INTERNATIONAL JOURNAL OF COGNITIVE NEUROSCIENCE AND PSYCHOLOGY

FROM MILD DEPRESSION TO SEVERE PSYCHOTIC DISORDERS: THE CLINICAL SPECTRUM OF MENTAL DISORDERS AND DIAGNOSTIC APPROACHES

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Abstract: Psychogeny (psycho - soul, related to the soul, genea - generation, birth) is a painful condition in the form of a short-term reaction or a long-term state (disease) that occurs under the influence of factors that injure the psyche (psychotrauma). According to its clinical manifestations, psychogeny can manifest itself as mental disorders at the neurotic level - neuroses (neuroses and somatoform disorders) and at the psychotic level - reactions to stress (reactive psychoses), as well as in the form of manifestations of somatic suffering - psychosomatic variants of somatic diseases. Psychotrauma is understood as a traumatic, emotionally negatively colored experience of the psyche associated with some life event (event, situation) that has subjective personal significance (emotional significance). In some cases, psychotraumatic life events (events, situations) can act as leading etiological factors (producing factor), in others - as etiological conditions (predisposition, manifestation and supporting factor). Often their combination plays a pathogenic role.

Key words: Psychological trauma, origin, diagnosis, prevention, pathogenesis, prognosis and treatment.

Introduction: Acute psychological trauma is understood as a sudden, one-time (limited time) psychological trauma of significant intensity. They are divided into: shocking, depressing and disturbing. As a rule, they cause reactive states and psychoses (acute reactions to stress).

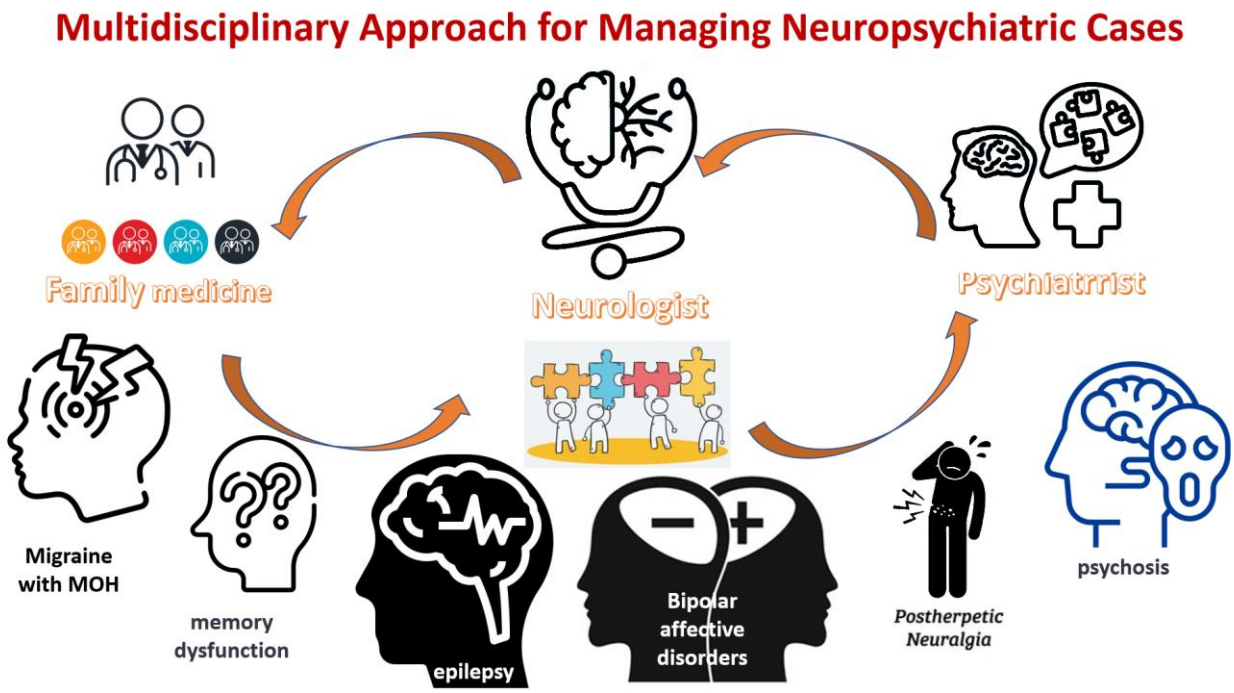
Chronic psychological trauma is understood as psychological trauma of less intensity, but existing for a long time. They usually lead to the development of neuroses (neurotic and somatoform disorders). There are also psychological traumas of universal (life-threatening) and individual significance (professional, family and intimate-personal).

