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"DIAGNOSIS IN PSYCHIATRY: INTEGRATING THE SCIENCES"

VIENNA (AUSTRIA)
JUNE 19-22, 2003

In collaboration with the
Austrian Society of Psychiatry and Psychotherapy

ABSTRACT BOOK
(SYMPOSIA)

Guest Editors: Heinz Katschnig, Mario Maj and Norman Sartorius

MASSON

The World Psychiatric Association (WPA)

The WPA is an association of psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 123, spanning 106 different countries and representing more than 150,000 psychiatrists. The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 55 scientific sections, aimed to disseminate information and promote collaborative work in specific domains of psychiatry. It has produced recently several educational programmes and series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996). Further information on the WPA can be found in the website www.wpanet.org.

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World Psychiatry

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SYMPOSIUM S01
Neurasthenia: What is it, Where is it and How Much of it is There?

Chairs: Simon Wessely - Norman Sartorius

Friday, 20 June, 8.30-10.00 am - Zeremoniensaal

S01.1
WPA CONSENSUS STATEMENT ON NEURASTHENIA

Sartorius, Norman, University of Geneva, Geneva, Switzerland

The diagnosis of neurasthenia is frequently made in some countries; in others the diagnosis is rarely used although epidemiological surveys indicate that there are significant numbers of people suffering from the neurasthenic syndrome. Treatment for neurasthenia is also disputed and so is the responsibility for care variously assigned to psychiatrists, internists, neurologists and others.
Faced with this situation, the World Psychiatric Association has undertaken to develop a consensus statement on neurasthenia. The text of the statement has been reviewed by many experts and approved by the General Assembly of the World Psychiatric Association in August 2002. The statement will be presented in this symposium as well as the prospects for future work on this matter.

S01.2
NEURASTHENIA: PREVALENCE, DISABILITY AND HEALTH CARE CHARACTERISTICS IN THE AUSTRALIAN COMMUNITY

Hickie, Ian, Department of Medicine, University of Sydney, Sydney, NSW, Australia; Davenport, T.; Issakidis, C.; Andrews, G.

Background: Neurasthenia imposes a high burden on primary medical health care systems in all societies. **Aims:** To determine the prevalence of ICD-10 neurasthenia and associated comorbidity, disability and health care utilisation. **Methods:** Utilisation of a national sample of Australian households previously surveyed using the Composite International Diagnostic Interview and other measures. **Results:** Prolonged and excessive fatigue was reported by 1,465 people (13.29% of the sample). Of these, one in nine people met current ICD-10 criteria for neurasthenia. Comorbidity was associated with affective, anxiety and physical disorders. People with neurasthenia alone (<0.5% of the population) were less disabled and used less services than those with comorbid disorders. **Conclusions:** Fatigue is frequent in the Australian community and is common in people attending general practice. Neurasthenia is disabling and demanding of services largely because of its comorbidity with other mental and physical disorders. Until a remedy for persistent fatigue is provided, doctors should take an active psychological approach to treatment.

S01.3
THE USE OF MULTIPLE PSYCHIATRIC RATING SCALES IN CLINICAL RESEARCH: A STATISTICAL APPROACH

Üstün, T. Bedirhan, Classification Assessment Surveys and Terminology - WHO - Geneva, Switzerland

Abstract not received

S01.4
NEURASTHENIA: WHAT IS IT, WHERE IS IT, AND HOW MUCH OF IT IS THERE?

Wessely, Simon, Institute of Psychiatry and King's College Hospital, London, United Kingdom

One hundred years ago there would have been no need to ask the question "what is neurasthenia?", since physicians across Europe and North America would have had no trouble answering the question. It was the principal diagnosis given to patients with complaints of easy fatigability, accompanied by other somatic symptoms, sleep problems, depression and anxiety. Its rise and fall is a fascinating story in diagnostic practices, and the cultural and social influences that decide what label we give for whom. One hundred years later neurasthenia has all but disappeared from Europe and North America, but of course is an exceptionally important category in the Far East, as well as in Eastern Europe and the states of the former Soviet Union. However, patients with the same complaints that were once labelled neurasthenia in the clinics and practices of Western Europe and North America have far from vanished, reappearing under the many disguises of the chronic fatigue syndromes. The nature of neurasthenia was a potent source of controversy at the end of the 19th century. In brief, it began as an organic neurological condition, often post infective in nature, affecting the most successful members of society, and for which the treatment was rest. However, after a generation, all of these changed, and it became seen as a psychological condition, not related to infection, commonest in the lower socio-economic groups, and for which the treatment was activity. We currently witness a similar debate over the nature of chronic fatigue syndrome. But there is one thing that is certain. Whatever we think of as the cause of neurasthenia, and its relationship or lack of relationship to chronic fatigue syndromes, it is very common indeed, especially in the general medical setting.

SYMPOSIUM S02
The Classification of Behavioural Syndromes in the Elderly

Chairs: Pandelis Giannakopoulos - Josef Marksteiner

Friday, 20 June, 8.30-10.00 am - Rittersaal

S02.1
DIAGNOSTIC SYSTEMS IN ALZHEIMER'S DISEASE: FROM BRAIN LESIONS TO CLINICAL PRACTICE

Giannakopolous, Pandelis, Clinic of Geriatric Psychiatry, Department of Psychiatry-HUG-Belle-Idee, Geneva, Switzerland

Neurofibrillary tangles (NFT), senile plaques (SP) and neuronal loss are the three major pathologic hallmarks of Alzheimer's disease (AD), however they are also observed in the course of normal brain aging. The relationship between the pattern and densities of NFT and SP lesions in brain aging and in AD has led to the development of neuropathological staging models of AD. Braak staging systems for NFT and Aß pathology describes a temporal pattern of its development in brain aging. The association between clinical severity and both staging systems is highly significant. However, the Aß-protein-based system was less able than NFT-based Braak staging to distinguish mild cognitive changes from dementia, and showed marked overlap among the various stages of cognitive decline. In a multivariate model, NFT and age together accounted for 27.2% and the addition of Aß-protein deposition staging could only explain an extra

2.9% of the clinical variability. New stereological data complete these observations by revealing that NFT and neuron numbers are the only valid predictors of cognitive status in AD.

S02.2
ASSESSMENT OF BEHAVIOURAL DISTURBANCES IN DEMENTIA

Kurz, Alexander, Department of Psychiatry and Psychotherapy, Munich, Germany

Non-cognitive behavioural symptoms represent an important facet of the clinical presentation of dementias. The most frequent of these symptoms are agitation, aggressiveness, anxiety, delusions, depression, disinhibition, sleep disorders, and wandering. These symptoms cause additional suffering for the patients and contribute more to the burden imposed on caregivers than cognitive impairment. Moreover, behavioural disturbances frequently precipitate nursing home admissions. For the comprehensive assessment of behavioural disturbances in patients with Alzheimer's disease and vascular dementia several instruments have been developed. These include the Behavioural Symptoms in Alzheimer's Disease (BEHAVE-AD), the Neuropsychiatric Inventory (NPI), and the Columbia Scale for Psychopathology in Alzheimer's Disease (CUSPAD). Irritability, eating disorder, and disinhibition are exclusively covered in the NPI, whereas misidentifications and illusions are only referred to in the CUSPAD. For the assessment of non-cognitive symptoms associated with diseases of the frontal lobe, the Frontal Behavioural Interview (FBI) has been designed. Since behavioural disturbances in dementia can be effectively treated, systematic assessment of these symptoms should be incorporated in every diagnostic protocol for dementia.

S02.3
ASSESSMENT OF BEHAVIORAL SYNDROMES IN THE ELDERLY

Marksteiner, Josef, Department of Psychiatry, Innsbruck, Austria

Old Age Psychiatry is a rapidly growing specialty within Psychiatry. There is a considerable complexity of cases. Psychiatric conditions may be modified by physical illness and organic mental changes and the coexistence of organic and functional illness. A close working relationship with primary care facilities or social services needs a diagnostic assessment to plan therapeutic interventions. For example, late-onset psychosis can present with a variety of symptoms, including delusions, hallucinations, and paranoid misidentifications. These symptoms may be found in different diseases such as dementia, depression or schizophrenia. In the last years assessment scales have been developed and validated to support the diagnostic assessment in old age psychiatry. The diagnostic teams are multi-professional and include Community Psychiatric Nurses, Mental Health Social Workers, Psychologists and Psychiatrists.

S02.4
DIAGNOSTIC ASSESSMENT, PSYCHOTROPIC MEDICATION AND THE RISK OF FALLS AMONG RESIDENTS IN OLD AGE HOMES

Weyrer, Siegfried, Central Institute of Mental Health, Germany

Objective: Falls in old age are frequently associated with impaired function and dependency. The aim of this study is to determine the association between the use of psychotropic medication and the risk of falling among residents in old age homes. **Design:** Prospective longitudinal study. **Materials and methods:** All residents (N=1922; mean age: 81.1 years; females: 77.1%) in 20 randomly selected residential and nursing homes in the city of Mannheim (Germany) were examined. The types and dosage of medication actually taken by the residents were recorded over a period of six months, together with information on their mental and physical health, ADL impairment and falls. **Results:** Our study confirms the wide-spread use of psychotropic drugs among the residents of old age homes. During the first 4 weeks of the research interval 58.0% of the residents had used such drugs: 37.4% antipsychotics, 12.7% antidepressants, 10.9% tranquilizers and 8.0% hypnotics/sedatives. In the succeeding 6 months 34.1% of all home residents fell at least once, 11.7% thereby suffering a fracture. Controlling for possible confounding factors (age, walking disability, cognitive impairment, depression, alcohol misuse, ADL impairment) the relationship between psychotropic drug use and subsequent falls remained significant (OR = 1.6; 95% CI: 1.2 – 2.1). In particular antipsychotics (OR = 1.6; 95% CI: 1.2 – 2.1) as well as tranquilizers (OR = 1.7; 95% CI: 1.1 – 2.5) increased the risk of falling. There was a positive but not significant relationship between hypnotics/sedatives (OR = 1.2; 95% CI: 0.7 – 1.9), antidepressants (OR = 1.4; CI: 0.9 – 2.0) and the risk of falling. **Conclusions:** The findings suggest that the use of psychotropic drugs constitutes an independent risk factor for falls in old age homes. Since medication represents a potentially modifiable component in fall prevention these findings have important practical implications.

S02.5
DEPRESSION IN THE ELDERLY

Niklewski, K.

Abstract not received

SYMPOSIUM S03
The Relevance of Symptoms, Diagnosis and Classification of Schizophrenia for its Treatment
WPA Section "Schizophrenia"

Chairs: Wolfgang Fleischhacker - Wolfgang Gaebel

Friday, 20 June, 8.30-10.00 am - Geheime Ratsstube

S03.1
DIFFERENTIAL RESPONSE TO NEUROLEPTICS WITH REGARD TO THE LEONHARD CLASSIFICATION OF PSYCHOSIS

Beckmann, Helmut, Department of Psychiatry, University of Würzburg, Würzburg, Germany

Beside the ICD 10 classification and the DSM-IV system there exists the Leonhard classification which operates with three large groups of schizophrenia, namely the cycloid psychoses, the unsystematic schizophrenia and the systematic schizophrenia. The cycloid psychoses consist of the subcategories: anxiety happiness psychosis; excited inhibited confusion psychosis; hyperkinetic, akinetic motility psychosis. The unsystematic schizophrenias exist as affective paraphrenia; cataphasia; periodic catatonia. The systematic schizophrenia consists of catatonic, hebephrenic and paranoid forms. All categories are diagnosed according to characteristic symptoms which all have to be present in a patient in order to substantiate the diagnosis. If one characteristic is missed, the whole diagnosis has to be abandoned.

From the cycloid psychoses the motility subform will be presented and its response to neuroleptics and/or antidepressives will be discussed. From the unsystematic schizophrenias, periodic catatonia will be examined and its response to neuroleptics will also be discussed. From the systematic schizophrenias one of the catatonic subforms will be outlined and its response to - often decade-long - neuroleptics will be discussed. Evidence will be given that the three forms show different responses and have to be dealt with differentially as farms as drug therapy is concerned.

S03.2
FROM PRODROMAL SYMPTOMS TO SCHIZOPHRENIA - DOES THE TREATMENT APPROACH DIFFER?

Hummer, Martina, Department of Biological Psychiatry, Innsbruck University Clinics, Innsbruck, Austria

Ever since antipsychotic treatment was introduced into clinical psychiatry almost half a century ago, a lot of effort was put into studies to optimize the results of treatment outcome for patients suffering from schizophrenia. Regarding optimal treatment outcome several questions have to be considered: 1) Which treatment is the best regarding the risk benefit profile? 2) How long are treatment interventions necessary? 3) When is the best starting point for treatment interventions? 4) Which doses are effective? In subjects already identified as cases of psychosis, the benefits of antipsychotic treatments are clearly higher than the disadvantages linked to it. Clearly, modern concepts of schizophrenia management also include psychosocial and psychotherapeutic measures. Furthermore, there appears to be a growing consensus about the importance to minimize the duration of untreated psychosis, which lasts, on average, 1-2 years. The belief that untreated psychosis may be toxic to the brain and the increasing knowledge that psychosis is “brewing” long before clinically definitive manifestation, have drawn more attention to the so-called pre-onset phases of schizophrenia. Research projects on early intervention are based either upon the use of psychotherapeutic interventions or psychopharmacological treatment or a combination of both. At this time pre-onset detection and interventional research have not yet yielded results that are conclusive enough to justify a move from the research approach to a public health policy.

S03.3
CLINICAL ASPECTS OF COMORBID SUBSTANCE USE IN SCHIZOPHRENIA

Barnes, Thomas R.E., Department of Psychological Medicine, Imperial College Faculty of Medicine, London, United Kingdom

The evidence suggests that even comparatively low levels of substance misuse can have a detrimental effect on the course and outcome of schizophrenia. People with schizophrenia and comorbid substance misuse have a greater risk of relapse, suicide, antisocial behaviour and psychosocial difficulties, and poorer adherence, than those with schizophrenia alone. Reported lifetime prevalence for substance use in community/outpatient samples has ranged from 10-60%. There have been few prevalence studies in the UK, but data will be presented from both the West London First Episode Schizophrenia Study and the Co-morbidity of Substance misuse and Mental Illness Collaborative study (COSMIC). The findings confirm the high prevalence of substance use, particularly nicotine, alcohol and cannabis, in people with psychotic illness, and its association with more severe symptomatology. In the first-episode study, patients with a history of substance use had a significantly earlier age of onset of illness. This may be explained by substance use precipitating illness among people with a predisposition, or perhaps early onset of symptoms is a risk factor for using substances. The high frequency of reported lifetime use raises the possibility that substance-related symptoms could confound retrospective estimation of the duration of untreated psychosis. Studies in this area have tended to rely on self-report of substance use. While some studies involving urine or hair analysis have provided evidence that selective under-reporting of recent substance misuse may occur with questionnaires, the results of other studies suggest that self-reported substance use can provide a reliable and valid basis for prevalence estimation.

S03.4
HOW DO COGNITIVE DEFICITS INFLUENCE TREATMENT AND OUTCOME IN SCHIZOPHRENIA PATIENTS?

Hofer, Alex, Department of Biological Psychiatry, Innsbruck University Clinics, Innsbruck, Austria

Neuropsychological deficits may be a core feature of schizophrenia, are seen early in the illness and cannot be entirely attributed to chronicity, antipsychotic medication or positive symptoms. Generally, it is assumed that schizophrenia patients show deficits across a large number of neurocognitive domains including attention, executive functions, memory, visuospatial abilities and fine motor skills. Several studies have demonstrated an association between these deficits and poor functional outcome, including performance of basic activities of daily living, social skills acquisition, social problem solving, occupational functioning and community outcome. Despite the clear benefits of conventional antipsychotics for psychotic symptoms, the effects of these medications on neurocognitive deficits are generally minimal. Specifically, positive effects have been observed on aspects of selective/sustained attention, and mild negative effects have been observed on aspects of motor function, consistent with evidence that these agents cause extrapyramidal symptoms. Memory may also be negatively affected, which appears to be attributable primarily to the use of adjunctive anticholinergic agents. The effects of second-generation antipsychotic medications appear to be different and more promising. There are sufficient studies to justify the conclusion that the newer antipsychotics are better for neurocognition than the older medications. However, it is currently unclear whether the differences between first- and second-generation antipsychotics stem from a true direct benefit of the newer medications or from fewer adverse effects.

S03.5
THE POLITICS OF DEFINING SCHIZOPHRENIA - RELATIONSHIP TO TREATMENT

Katschnig, Heinz, Department of Psychiatry, University of Vienna, Vienna, Austria

During the first half of the 20th century, before effective pharmacological treatments started to become available for schizophrenia, three major definitions of the disorder had already succeeded each other: Kraepelin’s “dementia praecox” (with its emphasis on a deteriorating course), Bleuler’s psychopathological schizophrenia definition (stressing cognitive and affective symptoms), and Kurt Schneider’s concept of first rank symptoms. The latter, first published in 1939, consisted exclusively of hallucinatory and delusional symptoms and turned Bleuler’s definition upside down, since Bleuler regarded these “psychotic” phenomena only as *accessory* symptoms. When chlorpromazine and its successors were discovered, it became

quickly clear that these drugs were effective mainly for hallucinations and delusions (later called "positive" symptoms), but not for cognitive symptoms. Often, due to the anticholinergic effects of tricyclic neuroleptics, cognitive symptoms even deteriorated. It is interesting to see that in the then dominating Anglo-American psychiatry Kurt Schneider's first rank symptoms became the leading symptoms for defining schizophrenia. Both in the PSE-CATEGO system and in DSM-III, hallucinations and delusions dominated, and cognitive and affective symptoms were of minor importance. Recently one can observe a rising importance of cognitive symptoms, from DSM-III to DSM-III-R and DSM-IV. In parallel, interest in research on cognitive symptomatology has been steadily increasing over the last decade. It is again noteworthy that this development coincides with the advent of the atypical antipsychotics, which are not only effective for delusions and hallucinations, but also for cognitive symptoms. It seems that this development is also related to a management issue - the increasing insight that failure of rehabilitation in the community is less the consequence of hallucinations and delusions than of cognitive deficits.

SYMPOSIUM S04
Classification of Substance Abuse Disorders and of Craving

Chairs: Wim Van den Brink - Otto Lesch
Friday, 20 June, 8.30-10.00 am - Trabantenstube

S04.1
CLASSIFICATION OF SUBSTANCE ABUSE DISORDERS AND CRAVING: INTRODUCTION

Van den Brink, Wim, Amsterdam Institute for Addiction Research, Amsterdam, Netherlands

Substance abuse disorders are very prevalent and cause considerable individual suffering and substantial harm to the patient, the family and society at large. Tobacco and smoking are associated with serious consequences in terms of excess morbidity and mortality, whereas illicit drug use and dependence is responsible for high level of criminal behaviour and serious public order problems. Originally, physical dependence (withdrawal and tolerance) was thought to be the main underlying mechanism for continued substance abuse. However, recently physical dependence has become an optional criterion in the definition of dependence and craving has become central in our thinking about dependence and relapse. In this symposium dr. de Bruijn will challenge the validity of the DSM-IV classification of abuse and dependence and its relative negligence of withdrawal and craving. Dr. Lesch presents data in defence of the subtyping of nicotine addicts similar to the subtyping of alcoholics, because these subtypes are likely to play an important role in outcome prediction and in future patient-treatment matching. Dr. Koeter takes us from alcohol and nicotine dependence to the classification and measurement of pathological gambling, one of the most prevalent non-chemical addictions. An instrument that is able to measure severity of pathological gambling is of great importance for international comparison of epidemiological data and the measurement of effect in treatment studies. Finally, Dr. de Wildt will present the findings of a large multi-center study testing different models of craving using the Obsessive Compulsive Drinking Scale.

S04.2
CRAVING AND WITHDRAWAL AS CORE SYMPTOMS OF ALCOHOL DEPENDENCE: EMPIRICAL FINDINGS AND CONSEQUENCES FOR DSM-V

de Bruijn, H., St. Lucas Ziekenhuis, Department of Psychiatry, Amsterdam, Netherlands; Korzec, A.; van den Brink, W.

Introduction: There is ongoing debate regarding the validity of the distinction of alcohol abuse and dependence, the distinction between normality and the alcohol abuse, and the lack of recognition of the central role of craving in the DSM classification of alcohol use disorders. In the present study, we study the discriminant validity of the DSM-IV diagnoses of abuse and dependence in three different populations and compare the results with an alternative classification that includes craving and withdrawal in the diagnosis of dependence and requires at least two DSM-IV abuse-dependence symptoms for the diagnosis of abuse (CWM). **Methods:** Patients from an alcohol treatment service (n=98), non-treatment seeking heavy drinkers (n=68) and psychiatric outpatients with or without alcohol problems (n=75) were grouped according to the presence of a DSM-IV CWM alcohol abuse/dependence diagnosis using the Composite International Diagnostic Interview (CIDI), and subsequently compared in terms of drinking behaviour, biomarkers for alcohol problems, and indicators of social dysfunctioning. **Results:** While the prevalence of any alcohol use disorder did not differ between DSM-IV and CWM, the distinction between normality and abuse and between abuse and dependence was much better for the CWM categories. **Conclusions:** In the preparation of the DSM-IV more attention should be given to the role of craving and withdrawal and to the distinction between abuse and dependence in the classification of alcohol use disorders.

S04.3
THE AUSTRIAN MULTICENTRE STUDY ON SMOKING: SUBGROUPS OF NICOTINE DEPENDENCE

Lesch, Otto Michael, Vienna, Austria; Walter, H.; Dvorak, A.; Hertling, I.; Ramskogler, K.; Saletu-Zyhlarz, G.; Mader, R.; Kunze, M.; Schobersperger, R.

Introduction: The heterogeneity of addiction is undoubted, but subgroups for special treatments are not yet defined. **Methods:** Participants of this multicentre study were 330 smokers, who were classified as nicotine dependent (ICD-10, DSM-IV). They were administered different diagnostic tests: Fagerström Test (FT), craving dimensions with LCRR and classification of subgroups (LCRR or LTQ; modified for smoking). **Results:** A decision tree was developed based on the results from the FT and the LTQ, separating 4 subgroups of nicotine dependent patients. Subgroup I is characterized by a Fagerström score ≥ 5, representing somatic nicotine addiction. Subgroup II (rest group) is a group with only mild biological addiction symptoms. Only subgroup II showed significant associations with LCRR craving dimensions: positive with depressed mood state; negative with stimulated mood state. **Conclusions:** These subgroups and their different conditions of craving reflect different somatic and psycho-social disturbances. Using this diagnostic subtyping, a detailed diagnostic manual will be produced to better predict outcome in studies on nicotine dependence.

S04.4

SEVERITY OF GAMBLING ADDICTION: DEVELOPMENT OF A NEW ASSESSMENT INSTRUMENT

Koeter, M.J.W., Amsterdam Institute for Addiction Research, Amsterdam, Netherlands; de Fuentes-Merillas, L.; Schippers, G.M.; van den Brink, W.

Introduction: Pathological gambling is currently classified in DSM-IV as an impulse regulation disorder. However, many authors have indicated that the constituting symptoms and the underlying mechanisms of pathological gambling closely resemble those of substance dependence and addiction. As a consequence, pathological gambling is often described as a non-chemical addiction. In the current study, we describe the development and testing of an assessment instrument directed at the measurement of the severity of pathological gambling, using the abuse-dependence model for substance use disorders as a starting point. **Methods:** Based on the DSM-III-R and DSM-IV criteria for pathological gambling and substance dependence, items from the South Oaks Gambling Screen (SOGS) and additional items mentioned by clinicians, a preliminary 46-item questionnaire was constructed. Data were collected from a heterogeneous sample of scratchcard players, non-treatment seeking pathological scratchcard gamblers, and treatment seeking pathological gamblers. Data were analysed using item response theory (IRT) for dichotomous items. **Results:** A 20-item revised Gambling Inventory Rating List (GIRL) was constructed that fits a Rasch model ($\chi^2(76)=95.33$; ns) and represents the four major a priori domains of pathological gambling with 5 items each: work and education; family and social relations; financial problems; psychological and emotional health. The 20-item GIRL correlates 0.81 with the SOGS. **Conclusions:** A new assessment instrument was developed that has excellent psychometric properties and allows the measurement of the severity of pathological gambling; a prerequisite for the comparison of different samples and for the study of the effectiveness of new treatments.

S04.5

THE STRUCTURE OF ALCOHOL CRAVING: RESULTS FROM A MULTI-CENTER STUDY USING THE OBSESSIVE COMPULSIVE DRINKING SCALE

de Wildt, Wajim, Jellinek Addiction Treatment Center, Amsterdam, Netherlands; van den Brink, W.; Schippers, G.M.; Lehert, Ph.

Introduction: Craving is currently one of the core concepts in addiction. Until now, different definitions and models have been applied and several multi-item, multi-domain self-report questionnaires have been developed to measure the nature and severity of craving. These multi-item questionnaires allow us to examine the 14-item Obsessive Compulsive Drinking Scale (OCDS). **Methods:** Subject were 533 alcoholic inpatients and outpatients who participated in different studies conducted in different countries with different languages. Using confirmatory factor analysis (CFA) and structural equation modelling (SEM), one empirical and four different theoretical models were tested and compared. Invariant group models techniques (IGMT) were used to assess invariance of the preferred model for country, age and gender. **Results:** The consensus 3 factor model (obsession, control, interference) based on various factor analytic studies in small samples (Roberts et al, 1999) and the theoretically derived obsessive-compulsive model and inhibition model had to be rejected. The only model with an adequate fit was an optimized cognitive behavioral model based on the Health Action Process Approach (HAPA; Schwartzer, 1992) and the relapse prevention model (Marlatt and Gordon, 1985). This model was invariant for country, age and gender. **Conclusions:** This is the first large scale study testing and comparing different models for craving in the same patients using the same assessment tool. A clear preference was found for a cognitive behavioral model of craving.

S04.6

FACTORS THAT MAY INFLUENCE CRAVING FOR ALCOHOL

Wetterling, T., J.W. Goethe University, Frankfurt / Main, Germany; Müller, E.; Wehrmann, P.; Grube M.

Background: Many alcoholics regard craving as causative for relapse or their inability to stop drinking despite negative consequences. But in the scientific literature the concept of craving is discussed very controversially. However, studies concerning alcohol-related and sociodemographic factors that may influence craving are widely lacking. **Aims:** To evaluate the association of factors from the alcohol history, psychometric ratings at treatment and sociodemographic parameters with craving measured by the German version of the OCDS. **Methods:** 83 recently detoxified alcoholics were included in this study and followed up monthly. **Results:** The OCDS scores measured at the end of a 15 h motivational enhancement treatment were associated with two parameters of the alcohol history (number of previous detoxifications and number of drinks consumed during the last drinking period), and with one sociodemographic variable (current life-events). Furthermore the OCDS scores strongly correlated with psychopathometric ratings (the Beck Depression Inventory or the Spielberger Trait Anxiety Inventory). The follow-up over 6 months showed that craving (monthly measured by the OCDS) only predicted relapse within the first month after therapy. **Conclusions:** Our results revealed that some factors, particularly depressive mood as well as anxiety, may influence the severity of craving. Thus, affective disorders should be considered in the measurement of craving.

