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CLINICAL PHENOMENOLOGY OF DEPRESSIVE BEHAVIOR DISORDER IN ADOLESCENTS: DIAGNOSIS, THERAPY, PREVENTION

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ABSTRACT

The informativeness of behavioral patterns of depressive behavior disorder in adolescents in the age and gender aspect is determined. It is proved that many variants of behavioral disorders in adolescents with depressive disorders indicate the complex nature of relationships formation of behavioral disorders presence, which is the practical value for the development of specific preventive therapeutic programs.

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Introduction. The World Health Organization (WHO) has named depression one of the most important causes of diseases in the world. More than 300 million people suffer from depression. According to WHO, depressive disorders annually cause global damage to the economy in the amount of $ 1 trillion. Currently, WHO estimates the part of children with mental health problems in 20% of cases, and special studies performed in Europe give an assessment within 14-30%, depending on the age of the group of children. In adolescents, the first place is occupied by anxiety disorders, followed by behavioral disorders and disorders of the affective sphere with the use of psychoactive substances (WHO, V. A. Rozanov, 2018). 30% of all depressions remain resistant to therapy, ineffectiveness and relapses of depression in 80% of cases are associated with therapy errors, non-compliance with recommendations, mental comorbidity and other factors.

Today, despite a large number of studies, the problem of depressive disorders in children and adolescents remains and is being updated due to the fact that the number of children with personal and behavioral deviations, academic failure, aggression, and suicidal behavior is increasing. Only 10% of children with depression seek medical help (most often to a neurologist or pediatrician), and only 20% of depression cases are diagnosed on time.

Official statistics of the Ministry of Health of Ukraine only partially reflect the real situation with the prevalence of depressive disorders among children and adolescents. According to WHO research, no more than 20% of Ukrainian citizens seek medical help for depression of their children.

Clinical and retrospective studies performed by employees of the State Institution "ICAHC NAMS" in the period 2010-2020 showed that most children exposed to depression are ignored by parents, peers and teachers. Depressive disorders aggravate school problems, which manifest themselves in a decrease in intellectual activity, decrease in interest in learning, difficulties in communication, impaired communication with peers, deeper sense of incompleteness, concentration on their own painful experiences, and decrease in the ability to realize their abilities. Defensive reactions of avoidance, denial, hypercompensation, shyness, sensitivity, reflection, resentment negatively affect the child's personality, making it even more fragile, vulnerable and confrontational.

Many of the internalizing signs of childhood depression are hidden, "masked", and difficult to diagnose by doctors, which highlights the need for more active implementation of new diagnostic and rehabilitation programs for children with emotional problems. The need for diagnosis and qualification of depression in children is dictated by its severity with age, a high risk of relapse at subsequent stages of ontogenesis, and a tendency to addictive behavior. In children with depression, cognitive disorders and behavioral disorders prevail, while the thymic component of the disease itself is rudimentary. Erased affective symptoms of depression in children can be hidden under the "mask" of pre-puberty and puberty manifestations, somatic and behavioral disorders, creating additional diagnostic difficulties.

To ensure the diagnosis, treatment and prevention of depressive disorders, including recurrent depression, the order of the Ministry of Health of Ukraine No. 1003 dated 25.12.2014 approved a unified clinical protocol of primary, secondary (specialized) and tertiary (highly specialized) medical care. The protocol allows to establish uniform requirements for the prevention, diagnosis, treatment and rehabilitation of patients with this type of pathology in accordance with clinical guidelines developed taking into account domestic characteristics of the organization of medical care and the economic situation in the country; ensure quality, effectiveness and equal treatment of patients with this type of pathology opportunities for access to medical care for patients with depressive disorders. But, unfortunately, all recommendations are designed for patients of the adult contingent and cannot be applied in children's and adolescent psychiatric practice, taking into account significant age differences in the diagnosis and treatment of depression.

Various psychopathological symptoms are considered as equivalents of depression – specific disorders of mental dysfunction, behavioral disorders, expand the concept of affective pathology in childhood and differentiation of depressive behavior disorder in children during puberty. The complex interweaving of affective symptoms, manifested puberty crisis, somatoneurological heaviness, including endocrine diseases (hypothalamic syndrome, anorexia, obesity) with manifestation during puberty, significantly complicate the diagnosis of depressive disorders. Therefore, the justification of approaches to the diagnosis of depressive behavior disorder in adolescents is an urgent necessity at the present time.