Life situations, when experienced by a particular individual, can lead to a state of stress with the possibility of developing diseases (psychogenesis). However, if the individual's attitude to such a life situation is flexibly changed in accordance with the conditions, it is possible to cope with stress (and prevent psychogenesis). This is possible due to coping mechanisms and psychological defenses.

When psychotraumatic conditions arise, coping mechanisms are first activated. These are various conscious or partially conscious strategies aimed at solving the problem that has arisen.

"Coping" ("coping with stress") is viewed as a human activity to maintain or maintain a balance between environmental demands and the resources that satisfy these demands.

With insufficient development of constructive forms of behavior, the pathogenicity of life events increases, and these events can become a "trigger" in the process of the emergence of mental disorders.



In general, the following are distinguished: 1) the strategy of mobilization and aggression (actively influencing the situation, winning in an acceptable way of activity), which involves active preparation for what awaits a person, forcing him to formulate a problem, is the most effective and constructive strategy; seeking special help from a psychologist or psychotherapist), 3) the strategy of escape (withdrawal) - leaving a situation in which it is impossible to overcome it (for example, avoiding failure). In addition, various personal coping mechanisms are distinguished in the behavioral (for example, cooperation with other people), cognitive (for example, problem analysis or religiosity) and emotional (for example, optimism) areas.

When coping mechanisms are ineffective, psychological defense mechanisms are activated. The concept of psychological defense was first formulated within the framework of classical psychoanalysis.

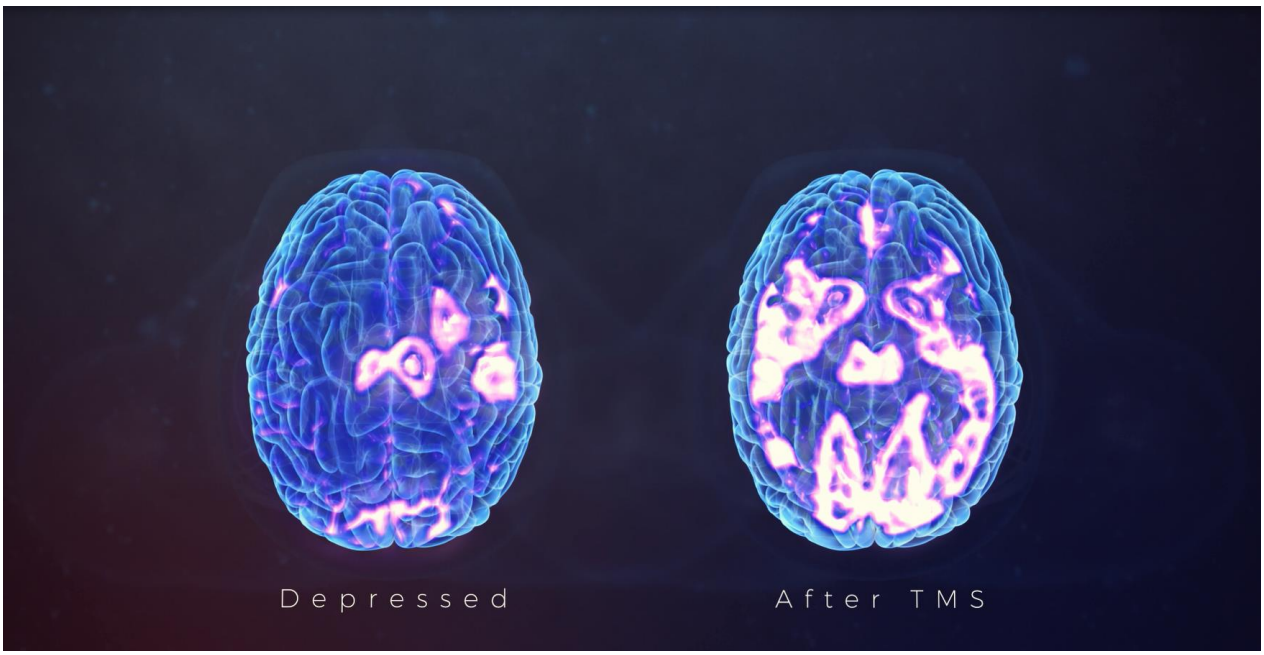
Psychological defense is an automatic reaction of the psyche to various threats, associated with the rejection of activity, individual, unconscious or partially conscious methods of reducing mental stress.

