

Depression, mood disorders: – diagnoses/characteristics

TREATMENT OF PANIC DISORDER AND AGORAPHOBIA: THE VIEW OF THE PATIENT

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Introduction: Among the drugs that have reliably proven effective against panic disorder with agoraphobia (PDA) in controlled studies are benzodiazepines (BZ), tricyclic antidepressants (TCA), MAO-inhibitors, and selective serotonin reuptake inhibitors (SSRI). Very few studies exist about the use of neuroleptics (NL) in PDA. Phytotherapeutic agents (PhA) have never been investigated in PDA trials. Among psychological treatments, behaviour therapy (BT) with in-vivo exposure has been found significantly superior to other methods (e.g., psychodynamic therapy or autogenic training).

Method: In a retrospective study, 100 patients with DSM-III-R panic disorder and agoraphobia (PDA) were interviewed about all psychopharmacological and psychological treatments they had received for their illness. Patients had to indicate the improvement experienced under a certain therapy by answering the question 'This therapy was helpful against my fears' on a 5-point Likert scale (from 0 = 'not true' to 4 = 'true').

Results: In the table, the percentage of patients having received a certain treatment once in the course of their illness and the central tendency of the improvement index is given. When 54 patients who had received both drug (excluding phytotherapeutic agents) and psychological treatment were asked which method had been the most helpful of all treatments applied, 48% nominated drug therapy and only 22 % stated that psychotherapy had been the most helpful (other reasons for improvement: 30%).

Drug Treatment	% pre-scribed	helpful (0-4)	Psychological Treatment	% pre-scribed	helpful (0-4)
Benzodiazepines	48%	2.6	Behaviour therapy	20%	2.6
SSRI	7%	2.6	Psychodynamic th.	33%	1.5
TZA	42%	2.4	Unknown	28%	1.4
Neuroleptics	29%	1.4	Autogenic training	43%	1.0
PhA	32%	0.9			

Conclusions: Although only few treatment modalities with drugs or psychotherapy have proven effective in controlled studies, patients received many different treatments, many of which never had been investigated in controlled studies. Patients were most content with treatments that have been proven effective in controlled studies (BZ, TCA, SSRI and BT).

AN ETHOLOGICAL STUDY OF THE INTERACTION OF DEPRESSED PATIENTS (P) WITH A PSYCHIATRIST BEFORE AND AFTER FORCED WAKEFULNESS (FW)

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Disturbed interpersonal communication is a major feature of depressed patients. Despite this, clinical ratings during treatment rarely include specific items of social interaction. Moreover, few studies assessing social interaction include adequate control groups. We videotaped 13 depressed (DSM-III-R) P and 13 age, sex and education matched volunteers (V) during a standardized interview before (Mean HDRS=21, without sleep items=16) and after FW (Mean HDRS=8, without sleep items). All interviews were done by the same experienced female psychiatrist. Ethological methods (Grant, Br.J.Med.Psychol. 144, 1968) were then used to measure changes in the frequencies of social elements in P, V and the psychiatrist. **Results:** Before FW the frequency of elements was (P/V) Look down: 21/4, Look aside: 42/24, Look up: 0/17, Look around: 0/4, Simple smile: 0/12, Upper smile: 0/6, Lips in: 4/1, Fumbling: 120/28, Speech pauses: 36/11, Raise of eyebrows: 0/9, Mouth corners down (duration in sec): 153/0.3 (all $p \leq 0.02$). Respective values after FW were: Look down: 11/9, Look aside: 13/14, Look up: 4/7, Look around: 0/0, Simple smile: 4/6, Upper Smile: 1/4, Lips in: 1/2, Fumbling: 66/56, Speech pauses: 5/6, Raise of eyebrows: 6/5, Mouth corners down (duration in sec): 109/56 (all differences n.s.). After FW in P, Look down, Look aside, Lips in, Fumbling, Speech pauses decreased, Look up, Simple smile, Upper smile increased (all $p \leq 0.02$), whereas the reverse pattern was found in some elements (Look down, Look around, Look up, simple and Upper smile, Lips in, Mouth corners down, (all $p \leq 0.05$)) in the behavior of V. Whereas in P and V both before and after FW no differences in frequency and duration of Look at were observed, the therapist looked less at the patients when they were depressed than when they were recovered ($p < 0.01$). **Conclusions:** Sociability is increased in depressed P, but decreased in healthy V after FW. In addition, the changes of the psychiatrist's gaze behavior may be an indicator of the reaction to the patient's sociability. Compared with conventional rating, ethological assessment allows for quantitative measurement of the effect of psychotherapy and pharmacotherapy on communicative efforts of both patient and therapist. Measuring of communicative aspects may be an important endpoint in clinical trials. Ethology seeks an understanding of the function of behavioral events within an evolutionary framework and therefore provides the concepts to the analysis of behavior in both animal and man. Ultimately, this may lead to much needed new animal models of psychiatric disease.

