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THE STRUCTURE, THERAPEUTIC DYNAMICS AND FORECAST OF LONG-TERM DEPRESSION

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Abstract: The problem of the existence of long-term depressive states is not new: descriptions of "chronic melancholies" are found in psychiatrists already in the 70 years of the XIX century. If we look at modern statistics of depression in general, we can see that not all depressive phases show a tendency to reverse development. In 40% of cases, the initial phase and a year later still meets the criteria for depression (N. Pincus, 2001), in 20% of cases it lasts for more than 2 years (N. Pincus, 2001) and in 17% of cases, depression continues throughout life (R. Kessler, 1994).
Keywords: Long-team depression, therapy, dynamics, depressive phases, psychopathological structure, dominant type of affect, depressive syndrome, mood swings, psychopathological system

The actuality of the problem. The urgency of prolonged subdepression is high, which often tends to be prolonged, i.e., chronic. When this condition is carefully analyzed psychopathologically, it will be possible to identify different options for the course, predict its consequences, and choose treatment tactics. The relevance of this study is the clinical and psychopathological system of long-term subdepression, nosological assessment, its role in the course of affective disorders, the definition of its consequences. In many countries, the number of depressive disorders has increased dramatically over the last 40 years, and by the end of the 21st century, depressive disorders will become a “major epidemic” and a global problem. According to data from the Harvard School of Health and the BJSS, depression was the fourth leading cause of illness in the 1990s, and by 2020 it was said to be second only to ischemic disease (J.L. Murray, A.D. Lopez, 1996). To date, the nosological differentiation of prolonged subdepression has been the subject of debate, indicating that insufficient research has been done on the problem. Some researchers exclude that this disorder falls into the framework of schizophrenia, which is not comparable to similar disorders in the structure of affective disorders. Other scientists, on the other hand, view prolonged subdepression as an exacerbation of a depressive condition, or do not draw a line between simple depressive and asthenic depression with shallow prolonged depression. Some researchers believe that shallow prolonged depression is a type of apathetic depression. Thus, the insufficient study of non-deep prolonged depression, the lack of a typological classification, is the basis for research on this disorder.

Keywords: psychopathological,

The purpose of the study. The clinical features of prolonged subdepression include the study of the laws of formation and therapeutic dynamics in the treatment process.

Research tasks.

1. Identification of long-term depressive states in the structure of affective disorders.
2. Analysis of the formation and dynamics of long-term depression.
3. To study the psychopathological structure of the long-lasting depressive phase as the main affect.

4. To determine the laws of change of psychopathological structure in prolonged depression.

5. Identify the role of factors influencing the longevity of depression.

6. To determine the importance of the psychopathological structure of depression in the effectiveness of therapeutic methods and prognosis.

Research materials and methods. The study was conducted at the Samarkand Regional Psychiatric Hospital for 2017-2020. The study included 100 patients, of whom 74 were diagnosed with long-lasting depression lasting 6 months to 1.5 years and included in the main group, while 26 patients with a depressive phase lasting 3 weeks to 4 months were included in the control group.

The criteria for patients included in the main group were as follows.

1. Prolonged depressive state within the framework of bipolar affective disorder (F31.3 or F31.4 according to MKB-10 classification) or recurrent depressive disorder, moderate or severe depressive episode (F33.1 or F33.2 according to MKB-10 classification) .

2. The duration of the depressive state is 6 months to 1.5 years at the time of the examination.

3. Expression of depressive symptoms on the Hamilton scale (HDRS 21, more than 20 points).

The control group was formed in this study according to the following criteria.

1. Prolonged depressive state within the framework of bipolar affective disorder (F31.3 or F31.4 according to MKB-10 classification) or recurrent depressive disorder, moderate or severe depressive episode (F33.1 or F33.2 according to MKB-10 classification) .

2. The duration of the depressive state should be 3 weeks to 4 months at the time of the examination.

3. Expression of depressive symptoms on the Hamilton scale (HDRS 21, greater than 20).

The main methods of examination of the study included clinical-psychopathological, structural-dynamic methods, in addition to these methods, subjective, objective anamnesis was collected from patients, information was obtained from outpatient cards, medical records. The Hamilton psychometric scale, which detects depression, was used to determine the severity of a depressive condition. For the study, those who received the Hamilton scale in the main group (HDRS-21, more than 20 points, average 28.2 ± 1.1 points), and those in the control group who received an average (24.8 ± 0.9 points) were included. Statistical data processing was performed using the statistical function of Statistica 5 0 and Microsoft Excel 5 0.

