

CLINICAL PARTICULARITIES OF RESISTANT ANXIOUS- AGITATED DEPRESSION

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Abstract:

Presently, an increase of the morbidity of depressive agitation is being stated with a relevant frequency of 3% of the population. 18 to 23% of women and 8 to 11% of men experienced at least once in a lifetime an evident depressive episode, and for 6% of women and 3% of men, in-patient treatment was necessary. The unipolar psychotic depression is ranked one of the first among the most frequent causes of disability, and is the most frequent cause of disability of adults. The unipolar depressive disorder constitutes 4.4% of the DALY index and 11.9% of the YLD (OMS, 2001). In the 15 to 44 age group, these manifestations amount to 8.6% of the number of life years wasted because of disability. For all that, the feeling of uselessness and guilt, the absence of motivation, the financial difficulties and the fear of social stigma are the factors that make the patients abstain from applying in due time for professional medical aid.

Key words: anxious-agitated depression, psychopathological structure, causes, risk factors

PAPER SUBJECT

To evaluate the causes and the risk factors entailing the installing of a refractory anxious-agitated depression, and to assign an appropriate treatment.

MATERIALS AND METHODS

This paper was executed at the Psychiatry Clinic of Chișinău, on the basis of a study involving 248 subjects with predominantly anxious-depressive symptomatology. The basic group (124 patients) benefited from both medication and therapy intervention, whereas the control group (124 patients) received medication-based treatment only.

RESULTS AND DISCUSSIONS

The psychopathological structure of these depressions was distinguished by the mobility of the affective disorders, a major presence of emotional instability, and the instability of the anxious affect, which was not just holding a dominant position, but also, as a rule, was a principal and determining factor, representing visibly an integer syndrome with characteristic components that were affective *per se*, as well as motor, ideational, and somatic. The agitation was sterile, unordered, paradoxical, chaotic, accompanied by perplexity; the patients moving from place to place without stopping, gesticulating, always looking towards the exit. The anxiety (247 cases – 99.60%) had a non-conscious character, and was, at the same time, accompanied by signs of slight psychomotor slowdown and melancholic affect, with a sensation of retrosternal heaviness. In these patients, the melancholic affect was appearing at a later time than the anxious effect, and was correlating with its degree of intensity, producing the impression of being secondary to anxiety. Concurrently with the characteristic thinking disorder, attention concentration difficulties were also manifested (116 cases – 46.77%), combined with a decrease in perspicacity and a subjective sensation of memory loss close to depersonalization. The patients were losing weight (181 cases – 72.98%); loss of appetite was noted in 184 cases (74.19%), and a noticeable reduction in libido was noted in 160 cases (64.52%). In female patients, menstrual disorders were noted, as well as tegument and mucous dryness.

The dominant anxious effect was experienced by the patients as a feeling of inquietude, vexation, internal tension, psychomotor agitation in 193 cases (77.82%), which agitation was, in fact, masking the slowdown. The sensations in the form of scorching, burning, tingling, prickling were localized most frequently in the area of the heart and behind the sternum. Also, feelings of internal tremor, pulsation in the body were characteristic. The motor disorders were manifested by the livening of the mimic and pantomimic reactions, a trend to movement, to an agitated step. The ideational disorders were manifested by fast, inconsistent, confused speech, with lengthy pauses, rare monosyllabic words. In all the observations, inclusions of melancholic affect were noted, albeit these were less evident, manifested by a narrowing of the thinking scope. Also, elements of passiveness, apathy, minor motor agitation were observed; however, a slowdown was noted in 3 cases only (1.21%). The sleeping disorders (202 cases – 81.45%) were characterized by both initial insomnia and premature awakenings in some cases (119 cases – 47.98%).

In the course of the day, an increased mobility of the depression was observed (236 cases – 95.16%), function of the intensity of feelings, with a prevalence in the morning hours. A connection was detected between the aggravation of the condition in the morning (180 cases – 72.58%), the deepening of anxious-melancholic disposition, and the augmentation of asthenia phenomena, including irascibility, in 151 cases (60.89%), but as well of the anxious ones, with a moderate reduction of despondency and pessimism in the time closer to the evening hours.

