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SOCIAL PREDICTORS OF DEPRESSIVE DISORDERS IN ADOLESCENTS

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ABSTRACT

The role of social-demographic and psychological factors in predicting of depressive disorder development in adolescents (infantilism, impaired cognitive social functioning, impaired family relations) is clarified. The role of psychotraumatic factors in the formation of depressive behavior disorder (violation of relations with peers and parents) is determined. The informative value of family environment, family adaptation indicators in the formation of depressive disorder in adolescents is determined.

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Introduction. Medical and social relevance of the problem of depression - the main cause of disability in the world, is determined by the fact of its maladaptive impact, which is measured by high values of disease global burden among the population, including the younger generation. Depressive disorders in adolescence are currently one of the most difficult medical problems, given the severe social consequences, which include suicide, violence, drug addiction and behavioral disorders.

The study of psychological aspects of depressive disorders in adolescents problem is becoming particularly important in the context of the growing prevalence of this pathology and the scale of its impact on the psychological well-being and social adaptation of young people [1-3]. Clinical and social prognosis, the choice of therapy and social rehabilitation methods for adolescents with depressive disorders depend on many factors assessment [4]. In the context of rehabilitation, it is especially important to determine the internal picture of the disease, imprinting psychological problems of a child with depressive disorders [5-6]. Researchers note that in adolescents, depression has a predominantly recurrent type of course, is associated with behavioral disorders, which complicates mental adaptation in the future [6]. Depressive disorders in adolescents are almost rarely diagnosed, because these conditions have different masks, and this complicates early diagnosis and therapy.

Sources of psychological destabilization and factors of formation of predisposition to socially negative behavior of adolescents with depressive disorders are: the crisis state of society, destructive aggression of mass media, instability of the intra-family environment, destructive changes in the motivational sphere against the background of biological and constitutional status in the absence of a comprehensive active planned program for the prevention of mental health protection of children and adolescents.

Purpose of the study. The purpose of this work was to study the clinical and psychopathological, social-ecological and psychological patterns of depressive disorder in adolescents in age and gender aspects.

Research materials and methods. 102 patients withdepression were examined, including 48 adolescents aged 12-14 (22 boys and 26 girls), 54 adolescents aged 15-18 (26 boys and 28 girls). Clinical and psychopathological, pathopsychological (depression detection test CDRS-R, structured psychological interviewing, Lusher test, 10-word memorization test, Platonov-Schulte tables, neurotic state test (B.D. Mendelevich); assessment of the features of family education (questionnaires

"Analysis of Family Education and the Causes of its Violation" ACB, (Eidemiller E.G., Dobryakov I.V., Nikolskaya I.M., 2007); Spielberger scale for assessment of personality and reactive anxiety; projective drawing tests, general clinical impression scale (CGI), Columbia University suicide severity scale (C-SSRS) (Posner, K. et al.)) were applied.

Results and their discussion. In all the adolescents studied, symptoms of depressive disorder showed a decrease in the mood background, irritability, anxiety, somatological symptoms, and sleep disorders. Based on the clinical manifestations of the disease, clinical variants of depressive disorder in adolescents were established, taking into account age and gender, structure and direction of affect, locus of externalization and interiorization of affect, which is essential in determining the tactics of treatment, rehabilitation and preventive measures.

Adolescents with depressive disorders have been found to have symptoms that determine signs of externalization of behavioral disorders – cognitive dysfunction, aggression, risk-taking, vulnerability to damage and trauma, rule violations, and age regression. Anxiety, infantilism, cognitive dysfunction, and the behavioral equivalent of affective disease – aggression are components of the psychopathology of depressive behavior disorder in adolescents.

Clinical variants of depressive disorder in adolescents are represented by the predominance of the dysphoric variant (63.7%). Apathetic and anxiety-obsessive (15.7% and 20.6%, respectively) variants were less common. Gender differences in clinical variants of depressive disorder were determined in the cohort of adolescents studied: in the group of boys, in comparison with girls, the dysphoric variant was significantly more often registered (73.5% and 57.1%, respectively). The apathetic variant of depression was significantly more often registered in the group of adolescent girls (35.7% and 11.8%, respectively). The anxiety-obsessive variant was registered in both boys and girls without a significant difference (14.7% and 7.2%, respectively).

In the study cohort of adolescents with a history of depressive behavior disorder at earlier stages of ontogenesis, a predominantly recurrent type of depression was recorded (62.9%). 29.0% of adolescents have recurrent episodes of depressive disorder, and 8.1% have bipolar depressive disorder.