Standardized diagnostic procedures recognized in the world do not encourage specialists in the field of child psychiatry to widely diagnose depressive disorders in children due to behavioral disorders. In DSM-5, three groups of depression are identified in children and adolescents: severe depression, dysthymic disorder, and mood regulation disorder with disruptive behavior. A new specificator is introduced in DSM-5, indicating a shortage of prosocial emotions. DSM-5 "with limited prosocial emotions" specificity is the result of attempts to search for markers of depressive disorders in children and adolescents.

Research purpose. Assessment of clinical phenomenology of impaired behaviors in adolescents with depressive disorders and development of measures for psychoprophylaxis of disease progression in adolescence.

Research materials and methods. 102 patients with depression were examined, including 48 teenagers aged 12-14 (22 boys and 26 girls), 54 teenagers aged 15-18 (26 boys and 28 girls).

Clinical-psychopathological, pathopsychological (depression detection test CDRS-R, structured psychological interviewing, Lusher test, 10-word memorization test, Platonov-Schulte tables, Shmishek characterological questionnaire, pathocharacteriological diagnostic questionnaire for teenagers by A. Lychko, general clinical impression scale (CGI)). The Spielberger scale was used to assess personal and reactive anxiety.

Results and their discussion. Manifestations of depressive behavior disorder in younger adolescents included: problems in learning and interpersonal relationships at school; slowness, "sticking", long motionless sitting in one position; anxiety; decreased concentration of attention; lethargy, passivity, boredom; irritation as a response to requests from parents; secret crying, whims, detachment.

Signs and symptoms of depression in adolescents aged 14-18 years included: sadness or waste; irritability, anger or hostility; tearfulness, frequent crying; running away from friends and family; loss of interest in previously loved activities; changes in eating behavior and sleep patterns. Among the other symptoms in this category of teenagers are anxiety and excitement; a sense of helplessness and guilt; lack of enthusiasm and motivation; fatigue and lack of energy; difficulty concentrating; thoughts of death or suicide. Anxiety, which is characteristic of younger teenagers, turns into a chronic anxiety-dreary depression with frequent attacks and depressive behavioral disorders that do not depend on the conditions of the surrounding environment. Manifestations of the

crisis of adolescence complement the picture of depression, in particular bipolar (variability and opposition) moods: vulnerability and demonstrative audacity, shyness and resolution, sensitivity and coldness, independence and expressed thirst to be noticed and recognized, denial of authority and imitation of idols, philosophizing and fantasizing.

There are ways that teenagers "play away" in an attempt to cope with emotional pain: problems at school, running away from home, drug and alcohol abuse, low self-esteem (depression provokes or increases feelings of ugliness, shame, failure, worthlessness), forming dependence on the internet (run away from their own problems), reckless behavior, violence.

The majority of teenagers with depressive behavioral disorders (88.2%) identified conflicts between teenagers and their parents. Predictors of depression are most often the conflict of parental instability, the conflict of overprotection, the conflict of inattention to independence.

In the course of the study, the risk factors for the development of depressive behavior disorders in adolescents were identified: depressive disorder in younger school age (40.2%), concomitant comorbid mental disorders (66.7%), cognitive disorders (89.2%), hereditary depression burden (31.4%), low social-economic status of the child (67.6%), chronic stress (76.5%). The level of social cognitive functioning is impaired in 100.0% of adolescents with depressive behavioral disorders. The phenomenology of behavioral patterns of depression in adolescents is represented by aggression (100.0%), characterological reactions (100.0%), communicative deviations (100.0%), autoaggression (34.3%), immoral and not-moral behavior (34.3%), and unsightly behavior (15.7%). The behavior model of teenage girls with depression was most often manifested in the form of self-injuries (cuts, burns).

Adolescents with depression have registered options for addictive behavior associated with food consumption (33.9 %); tobacco consumption (69.2%); alcohol consumption (27.5%); passion for watching TV shows (47.0%); internet addiction (78.4%); gambling addiction (15.7%); computer addiction (66.7%); consumption of cannabinoids (cannabis preparations – hashish, marijuana, drape, anasha) (10.8%).

