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THE SPECIFIC SOCIAL INFLUENCES ON THE DEVELOPMENT OF ANXIETY-DEPRESSIVE DISORDERS IN ADOLESCENTS

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Abstract:

This article is devoted to an important contemporary problem - depressive spectrum disorders in adolescents. It is shown that the problem of depressive disorders of adolescence remains relevant at present. It is noted that adolescent depression is nosologically nonspecific and one of the most frequent manifestations of mental pathology in adolescents. There is a tendency to an increasing number of severe, atypical and masked forms of depression, causing difficulties in diagnosis and adequate therapy. Affective disorders can occur in isolation or in combination with other psychopathological manifestations. Different mechanisms are involved in the formation of these conditions, and their prognosis depends to a greater extent on which nosology, psychological and personality components are involved. The available literature does not provide a clear clinical description of the symptoms of this disorder, as affective pathology is a heterogeneous group of disorders. This makes it difficult to understand the process and structure of the disorder.

Keywords: Depressive Disorders, Suicidal Behaviour, Suicide, Depression.

INTRODUCTION. Depression is currently one of the most common affective disorders. For many years, child psychiatrists dismissed the idea that depression occurs in childhood. The symptoms of depression were thought to be normal and temporary manifestations inherent in certain stages of childhood development. However, depression is as much of a problem for children and adolescents as it is for adults. It is now known that reduced mood disorder in childhood and adolescence is a frequent, not always recognisable, severe disorder with an ever-increasing prevalence of between 20% and 85%.

RESULTS: In a follow-up study of 49 children and adolescents with anxiety or depressive disorders, up to 50% had not recovered. In the 12 months preceding onset, there were no social factors that predicted recovery at follow-up. Between onset and follow-up, children were less likely to be exposed to adverse life events and significant improvements in trusting relationships with the mother were reported. None of these improvements predicted recovery rates at follow-up. Poor recovery is best predicted by moderate or poor friendships after the onset of the disorder, especially for those diagnosed with depression. There is further evidence that direct interviewing of children by trained staff using semi-structured charts is an effective method of identifying psychiatric symptoms and perceptions of recent friendships.

DISCUSSION OF THE RESULTS: Diagnosis of depression is often difficult because of the extreme variability, volatility and diversity of its manifestations, masked by somatic and autonomic symptoms, and the influence of many environmental factors. The course of depressive disorder in the form of typical melancholia, when diagnosis is unequivocal and therapeutic tactics are defined, is relatively rare in children. The timely identification of the depressive component of the pathological condition is essential for the prescription of adequate treatment. This is complicated by the fact that children and adolescents with affective disorders come to the attention of a psychiatrist too late, as behavioural disorders, which are regarded by others as a manifestation of "bad character and promiscuity", come to the fore. In these cases, the true nature of the pathological state is often discovered when the patient is admitted to hospital, often due to a suicide attempt that is unexpected to others, which is particularly high in depressive disorders. Because of the difficulty in recognising this pathological state, patients are not treated adequately for a long time. The peaks of suicidal activity occur between 15 and 22 years old ("youthful peak"), and over 45 years old ("involutionary peak"), with suicide attempts predominating at a young age, and suicides at an involutionary age. Although there is currently no single universally accepted classification of age periods, it is possible to agree with the WHO experts' optimal proposal to consider the age of adolescents to

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be between 10 and 20 years, as it is now accepted in most countries worldwide, taking into account somatic, psychological and social maturation. This age is extremely important for the further development of the individual, because during this period mental, physical and sexual development is completed and behavioural characteristics are developed and consolidated; it is not without reason that it is referred to as a critical age. On how the development of adolescence, and depends on the health and quality of life later personality. During adolescence, many previous relationships break down and rebuild, leading to permanent conflict. And if the individual is in a state of permanent conflict - a conflict between actualized needs and the impossibility of meeting them - depressive reactions are the most likely forms of mental reaction to the frustrating situation. In adolescents, the permanently frustrating situation is, on the one hand, the many aspirations for a sense of adulthood and, on the other hand, the unchanging social situation in which they are still students. This chronic conflict can lead to mental illness, and may very often lead to mental disorders that fall into the category of affective mood disorders. According to M.B. Keller et al, the average age at the onset of depression is 14. According to W. M. Reynolds and H.F. Johnston, 10-20% of adolescents may experience major depressive disorders but they often go unrecognised. The lifetime prevalence of this kind of disorder is 20.4%, and only 2.9% of adolescents were found to be depressed at the time of screening. The figures show an increasing incidence of depressive, particularly non-psychotic, disorders in adolescents in recent decades. However, some authors raise serious doubts about the possibility of depression developing during adolescence. Their beliefs are based on the fact that all normal adolescents experience severe mood and mood swings, but these are not signs of psychopathology: pronounced mood swings, social withdrawal, cognitive distortions and conflicts with peers and family are not necessary and typical for adolescents, but rather indicate mental ill-health.

