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ADAPTATION DISORDERS: GENDER ASPECT

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Порушення адаптації: гендерний аспект

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Нарушения адаптации: гендерный аспект

The article provides references to the first mention of the adaptation disorders terminology in scientific publication and the history of its development. It has been shown that along with such factors as the patient's age and his premorbid peculiarities, his gender is of great importance for specialists in psychiatry. The article also presents an analysis of publications dealing with differences between men and women in terms of peculiarities of their social functioning, formation of certain mental and somatic illnesses, especially under stress factors and subsequent formation of various adaptation disorders. These differences must be taken into account in psychiatric and psychotherapeutic practice and at all stages of rehabilitation work with such patients.

Key words: adaptation disorders, gender, men and women

У статті наведено літературні дані про перше наукове згадування та історію формування термінології, що пов'язана з адаптаційними розладами. Показано, що поряд з такими чинниками, як вік пацієнта, його преморбідні особливості, важливе значення для спеціаліста психіатричного профілю має також стать пацієнта. Проаналізовано літературні дані про відмінності між чоловіками та жінками в контексті особливостей їхнього соціального функціонування, формування тих або інших психічних, соматичних розладів, та особливо під час впливу стресорних чинників та наступному формуванні різних порушень адаптації. Ці відмінності необхідно враховувати у психіатричній та психотерапевтичній практиці на усіх етапах діагностичної та корекційної роботи з даним контингентом пацієнтів.

Ключові слова: порушення адаптації, гендер, чоловіки та жінки

В статье приведены литературные данные о первом научном упоминании и истории формирования терминологии, связанной с адаптационными расстройствами. Показано, что наряду с такими факторами как возраст пациента, его преморбидные особенности, важное значение для специалиста психиатрического профиля имеет также пол пациента. Проанализированы литературные данные о различиях между мужчинами и женщинами в контексте особенностей их социального функционирования, формирования тех или иных психических, соматических заболеваний, и особенно при воздействии стрессорных факторов и последующем формировании различных нарушений адаптации. Эти различия необходимо учитывать в психиатрической и психотерапевтической практике на всех этапах диагностической и коррекционной работы с данным контингентом пациентов.

Ключевые слова: нарушения адаптации, гендер, мужчины и женщины

The first scientific description of adaptation disorders dates back to 1666 after the Great Fire of London (the so-called Samuel Pepys's Diary) [9]. It provides a description of a mental trauma and its relation to factors of external environment. In 1863 Da Costa was the first to describe mental disorders of the American Civil War veterans caused by "extraordinary experiences" and called them the "irritable heart" [5]. Later E. Kraepelin (1891) and E. Bleuler (1920) following World War I gave a description of a mental disorders caused by combat action and referred to them as "traumatic neurosis" and "fright neurosis" [5]. During World War II military "stress syndrome" was described by Soviet researchers as well. For example, E. Krasnushkin (Soviet psychiatrist, Doctor of Medical Sciences, Full Professor, one of the founders of forensic psychiatry as a separate discipline in the Soviet Union) described one of these disorders in 1944 and called it "traumatic military neurosis" [3].

The risk of developing adaptation disorder manifestations impacted by a stress factor (affecting both the patient's microsocial network integrity and his social support as well as social values system on the whole) is to a great extent determined by such factors as the patient's age, his individual predispositions (e.g. certain personal traits or any previous neurotic disorders). The patient's gender is also an important factor to be considered by psychiatrists and psychotherapists, especially at the stage of therapeutic strategy development [10, 11].

It is clear that men and women in various situations follow different behavioral patterns. Men more often reserve to intellect, will and physical power, they are more straightforward, prone to aggressive reactions. Women are more cunning, clever, they demonstrate lower levels of aggression, however, in conflict situations they more often use verbalization and communicative solutions. In extreme situations men are more reserved and calm in their appearance, while women are more excitable, emotional, but the latter are more resilient to stress, capable of bearing it without much harm to health, which is partly a factor contributing to their longer life expectancy (in extreme social situations the mortality rate of men grows at a higher rate) [4].

In social respect women are more responsible, passive and obedient, while men are more self-confident, goal- and domination-oriented [1].

