

S45-4**MIXED STATES: IS THERE A INTERACTION BETWEEN DEPRESSIVE SYMPTOMS, GENDER AND AFFECTIVE TEMPERAMENTS?**

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Mixed States represent a complicated, confused and under-researched part of manic-depressive illness because of inadequate clinical definition and over-reliance on rigid categorical system. Dysphoric Mania (DM) is one of the most typical form of mixed states. According to modern clinical research, the definition of DM should be broader and tested following both categorical and dimensional approaches. The validity of a broader definition of DM was recently explored in a French multisite study (EPIMAN) in which 104 hospitalized manic (DSM-IV) were included. After attenuation of manic episode, affective temperaments were examined by semi-structured interview and self-questionnaires for hyperthymic (HT), depressive (DT), cyclothymic (CT) and irritable (IT) temperaments. The frequency rate of DM as defined by the presence of at least 2 DS is 37%. "Depressed mood" and/or "suicidal thoughts" were highly specific of "Definite DM" (≥ 3 DS). DM was characterized by female over-representation (84%), higher rate of associated psychotic and obsessive-compulsive features, longer latency before correct diagnosis and higher rate of mixed states in the first episodes. A more complex temperamental dysregulation (higher level on DT, CT and IT) was observed in DM by comparison to PM. Further analysis on the interaction between gender and illness confirmed that gender effect was statistically significant only on the HT (high level in males); the influence of illness was highly significant on DT and CT levels and a mild (but not significant) interaction between gender and illness on DT level. In conclusion, EPIMAN data are in favor of a broader definition of DM. The expression of dysphoria associated to mania runs along a spectrum that includes beside the co-existing depressive symptoms, the traits of depressive and cyclothymic temperaments. Finally, female over-representation in DM was not explained by gender influence nor by an interaction between gender and illness on DT.

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S45-5**THE COURSE AND OUTCOME IN BIPOLAR AFFECTIVE DISORDER**

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A cohort of 158 patients with bipolar affective disorder according to DSM III R and with at least three hospitalized phases was identified, in a geographically well-defined area of Copenhagen. Data from patients records, the Danish Institute for Psychiatric Demography, the National Register and the National Health Service showed, that only 60% of the patients were diagnosed as suffering from affective disorder at their first admission. Moreover, it appeared, that the mortality in the cohort was twice the expected one when compared to the background population. The standard mortality rate due to suicide was 27.27 compared to the expected mortality rate 0.22 for suicide in the background population. It was furthermore established, that previous suicide attempt was predictive value for later committed suicide. The meteorological

data measured - temperature, hours of sunshine, rainfall and wind velocity expressed in mean values/month - did not seem to have any impact on recurrence of episodes.

S45-6**LONG-TERM OUTCOME OF LITHIUM PROPHYLAXIS IN BIPOLAR DISORDER**

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The impact of lithium prophylaxis on the course of bipolar disorder has become a controversial issue, since studies carried out in routine clinical conditions have not confirmed the extremely positive findings of early double-blind trials. The present study collected information on all bipolar patients who started lithium prophylaxis at a lithium clinic over more than fifteen years (1).

The cohort included 402 patients who, as long as they remained on lithium, were evaluated bi-monthly by the CPRS and the SADS-C. Treatment surveillance conformed to internationally accepted guidelines. Five years after start of prophylaxis, all patients were evaluated by the Strauss-Carpenter Outcome Scale.

27.9% of the enrolled patients were off lithium at the follow-up evaluation, 38.1% were on lithium having had at least one recurrence during the treatment period, and 23.4% were on lithium having had no recurrence. Patients off lithium at follow-up had a poorer outcome than those on lithium, but those off all psychotropic drugs did not differ from those on lithium. Patients off lithium had had a higher frequency of psychotic features in the index episode than those on lithium. These data demonstrate that information, support and supervision are not sufficient to counteract the tendency of bipolar patients on long-term lithium treatment to drop out. In patients who keep on taking lithium for several years, a drastic reduction of the mean annual time spent in hospital is almost the rule. However, bipolar patients who remain on lithium for several years represent a self-selected population in which some groups at high risk of poor outcome may be underrepresented.

(1) Maj M. et al.. *Am. J. Psychiatry*, 155: 30-35, 1998.

S46. Schizophrenia: from psychopathology to treatment

Chairs: J Gerlach (DK), AC Altamura (I)

S46-1**PSYCHOPATHOLOGY OF NEGATIVE-POSITIVE DICHOTOMY OF SCHIZOPHRENIC SYMPTOMS**

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The positive-negative dichotomy has become a common parlance in psychiatry, but its conceptual and empirical justification is extremely shaky. It does not correspond properly to Bleulerian symptom division nor is it being used according to the Jacksonian view of dissolution of mental and cerebral functions. Rather, it refers to a common-sensical folk psychological approach to consciousness. In this framework, "negative" and "positive" refer respectively to a lack or an excess. Phenomenological analysis of "anergia" is presented to illustrate the incoherence of the current positive-negative dichotomy. Another proposal, based on temporal, experiential and phenomenologically essential aspects of the

symptoms is presented, as a potentially more pragmatically useful and theoretically more consistent framework for classification of schizophrenic symptomatology.

