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TEORIJA I PRAKSA EPIDEMIOLOŠKIH ISTRAŽIVANJA U DEČIJOJ PSIHIJATRIJI

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Apstrakt: U radu je dat pregled razvoja epidemioloških istraživanja u oblasti dečije psihijatrije u poslednjih 50 godina. I pored toga što su epidemiološka istraživanja u dečijoj psihijatriji kasnila u odnosu na ostale grane medicine, danas se smatra da su u samom vrhu savremenih epidemioloških istraživanja zbog podizanja svesti o značaju mentalnog zdravlja dece i adolescenata kao i zbog inovativnih metoda koje se danas koriste. Poseban je naglasak na specifičnostima epidemioloških metoda u ovoj oblasti psihijatrije gde je potrebno uključiti više osoba koje dete poznaju u različitim kontekstima kako bi se postavila adekvatna dijagnoza. Obično su u procenu uključeni roditelji, nastavnici i adolescenti, a što je dete mlađe, to su i važnije informacije od drugih jer ono nije u stanju da opiše prisustvo simptoma, njihovu težinu i trajanje. Predstavljeni su najčešći upitnici koji se koriste u epidemiološkim istraživanjima kao i značaj dimenzionalnih upitnika u proceni dece. Dat je i pregled studija o prevalenci i strukturi dečijih psihijatrijskih poremećaja, kako u razvijenim zemljama, tako i u zemljama u razvoju, sa posebnim osvrtom na dosadašnja istraživanja u Srbiji. Iz ovog pregleda istraživanja o prevalencama se vidi da se stope prevalence problema mentalnog zdavlja dece i adolescenata razlikuju značajno, ne samo zbog različitih metoda procene, nego i zbog različitog dizajna istraživanja. U zaključku se iznosi potreba sveobuhvatnog epidemiološkog istraživanja na reprezentativnom uzorku dece i adolescenata na području Srbije kako bi dobili jasnu sliku stanja i osnovu planiranja potreba za tretmanom dece koja se suočavaju sa mentalnim poremećajima.

Ključne reči: *epidemiologija, dečija psihijatrija, prevalenca, upitnici, mentalno zdravlje*

Uvod

Istraživanja ukazuju da su problemi mentalnog zdravlja dece u porastu poslednje dve decenije. Podaci o tretmanu i poliklinički kartoni ukazuju na povećan broj dece sa dijagnozom ADHD [1]. Takođe, epidemiološke studije ukazuju na povećanje prevalence autizma [1,2], a istraživanja o depresiji pronalaze višu životnu prevalencu u mlađim uzrasnim grupama ukazujući na raniji početak bolesti i povećanje prevalence ovog poremećaja [3,4]. Povećan je i broj bolničkih i ambulantnih prijema i poseta, kao i upotreba psihotropnih medikamenata [5-7]. Stopa kriminaliteta mladih je takođe povećana, kao i stopa suicida tokom poslednjih decenija [8-10]. Ipak, mnoga od ovih istraživanja imaju brojne metodološke probleme. Na rezultate su mogli uticati mnogi faktori kao što su: promena dijagnostičkih kriterijuma za postavljanje psihijatrijskih dijagnoza, bolje prepoznavanje dijagnoza od strane kliničara, promene u dostupnosti lekova i stručnih službi, promena prakse prepisivanja lekova, dostupnost bolničkih kreveta, smanjenje stigme [6].

Epidemiologija je po mnogo čemu slična kliničkoj medicini. Zajednička im je orijentacija ka prevenciji i kontroli bolesti kao i dostizanju naučnih saznanja o uzroku i toku bolesti. Razlika je u fokusiranju epidemiologije na kontrolisanje procesa bolesti u kontekstu populacije u riziku, dok je fokus kliničke medicine pojedinačni pacijent. Kada god opserviramo da postoji distribucija bolesti koja sledi neko pravilo, imamo i priliku da identifikujemo uzročne faktore koji utiču na pojavu bolesti. Tako recimo, znamo da je depresivni poremećaj učestaliji kod devojaka nakon puberteta i da ovaj porast nije karakterističan i za muški pol. Ova pravilnost distribucije depresivnog poremećaja govori nam da je pubertet kod devojaka uzročno povezan sa depresivnim poremećajem [4]. Zadatak epidemiologije je razumevanje opserviranih obrazaca distribucije bolesti u vremenu i prostoru i primena ovih saznanja u prevenciji i kontroli bolesti.

Razvoj epidemioloških istraživanja iz oblasti dečije psihijatrije

U početku razvoja epidemiologije kao nauke naučnici su se uglavnom bavili proučavanjem infektivnih i nekoliko hroničnih bolesti. Dečija psihijatrija je kasno počela sa epidemiološkim istraživanjima (sredinom 1960-ih godina), što u jednu ruku može biti i srećna okolnost, jer je tokom vremena učinjen ogroman napredak u empirijskom, teorijskom i statističkom razvoju epidemiologije zahvaljujući epidemiološkim istraživanjima u drugim granama medicine i psihologije.

Više je faktora koji se smatraju odgovornim za ovo „kašnjenje“ dečje psihijatrije u epidemiološkim istraživanjima: nedostatak usaglašenosti o tome šta je poremećaj, nejasni dijagnostički kriterijumi, nepotpuni podaci o klasifikaciji, nedostatak standardizovanih instrumenata procene i zajedničkih analitičkih tehnika, kompleksnost i mnogobrojnost rizičnih faktora koji doprinose pojavi poremećaja [11].

Od 1980. do 1990. je broj epidemioloških studija bio jednak ukupnom broju onih koje su urađene do 1980. godine [12]. Povećao se ne samo broj istraživanja nego i stepen metodološke sofisticiranosti, ciljevi i povezanost sa srodnim disciplinama kao što su psihologija, psihoterapija, neurobiologija i sociologija [11,12]. Rezultati ovih istraživanja su ukazali na značajnu različitost manifestacija mentalnih poremećaja, demonstrirajući da ovi poremećaji nisu tako uniformni kako se to ranije mislilo, i to kako u pogledu manifestacije poremećaja tako i u pogledu rizičnih faktora, toka, ishoda, pridružene nesposobnosti i oštećenja.

Početkom 21. veka, epidemiološke studije su postale baza politike javnog zdravlja u području dečije i adolescentne psihijatrije. U poslednjih 15 godina dečja psihijatrija je u samom vrhu novih epidemioloških istraživanja baveći se inovativnim pristupom longitudinalnim studijama i proučavanjem interakcije gena i okruženja [13].

Epidemiološke metode u dečjoj psihijatriji

Jasno je da broj dece koja se javljaju profesionalcima koji se bave mentalnim zdravljem ne daje pravu sliku o učestalosti i vrsti psihijatrijskih poremećaja u određenoj populaciji. Na javljanje profesionalcima utiče mnogo faktora: od zdravstvene politike i prakse u datoj zajednici, ekonomske situacije, stigme, pa sve do obrazovanja roditelja, edukovanosti nastavnika ili pedijatara koji upućuju dete na pregled psihologu ili psihijatru. Tako, klinički uzorak nudi neadekvatne informacije o prevalenci dečijih psihijatrijskih poremećaja i njihovim korelatima jer samo mali i atipični uzorak dece stigne u servise mentalnog zdravlja [14]. Zbog svega ovoga neophodno je istraživanje u zajednici kako bi se procenile potrebe kako tretmana, tako i prevencije dečijih psihijatrijskih poremećaja.

Glavni zadatak epidemiologa koji se bavi dečjom psihijatrijom jeste pronalazak adekvatnog „merača“ koji će registrovati poremećaj. Najpre se pribeglo prevodu taksonomskih dijagnostičkih priručnika u instrumente u vidu upitnika, intervjua i drugih vidova prikupljanja informacija koje su se dalje kodirale u dijagnostičke kategorije. Pokazalo se da su ti instrumenti ponekad i suviše skupi, neprimenljivi su u nekliničkoj populaciji, zahtevaju puno vremena, obučene ispitivače, a poseban problem je što se dijagnostički priručnici često revidiraju te i to doprinosi težoj proceni.

U novije vreme razvojem tehnologije pristižu i brojne inovacije u prikupljanju podataka potrebnih da bi se napravila procena. Tako brojni instrumenti imaju svoje kompjuterske verzije, gde se podaci dobijeni tokom razgovora sa roditeljem ili detetom ubacuju direktno u kompjuter. Takođe, postoje i programi gde upitnike za procenu popunjavaju roditelji ili deca bez prisustva ispitivača što se pokazalo korisnim naročito u prikupljanju informacija o osetljivim temama kao što je zloupotreba supstanci [15]. Koriste se i intervjui sa slikama, naročito pri proceni mlađe dece [1].

Za razliku od kategorijalne procene koja je uglavnom orijentisana na postavljanje dijagnoze, dimenzionalna procena je zasnovana na pristupu od „daljeg ka bližem“ i koristi se u empirijskim istraživanjima. Procenjuju se i daju se skorovi za određene opise dečjeg funkcionisanja. Skorovi specifičnih opisa se sumiraju u skale za merenje psihopatologije i drugih aspekata funkcionisanja. Svaki skor na određenoj skali može se uporediti sa skorovima normativnog uzorka kako bi se procenio stepen odstupanja deteta. Ovakvi upitnici imaju brojne prednosti ali i mane. Prednost je sposobnost upitnika da stvori sliku iskustva jednog deteta tokom određenog vremenskog perioda u različitim situacijama. Čak je moguća i procena retkih ponašanja koja se mogu propustiti tokom intervjua. Upitnici su jeftini i zahtevaju malo vremena. Ako postoje norme za određeni upitnik, svako dete se evaluira u odnosu na odstupanja od normi za reprezentativni uzorak. Isto tako, ovi upitnici imaju i mane kao što su strogost ili tolerantnost u proceni, „halo“ efekat i procena kroz prizmu skorijih modela ponašanja. Takođe, nedostaje nam perspektiva subjekta procene, njegovo/njeno lično iskustvo, direktna opservacija i mogućnost razjašnjavanja nedoumica.

Najčešće korišteni dimenzionalni upitnici za procenu dečje psihopatologije su Ahenbahovi instrumenti: Lista za procenu ponašanja deteta (Child Behavior Checklist-CBCL), Izveštaj nastavnika o ponašanju deteta (Teacher Report Form-TRF) i Lista samoprocene mladih (Youth Self Report-YSR) [16] i Gudmanov [17] Upitnik za procenu snaga i poteškoća (Strengths and Difficulties Questionnaire-SDQ). Ovo su upitnici koje popunjava dete, nastavnik, roditelj i/ili kliničar, vrlo su popularni za procenu psihopatologije i koriste se češće nego kompletni psihijatrijski intervju. Ovi instrumenti se koriste u školama, vrtićima, primarnoj zdravstvenoj zaštiti dece, ali i u brojnim nacionalnim istraživanjima. Koriste se u dve glavne svrhe: kao epidemiološki instrument za procenu prevalence nekog poremećaja na nivou populacije i za identifikaciju dece koja su u visokom riziku da imaju poremećaj [11].

Kada se dimenzionalni upitnik koristi kao *epidemiološki instrument* važna je adekvatna senzitivnost (postotak pravilno identifikovane dece koja imaju poremećaj) i specifičnost (postotak pravilno identifikovane dece bez poremećaja). Tada se može koristiti za procenu prevalence u populacionim studijama, kao što je to već i rađeno [11]. Takođe, se ovi upitnici koriste kao „skrining“ instrumenti tj. kao prvi nivo u studijama sa više nivoa, kako bi se povećao broj dece koja „moguće“ imaju poremećaj, te bi se ona na sledećem nivou detaljnije ispitala. Primenjuju se i u longitudinalnim studijama praćenja kada je potrebno više puta procenjivati jednu osobu i kada je važnija promena u intenzitetu simptoma nego promena dijagnostičkog statusa.

Svi dijagnostički instrumenti mogu praviti dve vrste grešaka: identifikuju i decu koja nemaju poremećaj (lažno pozitivni) i ne identifikuju decu koja imaju poremećaj (lažno negativni). Kada dimenzionalni instrumenti imaju dobru test-retest pouzdanost i validnost u odnosu na kriterijum merenja mogu biti vrlo korisni jer:

- Obezbeđuje korisnu aproksimaciju populacione prevalence (i pored mogućih grešaka, računa se da su greške tipa lažno pozitivnih i lažno negativnih ipak balansirane) [11].
- Jeftini su. Sa pravilnim dizajnom uzorka, moguće je smanjiti veličinu uzorka (time i troškove) bez značajnijeg porasta u varijansi, naprotiv, ukoliko se pravilno koriste mogu smanjiti varijansu i povećati snagu.
- Smanjuju pritisak na ispitanika, što je naročito važno za neklinička i longitudinalna istraživanja.

Ko sve procenjuje probleme mentalnog zdravlja dece?

Kako je klasifikacija psihijatrijskih poremećaja uglavnom zasnovana na fenomenologiji, tako su za postavljanje dijagnoze neophodne informacije o simptomima osobe koja se procenjuje. Što je dete mlađe, to su važnije informacije od drugih (koji dete poznaju i sa kojima provodi vreme), jer ono nije u stanju da opiše prisustvo simptoma, njihovu težinu, trajanje.

Postoji generalna saglasnost da je potrebno više onih koji daju informacije o detetu kako bi se sagledala celokupna slika funkcionisanja deteta [18].

S obzirom da informacije o detetu mogu pružati osobe koje dete viđaju u različitim kontekstima u kojima se dete može ponašati različito, tako se i njihova procena može značajno razlikovati. U meta analizi nekoliko istraživanja Ahenbah i sar. [18] su našli da je vrednost Pirsonove korelacije u proceni ponašanja i emocija deteta bila 0.60 između roditelja, 0.28 između roditelja i nastavnika i samo 0.22 između deteta i drugih osoba. Ova različitost u proceni je pre posledica različitosti konteksta nego nepouzdanosti osoba koje daju informacije i upravo to i ukazuje koliko su važne ove validne informacije iz različitih situacija. Neke osobe bolje procenjuju jednu vrstu problema od drugih. Eksternalizirajuće simptome bolje opisuju i primećuju nastavnici i roditelji, dok deca bolje opisuju svoja iskustva i internalizirajuće simptome [19]. Veća je usaglašenost između odraslih (majka/otac, roditelj/nastavnik) nego između deteta i nastavnika/roditelja, kao što je i veća usaglašenost među procenjivačima kada su u pitanju eksternalizirajući problemi nego internalizirajući.

Roditelji, najčešće majke, daju informacije i procenjuju probleme svoje dece kako u kliničkoj praksi tako i u istraživanjima. Procena očeva je značajno zanemarena i to najčešće zbog tradicionalnog naglaska na dijadi majka-dete, koja potiče još iz psihoanalitičke literature. Majke jesu stabilnije i prisutnije figure u životu dece; nakon razvoda deca najčešće ostaju da žive sa majkom, očevi globalno provode manje vremena sa decom te možda i zbog toga ne raspolažu sa toliko informacija o detetu kao majke. U poslednje vreme se sve više ističe potreba i neophodnost aktivnog učešća očeva u proceni ponašanja i emocija dece. Izveštaji roditelja su uglavnom umereno usaglašeni, mada percepcija očeva može biti pod uticajem potpuno drugačijih

faktora u odnosu na percepciju majke. Upravo zbog ovog jedinstvenog pogleda na dete, važna je procena oba roditelja.

U nekim istraživanjima očevi su prijavljivali manje problema kod dece u poređenju sa majkama [20], dok u drugim studijama nije bilo značajne razlike u proceni [18]. Navodi se i da očevi i majke prijavljuju različite vrste problema; veća je usaglašenost u proceni eksternalizirajućih problema, dok su manje usaglašeni u proceni internalizirajućih problema; procena očeva je povezana sa kognitivnim sposobnostima deteta, dok je procena majki povezana sa njenim sopstvenim psihičkim statusom i pogledom na brak [21]. Usaglašenost izveštavanja majka-otac, roditelji-deca je viša kod procene preadolescenata, a manja kod procene adolescenata [22]. Ipak, loši bračni odnosi su i kod majki i kod očeva povezani sa procenom veće učestalosti eksternalizirajućih problema kod dece.

Po Ahenbahu [11], izveštaj nastavnika je od krucijalnog značaja u proceni deteta iz više razloga:

- problemi mogu biti prisutni isključivo u školi,
- školske socijalne i akademske veštine su važne za adaptivni razvoj deteta,
- zahvaljujući svojoj edukaciji, iskustvu i mogućnosti opservacije deteta u grupi, nastavnici su u stanju da opserviraju drugačije vrste ponašanja od onih koje procenjuju roditelji,
- nisu pod uticajem porodične dinamike,
- često su uključeni u upućivanje specijalizovanim službama,
- imaju priliku da dete porede sa drugom decom sličnog uzrasta.

Svi ovi faktori mogu doprineti nalazu jedne studije u kojoj su se nastavnici pokazali konzistentnijim i pouzdanijim procenjivačem od roditelja [23]. Ipak, nastavnici ne poznaju dete toliko vremena koliko i roditelji, i opservacije nastavnika su uglavnom ograničene samo na školsku sredinu, dok su roditelji sa decom na različitim mestima i u različitim situacijama tokom vremena. Kao i izveštaji roditelja i izveštaji nastavnika mogu biti pod uticajem psiholoških faktora ili interpersonalne dinamike, mada ne postoji mnogo istraživanja na ovu temu. Faktori koji mogu biti povezani sa izveštajima nastavnika uključuju socioekonomski status (SES), pol deteta, nivo obrazovanja roditelja i bračni status roditelja [24]. Probleme dece iz malobrojnih porodica bolje opažaju roditelji, dok probleme dece koja potiču iz mnogočlanih porodica bolje identifikuju nastavnici [25]. Za skrinig psihopatoloških problema dece u zajednici izveštaji roditelja su najinformativniji a izveštaji nastavnika obezbeđuju informacije koje povećavaju senzitivnost skrininga. U jednoj studiji standardizovane informacije od roditelja i nastavnika su bile superiornije od standardizovane kliničke procene u smislu predikcije dugotrajnog tretmana, školskih problema i kontakta sa policijom ili problema sa zakonom [25].

Pregled studija o prevalenci i strukturi psihijatrijskih poremećaja kod dece

Istraživanje na ostrvu Vajt koje je sproveo Rater sa saradnicima tokom 60-tih godina prošlog veka smatra se prvim epidemiološkim istraživanjem iz oblasti dečije psihijatrije koje je dalo prevalence problema mentalnog zdravlja među opštom populacijom dece [26]. Rater je koristio semistrukturisani klinički intervju kako bi postavio dijagnoze u grupi od 2000 dece i našao da je prevalenca psihopatologije među decom uzrasta 10 i 11 godina bila 6.8%, a prevalenca na uzrastu od 14 i 15 godina je bila 21%. Nešto kasnije u Danskoj je rađena studija među decom uzrasta 5 i 6 godina i dobijena je prevalenca psihijatrijskih poremećaja od 15% [27]. Dalji napredak u proceni prevalence je napravljen tokom 80-ih prošlog veka sa konstrukcijom Dijagnostičkog intervjua za decu (Diagnostic Interview Schedule for Children-DISC) [28], i Liste za proveru dečijeg ponašanja (Child Behavior Checklist-CBCL) [11]. Ovi instrumenti koriste standardizovan način prikupljanja podataka i podstakli su izvođenje brojnih longitudinalnih istraživanja u zapadnim zemljama.

Postoji nekoliko preglednih članaka koji se odnose na epidemiološka istraživanja prevalence psihijatrijskih poremećaja kod dece. Najpoznatiji i najčešće citiran je Robertsov članak o pregledu 52 epidemiološke studije o mentalnim poremećajima dece i adolescenata [29]. Roberts i sar. ukazuju da postoje značajne varijacije u prevalenci koje idu od 1% do 50%, sa srednjom prevalencom od 15.8%. Ovi autori su takođe zabeležili da stopa varira zavisno od godina, pola i drugih faktora, sa porastom prevalence sa godinama: od 10.2% (3.6%-24%) pre 6.godine, do 13.2% u preadolescenciji (1.4%-30.7%), pa sve do 16.5% u adolescenciji (6.2%-41.3%) [29].

Na području dečije psihijatrijske epidemiologije suvereni su i Kostelo i Angold koji daju pregled prevalenci iz 8 studija izvedenih od 1982. do 1992., koje se kreću od 16% za mlađu decu do 26% za adolescente sa srednjom vrednošću od oko 20% [30]. Najnoviji pregledi prevalenci koji obuhvataju prethodne dve decenije, kada su rađena brojna populaciona, metodološki rigorozna istraživanja o dečijim psihijatrijskim poremećajima govore o prevalenci od 3%-22% među decom školskog uzrasta [6,11].

Istraživanja vezana za probleme mentalnog zdravlja dece i mladih u Srbiji

U Srbiji nikada do sada (koliko je poznato autoru) nije urađena sistematska studija prevalence mentalnih poremećaja među opštom populacijom dece i mladih. Postoji jedino istraživanje iz 2003. godine koje je urađeno u okviru aktivnosti Ekspertske grupe za mentalno zdravlje mladih Ministarstva zdravlja ali se odnosi samo na mlade od 15 do 24 godine [31]. Primenjen je upitnik YSR za samoprocenu, učestvovalo je 1126 srednjoškolaca iz deset gradova u Srbiji i 557 sudenata Beogradskog univerziteta. Rezultati su ukazali da 1/3 mladih manifestuje znake psihološkog trpljenja i mentalnih problema i poremećaja i da su ugroženije devojke i adolescenti u urbanim sredinama [31].

Istraživanje zdravlja stanovnika Republike Srbije 2006. godine bavilo se i mentalnim zdravljem dece i to pomoću skale psihološkog distresa, skale vitalnosti i upitnika o prisustvu napetosti i stresa ali se nije bavilo istraživanjem prevalence pojedinih poremećaja [32]. Rezultati ovog istraživanja govore da je 18% dece imalo osećaj napetosti ili je bilo pod stresom mesec dana pred ispitivanje, više je bilo starije dece sa ovim teškoćama, uzrasta od 15 do 19 godina (30.5%), nego mlađe dece (7%). Emocionalne probleme je imalo 16.5% mladih (8.8% mlađih i 23.3% starijih). Procenat mladih od 15 do 19 godina koje je imalo neku vrstu psihološkog trpljenja (mereno pomoću učestalosti nervoze, tuge, potištenosti, iscrpljenosti i umora) bio je 34%, a 67.7% je imalo negativan skor na skali vitalnosti. Nije bilo statistički značajne razlike u odnosu na geografsku oblast i socijalno ekonomski status ali je procenat mladih sa ovim problemima bio manji za 4% u odnosu na 2000. godinu.

Projekat "Balkanska epidemiološka studija o zlostavljanju i zanemarivanju dece" (B.E.C.A.N.) odvijao se od septembra 2009. do januara 2013. godine u devet balkanskih zemalja [33]. Za epidemiološko istraživanje korišćeni su ICAST upitnici (ICAST-CH i ICAST-P) koje je osmislilo Međunarodno udruženje za prevenciju zlostavljanja i zanemarivanja dece (ISPCAN) a prilagođeni su za svrhe projekta B.E.C.A.N. Ova studija je otkrila da je gotovo 70% dece u Srbiji, uzrasta 11, 13 i 16 godina, doživelo bar jednom tokom života psihološko ili fizičko nasilje. Više od četvrtine dece bar jednom u životu osećalo se zanemareno. Više od 8% dece preživelo je seksualno nasilje, od kojih je više od 25 dece u prethodnoj godini doživelo kontaktno seksualno nasilje. Devojčice su više izložene psihološkom nasilju i izveštavaju o više osećanja zanemarenosti. Dečaci su ugroženiji seksualnim nasiljem. Stopa teških oblika fizičkog, psihološkog i seksualnog nasilja iznosi između 0,5 i 1%, a to su deca koju sistem socijalne zaštite treba da uoči i interveniše [33].

Istraživanje klastera višestrukih pokazatelja je još jedna epidemiološka studija o zlostavljanju i zanemarivanju u porodici, izvedena u Srbiji [34]. U ovoj studiji se navodi da su kod 72.8% dece uzrasta između 2 i 14 godina roditelji kao disciplinske mere primenjivali telesno kažnjavanje i psihološko maltretiranje. Među ovom decom njih 51% je doživelo umerene, a 7% teške telesne kazne. Teška telesna kazna bila je dva puta češća (14%) kod dece iz veoma siromašnih porodica (ispod granice siromaštva) i tri puta češća (21%) kod romske dece u romskim naseljima [34]. Ovi nalazi nešto su viši od onih u BECAN studiji. Objašnjenje ovih razlika može se potražiti u različitosti uzorka i istraživačkog metoda.

Prvo regionalno epidemiološko istraživanje urađeno je na području grada Novog Sada, primenom instrumenata CBCL i TRF na reprezentativnom uzorku od 1005 dece uzrasta od 4 do 11 godina [5]. Rezultati su pokazali da je učestalost emocionalnih problema i problema ponašanja dece uzrasta od 4 do 6 godina očekivana i u skladu sa rezultatima drugih istraživanja i iznosila je 11.4%, dok je kod dece uzrasta od 7 do 11 godina prevalenca ovih problema bila značajno niža od očekivane i iznosila je 6.4% [5]. Ekster-

nalizovani problemi su bili učestaliji kod dečaka nego kod devojčica, dok je zanimljiv rezultat o jednakoj učestalosti internalizovanih problema kod dečaka i devojčica, kao i nalaz o visokoj učestalosti internalizovanih problema kod dečaka mlađeg uzrasta.

Zanimljiv je i rezultat o povezanosti sociodemografskih faktora i problema ponašanja i emocionalnih problema dece. Naime, u starijem uzrastu su ovi faktori imali veći značaj u odnosu na mlađi uzrast, te su deca koja imaju probleme češće imala i nezaposlene očeve, niže obrazovane majke, lošije uslove života, češće su poticala iz porodica sa jednim roditeljem ili iz novoosnovanih porodica, nisu imali ili su imali dvoje siblinga. Potvrđena je i povezanost problema dece sa porodičnom funkcionalnošću, tako su deca koja nisu imala probleme češće poticala iz porodica koju su funkcionalnije [5].

U Srbiji nema sveobuhvatnih epidemioloških podataka o mentalnim poremećajima dece iz čega direktno proizlaze potrebe i smernice za daljim istraživanjima [35]. Naravno, ukoliko epidemiološka slika nije dovoljno jasna, ne znamo dobro i dovoljno o potrebama, pa je vrlo teško bez pravih utemeljenja planirati programe prakse zasnovane na dokazima i osmišljavati evaluaciju istih.

Zaključak

Iz ovog pregleda istraživanja o prevalencama se vidi da se stope prevalence problema mentalnog zdavlja dece i adolescenata razlikuju značajno, ne samo zbog različitih metoda procene, nego i zbog različitog dizajna istraživanja. Procena prevalence mentalnih poremećaja kod dece i adolescenata nosi sa sobom nekoliko metodoloških problema, pogotovo u velikim, populacionim epidemiološkim studijama. Dijagnostički intervju, zasnovan na DSM-IV ili ICD-10, koji bi sproveo kliničar na reprezentativnom uzorku smatra se zlatnim standardom, ipak, ovaj način je vrlo skup i zahteva mnogo vremena. Jedan od načina je skrining psihopatoloških problema pomoću upitnika sa dobrim psihometrijskim karakteristikama uzimajući u obzir da skrining automatski ne vodi kliničkoj dijagnozi. Metodološki razlozi za razlike u prevalenci su i uzorkovanje, naročito reprezentativnost i veličina uzorka. Tu su i varijacije u definisanju poremećaja, zbog upotrebe različitih dijagnostičkih sistema.

