

### SUFFERERS OF CHRONIC FATIGUE SYNDROME AND THEIR CARERS: CHANGE OF COPING OVER TIME

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Chronic fatigue syndrome (CFS) is a disabling illness of unknown aetiology, and no treatment has proved to be effective so far in helping patients recover fully. Therefore, patients and their families are left to find out how to cope best with the symptoms and the emotional and social consequences of the illness. The present study investigated coping with the physical and emotional demands associated with the chronic fatigue syndrome across three time points: before the diagnosis, at the time of diagnosis, and following adjustment. Sufferers of CFS and their main carers completed a revised Ways of Coping Questionnaire for each stage and rated the effectiveness of using each coping strategy. Results showed that sufferers were very flexible in their coping efforts before the diagnosis, but did not regard any strategy as particularly helpful. When CFS was diagnosed, information-seeking and problem-focused coping dramatically increased in extent and helpfulness. Several months later these coping efforts were dropped and replaced by an increased acceptance of the illness, acceptance of responsibility and acceptance of possible benefits of CFS. A similar pattern emerged for carers, but the use and perceived helpfulness of problem-solving activities were less pronounced, and of acceptance were more pronounced than for sufferers across all stages. The influence of beliefs about the illness, perceived control, functional disability, and demographic characteristics on coping were also investigated. The results suggest that coping with CFS is a process which changes over time, in accordance with the changing effectiveness of various ways of coping as the illness progresses, and ultimately might lead to the acceptance of the illness and emotional adjustment. The importance of these findings regarding illness maintenance through maladaptive coping and coping skills training will be stressed.

### GENDER DYSPHORIA IN PSYCHIATRIC PRACTICE

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*Introduction:* The discussion concerning adequate management of patients requesting sex reassignment surgery (SRS) is an ongoing controversial issue. In recent years the clinical heterogeneity of individuals with gender dysphoria and their psychopathological and etiological diversity have been intensively evaluated and therapeutic consequences scrutinized. Along with the publication of DSM IV in 1994 and its deletion of the term transsexualism the guidelines to handle patients with the conviction of incorrect sex assignment once more become a matter of question. This investigation is meant as a contribution to the study of gender dysphoria and will underline some aspects relevant to proper clinical management.

*Methods:* This presentation will include the results of a retrospective analysis of all gender dysphorics ( $n = 30$ ) who have consulted the psychiatric outpatient clinic during a one year period (1992–1993) as well as the data of a prospective study on such patients with a standardized evaluation procedure ( $n = 25$ ). To enhance the basis concerning adequate clinical management and the specificity of prognosis, the assessment consisted of clinical interviews and a set of psychometric and explorative instruments covering psychopathology and psychodynamics. A follow up was strived for.

*Results:* Our results underline critical statements from the literature where concern is shown about rash surgical solutions of the “project transsexualism” and indicate significant psychopathological aspects and narcissistic dysregulation in most of our gender dysphoric patients. We interpret gender dysphoria syndromes as a heterogenous

group of disorders affecting the whole personality with diverse psychiatric implications.

*Conclusion:* Transsexual wishes have to be considered as a syndrome, which can result from a variety of underlying problems. The regressive request for SRS has to be interpreted in the context of personality and psychopathological factors associated with the inhibition of an adequate (gender) identity development. To secure the best clinical management of gender dysphoric individuals it is essential to enforce accurate differential diagnostic considerations on a basis of a substantial observation period and to emphasize a psychotherapeutic approach.

### PSYCHIATRIC IMPLICATIONS OF SELF-INFLICTED MUTILATIONS OF THE GENITALS

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*Introduction:* This contribution will focus on psychopathological and psychodynamic aspects of genital self-mutilations. The scientific literature on this topic is sparse, especially concerning such behaviour in women, and is limited to single case reports. So far there are no population based scientific studies. Most available publications concentrate on the urological management of self inflicted injuries.

*Methods:* Six case reports with genital self-mutilations are discussed in relation to the relevant scientific literature. This presentation takes into consideration underlying or concomitant psychiatric diagnosis essential for the interpretation of such acts, as well as psychopathological features, psychodynamic factors and other explanations. Additionally aspects of the specific management are dealt with.