Research results. The results of the study were based on the data of the comparative analysis of the main and control groups. Hereditary predisposition to mental illness is reliable enough for the formation of depression ($r < 0.01$, 64.9% in the main group, 96.2% in the control group), with a reliable advantage ($r < 0.01$) in the control group, homogeneous hereditary predisposition (14.9% and 42.1%, respectively).

When assessing cerebral-organic predisposition (neurologically and electrophysiologically), data were obtained on its reliable advantage ($r < 0.01$) over the long duration of the depressive phase (54.1% in the main group, 23.1% in the control group).

Long-term psychotraumatic factors (alcoholism of a close relative, family conflicts, loneliness, conflict at work, litigation) and acute massive psychogenesis (serious illness or death of a loved one, loss of a loved one, socio-financial crises) predominated in the course of prolonged depression ($r < 0.01$), 78.4% in the main group and 42.3% in the control group).

Somatic predisposition (insulin-dependent diabetes mellitus, cholecystitis, medical abortion, thyroid disease, climacteric period) was high enough in the development of the prolonged depressive phase ($r < 0.01$), 64.9% in the main group, 19.2% in the control group).

Reliable age differences (r <0.05) at the onset of the disease were identified in the primary and control groups. A large percentage of disease onset in the main group was observed after the age of 40 years (60.8%), in the control group up to 40 years (65.4%), while the deficiency of patients in the control group was observed in the elderly (34.6%).

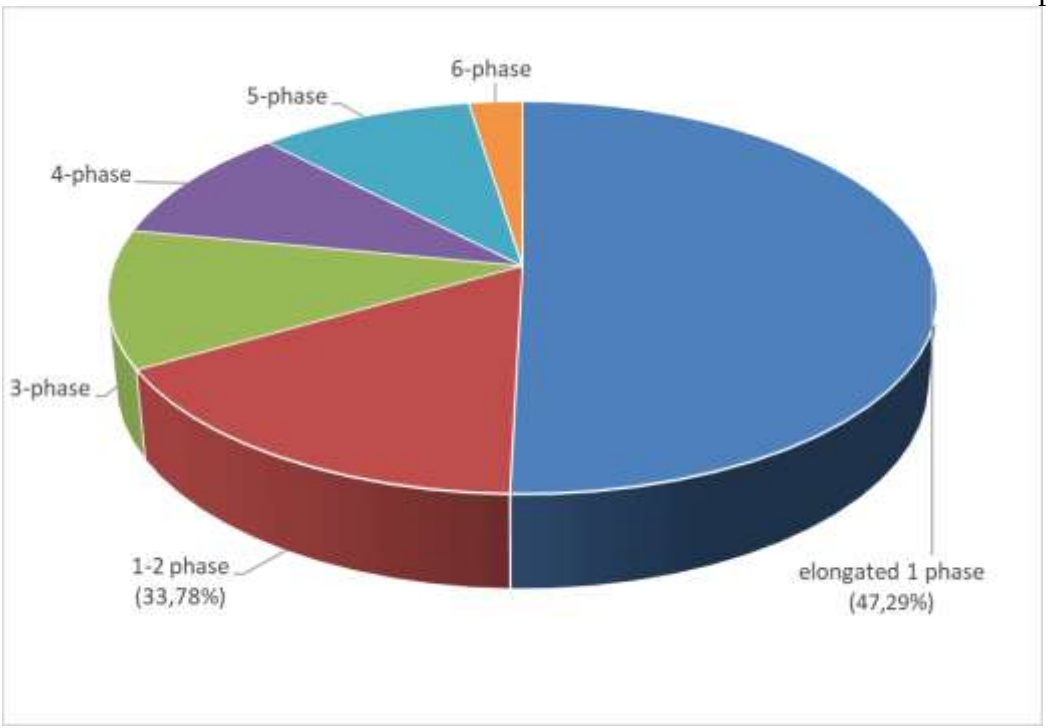
When the premorbid characteristics of the individual were studied, a reliable advantage (58.1%) was found in the main (r <0.01) group in panic suspects, and asthenic individuals (53.8%) in the control group (r <0.01).