SYMPOSIUM S05

The Importance of Religious Variables in Psychiatric Diagnosis

WPA Section "Religion, Spirituality and Psychiatry"

Chairs: Herman M. van Praag - Driss Moussaoui

Friday, 20 June, 8.30-10.00 am - Radetzky Appartement

S05.1

WHICH DIAGNOSTIC SYSTEM IS SUITED TO INCLUDE RELIGIOUS VARIABLES?

van Praag, Herman M., Department of Psychiatry and Neuropsychology, Academic Hospital, Maastricht, Netherlands

Diagnosis is the very bedrock on which psychiatry rests. Precise diagnosing is necessary for treatment programming and will gain in importance with increasing selectivity of treatment options. Diagnosis is essential for research, dependent as it is on precise definition of the psychopathological construct to be studied and its delineation from adjacent diagnostic constructs. Several strategies to diagnose axis I constructs are discussed: the categorical, the syndromal and the symptomatological/functional approach. They are not mutually exclusive but complementary and should be applied in combination. The prevailing system of diagnosing axis II disorders is categorical in nature. This system is unsuitable to acquire a more precise understanding of the psychological strengths and weaknesses of a particu-

lar individual. It should be replaced or at least complemented by a dimensional approach distinguishing and assessing various personality traits, such as dependence, emotional receptivity, impulsivity, communicative abilities etc.. A dimensional system of personality analysis could, in a natural way, include measures of intrinsic religiosity.

S05.2
ANTHROPOLOGICAL AND RELIGIOUS ASPECTS IN PSYCHIATRIC CLASSIFICATION

Moussaoui, Driss, Ibn Rushd University Psychiatric Centre, Casablanca, Morocco

Although mental disorders are universal, their expression is very much related to the cultural background of the patient. One of the components of the culture is religion. I proposed in the early eighties a way of introducing religion and other cultural aspects in a classificatory system, taking depression as a model. The societies have been segmented into 4 categories: - Pre-monotheistic society, corresponding to a rural environment, agriculturally oriented, with very strong community ties. Usually, the kind of depressive symptoms seen in such societies is coloured with possession ideas; - Monotheistic with strong family ties society, corresponding to villages and small towns, handicraft oriented, with strong enlarged family. Usually, the kind of depressive symptoms seen in such societies is coloured with persecutory ideas; - Monotheistic with weak family ties society, corresponding to major cities, with an industrial environment and nuclear families. Usually, depressive symptoms seen in this type of societies are coloured with guilt; - Monotheistic individualistic society, corresponding to a post-industrial environment, with highly competitive and individualistic society. No more interpretation is given to depressive symptoms, and the patient recognizes clearly that there is an illness, needing a medical diagnosis and treatment. This typology helps to better understand the depressive symptoms in relation with the social and religious organization, but all societies are in fact composite in their essence, and various types could be seen in the same society or even in the same family.

S05.3
ARE RELIGIOUS VARIABLES DIAGNOSTICALLY RELEVANT: CHRISTIAN POINTS OF VIEW

Verhagen, Peter J., Meerkanten GGZ, Ermelo/Harderwijk, Ermelo, Netherlands

The World Health Organization reckons spirituality and religion to the six domains of quality of life relevant across cultures (1995). But the religious or existential aspect of life is not only helpful in coping with difficulties by giving structure, meaning or providing a sense of well-being, it effects psychopathology itself, e.g., the way symptoms are experienced and expressed. According to this way of reasoning we are confronted with a few fundamental difficulties: 1) There is no neat separation between spiritual and non-spiritual problems. Where such a neat separation is presumed, ultimately psychiatrists may lose their patients, because they do not feel understood. 2) Religious or spiritual people pursue different ideals from those tacitly implied in most therapeutic theory and practice. These differences are connected with different views on the purpose and meaning of life. 3) It is unethical for psychiatrists and psychotherapists to force a specific religious, spiritual, non-religious, or ideological agenda on a particular patient (APA, 1990). It is unethical to try to alienate the patient from his own faith. 4) A psychiatrist or psychotherapist must be able to recognise the different connections between religiosity and spirituality and the patients' problems and symptoms. Spirituality and religiosity can intensify suffering, they can be a positive factor in therapy, and they can be a direct or contributive cause of the problems. At the conclusion of this presentation the importance of religious and spiritual variables in the psychiatric evaluation and clinical assessment of patients should be clear.

S05.4
THE MEASUREMENT OF RELIGIOUS AND SPIRITUAL BELIEFS

King, Michael, Royal Free and University College, London Medical Schools, United Kingdom

Despite claims that spiritual beliefs are conducive to better health, they are rarely considered in psychological or medical publications. Usually only the presence or absence of religious practice is considered. However, denomination and frequency of religious observance are inadequate measures of a person's strength of belief. Religious observance, such as attending church or temple, may involve strong social relationships as well as a common value system. It is important to distinguish social factors involved in observance from the more personal role of spiritual belief itself. Most religious rating scales are based on North American concepts of Christianity and few separate the religious and spiritual dimensions of belief. *Religion* pertains to the outward practice of a spiritual understanding and serves as a framework for beliefs, values, codes of conduct and rituals. It usually involves some form of communal observance. The term *spiritual* is more difficult to define. Some people regard it as a sense of relationship or connection with a power or force in the universe that transcends the present context of reality. Others may have broader notions in which belief in a universal power or force is absent. For them spiritual may refer to a search for meaning or a sense of unity with others. Although this concept is hard to define, strength of belief can be regarded as distinct from the precise nature of that belief. In this talk I shall discuss the measurement of spiritual and religious beliefs using examples of questionnaires that have been developed in Europe.

SYMPOSIUM S06
From Categorical to Dimensional Diagnosis in Psychiatry

Chairs: Raimo Salokangas - Tim Crow

Friday, 20 June, 8.30-10.00 am - Künstlerzimmer

S06.1
FROM CATEGORICAL TO MULTI-DIMENSIONAL PSYCHIATRIC DIAGNOSES

Angst, Jules, Zurich University Psychiatric Hospital, Zurich, Switzerland

Objectives: To supplement the traditional view of categorical comorbidity with a dimensional perspective of severity and multi-syndromal morbidity. **Methods:** In a community study conducted between 1979 and 1999, 591 selected subjects, representing 2599 persons from the general population, were interviewed 6 times between the ages of 20 and 40. Psychopathology was assessed on three levels: diagnoses, subdiagnostic syndromes and symptoms, in the areas of mania, depression, anxiety, panic, phobias, obsessive-compulsive symptoms, bulimia/binge eating, neurasthenia, abuse of/dependence on alco-

hol, drugs and sedatives, and suicidality. In addition, distress (on a scale from 0-100) and professional treatments were measured regularly across most of the syndromes. **Results:** Multimorbidity across 14 conventional syndromes will be demonstrated and their distress and treatment patterns will be compared. Marked differences in multimorbidity were found between bipolar-II and major depressive disorders suggesting that bipolar-II is a much more severe disorder. **Conclusions:** The traditional diagnostic classification should be supplemented by a holistic descriptive view of psychopathology. This complex approach is suggested as a more promising correlate for molecular genetic and other biological research.

S06.2
PROBLEMS IN CATEGORICAL DIAGNOSIS: DEPRESSION AND PERSONALITY DISORDERS AS EXAMPLES

Karlsson, Hasse, Turku University, Department of Psychiatry, Finland

Each new version of the DSM has added many diagnoses to those included in its predecessors. At the same time the frequency of comorbidity has increased. This inevitably raises the question of the validity of the categorical approach. This problem is most clearly highlighted in the group of personality disorders where symptom overlap is great and where premorbid personality traits often underlie the disorder. In this paper: 1. a brief account on the categorical-dimensional debate is given; 2. research on personality disorders and depression relating to the question is presented and some remarks on somatoform disorders are made; 3. the findings of these studies are discussed. It is concluded that the categorical approach should at least be complemented with some dimensional approaches.

S06.3
THE CONTINUUM OF PSYCHOSIS AND THE DIMENSIONS OF LANGUAGE

Crow, Tim, Prince of Wales SANE Research Centre, Warneford Hospital, Oxford, United Kingdom

In their classic 1970 paper Kendell & Gourlay cast doubt on the Kraepelinian binary model in an analysis of phenomenological data from the US/UK Collaborative Study, reinforcing the doubts that Kraepelin himself had expressed 50 years earlier. From this watershed no reliable dichotomisation of the psychoses has been achieved in family, imaging or treatment studies – it must be accepted that there is a continuum of psychosis. But what is the genetic basis of a continuum? What genetic advantage balances the biological disadvantage of psychosis? It is proposed that it is the single function that defines modern Homo sapiens - the capacity for language and that its anatomical correlate is the asymmetry (the "torque") of the human brain. The core symptoms of schizophrenia can be conceived as disorders (thought insertion and withdrawal) of the transition from thought to speech, and of the perception of speech (auditory hallucinations) and the extraction of meaning (delusions). Similarly the major affective syndromes can be considered as disorders of the initiation, control and affective interpretation of the symbols used in communication. Age of onset and sex are determinants of form of psychosis. Thus psychotic symptoms are the key to the hemispheric organisation of language.

S06.4
AXIS-I DISORDERS AND DIFFERENT LEVELS OF SUBPSYCHOTIC SYMPTOMATOLOGY

Suomela, Tanja, University of Turku, Department of Psychiatry, Turku, Finland; Korkeila, J.; Heinimaa, M.; Huttunen, J.; Ilonen, T., Ristkari, T.; McGlashan, Th.; Salokangas, R.K.R.

Background: Psychopathology that manifests during the prodromal phase of first-episode psychosis is various. Little is known about clinical diagnoses of the subjects who experience subthreshold psychotic symptoms. **Methods:** Samples of psychotic patients, first degree relatives of psychotic patients, treatment-seeking patients and a random community sample were assessed with the Structured Interview for Prodromal Symptoms (SIPS) and the SCID-I. Lifetime SCID-I diagnoses were compared within the whole sample after dividing subjects into four groups according to the severity of the subthreshold psychotic symptoms reported in the SIPS. **Results:** The number of the lifetime diagnoses received increased linearly as the symptomatology approached more psychotic-like phenomena. Subjects with lifetime subthreshold psychotic symptoms received 2,5 (mean) lifetime SCID-I diagnoses per subject. The mean number of lifetime SCID-I diagnoses among currently prodromal examinees was 2,9. Mood disorders and comorbid anxiety disorders were particularly common. **Conclusions:** Subthreshold psychotic symptoms are associated with a high number of lifetime Axis-I diagnoses. The amount of anxiety disorders is remarkable, and most subthreshold psychotic subjects can be diagnosed with a lifetime mood disorder. Subjects experiencing subthreshold psychotic symptoms require careful assessment of mood and anxiety symptoms and adequate treatment for their multiple disorders.

S06.5
FROM CATEGORICAL TO MULTI-DIMENSIONAL DIAGNOSIS IN MAJOR PSYCHIATRIC DISORDERS

Salokangas, Raimo, Turku University Department of Psychiatry, Turku, Finland

Since Emil Kraepelin, schizophrenia or dementia praecox has been divided into sub-diagnoses and separated from affective or manic-depressive disorders. However, in the 1930s, Jacob Kasanin showed that there are illness pictures, which resemble both schizophrenia and manic-depressive psychosis. In the 1980s, Tim Crow suggested that schizophrenia could be divided into two syndromes: Type I with positive symptoms and with a good outcome and Type II with negative symptoms and with poor outcomes. Later studies have proposed several additional symptom dimensions, such as positive, negative, disorganised, depressive-anxiety, neurocognitive deficit dimensions, which seem to be associated with patients' outcome. On the other hand, patients with uni- or bipolar depression may reveal psychotic first-rank symptoms as well as neurocognitive deficiencies. In the cases having both affective and psychotic symptoms, it is difficult to make a categorical distinction between schizophrenia and affective psychosis. Recent epidemiological studies on general population have also showed that there is a dimensional continuum between psychotic symptoms and frank psychosis. The essence of these major psychiatric disorders seems not to be categorical but dimensional. In clinical practice, categorical classification has not proved to be satisfactory. For example, psychiatrists do not treat schizophrenic or manic-depressive disorder itself but those of the symptoms or deficits the patients are revealing. Thus, both from scientific and practical point of view categorical diagnostic system seems to be unsatisfacto-

ry and should be replaced by a dimensional approach. Schizophrenia or manic-depressive disorders are not illness categories but crossroads of several symptom and deficit dimensions.

S06.6
COGNITIVE DYSFUNCTIONS AND SYMPTOMATOLOGY IN SCHIZOPHRENIA

Franck, Nicolas, Institute des Sciences Cognitives, Bron Cedex, France

Cognitive operations designate information processing underlying thoughts and actions. In the field of schizophrenia, studying cognitive operations can provide the link between abnormal brain structure and dysfunctioning on one hand and abnormal phenomenal experiences on the other hand. For example, positive symptoms of schizophrenia could be relevant to a dysfunction of the awareness of one's own action. Verbal hallucinations or delusions of influence could be related to a failure to attribute self produced thoughts or actions to their real origin. One possible explanation for this difficulty would arise from an impaired self-monitoring (Frith, 1992). This impairment would make patients unable to disentangle intentions that arise from external stimuli from those self-generated. Another hypothesis proposes that understanding actions performed by others could be based on internally simulation of those actions (Georgieff and Jeannerod, 1998). This theory is supported by the fact that different modalities of action representation share a subliminal activation of the motor system (Fadiga et al, 1995) and that cerebral activity during imagination, preparation and observation of a given action shows largely overlapping areas (Grèzes and Decety, 2001). The results of studies that evaluate the capacity of subjects to detect distortion between what they do and what they perceive show that patients with schizophrenia present impaired ability to correctly refer the origin of actions they perform (Frith, 1992; Franck et al, 2001). Regional cerebral blood flow recorded during a task of action attribution shows two main brain areas presenting a modulation of their activity in normal subject (Farrer et al, 2003), whereas no covariation is observed in patients (Farrer et al, in review).

SYMPOSIUM S07
Theoretical Fundaments of Clinical Diagnosis in Psychiatry

Chairs: Otto Doerr - Michael Schwartz
Friday, 20 June, 8.30-10.00 am - Schatzkammersaal

S07.1
MEDICAL AND ANTHROPOLOGICAL PERSPECTIVES ON PSYCHIATRIC DIAGNOSIS

Schwartz, Michael, University of Cleveland, Gates Mills, United States; Wiggins, Osborne P.

Psychiatric conditions can be approached in a variety of ways. In the modern era they are understood as having the basic form exhibited by other classes of illness: an ascertainable set of signs and symptoms expressing an ultimately disclosable etiology. Psychiatric conditions can also be conceived from an anthropological perspective. The anthropological perspective on mental disturbances allows for an approach to them that is broader and more inclusive than the medical standpoint because the latter takes the natural sciences to be the paradigms of knowledge. The anthropological perspective permits use of concepts, theories, and modes of reasoning characteristic of philosophy, the humanities, and the social sciences. These disciplines too are bound by their own rules of evidential justification and logical inference, but their rational methods may differ from those prevalent in chemistry, biology, and cognitive neuroscience. Central to the anthropological perspective is the thesis that there are *different ways of being human* due to differences in social history, culture, biology, and personal biography. The anthropological approach seeks to develop a comprehensive theory of the basic constituents of human existence. It does focus on biology and neurology, but it does so within a larger conception of the living organism. Moreover, the organism is viewed in terms of its essential relatedness to the world. From the anthropological perspective, mental disorders are viewed as ways of being human that are different in several crucial respects from others. The anthropological perspective on psychiatric conditions can undergird the medical one because the anthropological perspective can better specify what makes psychiatric conditions a pathology (namely, a being unable to experience and a being unable to behave), provides for a better understanding of them, and affords the clinician greater certainty in diagnosis. The anthropological perspective can also inform neuroscientific inquiry into brain correlates.

S07.2
ON THE LIMITS OF NATURALIZING THE MIND

Wiggins, Osborne P., Department of Philosophy, University of Louisville, United States; Schwartz, M.A.

In recent philosophy, special attention has been focused on the need to "naturalize" the mind. Within psychiatry, the mental disorders themselves are undergoing naturalization. Phenomenology, once considered the philosophical citadel of "pure consciousness", has been drawn into this concern with naturalizing the mental, and a book now bears the title *Naturalizing Phenomenology*. Since it is phenomenology that some seek to naturalize, we would like to take a phenomenological look at this project of naturalization. Our phenomenological interpretation of naturalization will adhere to the line of reasoning Edmund Husserl adopted in his last major text, *The Crisis of European Sciences and Transcendental Phenomenology*. Our exposition shall additionally utilize several formulations taken from Aron Gurwitsch. This contemporary concern with naturalization has a long history. That history is the history of modern *naturalism* itself. Naturalism as a metaphysical *Weltanschauung* requires that its adherents try to "naturalize" everything. There are numerous ways to express naturalism. We find W.V.O. Quine's formulation to be especially striking: "Physics is the arbiter of what is, that it is, and of what is not, that it is not". We suggest that it helps to slightly modify Quine's assertion as follows: "The natural sciences are the arbiter of what is, that it is, and of what is not, that it is not". Hence the mind, if it exists at all, must be explainable solely by the *concepts* and *laws* of the natural sciences, and such explanations must be based exclusively on the *methods* used by the natural sciences. In our essay, turning to a more phenomenological treatment of naturalism and naturalization, we shall trace naturalism back to the origins of the modern sciences of nature in seventeenth-century Europe. Within the context of the rise and development of these natural sciences, we shall critique the project of "naturalizing the mind".

S07.3
PHENOMENOLOGICAL VERSUS 'OBJECTIVE' DIAGNOSIS IN PSYCHIATRY, WITH SPECIAL REFERENCE TO OBSESSIVE-COMPULSIVE DISORDER
Dörr, Otto, University of Chile, Santiago, Chile

The current systems of classification and diagnosis in psychiatry attempt to imitate the model of somatic medicine, according to which the symptoms are the external or visible manifestation of an underlying pathological (invisible, but known) process: the illness. But the inference done by the somatic physician from the symptom to the underlying process is not possible in psychiatry since most of its diseases lack a known substrate. Modern psychiatry, empirically oriented, has attempted to obviate the problem by creating "operational criteria". So, diagnosis is made through the statement of a number of these criteria, which are definitely unspecific. This attitude neglects the personal and historical moment inherent to every human disease. A phenomenological diagnosis, not oriented to a supposed underlying illness, but to the "being ill of the person", could be contrasted with the "symptomatological" one. Its approach to the mental patient pretends an opening to the whole of the psychopathological phenomenon, e.g., a hallucination or an obsession. This allows in turn determining its specificity and its deviation degree with respect to a priori norms of the existence, such as temporality, spatiality, identity or interpersonal relationship. The author tries to demonstrate the previous regarding the so-called obsessive-compulsive disorder. A merely symptomatological approach finds these symptoms in the most different pathologies and ends up by interpreting these pictures as "co-morbidities", which in the case of major depression can reach up to 67%. Phenomenological diagnosis allows, on the contrary, discovering that which is specific of the obsessions in OCD, depression, schizophrenia and organic disorders.

S07.4
THE CONCEPT OF MENTAL DISEASE AS 'EXPROPRIATION' AND ITS RELEVANCE FOR CLINICAL DIAGNOSIS IN PSYCHIATRY
Pelegrina, Héctor, Spain

The concept of 'ex-propriation' is essential for the typification of any life process as pathological, being this biological or personal. On the somatic level, a structure or function is considered ill when it has lost its harmonic inherence to the self-constructing organic whole. On the behavioural level, a behaviour is considered pathological when the relationship organism-environment is not at the service of the renewal of material, energy or information, necessary for the preservation of the individual. The behaviour is pathological when it destroys the own and proper structures of a life system. On the contrary, it would be normal if it contributed to the preservation and development of the own life system, including the ecological niche, the organism and the appropriated behavioural structure. On the personal level, every psychopathological process is dynamically structured as an 'ex-propriation', or rather, as a 'dis-appropriation' activity in which the subject does not grasp something which is indispensable for his/her own being. In this process the person suffers the loss of some essential dimension of his/her own personal entity, e.g., it proves to be "ex-propriated", alienated. The alienated element of the personal 'dis-appropriation' is what appears as a symptom. The symptom is then something personal objectified as impersonal by the subject himself. So we may infer that neither the symptoms nor the syndromatic configurations constitute the true illness, since they are nothing but their externalized results. The true mental illness is the dynamic of depersonalisation through the process of dis-appropriation.

SYMPOSIUM S08
Classification of Sexual Disorders
WPA Section "Psychiatry and Human Sexuality"
Chairs: Rubén Hernández-Serrano - Antonio Pacheco-Palha
Friday, 20 June, 8.30-10.00 am - Erzherzog Karl Saal

S08.1
CONCEPTUAL BASES OF SEXUAL HEALTH
Pacheco-Palha, Antonio, Hospital San Joao, Porto, Portugal

A comprehensive definition of sexual health is presented and discussed having in mind the increasingly global arena for discussion of health concepts. Some historical landmarks are given before the presentation of the new advances in the physiological and psychological areas of human sexual responses. The ethical interpersonal and social cultural perspectives are explained inside the bio-phycho-socio-cultural approach of health. A short travel on the life cycle and sexual health is explored from infancy to older adulthood. Some considerations on Policy and Human Rights are stressed, namely what has happened in some international movement towards the assertion of specific sexual and reproductive rights including contraceptive choice. The problem of STD is considered as well as the role of international agencies, having the background of many documents which address human rights and their relationship with sexual health. Finally some comments and examples are done concerning the importance of communications and sexual health, particularly the doctor-patient relationship, the couple and family, the work place and the mass media. The problem of the education and professional training are dealt with at the end.

S08.2
DIAGNOSTIC FORMULATION
Berganza, Carlos, Private Clinic, Guatemala City, Guatemala

The need for a comprehensive approach to evaluation and diagnosis is, of course, not restricted to the case of sexual disorders. Such need has been articulated, in fact, for a number of disorders and even for the whole of psychopathology and human disease (Engel, 1977). The first comprehensive diagnostic models were termed multidimensional or multiaxial and were applied to general medicine (College of American Pathologists, 1977) and psychiatry [for a review see Mezzich, 1979]. They attempted to encourage the clinician to pay systematic attention to key informational domains by organizing the evaluation and diagnostic formulation along axes such as syndromes, etiology, adaptive functioning, stress and supports. Eventually, with various degrees of visibility, multiaxial models have been incorporated within contemporary classification systems such as the International Classification for Oncology (Percy et al, 1990), the mental health component of ICD-10 (World Health Organization, 1977), the American Psychiatric Association's DSM-IV (American Psychiatric Association, 1994), and the Cuban Glossary of Psychiatry (Otero, 1999). More recently, a comprehensive diagnostic model has been designed at the core of the World Psychiatric Association's *International Guidelines for Diagnostic Assessment (IGDA)* (World Psychiatric Association, 2000). This diagnostic model encompasses a standardized Multiaxial Formulation (I. Illness, II. Disabilities, III.

Contextual Factors, and IV. Quality of Life) and an Idiographic or Personalized Formulation. As part of the development of a World Psychiatric Association Educational Program on Sexual Health, an International Survey on Human Sexuality (Mezzich and Hernandez-Serrano, 1999) was conducted in 1999, with the participation of 187 qualified psychiatrists and 51 qualified sexologists from 75 different countries. Among its most prominent findings was the need for more professional training as well as patient and public education. Also importantly mentioned as key factors for dealing with sexual health were the comorbidity of sexual disorders, relationship issues, cultural, social and environmental factors, and ethical concerns. From the findings of this International Survey and the informed judgment of expert panels meeting in New York and Buenos Aires in 1999 and 2000, the need emerged for a comprehensive diagnostic approach to the evaluation of individuals experiencing sexual disorders. The components of such a comprehensive diagnostic model follows:

First Component: Standardized Multiaxial Formulation

A. Sexual Disorders (Sexual Dysfunctions, Paraphilias, and Gender Identity Disorders)
B. Other Mental and General Medical Disorders

II. Disabilities (social functioning)
III. Contextual Factors
IV. Quality of Life

Second Component: Idiographic or Personalized Formulation

This includes what is unique and meaningful as jointly perceived and formulated by the clinician, the patient, the couple, and the family. The areas covered are:

A. Contextualized Clinical Problems
B. Patient's Positive Factors
C. Expectations for Restoration and Promotion of Health

A comprehensive diagnostic model for sexual health that covers sexual disorders, their mental and general medical comorbidities, relationship and contextual factors, quality of life, and a complementary idiographic or personalized formulation is presented in the following sections. It is hoped that it will enhance scientific accuracy, therapeutic effectiveness, and ethical aspirations in this crucial area of human health.

S08.3
CONCEPTUALIZATION FIRST – CLASSIFICATION AFTER

Bianco, Fernando, Universidad Central, Caracas, Venezuela

The conceptualization of the field of sexology which came from clinical research data allowed us to conceptualize sexology as the field of knowledge that study gender(sex) and sexual function. The conceptualization of the physiological range at gender and sexual function level allowed the conceptualization of pathology in sexology. After the description of the physiologic aspects of the gender differentiation process the different pathologic entities were clinically characterized and properly classified. The same methodology was applied for the sexual function process. Clinical epidemiologic studies keep proving the extention of the field of sexology which coincides with the conceptualization made from the observational clinical research data. Application of these concepts to the therapeutic area allows the development of therapeutic programs in the field of sexology which are proving to be very effective.

S08.4
PARAPHILIAS: A PHENOMENOLOGICAL CLASSIFICATION

*Hernández-Serrano, Rubén, Universidad Central,
Caracas, Venezuela*

Paraphilias, before Sexual Aberrations, Perversions or Deviations, have been a subject for scientific study since old times. Kraft Ebing (1840-1902) initiated the work in describing in his Psychopathia Sexualis the fascinating world of sex and sexuality. Paradoxically we always speak about the bad or illegal aspects of sexuality, and this is a clear example. Since then, Freud, Money, Love, Francoeur, Boschi, Flores-Colombino and Hernandez-Serrano have written about different aspects of Paraphilias, trying to develop a formal and reliable classification. The task is enormous and every day increasing thanks to Internet. DSM-IV only mentions some of the most frequents types of non-accepted sexual behavior and ICD-10 only establishes the category F 52.7, Excessive Sexual Impulse, without mentioning any of the paraphilias and pointing out that research criteria, still to be developed, have to be used for their delimitation. This is another proof that scientific knowledge on sexual issues was completely neglected.

S08.5
DO WE NEED ALL THE PARAPHILIAS?

Kjaer, Reidar, Oslo, Norway

The ICD-10 diagnoses F-65.0 (fetishism), 65.1 (fetishistic transvestism) and 65.5 (sadomasochism) are no longer used in everyday Norwegian Psychiatry. But they still figure in the International and National ICD-10 manual. This paper addresses the pros and contras in the ongoing discussion about the revision of the diagnoses. A possible approach could be that national health authorities formally decide not to use these diagnoses, as was done in Denmark with 65.5 in 1995, and propose to delete them from the ICD list at the next revision. Parts of this discussion can be followed on the website www.revisef65.org.