Research methods and materials: Psychological discomfort is reduced with the help of psychological defense. However, this can lead to a violation of the reflection of oneself or one's environment and a narrowing of the range of behavioral reactions. Psychological defense mechanisms are aimed at maintaining psychological homeostasis. They can also participate in the formation of pathological symptoms.

The most commonly identified mechanisms of psychological defense are: repression, denial, isolation, identification, rationalization, projection, sublimation, etc.

The presence (combination) of certain "coping" mechanisms and psychological defenses depends on the innate characteristics of the individual and the conditions of his formation (education).

All types of psychogenic mental disorders are divided into two large groups: reactive psychoses and neuroses. This category includes diseases that arise as a direct result of acute or prolonged severe (massive) psychosocial stress (psychotrauma), leading to significant changes in life and long-term unpleasant situations. Such stress is the main and main causative factor, without the influence of which the disorder does not arise.



This is a group of painful mental disorders that arise under the influence of psychological trauma and manifest in the form of reactions and (or) conditions that reach a psychotic level:

As a rule, all of them end with a complete recovery. Most often this occurs at the stage called. postreactive asthenia . However, in some cases, they can be prolonged and develop . abnormal postreactive personality development (psychopathy)..

In general, the criteria proposed by Jaspers for diagnosing reactive psychoses are used to distinguish this group of mental disorders of psychogenic origin from other mental disorders.

However, it is necessary to take into account the relativity of these criteria, since: a) reactive states can appear late, b) the traumatic situation can manifest itself in the composition and in diseases of a different nature (for example, in schizophrenia), and finally, c) stopping the effects of a traumatic event does not always lead to final recovery.

a. Various reactive (psychogenic) mental disorders associated with psychological trauma (stress) are conditionally divided into the following, depending on the type of psychological trauma and clinical manifestations:
b. (here and below, the classification of the condition according to ICD-10 is given in brackets)
c. Affective-shock psychogenic reactions (Acute stress reaction).
d. Primitive hysterical psychoses (dissociative disorders)
e. Long-term reactive psychoses
f. A) Reactive depressions (Adjustment disorder. Depressive episode).
g. B) Reactive delusional psychoses (primarily acute delusional disorders associated with stress)
h. Post-traumatic stress disorder (this type of disorder was first identified in ICD-10)
i. Affective-shock psychogenic reactions (Acute stress reaction).

