P03.370
EFFECT OF AXIS I COMORBIDITY ON BIPOLAR II AGE AT ONSET

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Axis I comorbidity is common in mood disorders. Study aim was to find if axis I comorbidity was associated with lower age at onset in bipolar II. Different age at onset may be related to different genetics, and may support subtyping of mood disorders (McMahon et al 1994). Bipolar II is common in depressed outpatients (around 40%) (Benazzi, 1997, 1999).

Methods: The study was conducted by a senior psychiatrist in private practice, because private practice is more representative of mood disorder patients in Italy, where it is first or second (after family doctors) line of treatment of mood disorders, and where most severe patients are treated in national services or in university centers. Mood disorder patients from academic centers may not be representative of typical mood disorder patients (Goldberg and Kocsis, 1999). 218 bipolar II outpatients [age 40.4 y (SD = 13.8), females 69.4%], presenting for depression treatment, were included during the last 3 years. Substance and severe personality disorders were not included, because may be confused with bipolar II. Patients were interviewed by the author with DSM-IV Structured Clinical Interview. Family members or close friends supplemented clinical information. Means were compared with t test. Logistic regression was used to study associations (STATA 5). Two-tailed P < 0.05.

Results: Axis I comorbidity (not including substance disorders) was present in 62.8% (137/218) of patients. Mean (SD) age at onset (years) of first depression was significantly lower [23.9 (9.3) vs 28.7 (14.2), $t = 3.0$, $df = 216$, $p = 0.0029$] in bipolar II with axis I comorbidity ($n = 137$) than in bipolar II without ($n = 81$) axis I comorbidity. Axis I comorbidity was significantly negatively associated with age at onset (odds ratio = 0.9, $z = -2.8$, $p = 0.005$).

Discussion: Different age at onset supports subtyping of bipolar II based on presence of axis I comorbidity.

P03.371
PSYCHOTIC DEPRESSION: BIPOLAR II AND UNIPOLAR

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Background: To find if bipolar II psychotic depression (PD) was a severe variant of bipolar II depression, or a distinct disorder, by comparing bipolar II PD with bipolar II nonpsychotic depression (NPD), and with unipolar PD.

Methods: Two hundred and nineteen bipolar II, and two hundred and twenty nine unipolar, consecutive major depressive episode (MDE) outpatients, presenting for MDE treatment during the last three years, were studied in private practice. Private practice was chosen because it is more representative of mood disorder patients in Italy, where it is first or second (after family doctors) line of treatment of mood disorders, and where most severe patients are treated in national services or in university centers. Patients were interviewed by the author with the Structured Clinical Interview for DSM-IV. Family members or close friends supplementing clinical information. Outcome measures: Age, gender, age at first MDE onset, number of MDEs, chronicity (MDE/MDE without full interepisode recovery lasting more than 2 years), patients with atypical features, psychotic features, and axis I comorbid disorders, and MDE severity (assessed by Montgomery Asberg Depression Rating Scale, Global Assessment of Functioning Scale). Means compared with t test, and proportions with two-sample test of proportion (STATA 5). Two-tailed P values, $P < 0.05$.

Results: Bipolar II PD (n 20) vs NPD (n 199) had significantly more females, higher severity, and fewer patients with atypical features. Bipolar II (n 20) vs unipolar (n 21) PD had significantly more females, lower age at onset, and more axis I comorbid disorders.

Conclusions: As bipolar II PD was more severe than bipolar II NPD, and it had a lower age at onset than unipolar PD (different age at onset supports subtyping of mood disorders), results suggest that bipolar II PD is a severe variant of bipolar II depression, distinct from unipolar PD.

P03.372
FROM AMISULPRIDE TO REHABILITATION

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Major part of patients in psychiatric hospitals are the ones with chronic schizophrenia. Presence of prominent negative symptoms creates big problem for their resocialization. Hence, the question of management of deficiency states still remains open for researchers and clinicians. Present paper reflects the experience of new drug-amisulpride (Solian) administration together with psychosocial rehabilitation. 17 patients with diagnosis of paranoid schizophrenia (according to ICD-10 criteria) with the stabile defect in the phase of reconvalescence after the treatment with conventional neuroleptics were included in the stude on the basis of informed agreement. All of them were not able to discharge from the hospital because of persisting prominent negative symptoms and consequent difficulties in social adaptation. For 4 weeks patients participated in rehabilitation trainings program and simultaneously received 100 mg of amisulpride per day. Evaluation was done with PANSS in the beginning, on the 2d week and in the end of treatment course. As result, we achieved improvement in most of patients (67%) – that was evidenced by changes in PANSS negative cluster-and to diminish the term of stay in the hospital. During all the period of treatment no changes in biochemical parameters were revealed. Therefore, we could say that amisulpride in relatively low doses is able to influence the negative symptoms of schizophrenia, and in combination with appropriate rehabilitative measures benefit in restoring of social functioning of patients with chronic schizophrenia.

P03.373
EXPERIENCE OF STABLON (TIANEPTINE) ADMINISTRATION IN NEUROTIC STATES WITH ANXIETY

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Problem of neuroses became more actual in Ukraine today due to changes in economics and in social sphere with fall in well-being level. Conseqently, this leads to growth in number of neurotic patients. We observed 19 patients with neurotic states, who recieved treatment with new antidepressant - Stablon (tianeptine). All patients showed high anxiety level on the background of slight depression. Beside that, in 6 of them obsessive disorders were present. All patients previously recieved treatment with tranquillizers, but without significant improvement. As it is known, tianeptine is 5-HT reuptake enhancer and exhibits a mechanism of action, totally opposite to 5-HT reuptake blockers, providing antidepressive and anxiolytic effect. Group consisted of outpatients, who started treatment with 2 tablets/day (25 mg) with following increase to 1

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tablet 3 times/day (37.5 mg) on the third day of treatment. From the third day all patients reported the significant decrease in the level of anxiety, tension and severity of obsessions; mood improvement was registered in majority of cases with feeling of emotional comfort. Such dynamics permitted patients to function more productively and to show positive approach to problems solving. In such a way, tianeptine proved to be an effective mean for the treatment of neurotic states with depression, without excessive sedation, that makes it valuable for out-patient service.