Akutelno je i pitanje o tome da li je potrebno uključiti i funkcionalnu nesposobnost kako bi se postavila dijagnoza. Mnogi autori smatraju da je u praksi vrlo često teško proceniti da li je oštećenje/nesposobnost uzrokovano samim simptomima poremećaja ili drugim faktorima, kao i da li je oštećenje/nesposobnost dovoljno teško za postavljanje dijagnoze [36, 37]. Oštećenje/nesposobnost je sigurno važno da bi se donela odluka o tome da li je potreban, i ako jeste, koji tretman treba primeniti, ali u proceni dijagnoze uključenje oštećenja/nesposobnosti podrazumeva da poremećaj postoji samo ukoliko postoji i značajno oštećenje/nesposobnost. Kada bi ovaj kriterijum nesposobnosti primenili na druge dijagnostičke kategorije kao što su HIV ili

kancer, epidemiološka istraživanja bi isključila mnoge osobe koje imaju bolest ali ne i oštećenje/nesposobnost. Ahenbah [22] smatra da nam broj i težina simptoma može pomoći u proceni sigurnosti postojanja bolesti i njene težine i da je oštećenje/nesposobnost važna ali ne neophodna kategorija za postavljanje dijagnoze [18]. Važan je i način analize i prezentacija podataka kao i analiza subjekata koji nisu želeli da učestvuju u istraživanju [29].

U zaključku svog članka koji se odnosi na epidemiologiju dečijih i adolescentnih psihijatrijskih poremećaja Kostelo i sar. [38] navode: „Epidemiologija ove oblasti medicine konačno je uhvatila korak sa realnošću. Prestala je da se pita koliko dece ima ovaj ili onaj poremećaj, kao da postoji tačan odgovor na ovo pitanje. Jasno je da nema tačnog merača psihopatologije i da različiti intervjui, upitnici, testovi proizvode različite procene prevalence i to u zavisnosti od strogosti kriterijuma za postavljanje dijagnoze. Isto tako, ne treba zaboraviti da su ovi instrumenti dobri koliko i taksonomije po kojima su instrumenti operacionalizovani.“

THEORY AND PRACTICE OF EPIDEMIOLOGICAL RESEARCH IN CHILD PSYCHIATRY

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Abstract: This article presents an overview of the development of epidemiologoical research in child psychiatry over the past 50 years. Although the epidemiological research in child psychiatry were delayed compared to the research in other medical branches, today they are at the top of contemporary epidemiological research because of raising awareness about the importance of child mental helath as well as innovative methods used today. The emphasis is on the multi-informant approach to the evaluation of children mental health as it is one of the specifity of epidemiology in child psychiatry. Usually, assessment of youth is done by parents, teachers and adolescents. Young children are not able to describe symptoms, their severity and duration, so we need information from others who knows child well. We presented the most common questionnaires that are used in epidemiological reserach as well as we stressed the importance of multidimensional scales in the evaluation of children. There is a review of studies on the prevalence and structure of child psychiatric disorders, both in developed countries and in developing countries as well, with special emphasis on current research studies in Serbia. We found tremendous variations in prevalence rates, mainly because of different assessment methods, but also because of the different designs methods. Conclusion is that we need a comprehensive epidemiological survey of a representative sample of children and adolescents in Serbia in order to get a clear picture of the youth mental health in our country and to plan the best treatment strategies for those who have mental health problems.

Keywords: *epidemiology, child psychiatry, prevalence, questionnaire, mental health*

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OPSERVACIJA AGORAFOBIČNOG SINDROMA KROZ PRIZMU PSIHOANALITIČKE EPISTEMOLOGIJE

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Apstrakt: Fokus teksta je na psihoanalitičkoj epistemologiji agorafobičnog sindroma koji je u psihodinamskim parametrima još uvijek nedovoljno klarificiran. Iscrpna teoretska studija polazi od samog izvorišta, teoretskih i praktičih sugestija Sigmunda Freuda. U rana psihoanalitička razmatranja o agorafobiji inkorporirani su i psihodinamički modeli Karla Abrahama, Helene Deutsch, Edoarda Weissa i drugih značajnih psihoanalitičara koji su tokom proteklog stoljeća dali bitne doprinose metapsihološkom razumijevanju agorafobije. Nakon razmatranja krucijalnih teoretskih uporišta o psihodinamici agorafobije iz druge polovine XX vijeka, između ostalih ilustriranih radom Maurice Bouveta i Jannine Chasseguet – Smirgel, autorica obrađuje psihoanalitičke modele predočene psihoanalitičkoj naučnoj javnosti tokom prve i druge dekade XXI stoljeća. Obuhvata autističke objektne odnose agorafobičnog neurotika prema Donaldu Cartwrightu i sintetizira obilježja reprezentacija selfa i reprezentacija objekta oslanjajući se na rad Barbare Milrod. Vodeći nas ka zaključku autorica rezimira aktuelnu psihoanalitičku epistemologiju agorafobičnog sindroma ukazujući na centralnost neadekvatne razriješenosti stadija separacije – individuacije, kao i ego defekata asociranih uz agorafobični sindrom. Specifikum objektne relacije agorafobičnog neurotika ilustrira ukazujući na prirodu njegovog odnosa sa pratiocem, tu psihičku fuziju koja pruža osjećaj sigurnosti van utočišta vlastitog doma. Ovaj iscrpan pregled inače malobrojnih psihoanalitičkih publikacija posvećenih agorafobji rezimiran je akcentom na nužnost njenog daljnjeg izučavanja, kao i naznakom da iako neurotski poremećaj, agorafobični sindrom bar jednim svojim polom teži ka nozološkoj jedinici koja obuhvata poremećaje ličnosti.

Ključne riječi: *agorafobija, psihoanaliza, psihodinamika, teorija objektnih odnosa*

Uvod

Simptomi agorafobije prvi put opisani su u "Anatomiji melanholije" britanskog naučnika i pisca Roberta Burtona 1621. godine [1]. Porijeklo termina datira iz 1871. godine kada je nemački neuropsihijatar Carl Friedrich Otto Westphal načinio kovanicu grčkih riječi *agora* (trg, mjesto gdje se okupljaju ljudi) i *phobia* (strah). Ovim je obuhvatio kliničku sliku kojom dominira strah od prostranih, otvorenih prostora, poput širokih ulica, mostova, gradskih trgova i sl. Westphal [2] piše: "Tokom pokušaja da pređe otvoreni prostor izbija strah čim se poveća udaljenost od kuća ulice koja vodi ka otvorenom prostoru... Pojavljuje se osjećaj nesigurnosti, kao da više ne korača sigurnim korakom, i registruje kako se kaldrma rastapa... Stanje se poboljšava samim tim što se nanovo približava kućama".

Psihoanalitička epistemologija agorafobičnog sindroma

Rani teoretski doprinosi

Već u svojim ranim psihoanalitičkim razmatranjima Sigmund Freud preuzima Westphalovu nomenklaturu i napomene o agorafobiji nalazimo vrlo rano u njegovom opusu. U pismu Fliessu iz 1892. godine [3] u kojem razmatra etiologiju neuroza on agorafobiju smatra hroničnim oblikom anksiozne neuroze, pretpostavljajući općenito seksualni kauzalitet neuroza. Njegovo metapsihološko [4] formuliranje agorafobije evoluiralo je uporedo s razvojem psihoanalitičke teorije. Tako se već u "Predgovoru i fusnotama prevodu Charcotovih 'Predavanja utorkom'" Freud [5] javno razilazi s Charcotovim mišljenjem da je hereditet istinski uzrok agorafobije sugerirajući "abnormallnosti seksualnog života". Dvije godine kasnije u članku "Opsesije i fobije" [6] čini distinkciju između psiholoških mehanizama geneze opsesije i fobije, naglašavajući da je u osnovi fobije uvijek prisutna anksioznost, za razliku od opsesije gdje sugerira centralnost mehanizma supstitucije. Također, fobije diferencira u one "uobičajene[1] i "zavisne"[2], svrstavajući agorafobiju u drugu grupu, u okviru širokog nozološkog entiteta anksioznih neuroza.

U studiji "Analiza fobije kod petogodišnjeg dječaka" [7], poznatijoj kao "Slučaj malog Hansa", Freud demonstrira tezu da je edipalna problematika, odnosno kastracioni strah, centralni konflikt oko kojeg se organizira fobična simptomatologija. U "Inhibicijama, simptomima i anksioznosti", djelu poznatom po reformaciji teorije anksioznosti, Freud [8] donekle razrađuje i psihodinamiku agorafobije sugerirajući da je "anksioznost koja se doživljava u agorafobiji… izgleda strah od seksualnog iskušenja – strah koji… mora u svom porijeklu biti povezan sa strahom od kastracije". Klarificira kako je simptomatologija agorafobije komplicirana činjenicom da se ego ne ograničava u pravcu

[1] Odlikuje ih pretjeran strah od stvari kojih se svako gnuša ili plaši u izvjesnoj mjeri, poput noći, usamljenosti, smrti, bolesti, opšte opasnosti, zmija itd.
[2] Obilježava ih strah od posebnih stanja koje ga kod normalnog čovjeka ne provociraju.

odricanja. Kako bi se oslobodio opasnosti u izvjesnoj situaciji ego trpi regresiju u period djetinjstva koja postaje uslov čije ga ispunjenje oslobađa od nastojanja usmjerenih ka odricanju. "Na primjer, agorafobični pacijent može biti sposoban hodati ulicom ukoliko mu je obezbijeđena pratnja, poput malog djeteta, od strane nekoga koga poznaje i kome vjeruje; ili, iz istog razloga, može biti sposoban da samostalno izađe van ukoliko je ovo organizovano tako da ostaje na određenom rastojanju od svog doma i ne ide na mjesta koja su mu nepoznata ili gdje ga ljudi ne poznaju. Aranžman će ovisiti u svakom slučaju o infantilnim faktorima koji njime dominiraju putem neuroze. Fobija od biti sam je nedvosmislena u svojim značenjima, bez obzira na infantilnu regresiju: to je, u konačnici, nastojanje da se izbjegne iskušenje masturbacijskog zadovoljenja."

Freud nije publicirao nikakav klinički material o analizi agorafobije jer se nije osobito posvetio njenoj fenomenologiji. Ipak, notirao je neophodne modifikacije tehnike u tretmanu: "Teško da će se ovladati fobijom ukoliko se čeka dok pacijent dopusti da analiza utiče na njega da odustane… Npr. u agorafobiji… postiže se uspjeh jedino kad se može inducirati… da izađe na ulicu i izbori se sa svojom anksioznošću tokom ovih pokušaja" [9].

Karl Abraham [10,11] piše o lokomotornoj anksioznosti koju naziva i strahom od ulice, kao i topofobijom. On sugerira da osobe koje pate od ovog poremećaja imaju uobičajenu incestnu fiksaciju, zajedničku svim neuroticima. Oslanjajući se na Freuda on piše i o konstitucionalnoj predispoziciji koja se očituje u ugodi kretanja. Nju smatra osnovom za odabir agorafobičnog simptoma. Odabir simptoma obrazlaže time da pulzije usmjerene ka dosezanju ugode, a koje su konfliktne, involviraju lokomociju iz razloga što je ovo preferirani modus od strane datog subjekta. Neuspješno potiskivanje ove tendence prouzročit će neurotsku inhibiciju tjelesnog kretanja. U "Konstitucionalnoj osnovi lokomotorne anksioznosti" Abraham [10] navodi značajna obilježja agorafobije:

- Incestnu libidnu fiksaciju na osobu koja predstavlja pratioca;
- Pacijentov strah pred životom, simbolički reprezentiran ulicama;
- Strah od iskušenja koji ga obuzima čim napusti zaštitu roditeljskog doma;
- Strah od smrti koja bi ga mogla zadesiti iznenada kada je daleko od ljudi koje voli.

Rani kazuistički prikazi ubrzo se pojavljuju u Njemačkoj. Helene Deutsch [12] publicira "Genezu agorafobije" koja će postati klasični psihoanalitički tekst o ovoj tematici. Ona prihvata Freudovu ideju o prevashodno falusno-edipalnom kauzalitetu. Istovremeno, dodaje vrlo značajne psihodinamske dimenzije:

- ideju o povišenom agresivitetu usmjerenom na oba roditelja;
- snažnu mazohističku orijentaciju seksualnih fantazija;

- naglašava mazohističku identifikaciju s majkom kao devalviranim objektom.

Edoardo Weiss [13] smatra da je izbijanje agorafobije determinirano izvjesnim "superficijelnim faktorima". Ovim zapažanjem značajno je dopunio psihoanalitičku epistemologiju agorafobije. Na ove faktore gleda kao na zahtjev, predstavljen pred pacijenta, da "zakorači u pravcu neovisnosti". Skladno ovome on zaključuje da agorafobiju obilježavaju tri "glavna značenja":

- Ja sam emancipiran. Mogu činiti što mi se prohtije (što Weiss izjednačava sa seksualnom kušnjom);
- Pokazivanje sebe samog u javnosti (odnosno egzibicionističke fantazije ili konflikt);
- Odvajanje od majčinske zaštite.

Iste godine Bergler [14] publicira prikaz slučaja u kojem se, tokom psihoterapijskog postupka, koristio psihodinamskim odrednicama Freuda, Abrahama i Deutscheve. U ovoj publikaciji on skreće pažnju na nesvjesni osjećaj krivice i po prvi put u psihoanalitičkoj literaturi ukazuje na povezanost agorafobije i depresije.

U publikaciji Katanove [15] koja je uslijedila dvije godine kasnije notiraju se specifičnosti u analitičkom postupku agorafobije, vrlo slično onome kako je ranije sugerirao Freud. Autorica piše: "Prepoznati i interpretirati simboliku je od male terapeutske vrijednosti kao i čisto simbolička interpretacija sna. Jedino je interpretacija tog tvrdoglavog prianjanja za agorafobiju, koja je simultano služila kao odbrana od zastrašujućeg ponovnog premiještanja u infantilna konfliktna područja, bila terapeutski efektivna. Prva interpretacija objašnjava jedino sadržaj anksioznosti, druga razotkriva njenu funkciju, i u spoju s prvom implementira terapeutski cilj."

Fenichel [16] podsjeća na značaj seksualnih konflikata u genezi agorafobične simptomatologije. On diferencira agorafobiju u odnosu na druge fobije s obzirom na specifičnost eksternalizacije unutarnje opasnosti koja obilježava ovaj tip fobične patologije. Kod drugih fobičnih manifestacija notira centralnost supstitucije premiještanjem jednog vanjskog objekta drugim. Također, on napominje da prisustvo pratioca, u cilju ublažavanja fobične anksioznosti, nije invarijabla. Iz ovog razloga pratioca ne smatra esencijalnim obilježjem agorafobije.

O psihološkim sličnostima fobičnih ispoljavanja i manifestnog sadržaja snova pisao je Lewin [17]. Naglasio je kako su latentni sadržaji fobične simptomatologije podložni distorzijama od strane primarnog procesa. Ovim je skrenuo pažnju na iznimnu složenost konstruiranja agorafobičnog simptoma.

Miller [19] sugerira da je osim erotizacije hodanja, egzibicionističkih i voajerističkih poriva, konflikata provociranih od strane superega i promiskuitetnih tendenci, osobita tematika oko koje se organizira agorafobija strah od trudnoće. Kauzalitet iznalazi u promiskuitetnim porivima i restitutivnoj fantaziji da se ima dijete. Autor navodi specifične elemente agorafobije:

- Defektno funkcioniranje superega;
- Svjedočenje seksualnim aktivnostima odraslih tokom ranog djetinjstva;
- Premiještanje seksualnih poriva usmjerenih ka ocu na fantazije o prostituciji, usmjerene ka strancima na ulici;
- Hostilnost i znatiželju u odnosu na majčino seksualno funkcioniranje, što je asocirano uz kastracioni strah. Pridružena je i ideja o trudnoći i rođenju djeteta, uz identifikaciju sa majkom koja začećem i porodom daruje život, a sekundarno i fetusom u uterusu.

Skoro trideset godina nakon publikacije članka "Agorafobija i njen odnos s histeričnim napadima i traumama" Weiss [19] publicira ekstenzivnu studiju o agorafobiji, monografiju "Agorafobija u svjetlu ego psihologije". Razmatra agorafobiju kao koflikt ne samo na relaciji ego – id, već i kao konfliktno stanje unutar samog ega od kojeg potiču prijetnje njegovom integritetu. Autor piše: "Oscilacije ego stanja i stimulacija blokiranih nagona s lakoćom bude potisnute, značajne strukture ega, stoga prijeteći njegovoj integraciji. Tjelesni i mentalni poremećaji unutar ega umanjuju pacijentovo povjerenje u vlastitu sposobnost da adekvatno djeluje i da se primjereno ponaša. Samog sebe tako čini da se osjeća bespomoćnim i nesposobnim za samostalno funkcionisanje". Potom slijedi "regresija u ovisno vezivanje za majčinsku figuru... što je rezultat, a ne uzrok, poremećaja unutar ega koji povećava njegovu potrebu za sigurnosnim mjerama". Weiss u monografiji podržava tezu da je u izvjesnom obliku konstelacija agorafobične simptomatologije odbrana od promiskuitetnih želja, te utvrđuje tezu da se kod ovog poremećaja radi o insuficijentnoj kontroli nad nagonima.

Dopuna ranog psihoanalitičkog modela – druga polovina XX vijeka

U francuskoj psihoanalizi Bouvet [20] u odnosu na dubinu regresivnog pomaka sugerira razlikovanje genitalne i pregenitalne fobije. Prvu označava i terminom "histerofobija" ukazujući na karakternu strukturu koja je dosegla primat genitalnog ustrojstva. Posmatrano kroz prizmu teorije objektnih odnosa ovo znači da je u slučaju genitalne fobije kompletirana diferencijacija selfa i objekta [21]. Pregenitalne fobije terminološki su označene i kao "faloanalne". Agorafobija, prema ovoj diferencijaciji, spada upravo u ovu kategoriju. Njenu kliničku sliku determinira i problematika potekla iz pregenitalnog razvojnog perioda, posebno analnog. Ovako duboka regresija ukazuje na snažan upliv pregenitalnih pulzija i na nepotpunu diferencijaciju selfa i objekta tokom maturacionog procesa agorafobičnog subjekta.

Rhead [22] elaborira tezu o distorziji ega agorafobičnih neurotika. Nju iznalazi središtem emanacije fobične anksioznosti. Priroda ove distorzije potiče iz razvojnog neuspjeha da se tokom djetinjstva dosegnu individuacija i separacija. Izvorištem erupcije fobične anksioznosti smatra prijetnju integritetu simbiotske spone s majkom, pri čemu je spona regresivno i defanzivno

reaktivirana u cilju izbjegavanja efekata poremećaja unutar ega, usljed preplavljujućih stimulusa (infantilnih sadomazohističkih, egzibicionističkih i/ili voajerističkih). Ova "nespecifična distorzija ega" rezultira iz sadejstva nekoliko faktora [22]:

- Neuspjeh individue da dosegne stadij psihičke separacije, i prateća fiksacija na simbiotskog partnera;
- Majčina neadekvatnost i neuspjeh da zaštiti dijete od preplavljujućih stimulusa;
- Prerana kristalizacija ega, masivne identifikacije, uz prevladavanje primitivnih mehanizama odbrane.

Frances i Dunn [23] razmatraju odnos agorafobičnog subjekta s njegovim pratiocem. Specifikum ovakve simboličke spone reflektira se u doživljaju pratioca kao dijela selfa. Gubitak fobičnog partnera stoga može biti doživljen kao prijetnja konstantnosti selfa. O sličnim opservacijama piše i Ferro [24] ukazujući na povezanost prijetnji konstantnosti selfa i nedostatne diferencijacije između selfa i ne-selfa kod agorafobičnih pacijenata. Stoga se gubitak fobičnog pratioca doživljava kao katastrofični gubitak dijela nediferencirane self/objekt reprezentacije.

Chasseguet-Smirgel [20], kao vrlo značajan predstavnik francuskog psihoanalitičkog kružoka, drži da agorafobični pacijenti pate od falusne zavisti. Mehanizam nastanka agorafobije definira u sljedećem okviru:

a) Zavist za falusom rezultira potrebom da se on posjeduje. Ovim se negira narcistička trauma nanesena od strane majke, koja je doživljena omnipotentnom, falusnom. Ove fantazije su prisutne u vremenu ulaska u ediplanu fazu razvoja tokom koje očeva ličnost podliježe snažnijoj kateksi. Posljedica je da on biva investiran i kao agresivan i kao libidni objekat.
b) Strahovi aktivirani omnipotentnom reprezentacijom majke nadvladavaju se procesima introjektivne identifikacije. Ovo je razlogom pojave homoseksualnih pulzija. Otac je na nesvjesnom planu doživljen kao rival. Svjesno u odnosu na majku on je idealiziran i poprima ulogu zaštitnika.

Identificirajući se s falusnom majkom muškarac preuzima pasivni, feminini stav. Žena preuzima maskulini stav kojim afirmira posjedovanaje falusa. Ipak, u oba spola u nesvjesnom agorafobičnih pacijenata kontinuirana su pitanja: Posjeduje li majka falus ili ne? Odnosno, posjeduje li on lično falus ili ne? Tjeskoba usljed isčekivanja narcističke povrede aktivira hostilna osjećanja prema majci. Projekcija agresiviteta, te posljedična introjekcija istog, rezultirat će manifestacijom straha od širokih trgova, mraka, smrti, tj. supstituta za arhajski majčinski imago.

Compton [25] sugerira da se termin agorafobija zamijeni "agorafobičnim sindromom" posebno obzirom na kategorizaciju fobičnog sadržaja. Naime,

kazuistučki prikazi u psihoanalitičkoj literaturi, kao i pacijenti koje susrećemo u praktičnom radu, ispoljavaju niz strahova: od uskih ulica, štirokih ulica, trgova, tunela, otvorenih prostora, ulaska u radnje, mostova itd. Razmatrajući psihoanalitičku literaturu engleskog govornog područja koja je fokusirana na agorafobiju on zaključuje da se u pogledu dinamskog sadržaja koji obilježava ovaj poremećaj nije ništa esencijalno dodalo još od teoretskih formulacija Freuda i Deutscheve. Iz ovog razloga ukazuje na neophodnost daljnjeg istraživanja ovog psihopatološkog fenomena kako bi se bilo u mogućnosti predočiti detaljniju, jasniju psihodinamsku formulaciju o istom. Prema Comptonu ovo se posebno odnosi na pitanja: Da li agorafobični sindrom potiče iz određenog, posebnog razvojnog perioda? Postoje li posebni konflikti koji, tipično, obilježavaju ovaj sindrom? Postoje li posebne nesvjesne fantazije koje su redovno reprezentirane u sindromu, i na izvjestan način kauzativne? Da li je agorafobija neizbježni produkt abnormalnog generiranja anksioznosti?

Iste godine Giordanelli [26] publicira tekst o agorafobiji u kojem čini osvrt i na teoretske postavke pojedinih italijanskih autora. Autorica piše o "arhaičnom nukleusu koji ostaje ugrađen, težak da se dosegne". Upravo ovaj nukleus odgovoran je za propratne simptome kliničke slike agorafobije iz kog razloga se može govoriti i o agorafobičnom sindromu. Pozivajući se na Weissa autorica podsjeća da uzrok agorafobije treba da se traži u deterioraciji senzornih iskustava ogromnog, otvorenog prostora u okvirima tjelesnog ega, te navodi da su "tjelesne i mentalne granice ega vrlo blizu biološkog nivoa":

"Kao da su vlastite granice pomjerene, ne da bi se ostvario kontakt s granicama drugog i ostvario proces razmjene, već u cilju preuzimanja teritorije koja obogaćuje i štiti od mogućih invazija."

Autorica citira studiju Palliera i saradnika koji kauzalitet agorafobičnog sindroma iznalaze u veoma ranom razdoblju, iskustvu fuzije u primitivnoj relaciji majka-dijete, razvojnom periodu koji prethodi shizo-paranoidnoj poziciji. Loša iskustva tokom ovog životnog razdoblja smatraju se osnovom za "violentnu i posesivnu projektivnu identifikaciju koja teži anulirati odvojenost, individuaciju i separaciju" koja obilježava agorafobični sindrom.

Prelaz iz XX u XXI vijek i aktuelni diskurs

Rezultate istraživanja na tematiku postojanja poremećaja ličnosti kod subjekata koji pate od agorafobije objavljuju Latas i saradnici 2000. godine [27]. Ovim istraživanjem ustanovljeno je da 45% ispitanika sa agorafobijom i paničnim poremećajem ispoljava kriterije za postavljanje dijagnoze barem jednog poremećaja ličnosti. Ovim rezultatom potvđeni su rezultati ranijih istraživanja kojima se procjenjivala asociranost agorafobije i poremećaja ličnosti.

Iz psihodinamičke pozicije Cartwright 2006. godine [28] predočava zanimljivu ideju o vrlo primitivnim, "autističnim[3]" objektnim odnosima kao centralnom obilježju agorafobičnog sindroma. U ovom kontekstu agorafobični strahovi i asocirane odbrane sagledavaju se kao regresivni kompromis koji ujedno i prestravljuje i štiti, prevenira i omogućava kontakt s vanjskim objektom. U psihodinamskom razmatranju agorafobije autor izdvaja tri esencijalna uporišta:

- Ključna dinamika u generiranju agorafobičnih simptoma involvira regresivno povlačenje u materinski objekat, gdje se zaustavlja strah od dezintegracije. Iz ove perspektive vanjski objekti mogu biti korišteni kao "autistični oblici" koji postaju supstitut za granice selfa, tj. oblik protektivne inkapsulacije.
- Kao posljedica autistične inkapsulacije dolazi do ometanja odbrambenog funkcioniranja projektivne identifikacije. U fantaziji projektivna identifikacija se često koristi kao način oslobađanja selfa od loših objekata čime se oni projiciraju u vanjske objekte. U odnosu na specifičnost agorafobičnog doživljaja prostora, značajno je umanjen ovaj kapacitet tranzitornog rasterećenja selfa.
- Agorafobično iskustvo zbiva se u dijalektici između paranoidno-shiziodnog i autistično-graničnog modusa generiranja iskustva, u skladu s Ogdenovim predočavanjem različitih modela putem kojih se generira iskustvo.

Godinu dana nakon Cartwright-ove publikacije Milrodova [29] razmatra reprezentacije selfa i objekta kod agorafobičnih pacijenata te notira njihovu nekompletnost. Autorica podsjeća i na razvojne deficite ega, problematiku koju je akcentirao Weiss [19], docnije i Rhead [22]. Istovremeno ona upozorava da "ovi problemi tek trebaju zadobiti prominentnu ulogu u psihoanalitičkim formulacijama o agorafobiji". Tako, poput Comptona koji je to učinio petnaest godina ranije i Milrodova jasno ističe potrebu za daljnjim izučavanjem psihopatologije agorafobije.