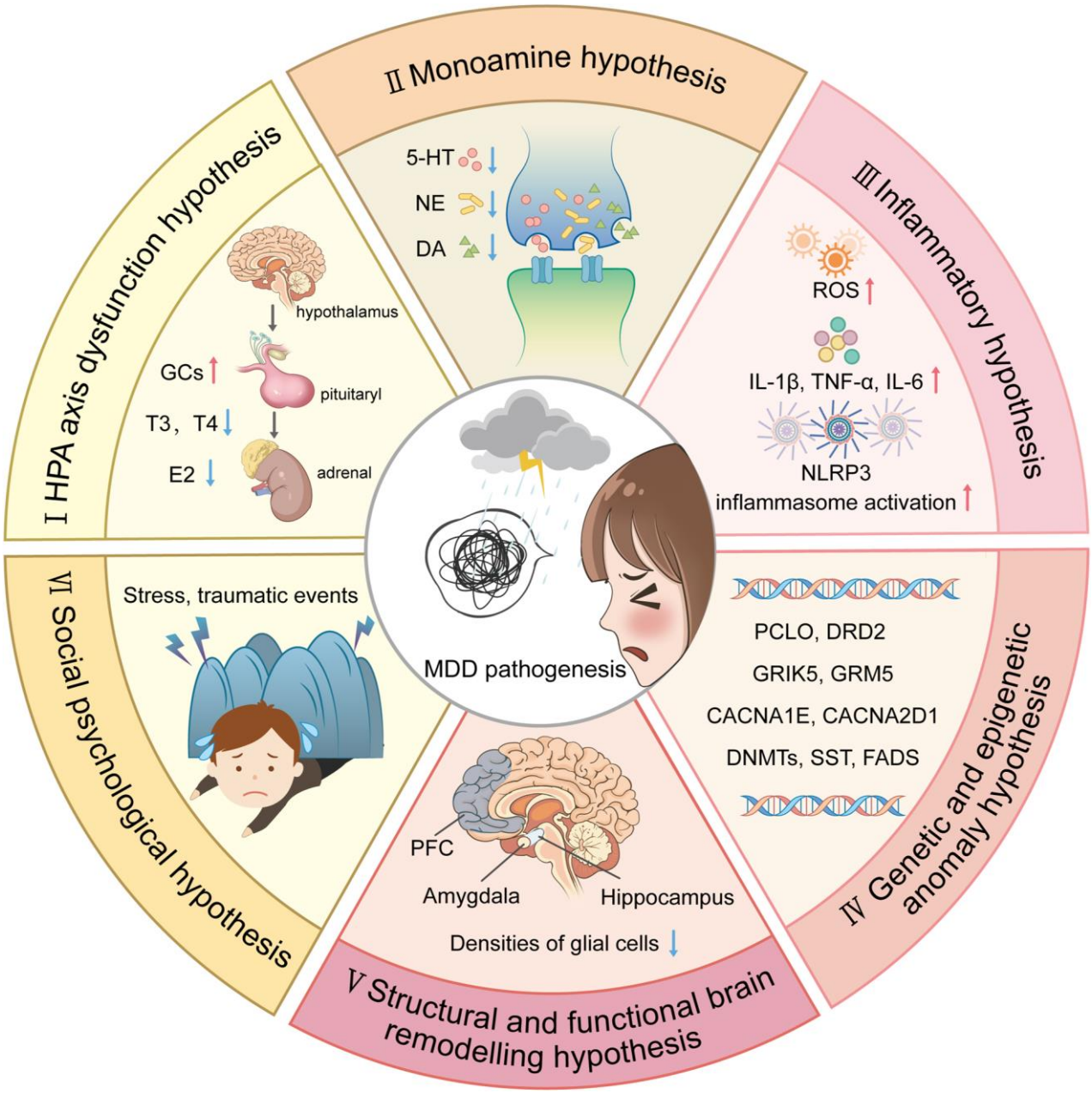
Consequences: These are, as a rule, short-term (transient) reactions of a psychotic level that occur, as a rule, in cases of acute, sudden, massive, psychological trauma, in individuals who have no previously apparent mental disorders.

In terms of content, psychotraumatic situations often manifest themselves in the following forms: a) a threat to the safety or physical integrity of the individual or a loved one (natural disasters, accidents,

wars, rape, etc.) or b) an unusually sharp and threatening change in the patient's social status and (or) environment (loss of many loved ones, fire in the house, etc.).

However, not everyone in such situations develops the aforementioned disorders.

The risk of deterioration increases in people: a) weakened by somatic disease, b) prolonged insomnia, c) fatigue, d) emotional stress, d) the presence of organically defective soil (elderly people).



The individual characteristics of the individual are less important in this type of disorder, especially when life is at risk (the so-called impersonal response). However, it should be noted that vulnerability and adaptive abilities vary from person to person. Moreover, they can be improved through targeted training and preparation for such situations (professional military, firefighters).

Clinical manifestations typically show a mixed and variable picture (which often leads to the need to classify the status within several relevant diagnoses).

Discussion: A state of acute horror and despair, abundant vegetative manifestations ("hair standing on end", "turned green from fear", "heart almost bursting out of the chest"), against the background of which an affective (affectogenic) narrowing of the field of consciousness occurs. Due to this, adequate

contact with the environment is lost (inability to adequately respond to external stimuli) and disorientation appears.