P03.374

VISUO-SPATIAL FUNCTIONS IN THE SCHIZOPHRENIC SPECTRUM

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Objective: This preliminary study investigated the function of the visuospatial processing in psychotic disorders with a task that had no memory component, but rather required judging the orientation and the location of lines.

Method: A sample of 30 DSM-IV schizophrenic patients, 15 patients with Delusional Disorder and 42 age, sex and educational level-matched controls was assessed elemental visual spatial processing abilities employing the Benton's Judgment of Line Orientation Test (JLO).

Results: Mean scores between groups showed an ability gradation. Controls were on the first rank followed by patients with Delusional Disorder followed by schizophrenic patients. Different levels of performance between groups with a low overlapping of specific ranges was demonstrated. The JLO had an excellent discriminant capacity between groups, a good sensitivity and specificity.

Conclusions: Data seem to suggest a sort of continuum between "normality" and the schizophrenic psychosis. Changes on test performance appear to be present in variable degrees throughout the whole distribution of patients. Further studies are recommended.

P03.375

THERAPY TREATMENT-RESISTANT DEPRESSIONS

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The aim of this trial is study of efficiency selective serotonin reuptake inhibitors (*SSRI*s) at therapy treatment-resistant depressions.

The trial included 60 patients had a history of Amitriptylin treatment nonresponse. All patients have received treatment course of adequate doze of Amitriptylin (175–300 mg/day) before beginning trial. Duration of previous treatment was 8 weeks. All patients have been investigated in the present study met criteria DSM-IV major unipolar depressive disorder. The patients were treated by *SSRI*s - Fluoxetin ***(Lilly)***, Fluvoxamin ***(Duphar)***, Sertralin ***(Pfizer)***. Trail lasted 8 weeks, after wash-out period of 7 days. Hamilton Raiting Scale for Depression (HAM-D_{17}) was used to assess the mental state. The criterion of good therapeutic effect was the decrement in HAM-D_{17} at least more than 50%. These patients composed the group of responders.

The searching of optimization ways therapy was conducted in two directions. There was use switching from TCA to SSRIs in first groups (45 patients. The *SSRIs-TCA* combinations were use in the second group (15 patients). The 22 patients (48.8%) have reacted positively on monotherapy *SSRI*s in first groups. Besides, 2 patients were registered selective sensitivity to Fluoxetin. Condition of patients was worsened after switching from Fluoxetin to other preparations (including other *SSRI*s) after the completion of study. Recurrent purpose Fluoxetin had a positive effect.

The 14 patients of the 15 were registered positive result of therapy in second group.

So, the *SSRI*s are efficient to some of patients treatment-resistant at therapy Amitriptylin. The *SSRIs-TCA* combinations therapy is more method at therapy treatment-resistant depression.

P03.376

TO PHILOSOPHIC STATEMENT OF A QUESTION ABOUT MENTAL HEALTH IN RUSSIAN CULTURE

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We mustn't give definitions of the particular from the point of Logic without knowing the definition of the general. Without having no definition of Man's health we mustn't give any interpretation of his deseases, that is declinations from the normal state. In the manuscript titled "A book about a soul" (Kitab an-Naphs) by Abu Ali Ibn Sina there are such words: *"Knowledge about the particular exists only to knowledge of the general. The corrent way of learning is to give first of all some information about "soul", and then some information about "body", than to speak at first about "body" and then about "soul". For the usefulness of learning emotional states is more important than the usefulness of learning "body" so that to learn the state of "soul", though each of them helps each other".* In the treatise "Kitab al-Isharat" Ibn Sina wrote the following: *"Logic of a Man means his canon weapon, and applying this weapon a man can defend his thought from not being in error or delusion... The way of learning X is through the well-known, but even knowing it is impossible to sought for the unknown quantity if there's no way, which could lead to this unknown quantity."*

Monach Avvakhum (XVIIth century) said: *"Be with Your intelligence, and I will be with my Apostolic foolishness".* We think that "Mental Health" means some religions approach to things. For atheism - is some way of religious thinking. The absence of phylosophy is by itself some definite phylosophy. There are the similar ideas said L.S. Vygotsky in his famous monography "Thought and language". Mental Health - is a harmonic trinity of three notions, three rhythmics in a Man, as its pictured in **Holy Trinity** by monach Andrey Rublev (XIVth century). We discove isomorphism-trinity in microcosmos and macrocosmos, as well as in a person and in a nation: 1) general religion - spirit, 2) general language - soul, 3) general body - blood-family relations.

P03.377

RUSSIAN PSYCHOANALYSIS MUST CORRECT THE FREUD'S MISTAKE

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Freud made a mistake on considering religion to be "collective neurosis". The rituals of an neurotic are similar from the first glance to the religious ones but it doesn't mean at all that religion is a "massive neurosis". Freud also made a mistake when he gave up hypnosis, that is to treat people by suggestion and by gaze. There are such ideas that you may find with Ibn Sina. Avicenna's words are the following: *"It goes without saying that in metaphysics that primacy matter of this world is subjected to soul and intelligence and that a way of thinking that appear in our soul, is a source to some extent of these images in this world. ...But a soul of Man is weak. And though a soul is weak, but it is like a world soul according to some actions. A soul of Man is out of a man's body,*

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