CUPRINS

ARTICOLE SPECIALE

- Dimensiunea spirituală a personalității și rolul său în sănătatea mintală
  Aurel Nireștean, Emese Lukacs, Gabriela Buicu, Monica Bilcă, Pokorny Vasile

ARTICOLE DE SINTEZĂ

- Modelul integrativ al psihoterapiei cognitiv-comportamentale în tulburările de personalitate
  Cosmin O. Popa, Mihai Ardelean, Tudor Nireștean, Gabriela Buicu

- Screening-ul depresiei la nivelul asistenței medicale primare - o intervenție cost-eficientă
  Raluca Ileana Nica, Mihail Cristian Pîrlog

- Ideație, comportament și tulburări de dispoziție în boala Parkinson - studiu clinic

ARTICOLE ORIGINALE

- Evoluția simptomatologiei și funcționalității la pacienți români cu episod depresiv major - studiu observațional

- Tulburări psihice în epilepsia copilului
  Elisabeta Racos – Szabo, Iriingó Száva, Anamaria Todoran – Butila

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THE SPIRITUAL DIMENSION OF PERSONALITY AND ITS ROLE IN MENTAL HEALTH

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Abstract:
The concept of mental health is a global concept and is complementary to psychiatry. That is also because psychiatry disorder is often a deformed and caricatured image of mental health. Both mental health and psychiatric disorders implies physical body, psychosis, as well as spiritual dimension of personality. Both of them interfere with individual and collective biography, with community traditions and customs, as well as with cultural, religious, and moral values. In the mental health and personality approaches the dimensional perspective plays a major role. According to this perspective, personality dimensions favor those spiritual experiences that enhance the coping abilities, self-determination, and are representing a way of cultivating those virtues which protect the mental health and allow the human being to respect also those things and events which don't depend of it.

Key words: mental health, personality, spiritual dimension

The term “spirituality” continues to be the subject of great controversy. The diversity of its definitions corresponds to its complexity (Cook, Powell, Sims 2009). No matter the perspective, the spiritual world is a vast territory which integrates not only existential meanings and goals and affective and cognitive references, but also transpersonal beliefs and experiences which lead to a deeper understanding of the connection between psychic normality and abnormality and the normality and abnormality of the personality. Mental health is a global concept complementary to psychiatry which incorporates both a public health objective and a point of reference which is simultaneously individual and collective (Prelipeanu, Mihailescu, Teodorescu 2000). Thus, mental health promotes the totality of objective strategies which aim to protect the wellness of the community in both mind and spirit. It takes into account all the favorable factors, as well as the trigger factors for the diversity of psychic episodes and illnesses. A second component of mental health is the subjective individual and collective state of wellness which is a result of a harmonious personality which integrates and assumes life experiences in a coherent manner. They insure well-balanced interpersonal relationships as well as common ability to reflect and liberating existential values. Knowledge of the governing principles of mental health becomes a major factor in the prevention of mental diseases and contributes decisively to eliminating the stigma associated with mental illness and psychiatry in general. This is due to the fact that both mental wellness and mental illness are conditioned by biology, psychology and social culture, and thus must be discussed taking into account not only an individual’s intentional subjectivity and ability to reflect, but also one’s freedom to decide, act and transcend one’s condition.

Five centuries ago already, the description of a series of vaguely delineated and fleeting psychiatric entities showed the connection between psychiatry and the social and economic environment. Using the health biography of two brothers from Basel, who upon returning to their city of residence, recovered from a severe mental condition, Hofer describes “nostalgia”, a condition which subsequently became very well known in Western Europe. A couple of centuries later, several other fleeting clinical psychiatric conditions such as the hysterical and epileptic pathological fugues, were identified and described. They were called “ambulatory automatisms” in France, and “ambulatory determinisms” in Italy. At the end of the 20th century, “multiple personality” is described by Hacking (1995). The list of psychiatric disorders directly connected to socio-cultural dynamics can continue with impulse-control disorders, PTSD, and Gulf Syndrome which appeared after the Vietnam and Gulf Wars, as well as pathological post-traumatic states induced by certain sadistic abuses whose perpetrators have not been condemned as moral authors of the crime.

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Mental health and psychic diseases must be discussed in terms of the self-conscious human being since they both deal with the biology, psyche, and spiritual values of the individual. Besides, the role of interpersonal relationships, autobiography and collective biography, community traditions and customs, cultural values and religion must always be discussed and emphasized.

It is well known that contemporary society and culture are dominated by science, technology, religion, and community values which all inform, motivate and control the dynamics of contemporary life. Today's culture is one of overproduction and excessive consumption of goods and leisure. It promotes hedonistic living in the present moment as well as an individual's freedom to organize his or her life in a strictly subjective way. New models of success and false values which throw one's aspirations and motivations into disarray and confusion are constantly created. People communicate and befriend one-another through the internet where they are more likely to have superficial, soulless encounters. Though not everything is “proper”, everything is permitted, and promoting moral norms and trust in the law become optional (Nirestean, 2009).

Culture is more and more removed from universal symbols that give it cohesion. It promotes form over substance and it feeds it to a public who readily digests it without discernment. In the spirit of the “new democracy”, everything goes in a world overwhelmed by individualism, which prefers the winners to those who live wisely, no matter the means of their success.

In contemporary society, human beings live for themselves and have a constant and insatiable desire for more. They make quick attempts at reaching peaks of real existential meanings, but are disadvantaged by selfishness and lack of self-control. The individual ego is hypertrophied but lacks substance. It turns within with an inauthentic and vulnerable self-esteem which is fed and sustained by a highly subjective interpretation of events and life experiences (Lipovetzky, 2007). This is the way human beings believe they can achieve the state of subjective wellbeing which is understood as a form of happiness - a main component of mental health.

One's self-image and self-esteem condition each-other in the whirlwind of the search for the perfect moment, of competitiveness and competition, where altruism and empathy have become undesirable. Individual identity is thus built on rationality and knowledge, not on interpersonal harmony, faith, or spiritual experiences. The contemporary “Homo Democraticus” is very different from “Homo Spiritualis”. Nevertheless, knowledge can also bring about wisdom when human beings open up to spiritual values and espouse - even for narcissistic reasons - the way of good intentions.

The structure of one's personality influences the somatic state of health - as is the case with certain cardio-vascular disease which are significantly affected - as well as one's psyche, in which it can be a breeding ground for addictions and a great diversity of psychic diseases. A mature personality takes coherent charge of its life experiences and has the ability to adapt to life's events and to its stress factors.

From a conceptual perspective, mental health must be defined in connection with the various stages of life and its critical periods, and from an utilitarian viewpoint, it is important to develop those factors which protect mental health and mental longevity.

The most appropriate way to understand the connection between personality and mental health is to consider the points of reference of the dimensional perspective. The most commonly used are the ones belonging to the seven factors. For example, during adolescence, a heightened search for novelty and childhood sensations can lead to impulse-control disorders, addictive behavior as well as impulsivity and aggression. During puberty and adolescence, heightened levels of nervousness can facilitate the onset of the metabolic syndrome and of obesity in the years to follow, while being more conscientious protects one's health and longevity. Also during adolescence, having a pleasant, attitude and being conscientious can positively influence self-control and the ability to learn, and protect one's health as an adult. The frequency of negative life events, addictive behavior and mortality rates also diminish. On the contrary, a low level of self-control leads to diminished activity, impulse-control disorders, hetero-aggressiveness, as well as high rates of suicide upon reaching adulthood. At the adolescent stage, the progressive and elaborate access to human values has a positive effect on mental health, in contrast with the transitory access to inauthentic and fleeting values which are so often promoted in contemporary culture.

In adults, having a high degree of nervousness, being unpleasant and not being conscientious can favor obesity, nicotine and alcohol addiction, as well as sustain a persistent pessimism and low self-esteem. On the contrary, being an extrovert means being active and sociable.

The structure of the personality as well as the concept of mental health integrates biological, psychological, social and spiritual components. The subjectivity and intentionality of each individual are constantly completed and changed by one's spiritual needs which connect the individual with the world of the senses, of existential motivations, and self-transcendence.

Spiritual needs reside at the foundation of the homonymous dimension of the personality. It molds together a diversity of attributes which are predominantly conditioned by culture, such as: intellectual abilities, curiosity, vision, originality, logic and depth, artistic and esthetic sense, wisdom, common sense, dignity, humor, but also the ability to control and transcend one's ego. Other major virtues of a spiritual person are tolerance, prudence, the ability to communicate, empathy, gratefulness, the ability to forgive and believe and respect that which we do not understand and which does not depend on us. This diversity of attributes of our spiritual being represents both a source of vitality and motivation, and a major framework of support for building self-esteem and a sense of belonging to the energy of the universe. They can also be said to represent a “divine calling” (Nirestea, 2011).

