physical, psychological, and social domains of functioning and has been employed frequently in medical contexts (Lent, 2004).

Much research has focused on QoL in relation to recurrent depressive disorder (RDD). Although a lack of consensus over the definitions of well-being and QoL has been reported in RDD literature, the two have been found to be closely related. Morton et al. (2017) found the concepts of functioning, health, subjective experience, and well-being to be related to QoL in RDD, in a thematic analysis of 275 papers. Research on QoL has allowed examination of physical, emotional, social, occupational, and spiritual well-being.

RDD can have significant adverse effects on QoL. In a qualitative study that explored a patient-centred perspective of the impact of RDD on QoL, 52 interviews with patients, caregivers, and healthcare professionals identified several themes to be central to QoL: routine, independence, stigma and disclosure, identity, social support, and spirituality. Participants reported that RDD had an immense negative impact on their QoL. The areas most impacted were noted to be education, vocation, financial functioning, and social and intimate relationships.

Hence, the QoL construct involves a highly subjective perception of personal well-being and functionality. Most clinical research has traditionally focused on symptom ratings as a measure of outcomes. However, the QoL construct has been proposed to be a measure of clinical change that is also complementary to traditionally used clinical tools. In a large study comparing 108 participants who had been 16 diagnosed with RDD to a 1,200 control participant group recruited from the general public, RDD was found to be associated with lower scores on the mental and physical measures of QoL. This association between RDD and lowered levels of well-being was prevalent, irrespective of mood state.

However, we should note that low mental quality of life was related to the early age of onset of the illness and depressive symptoms.

Pashkovskyy V.M.

COMORBIDITY IN NEUROLOGICAL AND MENTAL DISORDERS

S. M. Savenko Department of Nervous Diseases, Psychiatry and Medical Psychology
Higher State Educational Establishment of Ukraine
«Bukovinian State Medical University»

Medical care has traditionally been dominated by a separation between disciplines catering to physiological symptoms versus those catering to psychological symptoms. Emerging research points to psychiatric comorbidity in the primary care setting and in specialized services, especially with chronic conditions like cardiovascular disease and diabetes. Among psychiatric comorbidities, depression and anxiety disorders are the most prevalent and have been found to hinder treatment response, increasing disability and reducing functional outcome. Given the shared etiological processes between neurological disorders and psychiatric disorders, reports of 50% prevalence rates of depression and anxiety among neurology patients are not surprising. Despite ample evidence on comorbidity, the provision of psychiatric intervention for such patients remains lacking.

Several epidemiological studies have attempted to quantify psychiatric comorbidity in primary care and specialized services. The 52% of those with cardiovascular disease displayed symptoms of depression and anxiety, with 30% meeting the diagnostic criteria for depression. Similarly, a Belgian cross-sectional survey of primary care practices in the country revealed that although 5.4% of the 2,316 patients surveyed reported psychiatric complaints, 42.5% had an unreported psychiatric comorbidity. Mood and anxiety disorders were the most prevalent. Complications from diabetes are most prevalent in the presence of psychiatric disorders, and mortality rates increase in individuals with myocardial infarction if they also suffer from anxiety. Among 300 neurology patients surveyed in the UK, 47% met the criteria for a Diagnostic and Statistical Manual of Disorders, Fourth Edition (DSM-IV) diagnosis of depression and anxiety. In a Canadian community sample, individuals diagnosed with epilepsy were more likely to experience anxiety symptoms and had higher rates of suicidal ideation and those with migraine were more likely to experience major depressive disorder, bipolar disorder, panic disorder, and social phobia.

Moreover, it is often found that the patients with psychiatric symptoms are also those with the most disability and the least response to treatment, and are the most difficult to manage. They are also often the most frequent attendants in primary care services.

A multidisciplinary approach to disease management and education in primary care has been instrumental in managing the epidemic of psychiatric comorbidity in physical illnesses.

The current study aims to bridge this gap by investigating the prevalence of concurrent depression and anxiety symptoms among patients attending only neurology services at a local outpatient center offering both psychiatric and neurological services. The current study capitalizes on the availability of these conjoint services to determine the prevalence of mood and anxiety disorders in patients seeking only neurological services at the center. Moreover, the study looks at whether concurrent depressive and anxiety symptoms are detected by the attending neurologist based on patient self-report, the severity threshold at which referral to psychiatric services does occur, and whether referred patients attend these services.

Studies have shown that comorbidity between psychiatric disorders has been found to cause greater disability levels when compared to patients with a single psychiatric diagnosis. In a review by Hirschfeld, patients with concurrent depression and anxiety disorders responded to treatment longer, had slower recovery, utilized more medical resources, and had higher rates of recurrence and psychological disability than patients presenting with either disorder alone. Depressive symptoms and anxiety are found to overlap in many cases, and this necessitates careful discrimination between differences for a proper diagnosis and treatment plan. The current study highlights the need for proper and timely screening of psychiatric disorders at the neurological department.

Savka S.D.

PSYCHOPHARMACOTHERAPY AND PSYCHOTHERAPY OF NONPSYCHOTIC MENTAL DISORDERS ASSOCIATED WITH RHEUMATOID ARTHRITIS

S. M. Savenko Department of Nervous Diseases, Psychiatry and Medical Psychology
Higher State Educational Establishment of Ukraine
«Bukovinian State Medical University»

The objective of the research is to study clinical and psychopathological, pathopersonological and psychosocial features of the formation of nonpsychotic mental disorders associated with rheumatoid arthritis, to develop the principles of their diagnosis and correction.

The first basic group (BG I) consisted of 55 patients with a duration of rheumatoid arthritis disease up to 5 years, the second basic group (BG II) consisted of 65 patients with a duration of rheumatoid arthritis disease from 5 to 10 years.

At the first stage a patient supervision, experimental-psychological, psychodiagnostic research, diagnosis and comparative characteristics of the main and control groups; determination of features of nonpsychotic mental disorders depending on the duration of the disease by rheumatoid arthritis were carried out. At the second stage a correction of nonpsychotic mental disorders using psychotropic drugs and psychotherapy was conducted. At the third stage, statistical analysis, generalization and establishment of the impact of psychopharmacological and psychotherapeutic treatment on the level of anxiety, depression and quality of life of patients, analysis and generalization of research results, drawing general conclusions and practical recommendations were performed.

The following disorders appeared to be prevalent among a wide range of NMD associated with RA: depressive disorder (35.0%), anxiety disorder (21.7%), emotional-labile (asthenic) disorder (19.2%), adaptation disorders (12.5%), anxiety-phobic disorder (11, 6%).

With prolongation of RA duration (more than 5 years), the number of people with depressive disorder increases (from 18.2% to 49.2%, $p<0.01$) and anxiety disorder (from 16.3% to 26.1%, $p < 0.05$) and the number of persons with anxiety and phobic disorder decreases (from 20.0% to 4.7%, $p<0.01$), emotionally-labile (asthenic) disorder (from 27.3% to 12.3% , $p<0.05$) and adaptation disorders (from 18.2% to 7.7%, $p <0.05$).