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PSYCHOPHYSIOLOGICAL MECHANISMS OF DEPRESSION AND THEIR PREVENTION IN THE ADOLESCENT ENVIRONMENT

Resume: Depression is a dangerous psychological disease that can occur in a child during adulthood. At this point, it is very important to notice the first signs: if you do not start treatment in time, the disease can develop into a chronic form and manifest itself in adulthood with more severe consequences.

This article discusses the issues of the occurrence of depressive states in young people, their specificity at different ages, prevention.

Key words: depression, prevention, young age, Hamilton scale.

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ПСИХОФИЗИОЛОГИЧЕСКИЕ МЕХАНИЗМЫ ДЕПРЕССИИ И ИХ ПРОФИЛАКТИКА В ПОДРОСТКОВОЙ СРЕДЕ

Резюме: Депрессия – это опасное психологическое заболевание, которое может возникнуть у ребенка в период взросления. В этот момент

очень важно заметить первые признаки: если вовремя не начать лечение, заболевание может перерасти в хроническую форму и проявиться уже во взрослом возрасте с более тяжёлыми последствиями.

В данной статье рассматриваются вопросы возникновения депрессивных состояний у молодежи, их специфика в разном возрасте, профилактика.

Ключевая слова: депрессия, профилактика, молодой возраст, шкала Гамильтона.

Relevance. Depression is a psychiatric disorder characterized by a decrease in mood, loss of the ability to experience joy, impaired thinking and inhibition of motor activity[3].

Depression can occur in people of any age, even infants, but depending on age characteristics, the course of depressive disorders has its own characteristic signs [5,7].

Depression is currently one of the most common affective disorders. For many years, child psychiatrists rejected the idea of depression in childhood[1]. It was believed that the symptoms of depression are normal and temporary manifestations inherent in certain stages of childhood development[8]. However, depression for children and adolescents is the same problem as for adults.

Currently, it is known that reduced mood disorder in childhood is a common, not always recognizable severe disorder, the prevalence of which is constantly increasing and ranges from 20% to 85%[2]. Diagnosis of depression is often difficult due to extreme variability, instability and diversity of manifestations, masking somatic and vegetative symptoms, the influence of many external, environmental factors. The course of depressive disorder in the form of typical melancholy, when the diagnosis is unambiguous and the therapeutic tactics are determined, is relatively rare in children[4].

Unlike adults, the most striking symptoms of depression in a young person are often irritability or a feeling of anger, which may prevail over the usual depressive manifestations.

At a young age, a person develops rapidly physically, mentally and socially[1,6]. Young age is an important period in terms of the development of mental health. Already the child may show signs of depression, expressed in anxiety, self-isolation and behavioral disorders. The probability of depressive periods increases greatly in adolescence and subsequent age. Adolescence is characterized by experiencing strong feelings, as well as despondency and a dreary mood.

It is necessary to distinguish depression from the mood swings characteristic of adolescence[3,5]. Unlike adults, the most striking symptoms of depression in a young person are often irritability or a feeling of anger, which may prevail over the usual depressive manifestations.

The symptoms of youthful depression, however, also include the feeling familiar to adults that things that previously brought pleasure cease to interest[9]. It is necessary to take care of youthful depression when the behavior of a young person has changed significantly in comparison with the past.

Depression, at least, its diagnosis among girls is more common than among boys. Social support is extremely important for a depressed teenager or young person. Good relationships with friends and parents contribute to recovery[4,8]. It was revealed that the majority of young people suffering from depression have some other problems at the same time.

The most common are drug use, attention and behavior disorders, as well as eating and anxiety disorders. There are effective methods of treating all of these problems.

Hamilton Depression Rating Scale for Depression; HDRS is a clinical manual developed in 1960 by M. Hamilton (University of Leeds, UK) to

quantify the condition of patients with depressive disorders before, during and after treatment (observations of clinical dynamics)[1].

In addition to being widely used in clinical practice, this scale is also used in clinical trials, in which it is the standard for determining the effectiveness of medications in the treatment of depressive disorders[5]. Filled in by a clinician with experience in mental health assessment.

The purpose of the study. The aim of the study was to optimize the Hamilton Depression Assessment Scale (HAM-D) in terms of the constructive validity of diagnostic points.