Psihodinamska epistemologija agorafobičnog sindroma

Aktuelni psihodinamski model agorafobije moguće je sintetizirati na sljedeći način. Kod agorafobije centralne psihološke razvojne zapreke, tj. tačke fiksacije i regresivne trendove, psihoanalitička teorija iznalazi u pregenitalnom razvojnom periodu [12,20-25,27,28,30-33], na koje se nadovezuje kasnije neadekvatno razriješena edipalna problematika. Pre-gentitalne fiksacije i parcijalna regresija u ovaj razvojni period uzrok su snažnim neneutraliziranim nagonskim pulzijama koje intenzivno, i prepla-vljujućim obilježjima, agiraju u nesvjesnom stratumu agorafobičnog neurotika. Kada ličnosti prijeti prodor nagonskih pulzija, ego se koristi mehanizmima odbrane kako bi kontrolirao

[3] Autor se koristi terminom *autističan* kako bi ukazao na stanja uma kada se mentalni objekti i senzorne impresije koriste u cilju izoliranja i blokiranja iskustva.

opasnost [34]. Nju uvijek doživljava kao anksioznost koja je različitog intenziteta i kvaliteta, u odnosu na regresivna obilježja konfliktnog područja iz kojeg emanira. Shodno ovom, anksioznost se doživljava kao prijetnja selfu i objektnoj relaciji (tj. objektu) sa specifičnostima ovisnim o stupnju maturiteta objektne relacije. Stoga se, ontogenetski posmatrano, u psihoanalizi razlikuju različiti oblici anksioznosti. Primitivnije, preplavljujuće anksioznosti anihilacijskog, odnosno fragmentacijskog tipa obiljžavaju vrlo rani period života, stadij kada simbioza nije uspostavljena kao matriks egzistencije. Viši maturacijski stupanj, još uvijek u području pregenitalnih stadija, obilježen je strahom od gubitka objekta. Jedan je od obilježja simbiotskog razvojnog stadija. Edipalnu problematiku [35] prati kastraciona anksioznost koja je asocirana uz strah od gubitka ljubavi objekta, da bi adekvatnim razrješenjem triangulacione problematike zrela ličnost bila podložna anksioznosti prouzrokovanoj strahom od negodovanja od strane vlastitog superega.

Pregenitalne pulzije, kakve obilježavaju agorafobičnog neurotika, provociraju izuzetno visok kvantum anksioznosti. Strah od gubitka objekta produbljen je i probojem primitivne anksioznosti anihilacionog tipa. Prekurzori anihilacionih anksioznosti adultnog doba univerzalni su. U normalnoj ontogenetskoj progresiji registruju se u vrlo ranom periodu, početcima djetetovog ekstrauterinog života. Ovakav kvalitet anksioznosti provociran je neminovnim narušavanjem homeostaze novorođenčeta (glad, žeđ, kada je mokro, snažni zvukovi iz okoline i sl.). Ovaj disbalans ono doživljava preplavljujućim jer mu iznimno nezreo psihički aparat onemogućava obuhvatnije i „zdravije“ elaboriranje anksioznih doživljaja. Na razvojno arhaičniju anihilacionu anksioznost kod agorafobije se nadovezuje ontogenetski nešto mlađa anksioznost koja se očituje u vidu straha od gubitka objekta.

Strah od gubitka objekta, separaciona anksioznost, u optimalnom razvoju korespondira simbiotskom stadiju [36,37]. Tokom ovog životnog doba još uvijek je velikim dijelom nedostatna integracija libidnih i agresivnih pulzija asociranih uz „dobre“ i „loše“ introjekte [38]. Iz ovog razloga pritisci agresivnog stratuma snažno opterećuju ego koji je u ovom periodu još uvijek nedovoljno integriranih sintetičkih funkcija. Iz ovog razloga on se služi primitivnim mehanizmama ego odbrane u nastojanju da kontrolira anksioznost i „loše“ sadržaje eksternalizira van simbiotskog matriksa. Tako ego agorafobičnog neurotika permanentno koristi premiještanje, projekciju, izbjegavanje, negiranje, projektivnu identifikaciju. Interferencija snažnih, neneutraliziranih agresivnih pulzija ometa optimalnu strukturaciju psihičkog aparata, „izlijeganje“ iz simbiotske unije i dosezanje psihičke autonomije čiji krucijalan korak podrazumijeva ostvarivanje zadataka separacije-individuacije kako je definirala Malherova. Iz ovog razloga imperativ za zaštitom i očuvanjem dobre self/objekt reprezentacije, koja je kod agorafobičnog neurotika kontinuirano na nesvjesnom planu izložena plejadi hostilnih pulzija porijekla iz vlastitog selfa, rezultira mobilizacijom niza pomenutih arhaičnih ego odbrana.

Obzirom da je fobična ličnost strukturirana tako da primarni proces ima vrlo snažan upliv u kreiranju kompromisne formacije (tj. psihopatološke simptomatologije) agorafobični simptomi oblikovani su i distorzionim obilježjima primarnog procesa. Tako se psihopatološki simptom agorafobije, kao visoko simbolizirani, apstraktni iskaz neurotskog konflikta, oblikuje i procesima kondenzacije i simbolizacije. Fokalni proboj primarnog procesa kojim se oblikuje dio agorafobične simptomatologije ukazuje i na specifične slabosti, defekte ili distorzije ega.

Ukazuje se izvjesnim da je centralno konfliktno područje oko kojeg se organizira agorafobična simptomatologija problematika stadija separacije – individuacije. Tokom razvoja, sposobnost majke i djeteta da se fizički udalje jedno od drugog inducira i pospješuje psihičku diferencijaciju reprezentacija selfa i reprezentacija objekta. Na ovaj način dijete uspostavlja odvojenost selfa od majčinskog imagoa prakticirajući i fizičko udaljavanje od nje. Istovremeno, ono samostalno osvaja prostor katektirajući ga kao sigurnu teritoriju i u majčinom odsustvu. Djetetov stav prema vanjskoj, nepoznatoj sredini, kao i doživljaj selfa prilikom njenog istraživanja, velikim dijelom ovisit će o majčinim kapacitetima da bez isuviše tjeskobe tolerira njegovu znatiželju i nastojanja da se i fizički odvoji od nje. Isto tako, vrlo značajno je i majčino prihvatanje svog djeteta nakon njegovih „istraživačkih pohoda“. Evidentna fiksacija i parcijalna regresija u ovaj ontogenetski stadij ukazuje se očitim genetičkim domenom metapsihološkog tumačenja.

Sa ovako naglašenim pregenitalnim sadržajima onemogućeno je adekvatno razrješenje narednog maturacionog stupnja, edipalne problematike kod docnije odraslog agorafobičnog neurotika. U infantilnu genitalnu fazu (falusni stadij) dijete ulazi s masivnom identifikacijom s moćnom, omnipotentnom majkom, što je provocirano nedostatnom neutralizacijom agresivnih pregenitalnih pulzija. Ovo rezultira djetetovom pojačanom agresivnom kateksom majčinskog imagoa, svakako i s uplivom libidnih pulzija. Otac je usljed ovoga najčešće idealiziran, što također ukazuje na prisustvo snažnih agresivnih pulzija, s kojima se isprepliće i izvjesna količina libidne katekse. Ovo će, tokom edipalnog stadija, rezultirati nemogućnošću dječaka da se adekvatno separira od majčinog imagoa. Kastracioni strah, kao obilježje edipalnog stadija, snažno je pojačan nerazriješenim strahovanjima ranijih, predgenitalnih stadija. Pred ovakvim intrapsihičkim prijetnjama dječak nije u stanju na zdrav način separirat se od omnipotentne majke, te ostaje masivno identificiran s njenim imagoom preuzimajući feminini, pasivni stav. Ovim prolongira intrapsihičku fuziju s moćnim, falusnim, opasnim objektom. Djevojčica se, također, na optimalan način libidno ne okreće suprotnospolnom roditelju. I kod nje se kastraciona strahovanja intenziviraju usljed snažnog upliva neneutraliziranih agresivnih pulzija porijekla iz pregenitalnog stadija. I ona, regresivno, ostaje masivno identificirana s omnipotentnim majčinim imagoom, preuzimajući maskulini stav. Oba roditelja su, kao i u slučaju dječaka, pojačano katektirana agresivnim pulzijama, s izvjesnim uplivom i libidne katekse.

Tako stereotipno vraćanje nagonskih zahtjeva ida kod adultnog agorafobičnog neurotika provocira kontinuiranu upotrebu specifičnih ego odbrambenih manevara. Kompromisna formacija agorafobije specifični strah premiješta na područje prihvatljivijeg straha. Potom projicira isti u vanjske situacije gdje se anksioznost može vezati i na koncu izbjeći setom ponašanja koje razvija u cilju izbjegavanja fobogeno katektiranih situacija. Psihodinamski sagledano, može se reći da agorafobija „služi da zaštiti dijadni odnos na uštrb kreiranja opasnog vanjskog svijeta“ [23].

Objektna relacija agorafobičnog neurotika

Maturacioni nivo objektnih odnosa agorafobičnog pacijenta možda je najuočljiviji kada se analizira priroda njegovog odnosa s pratiocem. Ovu ulogu „zaštićenog zaštitnika“ po prvi put u psihoanalitičkoj teoriji podcrtava H. Deutsch [12], akcentirajući prisustvo snažnih simbiotskih spona. U praktičnom radu s osobama koje pate od agorafobije evidentno je da one vode takav životni stil da se ukazuju nekompletnim u situacijama kada su bez pratioca. Odnosno, ponašaju se kao da su „u psihičkoj fuziji“ [29] s istim. Ovo implicira neadekvatno rješenje procesa separacije-individuacije, te prisustvo nekompletnih objektnih reprezentacija, kako selfa tako i značajnog drugog. Tako npr. Battistini i Petronio [26] akcentiraju da je anksioznost kod agorafobije prouzrokovana strahom od gubitka objekta, i da ovaj tip fobije obilježava nedostatnost granica između onog što je unutra i onog iz vana.

Upravo usljed nedostatnosti autonomne strukture reprezentacija selfa pacijentu prijeti stalna opasnost od anihilacije, odnosno fragmentacije istog. Inicijalna intrapsihička opasnost projicirana je van, i vanjski prostor katektiran je kao opasni objekat koji prijeti cjelovitosti selfa. Agorafobični neurotik stoga razvija bihejvioralne obrasce kojima uporno izbjegava da bude izložen ovakvim prijetećim okolnostima. Stoga mu je potreban objekat kako bi se, kada je izložen fobogeno katektiranoj situaciji, u iluzornoj fuziji s njim osjećao cjelovitim i sigurnim. Iz ovog razloga gubitak fobičnog partnera doživljava se kao gubitak katastrofičnih razmjera jer je na intrapsihičkoj sceni u pitanju gubitak dijela simbiotske self/objekt unije.

Zaključak

Specifičnost kliničke agorafobičnog sindroma, kao i vrlo složena i dalje nedovoljno jasna psihodinamika nalažu njeno daljnje izučavanje. Agiranje predgenitalnih anksioznosti uz opipljive defekte ega i nedostatost diferencijacije self/objekt reprezentacije kao da agorafobiju, barem njenim jednim polom, približavaju poremećajima ličnosti [21,27] iako je sindrom, uistinu, bazično neurotske konstelacije.

OBSERVATION OF AGORAPHOBIC SYNDROME THROUGH THE PRISM OF PSYCHOANALYTIC EPISTEMOLOGY

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Abstract: Focus of the text is on psychoanalytic epistemology of agoraphobic syndrome which is still not sufficiently clarified in psychodynamic parameters. Detailed theorethic study starts from the very origins, theoretical and pratical suggestios of Sigmund Freud. Early psychanalyic formulations include psychodynamic models of Karl Abraham, Helene Deutsch and Edoardo Weiss, as wel as a number of other significant analysts who gave significant insight to the metapsychological formulations of agoraphobia in the beginning of XX century. After portraying crutial theoretic frames of dynamics of agoraphobia originating from French psychoanalysis, illustrated through the work of Maurice Bouvet and Jannine Chasseguet – Smirgle, author moves towards pschoanalytic models presented to the psychoanalytic community during the first and second decade of XXI century. This segment incorporates autistic objects of agoraphobic neurotic according to Donald Cartwright and synthesis of crutial traits of representations of self and representations of object according to Barbara Milrod. Leading us towards the coclusion author makes a resume of the actual psychoanalytic epistemology of the agoraphoic syndrome pointing out at the cenrality of non adequately solved separation – individuation stage, as well as ego defects associated to he agoraphobic syndrome. Specificity of object relatios of agoraphobic neurotic she illustrates poiting out at the nature of his relatioship with the follower, that psychic fusion which provides the feeling of certainty outside the safety of ones own home. This detailed overview of severely insufficient published literature devoted to agoraphobia is ressumed accenting the neccessity for its further research, as well as clear notion that although neurotic disorder, agoraphobic syndrome by at least one of its pole gravitates towards nozologycal unit marking personality disorders.

Key words: *agoraphobia, psychoanalysis, psychodynamics, object relations theory*

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WHY ARE THEY UNWILLING TO GROW UP? FAMILY THERAPY WITH ANORECTIC MALES

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Abstract: The prevalence of anorexia nervosa is increasing among males. However, there are only a few studies on the family therapy of eating disordered males. In this paper three case reports are presented, where the significant remission was due to family therapy. In the development of the symptoms the postadolescence described by Keniston was in the foreground in two patients. This phenomenon is increasing in the last decades, and may serve as a risk factor of late onset anorexia in males. Family therapy can be the method of choice in postadolescent males as well, because in spite of the late onset, the family dynamics are similar to that found in the family of adolescent anorectics. This paper examines the similar and different aspects of family therapy of male and female patients with anorexia nervosa. In the family therapy of male anorectic patients only a few gender specific characteristics were found.

Key words: *eating disorders, anorexia nervosa, males, family therapy, postadolescence*

Background

Formerly eating disorders were regarded as the disorders of white Western women ("3W"). This is less valid in the last decades, as the prevalence of eating disorders is increasing among non-white people, in non-Western countries and among males. Males with eating disorders have been reported since 1689, when Morton [1] published two cases, one of them was a male patient with "nervous consumption".

The proportion of males in the total number of eating disordered subjects is about 10%, and most studies on eating and body image disorders have included female samples. As a consequence, little is known about men's eating patterns [2]. It is likely that rates of eating disorders in males will continue to increase [3]. Because of the increasing number of male patients with an eating disorder there is an assumption that by the year 2050 the difference in the prevalence of eating disorders between males and females will disappear due to the great impact of the slimness ideal on males [4]. There are some subpopulations among males with a higher pressure towards thinness. For instance, body shape and thinness is much more emphasized among homosexual males than among heterosexuals. Some kinds of sports require thinness, and this may cause a very low body weight, for example, among jockeys and dancers. The male anorexia is often hidden, because the doctors are less likely to think of it [5].

There are some differences between the characteristics of male and female anorexia. Females try to lose weight continuously, but males stop losing weight at a low but not life-threatening body weight. Serious cases can evidently occur in both sexes. There is a book written by a seriously and chronically underweight male patient from the United States. He died after the second edition of his book [6]. Lowenstein [7] described the following predisposing factors and characteristics of male eating disorders: overdependence from the family; wrong identification with the father, close relationship with the mother; open malignity between father and son; too much worries because of weight; physical diseases, e.g. Crohn disease; high intelligence and good achievement at school; depression; low sexual interest, low level of testosterone, conflicts about homosexuality, general sexual anxiety; psychotic disorder; anxiety; overweight parents; restricted anger; too much dealing with food; obsessive traits and perfectionism.

Ousley et al. [2] in comparing 750 males and 750 females concluded that males with an eating disorder were less fearful about gaining weight and becoming fat, or heavy, than females with an eating disorder. However, Woodside et al [8] reported that men with eating disorders had higher rates of comorbid psychiatric diagnoses compared to men without eating disorders. Similar to females, males have increased rates of different psychiatric diseases, e.g., depression, anxiety disorders, and addictive disorders. The metabolic consequences are also frequent, such as the osteoporosis. Males with eating

disorders tend to externalize emotional distress, and cannot easily express their emotional state, or talk about their life events [3].

According to family dynamic observations, since the 1970s, it has been suggested that family therapy is one of the most important treatment options for patients, with anorexia nervosa. Later on, it was proposed in the treatment of bulimic patients, as well. Now, it is regarded as one of the major therapeutical methods in the treatment of adolescents with an eating disorder [9]. The family can be regarded as a resource of the treatment. For teenagers family therapy is the first-choice treatment method (not the pharmacotherapy). Controlled trials support the effectivity of family therapy, as well [10].

So far, there are only few publications about the family therapy of eating disordered males. In the first case report, Carr et al, [11] described the successful family therapy combined with behavioural therapy, where the separation-individuation process was in the foreground. Rechlin et al [12] presented a case study of a 22-year-old male patient. They stress the importance of the family system in the motivation for the loss of weight. Besides the individual diagnostic measures, several family tests were used as well (the Family Sculpture Test, the Thematic Apperception Test, the Family Interview, and the Family Rorschach Test). The authors underline the significance of cohesion, adaptability, the outer boundaries of the system, rules and norms within the family, and generational boundaries.

Lately, we have also published a case report of a 19-year-old male patient living in a patchwork family [13]. In this paper a 10-session long family therapy was described, and the reorganization of the family was in the focus. In our institute the family therapy is a central therapeutical modality in the treatment of eating disorders, and in the last years an increasing number of male patients sought treatment. This article will summarize the main characteristics of the family therapy of three male patients with anorexia nervosa.

Case vignettes

Case 1

The 30-year-old Robert (pseudonym) was an only child, who lived separately from his parents, but was employed in the car service of his parents, and received salary from his father, although he had no duties at all. His mother was talkative and overprotective, his father occasionally impulsive, did not define the job of supportive his son, accepting that as parents they should support their son. He has had a girlfriend, for three years, and a degree in a technological college.

Robert's maximum weight ever was 67 kg, at the time when he did bodybuilding. He started to lose weight two years ago. After a phone call the family therapy was proposed. His parents were worried about Robert's health. He spent most of his time with his parents, with whom he had fierce quarrels, because they considered him as a child. Robert's mother cried sev-

eral times. They wanted Robert to continue the work in the company, but he was too weak to participate, and he did not show any willingness to work. He enjoyed his parents' unconditional support.

At the first interview he was like an underweight, defying adult-baby (height: 180 cm, weight: 45 kg, BMI: 13.9). He had also obsessive symptoms (checking continuously his temperature and clothing), so he had been treated with an antidepressant (citalopram) for a few months. The diagnosis was anorexia nervosa, with a comorbitidy of obsessive-compulsive disorder.

During the 22-session family therapy and pharmacotherapy (20 mg citalopram daily) his obsessive symptoms disappeared, he started to take responsibility for his issues: he could manage to pay the bills of his flat, performed his personal duties, and started to put on weight slowly (one kilogram per month). Meanwhile, he broke up with his girlfriend, but later, they reconciled although he had quarrels with his mother, she became considerably less overprotective. The hardest task was to make his father understand Robert's needs to have important and real duties at their company. The breakthrough was brought about by the entrance of a young worker with whom Robert started to work together, and he became self-sufficing.

Robert changed his appearance, lately he has looked like a grown-up man. By the three-month follow-up he has gained 17 kilograms (body weight: 62 kilograms, BMI: 19.1). He was ready to increase his body weight. He was more involved in his parents' company, he had important duties and responsibilities. He could deal with the problematic issues in his relationship with his girlfriend, and they plan to marry.

In summary, a significant, but partial remission could be observed. The family therapy intervention was focused on the adult role of the patient, and the separation-individuation process.

Case 2

The 22-year-old Jonas (pseudonym) was an only child, living with his parents. He had an elder brother who lived separately. His mother was a housewife, his father was a businessman in a technological company.

At the time of the first interview, Jonas was a slow, underweight, and childish boy (height: 185 cm, weight: 54 kg, BMI: 15.8). He studied information technology at the university in the town where they lived. He has had an insulin dependent diabetes mellitus for 8 years. Besides that, he has had obsessive-compulsive symptoms from his childhood, aggressive and sexual obsessions, and hand washing. He began to lose weight two years before treatment. He was hospitalized a year ago, and regained only a few kilograms. He ate a little bit, but he had also a chewing and spitting out syndrome. Because of the obsessive symptoms, he has been treated with pharmacotherapy (10 mg olanzapine and 10 mg citalopram daily) by a psychiatrist. He did not perceive himself as underweight, and he was worried about

being overweight. The diagnosis was anorexia nervosa, diabetes mellitus, and obsessive-compulsive disorder.

His mother was overprotective, spending the most of the time at home. His father worked a lot, often absent from their home. They described Jonas as a silent person who was frequently bored, so he wanted to spend all his time with his mother, which was a pressure for her. The mother cried a lot due to her worry about Jonas's physical status while the father did not understand why his son could not recover. Jonas was isolated, had no girlfriend in his life, and had only superficial relationships with his university colleagues.

The aim of the family therapy was to strengthen the separation of Jonas, to decrease the overprotectiveness of the mother, and to involve the father more in the family affairs. There was tension between the parents, because the mother wanted to discuss the family problems with her husband, who refused that.

The family therapy lasted for four months, and consisted of 10 sessions. At the two-month follow-up, the mother was less overprotective, and the father spent more time with the family. They reciprocated favours, which helped to decrease the tensions in the family, and the family members became more attentive to each other. The diabetes of Jonas was stabilized. He began to take more responsibility for his body and weight. Chewing and spitting out occur sometimes. During the therapy, Jonas gained 15 kilograms, reaching the normal weight range, and was steadily 76 kilograms (BMI: 22.2) in the last weeks. Also, he became more active in the university, while his obsessive thoughts have decreased a little during the treatment. The family decided to follow the patient's individual therapy in their home town because of the obsessive symptoms.

In this case, similarly to the former case, the stimulation of the separation-individuation process was in the foreground of the therapy. The isolation of the patient decreased, and he began to take more responsibility in his own life. It is important to mention that the combination of the diabetes and anorexia nervosa is very dangerous, sometimes fatal.

Case 3

The 20-year-old Rudolf (pseudonym) lived far from his family in a rented flat because he was a student at a pedagogic college. His mother was a housewife, his father was a driver. Rudolf was the first born child, and had a 16-year-old brother, who went to grammar school. Rudolf had a good relationship with his parents. His mother took care of the family, his father spent a lot of time working abroad.

One year before the family therapy began Rudolf had started a diet, because he was 80 kg and felt slightly overweight (height: 177 cm, BMI: 25.5). He wanted to be liked by women. He had never had a relationship with a girl, but had some friends. He was treated with vitamins and antidepressants by the family doctor, but he continued to lose weight. He practiced

long-distance running, and used an exercise bike. His weight loss was constant, and at the time of the first interview he weighed 47 kg (BMI: 15.0). He knew that he was too slim, and wanted to gain weight to reach 65 kg (this would be a BMI 20.7). Because the pharmacotherapy was not effective to gain weight, his mother looked for other treatment opportunities, so she found our outpatient department.

Rudolf was talkative, but his mother dominated the first interview, getting into details of the everyday life of her son, demonstrating her overprotectiveness and the enmeshment between them. The father was supportive, but peripheric, without paying enough attention to the illness of his son, spending the majority of the week abroad. Because of that, he could participate only three times in the treatment process.

The diagnosis was anorexia nervosa. The family engaged in family therapy, which lasted for four months, including seven sessions. There was a follow-up in e-mail after three months.

The aim of the therapy was to decrease the maternal overprotectiveness, to increase paternal involvement and to increase Rudolf's self-confidence and his responsibility for his body. His health status was steadily improving, he became more open towards women, starting to attend some parties.

At the three-month follow-up, Rudolf had no symptoms, his body weight was 69 kg (BMI: 22.0). His relationship with his parents was harmonious, and he had a good social life. In this case, the process of the family therapy was essentially not different from the usual family therapy of female anorectic patients. The following issues were in the focus of the therapy: the self-confidence and the sexual anxiety of the patient, the structural characteristics of the family: maternal overprotectiveness, enmeshment, and the peripheric role of the father. The therapy ended with complete remission.

Conclusion

It is an open question, whether the family therapy of male anorectics differs from that of females, and if yes, in which regard. There can be similar and different aspects. The importance of the separation-individuation process, and the role of the structural family dysfunctions can be similar – especially the maternal overprotectivity, and the peripheral situation of the father [14]. In our cases, many of these characteristics could have been observed.

The first two cases demonstrated that the patients did not want to take the responsibility for their adult life. It was comfortable for them to live with their family. Although the patient in the first case was in his 30s, he was supported by his parents, and his relationship with them was like a quarreling teenager-parents relationship. He had no plans to have his own family although he had a girlfriend. The patient in the second case was involved only in his university studies and his family, but no other social activities or sexual interest. In the third case, the desire for a relationship played a central role.

Sexuality related anxiety and dissatisfaction with the body was similar to the phenomena in female anorexia nervosa.

In each case, the strong Oedipal relationship with the mother was striking. This relationship was ambivalent: although the patients were in their adult age, and the maternal worry and overprotectiveness caused frustration for them, they did not want to lose that, so they lacked the healthy and normal desire to separate from parents. Instead pursuing autonomy they assumed the role of a child.

A key feature of male anorexia nervosa is that the rate of weight-loss is not life-threatening, and the patients are satisfied with the stabilized low body weight. Unlike females, male patients lacked the resistance for continuous weight loss, and this is the one of the reasons why males have a better relationship with their mothers than female patients. The female anorectics tend to exhibit opposition and resistance to their mother. Their weight loss is frightening to the father as well. The attention of the father is very important in terms of their personality development while the "anorectics" are "hungry for their fathers' attention" as it was described in the literature [15].

In their overview, Brown and Keel [16], point out that the family based treatment of anorectic patients is advantageous because it balances the benefits of a controlled environment for producing weight gain with the external validity of achieving these aims within the home environment. In younger adolescent patients, who live with their family of origin, the family therapy proves to be the most effective treatment. Less evidence is available on the effectivity of family therapy in bulimic patients. One of the reasons is that the bulimia occurs a bit later, and the symptoms are frequently hidden [9,10].

Our patients were of postadolescent age (20-22-30 year old). There is an interesting phenomenon called "postadolescence among youths" which was first published by Keniston [17,18]. It can be characterized by the delay of accepting adult responsibilities. These young adults meet the psychological criteria of being adult, but they do not meet the sociological ones. The economic basis of independence and autonomy is missing.

This phenomenon covers up the following overdependence on the family; strong relationship with the mother; fights with the father; obsessive characteristics; perfectionism and, low sexual interest.

Kiecolt-Glaser and Dixon [19] reported four male cases of postadolescent onset anorexia, treated with individual therapy. The age patients at the onset of anorexia were 19-22 years. The authors suggest that postadolescent males seem to withdraw from the challenges of everyday living. They state that the withdrawal of these male patients from achievement and autonomy is a deviation from cultural sex-role norms. This may be the cause of the poorer outcome in comparison to females.

These males are afraid of having their own family, choosing the security of the parent's home which led them to the isolation. This is what distinguishes male anorexia nervosa from female anorexia nervosa also. Females

procrastinate growing-up too, but males may be afraid of different things, for example being the head of a family.