The representation about having a mental disease dominated in the patients' conscience. The statements of the subjects bore an egocentric character, which determined the content of ideas of self-accusing and blaming of the persons around them, but also ideas or acts of self-injury or suicide in 78 cases (38.34%). In 5 cases, suicidal raptus was noted, in the form of impulsiveness, brutality, unexpected behavior, with tendencies of jumping through the window. In conflicting situations, ideas of accusing the relatives for a hostile attitude towards them were often manifested. The patients accused themselves for an excessive credulity with regard to other people, increased anxiety and susceptibility, which fact could possibly induce disease. The patients feared future solitude, and the depression was perceived by the patients as a new state never experienced before, different from the anxious reactions from the previous period of their lives. The persistence of affective manifestations and their cyclic changes during the day, as well as a deepening of the depression with an accentuated anhedonia, the loss of interests and joys – in 168 cases (67.74%), the absence of emotional reaction to circumstances and extremely pleasant events – in 164 cases (66.13%), the loss of interest or pleasure in activities that are normally pleasant – in 160 cases (64.52%), were qualified by the subjects as signs of mental disorder aggravation.

The depression (246 cases – 99.19%) was manifested by a strong and violent despair, a sad and pessimist view on the future, in 232 cases (93.55%) with ideas of guilt and absence of value – in 213 cases (85.89%), suffering – in 204 cases (82.26%), loss of self-respect and self-confidence – in 175 cases (70.56%), when the excitement, sometimes induced by alcohol consumption – in 51 cases (20.56%), seemed to be a way to survive.

The psychotic symptoms of the anxious depression with a poor intellectual elaboration, a psychopathological phenomenology dominated by a sad and painful feeling, but interpreted and expressed in a delirious way, was manifested at the same time with perceptive disorders, by accusatory voices (45 cases – 18.15%). The delirious ideas (137 cases – 55.24%) were mainly of culpability, mourning, the belief that the close persons would die, sense of ruining, losing their fortunes, their property, their influence and possession, hypochondria (with the belief that they suffer from an incurable disease), of denial (with the belief that they would lack some internal organs), that were sometimes associated with themes of immortality but as well condemnation to torture, delirium related to the belief of being persecuted for their “crimes”. However, these delirious ideas were monotonous, and always dominated by a painful affective tonality, with a centrifugal nature of these ideas. The patients were convinced that they are themselves the source of their misfortune, that they are the only persons responsible for the suffering and misery of the nearest ones, and that they were doomed to mishaps. The nocturnal oneirism was manifested by experiencing some scenes of execution, fires, catastrophes, etc.

The somatic symptoms, the anxiety, the panic attacks made difficult the evaluation of the psychopathological phenomena. In case of anxiety being associated with despair, the subjects manifested brief episodes of perplexity, internal discomfort, profound affective tension, with ulterior agitation up to raptus, with a considerable suicidal risk. The feelings of asphyxia, the multiple cenestopathies had an obsessive-phobic nuance (119 cases – 47.98%) and generated a state of ceaseless agitation manifested by internal and relational discomfort, gesticulation, pacing with hands-rubbing, and crises of despair.

Table I. *Clinical presentation of the resistant anxious-agitated depression*

Parameters		Basic group		Control group		X ²	P
		abs	%	abs	%		
<i>Depressive mood</i>	Yes	124	100.00	124	99.35	2.02	>0.05
	No	0	0	0	0.65		
<i>Loss of interests and joys</i>	Yes	91	73.39	77	62.10	3.62	>0.05
	No	33	26.61	47	37.90		
<i>Growing fatigability</i>	Yes	42	33.87	11	0.81	47.29	<0.001
	No	82	66.13	123	99.19		
<i>Diminished activity</i>	Yes	26	20.97	0	0	29.05	<0.001
	No	98	79.03	124	100.00		
<i>Accentuated fatigue</i>	Yes	41	66.94	1	0.81	45.86	<0.001
	No	83	33.06	123	99.19		