The gender ratio also changes with age. Before puberty, the ratio of boys and girls suffering from depression is thought to be the same, while in adolescence girls begin to predominate. The double prevalence of boys among hospitalised depressed patients of childhood and prepubertal age has been noted in the recently published work of T.I. Ivanova. However, epidemiological studies in the early 1980s found an overrepresentation of males, particularly in cases of masked non-psychotic depression, among depressed patients who were not prepubertal but adolescent. Thus, we can see that the incidence of depression increases with age, from childhood to adolescence, but there is no consensus on the gender ratio across age groups to date. Depressive disorders in adolescence are one of the most challenging medical problems also because of the severe social consequences, which include suicide, violence, substance abuse and behavioural deviations. Most notably, depressive conditions in adolescence are associated with suicidal behaviour.

Suicidal behaviour is a consequence of socio-psychological maladaptation of a person in the conditions of experienced micro-social conflict. When considering the stages of formation of suicidal behaviour, the following can be conventionally distinguished: antivital experiences, passive suicidal thoughts, plans, intentions and the realisation of the latter in the form of attempts. The approximate ratio of suicidal thoughts, attempts and completed suicides is 100:10:1. As a rule, the majority of suicidal actions are aimed not at self-destruction, but at restoration of social connections with others; sometimes the suicidal behaviour is defined by aspiration to temporary "switching off" from a situation. In dynamics of the social-psychological disadaptation leading to a suicide, two phases are distinguished: prepositional and suicidal, and the decisive value for transition of the prepositional phase of disadaptation to a suicidal phase has a conflict. "Acute suicide" is rare among adults, but is seen in adolescents "by imitation" in the case of the suicide of their idol, etc. The term "suicidal behaviour" "encompasses all manifestations of suicidal activity - thoughts, intentions, utterances, threats, attempts, attempts". The term is especially applicable to adolescence, "when suicidal manifestations are diverse." The authors point to a definite connection between suicidal behaviour and the type of accentuation of the character. According to them, suicidal behaviour in adolescents is demonstrative, affective and true. Suicidal actions in adolescents are often "non-serious", demonstrative in nature, and can take on the features of "suicidal blackmail". The most frequent reasons for suicides include: family, sexual and school problems. The most tragic consequence of a depressive disorder is suicide. According to WHO, suicide amongst 15-20 year olds has doubled in the last 15 years, and takes 2-3 places among the causes of death in many economically developed countries. Over half a million young people around the world take their own lives each year, that is, more than 1,000 people a day.

In Uzbekistan, the frequency of suicides among adolescents has increased by a factor of 3 in

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the last decade and suicides in this age group are expected to grow the fastest in the next 10 years. In the aspect of the adolescent's intrapersonal conflict, suicidal behaviour can be seen as a way of revenge, as a result of the actualisation of hostility directed at oneself. When interpersonal relationships are disrupted, neurotic conflict and anxiety arise as a result of a lack of a sense of security in interpersonal relationships. As a rule, most suicidal behaviour is not aimed at self-destruction but at re-establishing social ties with others, sometimes suicidal behaviour is defined by a desire to temporarily 'switch off' from the situation.

