

limited space to the same trauma, which had its specific characteristics. The aim of this paper is to determine the following questions: a) Does identical trauma cause specific symptoms complex? b) Is there chronological order of symptoms development in PTSD, caused by the unique specific stressor?

The results of this investigation, based on the following the evolution of symptoms at admission, 6 and 12 months after the traumatic events, show that the development of the specific symptoms of the disorder is possible in the population exposed. These results direct us to the concept of traumatic memory that can be considered as a relevant theoretical approach, operatively more consistent than the theoretical model of interaction of the trauma and personality. On the other hand these results show that there exists a clear chronological developmental order of the symptoms, with the evolving cognitive symptoms in the latter phases of the disorder, and that they can be considered as restitutive.

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MODES OF ADAPTATION TO PROLONGED STRESS IN INDIVIDUALS WITH DEPENDENT AND PASSIVE AGGRESSIVE PERSONALITY DISORDERS

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The aim of the study was to explore whether there are differences in the manner in which persons with different types of personality disorders react to prolonged environmental stress.

Method: Twenty three persons with personality disorders of different types were assessed in detail and followed up for a period or one year. Several standardized and semistandardized evaluation instruments were used in addition to the standard clinical assessment.

Results: The ten years of personal, familial and professional uncertainty and stress due to political developments independent of the patient's actions resulted in a variety of disabling symptoms in all the 23 patients with personality disorders. These symptoms included fatigue, irritability, depressive ruminations, suicidal ideas, reduction of vigilance and concentration and a loss of motivation to plan for the future. Patients with passive aggressive and dependent personality who are usually characterized by higher ratings of neuroticism scales, a persistent weakness of coping mechanisms (each demand leading too severe destabilization), a chaotic and rigid approach to the resolution of social problems (as well as by anxiety, depressive mood and vulnerability) reacted to the situation of prolonged stress with overwhelming negative emotions, helpless rage and indignation. Of the nine patients with these diagnoses two committed suicide and one attempted it.

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DEPRESSION AND ANXIETY IN PRE-MENSTRUAL SYNDROME

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Investigations using women's retrospective self-report of menstrual symptoms showed quite clearly that a significant proportion of women reported negative affective changes during the menstrual cycle. In some studies that had included assessment measures taken at different points in the menstrual cycle, no increases in pre-menstrual and menstrual negative affects have been found. Nevertheless, in other studies of similar design increases in negative affect around the time of menstruation have been noted. Our prospective study is an attempt to explore and compare anxiety and

depression among patients suffering from Pre-menstrual syndrome (N = 30- I group), major depression (N = 30- II group) and patients with no physical or psychiatric problems (N = 30- Control group) during two consecutive menstrual cycles. The assessments were made during follicular phase as well as luteal phase of the each menstrual cycle with standard psychometric instruments employed: Hamilton scales for depression and anxiety, MMPI 201 and clinical interview. All patients that had a history of previous psychiatric disorder from the I group, as well as patients that use contraceptive medication or had some somatic illness were excluded. In the I group the highest levels of depression and anxiety were found during the luteal phase, that could be compared with the similar scores noted among the patients with major depression. Anxiety and depression scores significantly decreased during the follicular phase, while such rapid decreasing of mentioned symptoms were not found among the patients from the II group. Significantly lower scores and no variations were explored among the control subjects. High correlation was found between scores on Hypochondriasis, Hysteria, Depression, and Psychasthenia scores of MMPI with PMS. Such results are the consequence of hormonal changes during menstrual cycle, psychological characteristics of women complaining of menstrual symptoms, attitudes and expectations toward menstruation and the feminine role, reactions to early environmental events in a way which does not enable them to develop adequate coping strategies.

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QUANTITATIVE ASSESSMENT OF WAR-RELATED STRESSORS AND A LEVEL OF DISTRESS: A PILOT STUDY

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In spite of many instruments for measuring war stressors, there are considerable problems regarding their quantification. The objectives of our study were: 1. construction and evaluation of the instrument for quantitative assessment of war-related stressors both in terms of frequency of exposure to the stressors and a level of distress caused by them and 2. determination of the frequency of exposure versus subjective feeling of distress caused by exposure to specific stressors in relation to posttraumatic pathology.

Method: After the clinical interview and a semistructured interview for assessment of war-related stressors, a sample of 115 combat veterans and 101 civilians, refugees from Bosnia and Herzegovina and Croatia temporarily settled in FR Yugoslavia, evaluated list of 79 items, representing different war-related stressors, their frequency and level of distress. In addition, they were assessed with Impact of Events Scale, Mississippi Scale for Combat Related PTSD and Symptom Checklist-90-R.

Results: The items clustered in six broad categories of potentially traumatic war experiences: 1. combat stressors, 2. stressors beyond the front line 3. injuries, 4. stressors related to imprisonment, 5. war-related deprivation, 6. loss of organizational/military structure. Scales of Exposure and Distress were constructed for each of category of the stressors. Internal consistency of the scales (Cronbach Alfa) ranged from 0.71 (Injury Scale) to 0.91 (Combat Exposure Scale). Scales discriminate group of patients with diagnosis of posttraumatic stress disorder (PTSD) and non-PTSD group. Most of scales correlate (0.16 – 0.41) with Impact of Event Scale and Mississippi Scale for Combat-Related PTSD. In general subjective feeling of distress caused by exposure to