*Results:* According to literature, self-injuries of the genitals are considered to be rare, although there are no exact epidemiological data available. It must be assumed that many affected individuals do not seek any medical help. It has to be acknowledged that this phenomena can occur as part of certain religious or cultural practices as well as a symptom in a variety of clinical psychiatric diagnostic categories and psychological disorders. The often published predominance of psychotic deteriorations has to be scrutinized and may be an effect of bias. None of our presented patients were overtly psychotic or intoxicated at the time of the act. The inclusion of self-inflicted injuries of the genitals resulting of masturbatory accidents or mutilation procedures to gain erotic gratification in a complete scientific analysis is emphasized. The place value of genital self-mutilations in the context of self injurious behavior is discussed.

*Conclusions:* The phenomena of genital self-mutilation can originate from a diversity of background factors and conditions. To secure the best management concerning psychiatric implications, a careful evaluation of psychopathological and psychodynamic factors is essential. Follow up of affected individuals to improve knowledge in this field and continuous psychiatric/psychotherapeutic consultations are advocated.

### FAMILY EXPRESSED EMOTION IN EATING DISORDERED PATIENTS

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The study investigates family intervention using Expressed Emotion (EE) and related measures in clinic populations of eating disorder patients. EE ratings were performed, within a semi-structured family schedule—the Standardized Clinical Family Interview (SCFI; Kingston & Loader, 1984), on the relatives of 53 young adult patients who met DSM-III-R and ICD-10 criteria for anorexia nervosa (AN) and bulimia nervosa (BN). The SCFI is designed to be used with a wide range of labelled and non labelled families, in different stages of the

family life cycle, and of varying composition. The interview has a semistructured format, which allows a flexible use of standard questions, probes and statements about family life. The SCFI focuses on the family, while encouraging family members to interact spontaneously. The interview consists of four phases including topics such as family togetherness, areas of conflict and disagreement, discipline and decision making, and issues of roles and responsibilities.

The family interviews were video-recorded and later used for the rating of EE. This was conducted by following the same rules as for the rating of EE using the CFI (Left and Vaughan, 1985; Vaughan and Left, 1976).

The subjects in this study consisted of 53 families in two main groups: 41 families with an anorexic patient and 12 families with a bulimic patient. Our eventual sample of 79 relatives consisted of 40 mothers, 27 fathers, and 12 husbands. All patients were women and their mean age was 26 years (range = 18–45 years).

The results indicate that the levels of Critical Comments (CC), Hostility (HOS), Emotional Over-Involvement (EOI) and Positive Remarks (PR) were rated low (e.g. 16 families (30%) made no CC and 17 families (26%) made only one CC). The relatives were rated as being moderately warm in the way they related to the patient during the interview. A comparison between mothers and fathers showed mothers to be significantly more over involved than fathers ( $t = -3.68$ ,  $df = 25$ ,  $p < 0.001$ ). Mothers also scored significantly higher on PR ( $t = -2.78$ ,  $df = 25$ ,  $p < 0.01$ ) and Warmth ( $t = -2.56$ ,  $df = 25$ ,  $p < 0.01$ ) than did fathers. There was no significant difference among relatives in their level of CC and also between anorexics and bulimics in their level of EE index. The clinical and research implications for these findings are discussed.

#### THE SELF AND OTHER-BLAME SCALES (SOBS)

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This study describes the development and the evaluation of reliability of a new method for the assessment of self/other-blame. The SOBS is an observer-based rating instrument designed to assess self and other-blaming attributions and guilt feelings experienced by patients and their families.

The rating of Self/Other-Blame is decided on the basis of the SOBS segment of the initial family interview. Self/Other-Blame is measured on a 6-point scale from 0 to 5 (0 = none; 1 = little; 2 = some; 3 = moderate; 4 = high; 5 = marked).

