THE QUESTION OF THE FEATURES OF CLINICAL AND IMMUNOLOGICAL PARAMETERS IN THE DIAGNOSIS OF JUVENILE DEPRESSION WITH "SUBPSYCHOTIC" SYMPTOMS

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Abstract. *In modern psychiatry, an interdisciplinary approach to the study of mental disorders is most in demand. More research has focused on finding the biological basis of mental illness. The issues of their pathogenesis and pathodynamics have not been resolved, especially in the context of biochemical anomalies caused by the disease.*

Keywords: *mental illness, subpsychotic symptoms, depression, diagnosis, feature.*

Introduction. The current appeal to the problem of chronic depressions of minors is determined by their high prevalence, vague approaches to diagnosis and nosological assessment, as well as difficulty in choosing appropriate therapy strategies. In modern studies dedicated to long-term depression, there is practically no information about the characteristics of these conditions in adolescence [1]. However, according to epidemiological data, the rate of chronic depression in adolescence ranges from about 1.5% to 3% in the total population, with chronic depression accounting for about 20% among all depressions of this age. The high risk of chronification of depressive states in adolescence is associated with certain neurobiological and hormonal changes, which increases the particular weakness of the brain at a certain age, in particular, its sensitivity to stress hormones [2-4]. At the same time, these features, as well as disturbances in interpersonal interaction, social, educational, labor malfunctions, provoke atypia and polymorphism of the clinical picture of young chronic depressions, the breakdown and variability of psychopathological symptoms, a high frequency of comorbid mental disorders, wear of the thymic component [5]. Due to such an effect of the characteristics of adolescence on the psychopathological structure of chronic depressions, it is impossible to extrapolate the data obtained from the study of chronic depressions of a mature age for a certain age period [6, 7].

At the same time, morphofunctional changes in the main body systems observed in adulthood and restructuring of regulatory mechanisms play an important role in the formation of depressive disorders, lead to polymorphism of their pronounced atypical and clinical picture, increase the risk of developing side effects caused by psychopharmacotherapy, high frequency of comorbid pathology, which aggravates the course of the disease, worsens the prognosis, timely and correct diagnosis, often leads to the wrong choice of therapeutic strategy [8-12]. The latter is an additional factor in the chronification of the depressive state, and also helps to incorrectly identify depression as resistant if there is no therapeutic response [13].

It should be noted that there are many works dedicated to depression in youth, in which a very high frequency of chronification of these conditions (up to 20%) is highlighted, but there are

no special studies on long-term depressive states of this age. It should be noted that the fact of chronification significantly changes the structure of depression, gradually directing the direction of disorders to negative affectivity. Symptomatology is characterized by homogeneity, monotony, poverty of psychopathological symptoms, their gradual stereotyping and poverty [14-17].

The analysis of the effects of the painful stage, taking into account the peculiarities of the clinical picture of young chronic depressions and the patterns of development, predictive assessment criteria, as well as the influence of constitutional and personal characteristics on the formation of young chronic depression, remains unexplored. It is also required to clarify issues of nosological assessment of developing adolescent chronic depressions within endogenous mental disorders of the spectrum of Affective and schizophrenia [18-21].

Neurocognitive disorders and the properties of the neuroimmune state under similar conditions have not been studied. Algorithms for the treatment of chronic endogenous depressions of adolescents have also not been developed, taking into account modern psychopharmacological drugs and socioreabilitation methods [22-24]. Thus, the high frequency of juvenile chronic endogenous depressions, the complexity of diagnostic and nosological differentiation, the absence of detailed study of the clinical and psychopathological structure, the identification of predictive assessment criteria, unresolved issues of the choice of therapy determine the importance and necessity of the study [25-30]. In assessing the general condition of patients with endogenous mental disorders, it was found that the parameters of immunological reactivity determined in their blood are important. Previously, our studies showed that the acute stage of the disease is accompanied by the activation of inflammatory reactions (an increase in the enzymatic activity of Leukocyte elastase (Le) and an increase in the functional activity of an A1-proteinase inhibitor (A1-PI)) and the most severe and highly progressive forms of mental disorders are accompanied by the activation of autoimmune reactions (increased levels of autoantibodies to neuroantigens - to S100B and the main myelin protein (OBM)) [31-33]. All of the above is of particular importance in terms of the most relevant direction to date in search of the first signs of schizophrenia. Among the criteria for" psychotic risk", the main thing is the presence of" subpsychotic " symptoms, which are understood to be weakened psychotic experiences that are not part of the criteria for psychosis. Most often, "subpsychotic" symptoms occur in men in adolescence as part of depression [34-37]. The purpose of the study: to identify the possible differences between clinical and immunological parameters in the diagnosis of adolescent depressions with "subpsychotic" symptoms in order to determine the next course.

