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A Contemporary View of Depressive Symptomatology

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Abstract
Objectives. *The purpose of the study was to explore personality traits of women with depressive symptomatology. We assumed that women with depressive symptomatology have lower anxiety and high sensitivity, are emotionally unstable, display underconfident behaviour and unstable self-esteem.*
Design. *We present the results of a comparative analysis of two samples of participants: an experimental sample (n = 10) that included women with depressive symptomatology, and a control sample (n = 10).*
Methods. *To verify the above hypothesis, the study employed the methods of testing, questionnaire survey, expert assessment and mathematical-statistical analysis (Mann — Whitney U-test). The study was carried out in the regional psychiatric hospital.*
Results. *The study revealed marked differences between the values of dysthymia, suspicion, wittiness, charm, adaptedness, tearfulness, emotional instability and the level of discrepancy between the level of aspiration and self-esteem relative to character, intellect, and abilities.*
Conclusions. *The paper describes a typology of depressions based on E. S. Averbukh's classification of syndromes and includes: melancholic depression, anxious depression, senesto-hypochondriac depression, asthenic depression, depersonalization depression, obsessive-compulsive depression. Depressive symptomatology is most likely to occur in emotionally unstable women with inflated self-esteem. The paper has a practical value for professionals in the fields of psychology and psychotherapy.*

Key-words: Depression, Personality Factors, Symptom, Symptomatology, Depressive Symptomatology, External Manifestations of Depression, Syndrome, Behaviour.

Data Availability Statement
The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Practitioner Points

- The data obtained from the theoretical and methodological analysis enabled to suggest symptomatic typology of persons with depressive conditions, which has a practical value for consulting practice and psychotherapy.
- The findings from this study enable early detection of women's personality traits that determine the formation and development of depressive conditions. The identification of personality traits that correlate with depressive conditions makes it possible to elaborate a set of preventive activities.
- The data obtained from the study contribute to the effectiveness of communication between the doctor and the patient in a clinical setting, and the patient's inner circle during the subsequent rehabilitation.

1. Introduction

Depression is one of the most common illnesses. According to WHO, more than 150 million people worldwide are affected. About 15 million of them are in Russia, according to the Russian healthcare authorities (Kępiński, 2002). However, repeated depressive episodes occur in about 60% of depressed patients (Nuller, 1981).

It is important to emphasize that depression tends to have adverse effects. It affects the quality of life and personal adaptive capacity and greatly increases the risk of suicide. Depression can also lead to lowering or loss of the occupational status, family breakdown and even to complete disability. A WHO-sponsored research indicated that by 2020, the depression will rank second (after coronary heart disease) leading cause of disability (Smulevich, 2001).

The causes of depression include biological (illnesses, medications, etc.) and psychosocial and social (stress, bereavement, etc.) (Veltishhev, 2000; Frolova, 2011). Bipolar affective disorder is caused by biological reasons. Everyone is occasionally exposed to the psychosocial and social causes of depression, but not everyone develops this health condition. This raises the question: why identical adverse conditions cause depression in some people and does not cause it in others? The answer to this question is, in part, a provision about the personality types and traits that greatly increase the risk of depressive disorders (Gataulina & Demin, 2010; Podkopytov & Chaika, 2003; Haenel, 2009).

Meanwhile, one of the key conclusions at a conference on personal dysfunctions in individuals with depressive disorders that was held in the United States in 1988, was the assumption that personality factors may play the key role in the pathophysiology, progress and treatment of depression (Garanian, 2009).

It is known that depressive disorders are more common in women than in men (Bendas, 2006; Comer, 2001). It is also believed that women are more socially oriented than men, which is manifested in their certain personal characteristics (ICD-10).