Variants of disturbed behaviors in adolescents with depressive disorders in the age aspect are identified. Adolescents aged 12-14 years – auto aggression, eating disorders, destructive behavior; adolescents aged 15-18 years – internet-dependent behavior, behavioral disorders associated with the use of drugs, tobacco, alcohol. All subjects had a pathological (or borderline) level of neurotic depression. Pathological (or borderline) manifestations of anxiety (75.0%), obsessive-phobic disorders (75.0%), asthenia (85.0%), hysterical response type (70.0%) and vegetative disorders (35.0%) were also recorded at the same time. Consequently, the depressive state in adolescents was characterized by significant comorbidity.

Table 1 shows a list of psychotraumatic factors involved in the formation of behavioral disorders in adolescents with depressive disorders.

Thus, among the factors of psychological deprivation, the most significant in the formation of behavioral disorders in adolescents with depressive disorders, were registered: group autoaggression, population subculture (75.4%), destruction of personality defense mechanisms as a result of alcohol, hypnogenic drugs and drugs (40.2%), chronic frustration due to peer violence (38.2%), quite often a combination of several psychotraumatic factors (87.2%).

Auto aggression was significantly more often recorded in the cohort of girls compared to boys (89.3% and 14.7%, respectively, $p < 0.005$). Most of them were cuts in upper and lower extremities, in shoulders, neck. Selfies were registered only in teenage girls (39.3% and 0.0%, respectively, $p < 0.005$). Extreme sports were registered only in the group of children with depressive disorders (14.7% and 0.0%, respectively, $p < 0.005$). Super-valuable psychopathological seizures were reported in one-third of patients with depression, regardless of gender (35.3% and 32.2%, respectively). Immoral and not-moral behaviors were significantly more common in the group of children with depressive disorders (35.3% and 21.4%, respectively, $p < 0.05$). Immoral behavior was expressed in the form of actions and activities, the results of which objectively contradict ethical standards and do not depend on the assessment of the person who performs them. Non-moral behavior is immoral deviant behavior that is assessed by a person as immoral. Deviations in the style of behavior in adolescents with depression were characterized by style changes and disorders (deviations in the style of movement and behavior – facial expressions, gestures, movements; deviations in the style of speech – pronunciation, voice; deviations in the style of gaze). Suicidal behavior in adolescents with depressive disorders was 15.7%. The structure of suicidal behavior in adolescents with depression is represented by demonstrative and affective types with frequent relapses. Among adolescents with recurrent suicide attempts, a psychological tendency to

delinquency and signs of social maladaptation (leaving home, grouping with antisocial adolescents, lack of motivation to attend school) were significantly more common.

Table 1. List of Psychotraumatic Factors Involved in the Formation of Behavioral Disorders in Adolescents with Depressive Disorders

Psychotraumatic Factors	Patients with depressive disorders, n = 102	
	N	%
Loss of beloved	21	20.6
Hurt self-esteem	37	36.3
Destruction of the protective mechanisms of the individual as a result of the use of alcohol, hypnogenic narcotic drugs and drugs	41	40.2
Chronic frustration in connection with peer violence	39	38.2
Chronic frustration in connection with parental violence	32	31.4
Chronic frustration in connection with violence by teachers	11	20.5
Group auto aggression of population subculture	77	75.4
Psychological problems, related to sexual violence	8	7.8

A test for alcohol-related disorders (AUDIT-alcohol test) showed that half of adolescents with depressive disorders drink alcohol. In boys, this indicator is significantly more common than in girls (55.9% and 46.4 %, respectively, $p < 0.05$). From publications devoted to the AUDIT test, it is known that "drink" at the level of up to 7 points (inclusive) is considered relatively safe; 8-15 points – dangerous; 16-19 points – accompanied by harmful consequences and, finally, 20-40 points – accompanied by all signs of clinically expressed dependence. The rating of average values of alcohol addiction severity in adolescents with depressive disorders was beyond the "threshold" of relative safety (more than 7 points). A latent inferiority complex was registered in all the studied adolescents. Sociability combined with fear is registered in more than half of adolescents, regardless of age and gender.

