dimensional model based on the model of John Rolland which provides a categorization scheme that organizes characteristics of chronic illnesses integrating both psychosocial and biomedical perspective. The first dimension has been conceptualized as dependent variable — incapacitation; the second dimension — time phase of illness, conceptualized as categorical i.e. distinguishing three categories: crisis, chronic and terminal phase, in our sample was reduced to one category: chronic; third dimension included components of functioning in individual psychological, family and wider social context. *Multiple regression* (method: stepwise) — with *dependent variable:* incapacitation measured by score on Global Assessment of Functioning Scale (GAF) and *independent variables*: age, duration of PTSD, as well as scores on Family Inventory of Life Events (FILE), Social Support Index (SSI), Impact of Event Scale (IES), Family Coping Coherence (FCC), Family Hardiness Index (FHI), Relative and Friend Support (RFS) — shows that high scores on *Social Support Index* appear to be the *significant predictor* of higher scores on GAF scale i.e. lower incapacitation ($p = 0.0153$). This points at the significance of diagnostic model that integrates both psychological and social context in psychiatric estimation of PTSD.

DISSOCIATIVE MECHANISMS IN VICTIMS OF WAR

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It is widely assumed that dissociation is a defence mechanism employed to cope with overwhelming experiences, and that psychological trauma creates the fragmented sense of self that characterizes patients with stress-related disorders. Most of the instruments for assessment of PTSD are "symptom-oriented"; Impact of Event Scale (IES) registers manners in which subjects recall traumatic memories, apply or redistribute attention and deal with disturbing thoughts. The aim of our study was to assess latent structure of this instrument and its correlation with clinical picture of PTSD. Sample consisted of 158 patients with war-related trauma among whom 103 had PTSD diagnosed by DSM-IV criteria. They have all been assessed by IES, The Mississippi Scale for Combat-related PTSD, and The PTSD Checklist. The factor analysis of IES identified three factors: the first two corresponded clearly to intrusion and avoidance. The third factor consisted of dissociative symptoms. These factors were used for dicriminant analysis. The obtained results have shown that it is possible to clearly distinguish at least two groups of patients on the basis of predominantly used coping mechanisms: subjects who respond to intrusive symptoms with avoidance strategies, and subjects who use dissociation as a reaction to excessive trauma.

OCD: COMPARISONS OF SRI TREATMENT

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Obsessive-compulsive disorder (OCD) is a chronic illness that can be associated with substantial morbidity and often requires long-term treatment. Separate double-blind, multi-centre, placebo-controlled trials of the potent serotonin reuptake inhibitors (SRIs) clomipramine, paroxetine, fluoxetine, sertraline, and fluvoxamine have shown significant efficacy in the treatment of OCD. Antiobsessional effects of the SRIs are independent of their antidepressant effects. Two recent meta-analyses which compared efficacy between the SRIs in the treatment of OCD concluded that SRI is more effective than placebo and that clomipramine was associated with a significantly greater reduction in OCD symptoms from baseline compared with the other SRIs. However, there are methodological limitations associated with meta-analyses, and placebo-controlled, head-to-head comparisons remain the best means of assessing relative efficacy and tolerability of individual drugs. Several small direct comparisons reported have demonstrated similar efficacy, but reduced tolerability, for clomipramine versus other SRI medications. A recent large-scale multinational, randomised, double-blind comparison of paroxetine versus clomipramine versus placebo in 399 patients with OCD was recently completed. Paroxetine was as effective as clomipramine in the 12-week study and both were significantly more effective than placebo in reducing OCD symptoms. Moreover, paroxetine was associated with significantly less side effects and drop-outs due to adverse events than clomipramine treatment. These findings suggest that paroxetine possesses similar antiobsessive efficacy, but a superior side effect profile in comparison to clomipramine treatment. Long-term studies of paroxetine therapy have also demonstrated maintenance of efficacy and prevention of relapse. OCD is a chronic disorder that generally requires maintenance medication. Therefore, these results supporting paroxetine's antiobsessive efficacy and long-term tolerability may have important implications for many patients with OCD.

EFFICACY AND SAFETY OF PAROXETINE IN PANIC DISORDER

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The efficacy and safety of the selective serotonin reuptake inhibitor paroxetine has been evaluated in over 450 patients with panic disorder with or without agoraphobia. In a randomised comparison with placebo plus cognitive therapy in 120 patients with panic disorder, paroxetine plus cognitive therapy significantly reduced the frequency of panic attacks. A short-term comparative study over 12 weeks in 367 patients showed paroxetine to be at least as effective as clomipramine in the treatment of panic disorder. Moreover, paroxetine-treated patients demonstrated significant improvement over clomipramine in the reduction of panic attacks to zero (51% panic free vs 37%, $p < 0.05$). Paroxetine also appeared to have an earlier onset of action. In a long-term extension of this study, 176 patients continued medication under double-blind conditions and demonstrated that the efficacy of paroxetine was maintained over time. Additionally, paroxetine was significantly better tolerated than clomipramine. In a dose range finding study, 40 mg was shown to be the minimum effective dose and a long-term extension of this study showed paroxetine to be significantly more effective than placebo in preventing relapse. In all studies, paroxetine was also effective in reducing the associated symptomatology of panic disorder, such as depressive symptoms, generalised anxiety and phobias. In conclusion, paroxetine is an effective and well tolerated treatment for the control of panic disorder.