2. The Essence of Depressive Symptomatology

In the Dictionary of Psychiatric Terms, V. M. Bleicher and I. V. Crook interpret the concept of "symptomatology" as a combination of symptoms of illness or group of illnesses (Bleicher & Crook, 1986). Based on this definition, in this paper the term "depressive symptomatology" is understood as the complex of symptoms of depression. At the same time, as Yu. Nuller pointed out in his book "Depression and Depersonalization", the term "depression" is usually used to denote a vast and vaguely defined range of phenomena (Nuller, 1981). The difficulties here arise from the inaccuracy and ambiguity of the concept. In particular, the word "depression" has the following meanings: a symptom of depressed mood, syndromes that regard reduced mood as the main component and a health condition, which symptomatology is limited to purely affective syndromes: depressive or depressive and manic. C. Wenar and P. Kerig point out that depression as a symptom can be viewed as normal since most people occasionally experience the state of low spirits and blues (Venar & Kerig, 2007). The syndrome of depression is a set of symptoms that frequently appear together and include a sense of sadness, loneliness, agitation and anxiety. The disorder of depression (often referred to as "clinical depression") implies a severe form of these symptoms, a specific etiology, progress and outcome. Such combinations of symptoms cause distress and disrupt the body functioning. Yu. T. Frolova, when differentiating depression and normal emotional responses, suggests that healthy people have more adaptive strategies for coping with negative emotions, and provides the following examples: the ability to temporarily separate oneself from negative thoughts, acceptance of psychological help from family and friends, use of compensatory activities, which evoke a sense of gratification (Hjelle & Ziegler, 2002).

3. Types of Depression Symptoms

There is a variety of classifications of depression symptoms. Yu. T. Frolova describes a classification that divides them into primary and additional symptoms. The primary depression symptoms are the manifestations that occur almost in every case. Those include 3 symptoms: 1) Depressed mood (feelings of melancholy, sadness...), 2) Loss of interest in life and enjoyment 3)

Diminished activity. The additional symptoms are complementary and make the overall medical picture more diverse (those may appear in some cases, and not in others). This group of symptoms includes: 1) Poor concentration, 2) Reduced thinking capacity, 3) Indecision, 4) Delusional ideas (future adversity, suicide, feeling one's own sinfulness and guilt), 5) Slow and poor speech 6) Reduced self-esteem, a propensity to self-reproach, 7) Negative future perception, 8) Suicidal ideas, 9) Disturbed sleep, 10) Disturbed appetite, 11) Pain related to the feeling of melancholy, 12) Circadian and seasonal mood fluctuations, 13) Substance abuse. The book also states that a short-term low mood is not yet an indicator of a depression, and according to ICD-10, a duration of at least 2 weeks is required for diagnosis (Hjelle & Ziegler, 2002).

The ICD-10 categorizes the symptoms according to the above principle (Minutko 2006). It reckons the following symptoms as primary: 1) Depressed mood, regardless of the circumstances, for a long period of time, 2) Anhedonia (a loss of interest or pleasure from a previously enjoyable activity), 3) Severe fatigue during a long period of time. The list of additional symptoms includes: 1) Negative future perception (pessimism), 2) Feelings of guilt, uselessness, anxiety and (or) fear, 3) Low self-esteem, 4) Loss of concentration and indecision, 5) Thoughts of suicide or death, 6) Increased or decreased appetite, 6) A sweet taste in the mouth, without an apparent stimulating substance; 7) Disturbed sleep. According to ICD-10, two primary symptoms and at least three additional symptoms are required to diagnose a depression.

The classification in the A. B. Smulevich's book "Depression in General Medicine" is similar to the above typologies (Smulevich, 2001). The primary symptoms are the same as those listed in ICD-10, and the additional symptoms are also the same with a different wording. The book also draws attention to the fact that 20–30% of patients suffer from residual depressive symptomatology even during remissions (mostly asthenic or somatic and vegetative symptoms). The DSM-IV depression criteria have the same meaning as the symptomatology in the above classifications. However, the list has slightly different wording and includes one symptom that was not mentioned above: the psychomotor agitation (Bleicher & Crook, 1986).