S46-2

QUALITY OF LIFE: SYMPTOMS - SIDE EFFECTS - SOCIAL PERFORMANCE - MOOD

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Quality of life is often measured in terms of social disability or social adjustment. In contrast to stress, quality of life is a measure of outcome rather than cause of illness. In chronic disorders like schizophrenia, the WHO Classification of impairments and disabilities is very useful. The disability is a measure of performance of social roles. Quality of life goes beyond the WHO concept of handicap when defining the consequences of chronic illness. It is the subjective dimension on the sequence underlying impairments and disabilities. In clinical trials with antipsychotics in schizophrenia, quality of life is considered as the outcome measure capturing the balance between efficacy and safety from the patient's point of view. Schizophrenia-specific quality of life scales have been developed, but also generic scales have been used. Among the generic scales the Psychological General Well-Being Scale has obtained an acceptable applicability in schizophrenia. This scale measures both positive and negative well-being.

(1) Bech P: Quality of life in the psychiatric patient. London: Mosby-Wolfe, 1998.

S46-3

ANTIPSYCHOTICS: WILL THE ATYPICALS IMPROVE THE PATIENTS' QUALITY OF LIFE?

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The benefit of neuroleptic drugs in the treatment of schizophrenic patients is beyond doubt. However, most patients discontinue these drugs within a few months. This low compliance may be caused by a lack of insight into the disease and the necessity of therapy. Also of major importance are adverse effects, which are not restricted to motor symptoms but markedly affect drive and emotion. They are often too subtle to be detected by objective examination but are reported by patients, who complain of a reduced quality of life (QOL) with restrictions in emotionality, straight thinking, and spontaneity. This syndrome, similar to the negative symptoms of schizophrenia, has been named pharmacogenic depression or neuroleptic-induced deficit syndrome.

The patients' perspective in the treatment of schizophrenia has largely been neglected, perhaps because of the lack of agreement on a definition of QOL and its essential components or the lack of a specific model for QOL in schizophrenic patients under neuroleptic treatment. To date, there is no practical and therapy-sensitive scale to measure subjective QOL in schizophrenic patients. Another reason for the low scientific interest in QOL with neuroleptic treatment may be the misconception that schizophrenic patients are not able to evaluate their well-being or QOL.

However, numerous studies have demonstrated that between 63% and 95% of schizophrenic patients, most of whom were in remission, were able to self-rate their affective state or their QOL. The relationship between the subjected evaluation of QOL and expert-rated psychopathology is not strongly correlated. Most studies found significant correlations to only negative symptoms. The few studies in which the effect of atypical neuroleptic drugs on

QOL was investigated show that these drugs - namely clozapine, olanzapine, risperidone, and sertindole - are superior to typical neuroleptics.

Owing to the lack of relevant motor or affective side effects with atypical neuroleptics, compliance is relatively high, and patients are less often rehospitalized. Therefore, they are able to participate in long-term, psychosocial rehabilitative treatment, which finally leads to improvement of negative symptoms, subjective well-being, and QOL.

Moreover, numerous studies indicate that early and continuous neuroleptic treatment is of major importance for long-term prognosis. It might be possible that the broad use of effective, tolerable, and socially accepted atypical neuroleptics also results in a markedly better long-term prognosis.

S46-4

COMMUNITY PSYCHIATRY: THE CHALLENGE OF CO-ORDINATION AND FOCUS

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The management of long-term and disabling disorders such as schizophrenia in the community present major challenges for European teams. The general principle of sectorisation has the advantage of ensuring a prompt and usually multiprofessional response. It has inherent problems, however, in co-ordination (in particular between health and social care) and maintaining a focus on prioritising the needs of severely mentally ill individuals.

In the US case-management has been developed for co-ordination of care and published studies are encouraging. In Europe case-management studies have yielded mixed results. Maintaining a clinically appropriate focus has not been so widely written about or researched.

The Care Programme Approach in the UK has been an attempt to control both co-ordination and focus through central legislation. Current evidence suggests that such hybrid legislation achieves neither of its goals very well. Failing to recognise the vast range of levels of disability and needs in schizophrenia is the clearest example. It is proposed that the two are best separated so that the essentially more clinical nature of prioritisation can be recognised without down-playing the importance of management structures in co-ordination

S46-5

THE ASSESSMENT OF THE QUALITY OF CARE USING SOME PHARMACOECONOMIC PARAMETERS

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Schizophrenia is the most serious illness that psychiatrists treat. It is an expensive illness, costly in both social and financial terms. It begins early in life, produces maximal morbidity and lacks a comprehensive efficacious treatment. Most patients with schizophrenia experience a profound decrement in quality of life in all areas of functioning. The reduced quality of life is due to the manifestations of schizophrenia itself as well as to the side effects of classical antidopaminergic neuroleptic therapy. Major cost items are inpatient care as well as other types of residential and day care. The cost of pharmacological treatment contributes only a small percentage of the total costs of treating schizophrenia (1-5% of the total costs of care). In addition to direct treatment costs, 70-80% of patients are likely to be unemployed, resulting in costs of