et 14.4 ± 2 ans au moment de l'hospitalisation index et de 20 ± 3.4 et 20.2 ± 3.1 en 1993. Le recul moyen de l'étude est de 6 ans. Les paramétres pour lesquels une différence significative est mise en évidence entre les deux populations par le test du chi-carré concernent: la scolarité moins bonne chez les suicidants, leur consommation d'alcool plus importante, de même que leur nombre d'hospitalisation en psychiatrie et de suivi en consultation de santé mentale; la socialisation telle qu'elle a été étudiée est aussi moins bonne chez les suicidants. Par contre, aucune différence significative n'est mise en évidence en ce qui concerne les autres paramètres étudiés (vie familiale, emploi, pension d'invalidité, arrêts maladie et consommation de psychotropes).

Discussion et conclusion: Si certains résultats tendent à dédramatiser l'avenir des adolescents suicidants, d'autres sont par contre alarmants. Ces derniers justifient à eux seuls les efforts actuels pour mieux cerner les stratégies thérapeuthiques à court, moyen et long terme qui doivent être mises en place pour ces patients arrivant le plus souvent à l'hôpital dans un contexte d'urgence.

FORGIVENESS: AN COMPARISON BETWEEN PROSOCIAL AND AGGRESSIVE CHILDREN

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There has been surpassingly little research on how notions of vengeance and forgiveness develop and regulate behaviour. The proposed research examines how two group of children, prosocial and aggressive, resolve conflict raising issues of forgiveness. Understanding how they decide whether to retaliate, resent or forgive could be important for understanding the rising tide of youth violence and social maladjustment. Forgiveness may be a stable feature of children's socio-moral development, and therefore a solid base for social accepted behaviour.

PRISE EN CHARGE HOSPITALIERE DE L'ANOREXIE: INTEGRATION DES DIFFERENTS ABORDS PSYCHOTHERAPIQUES

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La prise en charge des anorexiques restrictives ou boulimiques nécessite la plupart du temps une hospitalisation dans un service psychiatrique spécialisé dans les Troubles du Comportement Alimentaire (T.C.A.) et un abord intégrant différents modèles psychothérapiques de façon harmonieuse. Une prise en charge cognitivo-comportementale est fondée sur un contrat thérapeutique, qui constitue la base de cette hospitalisation. Ce contrat a pour but le rétablissement d'un comportement alimentaire adapté et la restauration du statut pondéral. Il se fonde sur les principes des conditionnements vicariant et opérant, utilisant des techniques de désensibilisation, de modeling, d'exposition in-vivo et de prévention de la réponse. L'abord cognitif vise à réduire les erreurs cognitives par l'éducation et à une restructuration cognitive globale inspirée des techniques de Beck.

L'anxiété généralisée est prise en charge par une relaxation de type Jacobson, et l'anxiété sociale, par les thérapies d'affirmation de soi.

Parallélement, d'autres abords psychothérapiques peuvent être proposés, suivant les caractéristiques et les affinités de chaque patient. Il s'agit de psychothérapies d'orientation analytique, en face à face ou avec médiation (arthérapie). Ces médiations sont, à la Clinique des Maladies Mentales et de l'Encéphale, la peinture, le modelage, le collage ou la musique.

Les problèmes posés par l'intégration de psychothérapies reposant sur des fondements théoriques extrêmement différents sont ici étudiés.

THE LONG-TERM COURSE OF CHILDHOOD OBSESSIVE-COMPULSIVE DISORDER

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A 6–22 year outcome study of 47 patients with childhood onset OCD is presented.

Phenomenological aspects at baseline did not differ from that seen in children and adults in other parts of the world. Compulsive handwashing and obsessions regarding dirt and contamination were the most frequent symptoms, seen approximately in half of the patients.

At follow-up, the course of OCD was described according to 4 groups of outcome. Approximately one fourth of the patients fell in each group:

1. No OCD in adulthood;
2. Subclinical OCD symptoms in adulthood;
3. An episodic course of OCD in adulthood;
4. Chronic OCD in adulthood.

In practically all cases where psychopathology was present, OCD was the main disorder. The intraindividual continuity of specific obsessive-compulsive symptoms was low.

Frequent comorbid symptoms at follow-up were depression and symptoms of anxiety.

Probands with OCD at follow-up had significantly lower social functioning than probands without OCD.

NR21. Biological and treatment issues in affective disorder — II

Chairmen: T Dinan, S Checkley

EPIDEMIOLOGY OF BIPOLAR DISORDER: NEW DATA

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12 modern epidemiological studies have been carried out worldwide, using the Diagnostic Interview Schedule [1]. These studies have identified DSM-III bipolar disorder in 0.5% (mean) of the population, with a range of 0.0 to 1.2%. A further 6 studies however, reported rates of the bipolar spectrum affecting 1.6 to 6.5% of the population. These studies largely used other interviewing methods, and to a varying extent included atypical bipolar disorder, cyclothymia and hypomania in the bipolar spectrum. Methodological difficulties occur due to the frequent absence of insight or feeling ill of hypomanics, due to shortcomings in interview questions, or of the definitions. Data of the Zurich cohort study, indicates the prevalence of DSM-IV hypomania/mania in 5.5%; in addition 2.2% of subjects were suffering from recurrent brief hypomania (RBM). RBM demonstrates good validity, shown by a positive family history for depression and by a high lifetime suicide attempt rate. RBM is strongly associated with major depressive episodes or other forms of depression. About 50% of RBM cases overlap with cyclothymia. The inclusion of RBM as a diagnostic category is suggested. The true

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prevalence rate of the bipolar spectrum is estimated to lie between 5 and 7% of the population.