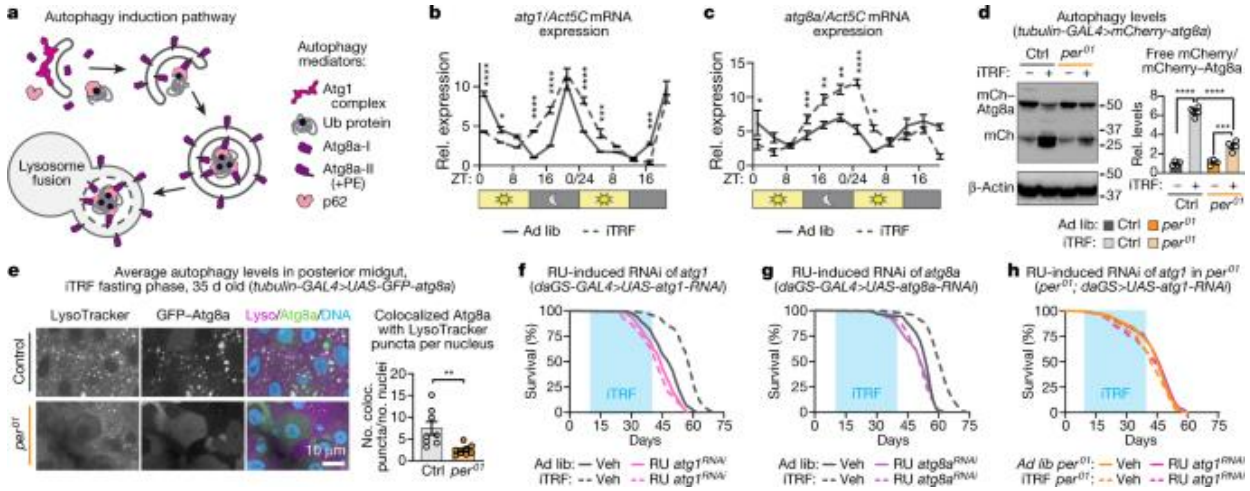
In its further development, this condition can be accompanied by two opposite variants of manifestation, which gave rise to the distinction between hypo- and hyperkinetic variants of affective-shock reactions.

Hypokinetic variant (dissociative stupor in the context of an acute stress reaction according to ICD-10) - manifests itself as a sudden motor slowdown ("frightening stupor"), in some cases complete immobility (stupor) and inability to speak (mutism).) is manifested by. In a state of stupor, patients do not notice those around them, do not respond to stimuli, an expression of horror appears on their faces, their eyes are wide open. Often, pale skin, severe cold sweating are observed, involuntary urination and defecation may occur (vegetative component). This reaction (since it is usually transpersonal) is the result of the revival of the most ancient forms of protective actions in living organisms in conditions of threat, the meaning of which lies in the strategy "if you freeze, they probably won't notice" (the so-called "apparent death").

The hyperkinetic variant (flight reaction within the framework of acute stress reaction according to ICD-10) is manifested by pronounced agitation and psychomotor agitation. Often, a large number of people at the same time - the so-called "crowd panic". Patients run aimlessly, rush somewhere, their movements are completely aimless, chaotic, they often shout something, cry with an expression of horror on their faces. The situation, as in the first variant, is accompanied by abundant vegetative manifestations (tachycardia, pallor, sweating, etc.). The initial evolutionary strategic meaning of such a response in the form of a "motor storm" is "perhaps some movement will save us."

The duration of such reactions is on average up to 48 hours, the stress effect persists. After its cessation, the symptoms begin to disappear on average within 8-12 hours. After the transferred state, complete or partial amnesia develops. If this disorder persists for a long time, the diagnosis is reconsidered.

This group of disorders often occurs in situations that threaten personal freedom. They are also figuratively called "prison psychoses". Forensic psychiatrists often deal with them. Although, in principle, such a condition can develop in other conditions.



Most often, such disorders occur in people with hysterical character traits, the main of which is a tendency to suggest and self-suggestion.

The disease arises from hysterical defense mechanisms (dissociation) from an unbearable situation for a person: “flight into illness”, “fantasy”, “regression” and reflecting the idea of the individual’s madness (“became a child”, “became a fool”, “became an animal”, etc.). Such primitive forms of response are rare today.

Under the influence of psychotraumatic impact, a complex, negatively affective state arises, which, including hysterical defense mechanisms, leads to a state of hysterical twilight narrowing of the field of consciousness. , against the background of which various variants of hysterical psychoses arise. They, in turn, can occur as independent forms or stages (stages). At the end of psychosis, amnesia occurs.