Materials and methods of research. We have carried out psychometric processing of HAMD in order to improve its diagnostic properties when used in the population of Andijan.

The study was conducted on the basis of the Hamilton Scale. The sample of subjects included 150 patients with depression of varying severity. The evaluation of the constructive validity of the items was carried out after constructing a Hamilton scale model based on the values of the indices of correspondence of the simulated responses to the observed responses of the subjects.

The results of the study. The methodological basis of the MSR consists in constructing the most plausible measuring scale based on a probabilistic analysis of the interaction of the respondent's responses, diagnostic points and the total score on the scale. Scales created on the basis of MSR are characterized by high stability of parameters and interpretation criteria, reliability and accuracy.

As a result of processing hamd using Rush metric technology, a 10-point modified depression assessment scale was created, characterized by sufficient reliability, including 10 valid points and capable of differentiating 7 statistically significant levels of depression severity. The Rush metric system contains implicit methods for checking the constructive validity of the scale based on the analysis of residuals. The smaller the value of the residuals from the difference

between the simulated and observed probabilities of the subjects' responses to diagnostic points, the higher the constructive validity of the scale. However, for a comprehensive assessment of the constructive validity of the scales created on the basis of the MSR, the study of convergent and divergent validity is of actual interest. These types of validity are directly related to the objective verification of the constructive validity of the scale. Convergent validity implies a relationship between scores on different scales measuring the same construct. Divergent validity means that there is no connection between scales evaluating different constructs.

During the research, I learned how to diagnose, process and analyze the data obtained. In the practical part of my work, the results of a diagnostic study are reflected and recommendations for adolescents and their parents, teachers on the prevention of depressive states are developed.

Depressive states in adolescence are dangerous in their consequences and are often combined with other problems, such as eating disorders, suicidal behavior, neuropsychiatric stress.

Depression is a fairly common phenomenon among adolescents. I often meet peers and younger guys who are most often depressed and in a bad mood. This prompted me to learn more and better understand what is happening to them and what it is.

Typing information for the theoretical part, I learned a lot of new things for myself. For example, what are the symptoms of a depressive disorder and what to do if a teenager has any.

The practical part helped me find out if there are teenagers in my environment with a tendency to depression or if one of them has it. It helped me to learn more about the condition of the guys around me.

In children up to a year old, when separated from their mother, there is a so-called anaclitic depression, which initially manifests itself as motor anxiety, crying, despair, after that comes lethargy, loss of appetite, weight loss, apathy,

refusal of games, sleep rhythm disturbance, decreased or disappearance of reactions to external stimuli, delay in the development of the psyche and motor skills.

Age-related features of depressive disorders in young children are divided into adynamic and anxiety depression. Symptoms of adynamic depression are lethargy, slowness, monotony, and anxiety depression is manifested by capriciousness, tearfulness, motor anxiety, negativism.

For depressive disorders in preschool children, vegetative and motor disorders are characteristic, but at the same time, a bad mood is noticeable in the appearance of children: facial expression, posture, quiet voice, complaints of unpleasant sensations in the extremities.

Depressive disorders of primary school children manifest themselves in behavioral disorders: lethargy, isolation, loss of interest in games, learning difficulties, less often irritability, aggressiveness, absenteeism.

In adolescence, depressive affect is already manifested, which is combined with vegetative disorders: sleep disorders, appetite, headaches. Boys often show irritability, girls - tearfulness, lethargy, depression. Ideas of self-accusation and hypochondria often arise.

Age-related features of depressive disorders in the elderly (late) age are associated with the process of age-related involution. A depressive reassessment of the past is characteristic (the past is perceived as happy and prosperous), fear for health and fear of financial difficulties. With age, anxiety-hypochondriac and anxiety-delusional disorders become more frequent, in which sleep disorders, appetite changes in body weight are characteristic.

Conclusion. The original Hamilton depression scale, when compared with the Rorschach method, is characterized by low convergent validity and reduced divergent validity. The low convergent validity is due to the disturbed monotonic connections between the overall score on the scale and the severity

levels of depression. Signs of low convergent validity are low values of correlations with indicators of depression and depression.

A comparative assessment of the correlations of HRSD and HRSDm with the indicators of ISIPMER found that the Hamilton scale modified on the basis of MSR has significantly higher correlations with the indicators of depression of the Rorschach method.

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