Parameters		Basic group		Control group		X ²	P
		abs	%	abs	%		
<i>Concentration and attention capacity reduction</i>	Yes	63	50.81	53	42.74	1.62	>0.05
	No	61	49.19	71	57.26		
<i>Loss of self-respect and self-confidence</i>	Yes	70	56.45	105	84.68	23.78	<0.001
	No	54	43.55	19	15.32		
<i>Ideas of guiltiness and lack of value</i>	Yes	109	87.90	104	83.87	0.83	>0.05
	No	15	12.10	20	16.13		
<i>Sad and pessimist view of the future</i>	Yes	108	87.10	124	100.00	17.10	<0.001
	No	16	12.90	0	0		
<i>Ideas or acts of self-injury or suicide</i>	Yes	77	29.84	41	33.06	0.30	>0.05
	No	87	70.16	83	66.94		
<i>Sleeping disorders</i>	Yes	95	76.61	107	86.29	3.84	>0.05
	No	29	23.39	17	13.71		
<i>Loss of appetite</i>	Yes	73	58.87	111	89.52	30.41	<0.001
	No	51	41.13	13	10.48		
<i>Diurnal variation</i>	Yes	112	90.32	124	100.00	12.61	<0.001
	No	12	9.68	0	0		
<i>Anxiety</i>	Yes	123	99.19	124	100.00	1.00	>0.05
	No	1	0.81	0	0		
<i>Suffering</i>	Yes	96	77.42	108	87.10	3.98	<0.05
	No	28	22.58	16	12.90		
<i>Evident and objective proofs or psychomotor agitation</i>	Yes	103	83.06	90	72.58	3.95	<0.05
	No	21	16.94	34	27.42		
<i>Irascibility</i>	Yes	76	61.29	75	60.48	0.02	>0.05
	No	48	38.71	49	39.52		
<i>Excessive alcohol consumption</i>	Yes	20	16.13	31	25.00	2.99	>0.05
	No	104	83.87	93	75.00		
<i>Histrionic behavior</i>	Yes	57	53.27	39	36.45		

Parameters		Basic group		Control group		X ²	P
		abs	%	abs	%		
	No	50	46.73	68	63.55	6.12	<0.05
<i>Exacerbation of pre-existent phobic or obsessive symptoms</i>	Yes	50	40.32	69	55.65	5.83	<0.05
	No	74	59.68	55	44.35		
<i>Exacerbation of hypochondriac preoccupations</i>	Yes	62	50.00	46	37.10	4.20	<0.05
	No	62	50.00	78	62.90		
<i>Loss of interest or pleasure in activities that are normally pleasant</i>	Yes	72	58.06	88	70.97	4.50	>0.01
	No	52	41.94	36	29.03		
<i>Premature morning awakening</i>	Yes	76	38.71	81	65.32	0.43	>0.05
	No	48	61.29	43	34.68		
<i>Absence of emotional reaction to pleasant external circumstances and events</i>	Yes	65	52.42	99	79.84	1.26	>0.05
	No	59	47.58	25	20.16		
<i>Morning aggravation</i>	Yes	92	74.19	36	29.03	0.32	>0.05
	No	32	25.81	88	70.97		
<i>Evident and objective proof of psychomotor slowdown</i>	Yes	2	1.61	1	0.81	0.34	>0.05
	No	122	98.39	123	99.19		
<i>Weight loss (5% of the body weight or more, in the last month)</i>	Yes	88	70.97	93	75.00	0.51	>0.05
	No	36	29.03	31	25.00		
<i>Significant libido loss</i>	Yes	87	70.16	73	58.87	3.45	>0.05
	No	37	29.84	51	41.13		
<i>Delirium</i>	Yes	90	72.58	47	37.90	30.15	<0.001
	No	34	27.42	77	62.10		
<i>Hallucinations</i>	Yes	32	25.81	13	10.48	9.8	<0.01
	No	92	74.19	111	89.52		
<i>Depressive stupor</i>	Yes	11	8.87	3	2.42	4.85	<0.05
	No	113	91.13	121	97.58		

The data listed above show that, in the case of recurrent anxious-agitated depression, the most frequent clinical manifestations were the depressive mood and “sterile” anxiety discovered in all the 248 patients, both in the basic and in the control group. These mental phenomena were out of the control of attention, will, and conscience, and were projected upon the past. The following manifestations proved to be very frequent as well: the diurnal variation – basic group (112 cases – 90.32%), control group (124 cases – 100%), with statistically significant differences ($\chi^2 = 12.61$, $p < 0.001$); sad and pessimist view of the future – basic group (108 cases – 87.10%), control group (124 cases 100.0%), ($\chi^2 = 17.10$, $p < 0.001$); psychomotor agitation – basic group (103 cases – 83.06%), control group (90 cases – 72.58%), ($\chi^2 = 3.95$, $p < 0.05$), ideas of guilt and lack of value – basic group (109 cases – 87.90%), control group (104 cases – 83.87%), ($\chi^2 = 0.83$, $p > 0.05$), feeling of suffering – basic group (96 cases – 77.42%), control group (108 cases – 87.10%), ($\chi^2 = 3.98$, $p < 0.05$), morning aggravation – basic group (92 cases – 74.19%), control group (36 cases – 29.03%) ($\chi^2 = 0.32$, $p > 0.05$).