Some authors divide symptoms into affective, motivational, cognitive, behavioral and vegetative symptoms (Beck, Rush & Emery, 2003; Comer, 2001). *Affective symptoms*: sadness, anxiety and melancholy, loss of sense of humor and gratification, apathy, loss of affection for family. *Motivational symptoms*: the desire to escape from their life, lack of motivation, no easiness or initiative. *Cognitive symptoms*: poor concentration and associated memory impairment, reduced intellectual ability, cognitive distortions (pessimism, ideas of guilt, etc.). *Behavioral symptoms*: passivity and associated lower productivity, alienation from people, retardation. *Physical or*

vegetative: sleep disturbances (insomnia or oversleep), change of appetite (increased or decreased appetite).

In her book "Depression and methods of treatment", A. Shirman divides the symptoms into the psychological symptoms (sadness, despair, low self-esteem, apathy, interpersonal problems, guilt, negativism, suicidal thoughts), biological (disturbed appetite, sleep, sexual frustration; lower energy, panic attacks, inability to enjoy anything [anhedonia]) and additional symptoms (poor concentration, excessive emotional sensitivity, rapid mood swings, alcohol and drug abuse, hypochondria). Such criteria as panic attacks and hypochondria distinguish this classification from the above typologies.

A. Shirman also notes that excessive concern about one's own health, while there are no physical symptoms of illness (hypochondria), is often a sign of undiagnosed depression. The same is observed by V. F. Desyatnikov in his book "The Masks of Depression": there are mental depressive conditions, in which mental disorders are almost unnoticeable, while the physical disorders prevail and disguise the depression to an extent that neither the doctor, nor the patient can understand the true roots of the problems (Desyatnikov, 1987). In such conditions, the somatic disorder is normally imaginary, and the physical pain is quite real and forces to seek medical help. This phenomenon was called masked depression. The patients with this disorder tend to take no notice of any negative neuropsychiatric changes and attribute their lower mood to somatic complaints. Such conditions are disguised under various symptoms ("masks"). There are a variety of such "masks": *psychopathological disorders* (phobic anxiety disorders: generalized anxiety disorder, anxious doubts, panic attacks, kenophobia; obsessive-compulsive: obsessions; hypochondriac; neurasthenic), *circadian rhythm abnormalities* (insomnia, *hypersomnia), vegetative disorders* (dizziness, skin itching, functional disorders of organs, etc.), *pain with various causes and location pathocharacterologic disorders*(disturbance of drive: dipsomania, drug addiction, inhalant abuse; anti-social behavior: impulsiveness, propensity to conflicts, outbreaks of aggression; hysterical reactions: resentfulness, tearfulness, propensity to dramatizing, etc.) (Smulevich, 2001).

M. Yapko suggests an interesting and very extensive classification of depression symptoms based on the dimension of experience in a variety of therapeutic theories and programs (Yapko 2002). M. Yapko distinguishes: *depression symptoms in the physical dimension* (disturbance of sleep and appetite, lack of sex drive; major weight changes; feelings of anxiety and fatigue; complaints about physical distress); *depression symptoms in the cognitive dimension* (negative expectations, low self-esteem, negative thinking, suicidal thoughts, indecision, self-obsession, poor concentrating, focusing on the past, propensity to generalizations, despair, change of perception (sharpened/reduced), rigidity); *depression symptoms in the behavioral dimension*

(hyperactivity/underactivity; suicidal behaviour; destructive actions; emergence of crying bouts; slowed speech; emergence of dependencies; impulsiveness; perfectionism; psychomotor agitation/retardation; behaviour that contradicts to the person's own values; behaviour interpreted as acting out; propensity to subordination); *depression symptoms in the affective dimension* (ambivalency, irritability, anhedonia, sadness, loss of sense of humor, loss of self-esteem, apathy, feeling of worthlessness and powerlessness, guilt, increased/reduced emotional responsiveness, concentration on depressive feelings), *depression symptoms in the dimension of relationships* (taking the victimized position and the desire for self-sacrifice, isolation, excessive need for approval and dependence on other people, excessive responsibility for others, passive-aggressive behavior, criticism in relation to people, problems in expressing feelings, using inappropriate patterns to build relationships, the desire for / avoidance of power, lack of meaningful social attitude, blurred / too clear boundaries of personality); *depression symptoms in the symbolic dimension* (nightmares; destructive fantasies; speculation about spiritual issues; symptoms that metaphorically represent internal experience; the idea of "miraculous recovery"); *depression symptoms in the contextual dimension* (predictable responses to certain situations; difficulties with assessment of the situation requirements; blurred or ossified boundaries of individuality that depend on the situation); *depressive patterns in the historical dimension* (severe losses the patient had to go through in the past; situations in which the patient did not control the course of events, the lack of a wide range of personal experience).