Recurrence was characteristic in primary and control group patients.

When analyzing the duration of the depressive phase, it was found that in the main group, long-lasting (more than 6 months in duration) and non-prolonged phases of disease progression were identified. In 43.2% of cases in the main group and in the 100% control group, the depressive phase lasted from 1.5 to 6 months, i.e., it did not last long. However, in 4 patients (5.4%) of the main group, the phase in each turn was longer than the previous one.

To study the characteristics of the formation of long-term prolongation, the ratio of the duration of the disease and the amount of depressive phases to the long-term phase for the first time was analyzed. Prolonged depression for the first time often develops at the onset of illness (47.3%) or during the first year of illness (17.6%), and 1-2 depressive phases (33.8%) are observed before prolonged prolongation.

Graph №1



The results show that the late onset of the disease (after the age of 40), cerebral-organic predisposition, the presence of a panic-suspicious person in the premorbid, prolonged psychotraumatic conditions, somatogenous factors predominate in the prolongation of depression.

To determine the clinical and psychopathological features, a comparative study of the clinical picture of the phases and the course of the disease was conducted in the main and control groups. The main depressive affective-sad, anxious, apathetic character (Vertogratova OP, 2016); The compatibility of the expression of the harmony of the depressive triad (the main elements of the depressive triad-ideator, motor and affective component) (Vertogradova

O.P., Voloshin V.M., 1999), the complexity of the psychopathological structure of depression was considered.

Table №1

Dominant affect

The type of dominant affect	The number of patients		p
	General group (п = 74)	Control group (п = 26)	
Panic	45 (60,8%)	10 (38,5%)	**<0,05**
Sorrow	22 (29,7%)	12 (46,1%)	>0,05
Apathy	7 (9,5%)	4 (15,4%)	>0,05
Overall	74 (100 %)	26 (100 %)	

Taking into account the dominant type of affect in the examined patients, when conducting a psychopathological analysis of the structural features of depression, panic affect (60.8%) in the main group, grief affect (46.1%) in the control group prevailed (r <0.05), apathetic the observation of affect was less pronounced in both groups (9.5% and 15.4%, respectively).

Vertogradov O P (2017), Keller M B et al (1983), Pies R. (1990), Akiskal H. et al (2006), Klein DN. et al Hecht H. et al (1990), Voytsexa V F (1990), Dmitrieva A.S (1991), Rouillon F et al (1992), Zorina V Yu (1996), Grigorevoy EA, Saveleva L N, Dyakonova A According to L, Ignatovicha L V (2015), in clinical practice, grief, panic and apathy are dynamically related, manifested at different levels of expression, but over a period of time, one of them predominates.

Table №2

The degree of expression of the affective component in the main group

Dominant affect	The affect option	Representation in points (average score)	
Panic 45 (60,8%)			2,6±0,1
	Panic-sorrow 32 (43,2%)	Panic Sorrow Apathy	2,7±0,2 1,3±0,2 0,4±0,2
	Panic-apathy 13 (17,6%)	Panic Apathy Sorrow	2,5±0,3 1,2±0,2 0,6±0,3
Sorrow 22 (29,7%)			2,5±0,2
	Sorrow-panic 11(14,9%)	Sorrow Panic Apathy	2,5±0,3 1,3±0,3 0,5±0,3
	Sorrow-apathy 11 (14,9%)	Sorrow Apathy Panic	2,4-±0,3 1,1 ±0,2 1,1±0,2
Apathy 7 (9,5%)			2,0
	Apathy-sorrow 5 (6,8%)	Apathy Sorrow Panic	2,0 1,8±0,4 0,6±0,5
	Apathy-panic 2 (2,7%)	Apathy Panic	2,0 1,0

		Sorrow	0

When analyzing the expression of depressive affect components, it was found that the complexity of its structure in the long-lasting depressive phase. Thus, when panic affect predominated (60.8%), the average expression of panic affect was higher than that of the sad and apathetic component, which distinguished between the panic-sad (43.2%) and panic-apathetic (17.6%) variant. showed that when the sad affect is dominant (29.7%) - the distress-sad variant (14.9%) and the sad-apathetic variant (14.9%) are distinguished, when the apathetic affect dominates (9.5%), showed that the apathetic-sad variant (6.8%) and the apathetic-vacillary variant (2.7%) were different.