The subjects in this study consisted of 36 families in two main groups: 31 (86%) families with an anorexic patient and 5 (13.9%) families with a bulimic patient. Our eventual sample of 91 relatives consisted of 36 patients, 27 mothers, 19 fathers, and 9 husband. Of the 36 patients, 34 were women and 2 were men. The mean age was 26 (range = 18–43).

All families were interviewed using the Standardized Clinical Family Interview (SCFI; Kinston and Loader, 1984). The SCFI is designed to be used with a wide range of labelled and non labelled families, in different stages of the family life cycle, and of varying composition. The interview has a semistructured format, which allows a flexible use of standard questions, probes and statements about family life. The SCFI consists of four phases including topics such as family togetherness, areas of conflict and disagreement, discipline and decision making, and issues of roles and responsibilities. Self/Other-Blame is rated from a segment of the interview in which the family beliefs about the origin of the illness and feelings of guilt-blame are explored. The family interviews were video-recorded and later used for the rating of SOBS. Two independent raters conducted the rating by following the SOBS scoring instructions. Interrater reliability was initially determined by comparing their blind ratings of a sample of 36 interviews.

The results suggest that the Interrater reliabilities calculated by Intra-Class Correlation (CCI) for all SOBS components are high or extremely high (0.80–0.98). A comparison between mothers and fathers showed mothers to be significantly more self-blaming than fathers ( $t = -3.89$ ,  $df = 18$ ,  $p < 0.001$ ). We found no other significant differences among relatives in their level of SOBS.

Applications of the instrument are discussed.

#### A MEASURE OF PATIENT'S RESPONSE STYLE TO THERAPIST AND THERAPY: THE DEVELOPMENT OF THE PATIENT RESPONSE STYLE SCALES (PRSS)

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This study describes the development and the evaluation of reliability of a newly designed Patient Response Style Scale (PRSS). The PRSS is an observer-based rating instrument designed to assess both verbal and nonverbal communicative aspects of the patient's attitudes and behaviours that are expected to facilitate or impede progress in psychotherapy. The PRSS describes the patient's style of involvement in the interaction and predict the ability to participate in a therapeutic interaction. This instrument is designed to be applied to tape recordings of psychotherapy. The PRSS presently is organized in two subscales, Self-Disclosure (SD) and Emotional Engagement (EE), rated on a 6-point scale.

Patients were 30 consecutive female referrals to the Maudsley Hospital Eating Disorder Clinic, referred for eating disorders who met DSM-III-R and ICD-10 criteria for anorexia nervosa (AN) and bulimia nervosa (BN) and were at or over the age of 18 years. The sample had a mean age of 27 years (range = 18–45). All subjects were interviewed using a clinical/research interview designed for patients suffering from eating disorders. During the interview the patient's eating disorder symptomatology, body weight, menstrual pattern, psychosexual and social functioning, at the interview and during the previous six months, were assessed. The interviews were video-recorded and later used for the rating of PRSS by following the PRSS scoring instructions. This was conducted by two independent raters. Interrater reliability was initially determined by comparing their blind ratings of a random of 30 interviews. The results indicate that the Intra-Class Correlation between two subscales are extremely high (0.92 & 0.94). Three different patient response style (PRS) were designated: dual low PRS, in which neither SD nor EE was high; mixed PRS, in which one PRSS (SD or EE) was rated high and the other was low; and dual high PRS, in which both SD and EE were designated as high. Eight patients were classified as dual low PRS, 3 patients as mixed PRS, and 19 patients as dual high PRS. Of these 3 mixed PRS, 2 patients were rated as high-SD, the other one were high-EE. Further results and discussion will be available when the follow-up study is completed. Applications of the instrument are discussed.

#### WAR INDUCED POSTTRAUMATIC STRESS DISORDER IN OUT PATIENT PSYCHIATRIC TREATMENT

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The aim of this study was to determine how many patients diagnosed as PTSD sent to undergo the psychiatric examination and therapy really suffer of that disorder and how many suffer from the combination of that disorder combined with other psychiatric disorders, especially alcoholism, or other disorders without PTSD.

We have done the outpatient psychiatric treatment on a sample of