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Studying Risk Factors in the Formation and Development of Depressive States of the Involutionary Period

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Abstract

In recent decades, approaches to assessing the outcome of depressive distress in people of serotonin age have undergone significant changes. Along with the conservation of traditional methodology in defining categories of an outcome of depression and their division into the congenial and unfavourable bunches (Jhingan H.P., Sagar R., 2001; Baldwin R. Cand Gallagley A., 2006), representation about criteria of reference of each concrete variant of an outcome to one of these categories has extended.

Keywords: Depression, involuntary period, suicide, anxiety, adaptation.

Introduction

According to researchers in different countries, over the past 10 years, from 1% to 33.4% of patients over 65 years of age suffer from generalized depression. In men, this indicator is slightly lower - 2%-22.4%. Other authors note a slight decrease in the incidence of "big depression" with age: for patients over 55 years old, the prevalence is 0.4-35%; over 70 years old - 1%-18%, over 85 years old - 4.9-13%. A decrease in the proportion of affective disorders among geriatric patients from 17.2% (60-69 years old) to 5.2% over 80 years old (partially due to an increase in the number of dementias).

The aim of the study is to investigate the risk factors for the formation and development of depressive states during the involuntary period

Material and Methods

Forty patients with depressive disorders aged 45-60 years were examined. Clinical-psychopathological, experimental-psychological research methods (DRALEX depression assessment scale (2012), Hamilton's psychometric scale) were used.

To achieve the stated goal and solve the research tasks, 45 patients with depressive disorders aged 45-65 years were examined. The median age was 55.9 years. Among them were 31 women (68.8%) and 14 men (31.1%). All patients underwent inpatient treatment at the City Clinical Psychiatric Hospital.

The main clinical criteria for selecting patients were: the presence of a clear pathogenetic connection between affective symptoms and psychogenic disorders; the predominance of anxiety and depressive manifestations in the clinical picture of mental disorders of endogenous nature; the

typical nature of the clinical picture of these disorders to establish diagnostic criteria; the combination of mental disorders with concomitant somatic pathology.

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

1. Age over 45 years;
2. Frequent referrals to psychiatric hospitals
3. Social adaptation disorders

The following disorders according to the 10th International Classification of Mental Diseases (ICD-10) met the above criteria: (Fig. 2)

F-31.0 (bipolar affective disorder);
F-32.0 (Mild-degree depressive episode);
F-32.1 (Depressive episode of moderate severity);
F-32.3 (severe depressive episode);
F-33. (Recurrent depressive disorder);
F-43.2 (Depressive reaction caused by disorder of adaptation).

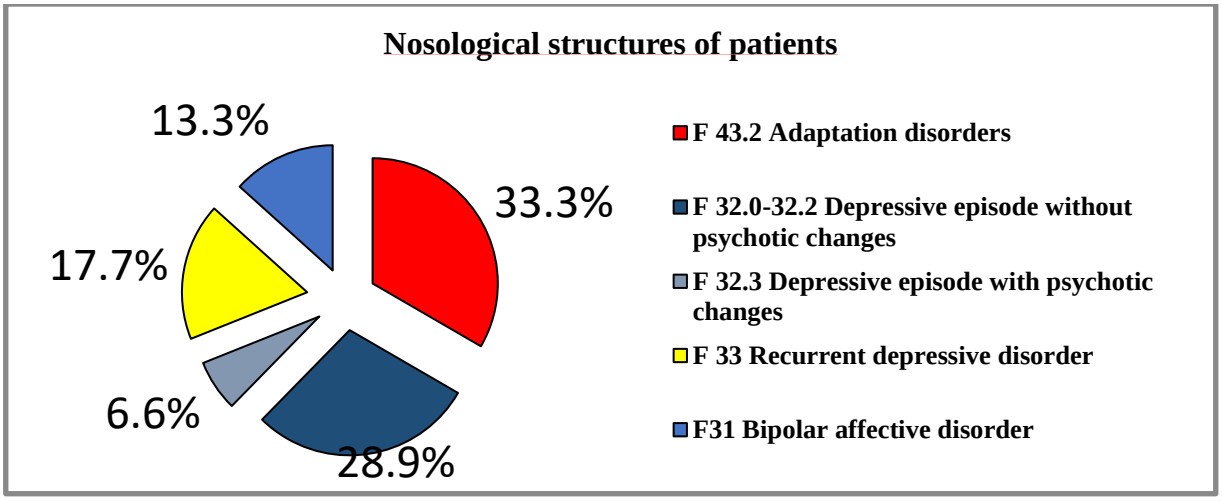

Figure 1. Distribution of patients by nosology (P<0,05)

The study did not include patients with depressive disorders in combination with chronic alcoholism, drug addiction, and mental disorders caused by organic CNS damage.