In the context of gender differences, it is necessary to note the predominance of aggression, auto-destructive behavior, food behavior disorders (anorexia) in teenage girls aged 12-14 years. Boys aged 12-14 with depression have gambling and internet addiction; teenagers aged 15-18 have gambling, drug and smoking addiction. Adolescents with depressive behavioral disorders have been diagnosed with persistent and situational components of anxiety states that affect adaptation processes. It was found that adolescents with depressive behavioral disorders indicate low family cohesion, extremely emotionally separated relationships with their parents (53.1% of adolescents and 17.7% of parents).

Methods of clinical psychodiagnostics of depressive behavior disorders in adolescents include: anamnestic questioning and observation (collecting information from adolescents and parents in order to establish the diagnosis and prognosis of the disease); individual conversation (family, study, relationships with peers, hobbies in the present and past, violations behavior in the past, the most unpleasant events in life and reaction to them, past illnesses, character traits); CDRS-R test (to assess the symptoms and severity of depression), Spielberg's test for determining situational and personal anxiety, tests for diagnosing character accentuation (PDO test by A.E. Lychko, Schmishek's test).

The task in treating depressive behavior disorders in adolescents is not only to eliminate the symptoms of the disease, but also to improve the quality of life of the patient, which is expressed in changing social and personal adaptation. Modes of psychological overcoming aimed at solving a problem or changing their own attitudes towards the situation included: real (behavioral or cognitive) problem solving; search for social support; analysis of the situation; emotional expression.

The complex of therapeutic intervention in adolescents with depressive behavioral disorders included: psychotherapy (long-term cognitive behavioral therapy, art therapy, family psychotherapy), pharmacotherapy (drugs of the first line of choice – selective inhibitors of reverse capture of serotonin (SSRIs) - sertraline, fluoxetine, citalopram), social interventions (social assistance to the family, providing adequate educational support to the teenager). Experience in the pharmacological treatment of depressive disorders in adolescents shows that SIRCS should be the first line of therapy, but there are warnings against use caused by increased risks of suicidal ideation and behavior.

In our study, the drug Depakin was used to correct depressive behavior disorder. Figure 1 shows the dynamics of anxiety and depression symptoms in adolescents against the background of Depakin administration. The assessment was performed on CDRS-R Depression Scale and the CGI Symptom Intensity Scale (in points).

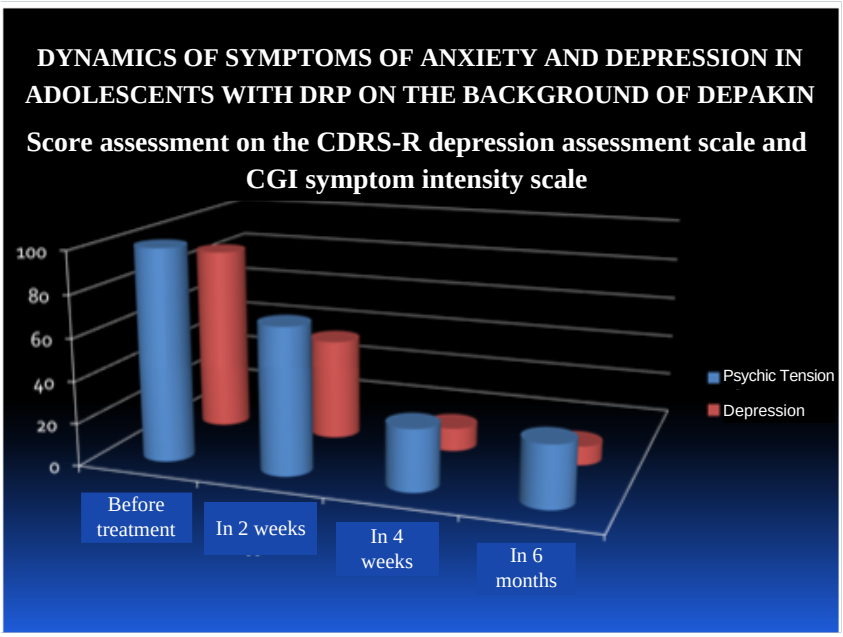

Fig. 1. Dynamics of Anxiety and Depression Symptoms in Adolescents with Depressive Behavior Disorder on the Background of Depakin Administration

Consequently, the administration of Depakin is justified in the treatment of depressive behavioral disorders in adolescents. The drug can stop depressive symptoms without prescribing antidepressants due to the relief of the anxiety component. The achievement of a therapeutic effect, high performance indicators, significant reduction in the risk of suicide during monotherapy with mood stabilizers compared to other drugs, and decrease in the number of relapses justify the use of Depakin in the treatment of depressive disorder in adolescents.