Today, the number of marriages decreases and the number of common-law marriages is growing. The other alternative to marriage, besides common-law marriage, is being single. The reason why males, who do not earn money and do not have a job, do not marry, is because they would not be able to maintain a family. Several sociological analysis support the idea that men lost they so called manlike behavior, and they are afraid assuming the role of the head of their own family. Parents have a remarkable role in the process of postponing growing up. The phenomenon of "lifelong parenting" is quite prevalent, which means that parents undertake the prolonged support of their children instead of stimulating their desire to become an independent adult [20].

According to the Hungarian data, 40 years ago 20% of adults below the age of 40 lived with their parents while this ratio was 40% in 2011. The reasons for this phenomenon are different: difficulties in buying a flat, the elongated time spent in higher education, difficulties in finding a job, and the decreased number of long-lasting relationships [21].

In the case of postadolescent females, the Oedipal relationship may be different from that of males. Mothers are the linchpins of a family, so the Oedipal relationship with the son can hold the son in the bond of the family more than in the case of daughters, because the Oedipal relationship of daughters with their fathers can be weak to hold the daughter in the bond of the family. As it was written in the case vignettes, the strong relationship between sons and mothers was the reason why the desire for independency was discouraged among them.

Family therapy is recommended for teenagers. Stressing the importance of postadolescence, eating disordered males in their 20s or even 30s seem to wish to stay teenagers forever – as Peter Pan did, who never wanted to grow up [22]. During the family therapy we realised that responsibility given to the patient helps the most. Besides, it was important to decrease the mother's overprotectiveness and the emotional distance of the father from the family.

In summary we can say that in the family therapy of male anorectic patients, only a few gender specific characteristic could be found. Our first and second case was typical examples of the postadolescence. In spite of the late onset of illness, the family therapy was an important and effective method of their treatment. In the third case, no prominent gender specific characteristics could be found. In general, the therapy did not essentially differ from the family therapy of female anorectics. The further research of the gender specific features in the context of the family therapy of anorectics is essential, and may bring new aspects to the therapeutical process. This may be easier in the next decade, since the number of male anorectics is increasing.

ZAŠTO SU NEVOLJNI DA ODRASTU? PORODIČNA TERAPIJA MUŠKARACA SA ANOREKSIJOM NERVOZOM

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Apstrakt: Prevalenca anoreksije nervoze je u porastu kod osoba muškog pola. Ipak, postoji mali broj studija učinka porodične terapije kod muškaraca sa poremećajem ishrane. U ovom radu predstavljena su tri slučaja koja su imala značajnu remisiju uz primenu porodične terapije. Kod dva pacijenta pozadinu simptomatologije činila je postadolescencija opisana od strane Kenistona. Ovaj fenomen je u porastu poslednjih decenija i može predstavljati faktor rizika za anoreksiju nervozu kasnog početka kod muškaraca. Porodična terapija može biti metoda izbora kod postadolescentnih muškaraca jer je, uprkos kasnom početku razvoja poremećaja, porodična dinamika slična onoj koja se viđa kod adolescenata sa anoreksijom. U ovom radu istražuju se sličnosti i razlike u primeni porodične terapije muških i ženskih pacijenata obolelih od anoreksije nervoze. Otkriveno je svega nekoliko specifičnosti u vezi sa polnim razlikama prilikom primene porodične terapije kod muških pacijenata.

Ključne reči: *poremećaji ishrane, anoreksija nervosa, muškarci, porodična terapija, postadolescencija*

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SVEMOĆ I KRIVICA KOD PSIHOTERAPEUTA

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Apstrakt: Autor polazi od pretpostavke da su svemoć i krivica ljudske egzistencijalije. Tok ovih suštastava u toku života individue (na putu ka Ličnosti) zavisi, najvećim delom, od toka vaspitanja u ranom detinjstvu. Psihoterapeut je posebno izložen značaju razvoja/pozitivnog i/ili negativnog/osećanja svemoći i krivice, pa je zato i više odgovornosti u radu sa klijentom u toku psihoterapije. Traženje i nalaženje harmoničnog odnosa između svemoći i krivice u subjektivnom doživljaju psihoterapeuta – takođe izloženog smenjivanju ova dva osećanja u toku svakog ličnog života, kao i njegov klijent – moguće je postići celoživotnim usavršavanjem psihoterapeuta, samoanalizom.

Ključne reči: *svemoć, krivica, psihoterapeut i njegov razvoj, moral i etika, samousavršavanje*

Nije mnogo pisano u stručnoj psihoterapeutskoj (prvenstveno psihoanalitičkoj) literaturi o ličnom, privatnom životu psihoterapeuta. Zašto? Verovatno se pretpostavlja da su didaktička analiza budućeg psihoterapeuta, kao i njegove neprestane analize kontratransfera u toku psihoterapije dovoljni da se ne pojavi razlog većih prepreka u radu sa klijentom. Pošto nisam uveren da su ove mere opreznosti kod psihoterapeuta uvek dovoljne da spreče moguće smetnje u toku psihoterapije, posvećujem ovaj članak životu psihoterapeuta izvan psihoterapije. Mogao bi neko da mi stavi primedbu da je jedna ovakva vrsta radoznalosti za privatni život psihoterapeuta, ne samo suvišna, već i sumnjive prirode. Ne mislim tako, pa ću opravdanost ovakvih razmišljanja pokušati da pokažem.

Najpre, niko od poznatijih psihoterapeuta iz područja tzv. dubinske psihologije, i kada su prošli kroz uspešnu školsku analizu, ne odriče značajan udeo ličnog života psihoterapeuta u toku celoživotne prakse jednog dubinskog psihoterapeuta. Ovakvo potvrđivanje neprestanog uticaja ličnog života psihoterapeuta na tok jedne, najčešće višegodišnje psihoterapije, počiva i na pisanom i nepisanom pravilu (čak aksiomu) da čovek ne poznaje samog sebe. Delfijsko upozorenje svim ljudima - *Gnothi se auton*, mora da je postojalo i pre nastanka stare Grčke, i na istovetan način nastavljalo se i preko preporuka hrišćanskih svetitelja (među njima, naročito, svetog Isaka Sirina iz VII veka) [1], plodno se uobličivši empirijskim iskustvom i dokazima savremene dubinske psihologije - najpre psihoanalize, a onda, svakako, i plodnim otkrićem Alfreda Adlera [2] i Karla Gustava Junga [3], koji su najpre potvrdivši, ali onda i korigujući preterivanje Frojdovog učenja, značajno doprineli proširavanju naših znanja (ali onda, svakako, i našeg neznanja) o veoma složenoj telesno-duševno-duhovnoj strukturi čovekovog bića. Tako je, na najbolji način za čoveka, čuvena misao *Upoznaj samog sebe*, ispisana na ulazu u delfijsko proročište ostala trajna opomena i pouka svakom čoveku na ovoj čudesnoj i zagonetnoj planeti Zemlji, da se ne ponese gordošću (svemoći), već da strpljivo i trpljivo, u toku celog jednog života, upoznaje sebe kroz proces individuacije i/ili oboženja.

Da se sada upitamo (smelo i pomalo neverovatno), kakav je najčešće lični život psihoterapeuta sa kraja XX i početka XXI veka u evroameričkim zemljama ili i kod nas (reč je uvek o psihoterapeutima koji pripadaju školama tzv. dubinske psihologije)? Možemo se odmah upitati zašto bi se njihov lični život razlikovao od onog prosečnog, nekog školovanog čoveka druge struke? Ne izdvajajući psihoterapeuta u neku posebnu, elitnu struku, ipak smatram da je lični (da li i slobodan?) izbor mladog čoveka da studira medicinu da bi postao psihijatar i psihoterapeut, odnosno da studira psihologiju da bi postao psiholog-psihoterapeut, dovoljan znak ili nagoveštaj da njegova odluka (opet pitam da li determinisana njegovim dotadašnjim ličnim životom, ili je ta odluka relativno slobodna?) povlači za sobom jednu posebnu vrstu odgovornosti pred Bogom (ako u njega veruje), pred ljudima i, naravno, pred sobom.

I, kakav je lični život danas nekog mlađeg ili sredovečnog psihoterapeuta? Da li je isti ili sličan, onako rastrgan, kao i nekog drugog intelektualca drukčije profesije? Ljudsko biće je, po mom mišljenju, shizofreno biće ("shizofrenija" bez shizofrenije!) jer u njemu najčešće vlada neusklađenost između onoga šta misli, oseća, govori i čini. Današnje vreme krize (prema jednom od značenja ove grčke reči, ona znači i sud) - da li je postojalo neko vreme, i u bliskoj i u daljoj istoriji sveta bez krize? - zahteva od odgovornog čoveka (kao da je sve više u celom svetu neodgovornih ljudi) pojačanu budnost i pažnju, u stalnom nadgledanju svoga ličnog života, od kojeg često zavisi, dobar ili rđav ishod, njegovog i ličnog (porodičnog) i profesionalnog odnosa prema drugima.

Kako je već odavno poznato da i eksperiment nekog strogog, egzaktnog naučnika delimično zavisi i od njegovog trenutnog, ličnog raspoloženja, koliko je potrebno pojačane budnosti kod nekog psihoterapeuta u toku samo jedne psihoterapeutske seanse, ne bi li, ovim neophodnim oprezom, sprečio da njegova subjektivnost ne poremeti relativno normalan tok psihoterapije! Naravno da smo daleko od pomisli da je uopšte moguće potpuno isključiti svoju ličnost iz toka neke dugotrajne psihoterapije. Možda takvo odstranjivanje subjektivnosti psihoterapeuta ne bi bilo ni dobro. Naglasak je jedino u mogućoj, mada ne uvek lakoj kontroli svoje subjektivnosti, i to naročito onda kada je ličnost psihoterapeuta u nekoj svojoj krizi (porodičnoj, profesionalnoj, materijalnoj, zdravstvenoj).

U kakvom odnosu stoji moralni i etički život psihoterapeuta, prema njegovoj svakodnevnoj psihoterapeutskoj delatnosti[1]? Da li je ovakvo pitanje opravdano? Uveren sam da jeste. Mi, nažalost, ne možemo praviti poređenje između nekog velikog umetnika ili filozofa sa psihoterapeutom, pa reći, kao što je to Jung pisao, da neki veliki stvaralac u ličnom životu može da bude filistar, podlac, duševno bolestan, karakterno rđav ili dobar čovek, a da takav njegov lični karakter ništa ne smeta snazi (često univerzalnoj) njegovog stvaralačkog dela, jer to delo najvećim delom proizlazi iz arhetipa *homo creator-a* njegovog kolektivno nesvesnog, koje je nezavisno od individualno ili familijarno nesvesnog. Čak ni jedna ovakva, realativno ubedljiva postavka K. G. Junga, kada on razmatra poreklo nekog genijalnog stvaralačkog dela, nije za svakog ubedljiva. Ostanimo na prosečnom dubinskom psihoterapeutu.

Moralni i etički život psihoterapeuta stoji u uskoj vezi sa njegovim osećanjem svemoći (omnipotencije) i krivice. Dobro nam je poznato, ne samo kao psihoterapeutima, već i kao introspekciji naklonjenijim ljudima različite profesije (nešto češće introvertovanim nego ekstravertovanim), da nam je ideja moći urođena. Ova ideja, najverovatnije, direktan je proizvod

[1] Da se podsetimo: moral u čoveku odgovara na pitanje: Šta treba da činim? Teži vrlini. Etika odgovora na pitanje: Kako živeti? Teži sreći. I moral i etika čoveka zapadnoevropske civilizacije i kulture, počiva na Kantovim pitanjima: Šta mogu da znam – Šta treba da činim – Čemu smem da se nadam?

jakog osećanja nemoći (Alfred Adler bi rekao urođenog osećanja inferiornosti malog deteta), ali onda i postojećeg (etolozi tvrde) urođenog agresivnog nagona. Još uvek mi je, donekle, zagonetan paradoks prisutan kod normalnog, zdravog deteta, u ranom detinjstvu, koje se kreće (nesvesno koleba) od osećanja gotovo potpune nemoći (slabosti) i gotovo apsolutne moći (omnipotencije). Nema sumnje da je identifikacija deteta sa oba roditelja (ako do nje dođe posle prolaznog, normalnog stadijuma imitacije) veoma značajna za ishod prirodne unutarnje (nesvesne) borbe deteta sa oba prisutna jaka osećanja: moći i nemoći. Zapravo, od ishoda pozitivnije ili negativnije identifikacije sa roditeljima, dobrim delom će zavisiti, kakav će karakter, a onda i ponašanje zadobiti tokom celog života budući čovek u detetu. Da neće do kraja biti presudna identifikacija sa roditeljima, govori (za mene, i ne samo za mene) činjenica postojanja urođenog principa Ja, koje može od početka života deteta da bude jako ili slabo.

Uzmimo primer psihoterapeuta koji u detinjstvu nije imao sreću da njegova identifikacija sa roditeljima bude uspešna. Da li to treba da znači da će njegovo osećanje moći, odnosno nemoći, a onda, možda nedovoljno kontrolisana agresija, škoditi toku njegove dugotrajne psihoterapije sa klijentima? Verovatno da će biti tako i pored relativno uspešne a neophodne školske analize, koja će ga pravovremeno upozoriti na opasnosti ispoljavanja moći, odnosno agresije, u toku psihoterapije.

U kakvom se odnosu, pitamo se, postavlja odnos osećanja svemoći u psihoterapiji sa osećanjem krivice? Ovaj odnos je, naravno, složen, ne samo zato što su osećanja straha i krivice, prema Martinu Hajdegeru [4], ontološke kategorije ljudskog bića, već što je nemoguće zamisliti čoveka bez osećanja krivice. Staro pitanje, da li se iza osećanja krivice uvek mora kriti neka stvarna krivica, i dalje je aktuelno i kod psihoterapeuta u toku njegove psihoterapije.

Zbog čega bi trebalo psihoterapeut da bude kriv? Zar ne zbog onih istih istupa koje počini svaki drugi čovek, ogrešujući se tako o svoje Nad-ja, ili o svoju savest[2].

Kao da smo opet na pragu moralnog i etičkog života psihoterapeuta. Znamo i to da život psihoterapeuta može, a ne mora, da stoji u vezi sa njegovim ateističkim ili teističkim "pogledom na svet". Moralnih ateista uvek je bilo, mada ne u velikom broju, kao što je bilo dovoljno (i danas ih ima) nemoralnih teista. Treba li ponavljati da je svaki čovek dualističko, rascepljeno biće u kome, nekad doživotno, vode borbu verovanje i neverovanje, dobro i zlo, odnosno, njegovo nesvesno (iracionalno) i svesno (racionalno) biće.

Zašto mi je značajno da u ovome članku o privatnom životu psihotera-

[2] Kao što je poznato, prema hrišćanskom uverenju, mada postoji bitna razlika između pojma savesti, kao "urođenog glasa Božjeg u nama", i pojma Nad-ja, onako kako ga je psihoanaliza objasnila, ova se razlika, donekle, umanjuje, kada je reč o toku jedne psihoterapije.

peuta obraćam pažnju na njegov svakodnevni život, i to najpre u porodici, odnosno, na njegovo ponašanje koje je u skladu ili nije u skladu sa opštim moralnim i etičkim pravilima religije (ne samo hrišćanske)? To je zato što sam uveren da se neka naša lična ogrešenja - neka budu i relativno površna - moraju odraziti, manje ili više, štetno na našeg klijenta, odnosno na tok psihoterapije. Zar nas nije već odavno upozoravao poznati francuski psihoanalitičar Saša Našt [5] u članku "Uzroci i mehanizmi neurotičnih deformacija Ja" (u njegovoj knjizi "Prisustvo psihoanalitičara") da za naše klijente treba da budemo "autentično dobar objekt" koga su oni nekada bili lišeni. Već sam jednom pisao o bračnim problemima psihoterapeuta [6] pa bih se ovom prilikom osvrnuo na neke važnije probleme u porodičnom životu psihoterapeuta (naravno, ako psihoterapeut ima porodicu) koji bi mogli da imaju odraz, pozitivan ili negativan, na tok psihoterapije.

Šta sa psihoterapeutima koji imaju dugogodišnji rđav brak, zatim sa onima koji su se više puta razvodili i ponovo venčavali[3] ili sa onim psihoterapeutima koji imaju teškoće sa odgajanjem dece, bilo da su ova još u školi, u adolescentnom dobu ili i kasnije? Šta sa psihoterapeutima homoseksualcima, ili psihički nestabilnim i pored obavljene školske analize? Mogu li ovakvi psihoterapeuti da budu ipak uspešni u svojim višegodišnjim psihoterapijama, sa različitim klijentima? Analiza erotskog i agresivnog transfera i kontratransfera, kod svakog školovanog psihoterapeuta podrazumeva se, ali, da li to znači da se problemi erotske i agresivne prirode više ne pojavljuju u njihovoj analizi pacijenta? Mislim da to nije moguće, ali kakav je onda ishod ovih problema kod psihoterapeuta kada se oni pojave, odnosno, kako na ovaj ishod utiče moralno ili nemoralno ponašanje psihoterapeuta u njegovom ličnom životu?

Govorim li ja to o nekom idealnom psihoterapeutu, o čistunstvu u psihoterapiji, ne pravim li se veći vernik nego što jesam, upadajući tako u zamku licemerstva ili i verskog fundamentalizma? Koliko sam u stanju da budem prema sebi objektivan, odnosno kritičan (što svakako ni za koga nije lak zadatak), što znači dovoljno introspektivan u doživotnoj samoanalizi [7] (preporučenoj i od samog Frojda), ne smatram sebe ni dovoljno (nikad dovoljno!) hrišćanskim vernikom, niti psihoterapeutom "bez mane i straha". Bila mi je samo želja da skrenem pažnju današnjim psihoterapeutima (ovde i sada), koji žive u vremenu, zbilja ozbiljne krize morala i etike, kada je, izgleda, sve više ljudi (mi ih u psihoterapiji zovemo psihopatama) koji čine krupne prestupe u životu, a da se, pri tome, na izgled, nimalo na kaju, niti hoće da priznaju svoju krivicu – da ostanu budni ili postanu budniji prema sopstvenom svakodnevnom životu, od njih se ne traži da budu hrišćanski svetitelji, ali da su u stanju da dovoljno dobro kontrolišu svoj moralni, etički, možda i religiozni život (ako misle da su religiozni), kako bi, siguran sam, bolje i dugotrajnije pomagali svojim klijentima. U čemu da im pomognu?

[3] Ne odričem mogućnost uspešnijeg drugog, čak i trećeg braka.

Naravno, u razrešavanju njihovih nesvesnih i svesnih konflikata agresivne, seksualne, ali i duhovne prirode, bez ikakvog nametanja (manipulacije i indoktrinacije) svoga "pogleda na svet", bilo onog teističkog ili ateističkog.

"Ako ne postanemo bolji, postaćemo gori" – često navodim ovu staru jevrejsku izreku, koju potvrđuje i dinamička psihologija, kao što je uvek potvrđivala svaka religija sveta, hrišćanska naročito. Na psihoterapeutima je da se doživotno bave sobom, koje će im (bavljenje) omogućiti uspešan proces individuacije (možda i obožen̄ja), a da, pri tome, ne izgube neophodan i dragocen odnos sa ljudima (Ja-Ti-Mi odnos!) [8], pomažući im i voleći ih. I to najpre voleći članove svoje porodice, svoje prijatelje i svoj narod, a onda i svoje klijente.

Svemoć i krivica moraju postići relativnu ravnotežu u duševno-duhovnom životu psihoterapeuta; mogu je postići onda kada otkrivanje "smisla života" zadobije u psihoterapeutu višu svrhu; samo tako će psihoterapeut uspeti da izbegne opasnost svemoći "čovekoboga" i opasnost mazohističkog doživljavanja (i neurotičnog uživljavanja) u krivicu, odnosno osećanje krivice. Krivica je tu, u nama, potrebna, ali i prepoznata, da bi bila okajana i tako prevaziđena; svemoć je tu u nama, potrebna i prepoznata, da bi uz njihovu pomoć ostvarili dugi put od „čovekoboga do Bogočoveka".

OMNIPOTENCE AND GUILT OF THE PSYCHOTHERAPIST

Vladeta Jerotic

Serbian Academy of Sciences and Arts

Abstract: The author starts from the premise that omnipotence and guilt are a part of human existence. The development of them during a person's lifetime (on his road to Personality) is affected mostly by upbringing in early childhood. The psychotherapist is especially affected by the significance of the development (positive and/or negative) of omnipotence and guilt, and due to that there is even more responsibility in working with the client during psychotherapy. Seeking and finding a harmonic relationship between omnipotence and guilt in the subjective experience of the psychotherapist – who is also affected by changes in these two feelings during his personal life, as his client is – is possible to achieve by self-improvement and self-analysis of the psychotherapist that should last his whole life.

Key words: *omnipotence, guilt, psychotherapist and his development, moral, ethics, self-improvement.*

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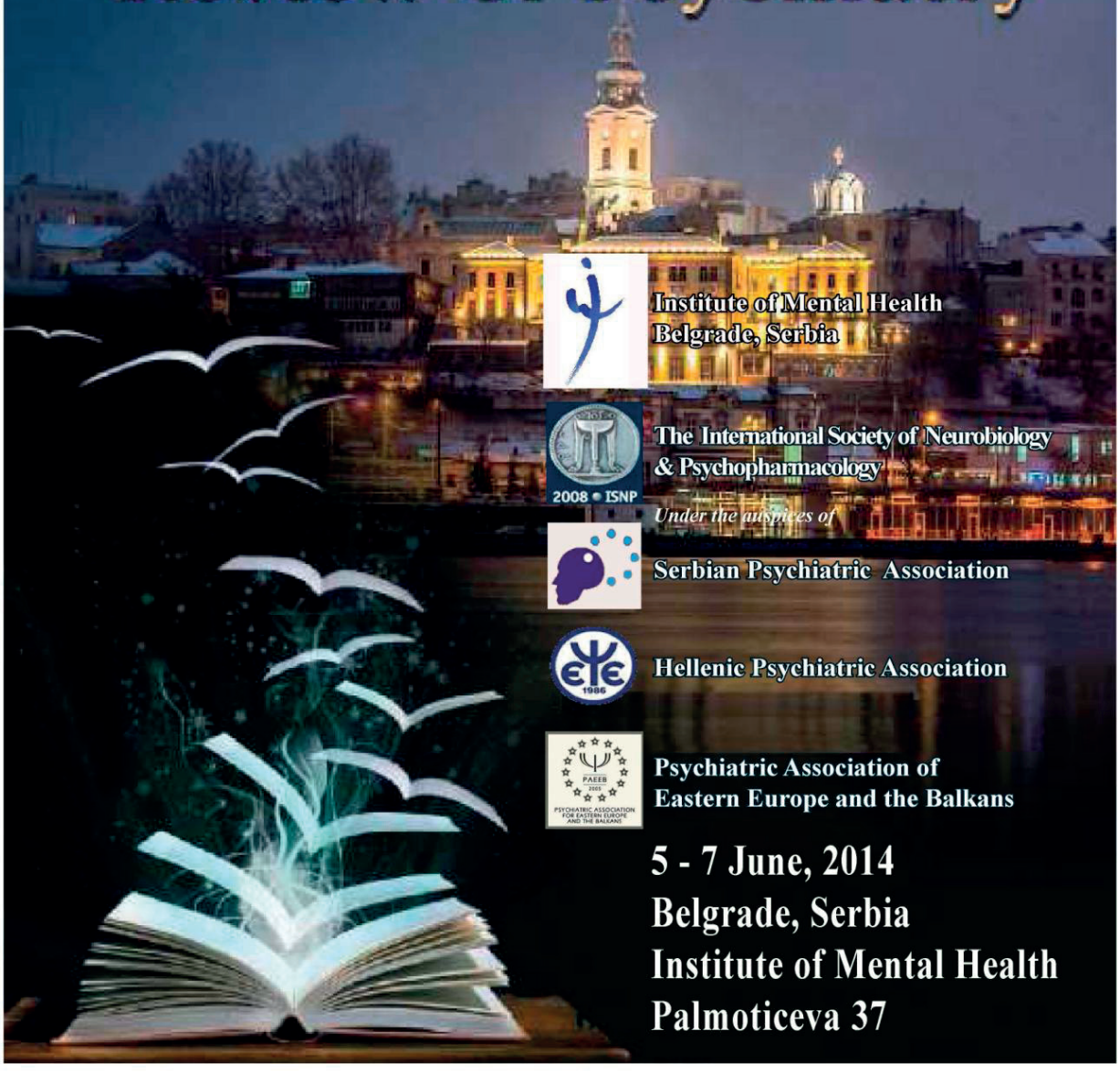

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5 - 7 June, 2014
Belgrade, Serbia
Institute of Mental Health
Palmoticeva 37

5 JUNE 2014 / 18:00 – 20:00 /
HOUSE OF CULTURE, TERAZIJE 34

CONGRESS OPENING
Opening addresses
Prof. Slavica Djukic-Dejanovic (Serbia)
Prof. Dusica Lecic-Tosevski (Serbia)
Assoc. Prof. Konstantinos N. Fountoulakis (Greece)

Musical performance & Cocktail

6 JUNE 2014 / 10:00 – 11:50 / Blue Hall, V floor

PLENARY LECTURES
Chairs: D. Lecic-Tosevski, S. Djukic-Dejanovic and K.N. Fountoulakis

Improving strategies for early interventions in schizophrenia – TGF-β as a biomarker
Slavica Djukic-Dejanovic (Serbia)

Most possible receptor targets for antidepressant therapy in bipolar disorder
Konstantinos N. Fountoulakis (Greece)

Guidelines for treatment of bipolar disorder
Siegfried Kasper (Austria)

Less is more – toward new classification of personality disorders
Dusica Lecic-Tosevski (Serbia)

11:50 – 12:30 Coffee break

SYMPOSIA

12:30 – 14:00 / Blue Hall, V floor

TREATMENT OF BIPOLAR DISORDER ACROSS LIFE SPAN – FROM RESEARCH INTO CLINICAL ARENA
Chairs: A. Serretti and G. Mihajlovic

Bipolarity in adolescent – difficulties for the diagnosis
Nicolas Zdanowicz, C. Messaud (Belgium)

Canadian biomarker integrated network in depression – CAN-BIND
Roumen Milev (Canada)

Strategies for resistant depression – recent updates
Alessandro Serretti (Italy)

12:30 – 14:00 / Red Hall, IV floor

CHILD AND ADOLESCENT PSYCHIATRY – NEW TRENDS AND CHALLENGES
Chairs: S. Popovic-Deusic and M. Pejovic-Milovancevic

Child psychiatry – Quo Vadis
Smiljka Popovic-Deusic, Nenad Rudic, Olivera Aleksic-Hill (Serbia)

Glutathione S-transferase (GST) gene polymorphisms in early onset psychiatric disorders
Milica Pejovic-Milovancevic, Vanja Mandic-Maravic, Marija Mitkovic-Voncina, Mulutin Kostic, Amir Peljto,Marija Pljesa-Ercegovac, Tatjana Simic, Dusica Lecic-Tosevski (Serbia)

Medication in perception of adolescents – friend or foe?
Zagorka Bradic, Sabina Jahovic, Marija Mitkovic-Voncina, Zeljka Kosutic, Dejan Todorovic (Serbia)

14:00 – 15:00

POSTER SESSION

Lunch break (IMH Club)