SYMPOSIUM S09
Mental Disorders in Women: Do They Need a Special Place in Classification Systems

WPA Section "Women's Mental Health"

Chairs: Anita Riecher-Rössler - Jules Angst

Friday, 20 June, 2.00-3.30 pm - Zeremoniensaal

S09.1
MENTAL DISORDERS IN WOMEN: ARE THERE DIAGNOSTIC CRITERIA RELEVANT FOR GENDER-SPECIFIC DIAGNOSES?

Dilling, Horst, University Psychiatric Hospital, Lübeck, Germany

Most epidemiological studies have shown that there are differences in the morbidity of male and female persons concerning psychiatric disorders, e.g. in disorders due to use of alcohol or in depressive states. These findings could hint at subgroups with gender-specific characteristics and thus a necessity to establish new diagnostic entities. Are there diagnoses in our classifications, ICD-10 and DSM-IV, that are only applied to females or which are almost exclusively found in females? Could we imagine further criteria for women and

their diagnoses apart from those that are linked to menstruation or puerperium? The conclusion will be that gender-prone diagnoses can be observed in several disorders, and these specific entities will have to be discussed. Hereditary factors and life-time morbidity will also have to be taken into consideration.

S09.2
GENDER DIFFERENCES IN DEPRESSION: THE IMPACT OF SOFT BIPOLARITY, ATYPICAL FEATURES, SEVERITY, IMPAIRMENT AND AGE (THE MENOPAUSE)

Angst, Jules, University Psychiatric Hospital, Zurich, Switzerland; Gamma, A.

Objectives: 1) To demonstrate that depression is heterogeneous and that gender differences vary widely between subgroups. 2) To examine the impact of diagnostic criteria (severity, impairment) and age on the diagnostic classification. **Methods:** The results of two epidemiological studies (the European DEPRES study and the prospective Zurich cohort study) and of a lifelong clinical follow-up study of hospital admissions will be reviewed and discussed. **Results:** Within unipolar depression, the gender ratio f:m is highest in severe major depression and relatively low in mild depression. In the bipolar spectrum, it is higher in bipolar II than in bipolar I and lowest in manic disorders with mild or no depression. Our data showed that atypical depression, considered the typically predominantly female form of the disorder, largely explained the gender difference. A minor contributing factor was women's higher symptom reporting even when stratified by impairment. **Conclusions:** The established finding that worldwide more women than men suffer from depression is not in question. But that finding is not differentiated enough to provide a fruitful basis for testable hypotheses. Good epidemiological data on subgroups of depression is still scarce. A more complex subclassification of depression by psychopathology and severity can significantly contribute to the explanation of gender differences.

S09.3
GENDER DIFFERENCES IN DIAGNOSTIC THRESHOLDS - INFLUENCE OF THERAPIST'S SEX

Stoppe, Gabriela, University Psychiatric Hospital, Göttingen, Germany

Objective: We performed a study to answer the question whether identical symptom presentations of depression in a male and female patient lead to similar recognition rates of depression in primary care. **Methods:** We performed a survey in primary care. Two written case vignettes were presented to 170 family physicians in a face-to-face interview which took place in their practices. The case vignettes described either a mildly depressed otherwise healthy old patient (case 1) or a severely depressed patient with somatic comorbidity (case 2). For each case different versions with regard to patient's gender were used: in case 1 only the gender of patient varied, in case 2 both the gender and the anamnesis (stroke/hypothyroidism) varied. Afterwards the interviewers asked standardized open questions. The physicians were not aware of the mental health focus and the gender focus of the study. **Results**: The study is representative with a response rate of 77.6%. For primary diagnosis, the female versions got the depression diagnosis more often. There was a non-significant trend for female physicians to consider depression more often, however also more in females than in males. **Conclusions:** The results show that gender related experience and stereotypes on the physicians' side influence the diagnosis of (old age) depression in primary care.

S09.4
POSTPARTUM DEPRESSION - DO WE STILL NEED THIS DIAGNOSTIC TERM?

Riecher-Rössler, Anita, University Psychiatric Outpatient Department, Switzerland

Objective: The diagnostic term "postpartum depression" is still widely used. It will be discussed if this is still justified in the light of recent research. **Methods:** Comprehensive review of literature. **Results:** Postpartum depression is not a specific entity in terms of having a specific aetiology. Rather, giving birth to a child with all its biological and psychosocial consequences seems to act as a major stressor, which - within a general vulnerability-stress-model - can trigger the outbreak of the disease in predisposed women. Nevertheless, it might still be justified to continue the use of this diagnostic term, as depression in early motherhood confronts us with specific needs. Thus, help-seeking is often delayed due to shame and stigma, and diagnosis is often missed due to misinterpretation of symptoms. Services often do not adequately meet these women's needs, as they do not take into account their specific situation, problems and fears. Untreated postpartum depression can have especially severe long term consequences, not only for the mother, but also for the child and the whole family. Therefore, special attention and special treatment is necessary. This means modifications of our pharmacological, non-pharmacological and psychotherapeutic treatment and also provision of new low-threshold mother-infant services. **Conclusions:** Although postpartum depression is not a specific entity from an aetiological point of view, the term should not be abandoned, but should still be used as a "specifier" as in DSM-IV, as depression in the postpartum period confronts us with specific needs.

SYMPOSIUM S10
Pathogenetic Factors in Diagnostic Decisions

Chairs: Cyril Höschl - Jiri Horacek

Friday, 20 June, 2.00-3.30 pm - Rittersaal

S10.1
IS THERE AN ASSOCIATION BETWEEN BORRELIA BURGDORFERI INFECTION AND PSYCHIATRIC MORBIDITY?

Hájek, Tomás, Prague Psychiatric Center and Charles University, 3rd Faculty of Medicine, Prague, Czech Republic; Pasková, B.; Janovská, D.; Bahbouh, R.; Hájek, P.; Libiger, J.; Höschl, C.; Martin, A.

Borrelia burgdorferi (Bb) infection can affect the central nervous system and mimic psychiatric disorders. We compared the prevalence of antibodies to Bb in psychiatric and healthy groups to find out whether there is an association between Bb and psychiatric morbidity and whether seropositive and seronegative patients differ in demographic and clinical variables. Between 1995 and 1999, 926 consecutive psychiatric patients admitted to Prague Psychiatric Center were screened for antibodies to Bb and compared with findings from 886 consecutive healthy subjects. Sera were tested by the enzyme-linked immunosorbent assay. Circulating immune complexes were isolated by polyethylene glycol precipitation. To control for potential confounders, we matched the two groups according to gender and age. Results were obtained in a sample of 499 matched pairs. 33% of psychiatric patients and 19% of healthy control subjects were positive in at least one of the four assays (test for equality

of two proportions, U= 5.3, p <0.001). Bb infection rates were uniformly increased in all main diagnostic categories (schizophrenia, mood, anxiety and personality disorders). Seropositive subjects were significantly younger than seronegative ones and there was a difference in this respect between psychiatric patients and controls. There were no significant differences between seropositive and seronegative psychiatric patients in hospitalization length, proportion of previously hospitalized patients and proportion of patients with family history of psychiatric disorders. These findings support the hypothesis that there is an association between Bb infection and psychiatric morbidity.

S10.2
COMT GENOTYPE AND BRAIN METABOLISM (PET) IN SCHIZOPHRENIA WITH RESPECT TO COGNITIVE FUNCTIONS: DIAGNOSTIC IMPLICATIONS

Horacek, Jiri, Center of Neuropsychiatric Studies and Psychiatric Center, Prague, Czech Republic; Kopecek, M.; Höschl, C.; Beranek, M.; Belohlavek, O.

Dopamine is postsynaptically broken down by catechol-O-methyl transferase (COMT). The genetic polymorphism at codon 158 of the COMT gene (22q11.2) influences COMT catalytic activity. COMT Val/Val genotype is able to inactivate released dopamine more rapidly comparing with the Met/Met genotype. The influence of COMT polymorphism is more important in prefrontal cortex than in striatum. Decreased prefrontal glucose metabolism is connected with negative symptoms and cognitive dysfunction of schizophrenia. The goal of our study was to determine the role of COMT polymorphism and dopamine action in the prefrontal metabolism and information processing. We tested the hypotheses whether COMT polymorphism regulates the prefrontal metabolism and if it is involved in psychopathology and cognitive outcome in a group of schizophrenic subjects (n=42). The resting metabolism was evaluated by the ^{18}fluoro-deoxyglucose positron emission tomography (PET) and DNA analysis was based on polymerase chain reaction determining the Val-Met polymorphism in the COMT gene. In the subgroup of Met/Met homozygotes we found a higher glucose metabolism in dorsolateral prefrontal cortex bilaterally (Inferior Frontal Gyrus, Brodmann areas 9 and 47, p = 0.001) compared with the Val/Val subgroup. Also, the cognitive outcome was influenced by the COMT polymorphism. Our data confirm the hypothesis that a higher dopamine level (given by the Met/Met COMT allele) is connected with a higher metabolism in prefrontal cortex and with a better cognitive outcome in schizophrenia. Diagnostic and treatment implications are discussed.

This project was supported by the grants CNS LN00B122 MSMT CR and IGA NF/6033-3/2000 MZ CR.

S10.3
CUE-INDUCED ACTIVATION OF THE BASAL GANGLIA IS ASSOCIATED WITH THE RELAPSE RISK IN ABSTINENT ALCOHOLICS

Heinz, Andreas, Humboldt University, Berlin, Germany; Braus, D.F.; Grüsser, S.M.; Wrase, J.; Klein, S.; Hermann, D.; Henn, F.A.; Flor, H.

Background: Animal experiments have provided evidence that the maintenance of drug intake may be associated with neuroadaptive changes in the basal ganglia. Cue-induced activation of the striatum may trigger relapse in alcohol and drug addiction. **Methods:** Functional magnetic resonance imaging and visual alcohol-associated and control cues were used to assess brain activation in ten abstinent alcoholics and control subjects. Patients were followed for three months and alcohol intake was recorded. **Results:** Alcohol-related but not neutral cues activated the putamen, medial, middle and superior frontal gyrus and the anterior cingulate gyrus in alcoholic patients compared with control subjects. The amount of subsequent alcohol intake within the next three months was exclusively predicted by cue-induced activation of the putamen. **Discussion:** Activation of the anterior cingulate may be associated with attribution of attention to drug-related cues, while cue-induced activation of the putamen may trigger habitual alcohol intake. These results point to brain areas that may mediate cue-induced relapse in alcoholism.

S10.4
VIRUS HYPOTHESES OF SCHIZOPHRENIA: DIAGNOSTIC RELEVANCE

Sperner-Unterweger, Barbara, Department of Biological Psychiatry, Innsbruck University Clinics, Austria

Schizophrenia is regarded as a vastly heterogeneous disorder with a still unknown etiopathogenesis. Many findings have, however, suggested that organic factors contribute to the manifestation and the course of this disease. Among these, genetic and environmental factors as well as immunological alterations have been indicated to be of importance. Immunological hypotheses in schizophrenia are supported by a large number of different immune alterations which have been reported during the last decades. Although most of these results are controversial, there are still some hints that viral infections might be considered as a possible pathogenetic factor at least for a diagnostic subgroup of schizophrenia patients. In this context, it has recently been postulated, on the basis of clinical and epidemiological observations, that retroviruses might play a role. Another interesting approach in this field, besides searching for a specific infectious agent, is represented by building up a more comprehensive theory that integrates genetic, neurodevelopmental, environmental, immune and neuropsychological features of the disease. For example: viral infections during pregnancy could affect different brain structures to a varying extent depending on the timing of the infection and on host factors. The latter include immunogenetics and the neurocircuitry reserve as well as specifically altered immune responses. Consequently, these variables could give rise to multiple disease subtypes. Identifying diagnostic subgroups according to different pathogenetic processes could eventually also lead to more specific treatment strategies.

SYMPOSIUM S11
How Does Biology Interfere with Mood Disorders?

Chairs: Alan Schatzberg - David J. Kupfer

Friday, 20 June, 2.00-3.30 pm - Geheime Ratsstube

S11.1
CLASSIFICATION OF MAJOR DEPRESSION IN THE MEDICALLY ILL

Evans, Dwight L., United States

Abstract not received

S11.2
EARLY ABUSE AND HPA AXIS DYSREGULATION IN MAJOR DEPRESSION

Nemeroff, C.B., Emory University School of Medicine, Department of Psychiatry and Behavioral Sciences, Atlanta, United States

There is considerable evidence that early untoward life stress, including child abuse and/or neglect, is associated with an increase in the prevalence rate of depression in adulthood. This presentation will summarize a series of preclinical studies and a clinical study, which all provide congruent results suggesting that CRF-containing neurons are rendered persistently supersensitive to stress after exposure to neonatal stress. Previous studies have clearly documented CRF neuronal hyperactivity in drug-free depressed patients as evidenced by hypothalamic-pituitary-adrenal (HPA) axis hyperactivity and increased cerebrospinal fluid (CSF) CRF concentrations. These CRF alterations are reduced by successful treatment of depression with ECT or fluoxetine. In an animal model of early untoward life stress in rats, maternal separation, we have repeatedly demonstrated long lasting hyperactivity of the HPA axis, as well as increases in CRF mRNA expression in the PVN, central nucleus of the amygdala and bed nucleus of the stria terminalis, CSF CRF concentrations and behavioral alterations reminiscent of depression. Similar findings were found in a bonnet macaque model of early stress. Treatment of adult rats exposed to neonatal maternal deprivation with paroxetine, the SSRI antidepressant, reverses these measures of HPA axis hyperactivity and CRF neuronal hyperactivity. Clinical studies in depressed women with a history of sexual abuse in childhood or adolescence reveal an increased HPA axis response to stress. These data, taken together, support the CRF hypothesis of depression and suggest that alterations in CRF neurons mediate the effects of early trauma in increasing an individual's vulnerability to depression. The therapeutic implications of these findings will be discussed.

S11.3
ZEITGEBERS AND THE CLASSIFICATION OF BIPOLAR DISORDERS

Kupfer, David J., University of Pittsburgh School of Medicine, Department of Psychiatry, Pittsburgh, United States

The classification of bipolar disorders is considerably more complex than the traditional overall classification of mood disorders. It was once thought that patients with bipolar disease had primarily discrete episodes of mania or depression that sometimes occurred with the frequency to be considered rapid cycling. Within the last 15-20 years, it has become clear that even bipolar I disorders (at least one discrete episode of mania) have several subtypes which can occur in the same person in a non-predictable pattern.

This presentation will focus on the primary subgroups of bipolar I disorder and how our new understanding of these subgroups is affecting our treatment recommendations and guidelines. The confluence of biologic and environmental factors plays a major role in determining the diagnostic and prognostic characteristics of the bipolar subgroups.

A second aim of this presentation is to review the impact of bipolar II and bipolar-spectrum subgroups which may play an important role in the overall classification of mood disorders and our ability to achieve successful recovery from depressive episodes.

S11.4
HPA AXIS DYSREGULATION, COGNITION, AND DIAGNOSIS OF PSYCHOTIC MAJOR DEPRESSION

Schatzberg, Alan F., United States; Posener, J.; Flores, B.; Solveson, B.; De Batista, C.

Over the past two decades considerable data have emerged that psychotic major depression (PMD) is a distinct subtype of depression. The disorder can be difficult to diagnose since patients often deny or hide their psychotic symptoms. This talk reviews data on two important facets of the disorder: hypothalamic-pituitary-adrenal (HPA) axis activity and cognition. Data indicate that patients with PMD, as compared with non-PMD subjects, have markedly elevated HPA axis activity as evidenced by elevated plasma cortisol levels, high rates of dexamethasone nonsuppression, extremely high post-dexamethasone cortisol levels, and high plasma ACTH levels. Recent studies indicate that PMD patients also demonstrate marked abnormalities in cognitive functions thought to be mediated by the prefrontal cortex, anterior cingulate, and medial temporal/hippocampal regions. Possible role excessive glucocorticoids play in these deficits is discussed as is the potential use of neuropsychological tests for developing new criteria or tests for diagnosing PMD.

SYMPOSIUM S12
Structural and Functional Neuroimaging in Psychosis and Affective Disorders - Implications for Diagnosis and Treatment Response

Chairs: Johannes Tauscher - Jeffrey H. Meyer

Friday, 20 June, 2.00-3.30 pm - Trabantenstube

S12.1
BRAIN DATA BASES BEYOND NOSOLOGY: SPECIFICITY OF BRAIN ALTERATIONS AND CONCEPTS OF PSYCHIATRIC DISORDERS

Meisenzahl, E.M., Psychiatrische Klinik der LMU München, Munich, Germany

During the last decade intensive research focused on putative structural brain abnormalities in psychiatric diseases, which may be part of their primary pathogenesis. Neuroimaging studies showed enlarged ventricles and reduced hippocampal volume in schizophrenia. Research in affective disorders and first results in personality disorders and post traumatic stress disorder showed similar structural brain changes.

These results lead to a basic question regarding the specificity of neuroimaging results: What is the importance of such brain abnormalities? Are they a hint for a shared pathophysiologic pathway, or is there a need for revisiting current nosologic concepts? The current presentation will focus on answering these questions by means of a large brain database across nosologic entities consisting of 360 brain MR datasets.

S12.2
ARE MONOAMINE TRANSPORTERS A SOURCE OF MONOAMINE LOSS DURING DEPRESSION? AN INTERPRETATION OF PET IMAGING DATA

Meyer, Jeffrey H., Centre for Addiction and Mental Health, University of Toronto, Toronto, Canada

Monoamine transporters have an important role in regulating extracellular monoamines. In the past, monoamine transporters during depression and suicide were only studied using post mortem techniques. Recently, selective radiotracers for positron emission tomography (PET) imaging of serotonin and dopamine transporters were developed. This technology can be applied to investigate the relationship between specific transporters and specific symptoms. In this presentation, the relationship between negativistic thinking (elevated dysfunctional attitudes) and the serotonin transporter binding potential (5-HTT BP) as well as the relationship between motor retardation and the dopamine transporter binding potential (DAT BP) will be shown. These studies sampled depressed subjects who were drug free (3 months or naive), non-smoking and who had no co-morbid axis I diagnoses. In these studies, we found that low regional transporter BP was associated with minimal symptom severity and greater regional transporter BP was associated with greater symptom severity. These investigations argue that serotonin and dopamine transporters have an important role as vulnerability factors for specific symptoms during depressive episodes.

S12.3
IMAGING DRUG EFFECTS WITH PET: FROM NOSOLOGY TO BIOLOGY

Gründer, Gerhard, Department of Psychiatry, University of Mainz, Mainz, Germany

This presentation will focus on the evaluation of drug effects in schizophrenic patients as assessed with PET and a variety of radiotracers. Using [^{18}F]FDOPA PET, we have demonstrated that subchronic treatment with haloperidol decreased the dopamine synthesis capacity (k_3^D) in brain of schizophrenic patients. Decrease of k_3^D in thalamus was highly significantly correlated with improvement of negative symptoms. The binding of various "atypical" antipsychotics (amisulpride, aripiprazole, clozapine, ziprasidone) to striatal and extrastriatal D_2-like dopamine receptors was characterized with [^{18}F]desmethoxyfallypride and [^{18}F]fallypride, respectively, in larger patient samples in comparison to normal controls. These studies not only clearly show that there are markedly different binding characteristics of these compounds; they also help to further elaborate hypotheses regarding the essential pharmacological properties of this heterogeneous class of drugs. The results of these studies will be discussed with regard to possible mechanisms of action including combined D_2/5-HT_2 antagonism, preferential mesolimbic binding, fast dissociation from the D_2 receptor, and partial dopamine receptor agonism. Finally, in order to elucidate the functional circuitry between the cortex and the thalamus in humans, we studied regional cerebral glucose metabolism with [^{18}F]FDG PET, while simultaneously recording the EEG, both before and after a lorazepam challenge. This paradigm was established in normals and recently applied to alcoholics and subjects at risk for alcoholism. We propose this paradigm as a model for the nosology-independent evaluation of cortico-thalamo-cortical circuits in neuropsychiatric disorders. PET like no other method is suitable to display in human brain *in vivo* the profound effects of psychotropic drugs.

S12.4
NEUROIMAGING OF THE SEROTONIN SYSTEM IN PSYCHOSIS AND AFFECTIVE DISORDERS – IMPLICATIONS FOR NEUROPSYCHOPHARMACOLOGY

Tauscher, Johannes, Department of General Psychiatry, University of Vienna, Austria

The serotonin system plays a crucial role in modulating symptoms of psychosis and affective disorders. With modern neurotransmitter receptor imaging techniques such as positron emission tomography and single photon emission tomography, characteristic disturbances of the serotonergic neurotransmission could be shown for schizophrenia, depression, eating disorders and personality disorders. Thus, possible targets for new neuropsychopharmacological treatment approaches may be identified. Further to that, these novel techniques provide a milestone in neuropsychopharmacology research because they provide a rationale for dose finding studies at the synaptic/molecular level. The relevance of these findings for the diagnosis of psychiatric disorders, and new emerging views about diagnostic entities will be discussed.

SYMPOSIUM S13
Diagnosis for the Person: Exploring the Levels of the Model
WPA Section "Classification, Diagnostic Assessment & Nomenclature"

Chairs: Juan Mezzich - Carlos E. Berganza

Friday, 20 June, 2.00-3.30 pm - Radetzky Appartement

S13.1
STANDARDIZED MULTIAXIAL PRESENTATION: I. CLINICAL DISORDERS

Banzato, Claudio, State University of Campinas, Campinas, Brazil

A major challenge still facing psychiatric diagnosis is to find out how to deal with the intentionally loose concept 'mental disorder' in a theoretically fruitful way. There are at stake here the boundaries between normal and pathological, as well as the boundaries within the highly heterogeneous group constituted by mental disorders themselves. Frontiers with normality seem to be somewhat blurred, indicating that continuity from normality may be the rule. Furthermore, the very *disease entity* concept is yet to be empirically corroborated for most mental disorders (Kendell and Jablensky, 2003). That is why it is vitally important to clarify what we mean by 'mental disorder' and how we actually use such concept (Fulford, 2002). Other key aspects to advance the diagnostic field include: 1. The current descriptive approach, focusing mainly on behavior, tends to reify not only diagnostic categories but also symptoms, overlooking the complex subjective dimension of experience (object of psychopathology). 2. The influence of the nosographic systems and nomenclatures on shaping subjective experience itself should be better examined. Hacking conceptualizes this phenomenon as looping effects of interactive kinds (people react to the way they are classified, not necessarily in a predictable way) (Hacking, 1999). While background itself changes, mental disorders would be like moving targets. 3. Sophisticated models of causality are needed to give a meaningful causal account of mental disorders. The INUS conditions (insufficient but nonredundant part of an unnecessary but sufficient condition) (Mackie, 1974) could illuminate the role of many factors (of several kinds) in the pathogenesis of mental disorders.

S13.2
STANDARDIZED MULTIAXIAL FORMULATION: II. FUNCTIONING AND DISABILITY

Üstün, T. Bedirhan, Classification Assessment Surveys and Terminology - WHO - Geneva, Switzerland; Chatterji, Somnath

Diagnosis entails multiple axes which formulate (1) a disease entity that corresponds to an underlying pathological process; (2) consequences of the disease in terms of functioning of the individual at body, person and society level; (3) impact of this disorder on the overall "Quality of Life" of the individual. This multi-axial formulation of diagnosis calls for independent, non-overlapping definition of these constructs and their respective measurement. Such formulation will clean the understanding of pathology since the "cause" and "effect" are to be defined in two different axes. While this is usually the case in so-called physical disorders, it is somehow confounded in the definition of mental disorders. We should therefore pay extra attention to define the mental disorders and any functional limitation on separate axes. Such a formulation will not only create a fair basis for understanding the mental disorders as brain diseases, but also provide parity for comparison with physical disorders. The WHO Family of International Classifications (i.e. International Classification of Diseases - ICD and International Classification of Functioning, Disability and Health - ICF) provide an operational basis to describe the disease and disability phenomena separately across all disorders. ICD provides an etiological and descriptive basis for the signs and symptoms of mental disorders whereas ICF provides a tool to give a profile of the individual in different domains of life such as cognition, mobility, self-care, work and usual activities and social participation. WHO has developed tools and instruments such as the ICF Checklist and WHO-DAS that can be used in practice to define and measure these domains. Such distinct measurements increase our ability to explain the health services variables such as needs, utilization, outcomes and costs in a better fashion.

S13.3
STANDARDIZED MULTIAXIAL FORMULATION: III. CONTEXTUAL FACTORS

Kastrup, Marianne, Centre Transcultural Psychiatry, Psychiatric Department Rigshospitalet, Copenhagen, Denmark

Multiaxial classifications have multiplied over the last decades reflecting a shift in attitude towards thoroughness and comprehensiveness in the psychiatric classification. From an international perspective searching for a balance between cultural diversity and universal standards, multiaxial classification is highly relevant. The prevailing classifications have developed multiaxial formulations. In the DSM system, a 5-axial approach has been chosen comprising psychiatric syndrome, personality, physical disorders, psychosocial stressors and global functioning. In the ICD-10, a tri-axial approach has been chosen with axes on psychiatric and somatic syndromes including personality aspects, adaptive functioning and circumstantial factors. In the International Guidelines for Diagnostic Assessment the ICD-10 tri-axial approach has been revised with the addition of an axis related to quality-of-life. In all these classifications one of the axes focuses on factors related to contextual, environmental and psycho-social aspects as well as problems related to lifestyle and life management. The paper will discuss the weaknesses and strengths of an axis assessing the contextual universe.

S13.4
STANDARDIZED MULTIAXIAL PRESENTATION: IV. QUALITY OF LIFE

Katschnig, Heinz, University of Vienna, Vienna, Austria

The concept of "quality of life" was introduced into medicine in the 1970s as a strategy to promote the subjective perspective of the patient as opposed to the then increasing reductionistic attitude of medicine. Oncology was the forerunner in this respect, and a slogan of the time was "add life to years and not only years to life". When assessing quality of life in mental disorders, it is useful to distinguish three dimensions: (1) subjective well-being, (2) functioning in daily life (self-care and social roles) and (3) external resources (material and social, whereby the former is often referred to as "standard of living"). Dimensions (2) and (3) are necessary complements to the assessment of well-being, since well-being might be contaminated by psychopathology (e.g. in mania or depression) and since functioning and the availability of resources "today" contribute to a person's quality of life of "tomorrow". Strategies for improving the quality of life of a person suffering from mental illness must incorporate all three dimensions, because each of them requires specific approaches. Also, improvement in one dimension can lead to improvement in the other two. Not the least reason for incorporating quality of life into a multiaxial diagnostic system is that it is becoming a powerful concept on the societal level, since all parties involved in health care – consumers, family members, professionals, administrators, politicians and even the health industry – agree that the improvement of quality of life should be a common aim of all health efforts.