The clinical manifestations of this group of psychoses are very diverse (indeed, like all hysteria). These include the following conditions:

Pseudodementia -false dementia. This is a relatively milder and less profound disease. A person in this state makes a weak impression. His behavior becomes abnormal, his eyes open wide, he looks around, he shows weakness (does not light a match, does not unlock the door, etc.). In a conversation, he stops answering questions correctly; he gives absurd answers to simple questions, but within the framework of the question. However, the contrast inherent in this condition between the manifestation of dementia in simple situations and the preservation of correct actions in more complex situations is striking. Development is gradual. The period of psychosis lasts up to several weeks with a complete decrease in symptoms and the development of amnesia.

Puerilism is a condition in which the patient acts like a child: speech becomes childish, he distorts words, lips, calls everyone "uncle" and "auntie". Behavior also takes on childish features: asking to be picked up, lying down, picking his nose, whining, sucking his fingers, playing with objects, etc.

Ganser syndrome is an acutely developing, more severe form of pseudomenti, characterized by speech transitions, phenomena of "presumptive responses", which may include phenomena of puerilism.

Mental regression syndrome (being wild) is a condition in which a person's behavior resembles that of an animal. He walks on all fours, snarls, bites, bares his teeth, sniffs things, leans over a bowl, etc.

Delusional fantasy syndrome - the emergence of delusional ideas based on excessive fantasy as a method of psychological defense. However, there is no accusation. However, they talk very convincingly, colorfully and demonstratively about their inventions, successes, escapes and incredible adventures that happened to them. The content, as a rule, in one way or another, reflects a traumatic situation with a changed plot and its role.

According to modern concepts (ICD-10), dissociative disorders of the psychotic level also include:

Dissociative (hysterical) amnesia is a loss of memory for recent significant events (usually the loss of loved ones or traumatic events such as accidents), not associated with organic brain damage and so severe that it cannot be explained by simple forgetfulness or fatigue. It is usually partial and selective, changing frequently over several days, but there is no constant ability to remember during wakefulness.

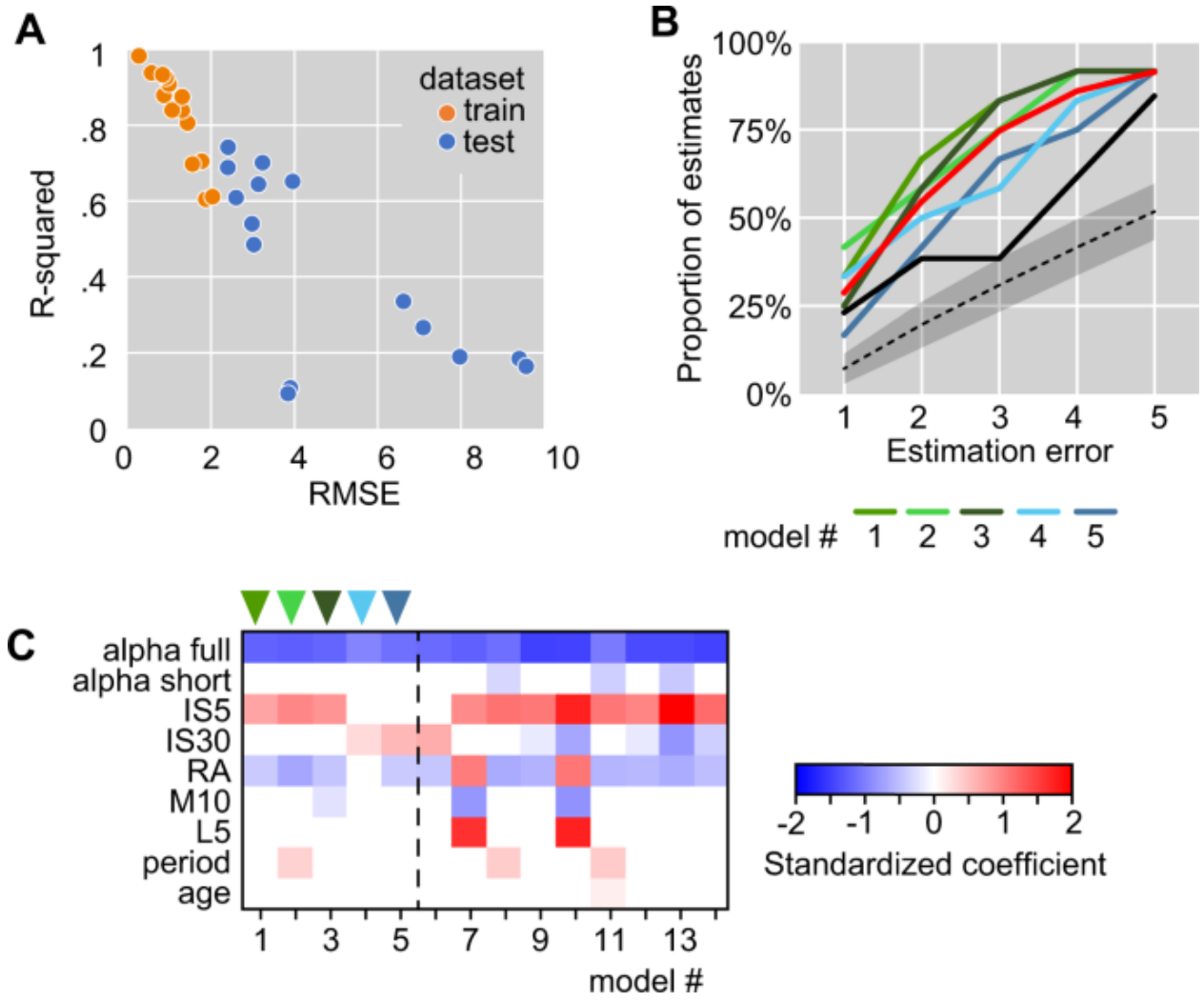
Dissociative (hysterical) fugue - has all the features of dissociative amnesia, combined with a seemingly purposeful journey outside of normal everyday life, during which the patient takes care of himself and engages in ordinary social interactions with strangers (for example, buying tickets, ordering food, etc.). Outwardly, this behavior may seem completely normal. This condition is not caused by organic brain damage.