In view of the above, the connection with the dominant attributes of mental wellness becomes evident. Among them are the self-control, the feeling of personal detachment, the ability to communicate intelligently and empathetically with those around you, the adaptability to stress and resilience or responsible involvement in one's life roles, accompanied by the ability to manage tasks.
which are seen as positive stimuli instead of sources of anxiety (Kobassa, Maddi, Zola, 1983). Optimism and self-assertion- which integrates both the ability to choose a professional option and that of developing feelings of friendship and love, are to be added to the list of characteristics of a mentally stable human being. The complex notion of mental wellness also includes the capacity to access the traditions and products of culture, faith and religion- mystical experiences being among those that confirm the unity of all things... A corollary of this diverse mental health structure is the state of subjective wellbeing with its two components, the cognitive and the affective. This “type of happiness” is fifty percent dependent on the quality of one's life and circumstances, but the rest correlates in an obvious manner to the dimensions of one's personality. Thus, high levels of neuroticism negatively affect the subjective wellbeing, while high levels of neuroticism stimulate it. Low levels of neuroticism allow for the growth of personal aptitudes and talents, and a rise in self-control. They also diminish addictive tendencies, stimulate vigilance, activism, empathy in interpersonal relationships, and group cohesion due to higher correctness and cooperation. The individual’s moral stance is also enhanced, as he or she can only become whole and gain self-worth by being surrounded by others. In the same context, when one is more pleasant, conscientious and outgoing, one is more likely to be also be drawn by meditation, the sacred, and prayer which often enhances one's ability for self-transcendence. A variety of spiritual experiences are enhanced, which in their turn shape and mobilize these dimensions of the personality.

In general, the growth in spirituality significantly influences the individual's psyche and behavior. People with a rich spiritual life can easily decide that God or Heaven is with them, and thus develop self-confidence and self-respect. Supportive, optimistic attitudes, thus sociability sustained by empathy and confidentiality in interpersonal relationships, are also influenced positively. The quality and duration of marriages grows, and in its turn favors longevity and the quality of life. It is a well known fact that the latter are clearly affected in people who live alone. Efficiency and creativity are dominant behaviors, and thus the conditions necessary to living a purposeful life are always present. Consequently, periods of personal satisfaction are more frequent, and existential meanings and motivations diversify. Under these conditions, self-image and subjective wellbeing are enhanced and positively condition each-other and can shape narcissistic type tendencies. Structured in this manner, they have an obvious adaptive role to play, and create a protective framework against various psychic episodes and illnesses as well as behavioral disorders including suicide. Nurturing one's talents as well as spiritual practice- including religious practice- have an obvious therapeutic and rehabilitative non-medical role to play in one's psychological state of being because they contribute to the awareness of illness and one's attitude towards it, even in extreme situations. It also enhances one's attitude of compliance to therapy. This role holds true not only for the superstitions and beliefs of proto-religions, but also under the conditions of religious liberalism and syncretism of contemporary society. All of the above show the complexity of the concept of mental wellness in which the physical person, the psyche, society and the supernatural coalesce.

Mental health is in the end a major attribute of human beings which is protected by the dimensions of personality such as, emotional balance, perseverance, imagination, common sense, wisdom, humor, faith, and the ability to transcend by accessing the sacred and the supernatural. This vast concept constitutes a major existential ideal, not only because “When God wants to punish humans, He first takes their minds away.”

Mature and truly self-aware individuals sometimes ask questions such as, "What is really important in life?"; "What can help us through difficulties?"; “Where and under what conditions do we feel good about ourselves?” "Are we capable of true faith or aligning ourselves with spiritual values?” For those who practice psychiatry, an exchange of ideas and experiences with priests, monks and spiritual counselors would certainly be of great value in answering these types of questions.

From the perspective of spiritual values, the concept of mental health- like the concept of personality- pleads for the union of man, society, nature and the universe. It is confirmed that spiritual beings have both a divine, contemplative, profound nature, and one that is worldly, and the union of the two can lead to all that is good, beautiful, right, emotionally supported and open toward transcendence in human existence. The harmony between the two teaches us to live “with something” and not “for something”, and gives us the freedom and authenticity which are being so strongly challenged in our world today.

REFERENCES
THE INTEGRATIVE MODEL OF COGNITIVE-BEHAVIORAL PSYCHOTHERAPY IN PERSONALITY DISORDERS

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Abstract
In their entirety, personality disorders represent specific clinical nosologies which affect areas of the patient’s functionality, especially in human relations. Cognitive-behavioral psychotherapy involves a number of guidelines/ strategies, most of them benefiting from a solid empirical support; thus, this paper deals with personality disorders from the perspective of the general integrative model of CBT and not from the perspective of a specific therapeutic strategy.

Keywords: cold cognitions, hot cognitions, cognitive restructuring, the ABCDE model, borderline personality disorder, narcissistic personality disorder

INTRODUCTION
The current cognitive behavioral therapy (CBT) paradigm starts from an integrative model that is based on the scientifically proven effectiveness in the psychological treatment of personality disorder (PD) treatments, some therapeutic strategies being derived from other psychotherapeutic guidelines. Thus, CBT is the integrative framework which could facilitate the connection between psychological and pharmacotherapeutic treatments whenever there is scientific support for this co-association. It however, requires a revision of these integrative issues but it is well-known currently that the treatment of choice of PDs is psychological interventions (1).

Personality disorders can be defined as sustainable patterns of some inner experiences found at the behavioral level, which significantly contradict the expectations of the individual, the culture to which he/ she belongs, these models being pervasive and inflexible. They are stable over time and occur in adolescence or early adulthood, and are responsible for the generation of stress and impairment (2). In terms of the model of cognitive-behavioral psychotherapy, personality disorders are associated with a dysfunctional pattern of thinking based and particularly influenced by dysfunctional beliefs/ cognitive schemas, manifested at the behavioral level by difficulty in adapting and in relationships (3) (4) (5). The central beliefs that occur in PD are specific patterns of thinking derived from the negative interaction of the patient and their genetic background with the disadvantaged physical environment in which the individual has evolved (6). Early maladaptive schemas (EMSS) are based on the dysfunctions that occur at one or more levels specific for attachment or development of the individual’s own identity since childhood, and which occur in adulthood in a latent/ manifested way mainly in PDs, being biologically determined (by temperament) (7) (8) (9) (10) (11) (12).

There are several strategies/ therapeutic guidelines that make up CBT, some representing new psychological methods, there already being empirical support that demonstrates effectiveness in the treatment of PDs (13) (14) (15). In terms of comorbidity between PD and a disorder from the non-psychotic psychiatric range, the result of the intervention CBT is as effective as in the case of the unique non-psychotic psychiatric one, especially in the case of co-occurrence between PDs and disorders of anxiety/ depression (16).

Clinically, PDs are worsening and maintaining factors of disorders from the field of psychopathology, but this depends on the specificity and intensity of the PD (17). The complexity of these cases required finding methods and techniques to complement the standard intervention intervention of CBT so that together with psychopharmacotherapy the clinical picture can be improved by the flexibility of maladaptive thinking schemas and the change of some maladaptive behaviors (18).

THE INTEGRATIVE MODEL OF COGNITIVE-BEHAVIORAL THERAPY
Most cognitive theories are based on the assessment of the so-called “cold cognitions” (descriptions/ inferences – e.g. “They are glaring at me and want to hurt me”), namely, what a person thinks in a difficult life situation about that particular situation, and under that assumption negative feelings arise because of these cold cognitions. This is only a half-truth, since “hot cognitions” are actually responsible for generating negative emotions, more precisely the significance a patient attaches to “cold cognitions” (e.g. “I need to be appreciated by people and it is catastrophic if they want to hurt me”). Thus, if a patient with avoidant personality

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disorder has an automatic negative thought in a social situation, such as: “others will laugh at me” (cold cognition), it is not the thought that causes anxiety but the significance that the person gives to the thought: “if they laugh at me, others will reject me and this is an unbearable and unacceptable thing” (hot cognition) (19) (20) (4). Both automatic negative thoughts (surface) and maladaptive cognitive schemas (depth) refer to include both hot and cold cognitions, which may occur in one of the two forms (1).

The application of cognitive techniques combined with behavioral and relaxation one, but mainly the focus of the therapist on modifying hot cognitions, belonging to Cluster C in PD, will result in modification and flexibility of some dysfunctional beliefs, which contributes to remission of comorbidities and to the change of some maladaptive behaviors (21) (22). There are cases in which PDs have a unique, complex, and high intensity specificity (such as Borderline PDs) so that identifying and changing dysfunctional cognitions (hot cognitions) requires a completion through the use of experiential techniques. This is due to the fact that in severe personality disorders causality implies traumatic life events such as sexual/ emotional/ physical abuse in childhood (23) (24).

In the case of such PDs, a storage of traumatic memories in the amygdala is determined by a mechanism similar to posttraumatic stress syndrome, as well as a storage of cognitive traumatic memories in the hippocampus and neocortex (11), these being mediated by the prefrontal cortex. In such cases, CBT is effective on the one hand because of the inhibition of the response of the amygdala that generates negative emotions associated with trauma and which bypass the cognitive system and reasoning, and on the other hand because CBT boosts the response of the prefrontal cortex (PFC), cognitive restructuring having the purpose of alleviating dysfunctional cognitions related to trauma, since the activation of the dorsal prefrontal cortex (DFPC) causes a decrease in activation of the amygdala. This implicitly suggests that the cognitive conscious processes have a role in emotional regulation (25) (26) (27).

