EV0404

Specificity in perceived social support in multiple sclerosis patients

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Introduction Social support is one of the functions of social relationships that modify stress. Social supportive resources play important role in helping patients to adjust to the disease. Not much is known about social support in multiple sclerosis patients while it is one of the available interpersonal resources.
Objectives and aims To examine the specificity in perceived social support in multiple sclerosis patients.
Methods The sample were 104 in-patients diagnosed with multiple sclerosis (both men and women; mean age 38, SD = 10). All patients included in this study filled out the 22-item Russian version of the social support questionnaire (F-SOZU-22, G. Sommer, T. Fydrich in 1989, adaptation developed by A. Kholmogorova in 2006). Among them there were patients with relapsing-remitting multiple sclerosis and secondary progressive multiple sclerosis.
Results The entire sample reported the normal level of social support. One can mention that multiple sclerosis patients did not differ in general level of perceived social support from the healthy subjects. The exception was the overall satisfaction of social support, which reflected its statistically higher level in multiple sclerosis patients ($P < 0.05$). Further analysis showed no significant differences in perceived social support in patients associated with gender factor and clinical forms of multiple sclerosis ($P > 0.05$).
Conclusions The perceived social support in multiple sclerosis patients is characterized by normal levels of its emotional and instrumental components and inclusion in the network of close social relationships. However, the patients of both genders do not feel stability of these relations and have a deceased sense of security that can be a significant risk factor for depression.
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Personality disorders and affective temperament in unipolar and bipolar mood disorder

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Introduction Personality disorders (PD) and Affective temperaments (AT) have been considered vulnerability factors for the development of mood disorder (MD).
Objective To study the simultaneous presence of PD and AT in patients with DU and differences between unipolar depression (DD) and bipolar disorder BD.
Methods An observational study was conducted. Patients were administered the Temperament Evaluation of Memphis, Pisa, Paris and San Diego questionnaire (TEMPS-A) for AT and the Structured Clinical Interview for DSM IV Axis II Disorders (SCID-II) for PD. The interrelationships of the different PD and AT were studied by factor analysis (principal component analysis, PCA) (orthogonal rotation, Varimax).
Results Participants were 156 adult patients with MD, 37.1% with DD and 62.9% with BD. DD patients presented with significantly more paranoid PD ($P = 0.009$), depressive ($P = 0.029$), anxious ($P = 0.009$) and irritable temperament ($P = 0.006$) compared to BD. PCA results showed four significant factors, explaining the 63.1% of total variance, corresponding to four potential groups of patients with specific PD and AT associations.
Conclusion The comorbidity between MD and PD and AT may differentiate DD from BD. Specific patterns of comorbidity may be useful as they may substantially influence the course of the mood disorders and how patients respond to treatment.
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Depressive disorders: A multidimensional non-drug approach

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In Europe, 25% of the population suffers from one type of depressive disorders each year. When depression is diagnosed, one on two people will actually be given a medication e.g. antidepressant and benzodiazepine (when correlated to anxiety or sleep trouble); the relapse risk is about 50%. This pathology and its chemical treatment affect the individual's health and life balance, e.g. cognitive impairments, family circle and career. Plus, side effects might create dependence, inability to focus or drive, disinhibition leading to suicide attempts. In addition, it also affects society at an economic level.
Comparing prior research, there are many causes to depressive disorders, a fragile balance that allows depression to begin and last. These causes include psychological factors (personal history, loss, trauma) biological factors (genetic predisposition, neurochemical dysregulation, bacteria) and environment (stress, social interaction, family circle, physical environment). Due to their multiple causes and maintenance factors, we consider depressive disorders in a multidimensional clinic through non-drug approach treatment and prevention. In severe depressive disorders and resistant depression EMDR therapy has shown effective results. Taking in account the high chance of relapses (50%), we highlight regular physical activity as a prevention factor that diminishes relapses chances compared to medication. Furthermore, meditation practice impacts cerebral plasticity. Finally, an environmental approach through luminotherapy (increase serotonin precursor) or nutritherapy (bacterium balance) helps healing and prevents relapses. These therapies can be easily adapted to any population and institutional context.
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Frequency of depressive disorders in a representative sample of Nicosia, Cyprus

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