The following factors are significantly (P<0.05) higher in the development of involuntary depression:

Social: chronic family conflicts; lack of active leisure time; material and domestic shortcomings; belonging to social groups of workers to provoke and maintain depressive symptoms of psychogenic origin.

Somatic: chronic somatic disease as a "soil" factor and trigger; sudden and gradual course of somatic suffering as a trigger and supporting factor; and rare hospitalizations as a "soil" factor and supporting factor.

Mental and psychological: aggressiveness (all three qualities); accentuated personality as a factor of "soil"; and hereditary burden as a factor of "soil" and provoking factor; psycho-traumas and excessive emotionality (all three qualities)

Among the **social factors** of psychogenic origin (Fig. 2), longer family conflicts, prolonged service conflicts with the provocation of depressive episodes and their maintenance (42.8%) showed a higher significance. On the other hand, for the group of endogenous depressions,

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household conditions (29.4%) and material condition (23.5%) had a higher significance as "soil" factors. The latter factor could also more often provoke and maintain the developed depressive state of endogenous origin.

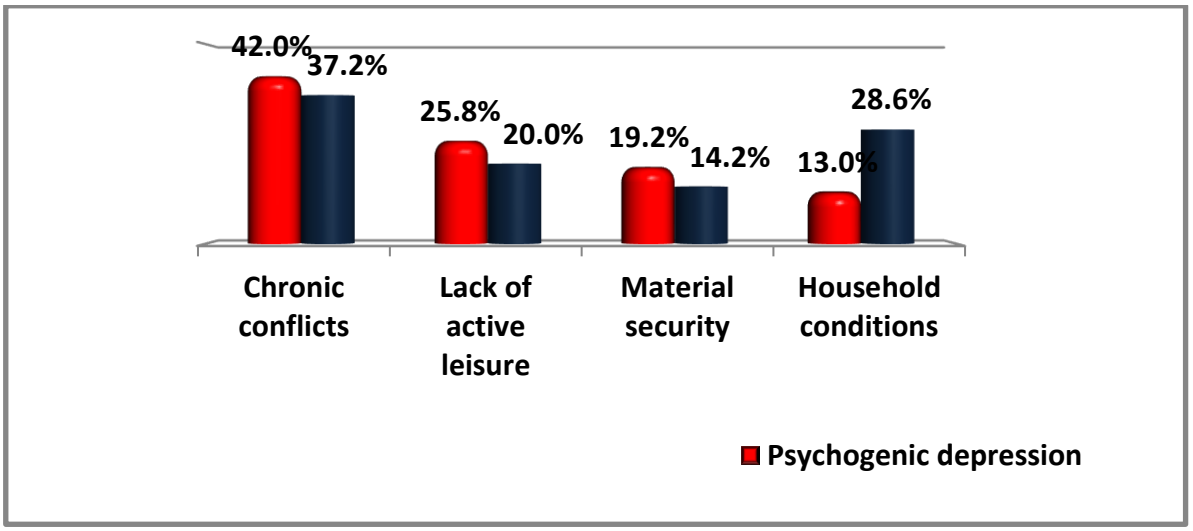

Figure 2. Social risk factors (P<0,05)

Somatic factors have shown a specific role in the development of depressive states and their psychogenic and endogenous origin. The limited mobility factor was no exception. Among other commonly occurring somatic factors were cancer, cardiological problems, hypertension, diabetes, and others.

Thus, as a predisposing and supporting factor, they were more frequently encountered in the group of psychogenic depressions, and as a provoking factor in the group of endogenous depressions. (Fig. 3)

For the group of **psychogenic depressions**, the following factors were more significant. The most significant chronic somatic disease as a predisposing and provoking factor. And the severe course of somatic suffering as a provoking and supporting factor.