[1] Robins LN, Helzer JE, Croughan J, Ratcliff KS (1981) National Institute of Mental Health Diagnostic Interview Schedule. Its history, characteristics, and validity. Arch Gen Psychiatry 38: 381–389

DIFFERENT ENLARGEMENT OF INTERNAL AND EXTERNAL CSF SPACES IN ENDOGENOUS AND SO-CALLED NEUROTIC DEPRESSION. A PLANIMETRIC CT-SCAN STUDY

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Purpose: The separation of 'endogenous' versus 'neurotic' depression in the ICD-9 criteria was abandoned in ICD-10. Nevertheless, different types of brain pathology could underly these disorders.

To investigate possible alterations in brain morphology in the two depressive syndromes, planimetry of different regions of internal and external CSF spaces in patients with so-called 'endogenous' depression and patients with 'neurotic' depression as compared to normal controls was performed.

Patients and methods: 23 patients with endogenous depression (ICD-9 296.1), 28 patients with neurotic depression (ICD-9 300.4), and 56 age and sex-matched healthy controls were investigated.

In 9 mm transversal CT-scans from patients and controls, planimetry of lateral ventricles, total brain area, third ventricle, all cortical sulci, Sylvian fissure, and interhemispheric CSF space was performed.

Ventricle to brain ratio (VBR) and the maximum area of third ventricle was calculated.

The sum of the areas of frontal and parietal-occipital sulci, Sylvian fissure and interhemispheric CSF space were expressed as ratio to whole brain area.

P-values were adjusted for the co-variate age.

Results: Both the endogenous and the neurotic patient-group showed significant morphological alterations compared to controls with a different pattern for each group.

Endogenous depressive patients had 25% larger maximum areas of third ventricle ($p = 0.046$) and an enlargement of left upper frontal ($p = 0.029$) and basal frontal left and right ($p = 0.041/0.036$) cortical sulci.

Neurotic depressive patients had larger upper frontal ($p = 0.045$) and upper parietal-occipital ($p = 0.046$) sulci on the left side and a smaller d a smaller Sylvian fissure in the superior plane (ramus ascendens) left and right ($p = 0.040/0.023$).

Conclusion: The results demonstrate that so-called 'neurotic' and 'endogenous' depressed patients have different types of brain pathology neurotic patients having more left hemispheric, endogenous patients more third ventricular and left upper frontal/bilateral basal frontal sulcal enlargement.

DISCRIMINATING PATTERNS OF REGIONAL CEREBRAL BLOOD FLOW (rCBF) IN THREE SUB-TYPES OF DEPRESSION. A LONGITUDINAL SPECT STUDY

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Objectives: The aim of this study is to identify rCBF patterns that discriminate patients with recurrent, bipolar, double depression (DSM-IV) and normal controls, and to study the behavior of these patterns after clinical recovery.

Method: Ten patients with bipolar depression, 13 with recurrent major depression, 9 with double depression and 12 normal controls were studied with Tc^{99} HMPAO SPECT. Fourteen ROIs were delimited, and ratios to average global flow were obtained. Fifteen patients were re-scanned after clinical recovery.

Results: Three canonical functions involving ratios in temporal (left and right), inferior frontal (left), basal ganglia (left) and thalamus (left) discriminated the 4 gro overall 59% efficacy (80% for bipolars, 69% recurrents, 44% double depressives and 41% normal controls). The specific rCBF pattern for recurrents disappeared after recovery, but the bipolar pattern persisted to great extent.

Conclusions: 1) Patients with bipolar and recurrent major depression exhibit specific patterns of rCBF, which in the latter tend to disappear after recovery.

2) A specific rCBF pattern for double depressives could not be determined.

ANHEDONIA, ALEXITHYMIA AND LOCUS OF CONTROL IN MAJOR DEPRESSIVE DISORDERS

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Introduction: Anhedonia is a main characteristic of major depression namely in the endogenous sub-type. Sifneos (1987) has suggested that anhedonic individual may or may not be alexithymic, while an alexithymic individual is always anhedonic. Kazdin (1989) has shown that anhedonics have a more internalized locus of control that non anhedonics but several studies have shown a more externalized locus of control in depressives than in normals. The aim of the present study is to clarify the relationships between these three dimensions first in unipolar major depressives compared to normals and secondly between the preceding depressives dichotomized into low and high anhedonics.

Method: Subjects and rating scales: 59 inpatients filled out the RDC criteria for unipolar major depressive disorder and 56 healthy subjects constituted the control group. They were not significant differences between the two groups concerning the age and the sex-ratio. The subjects completed the Physical Anhedonia Scale (PAS), the Toronto Alexithymia Scale (TAS), the Internal Powerful others Chance scale (IPC). Statistical analysis: First the depressives and the normals were compared on the preceding scales using Student's t tests, secondly the major depressives were divided into two subgroups using the PAS score. The depressives with a score higher than 29 were included in the anhedonic major depressive group (ANH) and those with a score lower than 19 were included in the hedonic major depressive group (HED). The sub-groups were compared on the preceding scales using Student's t tests. *Results:* the PAS and TAS scores of the major depressives were significantly higher than that of the normals. The Power others and Chance scores of the IPC were significantly higher in the depressive group than in the normal group. The Power others and Chance scores of the ANH were significantly higher than that of the HED. The TAS score of the ANH was higher than that of the HED but the difference was not significant.

Conclusion: Unipolar major depressives were more anhedonic and alexithymic than controls and showed an externalized locus of control. Anhedonic major depressives were more alexithymic and externalized than hedonic major depressives.