Table №3

The degree of expression of the affective component in the control group

Dominant affect	The affect option	Representation in points (average score)	
Sorrow 12(46,2%)			1,7±0,3
	Sorrow-panic 9 (34,6%)	Panic Sorrow	1,7±0,3 1,2±0,3
	Sorrow-apathetic 3(11,5%)	Sorrow Apathy	1,7+0,7 1,3±0,7
Panic 10 (38,5%)			1,7
	Panic-sorrow 10 (38,5%)	Panic Sorrow	1,7±0,3 1,5±0,3
Apathy 4 (15,4%)			2,0
	Apathetic-sorrow 4 (15,4%)	Apathy Sorrow	2,0 2,0

When analyzing the expression of depressive affect components in the control group, it was found that it had a somewhat simple structure with the predominance of the grief component and the absence of panic-apathetic and apathetic-panic variants.

When the psychopathological structure of long-term depression was studied, its clinically diverse range was studied, and given the structural features of depressive affect, the main affectes were divided into 3 groups: panic, grief, and apathy.

The group of long-lasting depressed patients dominated by panic affect included 45 patients (main group), 14 male (31.1%) and 31 female patients (68.9%). Of these, 32 (71.1%) were assessed as recurrent depressive disorder (F33), 13 (28.9%) - bipolar affective disorder (F31). At the time of follow-up, the mean age of the patients was 55.04 ± 4.5. The average score on the Hamilton Depression Scale (HDRS-21) was 31.6 ± 1.4.

The control group included 10 patients (4 male patients 40.0%, 6 female patients 60.0%), their mean age was 38.8 ± 6.7 years, 8 patients (80.0%) recurrent. with depressive disorder (F33); 2 patients (20.0%) were admitted with bipolar affective disorder (F31). The average score was 25.3 + 1.7 points.

When panic affect was predominant, the main features of the main and control group were that the premorbid was predominantly panic-suspicious, had a long history of psychogenic trauma (64.4% in the main and 60.0% in the control group), and an acute onset of the depressive phase. (Corresponds to 80.0% and 90.0%, respectively). In the main group of patients, the somatogenic effect was also reliable ($r < 0.01$), which was considered a factor leading to long-term prolongation (60.0% of cases).

In the long-term prolongation of the depressive phase, the dyshormonic variant of the depressive triad (80.0%) had a reliable index ($r < 0.01$) with 51.1% with panic-sad affect and 28.9% with panic-apathetic affect. The disharmonic variant of the triad in the control group was 10.0%.

The dissociated variant was observed with 20.0% in the main group and 20.0% in the control group with panic-sad affect. In the control group ($r < 0.01$), the harmonic variant of the depressive triad predominated (with the panic-sad variant of affect in 70.0% of cases). Thus, the disharmonic variant is characterized by the depressive triad of the depressive triad ($r < 0.01$) for the control group, when the panic affect dominates for the prolonged depressive phase.

Angedonia with dominant panic affect prevails in both control groups, patients lose the ability to enjoy life, are dissatisfied with work they were previously happy with, lose joy (77.8% in the main group, 70.0% in the control group), in front of close relatives. the idea of feeling guilty for not being able to help (51.1% and 40.0% of cases), the idea of low self-esteem (73.3% and 40.0%), 64.4% of basic and 50.0% of control Somatovegetative disorders (sweating, nausea, tachycardia, hypertension) were detected in 71.1% of the main and 70.0% of the control group, respectively.

In the structure of the prolonged depressive phase (68.9% in the main group), body sensations were of particular importance, while in the control group this condition was not detected ($r < 0.01$). , perceptual sensations in the abdomen are perceived. In 86.7% of cases in the main group ($r < 0.01$) hypochondriac ideas were formed on the basis of these sensations.