It is also noteworthy that 53.6% of respondents in this group called the factor "sudden onset of somatic disease" provoking the development of a depressive state. This means that half of the patients can name the day and hour of their somatic suffering, which triggered the development of depression. It should be noted that the exact day and hour of the onset of the disease is very characteristic of more severe cerebrovascular catastrophes: transient cerebrovascular disorders, strokes, cerebral infarcts, multi-infarction dementia.

Psychogenic depression, which is an undeniable precursor to these terrible conditions, undoubtedly has the same characteristic features, only significantly less pronounced clinically. It is no coincidence that many patients confidently mention the date of the onset of depression in the conversation: on such a day, a sudden pain arose in the chest (blood pressure increased, etc.), and then "the mood deteriorated," which subsequently became "ever worse."

Psychogenic depressions are more often secondary, representing the brain's reaction to an "external" somatic factor, somatopsychic or reactive in nature. In this group, such factors as aggression (25%) (all three qualities); personality accentuation (35.7%) as a predisposing factor and various psycho-traumas (28.5%) as a predisposing and provoking factor showed their

significance. The significance of the aggression factor in this group is difficult to overestimate. From the psychosomatic point of view, the identified behavioral pattern is an element of the pathological autoaggressive mechanism: "stimulus - anger affect - suppression - somatization of anger affect - vascular damage" (N.Veskeg, 1990).

By adding to this well-known pathogenetic process, the clinically expressed disease of the blood vessels we are studying - vascular depression - we obtain the mechanism of sublimation of anger into depression, somatic "retribution" for which is atherosclerotic disease of the blood vessels in general and the brain in particular. This means that psychogenic depression is an unspoken anger, unrealized aggression, suppressed personal protest.

The hereditary factor, aggravated by mental disorders, undoubtedly played a significant role in endogenous depression (Fig. 3).

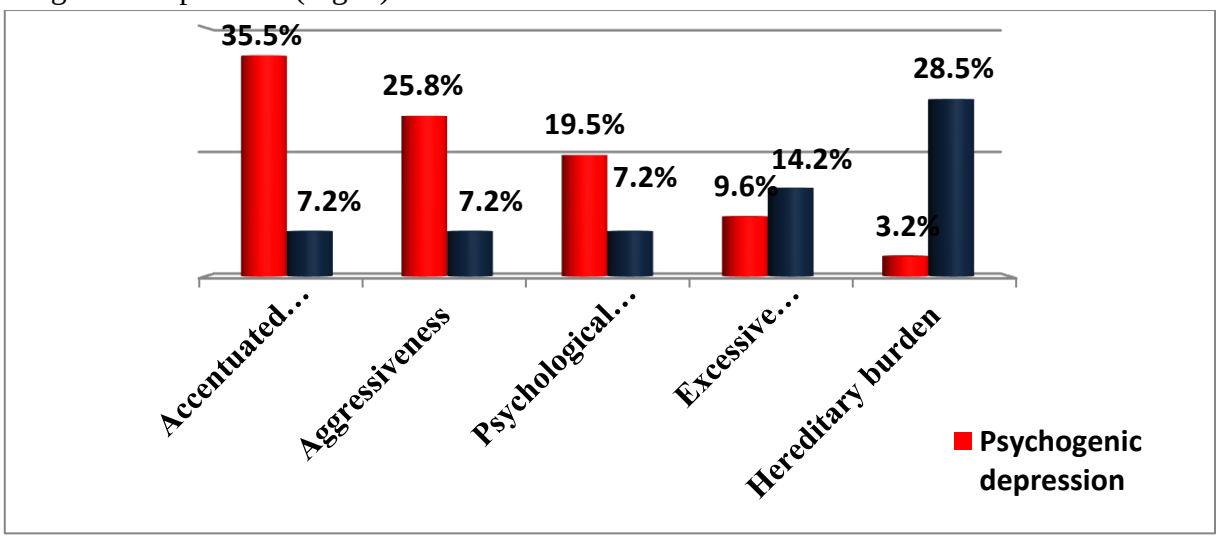

Figure 3. Psychological risk factors (P<0,05)

Therefore, the analysis of factors showed that the factors influencing the development of depressive states in late age in our study are distributed as follows. First, the factors influencing the clinical condition were divided into predisposing, provoking, and maintaining. Secondly, social, somatic, and psychological factors were distinguished by their origin.

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