20; maladaptive-0.40) with the leading coping "self-blame", in contrast to men (on average, 0.20 and 0.03, respectively, at $p=0.04$). It was found to be more pronounced in women, in comparison with men, with respect to adaptive variants (on average, female – 0.40; male-0.40).

0.13 at $p=0.02$), in particular, "emotional discharge" (on average, female-0.37, male-0.10 at $p=0.01$). The obtained data on the coping structure determine gender differences in psychogenic depressions in the emotional sphere, which indicate a greater adaptive resourcefulness of the emotional sphere in women due to better of stress in situations relative to adaptive coping options.

It should be noted that the presence in the conscious protective structure of both men and women, along with maladaptive variants of coping behavior, adaptive coping, indicates the ранность в целом early development of the patient's adaptive resource in general. Nevertheless, the obvious bipolar differentiation of coping (adaptive-maladaptive) in psychogenic depressions is probably a reflection of pronounced intrapersonal tension (conflict), which leads to instability, primarily, аффективного/соматовегетативного of the affective / somatovegetative status and determines the " targets " of complex therapy. психотерапии The " targets " of psychopharmacotherapy are, first of all, clinical symptoms and symptoms. The " targets " of psychotherapy and sociotherapy are the personality of patients with a maladaptive structure of coping mechanisms. But the greatest effectiveness can be achieved not by an isolated, but by a comprehensive approach ("pharmacotherapy opens the door to psychotherapy"). Taking into account the established gender differences of the clinic, actaproxetine (paroxetine) was prescribed for the pharmacotherapy of male depressions (anxiety - phobic depression and anxiety depression with neurasthenic symptoms

Another group of men with an variant and neurasthenic symptoms of psychogenic depression showed to acta paroxetine monotherapy. Using data from studies of resistant depression, which, in particular, indicate the complex structure of depression at the onset as a factor in the formation of resistance [1, 2, 7], combined pharmacotherapy with actaproxetine (at a dose of 20-60 mg in the morning) and mirtazoneal (15-30 mg at night) was used in this group of men). By the first week of combined therapy, along with the regression of anxiety symptoms, increased control over impulsivity and verbal aggression was noted. Despite some sedation at the initial stages of therapy and a decrease in activity, patients noted the onset of " mental relief ", recovery from expressed emotional tension, rest and a sense of cheerfulness in the late afternoon, and improvement in interpersonal communication with loved ones. The cauldron combination also has a good portability profile so far. Subjectively significant side effects were observed in three

men in the form of pronounced dizziness, visual instability, dry mouth and constipation, which were reduced with a decrease in drug dosages.

Conclusion: The emotional sphere of the coping structure is the most pathoprotective in both men and women with psychogenic depression. In women, in comparison with men, the adaptability of coping in the emotional sphere is higher due to relatively adaptive options. When conducting complex therapy, including psychopharmacotherapy with modern anti-depressants (sociotherapy and psychotherapy in individual group forms, it is necessary to take into account the gender factor that determines the features of the clinic, coping-mechanisms, which allows to increase its effectiveness.

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