The patients' state was grave both because of delirious ideas – basic group (90 cases – 72.58%), control group (47 cases – 37.90%), ($\chi^2 = 30.15$, $p < 0.001$), and because of the hallucinating phenomena – basic group (32 cases – 25.81%), control group (13 cases – 10.48%), ($\chi^2 = 9.8$, $p < 0.01$), but as well because of ideas or acts of self-injury or suicide – basic group (77 patients – 29.84%), control group (41 patients – 33.06%), the results being statistically conclusive. It was namely the excessively sad mood experienced in the form of moral pain and sentiment of culpability that produced this specific delirium of self-deprecation, self-accusation, expiation, entailing a major risk of suicide.

Table II. Subject distribution in relation to harmfulness in the pre-morbid period of the resistant anxious – agitated depression

Parameters		Basic group		Control group		χ^2	P
		abs	%	abs	%		
<i>Somatic disorders, including endocrine, infectious, tumors</i>	Yes	86	69.35	53	42.74	17.83	$p < 0.001$
	No	38	30.65	71	57.26		
<i>Surgical interventions</i>	Yes	38	30.65	17	13.71	10.30	$p < 0.01$
	No	86	69.35	107	86.29		
<i>Cranio-cerebral traumatism</i>	Yes	63	50.81	23	12.15	28.48	$p < 0.001$
	No	61	49.19	101	87.85		
<i>Psychoactive substances consumption</i>	Yes	17	13.71	18	14.52	0.03	$p > 0.05$
	No	107	86.29	106	85.48		
<i>Neurotic-level affective oscillations</i>	Yes	85	68.55	30	24.19	49.05	$p < 0.001$
	No	39	31.45	94	75.81		

The largest number of subjects insofar as pre-morbid period harmfulness is concerned, is represented by patients with somatic disorders, including endocrine and infectious diseases, tumors – basic group (86 cases – 65.35%), control group (53 cases – 42.74%), which is very significant from the statistical point of view ($\chi^2 = 17.83$, $p < 0.001$). The second most frequent cause is the

neurotic-level affective oscillations – basic group (85 cases – 68.55%), control group (30 cases – 24.19%), ($\chi^2 = 49.05$, $p < 0.001$). The rest of the factors are ranking as follows: patients with cranio-cerebral traumas – basic group (63 cases – 50.81%), control group (23 cases – 18.55%), ($\chi^2 = 28.48$, $p < 0.001$); patients with surgical interventions – basic group (38 cases – 30.65%), control group (17 cases – 13.71%), ($\chi^2 = 10.30$, $p < 0.01$); and patients that used psychoactive substances during the pre-morbid period – basic group (17 cases – 13.71%), control group (18 cases – 14.52%), ($\chi^2 = 0.03$, $p > 0.05$).