According to domestic authors and researchers in Europe and the USA, adolescents who attempt suicide most often resort to drug poisoning (more than 60% (more often in females) and self-cutting (more than 30%) (more often in males). Hanging is less common, at more than 2 per cent. In the field of education and labour, the prevalence of persons who are maladapted in this process has been established. The seasonal distribution of the frequency of suicide attempts showed that the highest number of attempts occurred in spring and autumn. Most adolescents make suicide attempts in the afternoon and in the evening. The problem of suicide among young people is extremely relevant in many countries, as suicide is the third leading cause of death among young people (WHO, 2021). D. Wasserman and colleagues studied suicide rates in adolescents aged 15-19 around the world using data from the World Health Organization (WHO) mortality database. In the 90 countries studied, suicide ranked fourth among male adolescents and third among female adolescents on the list of causes of death. In 13 countries suicide rates were 1.5 times or more above average, Sri Lanka having the highest rate, followed by Lithuania, Russia and Kazakhstan. Particular attention should also be paid to the problem of suicidal behaviour prevention among adolescents because "suicidal young people rarely want to die; they want to escape from circumstances they find intolerable". It was found that in most cases of teenage suicides, lack of communication was an important factor in their desire to commit suicide. It is becoming apparent that improving the relationship within the family can reduce the frequency of suicide. In addition, there are types of suicide such as induced suicide and group suicide, "imitation behaviour plays a role in provoking suicide, especially among adolescents". In recent years, evidence has emerged that states of depression and anxiety are accompanied by significant changes in the perception and processing of incoming information. One manifestation of these changes is a specific selectivity of cognitive processes in the form of unconscious preference for one kind of information at the expense of ignoring other kinds of information. Under conditions of stress, depressed and anxious individuals perceive and evaluate events in a distorted way, which leads to the development of states of neuropsychological maladaptation and intensification of experiences of depressive and suicidal nature. Depression is the most typical pre-suicidal state, stimulated by a stressful situation. A number of different factors lead to depression: changes in relationships with peers (e.g., loss of a friend or girlfriend, expulsion from peer group, etc.), family effects (lack of communication, arguments between parents), low self-esteem, poor school performance, lack of hope for the future. Adolescents complain of headaches, back or abdominal pain, changes in habits, sleep disorders, reduced activity levels; mood swings are observed (anxiety, reduced capacity for daily work, self-assertion in the form of violence, drug use, creating risky situations). An analysis of the content of psychologically traumatic situations among teenagers showed the following: in most cases, family conflicts lead to suicide attempts - more than 50 %, conflicts with peers and love conflicts are less frequent - about 13 %, school conflicts precede parasuicides - more than 8 % . Sometimes the desire to die and the suicidal wish of an adolescent are seen as two different phenomena. Suicidal thoughts in adolescents, according to the authors, can appear along with the development of an 'ego-structure'. The desire to die, on the other hand, is embedded in the constitutional depressive structure as a result of early emotional deprivation by the mother. Outwardly identical suicidal behaviour can therefore be based on two fundamentally different psychological mechanisms. This implies the need for differentiated psychotherapeutic help for such teenagers. At the same time, depressive conditions are often not recognized in time, so, according to M. G. Usov, almost one fifth of teenagers with depression commit suicide attempts on the pre-hospital stage. Suicidal behaviour is often the first sign which draws attention to the mental state of the adolescent. The identification of depressive states in adolescents is an important and hitherto unresolved problem. The difficulty of timely diagnosis is often due to the lack of syndromological delineation of depressive states in this age period. In the pubertal phase, when "the relative perfection and harmony of childhood" is "shattered" and "the emotional horizon widens", there is a tendency to unexplained mood swings, the adolescent

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"affective fluidity" indicates a disturbance of mental balance and characterizes the psychological development process in this age interval. However, the waning affective symptomatology may be masked by pubertal manifestations, creating additional diagnostic difficulties. Underlying changes in affective background usually result in an increase in emotional lability and a lowering of the threshold for emotional endurance, with a readiness for brief, situationally provoked episodes of low mood. Along with clinically delineated episodes, it is suggested that some shallow depressions are purely psychological reactions. The moment at which mood disturbance becomes a diagnosable disorder is a matter of clinical judgment, but the criteria for such judgment are not precise enough to lead different clinicians to a consensus. These studies essentially confirm Kraepelin's observation that mood disorders may be subtle at first, manifesting as subtle mood swings that persist for several years until a full-blown depressive syndrome develops. This suggests that differentiating between the clinical manifestations of pubertal depression and adolescent emotional lability and the timely fixation of signs of risk for later affective illness is a complex and unresolved problem.

CONCLUSIONS: Thus, it follows from the above that depressive disorders in adolescents are a heterogeneous group. The available scientific work on adolescent depression indicates considerable clinical polymorphism and atypicality of these conditions. Depressive disorders can occur in isolation or in combination with other psychopathological manifestations. Different mechanisms are involved in the formation of these conditions, and their prognosis depends to a greater extent on which nosology they are implemented within and on the psychological and personality components. This necessitates further study of the clinical and dynamic characteristics of depressive disorders in adolescents in order to optimise diagnosis and therapy.

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