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 underresearched 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-structrured 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" ($\geq$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 complexe 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-POSTIVE 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 ofdissolution 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