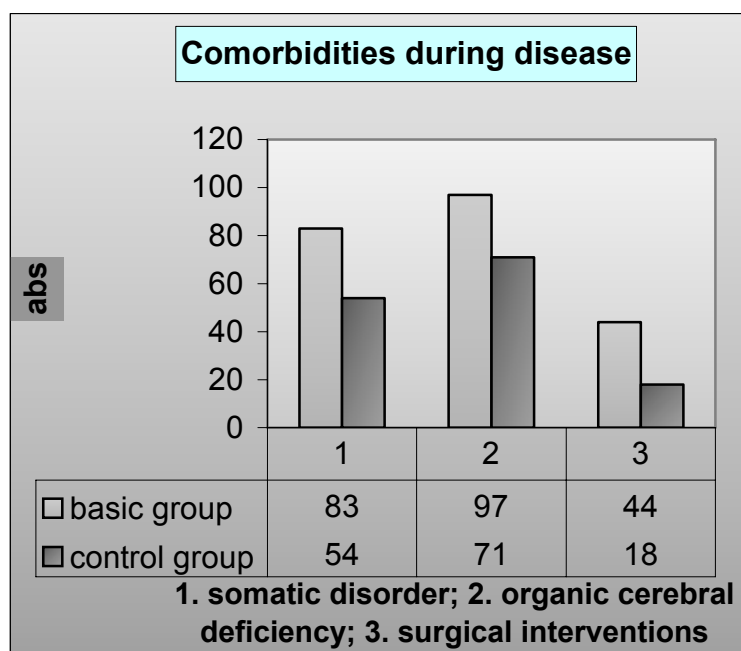


Fig. 1. *Comorbidities during disease in both groups*

The statistical comparison of the groups in relation to the comorbidities during disease proved that, for the basic group, the largest number of subjects have organic cerebral deficiency – 97 cases (78.23%), while in the control one, the number of cases amounted to 71 (57.26%), ($\chi^2 = 12.47$, $p < 0.001$). The patients with somatic disorders rank second in the basic group – 83 cases (66.94%), with 54 cases in the control group (43.55%), ($\chi^2 = 13.72$, $p < 0.001$). The most frequent diseases were cardiovascular system disorders, namely, blood pressure instability, so that the patients often manifested states of hypotension and pulse count modifications. Finally, the patients that had surgical interventions rank third, with 44 cases in the basic group (35.48%) and 18 cases in the control group (14.52%), which is significant from the statistical point of view, just as in the previous cases ($\chi^2 = 14.54$, $p < 0.001$).

A part of the subjects consumed several kinds of substances (alcohol, tobacco, caffeine, cannabinoids) during the depressive episode. These substances, being consumed in reduced or moderate doses, had apparently stimulating effect on the behavior, the alcohol, for instance, having lead to agitation with the increase of the dose, and to sedation with very large doses. However, no harmful use of the substances and neither the dependence syndrome, with a powerful or compulsive desire to use the substance, were observed; no difficulties related to the capacity of controlling the behavior related to the substance consumption with regard to: start, termination of consumption, consumed quantity, psychological state of servage, existence of tolerance, were noted, just as no servage syndromes with/without delirium or other psychotic disorders were observed.

The mental tensions, the states of conflict, other events causing psychological trauma (loss, illness or death of partner, or close relatives of friends, change of residence, reduction of physical and mental capacities, children getting married or leaving, fear of disease, failure to accept the reduction of capacities, overexertion in order to maintain one's former vitality and force, etc.) were

situations accompanying the disease. These cases were leading to the sentiment of loneliness; the subjects lost confidence; boredom appeared. Furthermore, the retirement was also determining the experiencing of some heavy feelings of uselessness, of burden for the family, of self-deprecation.

Table III. Subjects distribution function of psychiatric comorbidities during resistant anxious depression disorder

Parameters		Basic group		Control group		X ²	P
		abs	%	abs	%		
<i>Use of psychoactive substances</i>	Yes	19	15.32	29	23.39	2.58	p > 0.05
	No	105	84.68	95	76.61		
<i>Personality disorders</i>	Yes	54	43.55	18	14.52	25.36	p < 0.001
	No	70	56.45	106	85.48		
<i>Obsessive compulsive disorder</i>	Yes	35	28.82	20	18.69	0.13	p > 0.05
	No	89	83.18	87	81.31		
<i>Anxious disorder</i>	Yes	7	6.54	6	5.61	0.08	p > 0.05
	No	100	93.46	101	94.39		
<i>Post-traumatic stress disorder</i>	Yes	24	22.43	47	43.93	11.15	p < 0.01
	No	83	77.57	60	56.07		

The largest group of subjects insofar as psychiatric comorbidity during disease is concerned, is represented by patients with personality disorders – basic group (54 cases – 43.55%), control group (18 cases – 14.52%), which is significant from the statistical point of view ($x^2 = 25.36$, $p < 0.001$). The anxious disorder ranks second in the frequency distribution: the basic group (37 cases – 29.84%), control group (29 cases – 23.39%), ($x^2 = 1.32$, $p > 0.05$). The following rankings are as follows: patients with post traumatic stress disorder – basic group (36 cases – 29.03%), control group (27 cases – 21.77%), ($x^2 = 1.72$, $p > 0.05$), then patients with obsessive compulsive disorder – basic group (35 cases – 28.35%), control group (11 cases – 8.87%), ($x^2 = 15.37$, $p < 0.001$), and finally, patients using psychoactive substances – basic group (19 cases – 15.32%), control group (29 cases – 23.39%), ($x^2 = 2.58$, $p > 0.05$).

The average duration of the disease in the subjects from the basic group was of 9.65 ± 0.75 years, and of 15.96 ± 0.81 years ($p < 0.001$). The average number of previous episodes of the subjects in the basic group was of 5.47 ± 0.43 , and of 8.73 ± 0.49 ($p < 0.001$) in the control group.

The most frequent type of onset of the recurrent depressive episode, both in the basic and in the control group, is the brusque onset in 82 cases (66.13%) in the former and 100 cases (80.65%) in the latter group. The insidious onset in the basic group was observed in 42 cases, 33.87%, and in 24 cases, 19.35%, in the control group, which is significant from the statistical point of view ($x^2 = 6.69$, $p < 0.05$).