As a result, experiential, gestalt, mindfulness techniques and those which address the relationship of the object, cognitive-behaviorally conceptualized, may contribute to increased therapeutic efficacy in PDs, especially when the patient has a history of a trauma or psychotrauma in early childhood. The effectiveness of these techniques is given by the direct approach to early trauma using imagery and role-play, and by associated cognitive restructuring in order to increase the flexibility of dysfunctional beliefs with the aim of determining phenomena of awareness in these patients (28) (29). The resulting therapeutic benefits that stem from cognitive restructuring and awareness are essential in the process of changing maladaptive behaviors in PDs. Theory and, primarily, clinical practice indicates that, generally, PDs are egosyntonic, the patients are not aware of a multitude of reactions and maladaptive behaviors that they have in different life situations (30) (31). Due to this egosyntonic character, in terms of cognitive theory, we might consider that some of these types of behavior are determined by unconscious information processing (32). Identifying unconscious beliefs along with the conscious ones during the therapeutic process contributes to: 1) determining cognitions/ beliefs/ dysfunctional cognitive schemas associated to specific PDs (33), 2) flexibilizing them through cognitive restructuring techniques, 3) the assumption of adaptive thought patterns (34).

In designing the treatment plan specific for CBT, the PD conceptualization of the case has to include a causal/ inter-determination relationship of the stressors such as negative life events (triggering stimuli) and maladaptive cognitive schemas of the patient (which also include biological vulnerability). This interdependence determines the cognitive, subjective/ emotional, and behavioral symptomatic manifestations in these patients (35).

Conceptualization in PDs is important because the patient thus understands the causes and manifestation manner of their psychological problems; this is essential in establishing the therapeutic goals together with the patient. Especially in PDs, a correct conceptualization is done after at least three sessions of clinical psychological evaluation. From a psychometric point of view, the most useful instrument to identify the PD is SCID-II, Structured Clinical Interview, the degree of validity of this instrument being directly proportionate to the therapist's clinical experience (21).

A model of conceptualization that can be applied simply and effectively in PDs (but also in other psychopathological disorders) is the ABC (DE) model. Hyland, and Boduszek (2012) citing Ellis (1958, 1962, 1994), David and Freeman (2015), David et al., (2010) have shown that the ABC model can describe psychopathology in that cognitions are considered determinants of emotional, behavioral, and attitudinal reactions of a patient. In other words, when a person relates themselves to negative life events (A) through a set of central irrational beliefs (cognitive B-schemas: “I value nothing as a human”) he/ she will generate surface dysfunctional beliefs (B-automatic thoughts: “I will not succeed”) which then support the dysfunctional negative emotions and maladaptive behaviors (C). Identifying these irrational beliefs/ central and surface dysfunctional thoughts and their debate/ change (D) contributes to replacing them with rational/ alternative beliefs, which clinically contributes to the remission of the disorder and adopting a style of thinking effectively and rationally (E) (1) (36) (19).

In PDs, this model must be completed and insisted on more, particularly on the relationship between B (beliefs) and C (consequences). Due to cognitive and dysfunctional behavioral patterns, it is necessary to complete the ABCDE model, where D (discussion/ modification) may be supplemented by cognitive diffusion techniques and E by changing the relational framework. Even if diffusion cognitive techniques appear to some extent in cognitive restructuring specific for traditional CBT (37), in the case of PDs they should be applied systematically. This is due, for example, to the thought-action fusion phenomenon that usually occurs in obsessive-compulsive disorder (OCD) (38), but also in several other PDs (31). Hence, a patient with comorbid OCD may think: what if I am going to hurt children? This thought (assessed by hot cognitions “I must not hurt them and it would be catastrophic if I harmed them”) triggers feelings of anxiety because for the patient thinking is synonymous with acting. Cognitive diffusion will focus...
on the separation of the thought of event/ the person itself, the way semantics can influence the development of dysfunctional negative emotions being already demonstrated (39) (40), the patient regarding it as a mental construct, stringing phrases, etc., that is, the patient is taught not to identify themselves with the thought or the thinking process.

Also, another effective technique in these patients is framework changing/ relational context. With its aid, the patient with PD acquires coping adaptive mechanisms that help them learn to accept themselves as a person, to realize that thoughts are just thoughts, to live the present moment and to define the values of life, all of these being the attributes that belong to a psychological flexibility (41) (42).

Generating change in patients with PD is not achieved by using the therapeutic relationship as a framework for change, but by applying an ABC conceptual model in which the autobiography/ life history of the patient is brought to date “here and now” and faced with the current issue of the patient's life. For example, a patient with a narcissistic/ passive-aggressive PD can develop hostile behavior toward the therapist. In that particular moment, using the Socratic dialogue technique (asking questions the answer to which is mostly known by the therapist) the patient is asked “please let me know when, in your entire life, you have felt something identical, how you are feeling toward me/ behaving with me now (hostile feelings), or more precisely under what circumstances?” Reference to similar events in the history of mental illness and reporting to the present with subsequent extrapolation through the same ABC model to a problem that is present in the patient's life makes them understand the source of their problems and thus generate change by changing irrational beliefs/ dysfunctional thoughts (43).

Another important aspect of CBT intervention in PDs will be based on the autobiographical versus semantic cognition model (19). Perhaps more than in any other psychiatric condition, in PDs cold/ hot cognitions affect autobiographical memory, which in turn changes the sense of semantic cognitions. For example, cold cognition in narcissistic PD: “I am special and others must respect me” is related to semantic memory and is interrelated with it. Thus, hot cognition is associated with semantic cognition and determines: “It is terrible and unbearable not to be respected” (as cited by David, 2003) (44). This dysfunctional type of thinking specific to PDs is determined by maladaptive cognitive schemas which, through the bio-psycho-social tendencies they incorporate, influence the behavioral and attitudinal patterns of the patient. Confronting these schemas in PDs can be done both in a cognitive way and through (experiential) imagery with the purpose to change some of the maladaptive behavioral patterns (45) (46) (47). Mindfulness techniques can also be used, but caution is advised in their implementation, particularly because of excessive detachment of the patient from life events, which prevents them to confront their own schemas due to decreased motivation (48).

Since behavioral techniques consist of exposure to the anxiogenic stimuli and behavioral experiments, they can be implemented by combining them with cognitive techniques, first by exposure in the psychotherapist's office (in-vitro), followed by gradual exposure to real anxiogenic stimuli (in-vivo) (49) (50).

CONCLUSIONS:

CBT interventions in PDs require a holistic approach in which treatment involves customization depending on the particularities and specificities of the PD so that the therapeutic plan for these complex cases be based on a multimodal approach. The ABC model is defining both in terms of psychopathological conceptualization, and in terms of the therapeutic intervention itself, focusing on the application of a “bridge over time” in which the patient's past problems are brought to the present, the change thus being generated by modifying irrational beliefs “here and now”. It is necessary that the scientific support as known to date be supplemented with other studies that have immediate clinical application, this relieving the pathology associated to PDs and improving the relating of these patients.

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DEPRESSION SCREENING AT THE PRIMARY CARE LEVEL – A COST-EFFICIENT INTERVENTION

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Abstract:
Over 350 million people worldwide suffer from depression, and it is one of the leading causes of disability across the globe (1, 2, 3, 4, 5). In Europe, approximately 21 million people are affected by depression out of a population of 446 million people. Depression places a burden not only on individuals but also on the society due to its impact on health, social and economic systems. Depression accounts for 1% of the GDP of Europe (8), and amounted to approximately 118 billion euros, which translates to approximately EUR 253 per inhabitant (8). Given the magnitude of the burden of depression, there is a need for efforts to be directed at early identification to improve recovery and enhance treatment outcomes and ideally, to prevent depressive symptoms from developing into a clinical depressive episode. Depression is considered as a common mental health disorder (CMHD) given its high prevalence and many people presenting with depressive symptoms often seek care from their primary care physician or general practitioner first, making the general practitioner an ideal gatekeeper for screening and detection and management of depression (6, 7, 26). Screening for depression at the primary care level can have a significant impact on early recognition and treatment, prevention of the development of more severe forms of depression, better adherence to treatment of chronic conditions, enhancement of recovery outcomes and consequently on the associated costs. According to the studies, despite the high prevalence of depression and the fact that many people experiencing depressive symptoms first come into contact with the health system through their primary care physicians, depression is in fact only identified in 30-50% of instances by primary care professionals (27,34). Early intervention is key as previous research shows that 20% of people who committed suicide visited a primary care physician in the month preceding the suicide (12, 35). The purpose of this review is to search based on the existing studies what are the recommendations regarding depression screening at the primary care level. At present, at the international level based on the existing studies is not a uniform opinion about recommending the screening at the primary care level for depression and about the criteria to be met for the depression screening at the primary care level that could lead to a cost-efficient intervention. It is still incipient the research regarding the efficiency of this intervention and the conditions in which it becomes cost-efficient.

Keywords: depression, screening, primary care

The prevalence of depression regardless of severity among the general population ranges between 8% and 12% (24, 25) depending on the methodological approach and scales used to classify depression, while the prevalence of major depression at the primary care level is 5-10% (23, 24, 32). Of the number of people presenting with depression in primary care, approximately 10-20% have a comorbidity with another non-communicable disease such as diabetes mellitus, cardiovascular disease, or cancer (23, 42). Given the high prevalence of depression and given that the patient first access the primary care services, as in most of countries, Romania being one of them, GPs are the main gatekeeper for a multitude of health problems, including mental health problems, and as they often have many tasks and a high caseload, they require easy to use, quick and effective screening tools that help them be confident in identifying depression and taking action on it.