Dissociative (hysterical) stupor - the patient's behavior meets the criteria for stupor, there are no physical or other mental disorders that could explain the stupor, and there is information about recent stress or current problems (psychotraumatization).

This is a group of reactive (psychogenic) depressive states caused by subjectively significant psychological trauma.

The most common types of psychological trauma in such disorders are various psychosocial stresses in the form of emotional deprivation (death of a loved one, his departure, care, refugee status, simply moving, especially forced, etc.).

Although the main cause of the development of reactive depression is the presence of psychosocial stress (without which it does not develop), personality traits also play a significant role. Most often, such disorders occur in people with such traits as straightforwardness, rigidity, and intolerance.



Depression usually develops after a certain period of time (up to several days) after a psychological trauma, after internal processing of the event with an assessment of the significance of the loss, which is an attempt to psychologically cope with the deprivation (loss).

The clinical manifestations and severity of psychogenic depressive experiences can vary.

This can be a psychologically adequate experience of loss in the form of depression and grief (a grief reaction that does not go beyond ethno-cultural characteristics). It can reach the level of psychotic depression with a feeling of vital melancholy, hopelessness, unwillingness to live and ideas of self-blame.

It can last from a few days to several years, with possible periodic exacerbations.

There are several clinical variants of such depressions.

Psychogenic depression can manifest itself as an astheno-apathetic state, with lethargy, fatigue, inactivity, and indifference to everything.

Conclusion: The typical (pure) clinical picture is limited to symptoms of depression. Melancholic mood is accompanied by a delay in motor development and a slowdown in thought processes. All experiences are concentrated around the traumatic situation. It is impossible to switch attention and distract thoughts to something else. The future takes on dark tones. Ideas of self-blame ("I didn't protect you", "because of me") and lack of desire to live (suicidal tendencies) may appear. Melancholic usually intensifies towards evening. Melancholic can intensify when memories of past events are

revived (sometimes even months and years after recovery from depression). Sleep disturbances, loss of appetite and vegetative manifestations (hypertension, tachycardia, shortness of breath, etc.) are observed. Hypnagogic hallucinations may appear, reflecting the event that happened. They are usually observed in harmonious individuals, but have such characteristics as restraint, calmness, accuracy, determination, and a clear emotional attachment to loved ones.

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