The group of patients with long-lasting depression dominated by grief affect was 22 patients, of whom 5 were male (22.7%) and 17 were female (77.3%). 4 (18.2%) were rated as bipolar affective disorder (F31) and 18 (81.9%) were rated as recurrent depressive disorder. The mean age of the patients was 61.6 ± 4.8 years. The average score on the Hamilton Depression Scale (HDRS-21) was 24.0 ± 1.7.

The control group included 12 patients, including 2 male (16.7%) and 10 female (83.3%) patients. The mean age of the patients was 49.2 + 7.7 years. Six were diagnosed with bipolar affective disorder (F31) and six with recurrent depressive disorder. The average score was 24.8 ± 1.3 points.

Common features of this group were that premorbid predominance was an asthenic personality, low dependence on external factors (long-lasting and acute psychogenesis), gradual formation of a depressive phase (86.4% primary, 100% control group). Reliability ($r < 0.05$) was high in the main group of patients against the background of long-term phase development against the background of somatogenic factors (hypertensive crises, medical abortion, thyroid disease).

A psychopathological comparative analysis of the depressive scene revealed that in 50% of cases when the phase was prolonged, a depressant harmonic variant of the depressive triad and in 50% of cases a sad-apathetic harmonic variant were noted. In most cases of the control group, the harmonic variant was characterized by t ($r < 0.05$), which was noted in 83.3% of cases (58.3% of depressive affect with the grief-panic type, 25.0% with the grief-apathetic type). The dissociated variant of the depressive triad in patients was not noted with grief dominance.

The idea of low self-esteem was found in 77.3% of cases in the main, 58.3% in the control group, apathy in the main 68.2% and in the control group in 66.7% of cases. Pessimistic assessment of disease status, ideas of treatment ineffectiveness, angedonia were observed more in the control group (91.7%) than in the main group (86.4%). Suicidal ideation was high in both the primary (59.1%) and control (41.7%) groups. Somatovegetative disorders (loss of appetite, tachycardia, constipation) were observed in 86.4% of patients in the main group and 75.0% in the control group. These conditions were accompanied by pain in the heart and chest area, shortness of breath, and headaches.

In the structure of the long-lasting depressive phase, the idea of guilt temptation associated with the disease took a special place (86.4% in the main group, 33.3% in the control group), the difference in reliability - ($r < 0.01$).

The group of patients with long-lasting depression dominated by apathy affect was 7 patients, of whom 3 were male (42.9%) and 4 were female (57.1%). 1 (14.3%) was assessed as a bipolar affective disorder (F31) and 6 (85.7%) as a recurrent depressive disorder. The mean age of the patients was 57.2 ± 13.3 years. The average score on the Hamilton Depression Scale (HDRS-21) was 21.1 ± 2.3.

The control group included 4 patients, including 1 male (25.0%) and 3 female (75.0%) patients. The mean age of the patients was 59.3 ± 8.9 years. 2 were diagnosed with bipolar affective disorder (F31) and 2 with recurrent depressive disorder. The mean total score was 23.5 ± 2.3 points.

The main features of the main and control group were that premorbid epileptoid and hysterical personality prevailed, the presence of somatogenous factors was observed before the manifestation of the depressive phase (57.1% in the main group, 50.0% in the control group). , 7% in the primary and 100% in the control group was characterized by a gradual decrease in appetite, worsening of sleep, sensitivity, crying, asthenic symptoms, feeling of internal emptiness, lack of previous interests.

The disharmonic variant of the depressive triad (42.9%) and the harmonic variant ($r < 0.05$) predominated in the control group (100%) in the prolonged phase of the phase in which the apathy affect was dominant. The apathetic-panic variant of the affect was observed only in the main group (28.6%) with dissociation of the depressive triad.

In the psychopathological structure of the two study groups, signs of angedonia "existence without joy" (71.4% in the main and 75.0% in the control group), lack of enthusiasm, insecurity about recovery (57.1% in the main and 50.0% in the control group) were identified.

Anesthetic symptoms (71.4%) and somatodepersonalization (57.1%) predominated in the structure of the long-lasting depressive phase.