S13.5
IDIOGRAPHIC DIAGNOSTIC FORMULATION

Mezzich, Juan E., International Center for Mental Health, Mount Sinai School of Medicine, New York, United States

This is a component of the comprehensive diagnostic model incorporated in the WPA International Guidelines for Diagnostic Assessment. It complements the standardized multiaxial formulation through a narrative statement focused on what is unique and most meaningful clinically for the patient and family. The elements of the Idiographic Formulation follow: 1) Contextualized clinical problems, 2) Patient's positive factors for clinical care, and 3) Expectations for health restoration and health promotion.

SYMPOSIUM S14
Validation of Clinical Diagnoses: An Epidemiological Approach

Chairs: Martin Preisig - Johannes Wancata

Friday, 20 June, 2.00-3.30 pm - Künstlerzimmer

S14.1
ARE THE DSM-III-R SUB-TYPES OF DEMENTIA USEFUL? RESULTS POOLED FROM TWO EPIDEMIOLOGICAL SURVEYS

Wancata, Johannes, University of Vienna, Department of Psychiatry, Vienna, Austria; Benda, N.; Alexandrowicz, R.

Background: Several studies reported that patients suffering from "uncomplicated" dementia (i.e. not classified as a sub-type of dementia "with delusions" or "with depression") frequently exhibit non-cognitive symptoms such as aggression, irritability, and hallucinations. **Methods:** Data from two psychiatric surveys in Austria in nursing homes (N=249) and among medical in-patients (N=372) were used. Patients were interviewed by trained psychiatrists using the Clinical Interview Schedule. Diagnoses were given according to DSM-III-R. Demented patients with co-morbid psychiatric conditions or dementia "with delirium" were excluded. For the analyses of the non-cognitive symptomatology, only moderate, marked and severe symptoms observed during the interview were included (i.e. mild symptoms were excluded). **Results:** Of those with "uncomplicated" dementia, more than 80% exhibited any non-cognitive symptoms, while all demented "with depression" and all of those "with delusions" had such symptoms. If only marked and severe symptoms were considered, more than 20% of those with "uncomplicated" dementia had such symptoms. Cluster analysis yielded for each of the two samples 4 clusters (uncomplicated, depressive, paranoid-hallucinatory, and paranoid-depressive clusters). For both samples, the first 3 clusters show a high agreement with the corresponding dementia sub-types. Persons belonging to the paranoid-depressive cluster were diagnosed by psychiatrists usually as suffering either from "depression" or from "delusions" sub-type according to DSM-III-R. **Conclusions:** Our results suggest that there exist a further sub-type of dementia with a paranoid-depressive symptomatology. Analyses among the general population are necessary to confirm these findings.

S14.2
HEART COMPLAINTS AND DEPRESSION IN THE ZURICH STUDY

Eich-Höchli, Dominique, Zurich University Psychiatric Hospital, Social Psychiatry Research Group, Zurich, Switzerland; Neuhaus, C.; Ajdacic-Gross, V.; Gamma, A.; Angst, J.; Rössler, W.

Objective: To investigate whether major depression among other depressive disorders figures as a predictor of later heart complaints. **Methods:** In a community study conducted between 1979 and 1999, a representative stratified sample of 591 subjects was interviewed 6 times between the ages of 20 and 40, 278 persons participating in all interviews. In this analysis heart complaints in 1999 were compared with putative predictive variables assessed in previous interviews. The data were examined by bivariate and multivariate analyses. **Results:** Heart problems were indicated by 83 persons, chest pain by 37 and palpitations by 18 persons. In bivariate analyses, heart complaints were significantly correlated with smoking and a BMI above 25 in 1988 as well as with major depression. No correlations were found with gender, practice of sports, circulatory problems, caffeine intake, minor depression and recurrent brief depression. In the logistic regression model, later heart complaints were predicted by major depression and earlier heart complaints. Furthermore, the higher the smoking was in the previous years, the more heart problems were indicated. **Conclusions:** The findings suggest that major depression (but not minor depression and recurrent brief depression), heart complaints as well as the quantity of nicotine intake in a younger age are predictors for later heart complaints.

S14.3
DIAGNOSTIC ISSUES OF LATE LIFE DEPRESSION: EXPERIENCES WITH QUESTIONNAIRE SCREENING AND STRUCTURED PSYCHIATRIC INTERVIEW OF A REPRESENTATIVE POPULATION

Kovács, Mónika, Semmelweis University, Institute of Behavioural Sciences, Budapest, Hungary; Purebl, G.; Kopp, M.; Szádóczky, E.; Rózsa, S.

Aims and methods: To compare the prevalence of late life depression in Hungary measured by the shortened version of the Beck Depression Inventory (BDI) according to the data of a national representative health survey of the adult population (Kopp et al, 2002, N=12688), and by the Diagnostic Interview Schedule (DIS) in a representative sample of 2953 adults (16-65 years) (Szádóczky et al, 1995). **Results:** The rate of depressive symptomatology was increased by age, and was significantly higher in those above 60 years, than in those under: BDI≥10 (mild to severe): 41.3% vs. 23.7%, BDI≥19 (moderate to severe, clinically significant): 22.9% vs. 9.9%. The one-month prevalence of major depressive episode (DIS) was the highest in the 45-54 age group (3.1%), and was lower in those aged 55-64 years (2.3%), however there is no data of those above 65. **Discussion:** Differences between the prevalences are higher than that explained by the finding that BDI measures about 2.5 times more subjects as depressed than the DIS. Further explanations of the differences might be: 1) There are relatively more minor, atypical depression, not fulfilling the diagnostic criteria in the older; 2) Symptom profile of depression might be different in late life: depressed mood itself is sometimes less pronounced, while other symptoms – somatic complaints, hypochondria, working disability, sleep disturbances, fatigue, cognitive dysfunctioning, etc. – are more often present. 3) Items of symptoms relatively more pronounced in older depressed persons compared to younger ones are over-represented in the BDI. **Conclusions:** Although the rate of depressive syndromes meeting the strict diagnostic criteria seems to decrease with advanced age, that of depressive symptomatology with significant functional impairment seems to increase. Consequent research and clinical issues should be considered.

S14.4
GENDER DIFFERENCES IN THE EPIDEMIOLOGY OF DEPRESSION – FACTS AND POSSIBLE EXPLANATIONS

Kuehner, Christine, Central Institute of Mental Health, Division of Genetic Epidemiology in Psychiatry, Germany

Background: A number of recent large-scale studies from community and primary care settings report on the prevalence of unipolar depression including new data on the sex distribution of the disorder. **Objective:** To give an update on epidemiological findings on sex differences in the prevalence of unipolar depression and putative risk

factors. **Methods:** Systematic review of the literature. **Results:** Recent epidemiological research yields additional evidence for a female preponderance in unipolar depression, holding true across different cultural settings. Current explanations deal with artefacts, genetic, hormonal, psychological and psychosocial risk factors. Rather consistently, intrapsychic and psychosocial risk factors related to women's gender role have been identified which may contribute to the higher depression risk in women. Gender role specific aspects have also been found to be reflected in endocrine stress reactions and possibly influence associated neuropsychological processes. **Conclusions:** There is a need for more integrative models considering psychological, psychosocial, and macrosocial risk factors and their interactions, which should also connect these factors with psychophysiological and endocrine responses. Furthermore, it is conceivable that across life spans, as well as across cultural settings, individual risk factors will add with varying emphasis to the higher prevalence of depression in women.

S14.5
SUBTHRESHOLD MOOD DIAGNOSES: DO THEY AGGREGATE IN FAMILIES?

Preisig, Martin, Département Universitaire de Psychiatrie Adulte, Prilly-Lausanne, Switzerland; Ferrero, F.

Objective: As a consequence of recent epidemiological studies of mood syndromes that argued for a more dimensional approach to the classification of depression, the definition of subthreshold syndromes of mood disorders has gained increasing interest. One important validator criterion for diagnostic categories in psychiatry is the degree of familial aggregation of a postulated disorder. **Methods**: As part of a family study on mood disorders, we recruited 156 probands with bipolar or schizoaffective bipolar disorder, 28 with subthreshold bipolar disorder, 116 with major depressive disorders, 13 with subthreshold depressive disorder and 73 medical controls, with their 1478 adult first-degree relatives. Diagnostic assessment according to a best estimate procedure was based on direct interviews, family history information and medical records. **Results**: Adult relatives of bipolars with both threshold and subthreshold bipolar disorders were found to be at an increased risk of mood disorders. However, only relatives of bipolar-I probands revealed an elevated risk for bipolar-I disorder. Moreover, subthreshold bipolar disorders tended to be more frequent among relatives of bipolar-II probands. With respect to unipolar mood disorders, only threshold depression showed familial aggregation. **Conclusions**: Our results confirm 1) the familial aggregation of threshold mood disorders; 2) familial aggregation of subthreshold bipolar disorder within the mood disorder spectrum.

SYMPOSIUM S15
Subtypes of Alcohol Dependence - Relapse Prevention Strategies

Chairs: Otto-Michael Lesch - David Sinclair

Friday, 20 June, 2.00-3.30 pm - Schatzkammersaal

S15.1
DIAGNOSIS OF ALCOHOL DEPENDENCE – THE NECESSITY OF SUBGROUPS FOR THERAPY AND RESEARCH

Lesch, Otto-Michael, University Clinic Vienna, Department of Psychiatry, Vienna, Austria; Scholz, H.; Dvorak, A.; Hertling, I.; Ramskogler, K.; Walter, H.

Alcohol dependence is a disease that includes craving, loss of control, physical dependence and tolerance. For clinical and research purposes, the formal diagnostic criteria for alcoholism (ICD-10 and DSM-IV) have been developed. For therapy of the different stages of the illness we need to take into regard the heterogeneity of these patients. Moreover for the development of new compounds, being specific for withdrawal and relapse prevention, the necessity of the application of subgroups is meanwhile obvious. In order to determine the effects of different therapies and to design effective treatment combinations, we are seeking for signs and symptoms that a group of patients share and separate this group from others. If we keep on neglecting this need we may stick to insufficient results: 50 % of alcohol dependent patients treated as inpatients and/or outpatients relapse within 6 months after the start of the treatment. Mortality and suicide rates are very high compared to the normal population. Subgroups of alcohol dependence (Schuckit Type I and II, Cloninger personality traits, Babor Type I and II, Lesch Type I, II, III and IV, syndrome based diagnoses by Scholz, or assessment of the ASI) reflect different courses of alcohol dependence. Personality disorders and psychiatric and somatic co-morbidity should influence treatment concepts. There are enough data showing that the application of subgroups gives much better possibilities to choose the best concepts of treatment. Treatment and treatment combinations can be matched to these subgroups, in order to decrease relapse rates and to decrease mortality and suicide rates.

S15.2
DIFFERENT TYPES OF CRAVING IN ALCOHOL DEPENDENCE: A THREE-PATHWAY MODEL

van den Brink, Wim, The Amsterdam Institute for Addiction Research, Amsterdam, Netherlands

Introduction: Craving is currently regarded to be one of the central mechanisms in the continuation of alcohol abuse and relapse after prolonged periods of abstinence. Different models have been developed in animal and human research using both psychological and neurobiological paradigms. This paper reviews some of the main models and attempts to integrate these different models in a testable theory. **Methods:** Review of the literature and proposal to test some of the hypotheses that follow from an integrated craving model for alcohol. **Results:** It is concluded that converging evidence suggests a three-pathway psychobiological model of craving: reward craving, relief craving, and obsessive craving. Reward or positive craving is assumed to result from dopaminergic or opioid dysregulation and is associated a personality style of reward seeking. Relief or negative craving is assumed to result from GABA-ergic or glutaminergic dysregulation and is associated with a personality style of stress reactiv-

ity. Obsessive craving is assumed to result from some serotonergic deficiency and is associated with a personality style with low constraint and impaired inhibition. **Conclusions:** Three different subtypes of alcohol craving can be identified. These different subtypes are associated with specific neurotransmitter and personality patterns, which may in turn show to be predictive of the treatment effects of specific medications, such as acamprosate, naltrexone and disulfiram.

S15.3
ANXIETY DISORDERS AND ALCOHOL DEPENDENCE

Poldrugo, Flavio, University of Trieste, Office for Research and Innovative Programs on Alcohol, Trieste, Italy

Alcohol disorders may simulate psychiatric disorders and can cause resistance to treatment. They can add to an independent anxiety disorder, mask an underlying anxiety disorder, complicate the treatment of anxiety disorders and exacerbate the symptoms. Prevalence rates for anxiety disorders will be considered in the general population, and in psychiatric and specialist alcohol treatment centers. The reasons for the overestimation as well for the belief of frequency of dual diagnosis will be examined. Finally the management of this dual diagnosis needs to distinguish between symptoms and syndromes, clearly establishing primary versus secondary diagnoses. Anxiolytics should be used with caution preferring drugs specific to alcohol treatment (acamprosate, metadoxine, tiapride, etc.). Psychosocial therapy is preferred by males, individual therapy by females. True anxiety disorders may be successfully treated only when the alcoholic disorder is under control. If alcoholic disorders remain untreated, psychiatric patients show poor compliance and poor outcome.

S15.4
SUBTYPES OF ALCOHOL DEPENDENCE – RELAPSE PREVENTION STRATEGIES

Boening, Jobst, University of Würzburg, Department of Psychiatry, Würzburg, Germany

Over the last decade the Wuerzburg Addiction Research Group was involved in the clinical testing of several substances (acamprosate, naltrexone, ritanserin, flupenthixol, neramexane, actol) to pharmacologically prevent relapse in primary alcohol-dependent patients without comorbidity. These experiences led us to a closer investigation of biopsychological personality traits as predictors for treatment response. We found that psychoticism (Eysenck's Personality Questionnaire) and persistence (Cloninger's TCI) were the most discriminating variables. Their combination correctly predicted relapse in 62% and abstinence in 73% of our sample. Looking for a classification rule to determine in which category an individual falls due to his personality scores (tree-based approach: CART), we found this: alcohol-dependent men scoring low in psychoticism were at low risk for relapse – especially when combined with a low sensation seeking score (Zuckerman's SSS). On the other side, male alcoholics revealed an extraordinary risk for relapse when scoring high in psychoticism and low in persistence. A promising goal for future research might be to elucidate how these personality characteristics could be used for pharmacotherapeutical and/or psychotherapeutical treatment strategies.

S15.5
SUBGROUPING ALCOHOLICS ACCORDING TO THEIR AGE OF ALCOHOLISM ONSET

Wiesbeck, Gerhard, University of Würzburg, Department of Psychiatry, Germany; *Weijers, H.-G.; Boening, J.*

Many attempts have been made to subdivide populations of alcoholics into homogeneous subgroups. Growing evidence suggests that grouping them according to age of alcoholism onset might be of clinical importance. To elucidate the impact of this parameter we studied subjects with a diagnosis of primary alcohol dependence (ICD-10) who had entered an inpatient treatment program. We defined "onset of alcoholism" as the age when three ICD-10 dependence criteria clustered for the first time. An onset before 25 years of age was regarded as "early". In a first study we investigated the clinical applicability of Cloninger's type 1/type 2 concept in which age of alcoholism onset is regarded as an important grouping variable. However, subgrouping alcohol-dependent men without antisocial personality disorder according to their age of onset was not reflected by significant differences in type 1 and type 2 scores. In a second study we investigated the relation between age of onset and treatment outcome as well as between age of onset and the familial type of alcoholism. While there was a significantly higher rate of paternal alcoholism in individuals with early onset, we could not confirm previous reports of an association between early onset and treatment outcome as reflected by relapse/abstinence rates within one year after inpatient detoxification. Finally, we used a three-axes approach to subgroup alcoholics. We rated them on a clinical axis: age of alcoholism onset (early/late), on a personality axis: sensation seeking (high/low) and on a biological axis: dopamine receptor sensitivity (high/low). We found a subgroup which was characterized by early alcoholism onset, high sensation seeking and high dopamine receptor sensitivity. However, in a logistic regression these three variables were not able to significantly predict treatment outcome.

S15.6
RELAPSE PREVENTION ACCORDING TO THE TAXONOMY ACCORDING TO LESCH

Walter, Henriette, University Clinic of Vienna, Department of Psychiatry, Vienna, Austria; *Dvorak, A.; Hertling, I.; Ramskogler, K.; Lesch, O.M.*

Alcohol dependence defined as a disease has different origins. Frequently psychiatric disturbances and/or personality disorders mark the beginning. Those etiological factors may progress during the long term course. Chronic alcohol intake increases the severity of the basic psychiatric disturbances and leads to functional changes in all transmitter systems. Frequently anxiety disorders, depression, suicidal tendencies and organic psychosis can be encountered from the clinical point of view. Applying the Lesch typology in relapse prevention, we put an emphasis on those etiological disturbances and transmitter function changes. The Lesch typology was developed within a 18-year prospective follow-up catchment area study, performed in Burgenland, Austria. The easy use of this questionnaire and the application in different relapse prevention studies will be presented.

SYMPOSIUM S16
The Nosology of Mental Retardation: Unravelling the Gordian Knot
WPA Section "Mental Retardation"

Chairs: Luis Salvador-Carulla - Germain Weber

Friday, 20 June, 2.00-3.30 pm - Erzherzog Karl Saal

S16.1
THE CONCEPT OF MENTAL RETARDATION: AN UNENDING DILEMMA
Salvador-Carulla, Luis, Jerez, Spain

Mental retardation (MR) is a life-time disabling health condition that affects more people than Schizophrenia or Bipolar disorder, and which is associated to more direct health costs than any other chronic condition in developed countries. However, important problems related to its nosological classification persist and imply a major handicap both for research and for policy planning. The work related to the development of the 2002 AAMR Classification of Mental Retardation has re-opened the debate on the concept and typology of this health condition. Should we named it "intellectual disability" or "mental retardation"? Is it a disability, a deficit - and therefore coded in the International Classification of Functioning - or is it a disorder, and so properly coded in DSM-IV-TR or ICD-10? Other two major questions should be addressed: 1) Are current diagnostic criteria valid? Doubts appear with regard to the three established criteria based on IQ, on skills and abilities, and on age of onset; 2) Is the multiaxial coding system currently used suitable for MR? Despite recent advances in classification such as the UK Diagnostic Classification of Learning Disabilities (DC-LD), many of these questions remain unsolved, partly due to the basic conceptual dilemma underlying MR construct. It may be considered a syndromic grouping such as dementia, including a heterogeneous series of health conditions characterised by a deficit of brain functioning which is previous to skill acquisition through learning, and relates to a significant impairment of functioning.

S16.2
THE CLASSIFICATION OF PSYCHIATRIC DISORDERS IN MENTAL RETARDATION
Novell, Ramon, Fundacio Ave Maria, Barcelona, Spain

Over one third of people with Mental retardation (MR) suffer a psychiatric disorder. Dual diagnosis is associated to an increase in disability, personal and family burden and a reduction in social integration. However, diagnosis of psychiatric disorders in MR has not received adequate attention until very recently. Diagnosis is hampered by appearance of specific problems in this population, diagnostic overshadowing, interview difficulties, and scarcity of suitable assessment instruments and diagnostic criteria. DSM-IV and ICD-10 criteria have not been adequately tested or validated in people with MR and could not be reasonably applied in individuals with severe and profound MR. In the recent years significant developments have taken place such as the development of semistructured psychiatric interviews for people with MR and new criteria such as the Diagnostic Classification of Learning Disabilities (DC-LD) in UK and other international initiatives that will be discussed in this presentation.

S16.3
THE CLASSIFICATION OF BEHAVIOURAL PROBLEMS IN MENTAL RETARDATION
Weber, Germain, University of Vienna, Unit of Clinical Psychology, Vienna, Austria

Though persons with mental retardation show a higher variability and a higher prevalence for behavioural problems as compared to the non-retarded population, a consensus for a specific classification for this population in the area of problem behaviour has not been established. Moreover, no specific behavioural feature is uniquely associated with mental retardation. In addition, medical conditions with distinct biological background associated with mental retardation are characterized by certain behavioural symptoms (behavioural phenotype). Classifications for behavioural problems do exist in the leading systems (ICD-10, DSM-IV). However, these classifications predominantly focus on behaviour issues related to infancy, childhood and adolescence in the general population, with clear limitations for adulthood. First, various definitions of behaviour problems will be addressed, followed by an epidemiological overview of problem behaviour as observed in people with mental retardation. Next, the issue of differentiation between behavioural disorders and mental health disorders – the behavioural problem as one symptom within a psychiatric disorder - will be addressed. The presentation will close on the understanding of behavioural problems and its relevance within a classification of behavioural problems in mental retardation.

SYMPOSIUM S17
Should Personality Disorders be Classified Among Neurotic Disorders?
WPA Section "Personality Disorders"

Chairs: Peter Tyrer - Hans Peter Kapfhammer

Friday, 20 June, 4.00-5.30 pm - Zeremoniensaal

S17.1
IMPACT OF PERSONALITY ON THE OUTCOME OF PSYCHOTIC DISORDERS WITH PARTICULAR REFERENCE TO VIOLENCE
Moran, Paul, Institute of Psychiatry, Health Services Research Department, London, United Kingdom

The association between co-morbid personality disorder and violence in psychosis was examined using data from the UK700 study of intensive and standard case management in psychosis. 670 patients with established psychotic illness had personality status assessed at baseline. Physical assault was measured from multiple data sources over the next 2 years. Multivariate logistic regression was used to assess whether the presence of personality disorder predicted violence in the sample. 186 patients (28%) were rated as having a co-morbid personality disorder and these were significantly more likely to behave violently over the two-year period of the trial (adjusted OR: 1.74 ; 95% CI: 1.07 – 2.83). It is concluded that co-morbid personality disorder is independently associated with an increased risk of violent behaviour in psychosis and that early assessment of personality status should be part of the routine assessment of all psychiatric patients.

S17.2
IMPACT OF PERSONALITY ON SHORT- AND LONG-TERM OUTCOME OF NEUROTIC DISORDER AND ITS IMPLICATIONS FOR CLASSIFICATION

Seivewright, Helen, Imperial College London,
Department of Psychological Medicine, United Kingdom

A cohort of 210 psychiatric out-patients seen in general practice psychiatric clinics with a DSM-III diagnosis of generalised anxiety disorder (71), panic disorder (74), or dysthymic disorder (65), was followed up over 12 years. At 10 weeks, 2, 5 and 12 years current DSM diagnosis was made using a structured interview and assessments of anxiety, depressive and total symptomatology were made. After 12 years, social functioning and longitudinal outcome (i.e. combined outcome over the whole period) were measured using a new scale, the Neurotic Disorder Outcome Scale (Tyrer et al, 2001). The results showed that 36% of the patients assessed were well with no diagnosis at follow-up. Personality disorder had little impact initially but after 5 and 12 years was increasingly important as a negative factor in outcome. In a final predictive model after backward elimination only three baseline variables predicted poor outcome: greater depressive symptoms and personality disorder (any type, with more severe personality disorder having the greatest impact) and unmarried status at baseline. The results confirm the importance of personality disorder (classified by severity rather than category) as an important variable influencing the course of neurotic disorders.

S17.3
COMORBIDITY OF PERSONALITY DISORDER AND NEUROTIC DISORDER WITH PARTICULAR REFERENCE TO AGE

Tyrer, Peter, Imperial College London,
Department of Psychological Medicine, London, United Kingdom

In the Nottingham Study of Neurotic Disorder, 210 patients (mean age 35) received drug, psychological treatment or self-help in a randomised controlled trial (Tyrer et al, 1988) and had their personality status assessed at baseline using the Personality Assessment Schedule (Tyrer and Alexander, 1979). 12 years after entry to the study, 178 (97% of those still living) had their personality status reassessed using the same instrument. The personality traits of patients in the cluster B flamboyant group (antisocial, histrionic) became significantly less pronounced over 12 years, but those in the cluster A odd, eccentric group (schizoid, schizotypal, paranoid), and the cluster C anxious, fearful group (obsessional, avoidant) became more pronounced. The measure of agreement between baseline and 12 year personality clusters was statistically significant but clinically of little value (kappa [95%]: 0.14 [0.04, 0.23]) (Seivewright et al, 2002). The association of cluster C with neurotic diagnosis at the beginning of the study (Tyrer et al, 1990) was replaced by an association with cluster A at 12 years, suggesting that personality status is not nearly as stable as often defined and certainly not sufficient to link a specific group of personality disorders to a specific set of neurotic disorder diagnoses.

S17.4
IS THE CLASSIFICATION OF PERSONALITY DISORDERS RELEVANT FOR TREATMENT?

Kapfhammer, Hans-Peter, University of Psychiatry, Graz, Austria

Modern psychiatric classification systems (ICD-10, DSM-IV) are categorical by construction. This applies for major psychiatric disorders and personality disorders alike. Their principally polythetic approach to personality disorders usually leads to a relevant overlap of various personality disorders, a fact also called, even wrongly, comorbidity. By definition, personality disorders are characterized by stability and persistence. The course of illness, however, seldom confirms this basic criterion. What is generally missing in categorical systems, is a differentiation in several levels of severity. These problems of comorbidity, stability/persistence, and severity do have consequences for any psychiatrist reflecting on issues of treatment. On the other hand, trait-dimensional models promise alternative approaches avoiding many of these problems. Dimensional models, however, seem to meet the clinician´s longing for categorical guidance less favourably. Therefore, from the clinician´s point of view, some combination of categorical and dimensional approaches is to be recommended. This combined conceptual approach will guide the clinician best when confronted with such complex issues as differential treatment utilization by several groups of personality disorders, variable attitudes towards interventions requiring considerable commitment by patients, prominent states of psychiatric emergency and comorbidity of major psychiatric axis I disorders in the course of illness, both important indices of severity of personality disorders, natural course of illness in general, etc. And this dual approach will help the clinician to select from and/or to combine the various treatments available. This seems to be especially important for the basic decision to treat or not to treat regarding patient-centered versus social environment-centered approaches. And of course, this seems to be also of relevance in the case of psychotherapy and/or pharmacotherapy.

SYMPOSIUM S18
Alternatives to the Classification of Mental Disorders Based on Syndrome Descriptions

Chairs: Hans-Ulrich Wittchen - Terry S. Brugha

Friday, 20 June, 4.00-5.30 pm - Rittersaal

S18.1
THE STRUCTURE OF MENTAL DISORDERS IN THE COMMUNITY OVER TIME

Wittchen, Hans-Ulrich, Clinical Psychology and Psychotherapy/Technical University of Dresden, Dresden, Germany

Retrospective cross-sectional and prospective longitudinal studies in clinical and community samples suggest that there is considerable degree of comorbidity, both cross-sectionally and over a persons lifetime. Frequently starting with at least subthreshold manifestations of some types of mental disorders, a majority of all people affected by at least one disorder in the population are likely to fluctuate from one to another disorder as well as from symptomatic to subthreshold and full-blown threshold expressions of one or more mental disorders. There is further considerable evidence that such patterns of course are neither artefactual nor random, but vary by a number of factors, including type of initial, primary disorder, severity and persistence, and intervention. Such systematic patterns of comorbidity are also a

general characteristic of somatic disorders (see hypertension, diabetes, CVD etc). The presentation explores how such data can be used as one additional component for more adequate future classification models of mental disorders.