THE DEXAMETHASONE SUPPRESSION TEST IN VIOLENT SUICIDE ATTEMPTERS WITH MAJOR DEPRESSION

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Several studies have shown a positive correlation between DST non suppression and suicide attempts. However, some investigators have reported negative findings. Recently, Roy (1992) has suggested that the dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis could be associated with violent attempts. In the present study, we assessed DST results in relationship to suicidal behaviour in depression. The sample included 33 DSM-III-R unipolar major depressive inpatients with a history of suicide attempts during the current episode matched for gender, age and, in the case of women, menopausal status with 33 major depressive inpatients without history of suicidal behaviour. DST was performed with the oral intake of dexamethasone 1 mg and cortisol assayed at 4 PM in the following day. DST nonsuppression was defined by a cortisol level higher than 5 µg/dl. There was no statistically significant difference between suicide attempters and nonattempters for 4 PM postdexamethasone cortisol levels: 6.4 ± 6.4 µg/dl vs 6.8 ± 6.4 µg/dl ($p=0.8$). Mean postdexamethasone cortisol levels did not exhibit any significant difference between violent ($n=14$) and nonviolent ($n=19$) attempters: 5.7 ± 4.1 µg/dl vs 6.8 ± 7.8 µg/dl ($p=0.5$). Moreover, even if patients with a history of violent suicide attempts exhibited more frequent DST nonsuppression (57 %) than nonviolent attempters (37 %), this difference did not reach statistical significance ($\chi^2=1.33$, $p=0.25$). In conclusion, DST nonsuppression cannot be considered as a biological marker of suicidal behaviour.

PSYCHOPHYSIOLOGICAL CORRELATES OF SUICIDAL BEHAVIOR IN DEPRESSION. PRELIMINARY RESULTS

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P300 and Contingent Negative Variation (CNV) have been widely applied in psychiatry, and particularly in depression. Abnormalities of CNV amplitude and duration, as well as reduced P300 amplitude, have been reported in depressed patients. Moreover, the decrease of CNV amplitude has been related to the severity of depressive symptomatology and an impaired catecholaminergic activity. In the present study, P300 and CNV were recorded in 14 major depressive (DSM-III-R) inpatients subgrouped into suicide attempters ($n = 7$) and non-attempters ($n = 7$). The two groups differed significantly in the P300 amplitude (mean \pm SD) : 6.6 ± 5.3 µV in suicide attempters vs 16.6 ± 8.3 µV in non-attempters ($F = 5.0$, $p = 0.04$); and in CNV amplitude : $- 14.7 \pm 4.5$ µV vs $- 20.9 \pm 4.6$ µV ($F = 4.7$, $p = 0.04$). Moreover, a significant correlation was found between the suicidal risk (SR) scale of Plutchik and CNV amplitude. These results support the dopaminergic hypothesis of suicidal behavior in depression.

A REVISED AUTOMATIC INTERACTION DETECTOR (AID) APPLIED THE DETECTION OF PROGNOSTIC FACTORS OF PATIENT IMPROVEMENT IN THE TREATMENT OF DEPRESSION. A STUDY ON 2930 OUT-PATIENTS FOR ASSESSING MEDIFOXAMINE EFFICACY.

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Prognostic analyses and more generally epidemiological studies in psychiatry are characterized by a large number of predictors of various nature (cross-cultural, socio demographic, environment, therapy, illness severity). When attempting to detect prognostic factors of the patient improvement, the researcher faces methodological problems due to the highly multifactorial aspect, complicated by possible presence of multiple and unknown interactions between predictors. Full or partial factorial models of ANOVA are often untractable due to prohibitive combinatorics not compatible with the sample size. In this paper, we propose a new way for constructing a statistical model, based on the AID automatic interaction detector algorithm, with four major improvements: 1) The decision to split at any stage can be replaced by a stagewise regression, 2) The candidate variable at each stage ordinarily fixed by default by the algorithm can be modified at object time by the researcher, 3) Splitting is made on the basis of n -way tables and not oneway tables, which allows a true detection of interactions. 4) Alpha level is revised at each level tree.

We applied this model to the problem of finding prognostic predictors to the depressed patient improvement. Data material consisted in a recent multicenter open study of 2930 outpatients carried out for assessing Medifoxamine efficacy efficacy. Recruitment took place in general and psychiatrist practices. Trial duration was 7 weeks, MADRS was used as primary criterion, on each patient, and an extensive list of variables was documented. Initial severity was the first discriminant factor, and important interaction severity-social factors, and severity-antecedents was detected by the method. Our conclusion is that crude application of a statistical method on highly multifactorial problems often derives misleading results, due to the difficulty of detecting the interactions. The proposed revised version of AID algorithm is an attempt to palliate to this problem, in providing a exploratory data analysis technique allowing human reconsideration in real time, while in direct conjunction with inferential assessment.