Thus, in a psychopathological comparative analysis of the structure of prolonged depression (74 people) and in the control group (26 people), it was found that when the depressive phase is prolonged, the complex structure of depressive affect observed with the disharmonic variant of the depressive triad (67.6%) The presence of $r < 0.01$, the harmonic and dissociated variant was noted in 17.6% and 14.9% of cases. The harmonic variant of the depressive triad for the control group (80.8%) had a reliable index of $r < 0.01$, while the disharmonic and dissociated variants were recorded in 11.5% and 7.7% of cases, respectively.

In the long-term depressed phase structure (main group), low self-esteem ideas $r < 0.05$, guilt ideas $r < 0.05$, hypochondriac ideas $r < 0.01$, and body sensations $r < 0.01$ are more reliable.

Treatment of long-lasting depressive states is carried out taking into account the dominant affect, the variant of the depressive triad, the psychopathological structure of depression. The duration of this long-lasting depressive phase ranged from 6 months to 1.5 years from the onset of the disease, averaging 8.9 ± 0.9 months. We followed patients from 3

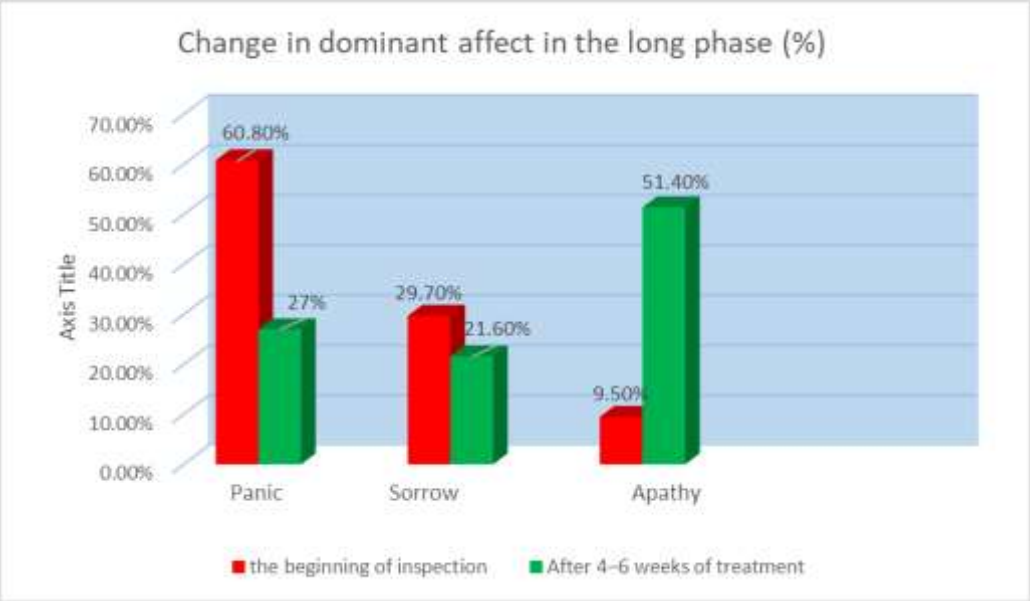
to 4 months, during which time there were clear changes in clinical condition. This was primarily due to the dominant type of depressive affect and the nature of the triad. Other components of depressive syndrome have been associated with predominant affect and its development.

The evaluation of the effectiveness of the treatment was conducted on the basis of the percentage reduction of the average total score on the Hamilton scale. The main characteristic of the treatment process was the achievement of remission, i.e. the reduction of scores on the HDRS scale, taking into account 7 and below.

The effectiveness of psychopharmacotherapy in the prolongation of the depressive phase was determined depending on the structure of the depressive state (the type of dominant affective disorder, the harmony of the depressive triad, the degree of expression of psychopathological symptoms). When treating patients in the main group with tricyclic antidepressants for 4–6 weeks, the largest percentage of symptomatic reduction on the Hamilton scale (HDRS-21) was detected in the dominant group with pain affect (p = 22) when treated with anafranil (52.7%). In the group dominated by apathy (p = 7) and panic (p = 45) affect, the total score on the Hamilton scale decreased slightly by 50%, corresponding to 41.2% when treated with melipramine and 39.7% when treated with amitriptyline. (Table №4).

At the same time, the generalized statistics obtained as a result of the analysis of the therapeutic dynamics of the main group allow to change the dominant affect in most cases (81.1%) when treated with tricyclic antidepressants. In most cases, after 4–6 weeks of treatment, a decrease in panic affect was observed from 60.8% to 27.0%) and grief affect (from 29.7% to 21.6%), followed by apathy (from 9.5% to 51). , 4% each).

