Tues-P4
PSYCHOPATHOLOGY OF DYSTHYMIA

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Dysthymia is defined as a chronic mood disorder of a mild to moderate degree, of at least two years duration. Symptomatology of dysthymia, insofar, has been studied more in relation to prevalence than to possible symptom aggregation.

In two multicenter collaborative clinical trials, we collected 512 subjects (age 48.4 +/– 12.3, M/F 34/66%) affected by dysthymia as defined in DSM-III-R. Aim of this paper is to analyze the observed symptomatology of dysthymia in this large caselist. The patients were selected to be non-placebo responders, not taking antidepressant drugs in the 2 weeks prior to evaluation, without diagnosis of abuse or dependence. The Montgomery & Asberg Depression Rating Scale (MADRS) and the Hamilton Anxiety Rating Scale (HAM-A) were administered by trained clinicians. The symptoms most frequently observed, beside depressed mood, were low energy or fatigue (96%), poor concentration or indecisiveness (88%), low self-esteem (80%), insomnia or hypersomnia (77%), poor appetite or overeating (69%) and feeling of hopelessness (42%). Interestingly, when considering patients with fewer than 5 symptoms quali-quantitative differences emerged. In these patients, the most frequent symptoms were low energy or fatigue (93%), poor concentration or indecisiveness (79%), the other symptoms being present in about half the sample. These results suggest that in the less severe form of the disease only cognitive functions are affected, while with increasing severity also neurovegetative functions are impaired. MADRS factor analysis identified two main factors: the first including apparent and reported sadness and the second including concentration difficulties and lassitude. As the two factors were not correlated when allowing oblique rotation, this may indicate that sadness and lassitude belong to distinct clusters of symptoms. HAM-A factor analysis identified two factors clearly differentiating somatic and psychic symptoms, with a prevalence of the latter.

Tues-P5
PERCEPTIONS OF SUPPORT AND COPING WITH CHRONIC FATIGUE SYNDROME

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Sufferers of chronic fatigue syndrome (CFS) and their carer relatives often describe insufficient medical and social support. As a consequence, many sufferers reject conventional medical treatment, and experience the break-up of interpersonal relationships. The present study investigated perceptions of instrumental, informational, and emotional support provided by health professionals, friends, and partners, more closely and assessed their impact on coping. Twenty sufferers and their carers were interviewed. Results indicated that perceptions of support differed according to illness duration, source, and type of support. Sufferers perceived their partners to be the greatest providers of tangible support especially shortly after the diagnosis. While both sufferers and carers expected increased medical support, sufferers' search for increased social support was in contrast to partners' frequent statements that 'a problem shared is not a problem half'. The findings suggest that perceived lack of support may play an important role in coping with CFS, which can have an important effect on compliance with treatment and adjustment to the illness.

Tues-P6
THE NUCLEAR AFFECTS IN ANXIOUS DEPRESSION

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The concept is based on the supposition of correspondence of the nuclear depressive affects (anxious, melancholic and apathetic) in personalities and depressive disorders. These relations are manifested in affective traits, psychopathology of depression and the type of psychobiological reactivity.

Methods: The type of the nuclear and masking affects has been studied in 107 patients with anxious depression (mild and moderate depressive episodes). The nuclear affects were valued by the associative test Pictogrammes (A. Luria, 1962). The Skin-Window test (J. Rebuck, 1955) was adapted to determine the variant of non-specific immunocompetent defensive mechanism.

Results: Anxiety has been revealed in two variants - as a nuclear or masking affect. Anxious nuclear affect has been associated with non-stable personality, psychopathology and psychobiology and with marked side effects of antidepressants treatment; melancholic nuclear affect - with stable personality traits, symptoms of depression and psychobiological reactivity; and apathetic nuclear affect - with hyperstable indicators that suppose the effectiveness of stimulating antidepressants treatment.

The results have demonstrated the significance of evaluation of nuclear affects for the diagnosis and treatment of anxious depression subtypes.

Tues-P7
SOMATIC COMORBIDITY AND DEPRESSION IN THE HOSPITAL SETTING

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The aim of this study was to determine the presence of physical illnes in patients who fulfilled the DSM-IV criteria for affective disorders in contrast with other psychiatric patients diagnosed of non affective disorders. Thus we examined all the patients of a Psychiatric Unit in a General Hospital for four months (January 1997–April 1997). We differentiated 5 medical states according to the observed pathology: cardiovascular (1), endocrine (2) and gastrointestinal diseases (3); B or C hepatitis or HIV infection (4), and others (5). The depressed patients showed a proportion of medical illness statistically similar (Chi square (2) = 4; $p > 0.05$) to the non depressed patients. We also observed a positive association between comorbidity and readmission (Fisher Exact Test: $p = 0.0575$). It could be expected that the somatic comorbidity complicated the assessment and the control of both the mental illness and the medical illness. The conclusions are extended to all the health professionals since we are facing the study of mental illness in patients with somatic problems.

https://doi.org/10.1016/S0924-9338(99)80456-8 Published online by Cambridge University Press