PATIENT DISABILITY IN PANIC DISORDER

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In addition to panic attacks, panic disorder is associated with high levels of secondary symptomatology, such as anxiety and depression. This disorder can lead to considerable disability in social functioning. Two scales which measure the level of disability have been used in multicentre panic disorder trials involving paroxetine: the Sheehan Disability Scale (SDS) and the Social Adjustment Self-report Questionnaire (SAQ). A 12-week placebo-controlled comparison of paroxetine and clomipramine in 367 patients with panic disorder compared SDS score at baseline and after treatment; both paroxetine and clomipramine were significantly better than placebo with respect to work, social life and family life/home responsibility. A long-term

extension (9 months) in 173 patients showed that continued therapy with either active treatment produced further improvement in all SDS items. The mean change from baseline in SAQ was measured in 231 patients after 10 weeks' treatment with either placebo or paroxetine 10 mg, 20 mg or 40 mg. This scale assesses how patients feel about work, spare-time activities, families and financial matters. All doses of paroxetine produced greater improvement than placebo, although the difference only approached statistical significance in the 40 mg group (the minimum effective dose in panic disorder). In the same study, all SDS items showed increasing improvement with increasing paroxetine dose at endpoint. These data indicate that eradication of panic attacks quickly leads to improvement in key disabilities.

ZOLPIDEM POST-MARKETING SURVEILLANCE (PMS) ON 16944 PATIENTS

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16944 insomniac patients treated with zolpidem under routine conditions of use were documented starting in April 1992 through November 1993 by 3229 office-based neurologists, psychiatrists, internists and general practitioners in Germany. The aim of the PMS was to collect data on the safety and tolerance profile of zolpidem, to document the causes of insomnia and to establish the dosage and concomitant medication for a representative insomniac population. 2/3 of the patients were female and 1/3 were male. More than 50% of all these patients were between 50 and 75 years old and 20% of all included patients were treated with 5 mg zolpidem and nearly 75% of them with 10 mg of zolpidem per night. 268 side-effects were registered in 182 patients, thus only 1% of all patients suffered from side-effects which were in decreasing order of frequency nausea, dizziness and malaise during the zolpidem treatment. The adverse event profile reflects the labelling of zolpidem and its pharmacological properties and is consistent with the cumulative international experience of the drug.

EATING-DISORDERED BEHAVIOR IN MALES: SIGNIFICANCE OF ADVERSE CHILDHOOD EXPERIENCES

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The authors examined the possible relationship of childhood sexual abuse, physical abuse, and dysfunctional family background, and the risk for developing an eating disorder in adult males. Several anonymous questionnaires were distributed to male university students. Of the 301 men, 12 (4.0%) had experienced childhood sexual abuse, 79 (26.2%) reported an adverse family background, 11 (3.6%) had been victims of physical abuse, and 14 (4.6%) had an increased risk for developing an eating disorder. There were no significant differences in the risk for developing an eating disorder and in total EDI between sexual abuse victims and nonvictims, but a significantly increased risk for an eating disorder in men with an adverse family background. The findings suggest that long-lasting negative familial relationships particularly in connection with physically abusive experiences may increase the risk for eating disorders.

TELEPHONE HELPLINE UNIT IN ATHENS: CHARACTERISTICS OF REPEATERS

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The Telephone Helpline Unit (SOS-175) in Athens offers emotional support, counselling and referral for people under a situation of "crisis". The unit is staffed by psychologists, psychiatric residents and social workers with special training and experience. From a random sample of 4877 callers seeking help by phone during a two years period (1988–89), 546 (11.3%) had two or more contacts with the service (Repeaters, group A). The aim of this study is to reveal the differential characteristics of Repeaters comparing those to a group of callers who had only a telephone call during the same time period (N = 4301, group B). Group A and Group B callers were compared in a number of parameters (i.e. sociodemographic, reasons of calling, use of psychotropic drugs, abuse of narcotics or alcohol, psychiatric diagnosis, management). For the statistical evaluation the SPSS package was used (statistical criterion x^2, correlation coefficient PRi-ϕ^2 or Cramer's V). The characteristics of repeaters are the following: single ($p < 0.0001$), older in age ($p < 0.0001$), unemployed ($p < 0.003$), with family ($p < 0.001$), marital ($p < 0.002$) or financial ($p < 0.001$) problems. More often they abused drugs or alcohol ($p < 0.0001$) had suicidal thoughts ($p < 0.0001$) and a diagnosis of psychiatric disorder ($p < 0.0001$).

BORDERLINE DEPRESSION OF PERSONALITY DISORDERS

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In spite of some explanatory hypotheses the relationship between personality disorders and depression still remains controversial. In this study 120 dysthymic patients, 61.6% of which had comorbid personality disorder, were examined by tests for depression (Schedule for Affective Disorders and Schizophrenia, Hamilton Rating Scale for Depression) and by psychometric tests for personality disorders, such as Millon Clinical Multiaxial Inventory, Structured Interview for Personality Disorders and the Diagnostic Interview for Borderlines Revised. Results of the study have shown the following: 1) frequency of the borderline personality disorder was very high in dysthymic patients, ranging from 56% to 75.8% on various tests; 2) there was no difference between borderline and depression dimensions across different categories of personality disorders, and 3) there is a high correlation between borderline and dysthymic dimensions. The borderline level of functioning (what is currently considered as borderline personality disorder) can be induced by depression in many personality disorders, i.e. depression leads to the "borderline decompensation" which can be successfully treated by the antidepressants. Depression of personality disorders, has specific clinical characteristics which authors call a "borderline depression".

COMMORBIDITY OF PERSONALITY DISORDERS IN SCHIZOPHRENIC AND AFFECTIVE DISORDERS: A COMPARATIVE STUDY

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We studied DSM-III-R personality disorders in a sample of 75 patients of both sexes with a schizophrenic (48) or affective disorder (27). Patients assessment of personality disorders was performed at a time of substantial remission of their symptoms by means of the SCID-III-R