Graph №3



The psychopathological symptoms characteristic of depression, dominated by panic and grief affect, are offset by changes during a prolonged phase. When the dominant expression of panic and grief was initially diminished, apathy prevailed over psychopathological phenomena.

In long-term depressive condition therapy (baseline group of 74 patients), treatment with tricyclic antidepressants for 4–6 weeks was not sufficiently effective. Despite the increase in the dose of the drug and parenteral administration, no further reduction of symptoms was observed. In this case, after 6 weeks there was a need to use another group of antidepressants

(ludiomil, lerivon, coaxil), tranquilizers (phenazepam, grandaxin), neuroleptics (chlorprotixen), normothymics (finlepsin, lithium carbonate).

Table №4: **The change in the total score on the Hamilton (HDRS - 21) scale**

Ehe average of the scores	The beginning of the investigation	4-6 weeks therapy %	%	The end of therapy	%
When panic affect is dominant 1.basic group (p = 45) 2.control group (п= 10)	31,3	18,9 **p<0,01**	39,7%	6,3 **p<0,01**	79,7%
	25,3	-	-	1,4 **p<0,01**	94,5%
When the affect of sorrow dominates 1.basic group (п = 22) 2.control group (п= 12)	24,0	11,4 **p<0,01**	52,7%	4,3 **p<0,01**	82,2%
	24,8	-	-	0,8 **p<0,01**	96,7%
When the apathy affect is dominant 1.basic group (п = 7) 2.control group (п= 4)	21,1	12,4 **p<0,05**	41,2%	4,6 **p<0,05**	78,4%
	23,5	-	-	2,8 **p<0,01**	88,3%

The duration of active therapy in the prolonged depressive phase was 6–8 weeks in the control group.

The median outcome of the therapy was lower on the Hamilton scale than for the depressed state in the main group (7 points) and 4.3 ± 0.8 points (r <0.01) for the grief-dominated group (22 people) and for apathy (7 individuals) had a score of 4.6 ± 1.04 (r <0.01), with a symptomatic reduction of 82.2% at the end of the study; 78.4%; Was equal to 79.7%. Table №4.

When the main group of patients was evaluated at the end of the study, the primary affect type had a high level. Residual symptoms remained from the dominant panic affect at the beginning of the study, which was manifested by the formation of hypochondriac fixation in the form of high attention to self-health, and mood changed periodically with panic symptoms, decreased self-confidence.

Periodic mood swings were observed in the exit of long-lasting depression, dominated by grief affect, often due to personality traits (rapid sadness, effectiveness), which was consistent with data from other authors (“depressive florist” R Ya Bovin, G E Mazo , M V Ivanov, 2003).

Decreased adaptive capacity in interests, hobbies, and sexuality was observed in patients with apathy affect.

Feelings of fatigue, weakness, malaise ("asthenic type reaction" V N Krasnov, 1997, AS Avedisova. 2004) have a special place in asthenic spectrum disorders. Asthenic symptoms were most often observed in older patients after the age of 50 (71.6%), in patients with a predisposition to somatic, cerebral-organic diseases.

The therapeutic dynamics of the depressive state in the control group (26 patients) was characterized by harmonic reduction of depressive symptoms. The duration of therapy in the control group was 6–8 weeks. The mean total score was 0.8 ± 0.5 points (96.7% reduction) in the group dominated by grief, 2.8 ± 0.9 points in apathy (88.3% reduction), and 1.4 ± 0.7 points in panic. (94.5% reduction). Table №4. When panic and grief affect were predominant, 22 patients (84.6%) underwent high-quality remission with no residual symptoms and good adaptive capacity. When apathy was predominant, 4 patients (15.4%) were more active in remission, but complained of weakness, fatigue, and malaise. The social status of patients in the main and control group did not change after the examination.

Thus, in the comparative analysis of the therapeutic dynamics of long-term depression in the primary and control group, a clear difference in the level of psychopathological symptomatology reduction, duration of therapy in the context of bipolar affective disorder and recurrent depressive disorder was observed.