Depression screening usually implies the administration of questionnaires to people presenting with depressive symptoms by primary care staff (physicians or primary care nurses). Questionnaires can either be self-report or administered by a physician or nurse, having a small or medium number of questions the can be self-administered or can be administered by the family doctor both to the patients with high risk for developing depression such as patients with chronic illness diagnosis (10, 36) but also to the other patients. One of the questionnaires that is frequently used by the primary care physicians to detect depression is patient health questionnaire 2 (PHQ -2), that contain 2 questions namely: Over the last 2 weeks, how often have you been bothered by any of the following problems? 1.During the past month, have you often been bothered by feeling down, depressed, or hopeless? 2.During the past month, have you often been bothered by little interest or pleasure in doing things? The possible answers for each of questions are: Not at all (scoring 0), several days (scoring 1), several days (scoring 1), More than half the days (scoring 2) and Nearly every day (scoring 3). The total scoring ranges from 0 to 6, the authors (44) identified a PHQ-2 score of 3 as the optimal cut point of the screening purposes and stated that a cut point of 2 would enhance sensitivity and a cut point of 4 would enhance specificity. These two verbal questions have also the advantage that are concise and detect the majority of the depression cases (31). The purpose of the questionnaire is to enhance routine inquire about the most prevalent and treatable mental disorder in primary care. The National Institute for Health and Care Excellence (NICE) (15) recommended in the depression guideline that the entire population should be screened for depression at the primary care level, done with the PHQ -
cognitive behaviour therapy (40,41), according to the

8) Accessibility to psychological interventions such as
treatment lasts between 6 months and one year (37)
while clinical guidelines recommend that depression
are offered (37), knowing that there is an attrition rate
7) For the treatment adherence psycho-education services
specialized services (33), patients from rural and isolated
areas being disadvantaged

5) A relatively high number of false positive results of
results of screening, a relatively low number of false

4) Reasonable accessibility of the patients to the
specialized services that can provide evaluation and
comprehensive treatment (medication, psycho-education,
cognitive behaviour psychotherapy) and a possibility for
accomplishing these aspect is the integration of
specialized services in primary care (20).

As a consequence, it is important that randomized
target groups. In addition, there is a concern regarding the
unjustified increase of the number of patients that due to the
correct figure arising from tools, resulting in clients being sent to specialist care when in fact it is not required
(27). On the other hand, studies of primary care patients
have found that health care costs are higher in depressed
patients than non-depressed in many categories, including
primary care visits, medical specialty visits, lab tests,
pharmacy costs, inpatient medical costs, and mental
health visits (8, 9). To illustrate, one study conducted in
England found that patients diagnosed with depression in
Great Britain show that patients diagnosed with depression have costs two time higher ($4246 vs $2371, P < 0.001) compared with the ones that are not diagnosed, this situation remaining similar one year after the initiation of antidepressant treatment ($3971 vs $2644) (28). However, there is still a need to understand how big this problem is: is it more of a cost risk that more people get referred to specialized care when in fact they could be managed in primary care, or more of a problem if people go undetected completed in primary care which is more of an ethical and low quality of life problem.

There are a number of aspects that should be taken into
account when doing depression screening which could influence the result of screening and its cost-effectiveness.
In order to recommend the screening as a cost-effective intervention at the primary care level there are some criteria which need to be met (23):
1) Patients who do not have this diagnosis agree to do the
screening (29)
2) A relatively high number of positive results of screening
are obtained (29)
3) Agreement of patients who screen positively to access the
specialized services for supplementary evaluation that
would validate/invalidate the initial result
4) Reasonable accessibility of the patients to the
specialized services (33), patients from rural and isolated
areas being disadvantaged
5) A relatively high number of false positive results of
screening are obtained (29)
6) Patient agreement for depression treatment one the
depression diagnosis was confirmed (29)
7) For the treatment adherence psycho-education services
are offered (37), knowing that there is an attrition rate
from treatment of 70% in the first three months (38,39),
while clinical guidelines recommend that depression
treatment lasts between 6 months and one year (37)
8) Accessibility to psychological interventions such as
cognitive behavioural therapy (40,41), according to the
recommendation of the NICE clinical guidelines (15).

An overview of the criteria listed above, leads to the
conclusion that a screening program in order to be cost-effective has to take into consideration at least three essential aspects: a relatively high number of positive results of screening, a relatively low number of false positive results of screening and the accessibility to specialized services that can provide evaluation and comprehensive treatment (medication, psycho-education, cognitive behaviour psychotherapy) and a possibility for accomplishing these aspect is the integration of specialized services in primary care (20).

Some previous research studies have found that
depressive symptoms do not change much as a result of
treatment at the primary care level. To illustrate, a 2008 Cochrane systematic review (28) evaluated five randomized controlled trials and found that there is no evidence of a reduction of depressive symptomatology in the general population as a result of depression screening in primary care settings without substantial staff-assisted depression care supports. In another research study from the Netherlands depression screening was done on a sample of 1687 patients with a high risk of developing depressions through a questionnaire sent by mail. Out of the 770 patients that returned the questionnaire filled in, 226 (29%) showing a positive result for depression, only 17 (1%) initiated depression treatment (22).

A research study done by a Spanish group of researchers (19,21), study that respected the randomization criterion and the cluster of patients screened consisted of patients with high risk for developing depression such as those with a depression history, those with somatic symptoms that are not caused by somatic illness and those with psychological comorbidities due to somatic illnesses and those with drug and alcohol abuse, the result showing that the depression rate 6 month after screening (15%) (21) was not different to the one in the control group (15,8%), (average mean difference −0.02 and confidence interval 95%−0.25 la 0.20) (18). In contrast, the American clinical guideline for depression (46) reviewed 9 randomised controlled trials and concluded that screening for depression is cost-efficient in the context of integrated primary care and specialized services but inefficient in the absence of the services' integration (17,30).

In sum, there seems to be mixed results supporting the
notion of screening for depression at the primary care
level. More research is needed for shading light on the
efficiency of recommending the depression screening in
the primary care services (11) and if this should be
recommended to general population or only to indicated
risk groups.

Conclusions:
At present there is insufficient evidence that universal
screening for depression at the primary care level is
beneficial from a cost-effectiveness or detection and
treatment point of view. That being said, primary care
professionals should still be aware of the following two
groups of patients presenting in primary care that should
be screened further for depressive symptoms:
1. Group of patients with high risk of developing depression due to a previous diagnosis of depression, presence of a chronic illness, a family history of depression, unexplained somatic symptoms, traumatic life events and those that have a frequent utilization of services without a resulting diagnosis.

2. Patients who present with depressive symptoms such as little pleasure or interest in doing things, feeling hopeless, chronic fatigue or insomnia.

The RCTs done up to now have inconclusive results with regards to the reduction of depressive symptoms and disappointing due to low percentage of people who accept to initiate the depression treatment, after being screened and diagnosed with depression at the primary care level. The absence of the research studies to demonstrate the cost-efficiency of universal screening for depression at the primary care level leads to the necessity that more research need to be developed in this direction, studies that should include more than the screening itself but also include the screening instruments, criteria for screening and treatment.

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CLINICAL STUDY OF THE MENTATION, BEHAVIOR AND MOOD DISORDERS IN PARKINSON'S DISEASE

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Abstract:
Introduction: Parkinson's disease is a general invalidating neurodegenerative disease. The impaired non-motor functions are well recognized as part of the clinical course of the disease with great impact over the quality of life of the patients. On the other hand, they are highly unrecognized by clinicians and pose great difficulty in detection and measurement. The UPDRS is widely used to assess and follow up PD patients and Part I is used to assess non motor functions such as mentation, behavior and mood disorders. Therefore, we used it in our study for the assessment of the prevalence of the non-motor symptoms measured by UPDRS Part I in PD patients. Objective: To show that there's high prevalence of mentation, behavior and mood disorders as measured by UPDRS Part I in PD patients. Methods: 293 patients with Parkinson's disease (129 men and 164 women) aged 58-79, randomly picked for an 8-year period (2005-2012) were studied. The study used the following assessment tools: 1. Unified Parkinson's Disease Rating Scale; Modified Hoehn and Yahr scale for assessment of clinical symptoms; Schwab and England Activities of Daily Living Scale. Statistical methods for processing the data received – SPSS statistics software with analysis of variances and alternates was used. Results: The mentation, behavior and mood functions were studied in 293 patients diagnosed with Parkinson's disease. Lack of motivation/initiative was most frequently observed – in 243 patients (83.6%), followed by depression – in 200 patients (68.2%)and memory disorders – in 199 patients (67.9%). Thought disorder was the least frequent (26.9%). As a result of these disorders all patients had a considerably reduced quality of life mainly due to the development of significant cognitive impairment. Conclusion: This results confirm the observation that mentation, behavior and mood dysfunctions are a highly prevalent and important feature of PD. Therefore, treating physicians should look for them routinely. The UPDRS showed that it is sensitive and reliable tool for detecting such symptomatology.Key words: Parkinson's disease, depression, UPDRS, cognitive impairment