The classifications above did not pay due attention to the external manifestations of depression, however many authors explore this aspect of the problem (Kępiński, 2002; Libin, 1999; Shapovalenko, 2005). Having analyzed their accounts of the external manifestations of depression, one can see that they form a universal image of a depressed person. For example, T. Haenel noted that oftentimes artists very accurately convey the posture of depressed people. Such artwork usually depicts the person sitting down with their head on the hands, their shoulders slumped, and back hunched (the same is observed while they are walking). V. L. Minutko also mentions the unkempt personal appearance of depressed people and gives a detailed account of their facial expression: Veraguth's eyelid folds (close to the outer part of the eyebrows), the drooping corners of the mouth, the look is directed down. The image can be complemented by A. Kępiński's observation about the slowness and heaviness of patient's movements.

Despite the variety of different classifications, it can be observed that most of the symptoms coincide, and the positive affectivity is in the foreground.

To cite Yu. Nuller, a stable constellation of symptoms that are hypothetically generalized by their conditioning pathophysiological mechanisms is called a syndrome (Nuller, 1981). He explains the hypothetical nature of such grouping of symptoms and the lack of a universal classification of syndromes by the fact that the pathogenesis of depression is not adequately investigated. He also distinguishes two lines in categorizing depression syndromes: 1) identifying syndromes based on frequent and stable combinations of symptoms; 2) combining symptoms into syndromes by singling out the most important symptoms and outlining symptomatology groups around them. Depression is not sufficiently studied, therefore the classification of syndromes is incomplete.

The variety of classifications of depressive syndromes is presented in the book "Depressions. Modern Therapy" by V. S. Podkopytov and Yu. Yu. Chaika (Beck, Rush & Emery, 2003). A popular in Russia E. S. Averbukh's classification is based on the principle of the presence of a persistent depressive mood and the presence or absence of the following symptoms: anxiety, hypochondria, asthenia, depersonalization, obsessions. The classification includes six syndromes: melancholic, anxio depressive, depressive-hypochondriac, as the node pressive, depersonalization-depressive and obsessive-compulsive depressive syndromes (Garanian, 2009). On its basis, the author presents below a syndrom-based classification of depressions.

For *melancholic depression*, the following are typical: melancholic mood, ideas of low self-worth, suicidal thoughts, loss of emotional responsiveness, guilt, retardation (motor and ideomotion), improvement of the condition in the afternoon, a painful insensibility localized somewhere in the chest ("atrial melancholy"), interruptions in the sleep-wake schedule, unawareness of own medical condition. Somatic symptoms are also present: pupils dilation, dry skin, reduced appetite, slowed intestinal peristalsis.

Anxious depression is characterized by the feeling of uncertainty and external threat, expecting an adversary. Anxious fears differ in terms of contents and represent overvalued ideas. The patient also experiences restlessness, motor anxiety, guilt, somatic and vegetative symptoms and deterioration in the condition in the evening.

Senesto-hypochondriac depression can be diagnosed by the following symptoms: a belief of having a certain illness with corresponding bodily sensations (senestopathies), somatic disorders, obsession with one's own bodily sensations, constant search for the causes of the illnesses, melancholy-anxiety affect with the prevalence of irritability and tearfulness.

Asthenic depression is manifested in vital asthenia, the underlying symptom of which is energy deprivation, which sometimes goes to impotence (as opposed to regular fatigue, the condition is persistent). It is characterized by both mental and physical exhaustion. Judgments of such patients

are superficial, and oftentimes lack the logic of reasoning, which is the consequence of the impaired concentration, memory, and intellectual performance. An increased sensitivity to interoceptive impulses is observed, patients may feel body pain and headaches. There are an emotional instability, irritability and weakness. The condition of such patients is sharply deteriorated in situations of abundance of impressions from the outside, noise or novelty. The mood is unstable, it is characterized by tearfulness, irritability, constant dissatisfaction, increased sensitivity, worries about intellectual weakness.