15:00 – 16:15 / Blue Hall, V floor

MIND AND BODY UNITY – COMORBIDITY OF MENTAL AND SOMATIC DISORDERS
Chairs: D. Lecic-Tosevski and R. Jokic

Comorbidity of schizophrenia and cancer – double trouble
Aleksandar Damjanovic (Serbia)

Exploring heart and soul – how much does stress really matter
Olivera Vukovic, Dusica Lecic-Tosevski, Miodrag Ostojic (Serbia)

In search of depression and diabetes link
Dusica Lecic-Tosevski, Olivera Vukovic, Nikola Jovanovic, Aleksandra Jotic, Nebojsa Lalic (Serbia)

15:00 – 15:45 / Red Hall, IV floor

TOPICS IN SCHIZOPHRENIA
Chairs: M. Selakovic and C. Miljevic

Relationship of stress, cannabis use and first psychotic episode
Mirjana Selakovic, Orestis Giotakos, Vasilis Kakavos, Georgios Mitropoulos, Dimitris Dikeos (Greece)

Schizophrenia as a progressive brain disease
Cedo D. Miljevic (Serbia)

15:45 – 16:30 / Crvena sala, IV sprat

SATELITSKI SIMPOZIJUM /Alkaloid/

Savremeni koncept tretmana shizofrenije
Goran Mihajlović

Tretman psihotičnih poremećaja – izazovi u kliničkoj praksi i naša iskustva
Saveta Draganić-Gajić

16:15–16:30 – Coffee break

16:30 – 17:00 / Blue Hall, V floor

GENERAL ASSEMBLY OF THE
SERBIAN PSYCHIATRIC ASSOCIATION

7 JUNE 2014 / 9:00 – 11:00 / Blue Hall, V floor

PSYCHIATRY – NEW CHALLENGES
Chairs: H. Herrman and M. Milovanovic

Partnership for mental health
Helen Herrman (Australia)

Blood and brain biomarkers of depression
and antidepressant drug response
Lucas Pezawas (Austria)

Functional neuroanatomy of insula
Mohandas (India)

Inductive effects of anti-epileptic drug on gingival fibroblasts of child and adult
Surena Vahabi, Bahareh Nazemi (Iran)

Interictal disphoric disorder – is it specific for patients with epilepsy?
Maja Milovanovic, Mirjana Jovanovic, Rada Djokic (Serbia)

11:00 – 12:00 / Blue Hall, V floor

TREATMENT OF BIPOLAR DISORDER –
CHALLENGES AND PERSPECTIVES
Chairs: D. Popovic and S. Draganic-Gajic

Individualized treatment of bipolar disorder – myth or an option?
Dina Popovic (Spain)

A prospective 4 years naturalistic follow up of 300 bipolar I & bipolar II patients
Christian Simhandl, B. König, B. Amann (Austria)

Bipolar affective disorder and parents'
socio-emotional investment in children
Saveta Draganic-Gajic, Desanka Nagulic, Goran Gajic, Snezana Stojanovic,
Milica Pejic, Dusica Lecic-Tosevski (Serbia)

11:00 – 11:45 / Crvena sala, IV sprat

FUNKCIONALNOST PACIJENATA – CILJ SAVREMENE TERAPIJE SHIZOFRENIJE /Satelitski simpozijum – Janssen/

Poboljšanje funkcionalnosti pacijenata kroz integrativni pristup lečenju
Dušica Lečić-Toševski

Dugodelujući antipsihotici – poželjan ili neophodan izbor?
Slavica Đukic-Dejanović

12:00 – 12:30 – Coffee break

12:30 – 13:15 / Crvena sala, IV sprat

SATELITSKI SIMPOZIJUM /Pfizer/
Generalizovani anksiozni poremećaj – novi koncepti u lečenju
Olivera Vuković

Uloga i mesto oralnih i parenteralnih atipičnih antipsihotika
Čedo D. Miljević

12:30 – 14:00 / Blue Hall, V floor

NEUROCOGNITIVE DEFFICITS IN MOOD DISORDERS
Chairs: K.N. Fountoulakis and F. Kouniakis

General neurocognitive functioning and intelligence quotient (IQ), psychomotor and mental speed and attention in mood disorders
Stella Miziou (Greece)

Memory and verbal and visuospatial skills in mood disorders
Eirini Tsitsipa (Greece)

Executive functions and social cognition in mood disorders
Stefania Moyidou (Greece)

Psychoeducation in bipolar disorder – the facts and the future?
Filippos A. Kouniakis (Greece)

13:15 – 14:00 / Crvena sala, IV sprat

SATELITSKI SIMPOZIJUM /Lundbeck/
Stabilna remisija i dobra komplijansa – izazovi i ciljevi
Milica Pejović-Milovančević

14:00 – 15:00 Lunch break (IMH Club)

15:00 – 16:30 / Blue Hall, V floor

DEPRESSION – THE REAL ACHIEVEMENTS OF TREATMENT OPTIONS
Chairs: Mohandas and O. Vukovic

Neuroimaging findings and depression – what are the real achievements of the last 20 years? Summary and perspectives
Nenad Vasic (Germany)

The complex relationship between depression and sleep
Ruzica Jokic (Canada)

Antidepressants in bipolar depression
Mohandas (India)

Assessment of burn-out impacts to quality of life in nursing professionals
Evangelos Fradelos, Spyridon Mpelegrinos, Chrysanthi Mparo, Chryssa Vassilopoulou, Panagiota Argyrou, Charalampos Staikos, Paraskevi Theofilou (Greece)

15:00 – 16:30 / Red Hall, IV floor

TREATMENT RESISTANT DEPRESSION – DIVERSITY IN NEUROBIOLOGY, CLINICAL ASPECTS AND ECONOMIC BURDEN
Chairs: S. Djukic-Dejanovic and G. Mihajlovic

Practical management of treatment resistant depression
Slavica Djukic-Dejanovic (Serbia)

Brain tumors as cause of theraporesistance in depression
Goran Mihajlovic (Serbia)

Economic burden and cost-effective therapeutics of treatment resistant depression
Dragan Milovanovic (Serbia)

16:30 – 17:00 / Blue Hall, V floor
CLOSING CEREMONY

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INFORMATION

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IMPROVING STRATEGIES FOR EARLY INTERVENTIONS IN SCHIZOPHRENIA – TGF- β AS A BIOMARKER

Slavica Djukic-Dejanovic, Milica Borovcanin

Faculty of Medical Sciences, University of Kragujevac,
Department for Psychiatry, Clinical Centre Kragujevac,
Psychiatric Clinic, Serbia

At today's level of knowledge, we can say that schizophrenia is most probably multifactorially caused, i.e. factors of biological, psychological and social nature are involved in its emergence and manifestation. Biological parameters in the prediction of possible disease progression and therapeutic response would have excellent research utility. Cytokines are important, not only for changes in behavior during the acutisation of disorder, but they can also cause long-term behavioral changes, that is to say, early infections can cause the appropriate immune response with adaptive or maladaptive consequences on subsequent behavior of a person. Establishment of cytokine profiles modification that would precede the acute psychotic relapse could just be a marker in the strategies of relapse prevention, prediction of disease progression and response to treatment. In our research we have demonstrated that type-1 and type-17 responses are blunted and type-2 overweight in schizophrenia. Also, we have presented increase in systemic production of TGF-β and decreased serum levels of IL-17 in psychotic patients. It had already been suggested that antipsychotics can suppress type-2 cytokines, but we have added the evidence that in psychotic patients the type-17 response is lower and immunosuppressive cytokine TGF-β was increased in patients with first psychotic episode. We have showed that elevated levels of TGF-β increase the risk for psychosis. According to our findings, TGF-β may be a useful biomarker in schizophrenia.

Key words: *schizophrenia, biomarkers, cytokines, antipsychotics, TGF-β*

Reference:

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MOST POSSIBLE RECEPTOR TARGETS FOR ANTIDEPRESSANT THERAPY IN BIPOLAR DISORDER

Konstantinos N. Fountoulakis

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The treatment of bipolar depression is one of the most challenging issues in contemporary psychiatry. Currently only quetiapine and the olanzapine-fluoxetine combination are officially approved against this condition. The neurobiology of bipolar depression and the possible targets of bipolar antidepressant therapy remain elusive. The current study performed a complete and systematic review to identify agents with definite positive or negative results concerning efficacy and afterwards a second systematic review to identify the pharmacodynamic properties of these agents. The comparison of properties suggests that the stronger predictors for antidepressant efficacy in bipolar depression was norepinephrine alpha-1, dopamine D1 and histamine antagonism, followed by 5-HT2A, muscarinic and dopamine D2 and D3 antagonism and eventually by norepinephrine reuptake inhibition and 5HT-1A agonism. Serotonin reuptake which constitutes the cornerstone in unipolar depression treatment does not seem to play a significant role for bipolar depression. Overall the results propose a complex model with multiple levels of interaction between the major neurotransmitter systems without a single target being necessary or sufficient to elicit the antidepressant effect.

Key words: *antidepressant therapy, bipolar depression*

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GUIDELINES FOR TREATMENT OF BIPOLAR DISORDER

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Bipolar disorder is a severe long-term illness with a lifetime prevalence of approximately 2% that is characterised by cyclical episodes of mania and depression. The impact of bipolar disorder on the patient is highly significant, such that the illness leads to 2% of all disability-adjusted-life years associated with non-communicable diseases worldwide. The considerable impact and frequency of episodes of bipolar disorder emphasize the importance of managing effectively symptoms to achieve the ultimate goal of mood stabilization. Treating acute mania effectively, together with the comorbidities, is the goal for long-term treatment. Importantly, the side-effect burden has to be considered already in the acute phase in order to secure adherence for the necessary long-term treatment. Whereas in the past there were only typical antipsychotics and lithium available, we now have the possibility to initiate the treatment with atypical antipsychotics as well as valproic acid, lithium and lamotrigine. The different treatment guidelines that are available help to aid the clinician's choice when treating patients with acute mania or depression and thereafter for long-term treatment. The scientific evidence for established agents has significantly increased over the last 5 years and new medications have become available. The recommendations should be based, whenever possible, on randomized controlled double-blind trials. However, such studies do not always reflect clinical reality and have their shortcomings, e.g. exclusion of comorbid, suicidal or medically ill patients, which may in turn lead to disappointment with some medication in clinical practice. Accordingly, adherence to these guidelines can be far ensuring a successful outcome in every case. However, it may be a helpful framework for the educated psychiatrist, planning the individual treatment of a patient taking all sources of information and all available treatment options into account.

Key words: *bipolar disorder, treating options, guidelines*

Dr Siegfried KASPER is professor of psychiatry and chairman of the Department of Psychiatry and Psychotherapy at the Medical University of Vienna, Austria. Dr. Kasper serves/served on the executive committees and advisory boards of several national and international societies, such as the European College of Neuropsychopharmacology (ECNP) and the European Psychiatric Association (EPA). He has been elected to the Executive Committee of the International College of Neuropsychopharmacology (CINP) for the period of 2012 to 2016. Dr. Kasper is Chair of the World Psychiatric Association (WPA) Section of Pharmacopsychiatry. He is Founding President of the Austrian Society of Drug Safety in Psychiatry (ÖAMSP) and of the Austrian Society of Neuropsychopharmacology

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LESS IS MORE – TOWARD NEW CLASSIFICATION OF PERSONALITY DISORDERS

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WHO Working Group for ICD-11 classification of personality disorders

Contemporary classifications of personality disorders (ICD-10 and DSM-IV) were a significant stimulus for research in the last two decades. However, their revision was necessary in order to overcome the problems such as neglect of a dimensional nature of personality disorders (PD). A dichotomous splitting of population on those who are „normal" and those who have a „personality disorders" does not reflect the wide range of personality variations nor the underlying level of psychopathology. The diagnosis of PDs is stigmatizing which has led to a resistance towards diagnostics in clinical practice, as well as to pessimism regarding their treatment although the epidemiological data have shown that their prevalence is high. The overlapping between categories of PDs is not rare (inadequately called comorbidity) and often it is not possible to determine which category is primary. Polythetic criteria for classification are also nonsatisfactory, and promote a heterogenous mixture od PDs without clear borders between them. The revision of classification has many challenges. WHO Working Group for ICD-11 classification of PDs is under influence of the central WHO objective – to create a classification of personality disorders which will be clinically applicable in all the countries, as well as in primary and secondary health care. The Group has chosen severity of personality problems as the first element in the structure of classification, in which the interpersonal functioning will be the main factor of differentiation. The essential changes from the ICD-10 are that the primary classification of PD covers five levels of severity as well as five monothetic trait domains – anankastic, dissocial, detached, disinhibited and negative emotionality. Our aim is to enable a simple algorhytm for classification which can be used in clinical practice. Hopefully the proposed changes, with less criteria will have more clinical meaning and will improve the application of PD diagnosis, reduse stigma and help in development and choice of adequate treatment.

Key words: *personality disorders, diagnostic criteria, ICD-11 classification*

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TREATMENT OF BIPOLAR DISORDER ACROSS LIFE SPAN – FROM RESEARCH INTO CLINICAL ARENA

Overall abstract: Bipolar Disorder is a serious, chronic and debilitating mental illness affecting approximately 0.4% to 1.6% of the population, and which occurs in children, adolescents, adults and the elderly. Individuals may receive care in both primary care and mental health settings, although under-diagnosis and under-treatment are common. Bipolar disorders (included subthreshold forms) are much more prevalent than previously believed and. there are clear consequences to the choice of treatment for these patients. Bipolar disorder among adolescents represents a major challenge to Psychiatry. Although diagnostic tools are still being developed, numerous studies suggest that the adolescent form of bipolar disorder still remains insufficiently identified. As with individuals of mixed ages, early diagnosis is essential to improve prognosis. In Primary Care settings, it is important that General Practitioners have a high index of suspicion for identifying bipolar disorder, particularly bipolar II disorder, as proper identification of these conditions is important for appropriate choice of treatment. In patients over 65 years of age, prevalence rates of bipolar disorder range from 0.1% to 0.4%. Until relatively recently, research on treatments for older adults with bipolar disorder has received little attention, despite the complexity of needs for this particularly vulnerable population. This presentation will overview bipolar disorder from a life-span perspective. New data on emerging assessment methodologies and treatments will be presented, and there will be discussion of the specific management requirements and unique clinical presentations seen among individuals with bipolar illness at varying life stages and in varying treatment settings.

BIPOLARITY IN ADOLESCENT – DIFFICULTIES FOR THE DIAGNOSIS

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Objectives: Bipolar Disorder among adolescents represents a major challenge to Psychiatry. This presentation aims to review (The emergence of adolescent bipolar disorder as a psychopathological entity; Diagnostic criteria for adolescent bipolar disorder; Evolution, risk factors, and co morbidity in adolescent bipolarity, Differences from and links to ADHD; and Treatment of bipolar disorder in adolescents). **Methods**: Review of the literature in Medline – Psycinfo – Psycarticles. **Results**: Over the past ten years, researchers have been attempting to test, among adolescents, the knowledge that has already been validated among adults through reproducing and analyzing the effects of the adults' treatment guidelines. Moreover, others have used various brain imagery anatomic analyses in order to compare structural abnormalities among adolescents and adults. As they have found, the specific aspects of adolescent bipolar disorder become manifest in some screening modalities and difficulties. Criteria such as bipolar phenotype – or having a first degree relative with bipolar disorder – are associated with the probability of bipolar emergence. Symptoms such as grandiosity, flight of ideas, decreased need for sleep, and hyper sexuality appear to discriminate bipolar disorder from ADHD. Finally, anti-social behaviours, drug consumption, and suicidal risk often complicate the clinical presentation. Lithium, anticonvulsant and atypical antipsychotic drugs remain the molecules of choice for treatment of bipolar disorder in adolescents. **Conclusions:** Although diagnostic tools are still being developed, numerous studies suggest that the adolescent form of bipolar disorder still remains insufficiently identified. However, early diagnosis is essential to improve prognosis.

Key words: *bipolar disorder, adolescents, diagnostic criteria*

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CANADIAN BIOMARKER INTEGRATED NETWORK IN DEPRESSION CAN-BIND

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Depression is a highly prevalent disorder, with chronic course and is associated with significant burden. Although a number of effective treatments are available the response and remission rates are still not very high. A better way of predicting treatment outcomes are necessary. Canadian Network for Mood and Anxiety Treatments (CANMAT) is a nonprofit academic organization involved in research and education. It is a collaboration of several academic centers across Canada and has achieved national and international recognition. Most recently it has produced sets of clinical guidelines and task reports for treatment of patients with Depression, Bipolar disorders and comorbidities. Canadian Biomarker Integrated Network in Depression was created three years ago as a consortium to study treatment outcome biomarker in depression. It has received funding form variety of sources, and its first trial is ongoing. This presentation will focus on some of the important points of this approach

Key words: *depression, CANMAT, treatment outcome biomarker*

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STRATEGIES FOR RESISTANT DEPRESSION – RECENT UPDATES

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The response to antidepressant treatment is still unsatisfactory: about 40-50% of depressed patients do not respond to first antidepressant and about 60% do not reach remission at all leading to the status of resistant depression. Several clinical factors have been reported in association with antidepressant response, age, duration of illness, personality disorders, cognitive status, comorbidities are the strongest clinical factors associated with resistance. In order to face this difficult situation, a number of strategies have been suggested, such as switching to another drug, combining two antidepressants and augmenting antidepressant treatment with other compounds. However there is a dearth of indication from guidelines about which is the best strategy and how to handle treatments. The present meeting will contribute to a better understanding of this challenge offering the latest updates in resistant depression treatment.

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CHILD AND ADOLESCENT PSYCHIATRY – NEW TRENDS AND CHALLENGES

Overall abstract: The field of child psychiatry, as an organized branch of medicine, has its origins nearly a century ago. The debate on the role of nature versus nurture has transformed itself into attempts to understand the interaction of all the various influences that shape development and behavior. The diversity and richness of the field at the present time is reflected in several issues. The role of trauma in children brings us back to the roots of child psychiatry and the effects of early experience on later development and behavior. Investigations emphasized the importance of focusing on different types of trauma and encouraged development of richer conceptualization of emotional maltreatment in children. Another challenge in child psychiatry are genetic and neurobiological issues in childhood disorders. Given that genetic effects in complex psychiatric disorders are likely to be mediated by several genes, it is not surprising that associations may be somewhat difficult to detect. Diversity of research in child psychiatry is showing that we must be concerned not only with etiological factors that range from society and the family to the gene, but also with the interaction of these factors and their impact on the developing child. Results from the recent studies imply the possibility that dysfunction of antioxidant defense system has a role in the etiology of psychotic disorders. Glutathione S-transferases (GSTs) are a family of enzymes with a crucial role in detoxification processes. The objective of this study was to determine the GSTM1 and GSTT1 gene polymorphisms in patients with early onset psychotic disorders in comparison to healthy controls. Study showed no significant differences in the distribution of GSTM1 or GSTT1 gene polymorphisms between the case and the control group. Although negative, this result might be considered important, taking into account that these are the first information from the Serbian population, and this is one of the rare studies that examined the whole early onset psychosis group. Exploring these findings in larger samples might help discovering other variables that may influence or moderate the relationship between GST variants and early onset psychotic disorders. The use of psychopharmacological treatment among youth represents a controversial topic and a challenging task for both – adolescents and psychiatrists. Adolescents' reaction to the suggestion of introducing psychotropic medication into treatment may range from rigid refusal to guarded optimism. Psychiatrists who provide integrated treatments, including medication and ongoing psychotherapy, as we are doing in the Day Hospital for Adolescents, are well positioned to evaluate the risks and benefits of medication while exploring the ambivalent responses of their patients initially and throughout the course of treatment. The findings may contribute to further understanding of the specific facet of psychotropic medication effects on youth, and direct our therapeutic resources towards continuous assessment and subtle adjustments related to these effects, in order to achieve adequate balance between adherence and proper developmental process.

CHILD PSYCHIATRY – QUO VADIS?

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The field of child psychiatry, as an organized branch of medicine, has its origins nearly a century ago. It drew heavily on psychiatry as well as pediatrics and psychology, and early great debates (e.g. about the relative roles of nature versus nurture) consumed much time and energy as the focus was largely on broader theoretical issues. Over the past 50 years the emphasis was much more on empirical research with less emphasis on the role of theory. So, for example, the debate on the role of nature versus nurture has transformed itself into attempts to understand the interaction of all the various influences that shape development and behavior. The diversity and richness of the field at the present time is reflected in several issues. The role of trauma in children's development and in the pathogenesis of clinical disorder has been a topic of great historical interest. Traumatized children have been examined and followed up. Studies emphasized the importance of focusing on different types of trauma and encouraged development of richer conceptualization of emotional maltreatment in children. The role of trauma in children brings us back to the roots of child psychiatry and the effects of early experience on later development and behavior. Other challenges in child psychiatry are genetic and neurobiological issues in childhood disorders. This is an area where knowledge has seemed to grow at an exponential rate, as attempts are made to relate disorder to underlying genetic or neurobiological mechanisms. Given that genetic effects in complex psychiatric disorders are likely to be mediated by several genes, it is not surprising that associations may be somewhat difficult to detect. Autism has a strong genetic component and many neurobiological findings have been done in this field. But its underlying neurobiology remains poorly understood. Diversity of research in child psychiatry is showing that we must be concerned not only with etiological factors that range from society and the family to the gene, but also with the interaction of these factors and their impact on the developing child.

Key words: *child psychiatry, development, pathogenesis, neurobiology, trauma*

Dr Smiljka POPOVIC-DEUSIC, neuropsychiatrist, professor psychiatry, Medical School, University of Belgrade**.** Curre position: Head of Clinic for Children and Adolescents and Depu Director of the Institute of Mental Health. Has great experience child and adolescent psychiatry, over 250 published articles; 1 chapters in books and 8 books. Special fields of interest: childho onset psychoses, pervasive developmental disorders, ment retardation, epidemiology in psychiatry.

GLUTATHIONE S-TRANSFERASE (GST) GENE POLYMORPHISMS IN EARLY ONSET PSYCHOTIC DISORDERS

Milica Pejovic-Milovancevic[1,2], Vanja Mandic-Maravic[1], Marija Mitkovic-Voncina[1], Milutin Kostic[1], Amir Peljto[1,3], Marija Pljesa-Ercegovac[2,4], Tatjana Simic[2,4], Dusica Lecic-Tosevski[1,2]

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Background: Results from recent studies imply the possibility that dysfunction of antioxidant defense system has a role in the etiology of psychotic disorders. Glutathione S-transferases (GSTs) are a family of enzymes with a crucial role in detoxification processes. The objective of this study was to determine the GSTM1 and GSTT1 gene polymorphisms in patients with early onset psychotic disorders in comparison to healthy controls. **Methods:** Our sample comprised 95 subjects diagnosed with early onset psychosis (age 21.50+6.95; male 65.3%), as well as 77 healthy controls (age 41.19+7.04; male 50.6%). The inclusion criterion for the case group was the presence of schizophrenia (n=50), bipolar affective disorder with psychotic symptoms (n=12), as well as the first psychotic episode (n=33), starting before the age of 18. The diagnosis was made based on ICD-10 criteria. Deletion polymorphisms of GSTM1 and GSTT1 were identified by polymerase chain reaction method. **Results:** When comparing the case and the control group, our study did not show differences in deletion GSTM1 and GSTT1 polymorphisms. Still, when examining the differences in the study group itself, we found some significant results. For both GSTM1 and GSTT1, the gender differences were close to significant (p=0.056 and p=0.051 respectively), with males having more deletion polymorphisms than females. Also, in the case group, patients with schizophrenia had significantly more GSTT1 deletion polymorphisms than the other two diagnostic groups (p=0.001). **Conclusion:** Our study showed no significant differences in the distribution of GSTM1 or GSTT1 gene polymorphisms between the case and the control group. Although negative, this result might be considered important, taking into account that these are the first information from the Serbian population, and this is one of the rare studies that examined the early onset psychosis group. On the other hand, examining the distribution of polymorphisms in the case group itself, our study showed significant findings regarding gender, as well as diagnostic subgroups. Exploring these findings in larger samples might help in discovering other variables that may influence or moderate the relationship between GST variants and early onset psychotic disorders.

Key words: *glutathione S-transferase, polymorphism, psychosis, early onset psychosis*

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MEDICATION IN PERCEPTION OF ADOLESCENTS – FRIEND OR FOE?

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The use of psychopharmacological treatment among youth represents a controversial topic and a challenging task for both – adolescents and psychiatrists. Adolescents' reaction to the suggestion of introducing psychotropic medication into treatment may range from rigid refusal to guarded optimism. Psychiatrists, who provide integrated treatment, including medication and psychotherapy, as we are doing at the Day Hospital for Adolescents, are well positioned to evaluate the risks and benefits of medication while exploring the ambivalent responses of their patients initially and throughout the course of treatment. Regarding identity formation, introducing medication untimely and without proper psychological preparation may contribute to the constructing "illness identity", affecting one of the main developmental tasks of adolescent process and fragile therapeutic alliance. Our study was aimed at exploring the adolescents' subjective experience of psychotropic medication, in relation to their personality dimensions and locus of control. The participants were older adolescents and emerging adults with depressive disorders, enrolled in outpatient or inpatient psychiatric treatment at the Day Hospital for Adolescents. The assessment has been carried out by a general questionnaire, Structured Clinical Interview for DSM-IV (SCID-I), Temperament and Character Inventory-Revised (TCI-R), modified Drug Attitudes Inventory (DAI) and Multidimensional Health Locus of Control (MHLC) Scale. The findings may contribute to further understanding of the specific facet of psychotropic medication effects on youth, and directing our therapeutic resources towards continuous assessment and subtle adjustments related to these effects, in order to achieve adequate balance between adherence and proper developmental process.

Key words: *adolescence, psychotropic medication, illness identity, Day Hospital for Adolescents*

Dr Zagorka BRADIC, psychiatrist and psychoanalytical therapist. Current position: Head of Day Hospital for Adolescents and member of the Board of Directors of the Institute of Mental Health. One of the founders of the Serbian Association of Adolescent Psychotherapists – UDAPS, its present President, as well as the national EFPP Child & Adolescent Section Delegate to the European Federation for Psychoanalytic Psychotherapy in the Public Sector – EFPP. Special field of interest: adolescent psychiatry and psychotherapy.

MIND AND BODY UNITY – COMORBIDITY OF MENTAL AND SOMATIC DISORDERS

Overall abstract: There are many important subfields, such as behavioral medicine, psychosomatics, and health psychology which investigate different aspects of the relationships between two or more diseases or conditions in the same individual. Although there is a considerable literature on the links between mental and somatic disorders, there is much less data about what the temporal ordering of these conditions across the life course can tell us about the direction of effect. Furthermore, the problem is that these comorbidities have often remained unrecognized, undiagnosed, and untreated. Associated somatic diseases that have been found commonly in patients with depression and schizophrenia and that we consider here include diabetes, coronary heart disease and cancer. International Prevalence and Treatment of Diabetes and Depression (INTERPRET-DD) is two-year prospective study, which is currently conducted in a 15 countries (Argentina, Brazil, China, Germany, India, Italy, Kenya, Mexico, Pakistan, Poland, Russia, Serbia, Thailand, Ukraine and Uganda). INTERPRET-DD aimed to enhance the understanding of the impact of the co-morbid depression on Type 2 diabetes and to identify the country specific most appropriate pathways via which patients receive their care. Preliminary data of this study will be presented. The relationship between schizophrenia and cancer is complex, and there are still issues which need further study. The data relating to predisposition, putative risk factors and the adverse effects of the first generation antipsychotics in schizophrenic patients with different forms of malignancy. The screening for the management of these comorbidities is given special attention. Numerous studies have clearly shown that there is a connection between the Type D personality and coronary artery disease (CAD), but the mechanisms by which a personality type contributes to the adverse CAD outcomes are still unknown. We Results of our experimental study will be presented. We have found that CAD patients with Type D personality had attenuated cardiovascular reactivity during the mental stress test under laboratory conditions. Overall, these finding will emphasize the importance of better understanding the relationship between mental and somatic disorders. A need for a holistic approach, including prevention measures, precise diagnostics as well as continuous follow up and treatment management are necessary.