INTRODUCTION
Parkinson's disease (PD) is a complex neurodegenerative condition manifested by characteristic motor impairment and a wide array of non-motor symptoms (NMS) (1, 2). Recently, sleep, fatigue, mood, cognition, pain and autonomic disorders have been recognized as important components of the disease, with a consistent impact on patients' health and quality of life (3, 4, 5, 6, 7). Despite of these problems and the high burden of NMS in most patients (4, 8) NMS remain frequently neglected (9) or undocumented (10). NMS thus present one of the biggest challenges for management by the clinician and a comprehensive approach that includes NMS as well as motor state of the patient is essential (11). NMS can be assessed by several tools specifically designed for these symptoms, including the NMS questionnaire (NMSQuest) (12), the unified PD rating scale (UPDRS) (13) and the PD sleep scale (PDSS) (14). Pathophysiological, NMS may be related to both dopaminergic and non-dopaminergic alterations. For example, PET studies reported dopamine dysfunction at the hypothalamus (15). Degeneration of cholinergic, adrenergic or serotoninergic pathways could also contribute to NMS genesis (16). Moreover, NMS can precede motor symptoms and thus PD diagnosis (17). Some studies suggest that NMS are common in all stages of PD and more common as the motor symptoms progression regardless of age of onset, levodopa dosage or disease duration. The most prevalent NMS in this study were highly similar to other previous international studies using the 30-item NMSQuest (18, 19 and 20). Non-motor symptoms dominate the clinical picture as PD progresses and may also contribute to shortened life expectancy (2, 21). Most do not respond to, and may be exacerbated by, dopamine replacement therapy (22). NMSs also account for the burden of hidden costs such as sick leave, early retirement and informal care not only for patients but also for caregivers in certain instances. The cost burden of NMSs is significantly high, especially in patients with advanced PD and increasingly severe symptoms, for which there is a poorer quality of life, reduced productivity and a greater need for health-care services, which in turn have an impact on direct and indirect costs. Thus, identifying disease-modifying treatments early in
the disease, before any functional or motor disability appears, is critical in reducing costs and preserving quality of life. Evidence suggests that initial therapy with non-levodopa agents is cost-effective, prolongs time to levodopa initiation and delays the onset of dyskinesia (23).

There is a significant interrelationship of severity of disease, quality of life, patients and caregiver's burden, and cost of illness. NMSs contribute to the overall PD burden, which is a major determinant of quality of life. An increasing awareness of ‘at-risk’ individuals, based on detection of some or a combination of NMSs, is essential for an early identification of PD patients. Identification of prodromal patients plays a key factor in preventing the burden of economic costs and improving quality of life of patients and caregivers. Keeping this in mind, it becomes important to optimize the management of all aspects of NMSs in PD (24). Therefore we conducted our study to evaluate the high prevalence of non-motor symptoms in PD patients, particularly those measured by UPDRS Part I as it is one of the most used clinical scales in PD and thus with great clinical significance.

OBJECTIVE
To show the high prevalence of mentation, behavior and mood disorders as measured by UPDRS Part I in PD patients.

MATERIAL AND METHOD
293 out patients with PD (129 men and 164 women) aged 58-79, all retired due to illness (PD), randomly selected in terms of different PD stages for an 8-year period (2005-2012) were investigated after the inform consent was signed. They were outpatient recruited from a PD center of Department of Neurology and Psychiatry. The patients received L-DOPA, dopamine agonists and antioxidants. The same team member who performed the clinical diagnosis also applied the scale. The patients have not been researched for concomitant illnesses. The study used the following assessment tools:
I. Unified Parkinson's disease Rating Scale (UPDRS) - Part I: evaluation of mentation, behavior, and mood. UPDRS is the most used scale to follow the longitudinal course of PD. (16, 17)
II. Modified Hoehn and Yahr scale for assessment of clinical symptoms;
III. Schwab and England Activities of Daily Living Scale; Modified Hoehn and Yahr scale for assessment of clinical symptoms and Schwab and England Activities of Daily Living Scale are parts of UPDRS, but are mentioned separately because were used alone in the process of diagnosing the disease. The complete UPDRS was used latter for the measurement of the progression of the disease.
IV. Statistical methods for processing the data received – SPSS 11 software with analysis of variances and alternates was used.

RESULTS
MENTATION, BEHAVIOR AND MOOD.
1. Intellectual Impairment. That symptom was observed in 199 patients (67.9%). No significant gender-related differences were found. From Part 1 of UPDRS the item 1 - “light consistent forgetfulness with partial recollection of events” and the item 2 – “moderate memory loss with disorientation to time and often to place” were considerably prevalent as compared to the item 4 “severe memory loss with orientation only to person” (p<0.05%) (Table 1).

2. Thought disorder. Thought disorder was found in 79 patients (26.9%). The item 2 - “benign hallucinations “with retained insight was most frequently observed. The item 3 – “Frequent hallucinations or delusions were almost equally frequent. Then came the item 1 - “vivid dreaming”, while persistent hallucinations and delusions were the least frequent. No significant gender-related differences were found (Table 2).

3. Depression (depression symptoms) the item 2 – “sustained depression, lasting more than a week was the most frequently observed in both genders. It was found in 90 patients (30.7%), followed by the item 1 – “periods of sadness and guilt”. Their values increased significantly as compared to the item 4 “severe memory loss with orientation only to person” (p<0.05%) (Table 3).

Table 1: Frequency of intellectual impaiment in Parkinson's disease.

<table>
<thead>
<tr>
<th>Clinical symptoms - stage of impairment</th>
<th>Gender</th>
<th>Total</th>
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<tr>
<td></td>
<td>Men</td>
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<tr>
<td>Light consistent forgetfulness</td>
<td>0</td>
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<tr>
<td>Moderate memory loss</td>
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<td>Severe memory loss</td>
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<tr>
<td>Total</td>
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Table 2: Frequency of thought disorders in Parkinson's disease.

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<th>Clinical symptoms - stage of impairment</th>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thought disorder</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vivid dreaming</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Benign hallucinations</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Frequent hallucinations or delusions</td>
<td>0</td>
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<td>Total</td>
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<tr>
<td>Benign hallucinations</td>
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<tr>
<td>Frequent hallucinations or delusions</td>
<td>0</td>
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<tr>
<td>Total</td>
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</table>
4. Motivation/Initiative. Lack of motivation and loss of initiative were most frequent among the PD patients. Those symptoms were found in 245 patients (83.6%). They were less assertive and more passive. Complete loss of motivation was the least frequent, the low results being statistically significant as compared to the milder impairment stages (p<0.01%) (Table 4). Apathy was observed in 54% of the patients diagnosed with mild to moderate PD related depressive symptoms

CONCLUSIONS:
This study showed moderate to high prevalence of non-motor neuropsychiatric disturbances in patients with PD in different stages of the disease as measured by the UPDRS Part 1. This confirms that they are important part of the disease. Therefore, treating physicians should look for them routinely in their effort for the improvement of quality of life in patients with PD. The UPDRS showed that it is sensitive and reliable tool for detecting such symptomatology.

DISCUSSIONS:
As PD is a multidimensional disorder, the disease progression and treatment efficacy should be assessed not only through motor symptoms but also through psychopathological and autonomic symptoms. The Unified Parkinson's Disease Rating Scale (UPDRS) was developed as a brief, valid, and reliable scale for the assessment of activities and non-motor symptoms in PD and has replaced many of the older assessment scales. (25, 26) Cognitive disorders in PD consist first of an intellectual slowing and difficulties to organize and manage the intellectual capacities, with preservation of global cognitive efficiency for long time. (27) Eventually, these disturbances can increase with the time and even progress to dementia. It is important to distinguish mild cognitive impairment from dementia, the latter being present only in a moderate percentage of PD patients. Our results revealed high prevalence of intellectual impairment (67.9%) as measured by the UPDRS which underlines the significance of its early recognition.

Hallucinations occur usually in a normal state of consciousness, without delirium, and have a chronic course. (28) The prevalence of complex visual hallucinations ranges from 22 to 38%. (29) Risk factors for hallucinations are older age, long duration of the disease, cognitive impairment, severity of PD symptoms, sleep disorders (somnolence), and visual disorders. (30) Risk of psychotic symptoms is increased in late onset PD, in patients taking high doses of dopaminergic drugs and suffering of REM sleep behavior disorder (RBD). Hallucinations must be identified by systematically questioning the patient.

Visual hallucinations are surprising, but their intensity is quite variable. Benign hallucinations are limited to presence sensation, passing lights or visions at periphery of the visual field, with great tolerance by the patient. (31) Our results showed moderate frequency of thought disorder in our study population. Thought disorder was found in 79 patients (26.9%) and the item “benign hallucinations “with retained insight was most frequently observed.

Depression occurs at any stage of the disease, even at the beginning or sometimes many years before the onset of the disease. (32) Depression can occur in up to 27.6% of PD patients during early stages of the disease. (33) Depression may consist in major depressive disorder (17%), minor depressive disorder (22%), and dysthymia (13%), and clinical significant depressive symptoms are present in 35% of PD patients. (34, 35) Our results show that the item “sustained depression, lasting more than a week“ was the most frequently observed in both genders. It was found in 90 patients (30.7%) in our study sample.

Apathy consists in a loss of motivation, which appears in emotional, intellectual domains and in the behavior. For the diagnosis of apathy, the decrease of spontaneous acting must not be imputable to motor disability, nor to severe cognitive decline. (36, 37) Indeed, this neuropsychiatric symptom is frequent, with a prevalence of 30% to 40% in PD patients. (38, 39) Apathy is one of the major determinants of a reduced quality of life in PD, even at early stages. As such, early diagnosis and efficient therapy are important in order to avoid further consequences on quality of life and disability. Lack of motivation and loss of initiative were most frequent...
among the PD patients. Those symptoms were with high prevalence in our study sample and was found in 245 patients (83.6%).