S18.2
THE ROLE OF EPIDEMIOLOGY IN IDENTIFYING CORE PSYCHOPATHOLOGICAL DIMENSIONS

Kessler, Ronald C., Department of Health Care Policy, Harvard Medical School, Boston, United States

The absence of definitive pathophysiological tests for common mental disorders makes it necessary to base initial diagnoses and treatment decisions on signs and symptoms and to base mid-stream corrections in diagnoses and treatment plans on short-term treatment response. In the face of such a situation, ongoing refinements in diagnostic criteria can be helpful in guiding practice. The current diagnostic systems are less helpful in this regard than they could be, though, because they lack the underlying dimensional structure needed to refine understanding of differential treatment response. A sustained program of clinical and community epidemiological research, including the collection of both biological and self-report data in parallel from clinical representative community samples, is needed to identify these dimensions. This presentation lays out a proposed agenda for such a program of research.

S18.3
CLINICAL JUDGEMENT IN DIAGNOSING MENTAL DISORDERS - A DIFFERENCE THAT MATTERS?

Brugha, Terry S., Section of Social and Epidemiological Psychiatry, University of Leicester, Leicester, United Kingdom

Many policy and public mental health information questions can only be answered by conducting large scale general population surveys, typically with sample sizes of 5K to 10,000 respondents. Major survey providers use fully structured self report 'yes-no' question formats administered by interview to achieve this. With considerable ingenuity instruments like the DIS, CIDI, CIS-R have been developed to collect data according to DSM# / ICD-10 criteria. In parallel, clinician administered assessments such as SCID-I and SCAN have been compared with these survey instruments but such comparisons (in community samples) demonstrate substantial differences – i.e. disagreements for diagnoses such as depression, GAD, phobia, etc. What does this difference mean and is it important? What can be done to maximise the quality of information on mental disorder collected in surveys? The paper will report on progress in tackling these and related theoretical and methodological questions including a discussion of the need for stability and continuity in international classification systems.

SYMPOSIUM S19
Classification of Delusional Disorders other than Schizophrenia
WPA Section "Schizophrenia"

Chairs: Wolfgang Gaebel - Veronica Larach W.

Friday, 20 June, 4.00-5.30 pm - Geheime Ratsstube

S19.1
SCHIZOPHRENIA SPECTRUM DISORDERS

Jablensky, Assen, University of Western Australia, Perth, Australia

The existence of a class of psychotic disorders which are symptomatologically and prognostically different from the major groups of schizophrenia and affective disorders is supported by clinical and epidemiological evidence that can, at present, be qualified as tentative. Assuming that such 'atypical' psychoses account for approximately 10% of all psychotic disorders (or for an even greater percentage in the developing countries), their placement within the 'mainstream' psychiatric classifications such as ICD and DSM has important implications for clinicians and researchers. The nosological questions posed by the non-schizophrenic psychoses lack at present definitive answers. There is clearly a case for further and better focused research.

S19.2
MIXED SCHIZOAFFECTIVE DISORDERS

Marneros, Andreas, Martin-Luther-University Halle-Wittenberg, Halle/Saale, Germany

Both ICD-10 and DSM-IV define additionally to schizodepressive and schizomanic episodes also a mixed episode. In spite of that clinicians make the diagnoses "schizoaffective mixed episode", according to our experience, only rarely. There are many reasons, mainly based on the difficult symptomatology, which could explain this phenomenon. Additionally there is only a limited research on the topic because of the same reasons. That is surprising because schizoaffective mixed episodes occur at least in the same frequency as affective mixed episodes. More than 30% of the patients having a schizoaffective disorder showed at least once during the longitudinal course schizoaffective mixed episodes. The occurrence of mixed episodes usually complicate the treatment as well as the prophylaxis. In contrast to pure affective mixed episodes it seems that there are no differences regarding gender distribution in schizoaffective mixed patients. A schizoaffective mixed episode is the most severe type of episodes which occur in bipolar patients, both affective and schizoaffective. The duration of the episode is the longest one, it is usually associated with suicidal behaviour and it is also a negative predictor of the outcome. Patients having schizoaffective mixed episodes during the course of the illness have the most severe social consequences and they become much more frequently unable to work than other bipolar patients. They also retire because of the mental illness significantly earlier in life than other patients. Schizoaffective disorders are an every day clinical reality and a challenge for clinicians and researchers. The paradigma of schizoaffective mixed states shows the necessity of more intensive research on the topic, not only for better understanding of the psychotic spectrum, but also for solution of urgent clinical problems.

S19.3
DELUSIONAL DISORDERS DUE TO MEDICAL CONDITIONS OR SUBSTANCE ABUSE

Pull, Charles, Centre Hospitalier de Luxembourg, Luxembourg

(Non-schizophrenic) delusional disorders represent a heterogeneous and poorly understood group of disorders. The nomenclature of these disorders is as uncertain as their nosological status. Little empirical evidence is available up to now, and the limited data and clinical tradition that are used instead to define these disorders have generated concepts that remain controversial. A considerable number of labels have been proposed to designate transient as well as persistent delusional disorders. Prominent concepts among transient delusional disorders are the *bouffées délirantes* of the French, the 'reactive' or 'psychogenic' psychoses and the 'schizophreniform' psychoses of the Scandinavian and the 'cycloid psychoses' of the German tradition, as well as a number of so-called culture-bound psychoses. Prominent among persistent delusional disorders are the concepts of paranoia and paraphrenia, the *délires chroniques* of the French tradition, as well as a variety of other concepts, either included in the preceding or separated from them, such as delusional jealousy, *folie à deux*, Capgras' syndrome, erotomania, Cotard's syndrome, and Kretschmer's *sensitiver Beziehungswahn*. The present report will briefly describe the main concepts of traditional nosology in this field and discuss the current position of transient and persistent (non-schizophrenic) delusional disorders as proposed in the 10th Revision of the International Classification of Diseases or ICD-10 and the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders or DSM-IV (and its recent Text Revision or DSM-IV-TR). The presentation will include a discussion of the concept of schizotypal disorder (ICD-10) and schizotypal personality disorder (DSM-IV).

S19.4
DELUSIONAL DISORDERS DUE TO MEDICAL CONDITIONS OR SUBSTANCE ABUSE

Falkai, Peter, Department of Psychiatry and Psychotherapy, University of Saarland, Germany

In substance abuse there is a prevalence of more than 30% for comorbid psychiatric conditions, mainly affective and personality disorders. Looking at medical conditions there is a similar situation, where up to 50% of patients from medical or surgical wards suffer comorbidly from affective disorders and/or organically based psychosyndromes. Especially in the latter case these conditions are often not detected leading to a worsened prognosis in the underlying medical conditions. Delusional disorders are part of these comorbidities, are usually stressing for the sufferers and bear a high risk for suicidal attempts or even suicides. Therefore especially in medical conditions psychiatric comorbidities have to be taken in account and once the diagnosis is made appropriate therapy is required. The other side of the coin is that delusional disorders – especially in older age – are the consequence of medical conditions and/or substance abuse. Therefore in such a circumstance a detailed organic work-up needs to be performed, including physical examination and some basic laboratory tests.

SYMPOSIUM S20
Issues Arising in the Assessment and Diagnosis of ADHD

Chairs: Jan Buitelaar - Rosemary Tannock

Friday, 20 June, 4.00-5.30 pm - Trabantenstube

S20.1
OVERDIAGNOSIS OR UNDERDIAGNOSIS OF ADHD: EPIDEMIOLOGY AND BURDEN FOR SOCIETY

Buitelaar, Jan, Netherlands

ADHD is among the common psychiatric disorders among schoolage children, with prevalence estimates being in the range of 3-5% when defined strictly and diagnosed by psychiatric interview, and up to 8-10% when defined by high symptom scores on behavior checklists completed by parents and teachers. Despite robust evidence that ADHD is a valid and neuropsychiatric syndrome, public and media attention for ADHD is often negative and critical. Public concerns particularly relate to overdiagnosis of ADHD in certain regions and overtreatment with stimulant medication, as is apparent from some epidemiological studies. On the other hand, there is clear evidence that ADHD is still underdiagnosed and undertreated in many areas in Europe and the Northern American Continent, and particularly among children from ethnic minorities, girls, adolescents and adults. This contribution reviews factors relating to under- and overdiagnosis of ADHD, and reviews the issues of the media debate, as organized into those surrounding the validity of the syndrome, the resistances to prescribing medication to children, and the putative side-effects of stimulants. The discussion of the dangers and drawbacks of the treatment of ADHD should be balanced against the burden for society of the disorder.

S20.2
DIAGNOSIS AND ASSESSMENT OF ADHD IN CHILDREN

Banaschewski, Tobias, University of Göttingen, Göttingen, Germany

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood psychiatric disorders, characterized by symptoms of inattention, hyperactivity and impulsivity leading to impairment in academic, occupational, social, and emotional functioning. A comprehensive assessment of ADHD requires a thorough and systematic review of information (direct observation in the clinical setting, reports of the child, parents and teachers) regarding the impact of the core symptoms on multiple domains of functioning and settings (e.g., home, school). Age-related diagnostic issues (preschoolers, adults), differential diagnoses and comorbid conditions have to be considered. The diagnosis is based on the clinical interview, a comprehensive medical history, physical examination, and developmental and psychological evaluation. Appropriately used, various rating scales of the specific ADHD symptoms can provide useful tools for a systematic and standardized assessment. Recommendations for the assessment and diagnosis of ADHD (DSM-IV) and hyperkinetic disorder (HKD; ICD-10) in children will be given on the basis of clinical practice guidelines.

S20.3
ASSESSMENT OF ADHD AND ITS COMORBIDITIES IN ADULTS

Wilens, Tim, Netherlands

Although, historically, ADHD has been considered only a disorder of children, it has become increasingly recognized as a commonly occurring disorder in adults. Recent data suggests the persistence of ADHD in up to 50% of young adults diagnosed as having ADHD in childhood. Adults with ADHD have been shown to have similar cognitive profiles, academic underachievement, and rates of psychiatric comorbidity compared to ADHD children. Neurobiologic findings including genetics and brain imaging have also indicated abnormalities in adults with ADHD. While children with ADHD typically have prominent hyperactive and impulsive symptoms, adults with ADHD present with more cognitive or inattentive symptoms of the disorder. In addition, they frequently have stubbornness, low frustration tolerance, and chronic conflicts in social relations with peers, spouses, and authorities. Adults with ADHD should additionally be evaluated for co-occurring mood, anxiety, and substance use disorders. The diagnosis is established by clinical history applying DSM-IV or ICD-10. Neuropsychological testing can be helpful in identifying co-occurring learning disorders and in providing evidence for the diagnosis. The treatment of ADHD in adults includes education, focussed psychotherapy, and medication. Whereas traditional insight-oriented therapy has not been found helpful, cognitive based psychotherapies have been shown to be useful in the treatment of medicated adults with ADHD. Medication treatment includes the use of stimulants (methylphenidate and amphetamine), noradrenergic agents (atomoxetine), and certain antidepressants (tricyclics and bupropion). Doses of the medication in adults with ADHD are typically higher than those used in children. Multiple agents may be necessary in the successful treatment of some ADHD adults with partial responses or psychiatric comorbidity.

S20.4
IS THERE A ROLE FOR NEUROPSYCHOLOGICAL/ COGNITIVE TESTS IN THE DIAGNOSIS OF ADHD?

Tannock, Rosemary, Netherlands

Converging evidence indicates that Attention-Deficit/Hyperactivity Disorder (ADHD) is highly heritable, has a substantial genetic component, and may be associated with neurobiological deficits in the prefrontal cortex and related subcortical and cerebellar systems, which mediate selective and sustained attention, inhibitory control, working memory, and other complex cognitive activities. Moreover, a burgeoning number of studies report that ADHD is associated with deficits on a wide array of neuropsychological tests of attention. Yet, from a clinical perspective, ADHD is still conceptualized as a disruptive behavior disorder and diagnosis is based solely on clinical evaluation of reports of developmentally inappropriate and impairing levels of inattentive, impulsive/hyperactive behaviour. To address this paradox, investigators have sought to identify a “cognitive marker” for ADHD by examining the efficiency of test-based diagnostic discriminations in clinical samples of individuals with and without ADHD. Results have been disappointing: single neuropsychological tests have limited discriminating ability, and combinations of tests improved prediction of ADHD status but overall diagnostic efficiency remains limited. Moreover, the ability of these tests to discriminate between ADHD and other clinical conditions (that frequently co-exist with ADHD) is unknown. Limitations of the current conceptualization and approach to evaluating the diagnostic efficiency of neuropsychological and cognitive tests are discussed, along with promising future directions.

SYMPOSIUM S21
Diagnosis for the Person: Perspectives of Users of the Diagnostic Model

WPA Section “Classification, Diagnostic Assessment & Nomenclature“

Chairs: Juan Mezzich - Somnath Chatterji

Friday, 20 June, 4.00-5.30 pm - Radetzky Appartement

S21.1
ADULT PSYCHIATRIC CLINICIAN PERSPECTIVE

Kuey, Levent, Istanbul University, Istanbul, Turkey

An adult psychiatrist, as a clinician, encounters the same question with every new patient: “how can I help this person to minimize his/her suffering and optimize his/her harmony?” In answering this question, the perspectives and tools used by the clinician determine his/her efforts of evaluating and managing the psychopathology of the person in need of psychiatric help. In this process the psychiatrist is under the tension of dual forces: “population-based universal objectivity” and “person-based unique subjectivity”. To overcome this tension, or not to be overwhelmed by one of these sides, the clinician needs a comprehensive tool, combining the nomothetic and ideographic elements of the diagnostic formulation. This diagnostic formulation is a bridge constructed by the clinician and the patient connecting the evaluation process to the management process. The perspectives of the patient and the clinician taken into consideration together, in every step of these processes help the effectiveness of the treatment. The principles and paradigms underlying such an integrative diagnostic formulation with some case samples will be discussed in this presentation.

S21.2
CHILD PSYCHIATRIC CLINICIAN PERSPECTIVE

Berganza, Carlos E., Clinica de Psiquiatria Infantil, Guatemala

Diagnosis in child psychiatry as a focus of professional development has been preceded by the same efforts in adult psychiatry. However, critical advances to improve reliability, validity and clinical utility of psychiatric diagnosis and the nosology of mental disorders have originated in the field of child psychiatry (Rutter et al, 1975). The very nature of clinical practice in child psychiatry demands that effective treatment be informed by a comprehensive diagnostic process involving the child, his or her family and other critical people in the life of the patient. Thus, to truly serve the person of the patient, diagnosis in child psychiatry must allow the clinician to not only decide whether the child suffers of a definable disorder, but also to clarify the role played by the active developmental process that characterizes the child, and the contributing factors involved in etiology and phenomenology of disorders in this special population. This presentation discusses some of the critical issues in the diagnostic enterprise in child and adolescent psychiatry. These issues include the importance of development in the definition of disorders, models of nosology, reliability, validity and clinical utility of diagnosis in child psychiatry, and effective sources of external validation of diagnostic categories in the field. Finally, a proposal is made concerning areas of improvement in the current nosological systems in child psychiatry.

S21.3
COMMUNITY / PUBLIC HEALTH PSYCHIATRIST PERSPECTIVE

Amering, Michaela, University of Vienna, Vienna, Austria

Psychiatry has moved into the community very successfully over the last decades and today mental health issues are a prominent focus of public health practice and debate. Multiaxial diagnostic formulations have great advantages over traditional uniaxial ones in accommodating these developments. The inclusion of the concepts of disability, context, health resources, and quality of life supports a diagnostic process that is relevant to life and work in the community. This complex and humane perspective allows the meaningful integration of the different backgrounds of many different professionals working together in multiprofessional teams as well as of concepts pertinent to users of services and their families and friends, who have developed new roles and interests through the advancements of the consumer movements, self-help and advocacy. The current and still growing orientation towards empowerment and patient self-determination in all fields of medicine including psychiatry puts new emphasis on subjective and individualized assessments and treatment approaches. A personalized narrative part of the diagnostic formulation not only respects this development, but also necessitates and thus has the potential to enable the establishment of a new form of collaboration between clinicians, consumers and families in a common natural language. In line with its emphasis on positive factors and expectations towards restoration and promotion of health this will play a key role in overcoming prognostic scepticism and stigma not only for the individual therapeutic relationship but also for the whole field of mental health and its role in society.

S21.4
A PROPOSED RESEARCH PSYCHIATRIC PERSPECTIVE ON CLASSIFICATION

Akiskal, Hagop, University of California, San Diego, United States

The American Psychiatric Association, the World Psychiatric Association, and the World Health Organization are eager to bring the best research findings to bear on revisions of the classification of mental disorders. Research represents a spectrum from basic science on mental functions and behavior, biological investigations of mental disorders, and clinical and services research. It is relevant in this context to raise the question: what level of science is most appropriate to the classification of mental disorders. In theory, and perhaps optimally, all levels should be used. Although a great deal of research has been conducted to help us understand the biological underpinnings of various "functional" mental disorders, little has emerged that would justify their use as biological markers in delineating a clinically useful and valid classification. We have to rely on classical validating parameters such as description, prevalence, gender differences, personality or temperament, comorbidity, familial aggregation, twin studies, treatment response, course, and prognosis. The next question is whose synthesis of the literature on these parameters would be most appropriate? Should it be based primarily on the expertise of public health-oriented experts who are usually not clinicians (and who have been criticized for their overemphasis on reliability rather than clinical relevance)? Past practice has used this approach with some success, in association with consensus among academic opinion leaders in the field. Regrettably, the research conducted in academic settings is not always relevant to the most common psychiatric problems. On the other hand, most clinicians who practice in private and community settings and who might serve on committees on psychiatric nomenclature, are not necessarily knowledgeable about the research arena most relevant to the scientific principles involved in valid classification. I therefore believe that what is needed are academic clinicians, as well as clinicians with some ties to academia, who conduct research relevant to delineating clinical subtypes of mental disorders. Although such research is conducted by relatively few individuals, I submit that their input should weigh greatly in any planned revisions of DSM-IV and ICD-10. In brief, I am suggesting that the elitism of psychometric nosologists and academic researcher types be at least matched by a cadre of more pragmatic yet rigorous clinical researcher types who derive scientific insights and data from actual contact with patients.

S21.5
THE PERSPECTIVE OF THE EDUCATOR REGARDING RECENT TRENDS IN PSYCHIATRIC DIAGNOSTIC APPROACHES

Tasman, Allan, University of Louisville, Louisville, KT, United States

Scientific advances in psychiatry in the last several decades have been dramatic, especially in the neuroscience arena. Further, advances in nosology have allowed for reliable diagnoses which have contributed to our ability to carry out research studies. At the same time, economic forces, especially related to the "managed care" phenomenon, have emphasized somatic interventions and the rise of the "15 minute medication check" as a standard approach to treatment. These and other factors have led to a de-emphasis of a biopsychosocial approach to understanding and intervention for psychiatric disorders. For example, the DSM changes emphasize a symptom checklist approach to psychiatric diagnosis, with diminished attention to psychological issues such as trauma, conflict, personality, and developmental concerns. These trends have affected psychiatric education in several ways, often to the detriment of our field. The presentation will review the impact of these changes on psychiatric education, and discuss specific issues of concern and possible solutions. The presentation will review the importance of other domains of assessment beyond a symptom cluster approach, focusing on issues related to the doctor-patient relationship, treatment compliance and resistance, and the value of a more humanistic approach to understanding. Clinical vignettes from the author's practice will be used to illustrate the issues being discussed.

SYMPOSIUM S22
Diagnosis and Classification of Vulnerabilities

Chairs: Wolfgang Maier - Joachim Klosterkötter

Friday, 20 June, 4.00-5.30 pm - Künstlerzimmer

S22.1
NEED OF EARLY RECOGNITION AND TREATMENT REQUIRES DIAGNOSIS OF VULNERABILITY AND HIGH RISK STATES

Maier, Wolfgang, Department of Psychiatry and Psychotherapy, University of Bonn, Germany

Programmes for early recognition and treatment of psychiatric disorders (mainly psychoses) have to rely on clinical signs and symptoms which are able to predict the immediate emergence of the targeted disorder. Currently attenuated symptoms associated with the targeted disorders define the most predictive features; however sensitivity and particularly specificity of these prodromal signs are insufficient and to be improved. One possibility comes from the family study and high risk research tradition where neurobiological or neuropsychological vulnerability factors were identified. Their potential role in increasing the predictive potency for psychoses will be discussed.

S22.2
DIAGNOSIS OF THE INITIAL PRODROME OF PSYCHOSES

Schultze-Lutter, Frauke, Department of Psychiatry and Psychotherapy, University of Cologne, Germany; Ruhrmann, S., Klosterkötter, J.

The majority of first-episode schizophrenic psychoses is preceded by a prodromal phase. Whereas in ICD-10, the initial prodrome was regarded as too unspecific and unreliably assessable to be included as an unequivocal diagnostic criterion, in DSM-III-R, an attempt was made to define prodromal symptoms of schizophrenia. Yet, these symptoms showed little specificity and reliability, were dropped in DSM-IV, and prospective studies of different symptomatology were requested. First empirical evidence of such symptoms was given by the prospective CER-Project in which early subtle self-experienced cognitive and perceptual disturbances showed prognostic/diagnostic accuracy comparable to that of positive symptoms of schizophrenia. Furthermore, preliminary data suggest that attenuated and transient psychotic symptoms herald the onset of frank psychosis within a year in about 40% of patients. Thus, prospective data on specific and reliable prodromal symptoms of psychosis has accumulated during the last five years and should be considered in future revisions of diagnostic criteria.

S22.3
DIAGNOSIS AND TREATMENT OF AT-RISK MENTAL STATES – NEW APPROACHES IN THE GERMAN COMPETENCE NETWORK SCHIZOPHRENIA

Klosterkötter, Joachim, Department of Psychiatry and Psychotherapy, University of Cologne, Germany

One of the main objectives of the German Competence Network Schizophrenia is the development, implementation and evaluation of a two-step inventory for an early recognition of psychosis and a detailed assessment of the course of symptoms and of different stage-specific early intervention strategies. Following the referral regulated by a short checklist, the present degree of risk is determined - late or early prodromal stage. Individuals in an early prodromal stage receive multimodal psychological treatment, those in a late prodromal stage combined pharmacological (atypical neuroleptic) and psychological treatment. Individuals are followed up for 3 years and compared with a control group receiving standard treatment. First results support the face validity of the early recognition instruments and indicate a good efficacy of the treatment strategies in the respective groups. It is evident that criteria of at-risk mental states should be included in an adequate classification of mental disorders.

S22.4
THE USEFULNESS OF THE “VULNERABILITY-STRESS-COPING” MODEL IN PSYCHIATRY

Katschnig, Heinz, Department of Psychiatry, University of Vienna, Vienna, Austria

Besides its potential usefulness for etiological, especially genetic research, the vulnerability concept - if expanded to a vulnerability-stress-coping model – provides a number of additional advantages for psychiatry as a whole. Since *vulnerability* for a specific disorder (genetic or acquired during pregnancy, at birth or later in life) implies that - depending on the presence of other internal or external factors - the actual disorder may or may not manifest itself, it is a more optimistic and more dynamic model than the traditional deficiency oriented disease concept. It is therefore better accepted by patients and their family members. It can accommodate social psychiatric research findings about external stressors, such as life events or high expressed emotion, and can thus first be expanded to a *vulnerability-stress* model. It also offers the possibility of a new understanding of preventive and coping interventions and could thus be understood as a *vulnerability-stress-coping* model. High expressed emotion research shows that relapse can be prevented in schizophrenia by specific work with relatives. Furthermore, patients themselves can learn how to avoid or cope with stressors and thus prevent relapse. Also, in this model, maintenance pharmacotherapy can be understood as reducing the vulnerability for relapse. Thus, the vulnerability-stress-coping model of mental disorders helps to integrate pharmacological, psychotherapeutic and social interventions and to communicate this integrative approach to patients and their families. Finally and perhaps most important, by doing this, it invites patients and relatives to actively participate in coping with the disorder. It is increasingly recognized that such “empowerment” is an important factor in recovery and prevention of relapse of mental disorders.

SYMPOSIUM S23
Is Craving a Symptom or a Diagnosis?

Chairs: Markus Gastpar - Norbert Scherbaum

Friday, 20 June, 4.00-5.30 pm - Schatzkammersaal

S23.1
PSYCHOPHYSIOLOGICAL CUE REACTIVITY IN OPIATE ADDICTS DURING VIDEO EXPOSURE

Rist, Fred, Department of Psychology, University of Münster, Münster, Germany; Schön, S., Gerlach, A., Scherbaum, N.

Craving has become one of the central concepts in our understanding of addiction and is usually assessed by self rating scales. However, its usefulness e.g. as a predictor of relapse has been limited, partly because of the questionable reliability and validity of the assessments, partly because craving is a multifaceted process. To investigate

the relation between craving and arousal, a drug related video and a control video were shown to 47 opiate dependent patients from a detoxification treatment unit and 24 controls. The drug video depicted for 90 seconds how heroine was bought, prepared and injected. As a control video with similarly arousing, but not drug related properties an instructional video on an endoscopically performed operation was shown. Throughout the presentation, we measured heart rate (HR) and skin conductance (SC), while subjects had to indicate their momentary subjective arousal by means of a sliding lever. Craving and mood were assessed before and after the presentation. Patients were more aroused by the drug video than controls, while controls reacted stronger to the operation video. Arousal was maximal at the beginning of the presentation, when only the drug dealing place was shown, which indicates large conditional responses to drug related cues. However, craving rated retrospectively following the presentation was only weakly related to these arousal changes. Thus, arousal and craving may change independently in response to drug related cues. The simultaneous assessment of both verbal and psychophysiological aspects of craving may be necessary to increase its clinical usefulness.

S23.2
REGIONAL BRAIN METABOLIC ACTIVATION DURING CRAVING ELICITED BY RECALL OF PREVIOUS DRUG EXPERIENCES

Wang, G.J., Medical Department, Brookhaven National Laboratory, United States; *Fowler, J.S., Cervany, P., Hitzemann, R.J., Pappas, N.R., Wong, C.T., Felder, C.*

Cocaine cues elicit craving and physiological responses. The cerebral circuits involved in these are poorly understood. The purpose of this study was to assess the relation between regional brain activation and cocaine cue elicited responses. Thirteen right-handed cocaine abusers were scanned with positron emission tomography (PET) and [F-18] fluorodeoxyglucose (FDG) twice; during an interactive interview about neutral themes and during an interactive interview about cocaine themes designed to elicit cocaine craving. In parallel the behavioral (rated from 0: felt nothing to 10: felt extreme) and cardiovascular responses were recorded. During the cocaine theme interview subjects reported higher self reports for cocaine craving (+2.5+/-3.3, p < or = 0.02) and had higher heart rates (+4.7+/-7.2%, p < or = 0.001), systolic (+4+/-4%, p < or = 0.0001), and diastolic blood pressures (+2.6+/-3.8%, p < or = 0.003) than during the neutral interview. Absolute and relative metabolic values in the orbitofrontal (+16.4+/-17.1%, p < or = 0.005; +11.3+/-14.3%, p < or = 0.008) and left insular cortex (+21.6+/-19.6%, p < or = 0.002; +16.7+/-19.7%, p < or = 0.01) and relative values in cerebellum (+17.9+/-14.8%, p < or = 0.0008) were higher during the cocaine theme than during the neutral theme interview. Relative metabolic values in the right insular region (p < or = 0.0008) were significantly correlated with self reports of cocaine craving. Activation of the temporal insula, a brain region involved with autonomic control, and of the orbitofrontal cortex, a brain region involved with expectancy and reinforcing salience of stimuli, during the cocaine theme support their involvement with craving in cocaine addicted subjects.