COMORBIDITY OF SCHIZOPHRENIA AND CANCER – DOUBLE TROUBLE

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After 100 years of research, the epidemiological puzzle of comorbidity between schizophrenia and cancer still remains unsolved, as the results so far have been suggesting both increased (up to 2.6%) and decreased rates (up to 0.59%) compared to general population. One of the reasons might stand in the methodological and geographical diversity of the studies as well as the changing diagnostic tools. However, evidence in the last decade indicated that patients with schizophrenia and their first-degree relatives are protected against the development of cancer compared to general population, but not to an increased mortality due to stigma and inadequate health care. The predisposition to cancer seems to show the gender diversity as well as change in time as the cancer risk inversely correlates with age at diagnosis and disease duration. However, the relationship between schizophrenia and cancer is complex and certainly not monodirectional so there are still issues which need further study. The comorbidity between the two is suggested to be an interplay of immunological, metabolic and epigenetic factors. Identification of the potential risk factors for malignancy in patients with schizophrenia is additionally important to clarify not only the possible biological pattern linking them, but also to reduce the already substantial burden of the disease. Epidemiological studies have reported contradictory results, but it is certain that patients with schizophrenia are more likely to suffer from risk factors for cancer development, such as increased alcohol abuse, obesity, nicotine dependence and decreased physical activity, neglect of physical health both by patients and physicians. Inconsistencies have been reported related to some specific cancer sites. Despite the relatively low cancer risk, the patients with schizophrenia show an increased risk of some forms of cancer (lungs, pharynx and endometrium). Studies point to the fact that particularly first generation antipsychotics have the ability to inhibit the growth of tumor cells via various mechanisms (effect on calmodulin, sigma receptors, prevention of mutation etc.). A need for a holistic approach, including strong prevention measures as well as precise follow up and treatment monitoring is mandatory. The paper gives guidelines for the treatment of cancer in patients with schizophrenia, as well as the possibilities of interaction between chemotherapy and psychotropic drugs. Particular attention should be paid to the application of antipsychotics that increase the level of prolactin, due to a possible risk of breast and endometrial cancer in predisposed patients with schizophrenia.

Key words: *schizophrenia, cancer, comorbidity, prevention, antipsychotics*

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EXPLORING HEART AND SOUL – HOW MUCH DOES STRESS REALLY MATTER

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Background: Numerous studies have clearly shown that there is a connection between the Type D personality and coronary artery disease (CAD), but the mechanisms by which a personality type contributes to the adverse CAD outcomes are still unknown. Possible mechanisms explaining the adverse effect of Type D personality include physiological hyperactivity, activation of immune system and insufficient treatment compliance. The aim of this study was to examine relation between the Type D personality and cardiovascular reactivity (CVR) during the mental stress test under laboratory conditions. **Method**: Consecutive seventy-nine CAD patients (mean age 52±8) were recruited from the Institute of Cardiovascular Diseases of the Clinical Centre of Serbia. All patients underwent a mental arithmetic and anger recall tasks, during which heart rate (HR) and blood pressure (BP) were recorded. Type D personality and its components Negative Affectivity (NA) and Social Inhibition (SI) were assessed with the D-Scale 14 (DS14). ANOVA with repeated measures was used to assess differences in stress response. **Results:** Type D personality was associated with reduced systolic blood pressure (SBP) reactivity during the mental stress test. The within-subjects analysis has shown statistically significant interaction between the values of systolic blood pressure (SBP) and Type D personality in the entire sample ($F[2,77]=8.27$; $p=.00$; partial $\eta 2=0.37$). There were no differences between CAD patients with Type D and non-Type D personality with respect to the heart rate (HR) and diastolic blood pressure (DBP) reactivity. **Conclusion:** CAD patients with Type D personality may show attenuated cardiovascular reactivity during the mental stress test under laboratory conditions. These findings suggest that Type D personality is a risk factor for CAD during prolonged stress, rather than during experimentally induced acute stress.

Key words: *type D personality, stress, cardiovascular reactivity*

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IN SEARCH OF DEPRESSION AND DIABETES LINK

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The course and outcomes of Type 2 diabetes have traditionally been linked to depression and other mental disorders. For instance, comorbid depression in patients with Type 2 diabetes is related to serious negative consequences, such as poor metabolic control, increased severity and number of complications as well as lower adherence to medications. The International Prevalence and Treatment of Diabetes and Depression (INTERPRET-DD) is a two-year longitudinal study, which is currently conducted in a 15 countries (Argentina, Brazil, China, Germany, India, Italy, Kenya, Mexico, Pakistan, Poland, Russia, Serbia, Thailand, Ukraine and Uganda). The study aims are to investigate the recognition and management of depression in patients with type 2 diabetes, as well as to obtain the impact of treatment of previously unrecognized depression on clinical outcomes of diabetes. Our preliminary results have shown that the instruments used to measure both symptoms and clinical diagnosis of depression are appropriate and can be used in different countries (i.e. PHQ-9, WHO-5, and Hamilton Rating Scale for Depression). INTERPRET-DD study aimed to enhance the understanding of the impact of the comorbid depression on Type 2 diabetes and to identify the country specific most appropriate pathways via which patients receive their care.

Key words: *depression, type 2 diabetes, comorbidity*

RELATIONSHIP OF STRESS, CANNABIS USE AND FIRST PSYCHOTIC EPISODE

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Background: To check if the interaction between cannabis use and stress induced by recruitment to the army is related to the emergence of first psychotic episode (FPE), we compared data on cannabis use between two groups of male patients, with FPE, a group of newly recruited soldiers (N=20) vs. a group of patients from public hospitals (N=20). All patients were of the same age (18-29 y.o.). **Method:** Cannabis use and its age of onset were assessed by taking of personal history. The use was considered as heavy frequent / when it occurred more than 50 times a year. Two groups were considered based on onset before or after 18 y.o. Current status clinical examination provided information on basic clinical characteristics of psychotic episode including presence of any delusions , bizarre delusions, agitation/ aggression, withdrawal, suicidal ideation. Statistical analysis was based on chi-square tests; significance was set at 0,05. **Results**: -9/20 newly recruited patients with FPE reported cannabis use (which for 6 was heavy/frequent) vs.13/20 general hospital patients with FPE (which for all was heavy/frequent). The difference between the two groups was statistically significant (p=0,025) regarding use being more often heavy/ frequent among general hospital patients. Delusions (p=0,025) and suicidal ideation (p=0,035) were more frequent among recruits than among general hospital patients. Agitation/aggression was associated with a history of cannabis use (p=0,018). Bizarre delusions seemed also to be more frequent among cannabis users (they were reported 5/22 cannabis users vs.1/18 non-users), but the difference was not statistically significant (p=0,130). **Conclusions:** Cannabis use frequency does not differ between general hospital patients with FPE and army recruits with FPE; there is an indication that it is more frequent and heavy among the former. Our hypothesis, that the interaction of being recruited to the army and cannabis use has a more negative impact on the onset of FPE than each one by itself is not supported. Stresses due to recruitment and cannabis use do not seem to interact in producing a stronger negative impact on the onset of FPE than the impact that each condition has by itself. Delusion and suicidal ideation are more frequent in the group of recruits vs. general hospital FPE patients, probably because of the inability of recruits to adapt quickly to a stress life situation, such as the service in army. Suicidal ideation is more frequent among army recruits who were substance users ([1]). Cannabis use seems to influence the kind and frequency of FPE symptoms.

Key words: *FPE, cannabis use, army recruits*

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SCHIZOPHRENIA AS A PROGRESSIVE BRAIN DISEASE

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Schizophrenia is a devastating mental illness which affects about 1% of population. The symptoms and course of the illness vary considerably between individuals. After the first episode all outcomes are possible. Some patients recover completely, many have a relapsing and remitting course, and others experience a severe progressive, disabling course. The neurodevelopmental model posits that disturbances caused by susceptibility genes and environmental factors occurring during early life cause developmental brain deficiencies that culminate in the onset of schizophrenia decades later. The lack of gliosis in brains of schizophrenic subjects, a relatively consistent finding, is one of the major support for this hypothesis according to which the observed structural brain abnormalities in schizophrenia are postulated to be static in nature. The progressive nature of some cases of schizophrenia seems unlikely to be solely the result of a static, previously completed pathological process. A neurodegenerative process may also contribute to disease progression and the worsening of symptoms with age, at least in a subgroup of patients. Evidence for a neurodegenerative process includes neuroimaging studies that show a decrease in brain grey matter associated with illness progression whish has been shown by a recent review of longitudinal studies. For example, in childhood-onset schizophrenia volume loss of cortical grey matter regions was more striking than that seen in control subjects. Also, in the first-episode patients an excessive decrease in whole brain and grey matter volume and progressive increase in cerebrospinal fluid volumes were shown. Moreover a recent MRI study showed excessive brain volume change that is predominantly confined to the first two decades of the illness. A larger cerebral volume loss in the first 20 years of the illness appears consistent with the clinical course of the disorder when the most symptoms and loss of function occur - one study suggested that excessive tissue loss is more profound in patients with poor outcome. Taken together these studies are consistent in demonstrating progressive ventricular volume increases and brain mass reductions in schizophrenia, with evidence for progressive cortical grey matter loss, particularly the prefrontal and temporal lobe cortices. The causes underlying these brain abnormalities are unclear and have been a focus of much debate. Finally, recent studies indicate that antipsychotics, the mainstay of treatment for schizophrenia patients, may also contribute to brain tissue volume decrement.

Key words: *schizophrenia, neuroprogression, brain disease*

Dr Cedo D. MILJEVIC, MD, PhD, received his medical degree (1991), performed his residency in psychiatry (1997), and earned his PhD in psychiatry (2001) at the Medical School University of Belgrade. Currently he is head of laboratory and pharmacology department at Institute of Mental Health, Belgrade and clinical assistant at School of Medicine, Belgrade University. His scientific interests and publications primarily include schizophrenia, depression and bipolar disorder, with a special focus on clinical and pharmacological aspects of disorders. He is an active member of national and international professional organizations.

PARTNERSHIPS FOR MENTAL HEALTH

Helen Herrman

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Service users and carers worldwide have the regular experience of stigma and discrimination in the community, and poor access to dignified care for mental and physical health problems. Achieving adequate support for mental health in any country requires a unified approach. Psychiatrists, governments and professional groups in a range of countries increasingly support the inclusion of service users and carers in decisions about treatment and rehabilitation, service development, research and policy. The WPA convened a Task Force chaired by Helen Herrman during the last triennium and invited service users and family carers to join in its work as members. The resulting recommendations for the international mental health community on best practices in working with service users and carers were approved unanimously by the WPA General Assembly in September 2011 together with an addition to the Madrid Declaration on Ethical Standards for Psychiatric Practice. The recommendations are expected to be relevant to people living in all regions, though their implementation will be different across regions and settings. The recommendations begin with respect for human rights as the basis for successful partnerships. Other recommendations include: clinical care is best done in collaboration between service users, carers and clinicians; as are education, research and quality improvement. Each country will need specific guidelines and projects to apply these recommendations and contribute to worldwide learning.

Key words: *stigma, inclusion of service users, human rights, guidelines*

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Dr Helen HERRMAN is Professor of Psychiatry and Director of Research at Orygen Youth Health Research Centre and the Centre for Youth Mental Health, The University of Melbourne, Victoria, Australia; and Director of the WHO Collaborating Centre for Mental Health in Melbourne. She is Honorary Fellow of the World Psychiatric Association (WPA), having served as WPA Secretary for Publications from 2005 to 2011. She is President-Elect of the Pacific Rim College of Psychiatrists, and Vice President of the International Association of Women's Mental Health. From 1992 to 2005, she wa Professor and Director of Psychiatry in St Vincent's Health (SVH) Melbourne and The University of Melbourne. She had responsibility for the clinical services and academic programs at SVH during development of an integrated community mental health service within Australia's national reform of mental health. In 2001-2002 she acted as regional advisor in mental health for WHO's Western Pacific Region. During this time, and subsequently, she has consulted on the development of community menta health services and mental health policy in countries in the region and elsewhere. Helen Herrman has a background of clinical, academic and service development work in the fields of community mental hea care for people with psychosis, the assessment of outcomes and quality of life for people with disabiliti and mental health promotion. She received the award of Practitioner Fellowship for 2010 to 2014 from the National Health and Medical Research Council of Australia, and leads a new research program on improving mental health for young people in out-of-home care. Other research programs currently include youth, technology and mental health, and depression in primary health care. She received the Royal Australian and New Zealand College of Psychiatrists' College Citation in 2010 for contributions national and international psychiatry, and International Distinguished Fellowship of the American Psychiatric Association in 2009. She was inducted to the Victorian Honour Roll of Women in 2013.

BLOOD AND BRAIN BIOMARKERS OF DEPRESSION AND ANTIDEPRESSANT DRUG RESPONSE

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The serotonin transporter (5-HTT) is encoded by the same single gene and is available in blood and brain, where it serves as target for the most prescribed antidepressants such as selective serotonin re-uptake inhibitors (SSRIs). In both, blood and brain 5-HTT is the the main determinant of extracellular serotonin (5-HT), which has repeatedly been implicated in depression-related pathophysiology in the synaptic cleft and cardiovascular disease in the blood. 5-HTT re-uptake in blood platelets has shown to correlate with synaptosomal re-uptake in neurons *in vitro* studies. Recent imaging work has demonstrated that platelet re-uptake predicts activation of the default mode network (DMN) in healthy subjects. This is intriguing since the DMN is known to be closely related to rumination in healthy subjects and major depressive disorder (MDD) patients are unable to suppress its activity during cognitive engagement, which leads to clinical symptoms such as lack of concentration and attention. However, not all MDD patients are responsive to SSRIs or other antidepressants, which is demonstrated by moderate antidepressant drug response rates ranging between 50-60% and even a smaller percentage shows full remission. Due to their delayed response and unsatisfying response rates, it would be great leap forward if MDD patients could be identified that are responders to SSRI monotherapy, which would lead to a personalized treatment regime with much higher response rates for this MDD subpopulation going along with an increased acceptance of psychopharmacological treatment. A recent FDG-PET study demonstrated that anterior insula metabolism is neuronal predictor of SSRI drug response in a large sample of MDD patients. Functional magnetic resonance imaging (fMRI) has been able to robustly replicate the importance of anterior insula activation in the prediction of SSRI drug response in a much smaller sample of MDD patients, which underlines the importance of brain imaging as tool to subtype MDD patients as responders or non-responders of SSRI drug response. While platelet 5-HTT re-uptake could possibly subserve as future diagnostic biomarker of depression, neural biomarkers such as anterior insula activation have recently emerged as potential biomarker of SSRI drug response. These findings, together with other recent advances, are highlighting that the discovery of clinical useful biomarkers of MDD diagnostics and treatment success are finally surfacing to the potential benefit of global disease burden. The coming years will be exciting for psychiatrists and upcoming studies will show if these and similar studies are able to fulfill high expectations of clinicians and patients in future tools of psychiatric diagnostics and treatment success prediction.

Key words: *serotonin transporter, MDD diagnostic and treatment, personalized treatment regime*

Dr Lukas PEZAWAS is currently working as a senior physician and asscociate professor at the Division of Biological Psychiatry, Department of Psychiatry and Psychotherapy at the Medical University of Vienna (Chair: Prof. S. Kasper). He is heading the main outpatient clinic, the electrophysiological lab, and the clinical neuroimang group. Dr. Pezawas acquired the doctoral degree of medicine in 1994 at the Medical University of Vienna, was trained as a psychiatrist and behavioral therapist at the Department of Psychiatry and Psychotherapy at the Medical University and approved as psychiatrist in 2001 by the Austrian Medical Association. After his residency he joind the Genes, Cognition and Psychosis Program (GCAP) (Head: Dr. D. Weinberger), National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Bethesda, USA as a post-doctoral fellow and became quickly member of the neuroimaging core. He returned in 2005 to Vienna, received the venia docendi for "*Functional and Structural Neuroimaging and Imaging Genetics*" in 2007, was promoted as an Assistant Professor in 2010 and as an Associate Professor in 2012. Professor Pezawas has published over 60 peer reviewed scientific articles mainly in the field of mood disorders, some of which rank amongst the most cited articles in the field (e.g. Pezawas et al. 2005, Nat. Neuroscience). He has collaborated and co-authored with well-known scientists such as J. Angst, A. Meyer-Lindenberg, D. Weinberger, S. Kasper, and U. Wittchen. Lukas Pezawas served as editor of a special issue on Imaging Genetics for Neuroimage, and is field editor for several journals.

FUNCTIONAL NEUROANATOMY OF INSULA

Mohandas

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Situated in the depth of sylvan fissure, the insular cortex has three concentrically arranged zones-rostro ventral granular zone, caudo dorsal granular zone and intermediate dysgranular zone. Broadman's areas 13 to 16 signify the insular cortical area. Insula may be subdivided into anterior and posterior sections based on connectivity, cytoarchitecture and function. Anterior insular cortex in its fifth layer contains large spindle shaped cells (von Economo neurons). The anterior insula involving the agranular region has extensive and reciprocal connections to limbic areas, higher order visual areas, olfactory areas and posterior insula. The posterior insula representing the granular and adjacent dysgranular region has reciprocal connections with higher order visual areas, auditory processing areas, somato-sensory areas and anterior insula. The functional neuro anatomy of insular cortex with functional implications will be discussed.

Key words: *functional neuroanatomy, insula, functional implications*

Dr MOHANDAS, MD the chief Consultant at Sun Medical and Research Centre, Trichur, Kerala. He received Asian Federation of Psychiatry International award for excellence in South Asia, Indo-Australian award for Excellence in Psychiatric training in South Asia, Indo-Global Psychiatric Initiative award for academic excellence and leadership, World Association of Psychosocial rehabilitation (Indian Chapter) award for Leadership in psychiatric rehabilitation, South India Psychiatric Society Visakha Award for Excellence in Academics and Administration, Manasa Oration Award from IPS-AP Chapter and Dr Suraraj Mani Memorial Oration Award. At the organizational level, current positions include Chair, WPA Section on Psychiatry in Developing Countries, Director, Skills and Training, UNESCO Bioethics, Asia-Pacific, Hon.Visiting Professor of Bioethics and Psychiatry, Father Muller Medical College, Mangalore and Visiting Professor, SRM University, Chennai. During the past 30 years many national and international presentations were made (around 400). Published 5 books.

INDUCTIVE EFFECTS OF ANTI-EPILEPTIC DRUG ON GINGIVAL FIBROBLASTS OF CHILD AND ADULT

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Background: It is estimated that about 30 to 50% of patients taking Phenytoin develop significant gingival alternations especially in buccal anterior part of oral cavity. Due to lack of enough information regarding the background mechanism of Phenytoin effect especially in synthesis of inflammatory mediators, this study was done to compare it in different ages. **Method:** Samples were collected from biopsy of a healthy gingival of four adults in 35-42 years old through crown lengthening surgery and four children in 4-11 years old through impact tooth surgery, after local anesthesia and from the keratinized soft tissues around the teeth. Gingival biopsies were transferred to a medium which containing DMEM and cultured on specific plates 25 cm2 and put on incubator containing CO2 with temperature of 37ºc. Supernatant of culture medium of test and control sinks were collected by sampler and concentration of IL1β, PGE2, IL6, TGFβ, TNF-alpha and IL8 were analyzed by ELISA. **Results:** Different proliferation rate of Phenytoin induced gingival fibroblasts in adults (0.073±0.177) as compared to children (0.056±0.028) was not significant. Production of PGE2, TGFβ and IL6 by Phenytoin induced gingival fibroblasts in children was increased as compared to adults ($p<0.05$). Production of IL8 by Phenytoin induced gingival fibroblasts in children was decreased compared to adults, this difference was statistically significant (P=0.02). **Conclusions:** Phenytoin induced gingival fibroblasts of children produce more amounts of IL1β, PGE2, IL6, TGFβ and IL8 as compared to adults' fibroblasts. More Comprehensive studies with well-documented designs using other methods are recommended to verify these results.

Key words: *inductive effects, anti-epileptic drugs, gingival alterations*

INTERICTAL DISPHORIC DISORDER – IS IT SPECIFIC FOR PATIENTS WITH EPILEPSY?

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Epilepsy beyond its well-known neurologic complexities tends to become complicated with a wide range of specific psychiatric changes: they occur on the establishment of a temporal-limbic focus of intermittent excessive neuronal excitatory activity that produces increasingly inhibitory responses. Psychiatric disorder of epilepsy may result from the inhibitory activity that develops as a reaction to the excessive excitatory activity of the chronic seizure disorder. The issue of phenomenology of mood disorders in epilepsy still remains controversial with atypical clinical presentation which often does not allow a straightforward classification according to standardized psychiatric diagnostic systems such as the ICD-10 or the DSM-IV (American Psychiatric Association, 1994). Subgroup of patients may develop an affective syndrome known as interictal dysphoric disorder (IDD) – intermittent and pleiomorphic affective-somatoform disorder that presumably occurs as a result of inhibitory mechanisms in chronic mesial temporal lobe epilepsy. In the detailed description of the interictal dysphoric disorder by Blumer, eight key symptoms, grouped in three major categories, are identified: labile depressive symptoms (depressive mood, anergia, pain and insomnia), labile affective symptoms (fear, anxiety) and supposedly "specific" symptoms: paroxysmal irritability and euphoric moods) (Blumer 2000, Blumer et al 2004). The dysphoric episodes are described as occurring without external triggers and without clouding of consciousness; beginning and ending rapidly and recurring fairly regularly in a uniform manner (every few days to every few months and lasting a few hours up to 2 days). Nevertheless, it seems that IDD is not typical only for patients with seizures but can be seen also in other central nervous system disorders such as migraine. We will present the study with three aims: (1) to assess prevalence of IDD in patients with epilepsy and in patients with migraine and to compare their clinical characteristics; (2) to assess clinical characteristics of epilepsy (etiology, localization, seizure severity index) in IDD group, and (3) to assess influence of IDD on quality of life in patients with epilepsy. Consecutive patients with a diagnosis of epilepsy or migraine will be assessed by using the Interictal Dysphoric Disorder Inventory (IDDI), a 38-item, self-report questionnaire specifically developed to evaluate presence and severity of IDD symptoms as well as their habitual association to seizures (coded as before, after, during, or when seizure-free). Patients will be also assessed with Quality of life in Epilepsy Inventory (QOLIE-31 – Serbian validated version; Seizure, 2010) and Symptom Check List-90 (SCL-90 R).

Key words: *epilepsy, interictal disphoric disorder, quality of life*

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INDIVIDUALIZED TREATMENT OF BIPOLAR DISORDER – MYTH OR AN OPTION?

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Due to the episodic and chronic nature of Bipolar Disorder, maintenance therapy represents a critical part of treatment. Clinical practice requires deciding upon the most appropriate treatment for each patient, which constitutes the backbone of the medical act, but is often challenging. In the present speech, clinical markers for response to first-line therapy will be examined. Another recurring issue in clinical practice is given by the difficulty in translating the results of research to therapeutic decision-making. For this reason, our group has recently developed Polarity Index, a metric retrieved by calculating Number Needed to Treat (NNT) for prevention of depression and NNT for prevention of mania ratio, as emerging from the results of randomized placebo-controlled trials, which indicates the relative prophylactic efficacy profile of existing treatments, and its external validity was examined in a naturalistic study. The Polarity Index provides a measure of how much antidepressant versus antimanic an intervention is in bipolar disorder prophylaxis, in the attempt to predict the most effective treatment for each individual patient. This could represent one of the first steps in the individualized treatment of Bipolar Disorder, with a potentially important impact on patients' therapeutic management.

Key words: *maintenance therapy, individualized treatment*, *bipolar disorder,*

Dr Dina POPOVIC has received her degree in Medicine, *cum laude*, from the University of Bologna (Italy), has specialized in Psychiatry and was awarded a PhD with European Label at the University of Pisa. Alongside with active clinical practice Dr. Dina Popovic performs clinical research at Bipolar Disorders Program of Hospital Clinic, University of Barcelona, Spain, headed by Prof. Eduard Vieta. Her scientific interests and publications primarily include Mood Disorders, Psychotic Disorders and dual pathology, with a special focus on clinical, pharmacological, genetic and neurophysiological aspects.
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A PROSPECTIVE 4 YEARS NATURALISTIC FOLLOW UP OF 300 BIPOLAR I & BIPOLAR II PATIENTS

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Objective: Naturalistic long-term data of bipolar disorder are rare. The information of highly selected and well funded research populations based on randomized controlled trials might bring us a lot of information, but the usefulness for practical treatment in every day life must be challenged. **Method**: We followed up 300 patients out of 515 bipolar patients who were admitted the first time to a new installed regional psychiatric department for a catchment area of 200.000 inhabitants between 200 and 2004. Patients were treated by their physician and followed up for 4 years until 2008. The information was gathered by trained physicians from the department when patients were seen at the hospital or by telephone or in semistructured web based interview at least once a year. Patients were assessed with respect to time to relapse, type of relapse and used medication. ***Results****:* 204 (68%) of 300 patients relapsed within 4 years, with a mean of 208 days (SD=356.2) until the next affective episode. Relapses correlated statistically significant with the index episode. We found no differences in the demographic variables and in the relapse rates between bipolar I and bipolar II patients. Using a Kaplan survival analysis, only lithium, not in combination with other prophylactic medication, delayed statistically significant the time to the next affective relapse. Other mood stabilizer medications like valproic acid, carbamazepine, lamotrigine, olanzapine and risperidone showed over the observational period no statistical significant results. Survival was also statistically significant reduced when medication was replaced by the psychiatrist or stopped by the patient. **Conclusion**: Bipolar patients have in a naturalistic setting a high risk of relapses. Lithium seems to have an advantage compared to other medication in preventing or delaying affective episodes. Patients in our sample tend to relapse with the same episode they suffered when they entered into the observation period. Replacement and changes of medication by the patient or the physician seem high risk factors for an earlier relapse.