The desire to tell lies was reliably more often registered in boys aged 15-18 compared to boys aged 12-14 (57, % and 33.3%, respectively, $p = 0.01$.)/ The desire to blame others, knowing that they are innocent, was reliably more often registered in boys aged 12-14 compared to boys aged 14-18 (31, % and 26.7%, respectively, $p < 0.05$). This indicator was found in 50.0% of girls, regardless of age. The indicator of "desire to avoid responsibility in decision-making" is quite high in children, regardless of age - 86.7% in patients aged 12-14 years and 89.5% in adolescents aged 15-18 years. Stereotyping and repeatability of behavior in general were recorded in 67.7% of the studied adolescents. In girls aged 15-18, this indicator was significantly higher than in girls aged 12-14 (78, % and 66.7%, respectively, $p < 0.05$).

Indicators of neurotic states of adolescents with depressive disorders were determined. All subjects had a pathological (or borderline) level of neurotic depression. Pathological (or borderline) manifestations of anxiety (75.0%), obsessive-phobic disorders (75.0%), asthenia (85.0%), hysterical response type (70.0%) and vegetative disorders (35.0%) were also recorded at the same time. Consequently, the depressive state in adolescents was characterized by significant comorbidity.

A study of situational (SA) and personal (PA) anxiety in adolescents with depressive disorders was performed. The average level of situational anxiety was (47.1±1.61) points. High SA levels were observed in 55.6% of adolescents with depressive disorders. The average level of personal anxiety was (54.2±1.37) points. A high level of PA was observed in 84.4% of adolescents with DD.

In the study of emotional state features, according to color projective diagnostics, it was determined that frustration of the need for self-realization, grievance experiences were recorded in 33.3% of patients; frustration of the need for emotional intimacy, anxiety - in 31.1%. Maladaptive methods of compensation in the form of protest reactions were observed with the same frequency (31.1%). Excessive criticism, skepticism, and arrogance were characteristic of 28.9% of adolescents with depressive disorders. Tendency to detachment, communication avoidance was observed in 24.4% of patients. Frustration of the

need for expectations, feelings of disappointment, loss of interest were observed in 71.6% of patients; humiliation, loss of self-esteem – in 87.3%, somatization of conflict - in 66.7%.

The following symptom complexes of pathological family relations of adolescents with depressive disorders that form behavioral disorders are determined: chronic conflicts in the family, hyper protection in relation to the child, projection of their own undesirable traits on the child, anxiety, hostility in the family situation, phobia of losing a child. When studying inharmonious aspects of parental impact in families of adolescents with depressive behavior disorders, it was found: hyper protection in relation to the child (42.9%); insufficient requirements-responsibilities (48.6%); insufficient requirements-prohibitions (34.3%), minimal sanctions (40.0%). In the structure of personal qualities of parents that contribute to the formation of false educational strategies, the first place was occupied by the phobia of losing a child (31.4%) and the projection of their own undesirable traits on the child (31.4%). Some parents experienced shifts in attitudes towards the child's gender (17.1%) and educational uncertainty, in which there is a redistribution of power in favor of the teenager (14.3%). According to the parameter of expressiveness in kinship relations, according to estimates of adolescents with depressive behavior disorders, low rates (46.5%) were diagnosed three times more often than according to estimates of parents (12.1%, $p<0.01$), which indicates the inability of adolescents to act openly and express their feelings, fearing deterioration of attitude or psychological destruction. Estimates of family cohesion in adults and adolescents varied significantly. Adolescents saw mostly disconnected, i.e. extremely emotionally separated relationships (53.1% vs. 17.7% for parents, $p<0.001$). Parents saw mostly connected (i.e. balanced emotionally belonging) relationships – 44.1% vs. 21.9% in adolescents, $p < 0.05$, or even linked, overly emotionally involved relationships-26.5% vs. 6.3% in adolescents, $p < 0.01$. Estimates of family adaptation of parents and adolescents were similar, with a predominance of flexible (38.2% and 43.8%, respectively) and chaotic (52% and 40.6%, respectively) options.

The assessment of the social climate in families of adolescents with depressive disorders was performed according to the family environment scale (FES) in three areas: indicators of relations between family members; indicators of personal growth; organizational indicators. Indicators of the social climate were determined by both survey of parents and survey of adolescents with depressive disorders.

Among the acute (high or low) indicators in parental assessments of relationships, it should be noted, first of all, high conflict-free (45.5%), that is, an excessive tendency to avoid confrontation, avoid sharp corners in relationships, inherent in almost half of families, according to the parents surveyed, low (30.3%) or, conversely, high (27.3%) cohesion.

Conclusions. Social and psychological determinants of depressive disorder in adolescence were determined. The role of deteriorated family adaptation was determined in the course and formation of depressive disorder behavior.

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