lowed for 26 months after cancer diagnosis. They and their partners were assessed using semistrutured interviews conducted by trained interviewers. Period prevalence rates were calculated for the 26 months following cancer diagnosis for DSM-III-R major depressive disorder (MDD) and total affective disorders (i.e. DSM-III-R MDD, DSM-III generalised anxiety disorder and minor affective disorders). Potential risk factors were assessed.

The 26 month period prevalence of total affective disorder (TAD) in female partners (12/50, 24.0%) did not differ significantly to that in male cancer patients (13/50, 26.0%), McNemar, $p = 1.000$. The prevalence of TAD in male partners (8/118, 6.8%) was significantly less than in female cancer patients (27/118, 22.9%), McNemar, $p < 0.001$. In both male and female partners the majority of affective disorders were accounted for by MDD. The prevalence of MDD in female partners was particularly high (10/50, 20.0%).

Most disorders in partners commenced 14–26 months after cancer diagnosis, significantly later than for cancer patients (McNemar, $p < 0.001$). The median duration of disorder in partners was 12 weeks, though this was a conservative estimate as nearly half of disorders were ongoing at the end of the study. Most of the 20 partners with affective disorder regarded their spouses' cancer as the cause of their disorder but only 12 consulted a doctor. Affective disorder in a partner was significantly associated with affective disorder in the corresponding cancer patient. Multivariate analysis showed three independent contributions to partners' affective disorder i.e. lower social class, female sex and past psychiatric history.

This is the only existing study to have used a standardised interview and operational criteria to compare rates of psychiatric disorder in cancer patients and their partners. Partners, particularly females, are at high risk of affective disorders. This raises the question of whether relatives/carers of patients with other chronic illnesses also suffer from high rates of psychiatric morbidity. Nearly half of partners with affective disorder did not receive treatment emphasising the importance of education for the public and health care professionals. The identification of risk factors may facilitate primary and secondary prevention of these disorders.

A DOUBLE-BLIND PLACEBO CONTROLLED TREATMENT TRIAL OF FLUOXETINE AND GRADED EXERCISE FOR CHRONIC FATIGUE SYNDROME (CFS)

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Objectives: To test the efficacy and acceptability to patients of two widely available treatments for chronic fatigue syndrome (CFS), with or without DSM-111R depressive disorders, fluoxetine (20 mg/day) and graded exercise.

Methods: Six month prospective placebo and time with therapist controlled randomised trial with allocation to one of four treatment cells: exercise and fluoxetine; exercise and placebo drug; appointments and fluoxetine; appointments and placebo drug. The drug treatment was double-blind; patients were blind to the exercise programme. Graded exercise was delivered by a physiotherapist. 136 patients meeting Oxford research criteria for CFS were recruited from a University department of medicine outpatient clinic.

Results: 90 (66%) patients completed the trial. Patients were more likely to drop out of exercise than non-exercise treatment ($p = 0.05$). There was a non-specific treatment effect on most measures. When patients complied fully with exercise, there was a significant effect of exercise on fatigue ($p = 0.04$), functional work capacity ($p < 0.001$) and health perception ($p = 0.03$). In patients who complied, fluoxetine had a significant effect on fatigue ($p = 0.02$) and depression ($p = 0.03$). On intention to treat, 12 (18%) patients had fully recovered from their fatigue symptoms in the exercise groups at six months compared to four (6%) who did not receive exercise ($p = 0.004$). Significant improvement with exercise only occurred in patients with DSM-111R depressive disorders who were prescribed fluoxetine.

Conclusions: CFS patients benefit from graded exercise and fluoxetine if they can tolerate these treatments. Depressed CFS patients do not benefit from graded exercise unless they also receive an antidepressant. Graded exercise and fluoxetine have clinically distinct effects in CFS patients.

PREVALENCE OF DEPRESSION DURING HOSPITALIZATION FOR BONE MARROW TRANSPLANTATION: EFFECTS OF DIAGNOSTIC CRITERIA

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Objective: This study used different approaches to case identification to examine prevalence rates for major (MD) and minor depression (md) in a group of patients with hematological malignancies.

Method: A consecutive series of 103 patients hospitalized for bone marrow transplantation at the Hospital Clinic in Barcelona were evaluated on admission and weekly until discharge. *Results:* Diagnosis according to DSM-IV (exclude somatic symptoms related to a physical condition), DSM-III (include all somatic symptoms), and Endicott's revised criteria (replace somatic symptoms with non-somatic ones) are shown in the following table:

Diagnosis	DSM-IV		DSM-III		Endicott Criteria	
	N	%	N	%	N	%
MD	3	3	26	25	10	10
md	31	30	16	15	25	24

Taking in account the existing literature, a low rate of major depression was obtained when using DSM-IV criteria. The higher rate obtained with DSM-III can be related to the prevalence of somatic symptoms. After receiving intensive treatment and during the following 4 weeks, 95–81% of patients reported an energy loss $\geq 30\%$, with 98–78% reporting a moderate decrease in appetite.

Conclusions: When somatic symptoms are prevalent, an approach that relies more in psychological features can increase the diagnostic accuracy for mood disorders.

PSYCHOSOCIAL ASSESSMENT OF TRANSPLANT PATIENTS. THE GREEK EXPERIENCE

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Research on psychiatric aspects of transplantation has been undertaken as transplantation is linked with increased psychiatric morbidity and also due to evidence that psychosocial factors influence the clinical outcome and the quality of life. The biopsychosocial model seems to be a necessary approach to these patients.

Since October 1994 we have evaluated and supported transplant patients referred from the two major Transplant Units in Northern Greece.

Our sample consist of all heart- ($n = 25$), lung- ($n = 5$), liver- ($n = 22$) candidates and recipients as well as a number of renal transplant patients ($n = 60$).

Results are presented using an 10-item rating scale for psychosocial screening of transplant patients (Psychosocial Assessment of Candidates for Transplantation, Olbrisch 1989). Mental health

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