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All the authors had an equal contribution and have similar rights. All the authors approved the final version of this article.

DISCLOSURES:
The authors report no conflict of interest for this article.

LIST OF ABBREVIATIONS:
PD – Parkinson's disease
UPDRS - Unified Parkinson's disease Rating Scale
MMSE – MiniMental State Examination
MOCA - Montreal Cognitive Assessment Scale
MCI - Mild Cognitive Impairment
NMS – Non-motor symptoms

REFERENCES

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EVOLUTION OF SYMPTOMATOLOGY AND FUNCTIONALITY OF ROMANIAN PATIENTS WITH MAJOR DEPRESSIVE EPISODE IN A COHORT OBSERVATIONAL STUDY

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Abstract:
Background: Depression is a common and disabling psychiatric condition which cause substantial impairment in daily functioning and increases the risk for both social and physical disability, and as a result, increases the costs for other medical services.
Objectives: The study aims at underlining particularities regarding the evolution and functionality of patients with major depressive disorder (MDD) under Agomelatine treatment. The most important objectives were to evaluate the daily functionality in MDD patients under treatment, the evolution of the symptomatology and treatment adherence.
Methods: We included in a prospective, observational and longitudinal study 1194 patients with depressive episode, who were assessed with Clinical Global Impressions Scale (CGI scale) and Quick Inventory of Depressive Symptomatology Scale (QUIDS-C16), in order to perform a correlational analysis.
Results: In this study, the target group had a moderate symptomatology (depressed mood, loss of concentration, anhedonia) and had a good evolution from the second week of treatment and a considerable improvement of anhedonia after 10 weeks of treatment.
Conclusions: The antidepressant treatment with Agomelatine was considered efficient and safe, with an important improvement of the symptomatology after 10 weeks of treatment, a good treatment adherence and improvement in daily functioning.
Key words: CGI scale, anhedonia, antidepressant treatment.

1. INTRODUCTION

Major Depressive Disorder (MDD) is a heterogeneous, complex and debilitating disorder that put a burden not only upon patients but also on their family and society (1). MDD considerably affects patient's daily functionality with important effect on their quality of life because the social functionality decreases as depression's severity increases. The literature data are showing that almost 52% of patients with Major Depressive Episode (MDE) have persistent and important symptomatology compared to 18% of patients with mild MDE that experience major difficulties in daily social interactions (2).

Even if the available antidepressants (AD) help patients to obtain a good response or remission of symptoms, there is a period of several weeks until their entire pharmacological action is perceived by patients and clinicians.
Even so many patients have inadequate response, comorbid symptoms that are not completely controlled or under a poly-pharmacotherapy that can be associated with tolerability issues (1).

There are still significant controversies regarding the moment when the symptomatic amelioration became significant on the evolution of MDE treated with AD. Even though several methodological limitations exist (like the focusing on the clinical response rather than upon symptomatology remission), the results collected from randomized clinical trials (RCT), meta-analyses and observational studies show that: (A) in general AD are associated with early amelioration of the symptoms which can be observed in the first 2 weeks since antidepressant treatment initiation (defined as a reduction ≥ 20% in depression severity measured by standardized rating scales); (B) several antidepressants like Agomelatine are associated with early amelioration of both central symptomatology (depressed mood andanhedonia) and specific symptoms like sleep-wake disturbances; (C) early amelioration is a predictor of symptomatology remission and early response. Subsequently, the lack of amelioration could be seen as a predictor of nonresponse (3).

According to analytical studies on factors and groups there has been shown that depressive mood (negative emotions), anhedonia and psychomotor symptoms are the elements that define major depressive disorders the best (4). Diverse studies showed that anhedonia can precede the onset of a depressive episode, it can influence its severity, can be a predictor of a bad outcome 12 months later and it is a residual symptom frequently present. The inclusion of patients in subtypes according to the type of symptoms and phenomenological approach could constitute a further step of the future psychopharmacology in order to prescribe the best antidepressant according to specific symptoms. There are articles on this subject in the literature but until now the results are not yet conclusive (5).

2. METHODS
2.1 Participants
The study population was constituted of in and outpatients from 59 representative centers in Romania. The investigators were psychiatrists working in the public health system (hospital or specialized ambulatory) or in private practice. The observational study took place between 1st of February 2012 and 8th of June 2012.

In the study were included 1194 patients with a first MDE or a recurrent MDE according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) [6], over 18 years old but under 75 years, whose doctors recommended Agomelatine before the inclusion in the study and who accepted in common agreement with their clinician to be monitored during study. In the final analysis we also included patients with bipolar disorder (2.68%, n=32) and patients without specification of MDE (10%, n=125) due to the fact that this was a naturalistic study and these diagnostics were modified after baseline.

Out of 1194 MDE patients included in the study, more than half (645 patients) were with recurrent MDE. The exclusion criteria referred to the patients that: (A) went to the doctor in emergency regime, (B) use of psychoactive substances, (C) have an age under 18 years or above 75 years old and (D) presented serious comorbidities and/or severe pathology which could affect their participation in the study (hepatic impairment, limited cooperation, legal limited capacity, another severe non-psychiatric disorder, cancer, medication abuse, severe cardiovascular disease or renal failure).

The main objective of this observational study was the evaluation of daily functionality in MDD patients under AD treatment, who were prospectively followed. The secondary objectives included MDE severity improvement and MDD symptomatology evolution in these patients and the adherence to the AD treatment.

The prospective observation of the patients lasted for 10 weeks and included 4 visits: V0- baseline, V1- 2 weeks since inclusion, V2 and V3 at 6 respectively 10 weeks since inclusion. At the initial visit (baseline) depressive mood, anhedonia and focusing difficulties/decision making were the most prominent symptoms as measured with Quick Inventory of Depressive Symptomatology scale.

2.2 Instruments
In order to evaluate the MDE standard instruments were used: CGI scale (Clinical Global Impressions Scale). The CGI scale is an instrument through which the clinician evaluates 3 different global parameters (7):

A. The severity of the disease: global evaluation of actual severity of patient's symptoms (CGI-S);
B. The global improvement: general comparison between patient's actual state and the initial (baseline) state (CGI-I);
C. Efficacy index: general comparison between patient's initial state and a rapport between the actual therapeutic benefit and severity of adverse reactions (CGI-E).

For severity evaluation of MDE Quick Inventory of Depressive Symptomatology scale (QIDS-C), - Rush et al., 2003) was used. The QIDS-C scale includes all the symptomatology domains, which was developed on the base of DSM-IV criteria for diagnosis of major depressive episode [8,9]: 4 items for evaluation of sleep disturbances; 2 items for evaluation of psychomotor disturbances (agitation or slowing of the psychomotor function); 4 for appetite/ weight evaluation (increasing/decreasing of appetite and weight gain/loss) and only one item for evaluating the other 6 domains (depressed mood, low interest, decreased level of energy, feelings of uselessness/ guilt, concentration/decision making difficulties, suicidal ideation). Each item is evaluated on a scale from 0 to 3. For the domains that require the evaluation of least 2 items, the highest score is considered. For example if at the beginning of sleep the value of insomnia is 0, the value of insomnia the middle of the night sleep is 1, for morning insomnia is 3 and 0 for hypersomnia, then the sleep disturbances domain gains a total score of 4 points. The total score varies between 0 and 27. The reference interval in the evaluation of symptoms severity is the 7 days period prior to evaluation. QIDS is sensitive to the change of the clinical state status associated with medical treatment, psychotherapy or somatic treatment, being a very good instrument in both research and clinical practice.
The degree of adherence to the treatment throughout study development was evaluated by the number of pills declared by the patient as taken from one visit to another. The study was prospective, observational and longitudinal; all the participants signed an informal consent before being included into the study.

2.3 The statistical analysis was done by CEGEDIM Company using Kynos Modalisa software with a confidence level of 95%, a maximum sampling error for all patients of ± 2.81% and p-value.

The symptoms evolution was statistically significant between visits and also at the final visit (Table 2). The symptoms were ameliorated by the AD treatment reaching a final score of 1.77 at V3 (the interval 0-5 is considered in normal range). The symptoms evolution was statistically significant between visits and also at the final visit (Table 3). The evolution of the symptoms severity at each evaluation (comparing to the initial moment) is graphically presented in Figure 1.