Key words: *bipolardisorder, follow up, relapse, medications*

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BIPOLAR AFFECTIVE DISORDER AND PARENTS` SOCIO-EMOTIONAL INVESTMENT IN CHILDREN

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Introduction: The relationship between the Bipolar Affective Disorder (BAD) and parenting styles of mentally ill persons is unique in many ways, and studies confirm that the offspring of Bipolar Parents (BP) have a greater risk of developing psychopathological problems. However, studies which explore the parenting quality of BP are still rare. **Objective:** Our objective was to assess specific aspects of the parenting styles of BP, which could be important for conceptualizing support and preventive programmes, as well as to explore the possible difference between patients and their spouses in parenting styles. **Method**: Our sample consisted of 30 subjects, all diagnosed with BAD, as well as 30 healthy controls, their spouses. The diagnosis was made based on ICD-10 criteria. All the patients were parents, and during the study they were in a period of remission. The assessment of their parenting styles was carried out by Parental Investment in Children (PIC), as well as a semi-structural interview that involved an open type questionnaire, specifically designed for this research. **Results:** When comparing the two groups, we have not found significant differences in the scales of Knowledge/Sensitivity, Separation Anxiety and Delights. However, the higher values were obtained concerning the Acceptance of the Parenting Role in both groups, indicating the high level of stress within these families. A domination of liberal parenting styles was established, as well as an important absence of utilizing any form of punishment during the raising their children. All the interviewed subjects acknowledged using rewards, with money and gifts as the most frequent means. **Conclusion:** The obtained results haven`t confirmed differences concerning the parent`s socio-emotional investment in children between BP and their spouses, but the high level of stress concerning parenting was confirmed in both groups. Our results suggest that families of BAD patients have strong positive potential, but family based interventions focusing on psycho-education and correcting certain dysfunctional patterns, as well as on strengthening their positive potential, could be valuable in reducing possible developmental risk for their offspring. By this, more targeted early prevention and intervention strategies can be developed and implemented.

Key words: *bipolar affective disorder, parenting styles, support programme, prevention*

Dr Saveta DRAGANIC-GAJIC, MD, PhD, is psychiatrist, family therapist, and an associate professor at the School of Medicine, University of Belgrade. She is Head of the Department for Couple and Family Therapy and Head of the Education at the Institute of Mental Health. Her primary scope of interests are family therapy and personality/personality disorders.

GENERAL NEUROCOGNITIVE FUNCTIONING AND INTELLIGENCE QUOTIENT (IQ), PSYCHOMOTOR AND MENTAL SPEED AND ATTENTION IN MOOD DISORDERS

Stella Miziou

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Euthymic patients with BD-I and MDD show specific deficits on tasks that assess attention. Neuropsychological deficits in attention have been demonstrated with regard to alertness, information processing speed, vigilance and sustained attention, as well as selective and divided attention. Studies reported that performance on tests measuring sustained and selective attention, memory, and executive function and on tests providing an estimate of global cognitive function was poorer in the patients than in the healthy control individuals. Some studies suggest that BD patients and their families manifest above average IQ and general intellectual functioning or at least they have intelligence similar to healthy controls. Neurocognitive function is reduced in major depression, but uncertainties remain about if and to what extent improvement in neurocognitive function follows remission of depressive symptoms. Improvement in depressive symptomatology from baseline to follow-up was positively correlated with improvement in verbal memory function. The recovered depressed group performed significantly worse than the never psychiatrically ill control group on the WCST.

Key words: *intellectual functioning, mood disorders, neurocognitive functioning*

Stella MIZIOU is a Psychologist in Thessaloniki, Greece. Ms. Miziou received her degree in Psychology in 2009 at the Aristotle University of Thessaloniki. In 2010 she started a postgraduate degree at the Hellenic School of Research for Behavior with a major in Cognitive-Behavioral Psychotherapy (CBT). Simultaneously Ms Miziou was working at a Private Psychiatric Clinic in Veria, Imathia from March 2010 till July 2011. As part of her undergraduate studies, Ms Miziou voluntarily assisted at the General Hospital of Trikala in the Department of Psychiatry and also at the Municipal House for Psychosocial Rehabilitation, where both positions were held in the summer of 2008 from June till September. Since 2005 till now, she has been attending Conferences and Seminars held in Northern Greece and has worked as assistant in a number research projects.

MEMORY AND VERBAL AND VISUOSPATIAL SKILLS IN MOOD DISORDERS

Eirini Tsitsipa (Greece)

There is considerable interest in the identification of neurocognitive impairment in patients with depression. Depression-related disturbances of cognitive function have been demonstrated in a range of domains, including learning and memory, verbal skills and visuospatial skills. Depression may negatively impact different types of memory, including explicit, implicit, short term, long term, and working memory. During the acute episode, paired associate learning, spatial recognition memory, rapid visual processing and visuospatial planning were impaired. In remission, is observed the improvement of visual learning ability, and spatial recognition memory. As far as the Bipolar Disorder the neurocognitive impairment, is an enduring component and represents a core primary characteristic of the illness, rather than being secondary to the mood state or medication. The deficit in learning and memory is reported to be present early in the course of the disorder. It is observed in different types of the memory, in verbal and associative learning. Bipolar Disorder is characterized by a significant impairment in the acquisition of new information, but not in retention, irrespective of illness phase. Usually testing of verbal skills includes mainly verbal fluency. Verbal skills are reported to be impaired during all phases of Bipolar Disorder. The visuospatial/constructional abilities are impaired not only in patients with Bipolar Disorder but in unaffected relatives as well.

Key words*: visuospatial skills, bipolar disorder, neurocognitive impairment*

Eirini TSITSIPA received her degree in Psychology (2012) from the Aristotle University of Thessaloniki. During her studies, she specialized in "dementias" at the Hellenic Association of Alzheimer's Disease and Related Disorders and she completed her internship at the 1st Neurological clinic of the Aristotle University of Thessaloniki. She has a Diploma in clinical training of mental health provided by the 1st Psychiatric clinic of the Aristotle University of Thessaloniki. She is competent in the use of neuropsychological and psychometric instruments. She has attended a number of workshops and also, she has participated in psychiatric conferences in her country. At the present, she is specialized in Cognitive–Behavioral Psychotherapy.

EXECUTIVE FUNCTIONS AND SOCIAL COGNITION IN MOOD DISORDERS

Stefania Moyidou (Greece)

Neurocognitive abnormalities in major depression appear to reflect a complex interaction between biased emotion processing and impaired executive control. Findings indicate that impaired executive function in unipolar depression is independent of medication status and symptom severity. Impaired executive function seems to be improved significantly with remission, possibly representing a relatively stable trait marker, although residual deficits may remain to some degree. Nevertheless literature is not consistent in whether patients recovered from depression have executive deficits. Similarly bipolar disorder is strongly associated with neurocognitive deficits in executive function. Several studies suggest that executive function may represent objective marker of bipolar disorder that persist across different mood states and in remission of the disorder, is present in first degree relatives of patients with bipolar disorder or exists to a greater extent than in unipolar depression. However this finding is inconsistent since other studies in bipolar and unipolar depression, suggest that executive dysfunction may be a depression-specific, but not bipolar disorder-specific. There is a lack of literature exploring social cognition in mood disorders. Findings suggest that depressed patients respond "catastrophically" to errors and have increased negative perceptions of social stimuli (i.e., vocal expressions, facial expressions) and self. Specifically for remission state it is found that MDD patients are oversensitive to loss trials, while BDII patients are generally intact and do not differ significantly from healthy ones. Other findings on Face emotion, both in children and adolescents, suggest processing biases rather than deficits to distinguish depressed from non-depressed.

Key words: *neurocognitive abnormalities, bipolar disorders, depression*

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PSYCHOEDUCATION IN BIPOLAR DISORDER – THE FACTS AND THE FUTURE?

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Despite the great number of pharmacological treatments, patients with bipolar disorder spend almost half of their lives with symptoms, mainly depressive ones. Recurrence rates for mania and depression in bipolar disorder are high. The term ‘‘psychoeducation’’ is usually used to describe a behavioral therapeutic model that consists of 4 elements; briefing in a rather detailed way the patients about their illness, offering them problem solving training and of course communication training along with self-assertiveness training. Psychoeducation has evolved into an independent therapeutic program with a focus on the didactically skillful communication of key information within the framework of a cognitive-behavioral approach. Through this, patients and their relatives should be empowered to understand and accept the illness and cope with it in a successful manner. Group psychoeducation in addition to maintenance medication is strongly recommended by most recent bipolar disorder practice guidelines for the maintenance management of bipolar disorder. Although there is evidence from RCTs of the clinical efficacy of group psychoeducation for bipolar disorder compared to group support in a specialist bipolar disorder service in Spain, the evidence base is still relatively thin. In particular, the experts have not yet reached a level of consensus on whether the content and style of group psychoeducation has any specific effect on time to relapse and other clinical and economic outcomes. There are also some limitations in psychoeducation’s usage in clinical practice that we should take into consideration.

Key words: *psychoeducation, bipolar disorder, RCTs,*

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NEUROIMAGING FINDINGS AND DEPRESSION – WHAT ARE THE REAL ACHIEVEMENTS OF THE LAST 20 YEARS? SUMMARY AND PERSPECTIVES

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Depressive disorders are one of the most important disorders in psychiatry and have already become one of the most important health problems in this day and age. The proceedings of the structural and functional neuroimaging in the past two decades, particularly magnetic resonance imaging (MRI), have provided an insight into neural mechanisms underlying both depressive disorders and some treatment strategies and their effects. A number of structural alterations (such as brain substance reductions in the prefrontal, cingulate or hippocampal regions), metabolic changes (for instance different patterns of metabolism in the cortical and subcortical areas) and functional abnormalities in the resting state or as a reaction to cognitive or emotional stimuli have been revealed. Some of these findings have cleared the way for some novel treatments, such as deep brain stimulation. Still, up to now in a number of areas the research findings seem to lack practical relevance – at least to a certain degree. In the proposed talk I intent to review and integrate the most prominent neuroimaging findings in the field of depression research in the context of their possible relevance for the practical diagnostics and treatment. I would try to outline and to discuss with the participants which steps in the field of neuroimaging are already made, which might be necessary – in order to further substantially improve both our understanding of and treatment options for depression – and which seem to be actually feasible in the future.

Key words: *depressive disorders, magnetic resonance imaging*

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THE COMPLEX RELATIONSHIP BETWEEN DEPRESSION AND SLEEP

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Objectives:
At the end of the presentation, participants will be able to:

1. Review common subjective sleep disturbances in depression and understand the importance of sleep architecture and its relationship with mood disorders
2. Discuss the importance of co-morbidity between sleep disorders, specifically Obstructive Sleep Apnea, and mood disorders
3. Become aware of the main principles of management of common sleep problems in mood disorders

Sleep disturbances are extremely common, but often neglected in treatment of depression. They can present in many subtle ways, destabilize illness and lead to treatment resistance. Patients with mood disorders complain of sleep disturbances before, during and after remission of the mood episode, with 65% to 75% of both adults, adolescents and children with depression complaining of insomnia or, more rarely hypersomnia. In addition to disrupted and non-restorative sleep during the mood episode, patients are more likely to complain of more awakenings, disturbing dreams and decreased sleep time. This presentation will address the neurological and sleep architecture changes significant for understanding etiology of insomnia in depression. We will emphasize the importance of recognizing co-morbid sleep disorders, specifically sleep apnea in patients with depression and present results of our research study in patients with treatment resistant depression, demonstrating that undiagnosed sleep disordered breathing is very common in individuals with TRD (51%). The presentation will involve an overview of Cognitive behavioral therapy for Insomnia and its application in patients with depression. We will provide an update on pharmacological treatments of sleep disturbances in depression and include complementary and alternative treatments in our discussion.

Key words: *sleep disturbances, depression, cognitive behavioral therapy*

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ANTIDEPRESSANTS IN BIPOLAR DEPRESSION

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There are multiple guidelines suggested for bipolar disorder. However, the use of antidepressants in bipolar depression is quite controversial. Even the recent ISBD task force report does not give any specific recommendation thanks to the limited data available. Some of the burning questions should be answered to provide any recommendations. These questions are: Do mood stabilizers have antidepressant action? Do atypical antipsychotics have antidepressant efficacy? Is bipolar depression antidepressant resistant? Do Antidepressants have mood stabilizing effect? Do mood stabilizers have antisuicidal action? Do antidepressants increase suicidal ideation? Do antidepressants produce switch? Do atypical antipsychotics produce switch? Do mood stabilizers prevent antidepressant induced switch? Is the switch 'up' or down? Can one differentiate spontaneous switch from treatment emergent affective switch (TEAS)? Are we clear about the neurobiology of switch? Is induction of hypomania good for BP II? Is cycle acceleration/rapid cycling by ADD a fiction? Can the cycle variations in bipolar disorder help in treatment? Are we depressed about BP guidelines?
A critical appraisal of antidepressant use in bipolar depression is attempted.

Key words: *antidepressants, mood stabilizers, antypsihotics, bipolar depression*

ASSESSMENT OF BURN-OUT IMPACTS TO QUALITY OF LIFE IN NURSING PROFESSIONALS

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Introduction: Burnout may be defined as a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding. A great deal of research has been devoted to the understanding of factors contributing to burnout and to its consequences for individuals and their health. Research indicates that stress and burnout are significant factors in the development of both physical and psychological illness. Moreover, other studies have indicated the association of burnout with different self-reported measures of distress. **Purpose:** The present study aims to: Asses the burnout levels and quality of life in nursing professionals as well as the possible impacts that burnout has to quality of life. Furthermore differences with regards to the levels of burnout in nursing professionals working in General and Mental hospitals is investigated to. **Method:** A cohort of 139 nurses will be recruited from General and Mental hospitals located within the broader area of Athens. From the total sample, 42 were men and 97 women with a mean age of 39.9 years of life. We used the following questionnaires: Maslach Burnout Inventory and the 36-Item Short Form Health Survey (SF-36). **Results:** There is a negative effect of burnout in the assessment of QoL ($p<0.01$) and a statistically significant correlation between age, education level and whether the staff has no position or responsibility, to both Psychiatric and General Hospital as well, in QOL and assessment of burnout. **Conclutions:** Socio-demographic factors appear to affect QoL and burnout levels of nursing staff working in Psychiatric and General Hospital as well.

Key words: *burn-out, quality of life, socio-demographic factors, nursing professionals*

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PRACTICAL MANAGEMENT OF TREATMENT RESISTANT DEPRESSION

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The incidence and prevalence of depression have been constantly uprising in the last decades. According to the World Health Organization, until the year 2020 depression will become the leading cause of death and disability in women and the second leading cause of death and disability in the total population. Better understanding of epidemiology, etiology, pathogenesis and clinical features of depressive disorders is a fundamental for an adequate therapeutic approach. The current classification criteria (ICD - X, DSM - IV) and clinical assessment scales can be used to quantify the clinical status when diagnose is established and monitor the effectiveness of prescribed therapy. The research of neuroplasticity in central nervous system had implications on the treatment of depressive disorders. Comparison of therapeutic guidelines with our clinical experience can be a basis for the improvement of everyday clinical practice. When two properly applied consecutive therapeutic treatments have no adequate response, this serious problem of treatment resistant depression must be resolved. Significant differences in chemical structure and specific mechanism of action of some antidepressants, prescribed in accordance to therapeutic guidelines, can be a possible solution. When it is possible, the analysis of the factors that influence the resistance must be conducted. Residual symptoms in depression, such as insomnia, fatigue, obesity and sexual dysfunction, can compromise already achieved remission and their afterglow may have a number of consequences. Selecting an adequate therapeutic approach can successfully resolve this issue.

Key words: *treatment, resistant depression, disability, treatment, therapeutic guidelines, mechanism of action, antidepressants, residual symptoms*

BRAIN TUMORS AS A CAUSE OF THERAPORESISTANCE IN DEPRESSION

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Introduction: Mental disorders are common in brain tumors. They are often the only manifestation and initial symptom of these types of tumors. The incidence of depression in patients with brain tumors varies in the range of 10% to 50%, depending on the study. The aim of this study was to determine whether there is a relationship of major depression episode with the size and localization of brain tumors and does surgery leads to withdrawal of depressive symptoms. **Method:** The study sample consisted of 115 patients who underwent surgery of brain tumors (resection of the tumor). The size and location of the tumor was determined by computed tomography and magnetic resonance imaging. The study sample was divided into two groups: the experimental group consisted of patients with brain tumors who showed the first episode of major depression according to ICD 10 diagnostic criteria (59 patients; 51.3%), while the control group consisted of patients that had brain tumor operation without diagnosed depression (56 patients; 48.7%). The Hamilton accord of 17 items was use to assess and quantify the symptoms of depression. Majority of the patients who had a major depressive episode have been treated with antidepressants (97.7 %). **Results:** The study found a statistically significant difference in the occurrence of depressive episodes when the tumor site was localized in the frontal lobe, compared to other localizations ($3 = -2570$, $p = 0.010$). Also, there was a statistically significant difference in the occurrence of depressive episodes in patients who had a tumor diameter greater than 4 cm, from the smaller ones ($X\ 2 = 24.376$, $p < 0.001$). Significant difference reduction was shown in depressive symptomatology after surgery (McNemar's test, $p = 0.004$). **Conclusion:** Our research has confirmed that the inadequate response to antidepressant therapy may be associated with brain tumors and that the surgical treatment leads to the withdrawal of depressive symptoms in this group of patients.

Key words: *depression, brain tumors, brain surgery, frontal lobe, inadequate response*

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ECONOMIC BURDEN AND COST-EFFECTIVE THERAPEUTICS OF TREATMENT RESISTANT DEPRESSION

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Treatment-resistant depression (TRD) refers to inability of achieving remission despite optimal use of at least two antidepressants. TRD frequency depends on different factors and varies from ~30% to ~75%. Studies examining the economic aspects of TDR reported a significant increase in direct (medical) and indirect (non-medical) costs. In USA, medical costs of TRD increased by 29.3% to 40%, and two-year cost of employees suffering from TDR as well as the average indirect costs are about 2 times higher compared to other people with major depression. Consequently, the compensation of employees who have TDR are more than two times higher than in employees with treatment-controlled depression and more than 3.5 times compared to other employees in a random sample. Annual costs of TDR for health system in Brazil increased by 81.5%, while in Israel the TDR patients have significantly higher costs for imaging diagnostics, physician visits, hospitalizations and loss of productivity. Therapeutic strategies in TDR are diverse and their economic aspects are the subject of intense research. The first strategy in TDR that could be economically justified is the earlier switch of the first-choice, insufficiently effective drug, or, better, augmentation therapy with another antidepressant. Combination therapy with lithium is more cost-effective than augmentation with atypical antipsychotics. Addition of cognitive-behavioral therapy to the standard treatment is a cost-effective for patients who did not respond to antidepressants. In some countries, transcranial magnetic stimulation is a cost-effective treatment for TRD compared to psychopharmacological and electroconvulsive therapy. Vagus nerve stimulation, a treatment mode from the group of neuromodulatory strategies, is approved for use in TDR in some countries and could be a cost-effective and even to make savings. Future studies will likely provide new evidence that investments in appropriate treatment of TDR achieve significant both medical and economic benefits.

Key words: *depressive disorder, treatment-resistant, economics, medical, costs and cost analysis, psychotropic drugs, cognitive therapy, transcranial magnetic stimulation, electric stimulation therapy*

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POSTERS

DURING LABOR AND DELIVERY DIFFERENT FACTORS INFLUENCE CORTISOL LEVELS

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Background: It has been proposed that hypocrtisolemia at the moment of exposure to traumatic event can cause symptoms of posttraumatic stress disorder. Labor and delivery are possible traumatic events even during regular delivery (vaginal delivery during 37 to 42 weeks of pregnancy with healthy child) and during this period different factors beside epidural anesthesia can cause changes in cortisol level. **Method**: The study included 149 primiparous women devided in epidural and nonepidural groups. Blood sampling was conducted during the first two hours after delivery to determine cortisol level. Heart rate and blood pressure were messured before that. Sociodemographic and data about applied medications, epidural anesthesia, partner presense were collected, too. **Results:** The only factor that significantly lowered cortisol level was epidural anesthesia. The most significant difference between groups with or without of epidural anesthesia was in the level of cortisol – the epidural group had lower levels of cortisol (nonepidural group 1938.1±496.9 vs. epidural group 1297.1±420.1; $p<0.001$). **Conclusion:** Our study has shown that epidural anesthesia lowers cortisol levels and lead to hypocortisolemia which can be a risk factor for development of posttraumatic stress disorder.

Key words: *cortizol, posttraumatic stress disorder, labor, delivery*

BDNF, COMT AND SERT GENETIC POLYMORPHISM COMBINATIONS AND THEIR EFFECT ON SUSCEPTIBILITY FOR DEPRESSION AND BRAIN STRUCTURAL CONNECTIVITY

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Introduction: Depression is a mental disorder that affects 350 million people worldwide and is the third leading cause of disability. Genetic polymorphisms in the serotonin transporter (SERT) 5-HTTLPR, BDNF val66met and COMT val158met have been shown to be linked to depression. The effect of combinations of these common polymorphisms on depression and brain structure has been less investigated. The aims of our study were to analyze (a) whether a combination of these three polymorphisms is associated with higher susceptibilty to depression and (b) whether it affects brain structural connectivity. **Methods:** Genetic screening was done for SERT 5-HTTLPR, BDNF val66met and COMT val158met polymorphisms in 77 patients who fulfilled DSM-IV-R criteria for current major depressive episode and 66 healthy controls. They underwent diffusion tensor (DT) MRI. DT MRI metrics were obtained from the major interhemispheric and long association white matter (WM) tracts and compared between groups according to their genetic background. The relationship between WM integrity and the patient clinical features was also assessed. **Results:** Patients were much more likely to have a combination of BDNF val homozygote/COMT met carrier/SERT L carrier (VML) than controls (40 out of 77 patients and 17 out of 66 controls; p=0.0007). Compared to controls, all patients showed reduced WM integrity of the body of the corpus callosum, right parahippocampal tract and bilateral superior longitudinal fasciculus (SLF). Furthermore, VML controls showed higher WM integrityof the corpus callosum compared to all patients and to no-VML controls. A significant relationship between patient WM damage and clinical features has also been observed. **Conclusions:** When evaluating specific combinations of these three polymorphisms, a difference in their frequency emerged between patients and controls. WM structural connectivity is affected by depression, however the majority of the difference in patients and controls was due to the high integrity of the VML control group. This might point to some "protective" factors that are likely to modulate this interaction in VML controls, as they showed the strongest brain structural connectivity.

Key words: *depression, gene, SERT, 5-HTTLPR, COMT, val158met, BDNF, val66met, diffusion tensor, MRI, white matter integrity, connectivity*

DOES SEX AFFECT THE DIAGNOSIS OF AUTISM SPECTRUM DISORDERS?

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Introduction: Studies have suggested a higher incidence of autism in boys than in girls, with ratios being around 4:1. Findings on sex differences in clinical manifestations among persons with autism spectrum disorders (ASD) are inconsistent. Our study examined the presence of mentioned differences and the way they might affect the diagnostics. **Method:** The study included 134 participants (108 males, 7.86±5.38 years old) diagnosed with Pervasive developmental disorders (PDD) based on ICD10 criteria (the upcoming diagnostic schedule – ICD-11 will introduce ASD). Assessment included Autism Diagnostic Interview – Revised for ASD diagnosis and determination of clinical symptoms, and Vineland Adaptive Behavior Scale, Second Edition, for the assessment of adaptive functioning. **Results:** There were no sex differences neither in the core autistic symptoms, nor in the examined adaptive functioning (with and without controlling for age). Still, when it comes to the diagnosis of specific PDD, males were more often diagnosed with typical autism. **Conclusion:** Our findings have shown no sex differences in clinical scores and adaptive functioning, whereas they have shown differences in diagnostic categories. Females were more often diagnosed with atypical autism, which leads to the conclusion that ASD might be underdiagnosed in girls. These findings might be significant in terms of using a different approach when examining male and female patients for ASD, therefore improving the sensitivity of diagnosing ASD in females, which is expected to be improved with the new classification in the future.

Key words: *autism, autism spectrum disorders, sex differences, pervasive developmental disorders*

THE SYMPTOMS OF DEPRESSION IN SCHIZOPHRENIA BASED ON THE PHASE OF ILLNESS

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Introduction: The goal of this study was to investigate the co-occurrence of depressive symptoms in patients who suffer from schizophrenia, as well as their associations with other clinical measures. **Method:** This prospective clinical study enrolled 100 patients with schizophrenia in acute impairment phase and remission phase. Psychometric assessments were made by using Positive and Negative Syndrome Scale for Rating the Symptoms of Schizophrenia, Scale to Assess the Unawareness of Mental Disorder, the Calgary Depression Scale for Schizophrenia and Global Assessment of Functioning Scale. **Results:** Depressive symptomatology prevalence in patients with schizophrenia in the acute phase of the illness was 23% in the study group, while in the remission phase was low – 13% of the sample. The group of schizophrenic patients with depressive symptoms turned out to live alone, and have little or no daily contacts with other people. Unlike the nondepressed, the depressed patients were mostly married, with children and without any complications at birth. Based on logistic regression, clinical factors in our findings were better predictors of depression in the acute phase than sociodemographic factors, while in remission phase it was the other way round. In the acute phase of the schizophrenic disorder the increased awareness was an important predictive factor of the occurrence of depression symptoms in schizophrenia. **Conclusion:** Depressive symptomatology often occurs in patients with schizophrenia. Better insight was significantly correlated with lower mood, as well as marital status and parenthood.

Key words: *depressive symptoms, schizophrenia, prevalence*

INFLUENCE OF DIFFERENT PSYCHOPATHOLOGY AND SOCIOPATHOLOGY ON PERSONALITY OF ADOLESCENTS

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Adolescence is a developmental periods with normative crises characterized by high growth potential, but also by unstable Ego strength that intensifies personality vulnerability towards socio-pathological phenomena and psychopathology. Connection between socio-pathological phenomena and structural psychopathology is significant and often represents a large problem in differential diagnostics due to frequent overlapping. The main aim of the study has been to establish differences in adolescent personality structure in three clearly defined clinical groups: socialized behavioral disorder, substances abuse and newly formed non-chemical addiction: "the Internet addiction". The sample consisted of 30 adolescents for each clinical group of the research, 30 adolescents from general population, diagnosed according ICD 10 criteria and Young's Internet Addiction Test – IAT. The adolescents' personality has been explored through Adolescent Temperament and Character Inventory: ATCI -4. Analysis of the adolescent's personality through the ATCI-46 indicated that each of the three groups of the clinical sample has a different expression of temperamental and character dimensions:

- Socialized behavior disorder: an extremely low expression of Persistence (P) and low expression of the dimension of Self-directedness (SD).
- "Internet addiction": an extremely high expression (NS) is characteristic, as well as low expression of Self-directedness (SD) and Cooperativeness (C).
- Substance abuse: slight expressions of temperamental dimensions, with the tendency of insufficient differentiation, and low expression of Cooperativeness (C) and Self Transcendence (ST).