Compared to men women are more prone to depressive manifestations especially when stressed. Under stress men also demonstrate depression though it is less expressed in terms of intensity [7]. Taking into account the fact that depression serves as a defense in severe stress situations it is more understandable that women compared to men are more resilient to various kinds of stress in terms of somatic health preservation, which affects, among other things, a longer life expectancy. Women are more resilient in terms of somatic health preservation both under stressful situations and in the remote periods. Men are more vulnerable to cardiovascular disorders (especially under psychogenic stress), they are likely to suffer from contagious diseases

(especially under astenizing influence) and have a higher rate of stress-induced gastrointestinal tract disorders. Men are more likely to demonstrate addictive behavior symptoms and a higher risk acquiring antisocial personal disorders and aggressive forms of behavior that may form suicidal tendencies. Women have a more developed self-preservation behavior: they are more likely to turn for medical treatment with various ailments, including both somatic and mental. Unlike men, women tend to avoid risk factors contributing to various diseases and they are more prone to developing healthy habits. As for endogenous mental illnesses it is more characteristic of women to have them at later stages in life (at least their paranoid forms) with a greater effect of antipsychotic therapy; while endogenous symptomatology of men may be stabilized in elderly age. Women are more vulnerable to Alzheimer's disease and demonstrate a higher rate of dementia symptoms development (perhaps longer life span accounts for that). Men are more stable in terms of mental illnesses development [2].

Researchers also find differences and certain peculiarities of men and women in case with posttraumatic stress disorder (PTSD). In particular men demonstrate a growing anxiety level with the aggravation of PTSD, while women demonstrate a moderate anxiety level regardless of PTSD intensity.

Both men and women have reminiscences (episodes of reexperiencing a traumatic situation in the form of obsessive recollections), sleep disorders, alienation, loss of interest in many things, etc. And while men's reaction to constant stress is aggression, women tend to demonstrate increased anxiety and fear susceptibility. A man "goes to war" with the world that seems hostile to him, while a woman "hides" from this world. She breaks social connections, tends to socialize and go out less, avoids contacts with the opposite gender. Even if she is in a relationship with a man, this relationship is often "not serious", superfluous, as a woman with PTSD is simply incapable of trusting another person to the extent that would allow her to feel relaxed, natural and unprotected. At the same time both men and women can demonstrate flashes of sudden aggression.

It is not only a woman's character that undergoes changes, her attitude towards her body changes as well. She may stop caring for her appearance, or, on the contrary, start wearing a heavy make-up and clothes that stand out. They both are the result of aversion to the present self and at the same time constitute a defense against the world in the form of a too plain or bright image.

Women with PTSD, just like men, are more likely to develop various addictions (drugs, alcohol). At the same time they are more vulnerable than men to various eating disorders. Most common among them are the loss of appetite, malnutrition with a prolonged asthenia in the result.

While men most commonly acquire posttraumatic disorders in combat, women are likely to develop PTSD as the result of mental, physical or sexual violence. Emotions that a patient experienced at that moment impact her behavior and personality.

Helplessness, recollections of the humiliation, the feeling of guilt, anticipation of the lack of understanding or even condemnation by the people around — all this contributes to increased levels of anxiety and fear. And the ongoing isolation from the world makes it even more difficult to return to a normal life.

Social stereotypes and upbringing conventions "allow" the woman to be emotional, though they don't recognize her right to show aggression. And so the woman unwittingly follows a conventional pattern and expresses the whole variety of her feelings in simplified but intense reactions of fear that only on rare occasions can be replaced by short periods of aggressive behavior.

Men with PTSD often demonstrate aggressive behavior towards people around them. Men show general alertness as well as willingness to engage in conflict along with sudden and unprovoked flashes of rage. Manifestations of aggression may vary from verbal threats to physical violence involving a weapon.

Constant stress, the feeling of being isolated from the rest of the world, painful experiences and reminiscences may often lead to alcohol and drug addictions.

It forms a self-destructive type of behavior that makes the situation and relationships at home and at work even worse. Patients with PTSD have a higher divorce rate, they find it more difficult to maintain social connections, exercise their working duties in a normal way, etc. All these stand in the way of recovery and return to a normal life.

Of course this is not the only scenario of PTSD development in men but this is the most common case.

Men often acquire PTSD as the result of participating in combat actions, rescue operations in armed conflict areas, catastrophes and emergencies — in general in situations that require a fast reaction, action, being always ready to extreme events and often violence. All this impacts the patient's behavior.

Another reason is the man's psychological peculiarities and upbringing. Boys are brought up with the convention of being reserved and refrain from showing emotions. This results in a greater level of internal tension. But fear, resentment, disappointment and other "unbecoming" emotions do not disappear anywhere. They torment a person from inside until he releases them in a form that he believes to be socially acceptable — in the form of aggression that was encouraged and welcomed by people who were with the patient in a traumatizing situation.