In the case of acute onset, the disease was manifesting itself unexpectedly and was gaining momentum rapidly, within 1 to 3 days. In the gradual onset, the disease was developing gradually, during 3 to 5 weeks. The attention disruption was becoming more prominent, a “blockage” of thoughts, a feeling of “emptiness in the head” was experienced. The patients experienced difficulties in digesting information, concentrating their attention, doing their usual work, after which the patients could do and redo the same task for several times, thus sapping at their work produc-

tivity, fact that aggravated even more their condition. Gradually, the feeling of non-conscious anxiety, being associated, in rare cases, with the depressing feeling of “gray sadness”, experienced by the subjects as a physical oppressing sensation of tension, swelling, wheezing, or internal tremor in the upper part of the body (in the head, epigastrium, behind the sternum). Feelings of pessimism, ruefulness, and despondency were specific to these experiences. The patients were blaming themselves for not being able to handle and deal with their daily work, and that they should have been fired. However, the ideas of self-punition, self-accusation and guilt were not dominant in their mental condition. A characteristic feature was the presence of diurnal oscillation of the mood with significant improvement of the mental condition in the second part of the day when the anxiety was becoming slightly less intense, including its physical perception, and the patients were growing calmer. Also, increased sweating, tachycardia, loss of appetite, weight loss, constipations were noted. For this type of depression, a characteristic feature was the combination of a physical sense of sadness with a massive coenesto-hypochondriac symptomatology. The patients were reporting burns in the stomach, pains and unpleasant feelings in the intestines, headaches of swelling or compressing nature. The intensified heartbeat was accompanied by a heart-compressing sensation, and palpitations or complaints of painful heart functioning. The patients were concentrating on these symptoms, were becoming restless, were nagging the medical personnel with always the same complaints, expressed anxious fears related to the activity of their gastrointestinal and cardiovascular systems. The subjects were afraid of having an incurable disease that was not probably detected yet and could lead to a fatal denouement.

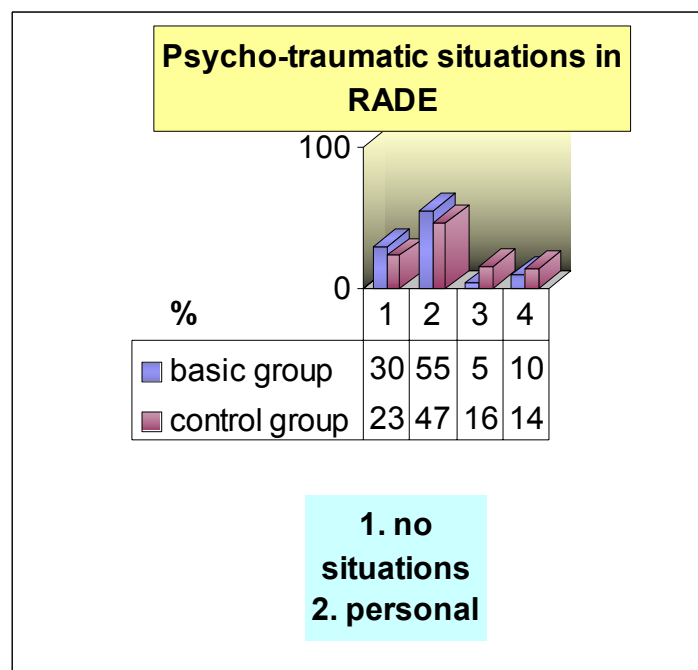


Fig. 2. *Distribution of psycho-traumatic situations in the manifestation of resistant agitated depressive episode*

The most frequent psycho-traumatic situations in the manifestation of recurrent depressive episodes were the personal ones noted at the majority of patients – 68 cases in the basic group, 55.84%, and 55 cases in the control group, 44.35%. 37 patients in the basic group, 29.84%, and 37 patients in the control group, 29.84%, did not experience any psycho-traumatic situations in the manifestation of recurrent depressive episode. The other situations are ranking as follows: patients with combined personal and professional psycho-traumatic situations – 13 cases, 10.48%, in the basic group, and 13 cases, 10.48%, in the control group, then, patients with professional-only

psycho-traumatic situations – 6 cases in the basic group, 4.84%, and 19 cases in the control group, 15.32%, which is statistically significant ($\chi^2 = 8.13$, $p < 0.05$).

