

Methods: We applied the self-rated cyclothymic temperament scale [CT], as described by Akiskal et al., to a sample of 177 individuals divided in 3 groups: [a] 100 "super-normal" subjects [healthy volunteers without any familial affective trouble antecedent, NFH]; [b] 37 "normal" volunteers, symptom free but with familial affective history [PFH]; [c] 40 subjects in the brotherhood of patients suffering from Bipolar-type I Disorder according to the DSM IV [BPR]. The two last groups defined clearly at risk subjects for affective troubles. To analyse our results, we used descriptive statistics, parametric tests [Student's t-test, Pearson's Chi-2] or non parametric test [mann-Whitney].

Results: Our results indicate that the CT is more frequent:

- in the BPR vs. the controls [16.22% vs. 3.64%; $X^2 = 5.74$; $p = 0.013$],
- in the group [PFH and BPR] vs. NFH [12.9% vs. 1%; $X^2 = 11.24$; $p = 0.001$].

Further, exhibit a higher rate of CT: [a] the subjects with a familial bipolar disorder antecedent [14.63%]; [b] the individuals with a familial only depressive trouble history [11.76%]. At last, the CT seems to predominate in the females compared to the males [respectively 8.6 and 4.1%].

Discussion and Conclusion: First, we will discuss first the accurate CT definition problem and the limitations of this study. Then, we will review the CT status among the bipolar disorder spectrum in light with the most recent studies focused on the subsyndromal troubles. The better understanding of this temperament is certainly of major relevance for the physiopathology and treatment of the bipolar condition. Perhaps, this could help us to define a more homogeneous phenotype for the affective troubles phenotype.

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THE NICOTINE DEPENDENCE IN INPATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

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Background: Numerous studies provide evidence that prevalence of cigarette smoking among patients with schizophrenia and schizoaffective disorder is very high. However, the causes of this phenomenon remain unclear. One hypothesis suggests that cigarette smoking in schizophrenia and schizoaffective disorder may represent an attempt to self-medicate symptoms of the illness.

Objective: The aim of this study was to examine 1) the prevalence of nicotine dependence in inpatients with schizophrenia and schizoaffective disorder, 2) the relationship of smoking with age, duration of psychotic illness, number of psychiatric hospitalisations and gender, 3) smoking habits and attitudes of patients to their nicotine dependence.

Methods: Schizophrenic and schizoaffective patients hospitalised in our clinic from January 1 to April 26 2000 ($N = 53$) were surveyed by semistructured interview on smoking habits. Data regarding age, diagnosis, duration of psychotic illness and number of psychiatric hospitalisations were obtained from clinic records.

Results: Current smokers comprised 29 (55%) patients, 17 (32%) patients were non-smokers and 7 (13%) of the patients were former smokers. Significant relationship was found between number of cigarettes smoked per day and number of psychiatric hospitalisations ($p < 0.05$), between number of cigarettes smoked per day and age ($p < 0.05$) and between number of cigarettes smoked per day and length of psychotic illness in male patients ($p < 0.01$) but not in female patients.

72% of current smokers (21 patients) reported some positive influence of smoking on their mental functioning. 52% of current

smokers (15 patients) reported decrease of anxiety or settling nerves, 14% of the patients (4 patients) reported improvement of thinking or concentration. Other patients reported increase of energy and improvement of depression after smoking.

Conclusions: We confirmed high prevalence of cigarette smoking among patients with schizophrenia and schizoaffective disorder. We found association between number of cigarettes smoked per day and number of psychiatric hospitalisations, age and length of psychotic illness (only in male patients). Self-reports of patients support the hypothesis that cigarette smoking in schizophrenia and schizoaffective disorder may represent an attempt to self-medicate symptoms of the illness.

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CHOLESTEROL CONCENTRATIONS IN HIGH AND LOW WOMEN SUICIDE ATTEMPTERS

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Aim of the Study: To evaluate whether women, who have committed high violence suicide attempt, have lower serum cholesterol concentrations than women who have committed suicide attempt by low violence method with regards to diagnosis and age.

Introduction: Previous studies have suggested that depression and suicide are related to alterations in total cholesterol serum concentrations. Trials of cholesterol lowering have shown an increased mortality from violent death and suicide. Studies found low serum cholesterol concentrations in people with a violent or aggressive behaviour. A biological mechanism for this relation is unknown. Some theories suggested, that low cholesterol might affect a microviscosity of membranes, which could contribute to a decrease in serotonin functioning. This may in turn increase an impulsive behaviour. Thus reduced cholesterol, whether through a medication or other reasons, could make such a complex behaviour as the violence towards the self or others much more likely.

Methods: The study used a case control design to compare the cholesterol levels of patients who had a history of high ($N = 19$) and low ($N = 51$) suicide attempts and controls of non suicidal subjects ($N = 72$). High violent suicide attempts include gunshot wound, hanging, jumping from height and drowning. A suicide by overdoses we consider as low violence suicide attempt. The analysis of covariance (ANCOVA) with age as covariate was used to analyse differences in cholesterol levels in groups according to diagnoses and violence.

Results: Using the ANCOVA method, a significant ($p = 0.016$) effect of the factor of violence on the level of cholesterol was discovered. A significant difference for the factor of diagnosis and for the interaction between factors was not found. Using the Sheefe's test, a significant difference ($p = 0.011$) was revealed between the group of high violent and low violent suicide attempters. A significant difference between the high violent suicide attempters and control group was described, too.

Conclusions: The study demonstrates that the women hospitalised after the high violent suicide attempt reveal lower cholesterol levels than the women after the low violent suicide. A significant difference between the cholesterol levels in the control group and patients after the low violent suicide attempt was not found. The results of this study refer to the correlation of low cholesterol levels with a violent, rather than suicidal behaviour.