There are a lot of factors that influence a person's gender and role socialization starting from the very birth throughout his whole life. The difference in aggressive behavior is among the most evident differences but they are not so considerable or very much influenced by biological differences as it may be suggested. Difference in aggression may be explained by gender roles that encourage men to show aggression in certain forms while women are discouraged from showing aggression. Men are often made to be aggressive by people around them who question their social status or self-respect. Women on the contrary are embarrassed to show aggression in public. Men prefer roles where they have to show aggression (army, sports) whereas for most women aggressiveness is absolutely inappropriate (e. g. a mother, secretary, teacher) [8].

Thus, the present analysis of publications and sources shows considerable difference between men and women in terms of forming adaptation disorders that must be taken into account when working with the whole spectrum of stress-related disorders.

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ПРОБЛЕМА АДАПТАЦІЇ ЛІКАРІВ-ІНТЕРНІВ ДО ПРОФЕСІЙНОЇ ДІЯЛЬНОСТІ В СУЧАСНИХ УМОВАХ

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Проблема адаптации врачей-интернов к профессиональной деятельности в современных условиях

V. V. Vjun

Problem of adaptation of doctors-interns to professional activity in modern conditions

У роботі виокремлені індивідуально-особистісні та соціально-психологічні чинники, механізми формування психологічної адаптації лікаря-інтерна до професіональному діяльності.

Визначені об'єктивні та суб'єктивні критерії ефективності адаптації лікарів-інтернів до професійної діяльності. Високий рівень дезадаптації виявлено у 9,2 % чоловіків і 12,5 % жінок; виражений рівень дезадаптації — у 10,3 % чоловіків, 14,0 % жінок; помірний рівень дезадаптації — у 36,2 % и 42,1 % відповідно.

Описано специфіку клінічних та психологічних проявів порушень адаптації у лікарів-інтернів. Виокремлено астенічний (25,5 %), гіперестезичний (21,6 %), депресивний (16,2 %), психосоматичний (14,2 %), апатичний (11,4 %), адиктивний (11,1 %) типи дезадаптивних реакцій.

На ґрунті отриманих даних, що відображають механізми формування розладів адаптації до професійної діяльності у лікарів, розроблені методи корекції та профілактики даних порушень з диференційованим використанням комплексу психотерапевтичних методів та психоосвіти.

Ключові слова: психологічна адаптація, професійна діяльність, дезадаптація, психотерапія, психоосвіта

В работе выделены индивидуально-личностные и социально-психологические факторы, механизмы и условия психологической адаптации врача-интерна к профессиональной деятельности.

Определены объективные и субъективные критерии эффективности адаптации врачей-интернов к профессиональной деятельности. Высокий уровень дезадаптации обнаружен у 9,2 % мужчин и 12,5 % женщин; выраженный уровень дезадаптации — у 10,3 % мужчин, 14,0 % женщин; умеренный уровень дезадаптации — у 36,2 % и 42,1 % соответственно.

Описана специфика клинических и психологических проявлений нарушений адаптации у врачей-интернов. Выделены астенический (25,5 %), гиперестезический (21,6 %), депрессивный (16,2 %), психосоматический (14,2 %), апатический (11,4 %), аддиктивный (11,1 %) типы дезадаптивных реакций.

На основе полученных данных, отражающих механизмы формирования расстройств адаптации к профессиональной деятельности у врачей, разработаны методы коррекции и профилактики данных нарушений с дифференцированным использованием комплекса психотерапевтических методов и психообразования.

Ключевые слова: психологическая адаптация, профессиональная деятельность, дезадаптация, психотерапия, психообразование

We have identify individual and personal, social and psychological factors, mechanisms of psychological adaptation of the doctors-interns to professional activity. Also we have identify objective and subjective criteria of efficiency of adaptation of doctors-interns to professional activity.

Specificity and clinical manifestations of psychological disorders in doctors-interns was described. High level of disadaptation it is revealed at 9.2 % of men and 12.5 % of women; the expressed disadaptation level — 10.3 % of men, 14.0 % of women; moderate level of disadaptation — 36.2 % and 42.1 % respectively.

We can identify the following types of maladaptive reactions: asthenic (25.5 %), hyperesthesia (21.6 %), depressive (16.2 %), psychosomatic (14.2 %), listless (11.4 %), addictive (11.1 %).

Based on the data that reflect the mechanisms of disorders of adaptation to the professional activities of doctors, we have developed methods of correction and prevention of these disorders with using a complex psychotherapeutic methods and psychoeducation.

Keywords: psychological adaptation, professional activity, maladjustment, psychotherapy, psychoeducation