Depersonalization depression is characterized by the sense of alienation of emotions, which is painful. The patients see the world as lifeless as they are. The following types of depersonalization are observed: auto depersonalization (alienation of feelings and thoughts), somatodepersonalization (no need for sleep, no sense of hunger...) and allopsychic depersonalization (the world is perceived lifeless). The painful torpor is accompanied by an anxiety, melancholy of apathy.

Obsessive-compulsive depression includes obsessive-compulsive experiences, combined with a melancholy or anxiety affects, psychomotor agitation and asthenic symptoms. When the compulsions are countered, they aggravate and are almost never actualized. They include ideational (obsessions), emotional (phobias) and locomotor (compulsions). The typical symptoms also include: irresistibility, stereotypy of repetition, unclear content, the nature of the patient's own thoughts (Beck, Rush & Emery, 2003).

Since after Yu. Nuller, the author understands depression as a medical condition which symptomatology is limited to depressive or depressive and manic syndromes, the author believes it is worth outlining the manic-depressive disorder (MDD), which is classified as an endogenous depression. At the same time, Yu. Nuller distinguishes two types of MDD progress: unipolar and bipolar. In his studies, he considered a complete absence of manic episodes to be the indication of a unipolar progress of depression. The group with bipolar progress included the cases where no more than four depressive episodes were observed before the first distinct mania (Nuller, 1981).

People with bipolar disorder have both depression (the symptoms mentioned above) and mania: sharp mood elevations. Statistically, unipolar conditions with no manic episodes are more common. The primary symptom of the manic disorder is the prevalence of euphoric mood, and at times, the mood becomes irritable and depressed (Gataulina & Demin, 2010). Behavior often does become extravagant, and when talking, "thoughts slip away", probably because of a short span of attention. Typical symptoms are psychomotor agitation, hyperactivity, no need for sleep. Self-criticism almost is not observed in this condition. Patients with bipolar disorder are at a high risk of suicide (Kępiński, 2002).

4. Conclusion

Summing up the above, it should be emphasized once again that basing on the definition of the term "symptomatology" in the Dictionary of Psychiatric Terms by V. M. Bleicher and I. V. Crook, we understand "depressive symptomatology" as the combination of depression symptoms. In turn, in the definition of the term "depression", we drew from a provision in the book "Depression and Depersonalization" by Yu. L. Nuller, which interprets it as a medical condition, the symptomatology of which is limited to affective syndromes: depressive or depressive and manic. Although there is no universal classification of depressive symptomatology, symptoms can be distinguished that are common for all of the above classifications, namely: lowered mood (sadness, melancholy...), anhedonia (a loss of interest or pleasure from a previously enjoyable activity), fatigue, pessimism (negative perception), feelings of guilt and anxiety, reduced intellectual ability, disturbance of appetite and sleep, suicidal thoughts. Symptoms can be combined into syndromes based on frequent and stable combinations of symptoms, or through combining symptoms into syndromes by singling out the symptoms the author believes to be most important and outlining symptomatology groups around them. It is noteworthy that a universal classification of depression syndromes or a universal classification of depressions do not exist. The paper described the syndrome-based classification of depressions which is based on E. S. Averbukh's classification of syndromes and includes: melancholic depression, anxious depression, senesto-hypochondriac depression, asthenic depression, depersonalization depression, obsessive-compulsive depression. A special symptomatology is typical for the masked depression i.e. a depressive condition in which mental disorders are almost unnoticeable, while the physical ones prevail. The symptoms of such depression are often referred to as "masks". There are a variety of such "masks": psychopathological disorders, circadian rhythm abnormalities, vegetative disorders, pain with various causes and location, pathocharacterologic disorders. Particular attention should be given to the bipolar disorder, which is characterized by both depression and mania (sharp mood elevations).