DIFFERENCES OF PSYCHOSOMATIC RELATIONSHIPS BETWEEN MALE AND FEMALE PATIENTS WITH DEPRESSIVE NEUROSI

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The aim of the present study was to compare the symptoms of depressive neurosis on the male and the female in- patients and at the same time central hemodynamics indices.

The symptoms of depressive neurosis were registered by H. Richter's questionnaire evaluated by patients and central hemodynamics was registered with rheoplethysmographic method by M. Tishtshenko (1973). Rheoplethysmographic curves were registered on patients lying position before, immediately after and on the 3 minute of the restitution period after small physical load.

16 male and 18 female in-patients were investigated. Mean age of male group was 39 ± 14 years and female group 31 ± 14 years ($p > 0.05$), mean height of the male group was 177 ± 6.3 cm and the female group 164 ± 5.0 cm ($p < 0.001$) and the mean body-mass of the male group was 76.8 ± 9.9 kg and the female group was 62.6 ± 7.6 kg ($p < 0.001$).

By evaluation of questionnaire the male patients had 34 symptoms more expressed than female patients and female patients evaluated 24 symptoms more intensively expressed. The differences were statistically significant to the following symptoms: loss of libido ($p < 0.05$), low back pain ($p < 0.05$), shiver ($p < 0.05$), have a cough ($P < 0.05$). The male patient had also higher point score for evaluating symptoms to be related mental problems ($p < 0.05$). From central hemodynamics indices had male patients higher stroke volume, stroke volume index, breathing rate, cardiac output and cardiac index and lower heart rate. These differences were statistically significant as concern to stroke volume ($p < 0.001$), stroke volume index ($p < 0.05$) and to cardiac output ($p < 0.001$).

We can conclude that the male patients with depressive neurosis had more intensive symptoms registered by questionnaire and their hemodynamics indices were also more higher.

COMPOSITE DIAGNOSTIC EVALUATION OF DEPRESSIVE DISORDERS (CODE-DD)

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The aim of study was to evaluate patients with depressive disorders using different diagnostic approaches. The symptoms of depression are individually different and they can be evaluated differently by various doctors. The sample of 78 depressive patients were diagnosed using DSM-III-R, ICD-9, ICD-10 and CODE-DD (Composite Diagnostic Evaluation of Depressive Disorders, Th. A. Ban, 1989). CODE-DD includes 25 different diagnostic systems for diagnosing depressive disorders. According to ICD-9 criteria 68% of patients were diagnosed as depressive neurosis (300.4). Using DSM-III-R criteria came out that 99% of the same patients were diagnosed as Major Depression, Recurrent, Severe. Using CODE-DD the same patients had diagnosis as Endogenous Depressive Illness (34%), Vital Depressive Illness (22%), Pure Endogenous Depressive Illness (12%). The patients received monotherapy of an antidepressant (inhibitor of norepinephrine uptake). The results (clinical rating scales, biochemical analyses, electrocardiography, somatic symptoms) were evaluated according to international clinical approbation criteria. The duration of treatment was 6 to 52 weeks.

The comparative analysis of different diagnostic criteria allows us to make conclusion that the exact recognising of the severity of depressive disorders is main premise for their effective treatment.

FACTORS RELATED TO DEPERSONALIZATION/DEREALIZATION SYMPTOMS IN PATIENTS WITH ANXIETY DISORDERS

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The quantitative aspects (frequency, intensity, duration) of depersonalization/derealization (D/D) symptoms as well as some factors related to their occurrence were investigated in patients with anxiety disorders.

214 patients (112 females, 102 males, age range 23-42 years, illness duration range 2-18 years) selected according to the DSM III-R criteria (generalized anxiety disorder, n=61, OCD, n=65, panic disorder, n=46, somatization disorder, n=19 and dysthymic disorder, n=23) were administered a D/D Symptoms Questionnaire, followed by a semi-structured interview concerning qualification of the questionnaire's items. A number of clinical and personality questionnaires were also given. 187 of the total sample admitted to having experienced some D/D over the past year prior to their participation to this study. However, only 146 of them (68.2% of the total sample) were able to provide convincing evidence regarding their D/D symptoms during the interview.

Distribution patterns of D/D failed to provide significant differences as far as sex and type of disorder were concerned. D/D episodes appeared to have a frequency of approximately once monthly, while their prevailing duration was less than 30 min. D/D symptoms appeared to occur mostly during the day, the hypnagogic stage, during emotional stress or following fatigue, while somatic health or drug and alcohol use did not show an association of importance to D/D occurrence. Disturbances of time perception or thinking difficulties were significantly associated with D/D while disturbances of body weight in contradistinction to those related to body shape or size were very frequently reported in this sample. The association of D/D with the clinical and personality measures employed indicated that the contribution of certain personality traits, such as "psychoticism" and "trait" anxiety were of importance, while depression, hypochondriasis or obsessiveness did not contribute significantly to the occurrence of D/D experiences in patients with anxiety disorders.