### Table 1 – Statistical parameters

<table>
<thead>
<tr>
<th>LEVEL OF ANALYSES</th>
<th>INDICATORS</th>
<th>SIGNIFICANCE TESTING</th>
<th>OPEN-ENDED QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All CRFs</td>
<td>- Absolute and relative frequencies for categorical variable</td>
<td>- Fisher’s F test – testing for significant differences among pre-defined groups</td>
<td>- Similar answers grouped in categories</td>
</tr>
<tr>
<td>- Splits on patient categories, e.g. gender, age categories</td>
<td>- Central tendency indicators for quantitative variables</td>
<td>- z-test for means, t-test for significant differences between visits</td>
<td>- Database keeps the original verbatim as well</td>
</tr>
<tr>
<td>- diagnosis</td>
<td>- Confidence levels provided in annex (Excel file)</td>
<td>- Chi2 test – testing for association among pre-defined groups</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Baseline characteristics of the MDD patients

<table>
<thead>
<tr>
<th>Visit</th>
<th>Average QIDS-C16 value</th>
<th>t-value (vs V0)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>V0</td>
<td>12.25 [12.05-12.45]</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>V1</td>
<td>8.41 [8.21-8.61]</td>
<td>46.08</td>
<td>0.00</td>
</tr>
<tr>
<td>V2</td>
<td>4.5 [4.33-4.67]</td>
<td>80.19</td>
<td>0.00</td>
</tr>
<tr>
<td>V3</td>
<td>1.77 [1.66-1.88]</td>
<td>96.72</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Table 3: Evolution of the MDE symptoms evaluated with QIDS-C16 scale

---

* n=1186-1189 for each domain evaluated with QIDS-C16

---

Depressive mood

<table>
<thead>
<tr>
<th>QIDS-C(_{16}) Items</th>
<th>V0 (W0) N=1186-1189</th>
<th>V1 (W2) N=1187-1190</th>
<th>V2 (W6) N=1181-1184</th>
<th>V3 (W10) N=1169-1171</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doesn’t feel sad</td>
<td>0.2</td>
<td>7</td>
<td>24</td>
<td>67</td>
</tr>
<tr>
<td>Feels sad in less than half of time</td>
<td>8</td>
<td>47</td>
<td>65</td>
<td>32</td>
</tr>
<tr>
<td>Sad mood more than half of time</td>
<td>56</td>
<td>43</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Sad mood almost all the time</td>
<td>35</td>
<td>3</td>
<td>1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Implication

| No change from the common level of interest toward other activities                  | 1                   | 9                   | 36                  | 76                   |
| Decreasing the interest of current activities                                       | 26                  | 52                  | 56                  | 23                   |
| Keeping only 1 or 2 activities from the old ones                                     | 51                  | 35                  | 8                   | 2                    |
| Having no interest from the old activities                                          | 22                  | 4                   | 0.1                 | 0                    |

Concentration/making decisions

| No change in the daily capacity of concentration and making decisions               | 1                   | 7                   | 25                  | 60                   |
| Sometimes feels undecided or observe that attention is diminished                   | 20                  | 49                  | 65                  | 39                   |
| Most part of the time trying to concentrate or making decisions                     | 61                  | 40                  | 9                   | 2                    |
| Cannot concentrating enough for reading or cannot making minor decisions            | 19                  | 4                   | 0.4                 | 0                    |

Table 4: The evolution of the depressed mood, anhedonia and impaired concentration/making decisions during the study (QIDS-C\(_{16}\))

Table 5: Z test applied on the QIDS-C\(_{16}\) items

The statistics revealed that while all the patients presented a significant improvement of the symptomatology, some categories have registered more progress, as follows (supplementary details can be obtained on request):

- **Age:** The elderly patients (age between 65 and 75) have a slower improvement than other age categories, for all the visits (p=0.002 at V1, p=0.001 at V2 and V3);
- **Major depressive episode (new/recurrent):** it has been noted significant differences between the patients with a new major depressive episode and recurrent in all that concerns the total scores (ANOVA), but the items scores (Chi2). The patients with recurrent MDD had a slowly recovery.

3. Comorbidities of the MDD on the patients of the study:

The presence of somatic comorbidity was observed in 26% of the patients; the most frequently reported comorbidities (n=307) were arterial hypertension (82%) and the ischemic coronary disease (30%).

3.4. Adherence to treatment during the study:

From the patients who had previous AD treatment (n=645, 54%), the main reason for switching/discontinuing was the loss of therapeutic response, followed by the patients’ choice not to be treated with that AD or considering that he does not need treatment anymore. Though, there are cases for which this reason could not be specified.
At the end of the study 98.5% of the patients (n = 1194) continued the AD treatment (7 patients discontinued the treatment due to economic reasons). During the observational study there have not been reported any adverse reactions linked to Agomelatine according to the investigators clinical judgement.

4. DISCUSSIONS

We noticed a concordance of the results of this study with the data from the literature regarding the percent of women with MDD and the low prevalence of depression in the age category under 25 years (2).

The group of patients enrolled in this study had a moderate symptomatology and this could be explained by the fact that patients who were addressing to the emergency services were excluded. Another explanation could be the presence of the residual symptoms in patients with recurrent depression and their treatment was changed because of the loss of therapeutic response (the main reason of the changing anterior treatment in this study).

For this group of patients, the symptomatology domains at the initial moments and who had a considerable improvement starting with the second week of treatment have been represented by the depressed mood, loss of concentration and making decisions and anhedonia. Of the three domains, after ten weeks of treatment anhedonia presented a better improvement. (3rd table). Considering that the medication for the study was represented exclusively by Agomelatine, it is possible that this substance plays an important role which can concord with the results of the recent studies (4, 10).

In this study, the patients recently diagnosed (<3months) and treated have presented a significant improvement after ten weeks of treatment compared with the patients diagnosed with depression more than one year before. Also, the patients with more than 65 years old diagnosed with depression more than one year before had a slow improvement during all the visits. These two observations sustain the importance of recognizing depression and the initiation of the treatment from the beginning, which allow a good improvement of the functionality.

A good adherence to the treatment is a great contributor to the improvement of the symptomatology and thus, to recovering the level of functionality before the disease episode. No side effects related to the AD treatment were recorded according to the clinician's judgement.

Considering that the medication was based almost exclusively on Agomelatine, the results of the study can be considered representative for this substance. In the same time, we cannot make specific correlations, the Chi test being extremely sensitive in big samples. Another limit can be represented by the short period of the study – 10 weeks, which can permit an observation of the evolution and the adherence only for the acute phase of the treatment. It was observed a good improvement of the functionality from the self-reported data by the patients. At the same time, it might be useful to make a correlation of the functionality with the symptomatology through the evaluation of the patient's response at a self-administered scale for functionality.

5. CONCLUSIONS

The AD treatment with considered efficient and the MDE patients. After 10 weeks of treatment it has been noticed a good improvement of MDE patients’ symptomatology, a good adherence to treatment and a good improvement of the functionality from the self-reported data by the patients.

6. DISCLOSURE

The authors declare that received in the past grants from Servier Pharma and other speaker fees. In addition, all the authors received in the past speaker’s fees and/or sponsorship from Servier Pharma and others companies for scientific research or communication. Dr. Traian Purnichi also works as a marketing specialist consultant for Servier Pharma and Dr. George Paraschiv and Iuliu-Alma Mitea are employees of Servier Pharma.

7. ACKNOWLEDGEMENTS

All the authors had an equal contribution and have similar rights. All the authors approved the final version of this article.

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- Cegedim Company that did the statistical analysis using a Kynos Modalisa software
- MedinteractivPlus for helping on the study draft
- Servier Pharma for offering the grant that made this study possible

8. FINANCIAL SUPPORT

This study was founded by a grant from Servier Pharma.

REFERENCES

List of abbreviations:

1. CGI scale - Clinical Global Impressions Scale
2. QUIDS - Quick Inventory of Depressive Symptomatology Scale
3. MDD - Major Depressive disorder
4. MDE - Major Depressive Episode
5. AD - Antidepressant
6. RCT - Randomized Clinical Trials
7. DSM-IV-TR - Diagnostic and Statistical Manual of Mental Disorders
MENTAL DISORDERS IN CHILD EPILEPSY

Elisabeta Racos – Szabo¹, Iringó Száva², Anamaria Todoran – Butila³

Abstract
Epilepsy is a chronic condition characterized by the presence of recurrent paroxysmal brain seizures (epileptic seizures), as a result of an excessive discharge of neurons. The prevalence of mental disorders in epilepsy is of 30-40%, and those of psychoses of 1-3%, being higher in patients with temporal lobe epilepsy. Psychoses and personality disorders are 3 times more frequent in those with temporal lobe seizures. Among the mental disorders in child epilepsy we care to mention: cognitive impairment, behaviour disorders with aggressiveness and psychomotor agitation, learning disorders, depression, anxiety.

Material and methods
There have been evaluated 24 children with epilepsy, admitted in 2014 in the Clinic of Pediatric Neurology and Psychiatry Tg-Mures, with ages between 12 and 18. There have been applied Raven's Matrices, various scales for depression and anxiety (MASC, Hamilton, Beck, Bender). The diagnosis of mental disorders has been established based on the criteria DSM-V and ICD 10.

Results
The prevalence of mental disorders in child epilepsy was of 12%, with the highest incidence in the group age between 10 and 12. These mental disorders have been: cognitive disorders (79%), behaviour disorders (37.5%), disharmonic personality developments (33%), anxiety (20.8%), psychosis (8.3%), depression (4.2%).

Discussions
Child epilepsy evolves having a high risk for the occurrence of cognitive impairment, behaviour disorders, language or mood disorders all the more so as the underlying structural disorders are higher. The early onset of the epileptic seizures under the age of 3, in a child with a psychic under development represents a vulnerability factor. Patients with temporal lobe epilepsy present a risk for psychoses, also 1/3 of the epileptics develop personality disorders.

Conclusions
The onset of epileptic seizures under the age of 3 constitutes a risk factor for the occurrence of language disorders, cognitive or behaviour disorders.

The prognostic in mental disorders in the epileptic child is influenced by the underlying structural brain anomalies responsible for the occurrence of epileptic seizures.

Key words: epilepsy, mental disorders, child.

