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DEPRESSION STRUCTURE AND SOCIAL FUNCTIONING (SPF)

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SPF in relation to depression was assessed. Using ICD-10 criteria an inventory of 7 spheres of SPF (professional, domestic and interpersonal duties, self-care, contacts, interests, sexual), statistical analysis, and evaluation of depression were carried out in a primary care department (PCD) among general (GH) and psychiatric (PH) hospital patients. In PCD (n=122), and GH (n=27) groups, there was a significant prevalence of dysthymic, anxious-phobic, somatovegetative and somatoform disorders, including panic attacks marked out (GH); in PH (n=71), recurrent depressive disorders with sadness-apathy, anhedonic, ideo-motor symptoms prevailed. SPF decreased by 37% (PCD), 43% (GH) and 68% (PH) with most influence being in the area of motor retardation, anhedonia, feelings of worthlessness, ideotoric retardation, and physical fatigue in all SPF spheres. There was no feeling of sadness, guilt regarding professional activity, domestic work,or level of contacts detected. Anxuety had no influence on SPF, but revealed positive correlations with somatovegetative disorders and self-image as a medical patient. Structural characteristics of depression display different amount of importance for SPF deviations.

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PERSONALITY CHARACTERISTICS IN DEPRESSIVE PATIENTS

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Objective: to reveal the role of personality characteristics in depressive patients.
Method: Use of psychopathological, pathopsychological, psychotherapeutic, diagnostic criteria of ICD-10, DSM-IV, tests (MMPI, SCL 90, Cloninger inventory), projective methods.
Results: Three types of personality were marked out in depressive patients. (i) Characterised with stheic, hyperthymic traits, high social activity in combination with over-responsibility, scrupulousness, pedantry, rigidity, perfectionism, low level of self-reflection, tendency to dependence. (ii) presented by borderline and narcissitic personality with traits of affective instability, unstable interpersonal relationship, chronic feeling of emptiness, with underlying split self-esteem, as well as a high level of affective and personality disorders comorbidity. (iii) patients corresponding to the criteria of cluster A of personality disorders, with emotional coldness, inappropriate or constricted affect, magical thinking and experience, and high vulnerability to quick changes of social-environmental conditions. These personality types should be taken into consideration in the assessment of depression structure and dynamics.

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CognitiveTraining and Family Therapy in rehabilitation of schizophrenic patients: cognitive and social results

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Schizophrenia is caracterized by a broad range of cognitive and social deficits These deficits are in part corrected or reduced by cognitive and family therapeutic approaches

The aim of the present clinical research is to evaluate the efficacy of Cognitive Training (CT) sub-programme of IPT (Integrated Psychological Therapy) and to determine whether cognitive changes are more prominent when CT is associated with Family Therapy.

18 chronic schizophrenic out-patients (DSM - IV) are included in the study All of them receive CT and 9 of them also receive an additionnal familly treatment All the patients take antipsychotic medication. A brief battery of neuropsychological tests is administred before and after CT. General indicators are considered to assess social functionning

Comparaisons of the two groups suggest that cognitive improvements occur independently of Family Therapy. Social outcome (GAS, Independent living skills) and rehospitalisation-rates at 12 months follow-up after the initial neuropsychological evaluation are also discussed in quantitative and in clinical terms

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INITIAL DREAM AND INPATIENT TREATMENT OF REFUGEES

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The aim of the paper is to indicate specific hospital treatment for refugees and the possibility of predicting the duration of hospitalization on the basis of the initial dream. From 1992 to 1996, analytically oriented psychotherapy was applied. The results, illustrated by clinical vignettes, indicate the the most common possibilities for hospital treatment of refugees are as follows: (i) the initial dream is the first in a series of repetetive traumatizing dreams the systematic interpretation of which significantly shortens hospital treatment, (ii) the initial dream does not appear for a long time, the refugees 'do not dream' but when they do it is most commonly a sign that the patient is ready to be released from hospital, (iii) the initial dream 'loses itself' in the abundance of dreams which overload the therapist mainly because he himself cannot think about experiences he has suffered and which he is unconsciously defending himself from, and not allowing the therapist to think; (iv) the initial dream is clear, its manifest and latent content are close to each other and analysis often indicated the dreams perform the function of gift to the therapist. The appearance and correct interpretation of the initial dream are significant in that they predict the duration of hospital treatment of refugees.

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