P01.05

CLINICAL VALIDITY OF ICD-10 NEURASTHENIA

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Background: 'Neurasthenia' was omitted from the DSM-III but is still present in the ICD-10. Therefore, we examined the clinical validity of ICD-10 neurasthenia in a consecutive sample of chronic pain patients.

Methods: 193 subjects were interviewed with the screening instrument for somatoform symptoms (SOMS, Rief et al., 1995): self-rating of 53 medically unexplained somatic symptoms and 11 additional screening questions concerning: illness/phobia, disease conviction, and preoccupation with pain. Operationalized psychiatric diagnoses were assessed according to ICD-10 (WHO, 1993).

Results: The mean age of subjects was 45.1 (SD ± 10.2), 121 subjects were female, 72 male. 37 subjects fulfilled ICD-10 operational criteria for somatization disorder, 78 for somatoform autonom functional disorder, 91 for neurasthenia, 64 for undifferentiated somatoform disorder, 25 for hypochondriasis, 137 for somatoform pain disorder, and 27 for sexual functional disorder. 33% of the subjects who fulfilled the criteria of ICD-10 neurasthenia fulfilled also the criteria of ICD-10 somatization disorder, 66% the criteria of ICD-10 somatoform autonom functional disorder, 69% the criteria of ICD-10 undifferentiated somatoform disorder, 14% the criteria of ICD-10 hypochondriasis, 85% the criteria of ICD-10 somatoform pain disorder, and 14% the criteria of ICD-10 sexual functional disorder.

Discussion: The clinical validity of ICD-10 neurasthenia remains questionable.

P01.06

ALEXITHYMIA IN DSM-IV DISORDER: COMPARATIVE EVALUATION IN SOMATOFORM DISORDERS, PANIC DISORDER, OBSESSIVE-COMPULSIVE DISORDER, AND DEPRESSION

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Objective: While increased levels of alexithymia were found in different mental disorders, only a limited number of studies has adressed a direct comparative evaluation of the alexithymia trait in these diagnostic groups.

Method: In a sample of 297 admittants for behavior therapy (mean age = 35.5 ± 10.8, % females = 60.3), DSM-IV diagnoses were determined using the SCID interview for DSM-IV. In addition, the TAS-20 was administered as a part of comprehensive psychometric investigation.

Results: In this sample, 75 subjects met DSM-IV criteria for somatoform disorder (SD), 176 for panic disorder (PD), 82 for obsessive-compulsive disorder (OCD), and 53 for a depressive disorder (DEP). None of the diagnostic subgroups differed significantly with regard to age, gender distribution, or educational level. Subjects with PD exhibited significantly lower TAS-20 total scores (50.2 ± 11.3) as compared to subjects with SD (54.2 ± 11.0), OCD (53.7 ± 9.2), and DEP (55.5 ± 12.6). As a result of linear regression analyses, DEP emerged as a significant predictor of the TAS-20 total score ($p = 0.04$), while PD was a significant negative predictor of the TAS-20 ($p = 0.02$). With regard to the tree subfactors of the TAS-20, subfactor 1 was significantly predicted by SD ($p = 0.03$) and a lack of PD ($p = 0.02$) and OCD ($p = 0.02$), and subfactor 3 was significantly predicted by OCD ($p = 0.001$) and DEP ($p = 0.008$), while none of the diagnoses showed a significant (positive or negative) relationship with subfactor 2.

Conclusion: Our data underline the multidimensionality of the alexithymia construct (as provided by the tree-factor structure of the TAS-20). Accordingly, elevated levels of alexithymia in different diagnostic subgroups may be due to divergent subsets of variables.

P01.07

REM-SLEEP BEHAVIOR DISORDER IN THE ELDERLY

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Objectives: REM sleep behaviour disorder (RSBD) is a serious but under-recognized condition. We conducted a study on its prevalence in a community sample of elderly in Hong Kong.

Methods: A sample of Chinese elderly aged 70 years or above were interviewed with a questionnaire on the presence of sleep-related injuries. Patients with suspected sleep disorders were further evaluated by clinicians and underwent sleep studies.

Results: Among the 1034 elderly interviewed, 4 had RSBD, giving an estimated prevalence of 0.38%. RSBD ran a waxing and waning course instead of a progressive deterioration as described in previous clinic samples.

Conclusions: RSBD frequently led to injuries but were frequently under-recognized. Clinicians should be alert to this condition.

P01.08

DEPRESSIVE MIXED STATE IN ATYPICAL DEPRESSION

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Background: Depressive mixed states (major depressive episodes with some hypomanic symptoms) (DMS) are not classified in DSM-IV, and are understudied. Study aim was to find the prevalence and clinical features of DMS in outpatient atypical depression. The anergia and hypersomnia of atypical depression suggest a slowing of mental and motor activity, making counterintuitive the presence of concurrent hypomanic symptoms.

Methods: Eighty seven consecutive bipolar II and unipolar depressed outpatients, presenting for depression treatment, were interviewed with the DSM-IV Structured Clinical Interview, in center dot private practice, during the last 6 months. Private practice is more representative of mood disorders in Italy, where it is the first or second (after family doctors) line of treatment of mood disorders. Mood disorders in academic centers may not be representative of typical mood patients (Goldberg and Kocsis, 1999). Main variables were DSM-IV hypomanic symptoms. Frequencies were compared with Fisher's exact test ($p < 0.05$).

Results: Three or more hypomanic symptoms were present in 50.0% of atypical depression patients (and in 20.3% of nonatypical patients, p 0.006) DMS mainly included irritable mood, distractibility, racing thoughts, and more talkative. Atypical depression was significantly associated with bipolar II. Limitations: single interviewer, non-blind, cross-sectional assessment, bipolar II diagnosis reliability.

Conclusions: Findings have important treatment implications, as antidepressants may worsen DMS, and mood stabilizers can be useful in DMS. Findings support the broad bipolar spectrum.

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