Research materials and methods. At the time of admission to the clinic in 2020-2022, patients with depressive disorders aged 68 years (16-25 years) were examined, who were diagnosed with "subpsychotic" symptoms that did not correspond to the actual psychotic level. As for the nosological differentiation of these cases, following the criteria of the formalized ICD-10, preliminary diagnoses were identified, according to which patients were divided into 3 groups: 1 Group (33 people – 48,5%) – mood disorders (F31. 3, F31. 4, F32 (f32. Except 2), F33 (except F33.3), F34.); Group 2 (17 patients-25%) psychopathic decompensation (F60), group 3 (18 patients-26,5%) schizotypal disorder (F21). Patients with concomitant mental (previously psychotic attacks, severe negative symptoms, organic mental illness, addiction to drugs), somatic or neurological pathology have been removed from the examination, making the examination difficult. Psychometric (HDRS scale for assessing depressive disorders and SOPS for qualitative and quantitative determination of" subpsychotic " symptoms), as well as clinical-psychopathological and statistical methods, have been used. Serum patients were identified: spectrophotometric method-enzymatic activity of Le and functional activity of A1-PI; enzyme -

linked immunosorbent analysis - to neurospecific antigens-S100B and levels of autoantibodies (AAT) to the main myelin protein.

Results and discussions. When a careful psychopathological examination was carried out, the "subpsychotic" symptoms contained in adolescent depressions were divided into the following types: Type I (19 patients – 28% of cases) on the mechanism of development of acute sensory delirium; type II (20 patients – 29,4% of cases) on the mechanism of acute catatonic disorganization (19 patients -14 patients-20,5% of cases); Type IV (15 22,1% of cases) on the mechanism of pathognomonic thought disorders. Briefly describing the characteristics of the "subpsychotic" symptomatology of selected species, we can say that type i psychotic experiences are represented by sudden, abortive and unstable psychopathological phenomena, similar to the process of "crystallization of delirium", accompanied by the effect of confusion.

Often elementary deceptions of perception appeared-ocliki, tactile sensations, pareidolic illusions, hypnagogic and hypnopompic hallucinations. Type II subpsychotic experiences are represented primarily by inconsistent ideas associated with sketchy ideas of exposure, the evil eye, and damage, which are accompanied by the formation of avoidant behaviors. Type III symptoms often reached temporary psychotic levels, but did not fall into the diagnostic criteria for "acute polymorphic psychotic disorder"due to the short term (minutes, hours). Such phenomena appeared more often after exogenous provocation and were ridiculous. Cognitive disorders similar to type IV schizophrenia were manifested in the form of breaks, currents, confusion of thoughts, short-term difficulties in expression, difficulty in perception. Thoughts could not be controlled, a stream of abstract meaningless figurative images was recorded.

In conducting a psychometric assessment of the severity of "subpsychotic" symptoms on the SOPS scale, the following results were obtained: in Type III patients, statistically significant differences were obtained in the subschall of positive symptoms compared to type IV patients and in the subschall of general symptoms compared to type II patients. Also, Type III patients scored the most points in the disorganization subchannel compared to type i ($p=0,06$), type II ($p=0,017$), and Type IV ($p=0,03$) patients.

An assessment of the severity of depressive disorders found more accurate depressive symptomatology on the hdrs scale compared to type III ($p=0,08$) and Type IV ($p=0,07$) patients in type i patients. Also, type i patients had higher overall symptom severity on the SOPS scale than Type II patients ($p=0,04$). Differences in the dynamics of development of depressive and "subpsychotic" diseases have also been identified.

Thus, in type i patients, "subpsychotic" symptoms developed at the height of depressive disorders and are usually characterized by a very short duration. With Type II, the parallel development of these diseases with depressive experiences and the reverse dynamics of subpsychotic and depressive disorders were noted. Type III patients were characterized by the development of depressive disorders following subpsychotic experiments. Type IV subpsychotic disorders have been identified prior to depressive symptoms and persist after its reduction.

In immunological examination, an increase in Le and A1-PI activity compared to the control group was found in all four types of patients ($p<0,001$). An intertipological comparison found that type i patients had significantly higher Le activity than Type II ($p=0,03$) and Type III ($p=0,001$) patients. In type i patients, AAT levels were statistically significant compared to S100B in Type II and Type IV patients ($p=0,018$ and $p=0,04$).

In the study of clinical and biological relationships, the following correlations were found: severity of negative disorders in type i patients-Le activity and SOPS scale ($p<0,05$); in Type II patients-severity of depressive symptoms on primary myelin protein AAT scale and hdrs scale

(p<0,05); in Type III patients AAT level S100B and severity of positive symptoms on SOPS scale (R=0,71, p<0,05).

Conclusions. The findings suggest different mechanisms for the development of "subpsychotic" symptoms in patients with adolescent depression, which may mediate different nosological affiliations of the described conditions. Early detection of" subpsychotic " symptoms helps to prescribe an adequate therapeutic response that can affect the course and outcome of the disease later.

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