ANALYSIS OF FORMS OF OBSESSIVE COMPULSIVE DISORDER IN ADOLESCENTS

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Annotation. This article is devoted to the analyzing the prevalence of obsessive-compulsive disorder in adolescents and assessing its severity at the ages of 10-11 and 15 – 16 . This period has been taken because it is called transitional, since at this time the child moves from a child's model of behavior to an adult. In addition, during this period the teenager experiences serious physiological changes.

Key words: obsessive – compulsive disorder, teenagers, psychological problems, threats, psychasthenic character, compulsion.

Nowadays we cannot deny that psychological problems become more and more actual issue of teenagers. Rapid changing in technologies, a huge amount of unverified information certainly leaves a mark on the psyche of teenagers. At the beginning we should understand that obsessive – compulsive disorder is a mental psychological state that combines a group of obsessive-compulsive syndromes (symptom complexes) associated with obsessive thoughts and actions, which get their name from the Latin words “obsession” and “compulsion”. To put it simply, obsessions are obsessive illogical thoughts, and compulsions are irrational actions imposed by them, which together are interpreted as an obsessive state.

Persons with a psychasthenic character are more prone than others to the occurrence of obsessive states - suspicious, superstitious, emotionally labile, prone to dramatizing events. In addition, factors such as:

• Mental trauma and associated memories and experiences.
• Stimuli that coincide with those that in the past provoked feelings of fear.
• Conflict situations that caused significant stress.

As for the hidden causes of obsessive – compulsive disorder, they may be due to the mental characteristics of a particular person[1.p. 400 – 405].

The initial stage of development of obsessive – compulsive disorder usually occurs in adolescence and young adulthood (10-25 years). Moreover, it is during this period that the most pronounced clinical picture of the disease is observed, the main manifestations of which are the following symptoms:

➢ The presence of obsessions - spontaneously arising painful thoughts, ideas and images that forcibly invade a person’s thinking, which he is trying to resist. This confrontation between the occurrence of obsessions and attempts to fight them can cause deep internal conflict in the human psyche. The form of obsessions can be very diverse - individual words, phrases, poems, song verses,

images, scenes, etc. Moreover, they can be quite shocking, lustful, obscene and disgusting.

- The emergence of obsessive stimuli - urges to commit certain actions, including dangerous, shameful and even sadistic. For example, running across the road in front of moving traffic, undressing in a public place, shouting obscenities, or even hitting a child.

- Performing obsessive rituals, of which there can be two options:

1. Mental in the form of mental repetition of a count or certain words. In this case, counting is often combined with words. For example, say the words “nothing will happen” or “everything will be fine” 6 times, and repeat this procedure three times. And also end with a verse of some unknown reason chosen song or poetic lines. The ritual is quite complex and demanding, because at the slightest failure it must be repeated, otherwise, in the opinion of the patient, it will lose its effectiveness.

2. Physical actions that are sometimes striking in their absurdity. For example, if washing your hands too often can be explained by the fear of infection, then looking in the mirror a certain number of times before leaving the house has no logical basis. Over time, rituals can become more complex and become a problem in everyday life and at work.

- Internal obsessive discussions regarding the arguments for and against certain actions. Obsessive doubts can concern even the most simple situations, for example, turning off household appliances, locking locks, fear of hitting someone while driving, remorse due to non-compliance with religious requirements, or the use of obscene language.

- Perfectionism - the desire for order and symmetry, when everything should be perfectly ordered and located in its place.

- Compulsions – regular repetition of actions that are protective and preventive in nature in relation to even the most unlikely situations that are potentially dangerous for the patient himself and his family. Often patients in this case avoid the circumstances and places with which their fears are associated. For example, kitchens where knives are located or workshops with piercing and cutting tools. It is difficult to imagine the torment of a housewife who is afraid to be in her own kitchen or a professional seamstress who is afraid of scissors and needles.

- Superstition, exaggerated attention to everything that may be associated with good or bad luck.

- Obsessive fears (phobias) up to panic attacks[2.p. 26-51].

All these psychopathological phenomena are accompanied by varying degrees of anxiety, which all obsessive and compulsive rituals are aimed at reducing.

Obsessions are also differentiated into the following types:

• Obsessions of neutral content, which include obsessive counting, memories of terms, insignificant situations, obsessive thoughts on neutral topics, etc.

• Contrasting, otherwise aggressive obsessions, which manifest themselves in the fear of harming oneself or loved ones, in blasphemous thoughts and/or sadistic ideas. Such obsessions are completely alien to the patient’s consciousness, are not motivated and are accompanied by strong affective manifestations.

• Obsessions with contamination and/or contamination (mysophobia). This group includes a variety of obsessive fears of contamination by dust, soil, excrement, toxic substances, and pathogens. The latter has become especially relevant today in the era of the coronavirus pandemic.

To assess the severity and dynamics of the clinical picture of obsessive – compulsive disorder, the so-called Yale-Brown scale is used. It consists of 10 points that the patient must answer during a conversation with the doctor. Answers are scored on a five-point scale from 0 to 4 and cover a one-week period. The sum of the obtained indicators allows us to differentiate the severity of obsessive – compulsive disorder symptoms, for example, a sum of up to 7 points indicates a subclinical course, and 32-40 points indicate an extremely severe course of obsessive – compulsive disorder. Comparison of weekly indicators allows us to evaluate the effectiveness of treatment and the course of the disease over time. It should be noted that adapted versions of the Yale-Brown scale have been developed for the patient’s self-assessment of his mental state.

The Yale-Brown scale is a clinical test developed by Wayne Goodman and his colleagues at Yale and Brown universities in 1989. Designed for quantitative determination of obsessive – compulsive disorder components and their dynamics:

1. obsessive thoughts (obsessions)

2. obsessive actions (compulsions)

This scale test consists of two tables and aiming at finding out what is stronger obsessions or compulsions. Both tables have 20 options.

In addition, people are afraid of small objects, such as glass shards or needles, entering the body. Preventive measures on the part of the patient often do not usually attract others, especially when frequent washing and wearing masks become justified and necessary in an epidemic. But when they acquire hypertrophied and irrational forms, it is no longer possible to explain them by excessive cleanliness or disgust. When a patient, under normal living conditions, without a real threat of infection, continues to observe the maximum security regime, does not leave the room and does not even allow loved ones near him, this already threatens complete desocialization and is not justified by the force of habit. Here you need the help of a specialist.

The list of the most common obsessions includes isolated monophobias in the form of movement disorders, most often originating from childhood. These may be such common phenomena as:

• smoothing imaginary falling hair, which actually lies perfectly in the hairstyle;

• getting rid of an imaginary speck in the eye by blinking;

• habitual tics;

• head movements simulating throwing off an invisible headdress;

• biting and licking lips;

• spitting, etc.

All these mono-disorders can be corrected and treated quite successfully, and also rarely progress.

A feature of the course of obsessive – compulsive disorder is the chronicity of the pathological process. The transition to isolated episodes and complete recovery are extremely rare, but a relative positive is that with properly organized treatment, as well as in mild forms of obsessive – compulsive disorder , long-term stabilization of the process and mitigation of symptoms can be achieved, which allows the patient to once again adapt to life in society.

Severe and complicated forms of obsessive – compulsive disorder in the form of various phobias can be persistent, difficult to treat, and often recurrent.

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