FC111 *Psychopathology and psychotherapies*

FROM RESEARCH TO PRACTICE : FIBROMYALGIA SYNDROME.

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The American College of Rheumatology developed a consensus definition of Fibromyalgia Syndrome (FMS), included in WHO's 10th revision, focusing on chronic generalized musculoskeletal pain, asthenia and sleep disorders. There's no specific treatment of FMS, which often consists in association of analgesics and psychotropic drugs.

According to Moldofsky's concepts, we hypothesize that FMS could occur after a chronic deep sleep deficiency, with numerous origins (benzodiazepines, chronic illnesses, depression or other mental disorders, restless leg syndrome or other sleep disorders, etc.).

Methods. 11 patients with FMS have been assessed, using SADS-LA-R interview (DSM III-R), Beck Depression Inventory (BDI), CGI, Pittsburgh Sleep Quality Index.

Results. 8 patients suffered from Major Depressive Disorder (revealed by SADS-LA-R, BDI and clinical impression), 9 had been suffering from significant chronic sleep disorders for several years (the 8 depressed patients +1), 6 had a benzodiazepine chronic treatment.

All These patients were successfully treated with cognitive psychotherapy and SSRIs, with disappearance of sleep disorders, and afterward complete recovery for 9 patients, and significant improvement for the other 2 patients.

Conclusion. Focusing on sleep disorders and depression, using cognitive therapy and SSRIs could enhance our quality of treatment for patients suffering from FMS.

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BEHAVIORAL PHENOTYPE AND PSYCHIATRIC DISORDER ASSESSMENT WITH A V.C.F. SYNDROME

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We report the case of a female patient with a velo-cardio-facial syndrome and suffering from a personality disorder and atypical psychiatric symptomatology. The correlation of this malformative syndrome, the behavioral phenotype, the personality pattern and the atypical psychiatric manifestations are discussed.

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PERFORMANCE LEVEL AT SCHOOL AND PSYCHIATRIC DEVIANCE

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A random sample of 1286 children were studied twice using questionnaires revealing psychiatric deviance. Rutter Scale A2 for parents and Rutter Scale B2 for teachers. The interval between the studies was four years. The mean age of children was 8.5 years in Study 1 and 12.5 years in Study 2. Out of those who scored above the 90th percentile of the cumulative frequency distribution of symptoms on either the Rutter Scale A2 or the Rutter Scale B2 in Study 1, 42.9% were still scoring above the 90th percentile of the cumulative frequency distribution four years later in Study 2. Sixty-four (9.9%) boys and 53 (8.5%) girls scored high in both Studies. One third of those who scored high in both studies were reported to perform below average at school. Out of those who scored high in one of the two studies one fifth performed below average. Of children who scored low in both studies, 9.7% performed below average at school. The difference was statistically significant. The importance of the performance level and other factors which may influence the persistence of the deviant status of the child will be analyzed and discussed.

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VALIDATION OF DIMENSIONAL MODELS OF FIRST-EPISODE SCHIZOPHRENICS

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The study investigates the dimensional structure of non-psychotic and psychotic symptoms in 232 first episode schizophrenic patients (clinical ICD-9 diagnosis 295, 297, 298.3 or 298.4: broad concept of schizophrenia). This structure has been determined at index admission and at different cross-setions up to 5 year follow-up. The issue was to validate and compare Liddle's three factor model with Crow's dual process model and Andresasen's bipolar model. The study is part of the Mannheim ABC-Schizophrenia Study, the analysis is based on the "Scale for the Assessment of Negative Symptoms" (SANS) and the "present State Examination" (PSE).

A comparison of all three models on the basis of confirmatory factor analysis (Maximum-Likelihood estimations) showed that at first admission, the correlated "three factor model" of Liddle fitted in best with the data. Liddle's model could also be replicated at all 5 cross-sections up to 5 year follow-up. Additionally, we investigated the prognostic value of Liddle's dimensions (psychomotor poverty, disorganisation, reality distortion) at index admission for the prediction of symptomatology, social disability and further objective indicators of social development 5 years after. The stability of these dimensions from index admission to the single cross-sections over 5 years has also been analysed.

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