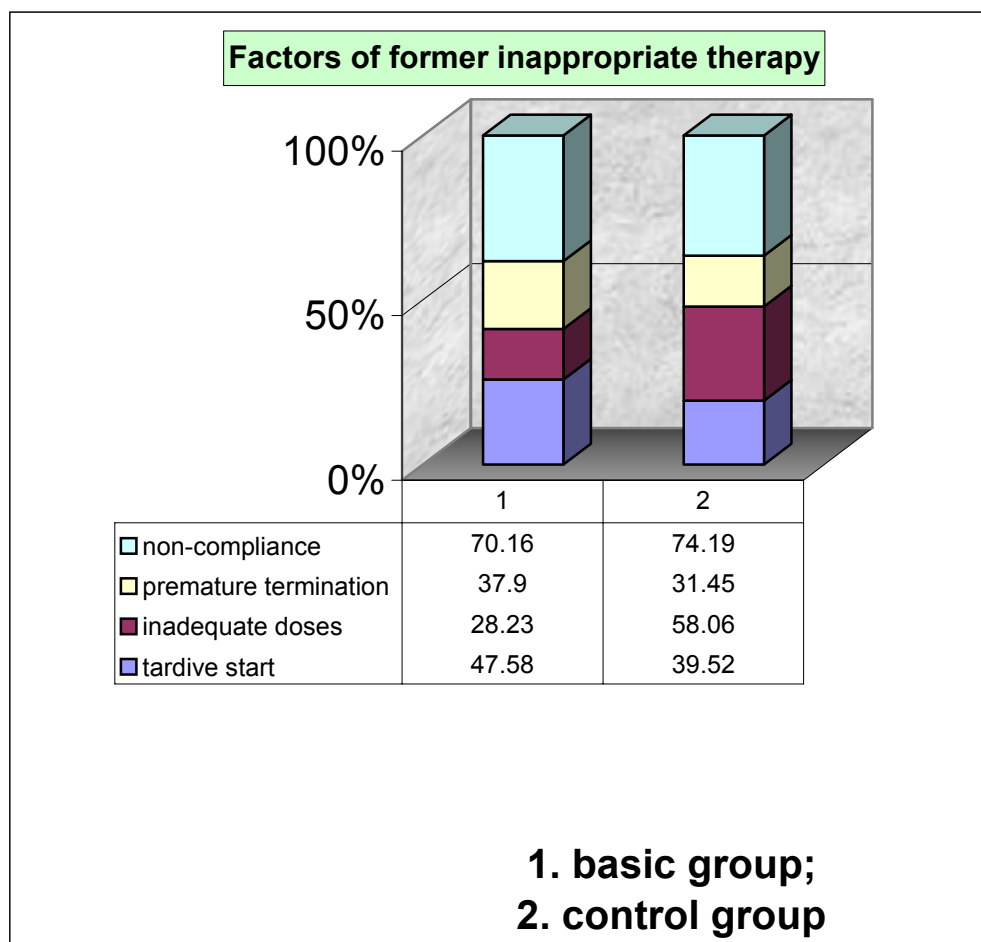


Fig. 3. *Factors of inadequate therapy formerly applied in both groups in the case of recurrent anxious – agitated depression*

The inadequate doses (basic group – 89 cases, 71.77%, control group – 52 cases, 41.94%) ($\chi^2 = 22.50$, $p < 0.001$) and the non-compliance (basic group – 87 cases, 70.16%, control group – 92 cases, 74.19%) ($\chi^2 = 0.50$, $p > 0.05$) were the most frequent factors of former inappropriate therapy. As for the other factors, one can state that the tardive start was noted in 65 cases, 52.42% in the basic group, and in 49 cases, 39.52%, in the control group ($\chi^2 = 4.16$, $p < 0.05$). The early termination was noted in 47 cases, 37.90%, in the basic group, and in 39 cases, 31.45%, in the control group ($\chi^2 = 1.14$, $p > 0.05$).

The morbid condition was demonstrated by profound anxiety, empty agitation, paroxysms of despair, fear, for example, fear of rape, of punishment, but also by rage, tensioned discharges, disgust and vital sadness, which affected the behavior, disorganizing the patient. In some cases, the emotions were dominated by the emergence of melancholic raptus manifested by a state of anxiety, motor disorder of great violence, including blows, impulsions of self-injuries that erupted without any apparent motive or were triggered by minor external occurrences.