S23.3
CRAVING IN SUBGROUPS OF ALCOHOL DEPENDENT PATIENTS

Schmidt, L.G., Department of Psychiatry, University of Mainz, Germany

Craving by alcoholics describes an irresistable need for alcoholic beverages that may be elicited by conditioned drug-related stimuli and that is considered to play a major role in the development and maintenance of dependent behavior. In order to evaluate the role of craving during cue exposure treatment for relapse prevention, alcohol dependent patients were treated with cue exposure sessions (favourite drink vs water as a control condition) in a laboratory setting after detoxification treatment. Outcome was assessed regarding subjective craving, physiological data and resumption of drinking after hospital discharge. As a result of the study it was shown that patients could be characterized as cue reactors and non-reactors; in most cue reactors, subjective craving decreased due to a habituation process. There was no clear relationship with relapse; however, cue exposure was associated with smaller amounts of alcohol drinks during relapse than was shown with relaxation pretreatment (as a control condition). The role of type I/II (according to Babor et al) for cue elicited craving will also be evaluted.

S23.4
WHEN SMOKERS CRAVE: A COGNITIVE AND AFFECTIVE ANALYSIS

Sayette, Michael, University of Pittsburgh, United States

Researchers have long posited a relationship between craving and addiction. Yet the importance of this relationship, and the very nature of the craving construct, has been debated. Nevertheless, there has been increased study of craving from a variety of biological and psychological perspectives. With respect to cigarette smoking, several recent studies reveal that self-reported craving predicts smoking relapse. This talk focuses on changes in cognition and affect that occur during craving states, and which may promote smoking behavior. Several studies are presented in which craving was induced by exposing nicotine-deprived smokers to potent smoking cues (holding a lit cigarette). Results indicated that while craving, smokers highly valued the opportunity to smoke immediately. Data using an Emotional Stroop task suggested that craving biases attention toward smoking-related stimuli and that performance on this task predicts smoking relapse. Smokers also processed smoking-related information differently while craving than while not craving. Specifically, while craving, smokers generated more positive consequences of smoking and judged positive consequences of smoking to be relatively more likely to occur than did those who were not craving. This positive bias is thought to increase the likelihood that a smoker will choose to smoke. In addition, smokers who expected to smoke soon reported stronger cravings than did smokers who did not expect to smoke soon. Further, use of the Facial Action Coding System to analyze expressions thought to be related to emotion revealed that expectations regarding being able to smoke the cigarette influenced the emotional experience of the cravings.

S23.5
ACTIVATION OF AN ADDICTION RELATED SEMANTIC NET IN OPIATE ADDICTS

Scherbaum, Norbert, Klinik für Psychiatrie und Psychotherapie, Essen, Germany; *Nowack, C.; Gerlach, A.; Rist, F.*

Habitual drug seeking behaviour leads to specific biases when processing drug related cues. The "emotional stroop" paradigm has been employed to show this attentional bias in alcohol and in tobacco addicts. As in the traditional stroop experiment, the colour of words presented on a monitor has to be pronounced. Words related to drug effects and drug consumption are shown instead of colour words. Reading these words interferes with naming the colour of the words, increasing response latencies. In this study, opiate dependent patients of a closed ward for detoxification treatment (N = 36) were compared to controls recruited from the staff (N = 19) using the emotional stroop procedure. Heroin related words referred to consumption and effects of heroin, control words designated clothing and food items. All subjects took longer to pronounce the colour of heroin related words than the colour of control words. This effect was only marginally larger in patients than in controls. Thus, the interference effect produced by heroin related words is not specific. However, while the interference effect declines over successive trials in controls, it remains stable in patients. In addition, the interference effect for heroin words was correlated with actual dysphoric mood. These two results point to mediating effects of drug related semantic representations in the process of drug seeking behaviour.

SYMPOSIUM S24
Diagnostic Dilemmas in the Diagnosis of Eating Disorders

Chairs: Suzanne Abraham - Andreas Karwautz

Friday, 20 June, 4.00-5.30 pm - Erzherzog Karl Saal

S24.1
ARE EATING DISORDERS AN UMBRELLA FOR OTHER PSYCHIATRIC DISORDERS?

Russell, Janice, Department of Psychological Medicine, University of Sydney, Greenwich, Australia

Eating disorders are not infrequently seen in association with other conditions such as depression, anxiety disorders, body dysmorphic disorder, somatoform disorders, personality disorders, addictions and schizophrenia. Shared clinical features and the relative rarity of the 'pure" forms have led to questions concerning the true nature of eating disorders, e.g. is bulimia nervosa a form of depressive illness, is anorexia nervosa a "forme fruste" of schizophrenia, are all eating disorders essentially body dysmorphic disorders, food phobias or addictions? There is a temporal profile whereby certain of these disorders predate the diagnosis of the eating disorder, may be exacerbated by it and recede when it is treated, whilst others accompany chronicity. The primacy of the eating disorder with its physical/medical features, psychological and behavioural components, which together constitute a self perpetuating vicious cycle, must be determined and addressed. The question remains as to whether the conditions or clinical syndromes seen so consistently in association with eating disorders constitute true comorbidity or whether the component clinical features are in reality those of the eating disorder itself. Alternatively the eating disorder might be seen as presenting feature or consequence of a variety of psychiatric illnesses. The answer mandates a better grasp of aetiopathogenesis in all its complexity. Whether umbrella or a bucket the eating disorder must be attended as a matter of priority and comorbid conditions managed as a matter of course and not used as a reason for refusal of treatment.

S24.2
ARE EATING DISORDER DIAGNOSTIC FEELINGS AND THOUGHTS ACCURATE?

Boyd, Catherine, University of Sydney, St. Leonards, Australia

The appropriateness of DSM-IV criteria for diagnoses of anorexia nervosa and bulimia nervosa were examined in 372 community women and 89 women with eating disorders using a computerized self-report questionnaire. All women were post-pubertal and 14-25 years. For DSM-IV criterion B for anorexia nervosa, an "intense fear of gaining weight or becoming fat, even though underweight", the data from the question "How many days out of the past 28 days did you fear you might gain weight or become fat or fatter" were examined. This criterion appears neither sensitive (23% of individuals with anorexia nervosa don't fear fatness more than half the days in the previous month), nor specific due to the high prevalence of a fear of fatness in the community. DSM-IV criterion C for anorexia nervosa is a "disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight and shape on self-evaluation, or denial of the seriousness of the current low body weight". This criterion, being more of a concept than a question is difficult to interpret. Suggested interpretations include "feeling fat" when one is obviously not overweight, or "feeling that weight/shape are important for self esteem". Our results suggest that neither of these interpretations is specific or sensitive for a diagnosis of anorexia nervosa. Alternative criteria examined were a loss of control over eating, preoccupation with thoughts of food/eating and preoccupation with thoughts of body weight or shape. These alternative criteria may be more specific and sensitive for the eating disorder diagnoses.

S24.3
ARE BODY WEIGHT AND AMENORRHOEA USEFUL EATING DISORDER CRITERIA?

Luscombe, Georgina, Department of Obstetrics and Gynaecology, Sydney, Australia; Pettigrew, B.

The ICD-10 (WHO) diagnostic criteria for AN suggest either weight or BMI (body-mass index) should be used: body weight is maintained at least 15% below that expected (lost or never achieved), or BMI is 17.5 or less. Prepubertal patients "may show failure to make the expected weight gain during the period of growth". BMI is a good, easy to obtain measure of adiposity but is influenced by other variables. In our study of over 500 Australian secondary school students we found an ethnic difference in BMI (Asian students have a lower BMI than Caucasian ones) and that menarche is a determinant of BMI (lower for premenarchial). Often BMI is the only criterion which distinguishes a diagnosis of anorexia from bulimia nervosa. Is a change across the BMI 17.5 cut-off meaningful and clinically significant, particularly as age, puberty, gender, ethnicity, body composition and possibly other factors influence BMI? To investigate amenorrhoea as a criterion in the diagnosis of eating disorders the histories of 223 female eating disorder patients were assessed on admission to hospital. The spontaneous menstrual status of 71 (32%) could not be assessed (taking oral contraception, had never menstruated and were <16 years, postmenopausal or hysterectomized). The reproductive system appears to be more resistant to low weight

amenorrhoea as women become older. There is insufficient evidence to support the retention of amenorrhoea as a criterion for the diagnosis and recovery of anorexia nervosa patients.

S24.4
THE NEED FOR ACCURATE PHENOTYPE DEFINITION FOR FUTURE GENETIC STUDIES IN EATING DISORDER ETIOLOGY

Karwautz, Andreas, University Clinic of Neuropsychiatry of Childhood and Adolescence, Vienna, Austria; Treasure, J.L.

Defining the accurate phenotype as pre-requisite for genetic studies is a very difficult and sophisticated enterprise. Recently, papers dealt with this problem in major psychiatric disorders with complex aetiology such as bipolar illness, autism, obsessive-compulsive disorder, ADHD, and schizophrenia. The problem of defining accurate phenotypes for genetic studies in eating disorders was focused on mainly in recent papers from the Price Foundation Collaborative Group. Our paper aims to review the topic of phenotypes in eating disorders research, discusses the problems of diagnostic instability over time, heterogeneity of the eating disorders, sub-typing, candidate phenotypes and endo-phenotypes which can be used in genetically informed research into the etiology of the eating disorders.

S24.5
NEW SIMPLE CRITERIA FOR ANOREXIA-LIKE AND BULIMIA-LIKE DISORDERS

Abraham, Suzanne, Department of Obstetrics and Gynaecology, Australia; Hart, S.; Boyd, C.

The current criteria for the eating disorders, anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified, are not adequate for clinical or research purposes. The data to support this will be presented in this Symposium. The factors involved in the development (menarche) and maintenance of the eating disorders will be examined and taken into consideration when we are considering possible new criteria. In the first instance we are proposing simple criteria for eating disorders involving energy balance, negative or inappropriate episodes of positive or negative balance, with features of control of and preoccupation with eating, weight, shape and overall body, including exercise.

SYMPOSIUM S25
Ethics and Psychiatric Classifications

Chairs: Ahmed Okasha - Driss Moussaoui

Saturday, 21 June, 8.30-10.00 am - Zeremoniensaal

S25.1
ETHICAL DIFFICULTIES RELATED TO SUBTHRESHOLD DISORDERS AND VULNERABILITY IN PSYCHIATRY

Okasha, Ahmed, WPA President, Cairo, Egypt

Many studies have shown that we are faced in our daily clinical practice with many patients, who do not fulfill the criteria of either ICD-10 or DSM-IV. They may be included under atypical, unspecified or not elsewhere classified. Subthreshold cases or prodromata of psychotic or non-psychotic clinical cases are encountered frequently in clinical practice, and because of some ethical issues their needs are unmet. Pharmacological interventions in such conditions are denied in some countries, especially with managed care, where maximization of profit and minimization of cost is the main objective. It has been reported that early treatment of many clinical conditions ensures a better outcome and better assimilation in society and reduces residual manifestations. This paper will discuss and clarify the ethics of treating patients suffering from prodromata or subthreshold diagnosis especially in the field of psychosis in which delayed treatment may produce a lot of harm to the patient and society. It is a very sensitive issue and the decision is controversial and debatable, especially after the claim that second generation antipsychotics have minimal sides effect, no EPS and may improve cognitive aspects and quality of life. Discussions of premorbid vulnerability will be evaluated.

S25.2
LEGISLATIVE FIATS AND MORAL DUTIES

Arboleda-Florez, Julio, Queen's University Department of Psychiatry, Hotel Dieu Hospital, Kingston, Canada

Integrated mental health systems are vital for the well being of any community and should cover the span of services - promotion of good mental health practices and prevention of psychiatric illness to treatment and rehabilitation in the best and least restrictive alternative. These systems are usually anchored in legal frameworks that determine what is possible and that become springboards for action. Mental health legislation forms, along with funding and public support, a tripod that is a sine qua non for any mental health system to function optimally. Unfortunately, often, mental health legislation is drafted with the sole intention of ferreting out the mentally ill and corralling them into institutions as if the whole exercise of a mental health system were to imprison, to drug and to forget the mentally ill. Responsibility for drafting mental health legislation often falls to bureaucrats with little or no mental health knowledge and who proceed without proper public input, oblivious of funding implications, and blinded to the negative impacts of restrictive laws not only on the mentally ill but on society in general. Seldom do bureaucracies deal with ethical responsibilities and, yet, the impacts of their decisions go well beyond their offices and well beyond their lifespan. What moral duties are to be ascribed to bureaucrats and to their political masters as they issue fiats that impact profoundly on the lives of millions in the nation? Can populations be empowered through spirited debate on mental health legislation to see, prevent and stop bureaucratic moral bankruptcy?

This essay will attempt to unravel the ethics of policy making and the moral duties spanning there from.

S25.3
DIAGNOSTIC AND ETHICAL ISSUES RELATING TO PSYCHIATRIC PROBLEMS IN FOREIGNERS IN JAPAN

Akiyama, Tsuyoshi, Department of Psychiatry, Kanto Medical Center, Japan

Unfortunately there exist a number of serious adverse facts regarding diagnostic and ethical issues relating to psychiatric problems of foreigners in Japan. 1. Issue of Diagnosis. Though ICD-10 and DSM-IV are known, in general Japanese psychiatrists are still not accustomed to make diagnosis operationally. Many psychiatrists still use the "traditional" diagnosis without attesting the evidence of the judgment. The lack of language skill and of understanding of the background culture can only exacerbate the problem. There takes place an extreme frustration between a Japanese psychiatrist and a foreigner patient regarding the discussion of diagnosis and the treatment plan based on the diagnosis. 2. Lack of Institution. No psychiatric institu-

tion has been officially assigned to provide service for the foreign population. 3. Lack of Appropriate Financing. The insurance pays very little to psychiatric service. For example, outpatient interview is paid 3,600 yen (30 euro) per session regardless of the length of the interview. Therefore psychiatrists afford only 5 minutes “medication guidance”. 4. Lack of Availability. Due to these factors, there are only a handful Japanese psychiatrists who are willing and capable to provide treatment to foreign patients. 5. Ethical Issue. The international community in Japan is not large, and the available psychiatrists are limited. Therefore these psychiatrists end up treating acquaintances or even friends. 6. Solution. Tokyo English Life Line (TELL) provides anonymous and confidential telephone counseling. In order to solve the small community issue, phone counselors keep their anonymity as well. In cooperation with Japanese Society of Transcultural Psychiatry and embassies, TELL is trying to organize a psychiatric support network for the foreigners. Cross-cultural psychiatry is still in its infancy in Japan.

S25.4
CULTURAL ADAPTATIONS OF CURRENT PSYCHIATRIC CLASSIFICATIONS

López Ibor, Juan José, Clinica López-Ibor, Madrid, Spain

In spite of the limitations of modern nosological systems, the development of cultural adaptations is a step backward leading to unavoidable pitfalls, in spite of the fact that cultural diversity is imposing new attitudes and demands on psychiatrists. Cultural adaptations challenge the principles of the universality of science and of ethics. ICD-10 and DSM-IV rely on the symptoms present to classify psychiatric diseases. This kind of classification has many advantages: it is atheoretical, close to clinical reality, easy to grasp and less prone to untested hypothesis. But they have some drawbacks, as they do not say what diseases are, as the concept of symptom is not totally clear in psychiatry. The greatest disadvantage of this approach is the dispersion of disorders that may be related or even unique. Furthermore, sometimes too many symptoms are present. This method requires a hierarchical structure (as in DSM-III) unless one is willing to live with multiple diagnoses, the so called co-morbidity (as in DSM-IV). But other times, too few symptoms are present, leading to atypical, waste basket categories and subsyndromal categories. Another problem is that symptoms may not be consistent across cultures, therefore leading to the need of cultural adaptations. Cultural adaptations of internationally accepted classifications are looked for if symptomatic criteria are used when symptoms are not consistent across cultures. But in a closer look, very often the symptoms are not so different and it is only the cultural halo which makes them attractive, and when they are particular they can easily be interpreted (i.e., the penis invagination of *latah*). Indeed they represent a way of experiencing common feelings such as anxiety and (i.e., the *susto* of Latin America, which is a typical panic disorder) depression. To put too much emphasis on local symptoms has the risk of yielding to social and cultural pressure.

SYMPOSIUM S26
Do we Treat Psychiatric Symptoms, Syndromes or Diseases?

Chairs: Siegfried Kasper - Alexander Neumeister

Saturday, 21 June, 8.30-10.00 am - Rittersaal

S26.1
EVIDENCE FROM EPIDEMIOLOGY ABOUT DIAGNOSTIC VALIDITY

Lepine, Jean Pierre

Abstract not received

S26.2
WILL BRAIN-IMAGING TECHNIQUES CHANGE OUR VIEW ABOUT DIAGNOSTIC ENTITIES

Tauscher, Johannes, Department of General Psychiatry, University Hospital for Psychiatry, Vienna, Austria

Functional neuroimaging with functional magnetic resonance imaging (fMRI), positron emission tomography (PET) or single photon emission tomography (SPECT) in psychiatry serves as a tool in basic research to understand the underlying pathophysiology of neuropsychiatric disorders. Studies of cerebral blood flow and metabolism revealed characteristic patterns for depression, anxiety disorders, schizophrenia, certain substance abuse disorders, and dementias. Further to that, neuroreceptor imaging with PET and SPECT revealed characteristic disturbances of the serotonergic and dopaminergic neurotransmission in schizophrenia, and disturbances of the serotonergic system in depression, eating disorders and personality disorders. The relevance of these findings for the diagnosis of psychiatric disorders, and new emerging views about diagnostic entities will be discussed. Future applications comprise a role in the diagnosis of dementias, predicting clinical response to specific therapeutic interventions, and in combination with genetic studies that attempt to find genotype-phenotype associations typical for specific neuropsychiatric disorders.

S26.3
SYMPTOMATOLOGY INDUCED BY DEPLETION PARADIGMS - WHAT DO WE LEARN FOR THE DIAGNOSTIC PROCESS

Neumeister, Alexander, NIMH, Mood and Anxiety Disorders Program, Bethesda, United States

Major depressive disorder (MDD) has been associated with abnormally reduced function of central serotonergic and catecholaminergic systems by various types of evidence. One instructive paradigm for investigating the relationship between monoaminergic function and depression has involved the mood response to tryptophan depletion (TD) and catecholamine depletion (CD), achieved by oral loading with all essential amino acids excepting the serotonin (5-HT) precursor, tryptophan and administration of the tyrosine hydroxylase inhibitor alpha-methyl-para-tyrosine (AMPT), respectively. Depletion studies involving depressed patients during an episode of MDD and during remission on and off treatment suggest that pharmacological and non-pharmacological (light therapy, sleep deprivation) treatments for MDD treat the symptoms of MDD but do not correct for the underlying deficit. Combining depletion paradigms with genetic variables may be helpful to identify high-risk populations for MDD. Depletion studies combined with functional brain imaging in

unmedicated remitted MDD patients off treatment may help to identify the brain circuitries involved in the pathogenesis of MDD. This hypothesis is supported by an ongoing study showing that overall, the pattern of changes in relative metabolism during TD-induced depressive relapse resembles that found in the unmedicated phase of MDD. This is important because TD has been shown capable to predict the future course of MDD, and thus may be a tool to identify those people with MDD who may have the greatest benefit from long-term treatment.

S26.4
DO PSYCHOPHARMACOLOGICAL TREATMENTS VARY ACROSS DIAGNOSTIC ENTITIES?

Kasper, Siegfried, Department of General Psychiatry, University Hospital for Psychiatry, Vienna, Austria

Since the introduction of psychopharmacological compounds for treatment of mental disorders, researchers set out to treat the specific diseases based on psychopathological concepts derived from the beginning of last century, as early as Kraepelin´s dichotomy. However, it soon emerged that syndromes rather than diseases can effectively be treated with the different agents. Based on the available animal models new compounds were developed with either antidepressant or neuroleptic properties. The introduction of the Research Diagnostic Criteria (RDC) laid the ground for modern psychopharmacological research. It soon emerged that neuroleptics as well as antidepressants are not only therapeutic in the field of psychosis or depression but also in different other diseases that are characterised by specific symptoms and syndromes. Within the depression/anxiety spectrum serotonergic compounds have shown a large array of therapeutic properties, although different dosages need to be applied. Atypical antipsychotics not only demonstrated beneficial effects in schizophrenia but also in bipolar disorder, treatment refractory depression, personality disorders as well as behavioural and psychological symptoms associated with dementia (BPSD). Since doctors in the field are oriented on a model of diseases that can be treated by specific compounds it is likely that the response to psychopharmacological agents will change the way how patients are diagnosed and understood. The future of psychopathological and diagnostic research will have to include the latter thoughts in order not to lose the connection with doctors treating patients in everyday practice.

S26.5
HOW TO INCLUDE MOLECULAR PSYCHIATRY IN DIAGNOSTIC PROCESSES IN PSYCHIATRY?

Maier, Wolfgang, Universitätsklinikum Bonn, Klinik und Poliklinik für Psychiatrie und Psychotherapie, Bonn, Germany

All psychiatric disorders are clustering in families and are under genetic control. Yet, the specific genetic determinants on an DNA-level remains obscure. Under this constellation, positive family history with the same disorder had the status of a research criterion for the validation of diagnoses, a criterion for increasing the certainty of an individual diagnosis. This scenario has changed recently. After years of frustration, several susceptibility genes (e.g. dysbindin, neuregulin1) have been identified, particularly for schizophrenia. Although the pathogenic mutation is not known for any of these strong associations, marker haplotypes with schizophrenia were replicated. The consequences for the diagnosis of schizophrenia are discussed.

SYMPOSIUM S27
The Contribution of Neurocognition to the Diagnosis of Schizophrenia

Chairs: Richard Keefe - Terry Goldberg

Saturday, 21 June, 8.30-10.00 am - Geheime Ratsstube

S27.1
THE RELIABILITY, VALIDITY AND HEALTH VALUE OF SCHIZOPHRENIA AND FAST FOOD

Murray, Robin, Institute of Psychiatry, London, United Kingdom

Abstract not received

S27.2
SPECIFICITY OF COGNITIVE IMPAIRMENTS IN SCHIZOPHRENIA: OBSERVATIONS FROM MULTIPLE LEVELS OF ANALYSES

Goldberg, Terry, National Institute of Mental Health, Bethesda, Maryland, United States

Schizophrenia is a neuropsychiatric disorder reliably characterized by cognitive impairments in working memory, episodic memory, executive function, and early attentional processing. However, it is unclear if this “profile” is specific to schizophrenia or is a nonspecific function of dysfunctional information processing. To attempt to resolve this issue data will be marshaled from several different areas of research. First, patients with schizophrenia will be compared to patients with other neurological and psychiatric conditions, including those with bipolar disorder, temporal lobe epilepsy, Parkinson’s disease, Huntington’s disease, and Alzheimer’s disease. Second, patients with schizophrenia will be compared to other psychiatric groups on outcome measures, including expert performance and GAF. Last, the impact of COMT, BDNF, and G72 genotype on cognition in schizophrenia and affective disorder will be compared. It is hoped that these approaches will yield a nuanced view of areas of overlap and difference in contrasts between schizophrenia and other neuropsychiatric groups.

S27.3
SHOULD NEUROCOGNITIVE IMPAIRMENT BE A PART OF THE DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIA?

Keefe, Richard, Duke University Medical Center, Durham, North Carolina, United States

Patients with schizophrenia have cognitive deficits that are, on average, moderately severe to severe compared to healthy controls. The average patient with schizophrenia performs similarly to the lowest 5-15% of healthy controls. Patients with schizophrenia have more severe cognitive deficits than patients with major depression, bipolar illness, or obsessive-compulsive disorder. Does the severity of this impairment suggest that cognitive impairment should be a part of the formal diagnosis of schizophrenia? The areas frequently investigated for purposes of validating classification in psychiatry include outcome, clinical description, biology, exclusion criteria, and family study. This presentation will consider whether the criteria for schizophrenia would be improved in these areas if cognitive function is included. For instance, regarding outcome, cognitive impairment is more strongly associated with functional disability than positive symptoms or negative symptoms. Including cognitive impairment as part of the criteria for schizophrenia may thus improve the predictive validity of a schizophrenia diagnosis. Other areas of validation will

also be considered, as will the diagnostic sensitivity and specificity of cognitive impairment in patients with schizophrenia versus other symptom domains that are currently a part of the criteria, such as delusions, hallucinations, disorganized speech, grossly disorganized behavior, and negative symptoms.

SYMPOSIUM S28
The Role of Prognosis in the Classification of Mental Disorders

Chairs: Michaela Amering - Glynn Harrison
Saturday, 21 June, 8.30-10.00 am - Trabantenstube

S28.1
THE RELATIONSHIP BETWEEN DIAGNOSIS AND PROGNOSIS IN MENTAL DISORDERS

Sartorius, Norman, University of Geneva, Geneva, Switzerland

The second part of the 20th century was marked by efforts to develop criteria, which would enable doctors and researchers to use the same diagnoses for the same disorders. Major advances have been made towards this goal and the ICD-10 and DSM-IV classification systems have come into use in most of the world's research institutions and in numerous mental health service organizations. The definitions of criteria concerning duration of illness and its prognosis caused and continue to cause most difficulty in the process of creating a common language for psychiatry. This is in part due to the lack of firm evidence about medium and long-term prognosis of most mental disorders and in part to the advances in social and biological treatment in recent years that seem to improve changes of concepts of mental illness. To make progress despite the lack of evidence about the course and outcome of many mental disorders, it seems necessary to decrease the reliance on the duration or prognosis of illness as a determinant criterion for diagnosis and classification of mental disorder while paying more attention to laboratory (e.g. NMR) findings in the diagnostic process; and, at the same time, intensify studies that will acquire unbiased information about the course and outcome of mental disorders in different cultures, possibly developing a classification of these disorders based on course of illness as an alternative hypothesis for the basis of classifications of mental illness.

S28.2
CHRONIC COURSE AS A CLASSIFIER FOR DEPRESSION AND BIPOLAR DISORDERS

Angst, Jules, Zurich University Psychiatric Hospital, Zurich, Switzerland; Gamma, A.; Ajdacic-Gross, V.; Eich, D.; Rössler, W.