5. Compliance with Ethical Standards

Conflict of interest: The author declares that there is no conflict of interest.

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References

Beck, A.T., Rush, A.J., & Emery, G. (2003). *Cognitive Therapy of Depression.* St. Petersburg, Piter Publ. ISBN 5-318-00689-2

Bendas, T.V. (2006). *Gender Psychology.* St. Petersburg, Piter Publ. ISBN 5-94723 -369-X

Bleicher, V.M., & Crook, I.V. (1986). *Diagnostics in Abnormal Psychology.* Kiev, Zdorovya Publ.

Comer, R. (2001). *Fundamentals of Abnormal Psychology*. St. Petersburg, Neva Publ. ISBN 5-89570-005-5

Desyatnikov, V.F. (1987). *The Masks of Depression.* Moscow, Znanie Publ.

Frolova, Yu. G. (2011). *Medical Psychology*. Minsk, Vysheishaya Shkola Publ. ISBN: 978-985-06-1963-1

Garanian, N.G. (2009) Depression and Personality: Survey of Foreign Studies. *Social and clinical psychiatry, 1*, 79.

Gataulina, O.V., & Demin, E.I. (2010). Depression as an Pressing Social Problem. *Zdorov'e – osnova chelovecheskogo potentsiala: problemy i puti ikh resheniya, 1*, 416.

Haenel, T. (2009). *Depression or Life with a Lady in Black.* St. Petersburg, Piter Publ. ISBN 978-5-49807-196-1

Hjelle, L., & Ziegler D. (2002). *Personality Theories.* St. Petersburg, Piter Kom Publ.

Kępiński, A. (2002). *Melancholy.* St. Petersburg, Nauka Publ. ISBN: 5-02-024984-X.

Kholmogorova, A.B. (2011). *Integrative Psychotherapy of Disorders of the Affective Spectrum.* Moscow, Medpraktika-M Publ. ISBN 978-5-9880323И.

Kovpak, D. V., & Tretiak, L. L. (2009). *Depression: Diagnostics and Treatment Methods.* St. Petersburg, Nauka i tekhnika Publ. ISBN: 9785943874819.

Libin, A.V. (1999). *Differential Psychology: at the Intersection of European, Russian and American Traditions.* Moscow, Smysl Publ. ISBN 5-89357-0448.

Minutko, V.L. (2006). *Depression.* Moscow, Geotar-Media Publ.

Nartova-Bochaver, S.K. (2012). *Differential Psychology*. Moscow, FLINTA Publ. ISBN 978-5-89349-435-8.

Nuller, Yu. L. (1981). *Depression and Depersonalization.* Leningrad, Medicine Publ.

Podkopytov, V.S., & Chaika Yu. Yu. (2003). *Depressions. Modern Therapy.* Kharkov, Tornado Publ. ISBN 966-635-495-0.

Rudnev, V.P. (2002). *Characters and Personality Disorders.* Moscow, Nezavisimaya firma Klass Publ., ISBN 5-86375-045-6.

Shapovalenko, I. V. (2005). *Developmental Psychology*. Moscow, Gardariki Publ. ISBN 5-8297-0176-6.

Smulevich, A. B. (2001). *Depression in General Medicine: Doctors' Guide.* Moscow, Meditsina Publ.

Veltishhev D. Yu. (2000). *Clinical and Pathogenetic Regularities of Situational Disorders of the Depressive Spectrum.* Thesis of Doc. Diss. (Medical Sciences). Moscow.

Venar, C., & Kerig, P. (2007). *Developmental psychopathology*. Prime-EVROZNAK Publ. ISBN 978-5-93878-518-2.

WHO Country Office Moscow (2003). *ICD-10 (International Statistical Classification of Diseases).* Moscow, Meditsina Publ. ISBN 5-225-03268-0.

Yapko, M. (2002). *Hypnosis and the Treatment of Depressions.* Moscow, Tsentr psikhologicheskoi kul'tury Publ. ISBN: 5-7856-0270-9.