The regression of psychopathology of recurrent anxious-agitated depression was evolving slowly and gradually. In the first place, the anxious-phobic manifestations were reduced, and only after that the mood *per se* improved. Thus, by the end of the first week, the suicidal ideas receded; the patients became more talkative, showed interest in some activities, the sleep and appetite disorders were losing their intensity. By the end of the second week the mood improved, the anxiety

was reduced. The patients stopped labeling their situation as being desperate. By the end of the third week the ideas of culpability were reduced. By the end of the treatment all the basic symptoms were reduced, with an “awakening” from the disease. After the reduction of the principal depressive symptomatology, however, in the case of partial remission, during 4 weeks more, increased fatigability, episodic cephalaea were yet observed; the patients could not handle more lengthy emotional and physical tasks; propensity to tears, susceptibility, anxious fears related to the eventual discharge were noted.

In order to evaluate the effects of the medication and to validate the therapeutic responsiveness level, we used repeated clinical examinations and the application of specific psychological tests: HAMD (Hamilton Rating Scale for Depression), MADRS (Montgomery-Asberg Depression Rating Scale), and BDI (Beck Depression Inventory).

Table IV. Score modification dynamics in accordance with the rating scales in both groups within the observation period in the case of resistant anxious-agitated depression

Evaluated parameters		Basic group (n=124) M±m	Control group (n=124) M±m	P
First examination	HAMD	29.61± 0.34	28.41± 0.27	p<0.01
	Beck	40.91± 0.35	36.60 ± 0.25	p<0.001
	MADRS	45.72 ± 0.34	44.61± 0.28	p>0.01
Second examination	HAMD	21.13 ± 0.20	22.40± 0.19	p<0.001
	Beck	28.35± 0.30	25.39± 0.21	p<0.001
	MADRS	31.30 ± 0.30	31.06±0.26	p>0.05
Third examination	HAMD	13.83 ± 0.14	13.68 ± 0.24	p>0.05
	Beck	17.53± 0.20	15.63 ± 0.28	p<0.001
	MADRS	19.38± 0.21	19.15± 0.28	p>0.05
Fourth examination	HAMD	7.04 ± 1.08	7.95± 0.26	P<0.01
	Beck	9.08 ± 0.12	10.05± 0.26	p<0.001
	MADRS	11.13 ± 0.16	12.15 ± 0.24	p<0.001

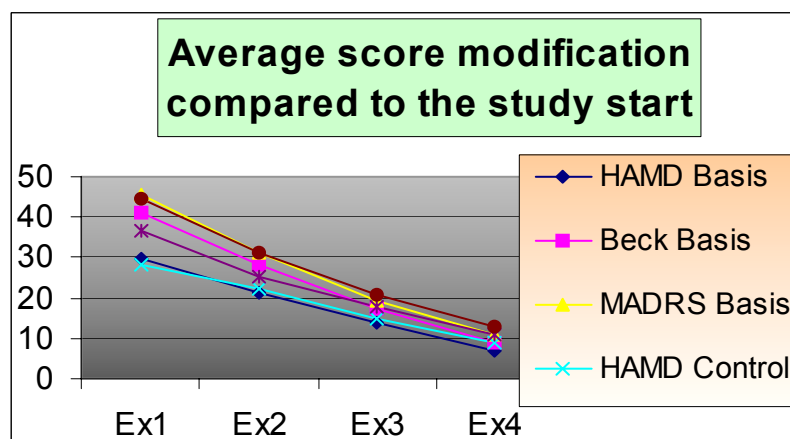


Fig. 4. Average score modification compared to the study start in the case of resistant anxious-agitated depression

Table V. Final results under the influence of treatment in the case of resistant anxious-agitated depression

Basic group						Control group					
Remission		Partial remission		Zero response		Remission		Partial remission		Zero response	
abs	%	abs	%	abs	%	abs	%	abs	%	abs	%
99	79,9	25	20,1	-	-	85	68,5	24	19,3	15	12,2

CONCLUSIONS

The determination of the correct diagnosis in due time and the efficient treatment of anxious depression are imposed. The choice of therapeutic methods was made function of the nature of the clinical picture, the symptoms' degree of acuteness, the ethiopathogenic background of the disorder. The suicide rate can grow because of underestimating diagnosis of the depression, of insufficient doses of antidepressants, therapeutic non-compliance or inadequate therapeutic option. In the initial stages, biological methods were mostly used, whereas across the establishment of the remission, the biological methods were combined with the psychological ones.

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