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Features of Depressive Disorders in Women of Childbearing Age and Treatment Issues

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Abstract: Being the most common mental illness, depression is the main problem that people suffer from all over the world. Despite the availability of effective treatment methods, in many countries approximately 80% of patients with mental disorders remain untreated. Depression is more common in women; it reduces the quality of life and in many cases leads to suicide.

Keywords: depression, women, disorder.

An Australian study found that perimenopausal and postmenopausal women are at greater risk of developing more severe symptoms of depression than women of fertile age who have no history of depression (Ferrari, AJ; Somerville, 2013).

Depression reduces the quality of life and in many cases leads to suicide. The pathogenesis of depression was influenced by many new biological factors, including vitamin D, thyroid hormones and heart disease. Depressive ideas are a high risk factor for the suicidal movement. It is believed that the idea of suicide and behavior are influenced by various biological, social and psychological factors. A theory of psychological stress has been proposed to explain suicide. Unlike normal tension, tension consists of at least two opposite stresses that pull or push a person in different directions. Thus, psychological stress causes more harm to human health than just stress. Psychological stress is very similar to cognitive dissonance, but in terms of psychological impact, it can be more intense, serious and threatening.

Women of menopausal age make up about 5% of the entire world population [1]. According to epidemiological studies, the pathology of the menopausal period occurs in 35-80% of women [2-4]. And although menopause* is a physiological phenomenon characterized by the extinction of menstrual and reproductive function, under certain conditions and under the influence of unfavorable factors, it becomes pathological and manifests itself as a so-called climacteric, or menopausal, syndrome, including vegetative-vascular (vasomotor), metabolic-endocrine and mental disorders [2, 3, 5]. Purely menopausal symptoms are considered hot flashes to the head and upper torso, night sweats, atrophic vaginitis [1, 2, 6], which are the true manifestations of an age-related decrease in estrogen levels. Other numerous symptoms (increased blood pressure, palpitations, headache, dizziness, chilliness, chills,numbness, burning, itching, obesity) are quite common, but many authors do not consider them specific for menopause [3, 6-8].Mental disorders are more or less necessarily present in the structure of menopausal syndrome, and in some cases they are dominant. Their presence is associated with the hypothalamic nature of this syndrome, a violation of regulation in the hypothalamic - hypophysis - cortex of the adrenal glands [1, 2, 9].The conditionality of mental disorders, especially affective ones, by a decrease in the level of monoamines, monoamine oxidase, endorphins is discussed, which, probably, may be a consequence of an age-related decrease in the level of estrogens [1, 3].

However, the course of menopause depends not only on biological, but also on psychological, social factors. On the one hand, the natural process of neuroendocrine restructuring contributes to the tension of adaptive mechanisms [3, 10, 11]. In these conditions, psychologists, therapists. Some of the patients went to the clinic in connection with mental disorders that first appeared against the background of pathologically occurring menopause. As a result of a thorough analysis of psychopathological symptoms, somatovegetative manifestations of menopause, premorbid features, dynamics of the disease, including under the influence of hormonal therapy and psychotropic drugs, four types of depression were identified: climacteric (in 46 patients), psychogenic (in 35), endogenous in the framework of manic-depressive psychosis – MDP (in 42) and involutional (in 27).

Results and their discussion. Half of the patients (77, or 51.3%) had premenopause at the time of treatment at the clinic. There were 32 premenopausal menopausal depression patients (69.6%), 25 psychogenic (71.4%), 20 endogenous within the framework of the MDP (47.6%). Patients with involutional melancholia were postmenopausal, except for 2 patients who had premenopausal phenomena. The age of menopause was 49-50 years old, it was not significantly different in the groups of patients (see table) and corresponded to the average age of menopause in the population of Moscow women [2].11 (15.6%) patients had early menopause, of which 3 (18.8%) suffered from menopausal depression,2 (20%) – neurotic, 3 (13.6%) – endogenous, 3 (11.1%) – involutional, which indicates a sufficiently high frequency of menopause at a young age in women with severe affective pathology in the framework of menopausal syndrome and mental illness.

The majority (125, or 83.9%) of patients had premenopausal phenomena. Average age of onset premenopause differed in groups of women with different types of depression (see table). The differences between the groups of patients with psychogenic and endogenous depression ($p<0.01$), menopausal and endogenous depression ($p<0.01$) were significant. There were no significant differences in this indicator between the groups of patients with psychogenic and menopausal depression. Patients with involutional depression significantly differed in the average age of the onset of premenopause from patients of the other three groups, but did not differ from the population of mentally healthy women. These data indicate that patients with neurotic mental disorders against the background of menopause have signs of premenopauseand the appearance of both somatovegetative and mental disorders, as evidenced by the growth of somatic and mental diseases during perimenopause [7, 10]. A woman becomes more vulnerable psychologically – for her, such factors that were not pathogenic before menopause (for example, loneliness, conflicts at work) become important.On the other hand, menopausal syndrome is a psychosocial problem, since it is to a certain extent connected with the social position of women in society and the traditional attitude of society to the problems of women of menopausal age [4, 12]. The society's bet on youth, beauty, as well as the assessment of the menopause period as a sign of aging, withering, and the decline of life [8, 10, 13] turns the fact of menopause into a psychotraumatic situation.

During this period, factors such as marital status, relationships with her husband, children, friends, the health of loved ones, the availability of work, and prosperity become especially important for a woman. All these factors, depending on their orientation, can either contribute to the adaptation of women in the transition period, or complicate it [3, 10]. At the same time, not individual events themselves, but their specificity - severity and emotional load – can lead to decompensation of the mental state and the occurrence of mental disorders [3, 10].

The occurrence of menopausal disorders, their course, as well as the nature of mental disorders, are associated by many authors [1, 4] with premorbid personality traits that determine the ability to deal with difficulties and adapt to the situation. It is established that such character traits as self-doubt, a tendency to anxiety, emotional dependence, egocentrism, poor adaptability in society, poverty of interpersonal relationships contribute to the appearance of menopausal complaints [3, 4, 13]. Women with a negative attitude to menopause and a low level of life satisfaction suffer more from menopausal syndrome.

Mental disorders manifested during menopause are diverse [3, 7, 10], but the greatest diagnostic

difficulties usually arise in cases of manifestation of mental disorders, especially of the affective circle. In this regard, the purpose of this work is The aim was to study the clinical features of depression manifested during perimenopause, develop their differential diagnostic criteria and substantiate therapeutic tactics.

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