In the treatment of depressive behavioral disorders in adolescents, it is advisable to use Eglonil (sulpiride)**.** One of the most important specific feature of sulpiride use in the clinic is the presence of "double" dose range. In doses up to 200 mg/day, the drug has exclusively antidepressant, psychostimulating, anxiolytic, vegetative-stabilizing and analgesic effects, and only in doses above 300 mg/day or more, an antipsychotic effect is actually noted. Such a significant dose-based "dilution" of the main effects of Egloin directly determines the possibility of its use in adolescent practice in depression treatment. Eglonil can be considered as a unique drug with peculiar combined properties of a proper neuroleptic, antidepressant and anxiolytic. Characteristic features of Eglonil are the selectivity of action on the main target of drugs of this group in the brain – dopamine D2 receptors and the presence of a double dose range. Eglonil affects only D2 receptors localized in the neural pathways connecting the cortex to subcortical centers – mesolimbic and mesocortical, and minimally located in the hypothalamic-pituitary system, without affecting D2 receptors in the nigrostriatal system.

Figure 2 shows the dynamics of psychopathology in depressive behavior disorders in adolescents against the background of Eglonil administration.

Consequently, Eglonil helps to correct the entire spectrum of psychopathological symptoms in adolescents with depressive behavioral disorders. An important rehabilitation factor is the family, which ensures the formation of stable moral standards and values in child, education of emotional tolerance skills to negative factors of adaptation disorders and the risk of deviant and suicidal behavior. In the correction of cognitive disorders in adolescents with depression, a positive effect of Kognum administration with a course of up to 4 weeks is obtained.

Prevention of deviant behavior in adolescents with depressive disorders can be organized through the initiation of meaning and goal setting in the unfolding process of scenario construction of life activity, creation of images of a socially acceptable and desired future and adequate professional projections. Formation of prosocial behavior is possible with the accompanying development of the semantic sphere of the personality of adolescents through the system of solving personally significant tasks, formation of value attitude to the time of life and subsequent acquisition of appropriate levels of self-organization. Self-organization is considered as a product of the formation of a subjective attitude to the space of personal temporal development, which requires mastering the actions of life time organization in order to realize personally significant goals and meanings.

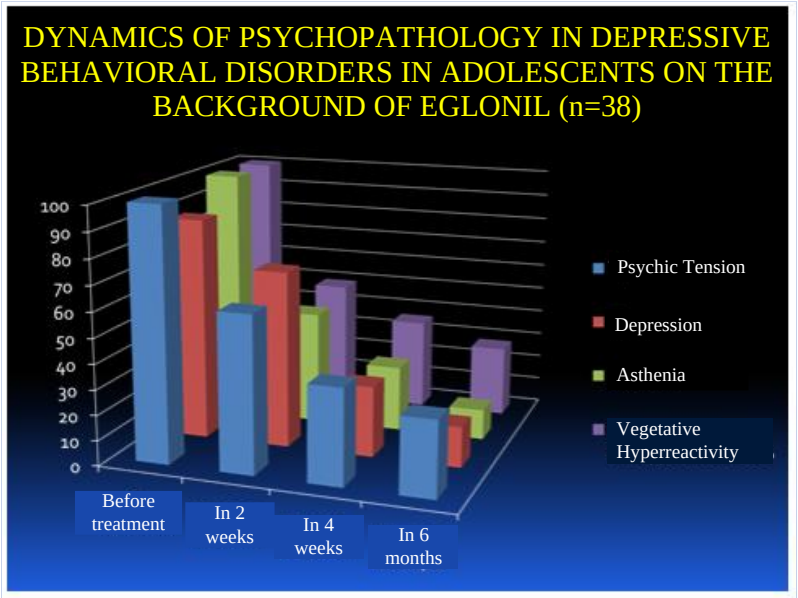

Fig. 2. Dynamics of Psychopathology in Depressive Behavioral Disorders in Adolescents Against the Background of Eglonil Administration

Conclusions. The presence and typology of behavioral disorders in adolescents with depressive disorders is identified. The specifics of age-dependent behavior disorders are established: autoaggression, anorexia, destructive behavior in adolescents aged 12-14 years, gaming and internet addiction, gambling, drug-dependent behavior and tobacco smoking in adolescents aged 15-18 years. The effectiveness of alternative therapeutic intervention in adolescents with depression is presented.

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