Objectives: To investigate whether chronic course is a desirable classifier in the diagnostic system of mood disorders. **Methods:** In the prospective Zurich cohort study the course of depression was assessed twice, when the interviewees were 34/35 and 40/41 years of age; subjects identified their own course patterns from graphic illustrations offered to them. **Results:** Major depressive episodes (MDE) were chronic in 23.4%, recurrent in 62.9% and manifested as single episodes in 13.7%; there was no gender difference. The distinction between bipolar (BP) and unipolar (UP) subgroups gave chronicity rates of 18.8% for bipolar and 28.3% for unipolar depression (p=.05). The age of onset of both chronic UP and chronic BP was about 5 years earlier than in single episode cases; recurrent cases took an intermediate position. Chronic UP and BP MDE cases tended to have a lower family history rate for depression than cases with a phasic course, although a positive family history was correlated with an earlier age of onset. Chronic vs. phasic course was associated with higher lifetime rates of suicide attempts (41% vs. 23%). **Conclusions:** Chronic depression should be kept as a defined subgroup in the classification system: apart from its great clinical significance, the lower genetic load and the early onset suggest that other developmental or environmental factors may be etiologically involved. These factors seem to play a role in both UP and BP MDE.

S28.3
DO SUBTYPES MATTER IN THE PROGNOSIS OF ATTEMPTED SUICIDES? - A 30-YEAR FOLLOW-UP

Katschnig, Heinz, Department of Psychiatry, University of Vienna, Vienna, Austria; Freidl, H.; Hanika, H.; Krautgartner, M.

In 1971, when all attempted suicides of Vienna (1,7 million inhabitants), were referred to a central detoxification unit at the Department of Psychiatry of the University, a one-in-four sample of patients admitted due to attempted suicide were selected for a prospective follow-up study. Of 276 patients in the sample 15 had died while on the detoxification unit and 261 remained to be followed up. A cluster analysis with a few easily to collect variables was carried out for the baseline population and yielded 7 distinct clusters, with a large cluster comprising predominantly young women who had taken overdoses of medication which had not led to unconsciousness, and, among others, a cluster with predominantly elderly persons who were all retired. The fate of these patients in respect to whether they had died and what the cause of death was, could be cleared for 231 (88,5%) of these patients 30 years later. 30 (11,5%) could not be traced. Of the 231 persons, whose fate could be cleared, 125 (54,1%) were still alive 30 years later, and 106 (45,9%) had died. 22 patients (8,4% of the original population) had committed suicide, 7 (2,7%) had died from an unclear cause, and 77 (29,5%) from a natural cause. For the total group the suicide risk was 10 times higher than expected in a matched group of the general population and it was unevenly distributed among the clusters, with the lowest value in the large "young woman" cluster (only 3 times higher) and the highest in the "old" cluster (18 times higher).

S28.4
MAKING DIAGNOSES AND PROGNOSES IN FIRST-EPISODE PSYCHOSIS: 15 YEAR FOLLOW-UP DATA FROM THE INTERNATIONAL STUDY OF SCHIZOPHRENIA

Harrison, Glynn, Division of Psychiatry, University of Bristol, United Kingdom

For much of the last century, a diagnosis of schizophrenia was synonymous with poor course and outcome. The International Study of Schizophrenia (ISoS) investigated long term (15 year) outcome trajectories in 14 representative cohorts of first episode psychosis in 12 different countries. Study findings challenged assumptions of chronicity, with significant heterogeneity across different outcome domains and marked variation between centres. Nevertheless, within the non-affective psychoses, a baseline diagnosis of schizophrenic disorder (in several classificatory systems) was consistently associated with inferior long-term outcome. Comparing the performance of diagnostic systems at 3 year and 15 year follow-up periods, both ICD-10 and DSM-III-R showed considerable instability in the short-term, but had comparable predictive validity over the long-term. The predictive strength of DSM-III-R was accounted for entirely by the 6

month duration criteria and sensitivity was lower compared with ICD-10. The 1 month duration criteria of ICD-10 proved less restrictive in terms of sensitivity, and without major losses in predictive validity or stability. Schneider first rank symptoms (S+) had no predictive validity whatsoever. In regression analyses diagnosis explained a small proportion of the variance in long term disability outcomes, but its contribution remained relatively modest compared with demographic and early course predictive factors. We conclude that the differentiation of non-affective psychoses is remarkably heterogeneous and plastic; categorical diagnoses have some predictive value but they remain a blunt and unreliable tool.

S28.5
THE RECOVERY MOVEMENT - IMPLICATIONS FOR LANGUAGE, PROGNOSTIC OUTLOOK, AND CLASSIFICATION IN PSYCHIATRY

Amering, Michaela, Department of Psychiatry, University of Vienna, Vienna, Austria

The concept of recovery has emerged as a new paradigm and model for self-help and professional services in the field of mental health. It is described as a move away from the limitations of a patient role based on a diagnostic label and as a process towards social integration defined by meaningful relationships, roles, and responsibilities in the community. Social exclusion and stigma resulting from mental illness are strongly influenced by how mental illnesses are viewed by psychiatry as well as by the public in terms of their prognostic outlook. The 1999 WPA Consensus Statement on Preventive Psychiatry lists the "reduction of prevailing scepticism regarding the possibility of cure" as a main goal towards reducing distress, inpatient treatment and stigmatisation of mental diseases and improving quality of life. Major advances in social and biological treatments as well as epidemiological data support efforts to urgently emancipate diagnoses such as schizophrenia from unjustified prognostic negativity. Efforts to establish a definition of recovery have led to discussions of related concepts such as remission, episode, relapse, chronicity, and cure as well as normal and near-normal functioning. Current research concentrates on validating operational definitions as well as on different dimensions, determinants, courses, and obstacles for recovery processes. Important considerations around the concept of recovery also pertain to the question of coverage of preventive measures - especially tertiary and quaternary prevention - without the hindrance posed by lack of hope and empowerment resulting from some diagnoses and their prognostic implications.

SYMPOSIUM S29
The Role of Culture in Psychiatric Diagnosis and Classification

Chairs: Pedro Ruiz - Roger Montenegro

Saturday, 21 June, 8.30-10.00 am - Radetzky Appartement

S29.1
THE IMPACT OF SYMPTOM FORMATION ON DIAGNOSIS

Ruiz, Pedro, University of Texas, Medical School at Houston, Houston, United States

From a clinical dimension, behavioral manifestations are deeply influenced by the norms and values of any given culture. Over time, these cultural influences produce behavioral characteristics that become an intrinsic part of a given cultural group. In this context, what it might appear pathological to a given clinician could be normal if assessed from a cultural viewpoint. Likewise, certain idioms of distress manifested within the boundaries of a given cultural group might not be clinically understood well by a diagnostician who is not familiar with the culture in which these idioms of distress are manifested. At times, however, the challenges are based on racial and ethnic dimensions. For instance, certain diagnoses or conditions might be overlooked among some ethnic or racial groups. For example, Bipolar Disorders are less diagnosed among African American populations in the United States than among Caucasian populations. In other occasions, the diagnostic challenges are not based on ethnic, racial or cultural connotations but on the unique diagnostic patterns of a given system of care. In these instances, the diagnoses can change from admission to admission or from systems of care to systems of care. In this presentation, the different factors that challenge the development and implementation of a more unified diagnostic classification across the world will be addressed. Hopefully, by discussing these challenges, new ideas will be developed which in turn will permit a better integration of diagnostic systems at an universal level.

S29.2
THE ROLE OF CULTURE IN PSYCHIATRIC DIAGNOSIS AND CLASSIFICATION

Bailey, Rahn, University of Texas, Medical School at Houston, Houston, United States

We all live in a diverse society with ever-growing ethnic and racial differences. One third of the United States population are nonwhite and speak a language other than English at home. Different sectors of society – public policy, healthcare, education, and employment are confronted with issues of multiculturalism, cultural diversity, and ethnic differences. Racism ultimately influences health through intermediary risk factors that directly affect individual patients. It continues to be a major contributor to disparate health outcomes experienced by ethnic minorities. Issues and concerns related to culture differences and language proficiencies are instrumental in making a clinical diagnosis, particularly in psychiatric illnesses. It has been well described in the psychiatric literature that ethnic differences in the patient's presentation of symptomatology may lead to error in diagnosis. The reasons for these differences in clinical assignment of psychiatric diagnosis remain unclear. Organic disorders are more likely to be diagnosed among Whites, whereas affective and personality disorders are more frequently diagnosed for Blacks and Hispanics. Minorities suffering from bipolar affective disorders, especially Blacks and Hispanics, are more likely to be diagnosed with schizophrenia. Language is frequently a major concern since minorities, especially migrants and refugees, cannot relate and express well their presenting problem. Clinicians should be aware of biases in psychiatric diagnosis and risks for misdiagnosis when treating a culturally different patient. Increase in knowledge of cross-cultural and multicultural differences as well as enhanced cultural sensitivity are needed to minimize discrepancies in diagnosis and disparities in healthcare outcomes.

S29.3
DIAGNOSIS ACROSS CULTURES

Montenegro, Roger, Institute of Postgraduate and CME, Buenos Aires, Argentina

Diagnosis is one of the most central concepts in medicine, and of course, in psychiatry, as it defines the field. It describes the whole clinical condition of the patient in a way that is helpful for effective treatment and health promotion. Thus, diagnosis is fundamental for clinical training, clinical research, management, economic and legal aspects, etc. Furthermore, it informs the conceptualization of what a case is and the methodology for its assessment in epidemiology and public health. In our increasingly multicultural world, it is essential to strive for an effective integration of universalism (which facilitates professional communication across centers and continents) and local realities and needs (which address the uniqueness of the patient in its particular cultural context). There is the variety of origins of values: individual, professional, familiar, social, cultural. Human values differ widely and legitimately, from person to person, for the same person in different contexts or at different times, from culture to culture, and in different historical periods. This presentation will concentrate on the differences across cultures, as diagnosis may be nosological or differential, but it basically has to do with understanding what is happening in the patient's mind and body, within his own culture.

S29.4
PATTERNS OF DIAGNOSIS OVER TIME

López-Ibor Alcocer, Maria Ines, Psychiatric and Psychological Medicine, Complutense University, Madrid, Spain

The expectations from classifications of mental disorders are many. A classification is expected to be useful in clinical settings as well as being valid for legal, financial and research purposes. There are many different ways in which classifications can be constructed. The fundamental choice is between a categorial and a dimensional structure. Although most sciences start with a categorial classification of their subject matter, they often replace this with dimensions as more accurate measurements are available. The requirement that categories of a typology should be mutually exclusive and exhaustive has never been fully met by any psychiatric classification. The cardinal disadvantage of categorial model is to encourage a unique entity view of the psychiatric disorders. On the other hand the difficulties with dimensional models are the lack of agreement on the number and nature of the dimensions required to establish a diagnosis, and in the evaluation of the severity and/or change. Categorial and dimensional models need not to be mutually exclusive as a classification can combine qualitative categories with quantitative trait measurements, specially if it has a multiaxial structure. Research data support new tendencies in the way some mental disorders are classified, for instance personality disorders or schizophrenia. In both categorial clinical descriptions are compatible with the classification of quantitative traits such us attention, cognitive impairment or volumetric changes of cerebral structures. Molecular genetics, molecular biology, neurochemistry, neuroanatomy, neurophysiology, structural and functional neuroimaging data should be considered in new classifications.

S29.5
DIAGNOSIS AND CULTURE BOUND SYNDROMES

Matorin, Anu, University of Texas Medical School at Houston, Houston, United States

Despite the gains secured from a diagnosis and classification point of view in recent years, much remains to be understood and addressed; particularly, from a cross-cultural perspective. For instance, the World Health Organization has studied diagnosis of mental disorders among various cultures; also, the International Pilot Study of Schizophrenia confirmed that schizophrenia exists among all groups studied (i.e. Taiwanese, Laotians, Nigerians, Danes, etc.) and is constant across cultures. However, there are certain unique symptomatic manifestations consistent with a group of psychiatric conditions that are found primarily in certain cultures or among certain groups of people; that is, "culture-bound syndromes", which are often not understood well across different ethnic and racial groups. Historically, from both a clinical and psychiatric training and education perspective, psychiatric symptomatology and diagnosis are viewed primarily from a Western prism, with little emphasis on the impact of culture on symptoms, clinical manifestations and diagnosis. In a large part, this lack of awareness may be due to limited knowledge about cross-cultural factors impacting psychiatric conditions or a lack of emphasis on culturally related diagnosis during medical school and graduate and postgraduate psychiatry training. This presentation will identify "culture-bound syndromes" across various ethnic and racial groups. Primary emphasis will be placed in addressing current challenges and in developing global strategies to better integrate diagnostic classification systems in psychiatric training and practice.

SYMPOSIUM S30
Classification Issues and Psychiatric Rehabilitation

Chairs: Robert Cancro - Johannes Wancata

Saturday, 21 June, 8.30-10.00 am - Künstlerzimmer

S30.1
CONSENSUS STATEMENT ON REHABILITATION OF PERSONS IMPAIRED BY MENTAL DISORDERS

Cancro, Robert, New York University Medical Center, Department of Psychiatry, New York, United States

Almost by definition psychiatric disorders involve the higher levels of nervous system functioning. These levels include cognition, emotion, relatedness, mood, etc. The degree of impairment and the area in which that impairment occurs determines the form and extent of rehabilitation required by that particular diagnostic category. Obviously, individuals differ in severity and that is another factor that has to be taken into account. Historically, rehabilitation efforts tended to focus on the persistently and severely mentally ill. These were individuals who had difficulty sustaining themselves outside of an institutional setting. While this has been a vital component in the work of specialists in rehabilitation, it has in some ways obscured the need for rehabilitation in other psychiatric disorders which are less severe. As an illustration of this point, even an anxiety disorder can have a significant impairment in the quality of the individual's life. It follows then that every psychiatric patient must be evaluated in terms of the quality of their biopsychosocial functioning. Appropriate treatment goes far beyond symptom suppression and must include the maximization of the adaptive potential of the individual. Rehabilitative

efforts must span the spectrum of human activities that can be impaired in psychiatric disorders.

S30.2
ARE PSYCHIATRIC DIAGNOSES USEFUL FOR PLANNING PSYCHIATRIC REHABILITATION?

Reker, Thomas, Westfälische Klinik für Psychiatrie und Psychotherapie Münster, Germany

The value of psychiatric diagnosis for planning rehabilitation interventions has undergone substantial change in the last decades. The opinion that psychiatric diagnosis and psychiatric symptoms have no relevance at all for social and vocational functioning or the course and outcome in psychiatric rehabilitation was replaced by a more differentiated view. Psychiatric symptoms and diagnosis on the one hand and functional assessment and social functioning on the other hand are two different but overlapping perspectives on persons with severe and enduring mental disorders. They should be seen as complementary perspectives, not as in contradiction with each other. The WHO concept of impairment, disability and handicap (ICIDH) and its 2001 revision, the International Classification of Functioning, Disabilities and Health, are based on this view. In particular in the field of vocational rehabilitation there is a lot of empirical evidence on the complex relationship of mental illness and disability which will be summarised in the presentation: vocational rehabilitation programmes not only influence social functioning and vocational integration in a positive way but reduce psychiatric symptoms. Psychiatric diagnosis and symptoms are correlated to the capacity to work and relevant predictors for rehabilitation outcome. A comprehensive view on persons with severe and enduring mental disorders has to integrate psychiatric diagnosis/symptoms and the functional perspective of skills assessment and environmental resources. Therapeutic and rehabilitation measures have to be combined in an individual programme.

S30.3
REDUCING THE COMPLEXITY OF PREDICTORS FOR SUCCESSFUL VOCATIONAL REHABILITATION IN SCHIZOPHRENIA: A FACTOR-ANALYTIC APPROACH

Hoffmann, Holger, Universitäre Psychiatrische Dienste Bern, Gemeindepsychiatrie, Bern, Switzerland; *Kupper, Z.*

Background: Vocational rehabilitation is a central issue in the rehabilitation of patients with chronic schizophrenia. However, even with the help of comprehensive integration programs, achieving this objective remains a very ambitious and difficult undertaking. Therefore, a profound and up-to-date knowledge of vocational outcome predictors in patients who have the goal to return into competitive employment is imperative. The objective of the present study was to minimize the influence of the instruments generally used for assessing vocational capacity, since there is considerable overlap between most of them. **Methods:** Ten factors were derived from a factor analysis including 32 variables from instruments assessing different aspects known to be relevant to vocational functioning. The predictive value of these ten factors centering on vocational outcome was tested in a sample of 76 schizophrenia patients enrolled in a re-integration program into competitive employment. **Results:** Participants who had a successful outcome showed a good vocational capacity before and during the two-week assessment phase, had no social deficits and no depressive-resignative coping strategies, e.g. had not given up the hope to influence their fate. Psychopathology and cognitive deficits, however, were of minor relevance in this highly selected sample. **Conclusions:** The results of our factor-analytic approach confirm earlier findings that vocational functioning observed in a sheltered setting and social competence are the best predictors for successful vocational rehabilitation. Moreover, they serve to substantiate the necessity of promoting programs designed to transform fatalistic beliefs into feelings of hopefulness, thereby enhancing the readiness of schizophrenia patients to enroll in rehabilitation programs.

S30.4
CARERS' NEEDS ASSESSMENT SCHEDULE: A NEW APPROACH TO CLASSIFY THE NEEDS OF SCHIZOPHRENIA RELATIVES

Wancata, Johannes, University of Vienna, Department of Psychiatry, Austria; *Krautgartner, M.; Berner, J.; Freidl, M.; Scumaci, S.; Rittmannsberger, H.*

Objective: The aim of this study was to develop a research instrument to assess the needs of schizophrenia care-givers. While previous needs instruments often mixed problems and interventions, we tried to clearly distinguish interventions (e.g. group for psychoeducation) from the problems which justify an intervention (e.g. not enough knowledge about the illness). **Methods:** Based on a systematic review of the literature and qualitative interviews, an instrument was developed to assess the needs of care-givers. Then, consensual and content validity were investigated by interviews with 50 psychiatric experts and 50 relatives. Inter-rater and retest reliability were investigated among 50 other relatives. **Results:** The instrument consists of 18 sections and of 4 sub-sections (median, range 2-6) for each section. Experts confirmed that this instrument includes the most important problems (98%) and interventions needed by relatives (94%). 89% of the experts agreed that this instrument is easy to use and 86% that its content is important for clinical work. Regarding all sections and sub-sections together 82% of the relatives agreed they are important or very important. The inter-rater agreement was excellent (kappa >0.75) for 72.2% of the problem sections and for 88.9% of the interventions (= sub-sections). The retest reliability of the interventions was good or excellent (kappa >0.60) for 58.8% and sufficient (kappa 0.40-0.60) for 41.2%. Similar results were found for the problem areas. **Conclusions:** Overall, it appears that it is possible to clearly distinguish interventions from problems when assessing needs. The results for consensual and content validity are surprisingly good.

SYMPOSIUM S31
Pharmacotherapeutic Implications of Diagnostics in Psychiatry

WPA Section "Pharmacopsychiatry"

Chairs: Bernd Saletu - Ulrik Malt

Saturday, 21 June, 8.30-10.00 am - Schatzkammersaal

S31.1
THE USE OF PSYCHOMETRICS IN THE PHARMACOTHERAPY OF MENTAL DISORDERS

Hindmarch, Ian, HPRU Medical Research Centre, University of Surrey, Surrey, United Kingdom

Most researchers in pharmacotherapy of mental illness are familiar with and use clinical rating scales, e.g. HAM-D, MADRS, for assessing not only the severity of psychiatric illness, but also the impact of pharmacotherapy on the scores obtained from these clinical assessments. To date, there has been a limited use of objective psychomet-

rics, e.g. Critical Flicker Fusion (CFF) Threshold, Actigraphy, Choice Reaction Time and computer-assisted tests of memory and cognitive function in clinical trials other than to measure the side effects of medications. However, many of these objective psychometrics are utilisable as primary outcome measures yielding both directly and indirectly valuable information regarding not only changes in the severity of anxiety and/or depression, but also providing a continuous indication of the clinical progress of the disease/drug treatment regimen. The utility of some of these measures will be illustrated with specific examples. CFF has been known to correlate with clinical measures of anxiety since the 1950s. The large-scale trials of benzodiazepines in the latter part of the last century afforded an ideal opportunity to use CFF as an outcome variable for the development of non-sedative anxiolytics. Gross psychomotor retardation is a well-established feature of major depressive illness. It is possible to demonstrate this in depressed patients using actigraphy, where overall measures of patient activity can be plotted on a circadian basis. Improvements in daytime activity levels (measured as a reduction in periods of daytime sleepiness) will be shown to correlate with reductions in overall clinical rating of the severity of depressive illness. Similarly, the freedom from seizures following the use of anticonvulsant therapy will be shown to reflect improvements in psychometric assessment of memory and cognition. These examples will serve as the basis for illustrating and discussing the role of psychometrics in psychiatric illness.

S31.2
ELECTROPHYSIOLOGICAL NEUROIMAGING IN DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS: EVIDENCE FOR A KEY-LOCK PRINCIPLE

Saletu, Bernd, Department of Psychiatry, University of Vienna, Vienna, Austria; Anderer, P.; Saletu-Zyhlarz, G.M.; Pascual-Marqui, R.D.

Clinically well-defined diagnostic subgroups of mental disorders, such as schizophrenia with predominantly plus and minus symptomatology, major depression, generalized anxiety disorder, agoraphobia, obsessive-compulsive disorder, multi-infarct dementia, senile dementia of the Alzheimer type and alcohol dependence, show EEG maps that statistically differ both from each other and from normal controls. Representative drugs of the main psycho-pharmacological classes, such as sedative and non-sedative neuroleptics and antidepressants, tranquilizers, hypnotics, psychostimulants and cognition-enhancing drugs, induce - as compared with placebo - significant and typical changes in normal human brain function, which in many variables are opposite to the above-mentioned differences between psychiatric patients and normal controls (key-lock principle). This is supported by low-resolution brain electromagnetic tomography (LORETA), which identifies brain regions affected by psychiatric disorders and psychotropic drugs. 3 mg haloperidol, for instance, induced in normals delta, theta, alpha-1 and alpha-2 changes in those regions where opposite differences between schizophrenics and normals had been described. Furthermore, untreated GAD patients exhibited an increase in delta and theta (mainly occipitally), alpha-1 (frontally, occipitally), alpha-2 (frontally) and beta-2 power, as compared with normal controls, while anxiolytic drug treatment induced just the opposite changes as compared with placebo after 4 weeks of treatment. Thus, by considering the differences between psychotropic drugs and placebo in normals as well as between mental disorder patients and normal controls, it may be possible to choose the optimum drug for a specific patient according to a key-lock principle, since the drug should normalize the deviant brain function.

S31.3
NEUROPHARMACOLOGY OF SIMPLE AND COMPLEX WORKING MEMORY DEFICITS IN SCHIZOPHRENIA

Umbricht, Daniel, Division of Psychiatric Research, University of Zurich, Zurich, Switzerland

In schizophrenia deficient generation of the auditory event-related potential (ERP) mismatch negativity (MMN) and specific deficits in an ‘AX’-type continuous performance test (AX-CPT) indicate abnormalities in simple and complex working memory systems. In studies in human volunteers we sought to investigate the exact role of the NMDA and 5-HT2A receptors in these cognitive deficits. In two separate placebo-controlled studies we investigated effects of the NMDA antagonist ketamine and the 5-HT2A agonist psilocybin on simple and complex working memory tasks (Ketamine study: N=20, Psilocybin N=18). Both drugs induced patterns of performance deficits in AX-CPT performance that were remarkably similar to the deficit pattern in schizophrenia. In contrast, the effects on auditory ERPs differed markedly between the two drugs. Ketamine led to a significant reduction of MMN, but not N1 – a sensory ERP manifesting initial stimulus registration. In contrast, psilocybin significantly reduced N1, but not MMN generation. Thus, these compounds differed in the pattern of their overall effects on simple and complex working memory. Their specific effects on MMN and N1 generation most likely represent direct actions at their respective receptor sites, whereas secondary pharmacological effects may be the common mechanism underlying impairments in AX-CPT performance. Both NDMA antagonists and 5-HT2A agonists indeed lead to comparable disruption of neurotransmitter systems downstream to these receptors – in particular the glutamate and the dopamine system. Thus, in schizophrenia, dysfunctions of 5-HT2A and NMDA receptor-related neurotransmission may be associated with distinct deficits at the level of preattentive auditory information processing and simple auditory working memory systems. In contrast, such dysfunction may independently lead to similar abnormalities in the dynamics of glutamatergic and dopaminergic systems resulting in comparable deficits in higher cognitive functions such as complex working memory systems.

S31.4
DIFFERENTIATION OF BIPOLAR DISORDER SPECTRUM FROM BRIEF RECURRENT DEPRESSION: IMPLICATIONS FOR PHARMACOTHERAPY

Malt, Ulrik Fredrik, Department of Psychosomatic Medicine, University of Oslo, Norway

Recurrent Brief Depression (RBD) is a depressive illness characterised by very frequent (10-12 episodes/year) and severe, but brief (mean 3 days), depressive episodes. The prevalence of suicide attempt is about 14% compared to 3% in the general population and about 20% in severe major depressive episode. The male to female ratio is about 1. RBD mostly starts in the teens. The prevalence is not finally established (2-10%???). Due to the frequent episodes, the euthymic periods are often overlooked. RBD is often mistaken for being dysthymia or unstable (borderline) personality disorder. Bipolar spectrum disorders include bipolar type I, II, III and IV and cyclothymia as well. In cases of bipolar I, the presence of manic episodes makes the diagnosis easy in most cases. In contrast, in bipo-

lar type II disorders, hypomanic episodes may be brief and dominated by overactivity more than mood elation. Accordingly, the disorder may often be mistaken for a unipolar depressive episode. If the course is that of rapid cycling, the disorder may be mistaken for being recurrent brief depression (RBD). Similarly rapid cycling courses of bipolar III disordes may be mistaken for being RBD. Sometimes also cyclothymia may be mistaken as RBD. Based on preliminary data from an ongoing study of the neurobiology of RBD, this presentation will discuss the implications of precise diagnosis of bipolar spectrum disorders and RBD respectively for the pharmacotherapy of these two disorders.

S31.5
PET, PHARMACOTHERAPY AND MAJOR PSYCHIATRIC DISORDERS

Burrows, Graham, Australia

Abstract not received

SYMPOSIUM S32
The Classification of the Delusional Misidentification Syndromes

Chairs: George N. Christodoulou - Lefteris Lykouras
Saturday, 21 June, 8.30-10.00 am - Erzherzog Karl Saal

S32.1
THE DELUSIONAL MISIDENTIFICATION SYNDROMES: CLASSIFICATION ISSUES. INTRODUCTION

Christodoulou, George N., Athens University,
Department of Psychiatry, Athens, Greece

The four basic Delusional Misidentification Syndrome (DMS) subtypes occur in a variety of nosological settings, mainly schizophrenic disorders, affective disorders and organic psychosyndromes. However, in the majority of them an organic component expressed clinically (*deja* and *jamais vu*, depersonalization, autoscopy etc.) or revealed by laboratory methods (e.g. EEG) is present. Would this justify classification of these syndromes under a broadly defined diagnosis of organic disorder? This question is discussed and the conclusion is reached that although the organic disorder diagnosis is valid for a great number of cases, yet it is not applicable to all DMS syndromes.