Key words: *personality, adolescence, behavioral disorder, internet addiction, substance abuse*

CULTURAL INFLUENCE ON AFFECTIVE TEMPERAMENTS

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Introduction: Temperament and affective traits portray emotional reactivity and represent the fundamental predisposition that underlies personality and behavioural manifestations (Akiskal & Akiskal, 2005a). However, we can also expect that different cultural influences may affect the frequency of dominant affective temperaments. The *aim* of the present descriptive study was to investigate the characteristics of distribution of dominant affective temperaments in different national studies in the same geographical region. **Method:** We included three studies published in different countries: Serbia (Ristic et al 2014), Slovenia (Dolenc et al., 2012) and Hungary (Rózsa et al., 2008), which investigated a large sample of non-clinical population using TEMPS-A, and reported frequencies for dominant affective temperaments. **Results and Disscusion:** Similar to previous studies, the five temperaments were not independent from each other (mid to high positive correlations), with the exception of hyperthymic, which considerably differs from the others.A small number of dominant hyperthymic and an increased number of cyclothymic individuals in Serbian sample may reflect some environmental influences which reinforces more active and outgoing behaviours (Ristic et al 2014). Similarly, Dzamonja-Ignjatovic et al. (2010), who administered the TCI-R scale on Serbian population, assumed that social, economic changes and civil wars in Serbia during the previous twenty years, were replaced by personal freedom and entrepreneurship, which brought forth increased activities, openness to new experiences and novelty seeking. High correlations between hyperthymic temperament and novelty seeking obtained in Serbian study, supports this thesis. On the other hand, the frequency of 5.8% of the participants with dominant depressive temperament was significantly higher among all studies. An alternative explanation could be that collectivist cultures (Serbia may be categorised as such) tend to promote the emphasis of strong connectedness and cohesive integration among people, which resembles the evolutionary advantages associated with depressive temperament (Gonda et al., 2011). Irritable temperament in Serbian population differs from Hungarian being significantly lower, whereas the frequency of dominant anxious temperament does not differ among these three national studies. As for the gender differences in in all three studies women obtained significantly higher scores on depressive and anxious subscale (in Serbia and Slovenia also on cyclothymic), whereas men scored significantly higher on hyperthymic subscale. **Conclusion:** Even we found some differences in the frequency of affective temperaments between geographically close nations, due to the somewhat different methodology procedures in these studies, future deeply analysis is necessary.

Key words: *affective temperaments, hyperthymic subscale*

SUICIDAL PATIENTS – CLINICAL EXPERIENCES

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Background: Suicide is a major public health problem. Suicidal spectrum may be categorized as suicide-related ideation, suicide-related tendencies, suicide attempts and completed suicide. The frequency and distribution of suicide attempts are in relation to demographic characteristics, psychiatric disorders and the manner of suicide attempt. The aim of this study was to assess the suicidality at the moment of admission in a period of six months as well as correlation with gender, psychiatric disorders and method. **Method:** The sample consisted of 145 patients hospitalized on the Clinical Department for Psychotic Disorder. Assessment has been carried out by the MINI-5 and Columbia Rating Scale. **Results:** Our findings have shown that 34% of patients were suicidal, 6.2% with suicidal ideations, 12.4% with suicide-related ideation and tendencies, and 15.2% patients with suicide attempt. Women were 57%, man 43% of whole sample. The most frequent disorder was recurrent depressive disorder with 33% and the most common suicidal method was poisoning by medications – 97.2%. **Conclusion:** An increased number of hospitalizations due to suicide attempts were noted, therefore, special attention should be paid to detection, prevention and treatment of risk groups of population.

Key words: *suicidality, suicide attempt, risk factors*

VERMIS HYPOPLASIA AND RHOMBENCEPHALOSYNAPSIS IN A PATIENT WITH SEVERE BORDERLINE PERSONALITY DISORDER – CASE REPORT

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Background: There is an increasing number of findings supporting the fact that cerebellum, apart from its significance in movement coordination plays an important role in cognitive and emotional regulation. **Case description:** In this paper we presented a young woman who had been repeatedly hospitalized since she was 16, because of self-destructive behaviour, affective instability and impulsiveness, and had been diagnosed as borderline personality disorder. Since the neurological and neuropsychological reports pointed to signs of cerebellar dysfunction and dysexecutive syndrome, we performed magnetic resonance imaging of brain which has shown partially developed vermis and rhombencephalosynapsis. **Discussion:** These findings match the description of cerebellar cognitive affective syndrome and suggests the importance of neurological and neuropsychological evaluation of patientswith severe personality disorders.

Key words: *vermis, borderline personality disorder, cerebellar cognitive affective syndrome, rhombencephalosynapsis*

GROUP WORK WITH CHILDREN AND ADOLESCENTS

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Group work as therapeutical model is very useful, giving the opportunity to participants to talk about topics that are confusing them. By implementation of group work we try to achieve emotional relaxation of participants, and encourage the expression of their feelings and interactions in new circumstances or group reality The group work is particularly effective approach with children and adolescents because, being social beings they are interested in interaction with their peers. Group gives them the opportunity for verbalization of their fears, anger, hopelessness, which helped them in one moment to cope with emotional turbulences, but had a great impact on their self-confidence and maturation, later on. In this paper we shall present the variety of group work conducted with children and adolescents (inpatients and outpatients) at the Clinic for Children and Adolescents of the Institute of Mental Health in Belgrade. The presentation will encompass the ongoing activities, as well as the new ones: group work with outpatients called "12+", "social skill games", specific occupational therapy in inpatients unit and mixed group of inpatient children/adolescents and their parents. The methodology of group work is based on psychosocial approach with combination of activities and talk in which two therapists are involved. Group work includes group support, learning of the others, testing own opinion in regards with others, practice of social skills and social behavior. Duration of group work is one hour.

Key words: *children, adolescents, group work, social skills*

DEEPER INSIGHT INTO DEPRESSION PATHOLOGY THROUGH MODULATION AND CHALLENGE PHMRI

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Background: Depression is a highly prevalent psychiatric disorder, contributing to significant distress and burden and is the main contributor to life years lived with disability. Due to its prevalence and the associated disability, we have a large number of medications acting via different mechanisms. However, in spite of this, we do not have sufficient understanding either of the neurobiology of depression, or the mechanism of action of currently used antidepressive medications. Imaging approaches using pharmacons such as pharmaco fMRI (phMRI) could present a possible route to deeper understanding the processes involved in depression and its pharmacotherapy using currently available antidepressant medications. The aim of our present work is to review the published scientific literature, and present a summary of results obtained so far using modulation and challenge phMRI with different SSRIs. **Method:** A PubMed search was conducted using the key words "pharmacoMRI" or "phMRI" and "depression" and "SSRI" including papers investigating human subjects published in English before April 2014. **Results:** Challenge phMRI is not widely used in human research, the only effective study was performed by McKie et al in 2005 with 12 healthy partipicants. They found activation in the ventrolateral prefrontal cortex, anterior cingulate cortex, caudate, parahippocampal gyrus, thalamus and the amygdala as the effect of acute intravenous citalopram, but these result has not been reproduced so far. In case of modulation phMRI the most frequently studied process is emotional processing which is insufficient in depression, using an emotional processing task to observe changes in brain activity caused by face emotion recognition or other visual stimuli, representing different emotions. The most significant effect observed in depression in phMRI studies is decreased amygdala activation to a single dose of SSRI in case of negative stimuli. In addition, one study reported decrease of the activity in the orbital prefrontal cortex. However, there are inconsistencies in the literature related to modulation phMRI results which can be explained by different patient samples and study designs, besides. **Conclusions:** PharmacoMRI studies provide a promising approach to study the neurobiological background of depression and the effects of antidepressant treatment. Although the number of studies is low so far, further widening the scope of this approach could contribute to valuable knowledge into different pathological processes in the background of different subtypes of depression, as well as to the action of antidepressive pharmacons in these different subtypes.

Key words: *pharmaco MRI, phMRI*, *depression, SSRI*

IMAGING STUDIES IN PSYCHIATRY – DELINEATING THE NEUROBIOLOGY OF DEPRESSION AND RELATED CONSTRUCTS USING PET

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UK and Manchester Academic Health Sciences Centre

Background: Although depression is a universally prevalent phenomenon contributing not only significant disability, but also a great burden for the society as well, we still do not possess sufficient knowledge concerning its neurobiological background. Different imaging approaches may deepen our understanding in understanding the pathological processes in depression at the receptorial level understanding the complexity and heterogeneity of this disorder. **Method**: The purpose of our work is to review the scientific literature published so far and present a summary of results using PET (positron emission tomography) to examine the function of the serotonergic system in healthy and depressed patients. **Results**: According to the literature to date, PET can be an effective method to investigate serotonergic receptors, although the results are often inconsistent because of the diversity of the tests applied. Although studies investigating $5HT_{2A}$ receptors yielded different results, it has been repeatedly found that the binding potential was correlated with pessimism in depressed patients which is in line with the hypothesis that monoamine deficiency leads to an increase in receptor density. Results concerning $5HT_{1A}$ receptors in depression are controversial, in part probably due to differential study designs. Therefore most studies applying $5HT_{1A}$ receptor antagonists do not indicate that decreased 5HT levels in depression are a consequence of increased $5HT_{1A}$ receptor density, but an increasing number of studies indicate decreased postsynaptic $5HT_{1A}$ receptor binding potentials in depression. Results concerning the serotonin transporter are also controversial, however, studies applying various methodologies and even some PET studies indicate increased serotonin transporter density in depression. **Conclusion:** Although depression is a highly prevalent illness contributing to high treatment associated costs, and although there are numerous psychopharmacological options available for the treatment of depression, the efficiency of these pharmacotherapies is still not sufficient, in part due to our inadequate understanding of the neurobiology of depression and its different subtypes preventing us from matching a given antidepressant to a given subtype in a patient. It is also possible, that the controversial results in imaging studies are in part due to not applying homogenous samples with respect to subtypes of depression. Imaging approach in psychiatric research and PET studies may provide us with important tools in understanding depression and differentiating between its subtypes at a neurobiological level.

Key words: *depression, antidepressant,* efficiency*, imaging, PET studies*

INHIBITION OF CENTRAL ANGIOTENSIN II ENHANCES MEMORY FUNCTION AND REDUCES OXIDATIVE STRESS STATUS IN RAT HIPPOCAMPUS

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While it is now well established that the independent brain renin-angiotensin system (RAS) has some important central functions besides the blood pressure/vascular ones, the relevance of its main bioactive peptide angiotensin II (Ang II) on the cognitive processes, as well as on oxidative stress status are not completely understood. In this way, the aim of the present work was to evaluate the effects of central Ang II inhibition with either AT1 and AT 2 receptor specific blockers (losartan and PD-123177, respectively) or an ACE inhibitor (captopril) on short-term memory (assessed through Y-maze) or long-term memory (as determined in passive avoidance) and on oxidative stress status from the hippocampus. Our results provide evidences regarding the cognitive alteration and increased oxidative stress induced by the administration of Ang II, while its blocking through the aforementioned methods resulted in opposite effects. Moreover, we found here significant correlations between all of the memory related behavioral parameters from Y-maze and passive avoidance tasks and the main oxidative stress markers (two antioxidant enzymes: superoxide dismutase-SOD and glutathione peroxidase-GPX, as well as a lipid peroxidation marker: malondialdehyde-MDA) from the hippocampus, which is known for its implication in memory processes and also where RAS components are well expressed. This could be relevant for the complex interactions between Ang II, behavioral processes and neuronal oxidative stress, while these aspects could generate important therapeutic approaches.

Key words: *angiotensin II, memory, oxidative stress*

ANGIOTENSIN-(1-7) CENTRAL ADMINISTRATION INDUCES ANXIOLYTIC-LIKE EFFECTS IN ELEVATED PLUS MAZE AND DECREASED OXIDATIVE STRESS IN THE AMYGDALA

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There is increasing evidence that besides the well-known angiotensin (Ang) II, other renin-angiotensin system (RAS) peptides, including Ang-(1–7), could have important effects at the central level, besides those related to blood pressure and hypertension. However, very few things are known about the central actions of Ang-(1-7), while the effects of its administration alone on anxiety were not tested to this date, according to our knowledge. In this way, we were interested in studying the effects of Ang-(1-7) intracerebroventricular administration on anxiety levels, as studied through some main behavioral parameters in the elevated plus maze, as well as the importance of Ang-(1-7) in the oxidative stress status from the amygdala, which is one of the key brain regions involved in mediating anxiety. In this way, we report here for the first time in our best of knowledge a possible anxiolytic-like effect of Ang-(1-7) administration, as demonstrated by the increased percentage of time spent and frequency of entries in the open arms of the elevated plus maze, as well as increased head-dipping behavior in the open arms and decreased stretching in closed arms. Also some antioxidant effects of Ang-(1-7) are suggested since a significant increase of GPX specific activity and a decrease of the main peroxidation marker MDA were observed in the amygdala. Moreover, we found a significant correlation between most of the behavioral parameters in the elevated plus maze and the levels of the oxidative stress markers. However, further studies are necessary in order to elucidate the effects of Ang-(1-7) administration on anxiety and oxidative stress status and also on the possible correlation that might exists between these aspects.

Key words: *angiotensin-(1-7), anxiety, oxidative stress*

CARDIOVASCULAR RISK FACTORS AS POTENTIAL MARKERS FOR MILD COGNITIVE IMPAIRMENT AND ALZHEIMER'S DISEASE

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Background: Mild cognitive impairment (MCI) is an early stage of cognitive decline that has a significant risk of converting to dementia. Cardiovascular pathology appears to have a major impact in cognitive decline, and it is clear that early identification and correction of cardiovascular morbidity could have a major impact on cognitive functioning. **Method:** Our study was conducted in order to identify some cardiovascular risk factors among patients with cognitive decline (MCI or Alzheimer disease-AD) and to find if there is any correlation with the degree of cognitive decline. We evaluated the body mass index, total cholesterol, hypertension, history of smoking, alcohol consumption and diabetes mellitus in patients with MCI and AD, compared with an age-matched control group. **Results:** Regarding the body mass index, we observed a progressive decrease in patients with MCI and AD, in comparison with the control group. Similar aspects were also observed in the case of cholesterol levels, only that post hoc analysis revealed no significantly statistical differences between MCI and AD groups. The systolic blood pressure was increased in the patients with MCI and AD. Also, as in the case of cholesterol levels, post hoc analysis revealed no significantly statistical differences between MCI and AD groups. Pearson's correlation showed significant connections between the cardiovascular risk factors and the results of the cognitive evaluation. **Conclusions:** Our results constitute additional evidence that cardiovascular risk factors are involved in cognitive regression. This finding could have an important impact on the management of dementia.

Key words: *cardiovascular risk factors, mild cognitive impairment, Alzheimer's disease*

ESTABLISHING ECHOCARDIOGRAPHIC AND ARTERIAL STIFFNESS MARKERS PREDICTORS FOR COGNITIVE DECLINE

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Different factors seem to contribute to cognitive impairment in elderly population. Still, it is unclear which cardiovascular risk factors are the most significant contributors to the cognitive decline. Although there are several recent neuropathological evidence that vascular lesions and atherosclerotic occlusion of cerebral arteries may unmask or strengthen the clinical expression of cognitive decline and dementia, there are still very few knowledge about the relevance of echocardiographic and arterial stiffness markers predictors for the cognitive decline. In this way, in the present study we decided to investigate whether and how the severity of the cognitive impairment could be related to the cerebral hemodynamic impairment, as well as the possible contribution for the alterations in cerebral hemodynamics (as expressed through some echocardiographical and arterial stiffness markers) to the progression of cognitive decline in a group of patients with cognitive impairments, as compared with a control group with no cognitive deficits. The main finding of our study indicated significant differences in terms of echocardiographic and arterial stiffness markers between the two groups we studied here, one composed from patients with cognitive impairment and one with normal-cognitive patients, which suggests an association between these parameters and poor cognitive function. While these functional changes of the cerebral vessel functions could have an important role in the pathogenesis of dementia, the identification of simple and accurate measures that are acceptable to patients and can serve as indicators of current cognitive impairment or risk of cognitive decline could be very helpful in developing long-term preventive and therapeutic aspects for these patients.

Key words: *echocardiographic, arterial stiffness, markers, cognitive decline*

THE RELEVANCE OF BODY MASS INDEX IN THE COGNITIVE STATUS OF DIABETIC PATIENTS WITH DIFFERENT ALCOHOL DRINKING PATTERNS

Daniel Timofte[1], Cristina Toarba[1], Simona Hogas[1], Adrian Covic[1], Radu Lefter[2], Alin Ciobica[2], Roxana Chirita[1], Emil Anton[1], Mariana Graur[1]

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Nowadays the general relevance of alcohol consumption in diabetes is extremely controversial, considering that there are recent reports describing that alcohol could result in a decreased incidence of diabetes, as well as variety of other studies demonstrating a positive association between drinking alcohol and type 2 diabetes, but also an inverse association between these two or no correlation at all.
The different results obtained in these studies could be mainly explained by the existence of several confounders that could influence in an important matter the final outcome of the aforementioned studies. Thus, in this report we studied the possible relevance of the Body Mass Index (BMI) as a confounder in the relationship between alcohol consumption in diabetes and the cognitive function, by mainly analyzing the correlations between the BMI values in these diabetic patients with different alcohol drinking patterns and the subdomains from some main psychometric tests, like MMSE (Mini-Mental State Examination) and MOCA (The Montreal Cognitive Assessment).Our results described here provide important evidence regarding BMI as a possible confounder of the relationship between alcohol consumption in diabetes and the cognitive function, since we found a significant increase ($p<0,0001$) in BMI values in patients with diabetes, as compared to our control group and, most importantly, significant correlations between BMI parameters in these alcohol-consumers diabetic patients and most of the subdomains for the aforementioned psychometric testing.

Key words: *diabetes, alcohol, cognitive, body mass index*

ESTABLISHING THE CONNECTIONS BETWEEN ALCOHOL INTAKE, COGNITIVE FUNCTIONS AND TYPE 2 DIABETES

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Background: Lately an increased amount of attention has been paid to the role of alcohol in type 2 diabetes. However, the studies reporting the relevance of alcohol intake in the diabetic pathology resulted in contradictory results, with authors describing an increased risk of diabetes in alcohol consumers, while others have reported an opposite protective effect, manifested though a reduced incidence of type 2 diabetes. There are also recent theories that alcohol consumption may influence the cognitive decline in the patients with type 2 diabetes. **Method:** In the present report we were interested in studying the associations that might exist between alcohol consumption, the cognitive functions and the diabetic pathology in patients with type 2 diabetes. Alcohol intake was classified into 6 groups: nondrinkers, 0.1–9.9, 10.0–14.9, 15.0–29.9, 30.0–49.9 and ≥ 50.0, according to the total amount (grams/day) of alcohol consumption, in our 219 patients diagnosed with diabetes. **Results:** Our results presented here are mainly confirming that moderate alcohol consumption may reduce some neuropathological aspects of the type 2 diabetes, as demonstrated for example by the decrease of the glycemic levels in the groups of patients that consumed increased levels of alcohol (30.0-49.9 g/day), when compared to non-drinkers (p=0.04) or the groups with 0.1-9.9 (p=0.01) or 10.0-14.9 (p=0.02) grams of alcohol intake per day. **Conclusions:** Regarding the results of the cognitive testing, we noticed a significant increase in the values of the MMSE score, when we compared a lower dose of alcohol intake (0.1-9.9 g/day) with the higher ones: 30.0-49.9 g/day (p=0.008) and ≥ 50.0 g/day (p=0.047). However, further studies in which the alcohol consumption can be analyzed prospectively and the modifications of the cognitive functions could be observed on longer follow-up time, as well as studies with larger samples are necessary in order to better understand the association between alcohol intake, cognitive functions and type 2 diabetes.

Key words: *type 2 diabetes, alcohol intake, cognitive functions*

THE RELEVANCE OF OXIDATIVE STRESS STATUS IN FIRST EPISODE AND RECURRENT DEPRESSION

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It seems that oxidative stress could play an important role in the pathogenesis of major depression disorder (MDD). However, there are very few studies regarding the implication of oxidative stress in MDD, most of them showing contradictory results, with both increased and decreased levels of antioxidants in depressed patients. In this way, the aim of the present work was to evaluate the specific activity of the main peripheral antioxidant defences (superoxide dismutase – SOD and glutathione peroxidase – GPX) and the level of malondialdehyde – MDA (a lipid peroxidation maker), in depressed patients, as compared to an age-matched control group. Moreover, considering that to our knowledge there is no previous study regarding the relevance of the disease chronicity on oxidative stress status in depression, we were interested to see if there are any differences between first episode vs. recurrent depression groups, in terms of oxidative stress markers. Additionally, we want it to investigate the effects of different antidepressant medication (mirtazapine, venlafaxine, tianeptine and escitalopram) on oxidative status of depressed patients. Our results showed an increased oxidative stress status in the serum of patients with MDD, expressed by a significant decrease of both SOD and GPX specific activities and a significant increase of the lipid peroxidation marker MDA, as compared to the control group. When we analyzed the oxidative stress status in depressed patients based on chronicity, regardless of their treatment, we observed significant decrease of SOD and GPX specific activities in recurrent depression group, as compared to the first episode group. Moreover, a very significant increase in MDA concentration was observed in recurrent depression patients, as compared to the first episode group. Regarding the treatment, we did not find any significant differences in the treated groups versus the controls, while post-hoc analysis revealed a possible beneficial effect of the venlafaxine administration, as compared to the other treated groups. Our results provide additional evidences of increased oxidative stress in MDD, expressed by altered antioxidant enzyme activity and increased levels of lipid peroxidation. Additionally, we demonstrated here for the first time in our knowledge a significant difference in terms of antioxidant enzymes and lipid peroxidation between the first episode and recurrent depression patients.

Key words: *major depression disorder, oxidative stress, first episode and recurrent depression*

KALENDAR KONGRESA

2014.

VI Forum of the Institute of Mental Health and
1st International Review of Psychiatry (InteRΨ2014)
Organized by The International Society on Neurobiology and Psychopharmacology (ISNP)
Co-organized by the Institute of Mental Health, the Serbian Psychiatric Association and Psychiatric Association of Eastern Europe and the Balkans
June 5-7, 2014, Belgrade, Serbia
http://www.psychiatry.gr

WPA Thematic Conference – Neurobiology and Complex Treatment of Psychiatric Disorders and Addiction
June 5-7, 2014, Warsaw, Poland
www.wpatcwarsaw2014.com
E-mail: wpatcwarsaw2014@guarant.cz

2nd Eurasian Regional Congress of Biological Psychiatry in Bursa
June 5-8, 2014, Bursa, Turkey
http://www.eurasianbiologicalpsychiatry-bursa2014.org/
E-mail: burkonturizm@euromsg.net
E-mail: kongre@burkon.com

54th INPC Congress
June 18-22, 2014, Pula, Croatia
www.pula-cong.com

29th CINP World Congress of Neuropsychopharmacology
June 22-26, 2014, Vancouver, Canada
www.cinp2014.com

Royal College of Psychiatrist's International Congress 2014
June 24-27, 2014, London, UK
The deadline for abstract submission – **07 March 2014**
http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/internationalcongress2013.aspx
Email: ljohnson@rcpsych.ac.uk

The first international Health Services Research: Evidence-based practice conference
July 1-3, 2014, London, UK
http://www.health-services-research.com/conference
nick.moss@biomedcentral.com

15th European Symposium on Suicide and Suicidal Behaviour (ESSSB15)
August 27-30, 2014, Tallinn, Estonia
www.esssb15.org
www.suicidology.ee

XVI World Congress of Psychiatry – Focusing on Access, Quality and Humane Care
September 14-18, 2014, Madrid, Spain
http://www.wpamadrid2014.com/
E-mail: secretariat@wpamadrid2014.com

27th ECNP Congress
October 18-22, 2014, Berlin, Germany
www.ECNP-CONGRESS.EU
E-mail: berlin2014@ecnp.eu

2nd Joint WPA-INA-HSRPS International Psychiatric Congress
October 30 – November 2, 2014, Athens, Greece
www.erasmus.gr
E-mail: info@psych-relatedsciences.org

World Psychiatric Association Regional Congress 2014 – Yin and Yang of Mental Health in Asia Balancing polarities
December 12-14, 2014, Hong Kong, China
http://www.wpa2014hongkong.org/scientific-info/overview.html
E-mail: wpa2014@hkam.org.hk

2015.

28th ECNP Congress
August 29 – 1 September 2015, Amsterdam, Netherlands
www.ecnp-congress.eu/submitproposal2015

4th International Congress on Neurobiology, Psychopharmacology & Treatment Guidance
May 27-31, 2015, Thessaloniki, Greece
www.psychiatry. gr

4th WACP Congress 2015 – Global Challenges & Cultural Psychiatry – Natural Disasters, Conflict, Insecurity, Migration and Spirituality
October 30 – Novembar 1, 2015, Puerto Vallarta, Jalisco, Mexico
www.4wacpcongress.org

2016.

22nd International Association for Child & Adolescent Psychiatry and Allied Professions
July 16-21, 2016, Calgary, Alberta, Canada
http://htp://www.iacapap2016.org/

WPA SCIENTIFIC MEETINGS REPORT

2013.

WPA REGIONAL CONGRESS (Zone 9)
April 10-13, 2013, Bucharest, Romania
Dr. Dan Prelipceanu - prelipceanudan@yahoo.com
Eliot Sorel - esorel@gmail.com

WPA THEMATIC CONFERENCE (Zone 8)
Third Thematic Conference on Legal and Forensic Psychiatry
June 12-14, 2013, Madrid, Spain
Dr. Alfredo Calcedo Barba
alfredoclacedo@gmail.com

WPA INTERNATIONAL CONGRESS (Zone 8)
June 19-23 2013, Istanbul, Turkey
Dr. Levent Kuey
kueyl@superonline.com

WPA CO-SPONSORED MEETING (Zone 8)
21st World Congress of Social Psychiatry – "The bio-psycho-social Model: the Future of Psychiatry".
29 June to 3 July 2013, Lisbon, Portugal
www.wasp2013.com

WPA REGIONAL CONGRESS (Zone 3)
"WPA Regional Congress and XXIII APM National Congress"
September 12-16 2013, Guadalajara, Jalisco, México.
www.psiquiatrasapm.org.mx

WPA CO-SPONSORED MEETING (Zone 7)
The International Society on the Study of Personality Disorders (ISSPD),
XIII International Congress on Disorders of Personality - Bridging personality and psychopathology: The person behind the illness
September 16-19 2013, Copenhagen, Denmark
www.isspd2013.com

WPA Thematic Congress (Zone 18)
"Human Factors in Crisis and Disaster Interventions"
30 September - 3 October, 2013, Melbourne, Australia
www.wpadisasterpsych.com

WPA International Congress (Zone 8)
Future Psychiatry: Challenges and Opportunities
October 27-30, 2013, Vienna, Austria
www.wpaic2013.org

2014.

WPA Regional Meeting (Zone 14)
February 6-8, 2014, Kampala, Uganda
Uganda Psychiatric Association
Dr. Fred Kigozi
E-mail: buthosp@infocom.co.ug; fredkigozi@yahoo.com

29th CINP World Congress of Neuropsychopharmacology
June 22-26, 2014, Vancouver, Canada
www.cinp2014.com
cinp@northernnetworking.co.uk

UPUTSTVA SARADNICIMA

PSIHIJATRIJA DANAS je zvanični časopis Udruženja psihijatara Srbije. Izlazi dva puta godišnje i objavljuje pregledne i istraživačke radove, prikaze slučajeva, prikaze knjiga i pisma uredniku.

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Prikazi slučaja treba da sadrže zanimljive kliničke izveštaje i opise slučajeva u kojima su primenjeni novi dijagnostički i terapijski metodi. Ne smeju imati više od 1500 reči.

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Specijalni radovi pokrivaju oblasti od posebnog značaja i najčešće se pišu po pozivu.

Prikazi knjiga sadrže kritičke prikaze izabranih knjiga.

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