Rezumat
Epilepsia este o afecțiune cronica caracterizata prin prezența crizelor cerebrale paroxistice recurente (crize epileptice), ca urmare a unei descarcari excesive a neuronilor. Prevalența tulburărilor psihice în epilepsie este de 30-40%, iar cea a psihozelor de 1-3%, fiind mai mare la pacienții cu epilepsie de lob temporal. Psihozele și tulburările de personalitate sunt de 3 ori mai frecvente la cei cu crize de lob temporal. Dintre tulburările psihice în epilepsia copilului amintim: deficitul cognitiv, tulburările de comportament cu agresivitate și agitație psihomotorie, tulburările de învățare, depresia, anxietatea.

Material și metode

Rezultate
Prevalența tulburărilor psihice în epilepsie a fost de 0,14%, cu incidența cea mai mare la grupa de vârstă între 10 și 12 ani (33%). Acestea au fost: tulburări cognitive (8.3%), tulburări de comportament (37.5%), dezvoltare dizarmonice de personalitate (20.8%), anxietatea (20.8%), depresia (4.2%).

Discuții
Epilepsia copilului evoluiează cu risc crescut de aparitie a deficitului cognitiv, tulburărilor de comportament, a celor de limbaj sau de dispoziție cu atit mai mult cu cit tulburările structurale subiacente sunt mai mari. Debutul precoce al crizelor epileptice sub vârsta de 3 ani, la un copil cu un psihic în dezvoltare reprezinta un factor de vulnerabilitate. Pacienții cu epilepsie de lob temporal prezinta risc pentru psihoze, de asemenea 1/3 dintre epileptici dezvoltă tulburări de personalitate.

Concluții
Debutul crizelor epileptice sub vârsta de 3 ani constituie factor de risc pentru aparitia tulburărilor de limbaj, a celor cognitive sau de comportament. Prognosticul in tulburările psihice la copilul epileptic este influentat de anomalii structurale cerebrale subiacente responsabile de aparitia crizelor epileptice.

Cuvinte cheie: epilepsie, tulburari psihice, copil.
Introduction

Epilepsy is a chronic condition characterized by the presence of recurrent paroxysmal brain seizures (epileptic seizure), as a result of an excessive discharge of the neurons within a structural or biochemical epileptogenic brain injuries (according to the International League Against Epilepsy approved by World Health Organization).(1,2) The association of epilepsy with mental disorders is already known from antiquity(8). Later Kraepelin affirmed that patients with epilepsy present personality disorders and predisposition for psychoses.(9) The prevalence of mental disorders in epilepsy is of 30-40%, being able to exceed even 60% in those with different neurological impairments, and the psychoses one is of 1-3%, being higher in patients with temporal lobe epilepsy(5,7). Kaplan mentions that epileptics present mental disorders, depression being present in 7.5 up to 34% of them. At the same it is to be mentioned that psychoses and personality disorders are 3 times more frequent in patients with complex partial seizures. (9) The most frequent comorbidity in epilepsy is depression, the estimated prevalence of it vary between 50-55% in patients attending hospital, or ambulatory system, 20-30% in those with recurrent seizures, and 6-9% in those in remission. Depression can appear after epilepsy surgery too.(4) The suicide rate in population suffering of epilepsy is 5% (in the whole population 1,4%).(11) The epilepsy treatment can also lead to depression, nervousness, abnormal thinking (Topiramate, vigabatrin) (4,6).

The mental disorders in the epileptic child are different depending on age(10). Thus, we care to mention behaviour disorders with instability and psychomotor agitation, cognitive impairment, personality disorders (with viscosity, aggressiveness, irritability, egocentrism), learning disorders, attention deficit, hyperactivity disorder, anxiety, depression, psychosis. (12)

Material and methods

A study has been performed within the Clinic of Pediatric Neurology and Psychiatry from Tg-Mures during 2014, being monitored 24 children with various forms of epilepsy, aged between 10 and 18, who presented neurological disorder as well. The patients have been examined neurologically, paraclinically by EEG, brain imaging (CT scan and brain MRI), also psychiatrically by Raven's Matrices, projective tests, depression and anxiety scales (MASC, Hamilton, Beck, Bender).

Results

Out of the 171 cases of epilepsy diagnosed in our Clinic of Pediatric Neurology and Psychiatry from Tg-Mures in 2014, the prevalence of epilepsy associated with mental disorders was of 12%.

The specialized literature mentions a higher incidence of epilepsy in male gender, in the studied cases this being of 71%.

The maximum incidence of mental disorders in epileptic children has been in the group with ages between 10 and 12, namely 33% (6 cases), 12-14 years old 29% (7 patients), 14-16 years old 25% (6 patients), 16-18 years old 13% (3 patients).

Figure 1: Mental disorders prevalence in child epilepsy

Figure 2 : Distribution of cases on genders

Figure 3 : Distribution of cases on age groups

Figure 4 : Incidence of mental disorders in child epilepsy

The incidence of mental disorders in epileptic children according to their background has been equal between the
The mental disorders encountered in the child diagnosed and treated for epilepsy have been:
- cognitive disorders: (37%);
- behaviour disorders: (17%)
- disharmonic personality developments: (15%)
- attention deficit hyperactivity disorder: (9%)
- anxiety: (9%)
- learning disorders: (7%)
- psychosis: (4%)
- mood disorders of depressive nature: (2%)  

Behaviour disorders have been encountered in 11 patients consisting in irascibility (2 cases), disobedience and stubbornness (4 cases), auto- and hetero-aggressive manifestations (5 cases).

Personality disorders have been encountered in 8 cases, consisting in withdrawal (1 case), viscosity (1 case), impulsiveness (4 cases), antisocial manifestations as theft and consumption of alcohol (2 cases).

The psychotic type of disorder has been the most severe mental disorder in the epileptic child, consisting in mystical and paranoid delirious ideas, in 2 cases (8%). Language disorders were also present consisting in dyslalia, stuttering, dysarthria in 13 children. Also there have been encountered affective and mood disorders namely: 1 case of depressive disorder, and also 1 case of anxiety.

The associated cognitive impairment in the children patients with epilepsy under treatment, has consisted in mild mental retardation (intellectual disability) with schooling in aided school in 25% of cases, moderate mental retardation in 17% of cases and severe mental retardation in 37% of cases, and 21 % of the patients had a normal cognitive level.

The severity of the cognitive impairment has been correlated with the age at the epilepsy onset, thus in 45.8% of cases the onset of the epileptic seizures has occurred before the age of 3. 17% of the epileptic children have not been schooled, due to the seizures frequency and lack of favourable response to the antiepileptic treatment, at the same time due to the associated cognitive impairment.

Discussions
Recent studies point out the fact that child epilepsy evolves with a high risk for the occurrence of cognitive impairment, behaviour disorders, emotional disorders, language or mood disorders. This risk is all the more higher as the structural underlying disorders to the epileptic process are more pregnant(2). The monitored patients presented a cognitive impairment in most of the cases (79%), only 21 % of them having a normal cognitive level. At the same time the behavioural disorder consisting in disobedience, irascibility, impulsiveness with auto- and hetero-aggressiveness has been present in 11 patients.(12) In most of the epileptic children within the study (45.8%) the onset of the epileptic seizures occurred before the age of 3, when the child’s psychic is at its peak of development, therefore the psychic vulnerability is higher, aspect mentioned also in the specialized literature (1,2,6) Personality disorders appear in a 1/3 of the epileptic
patients, fact emphasized also in the children within the study, namely in 33% of them, under the form of viscosity, adhesiveness, antisocial type of elements, instability, impulsiveness, consistent with the specialized literature data.(9,12)

It is mentioned the occurrence of psychosis in patients with temporal lobe seizures (5).

Epileptic children with psychotic decompensation within our study (2 cases) have presented seizures of complex absence type, complex focal seizures secondarily generalized, the structural lesion being in the temporal lobe.(5,7)

Some of the antiepileptic medications may cause reactions of behavioral or cognitive type (12). Within the study performed it could not be established if cognitive or behavioral disorders had a bearing on the antiepileptic medication treatment.(6)

Conclusions

Among the mental disorders in epileptic children, the most frequently emphasized was the cognitive impairment (79%).

The maximum incidence of mental disorders was in the age group between 10 and 12.

The early onset of epileptic seizures under the age of 3 constitutes an unfavourable prognostic factor for the occurrence of mental disorders as language disorders, cognitive impairment, behavioral disorders.

The prognostic of mental disorders in child epilepsy is influenced by brain structural anomalies responsible for the epileptic seizures, also the therapeutic response at specialized medication.

Bibliography

7. Sander JW: Epilepsy, Questions and answers, 2000

***
INSTRUCTIONS FOR AUTHORS

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CONTENTS

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- The Spiritual Dimension of Personality and its Role in Mental Health
  Aurel Nireștean, Emese Lukacs, Gabriela Buicu, Monica Bilcă, Pokorny Vasile

REVIEW ARTICLES

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  Cosmin O. Popa, Mihai Ardelean, Tudor Nireștean, Gabriela Buicu

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  Raluca Ileana Nica, Mihail Cristian Pirlog

- Clinical Study of The Mentation, Behavior and Mood Disorders in Parkinson's Disease
  Iordan Ganev, Toni Donchev, Krasimir Kostadinov, Velina Mancheva-Ganeva, Lachezar Manchev, Ivan Manchev, Mihai Pirlog, George L. Paraschiv, Ruxandra C. Banu, Traian Purnichi

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