S32.2
CO-EXISTENCE OF VARIOUS DMS SUB-TYPES: IMPLICATIONS FOR CLASSIFICATION

Lykouras, Lefteris, University of Athens, Department of Psychiatry, Athens, Greece

The Delusional Misidentification Syndromes (DMSs) include four basic subtypes: Capgras syndrome, Fregoli syndrome, the syndrome of inter-metamorphosis and the syndrome of subjective doubles. The DMSs may occur in the context of a variety of nosological settings such as schizophrenia, mood disorders and organic mental disorders. Throughout the years the list of DMSs has been extended by presenting new cases and proposing new variants. Many authors have claimed that they are rare but this idea has been questioned by others who insist that they are less rare than commonly reported. All syndromes are a variance of the same basic concept and this is why a unitary approach was followed by most investigators. Regardless of clinical diagnosis and demonstrable brain pathology, a coexistence of DMS types has been reported. The Capgras syndrome may occur in association with the Fregoli syndrome and these two are often accompanied by other variants. The cooccurrence of the various DMS sub-types suggests some commonality of experience and aetiology. It also points to taxonomising these syndromes under a common denomination.

S32.3
PSYCHOPATHOLOGICAL AND NOSOLOGICAL ASPECTS OF DELUSIONAL MISIDENTIFICATION IN SCHIZOPHRENIA

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Ortwein-Swoboda, G.; Marquart, B.

Delusional misidentification primarily appears in schizophrenia and organic psychoses. The aim of this investigation was to define the psychopathological and nosological context of this symptom. For this reason 220 schizophrenic subjects were classified according to DSM-IV, ICD-10, Leonhard and Bleuler. Additionally psychotic features like hallucinations, first rank symptoms and contents of delusions were assessed. 72 (32.7%) of the patients expressed one or more of delusional misidentification symptoms. It turned out that in all classification systems applied delusional misidentification is a symptom associated mainly with acute subtypes (schizoaffective disorders, cycloid psychoses). In particular Leonhard classification showed that the frequency of this symptom linearly declines from the most acute forms with complete remissions (cycloid psychoses; 51.9%) over those with only partial remissions (unsystematic schizophrenias; 36.3%) to the chronic forms (systematic schizophrenias; 21.3%) (p=0.007). Logistic regressions pointed out that delusional misidentification symptoms are significantly associated with visual hallucinations (OR: 2.37; 95% CI: 1.33-4.21), thought broadcast (OR: 3.04; 95% CI: 1.40-6.64), thought insertion (OR: 2.80; 95% CI: 1.53-5.13), delusions of persecution (OR: 3.21; 95% CI: 1.11- 9.30), delusions of love (OR: 4.49; CI: 1.37-14.68) and religious delusions (OR: 4.67; 95% CI: 2.51-8.68). The meaning of these results will be discussed.

S32.4
CLINICAL PARAMETERS PERTAINING TO CLASSIFICATION ISSUES IN THE DMS

Margariti, M.M., Athens University Psychiatric Department,
Eginition Hospital, Athens, Greece

DMS classification attempts are up to now mostly descriptive. This is partly due to the numerous and diverse explanations that have been proposed as regards the origin of the delusional misidentification syndromes. Most of these hypotheses surrounding the pathogenesis of those syndromes are dealing especially with the Capgras syndrome, avoiding the other syndromes, since they cannot easily be applied to the rest of the syndromes. We consider that there is a lot of evidence suggesting that all DMSs are part of the same family and are based on a similar pathology, which we attempt to investigate. Based on clinical observations and cases reported in the bibliography, we try to follow the core pathogenetic factor. This factor may be the loss of “singularity” of the self and the others as perceived by the patient.

S32.5
PSYCHOPHYSIOLOGICAL CORRELATES IN DELUSIONAL MISIDENTIFICATION SYNDROMES: A P300 STUDY
Papageorgiou, C., University of Athens, Department of Psychiatry, Greece; Lykouras, L.; Alevizos, B.; Christodoulou, G.N.

There is a debate on whether delusional misidentification syndromes (DMS) and schizophrenia are distinct disorders. Information-processing deficits have been found in both. Since the P300 component of event-related potentials (ERPs) reflects attention and working memory (WM) mechanisms, the P300 elicited during a WM test was studied in patients with DMS in comparison to schizophrenic patients and controls. Nine patients with DMS, 11 patients with schizophrenia and 11 healthy controls were tested with a computerised version of the digit span test of the Wechsler batteries. Auditory ERPs were measured during the anticipatory period of the test. P300 amplitude in prefrontal areas was found to be significantly reduced in schizophrenics and markedly less in DMS patients compared to controls. P300 latency in the central midline brain region was significantly prolonged in DMS patients compared to the other groups. Memory performance was significantly reduced in DMS and schizophrenic patients in comparison with controls. The results may indicate abnormalities in both allocation of attentional resources and automatic orientings in DMS patients due possibly to degenerative deficits in interhemispheric and prefrontal circuitry. In contrast, even though schizophrenic patients exhibit partial similarities with DMS, they show excessive reduction of P300 amplitude located at the left frontal area.

SYMPOSIUM S33
Are all Anxiety Disorders the Same?
Chairs: Heinz Katschnig - Carlo Faravelli
Saturday, 21 June, 4.00-5.30 pm - Zeremoniensaal

S33.1
SPLITTING AND LUMPING: TRENDS IN THE CLASSIFICATION OF ANXIETY DISORDERS
Katschnig, Heinz, Department of Psychiatry, University of Vienna, Vienna, Austria; Freidl, M.; Hanika, A.; Krautgartner, M.

While ICD-8 and ICD-9 still contained a large category of "anxiety neurosis", this was divided up in DSM-III (1980) into "panic disorder" and "generalized anxiety disorder". "Anxiety neurosis" itself had been sorted out from "neurasthenia" by Freud in 1894. Incidentally, "neurasthenia" had been described by Beard in 1880, exactly 100 years before "panic disorder" was created in DSM-III. "Panic disorder" and "generalized anxiety disorder" are thus the result of successive splitting of first neurasthenia and then anxiety neurosis. On the other hand, DSM-III brought two disorders closer to each other, which had been seen as separate entities before: "agoraphobia" and "panic disorder". "Agoraphobia", first described by Westphal in 1871/72, was lumped together with "panic disorder" in the category of "agoraphobia with panic attacks" in DSM-III, while in DSM-III-R and DSM-IV the logic was turned around and agoraphobia became a by-product of panic disorder in the category of "panic disorder with agoraphobia". More recently also the ICD has abandoned the concept of a unitary "anxiety neurosis" in its 10th revision (ICD-10, 1992), but has not followed the developments of DSM-III-R and DSM-IV, subsuming the frequent combined condition of "panic attacks and agoraphobia" under the phobias and creating a category of "agoraphobia with panic disorder", which corresponds to DSM-III. These differences in grouping anxiety disorders together with the high comorbidity among all anxiety disorders – in addition to those mentioned also "social phobia" and "specific phobia", in DSM-IV also OCD and PTSD – suggest that the field is not yet in its definitive shape and still open to closer exploration.

S33.2
SIMILARITIES AND DIFFERENCES IN THE PHENOMENOLOGY OF THE ANXIETY DISORDERS: EPIDEMIOLOGY, COMORBIDITY AND COURSE
Faravelli, Carlo, Università di Firenze, Policlinico Careggi, Firenze, Italy

Since DSM III abolished the concept of neurosis, most of the disorders previously called "neurotic" were grouped into the category of anxiety disorders. The earlier aggregations of "anxiety neurosis" and "phobic-(obsessive) neurosis" were lost and split into a variety of more specific disorders. The initial consideration for this division was based on the pharmacological dissection, by which panic and panic-like syndromes would respond preferentially to antidepressants. Almost a quarter of a century later, though the pharmacological dissection is no longer true for distinguishing anxiety disorders, the division of anxiety disorders is well-established in present psychiatric classifications. There are, however, several issues that point out a consistent degree of similarity between panic disorder, social phobia, generalised anxiety disorder, simple phobia, and others:
a) A comorbidity rate extremely high; having more than one anxiety disorder is the rule, rather than the exception, both in clinical and in epidemiological samples.
b) Family concentration.
c) Response to the same drugs (antidepressants) and hypersensitivity to drugs.
d) Common psychopathological features: excess of anticipation, dramatisation, overestimation of risk, etc.

In the Sesto Fiorentino study, a representative sample (N = 2363) of the general population was interviewed by psychiatrists. 16.9% of these suffer or had been suffering from anxiety disorders (11.3% excluding anxiety not otherwise classified), with an extremely high degree of comorbidity and a noteworthy overlap of clinical features. Prevalence figures, lifetime and current comorbidities, age of onset, family history, response to treatment, costs of illness and outcome will be reported.

On the basis of this naturalistic observation, the following hypotheses will be discussed:
a) Anxiety disorders are separate entities.
b) Anxiety disorders represent different stages of the same, progressively changing, phenomenon.
c) Anxiety disorders represent different expressions of a common liability.
d) The concept of neurosis still should be retained as the common basis of anxiety disorders, with differentiations due to modulating factors.

S33.3
COGNITIVE SPECIFICITY OF ANXIETY DISORDERS REVISITED: IMPLICATIONS FOR DIAGNOSIS, CLASSIFICATION AND TREATMENT

Starcevic, Vladen, University of Sydney Faculty of Medicine, Department of Psychological Medicine, Penrith, Australia

Background and objective: A meaningful distinction between anxiety and depression and between various anxiety disorders would imply that there are significant differences in terms of specific cognitive constructs, styles and/or processes that are associated with them. The objective of this presentation is to review the cognitive content specificity hypothesis both within the group of anxiety disorders and in the relationship between anxiety disorders and depression. **Method:** A review was undertaken of studies that examined cognitive constructs, styles and/or processes presumed to be specific for all anxiety disorders (exaggerated appraisal of threat) and particular anxiety disorders (e.g., anxiety sensitivity for panic disorder, pathological worry for generalized anxiety disorder and thought-action fusion for obsessive-compulsive disorder). **Results:** The cognitive style presumed to be specific for all anxiety disorders was not able to differentiate anxiety disorders from depression. Almost all of the purportedly disorder-specific cognitive constructs, styles and/or processes characterized several anxiety disorders and/or depression. Some anxiety disorders were more characterized by a general anxiety-prone cognitive style than others, but this style was also associated with depression. **Conclusions:** The classification of anxiety disorders, as a nosological group separate from depression, is not supported on grounds of cognitive specificity. There is only partial support for differentiation between various anxiety disorders on the same grounds. These findings suggest that common procedures and goals (e.g., cognitive restructuring and elimination of maladaptive/erroneous cognitions) apply to cognitive therapy for all anxiety disorders, with differences between treatment approaches to different anxiety disorders appearing less pronounced than their similarities.

S33.4
HOW SPECIFIC ARE BIOLOGICAL MARKERS AND TREATMENTS FOR DIFFERENT ANXIETY DISORDERS

Bandelow, Borwin, Department of Psychiatry and Psychotherapy, University of Goettingen, Germany

Because of a substantial comorbidity among the different anxiety disorders, or between anxiety disorders and other psychiatric disorders, e.g. depression, it has been questioned whether all anxiety disorders represent a separate diagnostic entity. Some researchers favor a “general neurotic syndrome”. However, although there is substantial overlap of symptomatology among the various anxiety disorders, in most cases the predominant syndrome can be identified. Anxiety disorders also differ with regard to age of onset. While social anxiety disorder has its onset around the age of 15 years, panic disorder and generalized anxiety disorder begin in the end of the third decade. There are no reliable biological markers for any psychiatric disorder. Therefore, neurobiological dysfunctions have not yet been identified that are able to distinguish reliably between the different anxiety disorders or between any anxiety disorder and depression. The anxiety disorders (and depression) share some disturbances in the serotonergic and noradrenergic neurotransmission, hypothalamic-pituitary-adrenal (HPA) and hypothalamic-pituitary-thyroid (HPT) axis function, and response to lactate, CO_2 and other anxiogenic substances. Also, response to medication and other somatic treatments shows little specificity for the anxiety disorders. Antidepressants, in particular the serotonin reuptake inhibitors, are not only effective in depression, but also in all anxiety disorders. Benzodiazepines are effective in treating panic disorder, generalized anxiety disorder, and social anxiety disorder, but are not regarded as standard treatment in obsessive-compulsive disorder and depression. Electroconvulsive therapy and sleep deprivation are effective in treating depression, but not in the anxiety disorders.

SYMPOSIUM S34
The Relevance of Measuring Symptoms and Syndromes for Diagnostic Decisions

Chairs: Istvan Bitter - Michael B. First

Saturday, 21 June, 4.00-5.30 pm - Rittersaal

S34.1
THE RELEVANCE OF MEASURING SYMPTOMS AND SYNDROMES FOR DIAGNOSTIC DECISIONS

Bitter, Istvan, E. Lilly Regional Operations Ges.mbH, Vienna, Austria and Semmelweis University, Budapest, Hungary

Measuring psychopathology and other relevant symptom/syndrome domains such as extrapyramidal symptoms helps in describing them cross-sectionally, following their changes and assigning individual patients to diagnostic categories. Standardized rating scales and structured interviews are used for evaluating individuals for the definition of incidence and prevalence of disorders and of efficacy and safety of treatment methods. The data collected with the help of these instruments are used for communication between researchers and practitioners as well as between such organizations as pharmaceutical industry and drug regulatory agencies, insurance companies and governments, etc. Proper measurement can improve the validity of diagnoses and the efficiency of treatment methods, can help in the early detection of side effects and in properly addressing disability due to psychiatric disorders. Patients and medical professionals may differ in their evaluations, thus subjective experiences of patients must be, and in fact are, included in diagnostic and treatment evaluation criteria. Measuring symptoms and syndromes with different instruments is subject to statistical rules, however training in statistics is not well represented in undergraduate and postgraduate curricula. Various instruments may overlap, which creates problems such as added financial costs and an increase in measurement errors. The symposium on “The Relevance of Measuring Symptoms and Syndromes for Diagnostic Decisions” will address the questions/issues summarized in this abstract.

S34.2
USING EMPIRICAL DATA AS A BASIS FOR CHANGING DIAGNOSTIC CRITERIA: EXAMPLES FROM DSM-IV

First, Michael B., Columbia University, New York, NY, United States

The centerpiece of the DSM-IV revision process was its reliance on empirical data as the basis for making changes. A three-stage process of empirical review was established consisting of 150 issue-centered literature reviews, 40 reanalyses of previously collected data sets, and 12 diagnosis-focused field trials. When considering criteria set changes, a major challenge was the lack of a diagnostic “gold standard” for determining whether a criteria set change was advantageous. In lieu of such a gold standard, a number of alternatives were

used including 1) reducing false negatives by including additional cases having the same levels of morbidity as true cases; 2) setting diagnostic cut-points by establishing zones of rarity; 3) reducing false positives and false negatives by maximizing concordance with "expert clinical diagnosis"; 4) maximizing external validators (e.g., predictive validity, treatment response); 5) eliminating criteria because of inadequate diagnostic reliability or internal consistency; and 6) improving clinical utility (e.g., simplification) or descriptive validity while demonstrating no change in caseness. In order to illustrate how these alternative standards were applied three specific examples of changes are presented: 1) revision of the threshold for panic attacks in Panic Disorder using morbidity as the standard; 2) establishing the cut-off for the number of mood episodes for rapid cycling by demonstrating a "point of rarity"; and 3) developing the criteria sets for Autistic Disorder using signal detection techniques with clinical diagnosis as the diagnostic standard.

S34.3
FUNCTIONING AND DISABILITY - A CONSTRUCT TO EXPLAIN CLINICAL SIGNIFICANCE

Üstün, Bedirhan, Classification Assessment Surveys and Terminology, WHO, Geneva, Switzerland

Diagnosis entails a formulation of a disease entity which comprises a constellation of signs, symptoms which are surface markers for an underlying pathological process. This formulation of diagnosis does not necessarily require that the subjects with the disease should have any limitations in carrying out their daily lives or performing any duties. For example, one may have tuberculosis with bacillus positive status, however, may not exhibit any functional limitations. Similar examples could be given for HIV infection and other infections, non-communicable diseases such as diabetes and hypertension or any type of cancer. In all these conditions diagnosis is conditional on the presence of a physiological disturbance and does not require any disability be present. Contrary to the formulation of so-called "physical" diseases, DSM approach of formulation calls in for the presence of significant disability (i.e. functional impairment in DSM parlance). This criterion creates an unfair diagnostic formulation for the description of mental disorders. The WHO Family of International Classifications (i.e. International Classification of Diseases - ICD and International Classification of Functioning, Disability and Health - ICF) provides an operational basis to describe the disease and disability phenomena separately across all disorders. This approach provides a "conceptual parity" to put the diagnosis of mental disorders in an equal footing with so-called physical disorders. In addition give better and cleaner definition of signs and symptoms of disease process. WHO has developed tools and instruments such as the ICF Checklist and WHO-DAS that can be used in practice to define and measure the dimensions of disease and disability separately.

S34.4
MEASURING SIDE EFFECTS: THE DRUG-INDUCED EXTRAPYRAMIDAL SYMPTOMS SCALE (DIEPSS)

Inada, Toshiya, Department of Psychiatry and Psychobiology, Nagoya University, Graduate School of Medicine, Japan

The importance of training raters in the use of psychiatric rating scales to obtain consistent and stable data has been emphasized. A systematic training system for the Drug-Induced Extrapyramidal Symptoms Scale (DIEPSS) has been established in Japan, and DIEPSS raters' training meetings have been held 16 times during the period from September 2001 to January 2003. In each training session, between 5 and 34 raters attended, saw a total of 8 to 14 video clips showing the extrapyramidal symptoms seen in schizophrenic patients receiving neuroleptics in order, evaluated independently the severity of the DIEPSS subitem indicated in each video clip, and discussed together possible causes of disagreement. The numbers of video clips used for evaluation of DIEPSS subitems in these training sessions were gait (n=2), sialorrhea (n=5), tremor (n=9), akathisia (n=1), dystonia (n=3), and dyskinesia (n=10). The order of video clips used for these training meetings was changed in each session. A number of video clips showing low inter-rater reliability were identified at initial evaluation. However, the rate of agreement with the gold standard was observed to increase in most of them when evaluated after the training in one or more cases for the same subitem. In the present symposium, the author presents a number of these examples and discusses the usefulness of establishing a systematic training system before beginning clinical studies, and of using videoclips to learn visually the exact severity when evaluating movement disorders during antipsychotic therapy.

S34.5
THE USE OF MULTIPLE RATING SCALES IN CLINICAL RESEARCH: A STATISTICAL APPROACH

Czobor, Pál, N.S. Kline Institute for Psychiatric Research, Orangeburg, NY; New York University; DOV Pharmaceutical, Inc., Hackensack, NJ, United States

Researchers study multiple facets of psychiatric disorders through the simultaneous use of several psychometric instruments. The fact that the various instruments (scales) often overlap, however, creates a range of problems, including the added financial costs and increase in measurement errors. In addition, when several such scales are investigated in a single study, the data analysis contains multiple tests and multiple comparisons. Ignoring this multiple testing aspect can lead to incorrect conclusions; correcting for it (or 'overcorrecting' by conservative approaches) can be quite costly in terms of statistical power. For these reasons, it is essential that questions with respect to the interset relationship of a scale with other scales be clarified before it is used in practice. A fundamental question of interest is whether a particular instrument is redundant with other instruments; this important issue has not been given due attention in the literature. The presentation will give a conceptual framework for studying the redundancy and association between psychometric scales. Empirical data on negative symptoms in schizophrenia will be used for illustration. In particular, the interset relationship between two psychometric scales, the BPRS and the SANS, will be investigated. The extent of redundancy and potential strategies to deal with the problem will be discussed.

SYMPOSIUM S35
The Role of Animal Models in Defining Psychiatric Syndromes

Chairs: Fritz Henn - Barbara K. Lipska

Saturday, 21 June, 4.00-5.30 pm - Geheime Ratsstube

S35.1
THE ROLE OF KO AND CONDITIONAL KO MODELS IN DEFINING THE GENES CONTROLLING AFFECT

Gass, Peter, Central Institute of Mental Health,
University of Heidelberg, Mannheim, Germany

Several classes of genes have been postulated to participate in the pathogenesis of affective disorders, e.g. monoamine and corticosteroid receptors, neurotrophins etc. Since *in vivo* expression and functional studies of these gene products are difficult in the human central nervous system, such analyses have to be done in animal models. Transgenic mice with mutations of candidate genes for affective disorders are promising tools which allow to investigate their role in the pathogenesis of symptoms characteristic for depression and anxiety. This talk summarizes behavioral and neuroendocrinological findings that have been obtained in mouse strains with specific mutations of corticosteroid receptors and neurotrophins. So far, single depressive symptoms could be identified, but none of the mouse strains investigated could be viewed as an animal model of a specific affective disorder defined by common diagnostic criteria. The lack of a full depressive syndrome in these mice may result from compensatory developmental mechanisms, because conventional gene manipulations are already effective during development. Therefore, the next generation of transgenic animals must be based on conditional and/or reversible mutagenesis.

S35.2
NEONATAL HIPPOCAMPAL DISCONNECTION IN THE RAT. IMPLICATIONS FOR SCHIZOPHRENIA

Lipska, Barbara K., CBDB, NIH, Bethesda, United States

The excitotoxic lesion of the hippocampus, a brain region implicated in schizophrenia, results in early adulthood in the emergence of abnormalities in dopamine related behaviors, impaired social behaviors and working memory problems. Our molecular and electrophysiological data suggest that aberrant development of the prefrontal cortex in the context of early damage to the hippocampus may be a critical factor in the onset of the syndrome. In this study, we hypothesized that transient inactivation of the ventral hippocampus during a critical period of development, that produces no obvious anatomical changes in the hippocampus, may be sufficient to disrupt normal maturation of relevant regions. We used tetrodotoxin (TTX) to inactivate the ventral hippocampus on postnatal day 7 and then assessed behavioral changes later in life. The overall characteristics of behavioral changes and their temporal pattern were reminiscent of the disturbances associated with the permanent excitotoxic lesion. Neonatally TTX-infused rats displayed in adulthood motor hyperactivity in response to stress, amphetamine and MK-801. Analogous TTX infusions in adult animals did not alter these behaviors. No morphological changes were detected in the hippocampus of neonatally TTX infused brains by Nissl or Black-Gold histochemistry. These data suggest that transient loss of ventral hippocampal function during a critical time in maturation of intra-cortical connections permanently changes development of neural circuits mediating certain dopamine- and NMDA-related behaviors. These results represent a potential new model of aspects of schizophrenia without a gross anatomical lesion.

S35.3
BREEDING ANXIOUS STRAINS – WHAT DOES THIS SUGGEST ABOUT DEFINING ANXIETY DISORDERS/DEPRESSION?

Landgraf, Rainer, Max Planck Institute of Psychiatry, Munich, Germany; Wigger, A.

After decades of bi-directional selective breeding, rats displaying either high (HAB) or low (LAB) anxiety-related behavior represent extremes in trait anxiety as measured on the elevated plus-maze and a variety of additional behavioral tests. Cross-mating studies confirmed a genetic determination of the behavioral extremes. Resembling psychiatric patients, HABs prefer passive coping strategies indicative of depression-like behavior and show increased susceptibility to stressor exposure. Neuroendocrine correlates of high trait anxiety include a hyper-reactive HPA axis due to an over-expression of vasopressin, but not CRH, in the paraventricular nucleus (PVN) of HABs. Long-term antidepressant treatment with paroxetine abolished the pathological outcome of the Dex/CRH test in HABs and shifted their behavior towards active coping. Remarkably, paroxetine treatment resulted in a normalization of vasopressin over-expression in the PVN of HABs, while leaving the (normal) expression in LABs unchanged, further substantiating the functional impact of central vasopressin. The phenotyping gave rise to the hypothesis of the vasopressin gene as a candidate gene of trait anxiety, which was confirmed by the finding that the promotor structure of this gene contains single nucleotide polymorphisms (SNPs) in HABs only. Preliminary results indicate that particular (functional) SNPs may underlie the vasopressin over-expression, thereby possibly contributing to behavioral and neuroendocrine phenomena of trait anxiety. HAB/LAB rats are a useful tool for studying the genetic basis of trait anxiety/depression. A recently established mouse model of trait anxiety will be similarly helpful in pursuing this approach. Both animal models of human susceptibility to anxiety may have clinical implications.

S35.4
ANIMAL MODELS TO LOOK AT GENE-ENVIRONMENT DETERMINANTS OF BEHAVIOR – DISCRETE DISEASES VS. BEHAVIORAL SYNDROMES

Henn, Fritz A., Central Institute of Mental Health,
University of Heidelberg, Germany

Psychiatric conditions have been defined in categorical classification systems, which are not based on etiology but rather on symptoms which have a dimensional character. That is why we define a "discrete" disease such as depression using degrees of sadness, sleeplessness, etc. to establish the condition. The problem is: do we have a real discrete disease or rather a series of syndromes which share symptoms and perhaps even a final common pathophysiology, but have different etiologies. One way to examine this is to use animal models which have face validity, i.e. reproduce the general symptoms of a given condition, but can be produced using a variety of genetic manipulations or environmental events. Using models of depression and schizophrenia which involve either genetic or environmental manipulation we will explore the possibility that distinctly different pathways can lead to similar behavioral syndromes. This may help us

understand the limitations of our current diagnostic approaches and the limits to our therapeutic success.

SYMPOSIUM S36
The Classification of Child and Adolescent Mental Disorders: Is There Enough New Knowledge to Warrant its Change?

Chairs: Fritz Poustka - Eric Taylor

Saturday, 21 June, 4.00-5.30 pm - Trabantenstube

S36.1
THE DIAGNOSES OF PSYCHIATRIC DISORDERS OF INFANCY ARE IN THEIR INFANCY

Tamminen, Tuula, Medical School, University of Tampere, Tampere, Finland

The diagnostic classification of mental health disorders during infancy has been the most unsatisfactory part in both the American (DSM) and WHO (ICD) classification systems. Therefore, fifteen years ago (1987) the National Center for Clinical Infant Programs in the United States established an international task force to produce a diagnostic manual based on rapidly grown research knowledge achieved with new assessment tools and systematic evaluation processes with infants and their care-givers. In 1994 a developmentally sensitive, Multi-situational and Multiaxial Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC 0-3) was published. DC 0-3 has proven to be very useful clinically but it is even more valuable in providing much better bases than earlier for empirical research on diagnostic issues during the first four years of life. In 2001 the Journal of American Academy of Child and Adolescent Psychiatry (40:1, 2001) published a special section reviewing the diagnostic research in the field of infant psychiatry. So far, there is slowly cumulating evidence both supporting the DC 0-3 diagnostic system (PTSD, PDD, regulatory disorders) and pointing out the problems it has. Based on nearly ten years' experiences DC 0-3 manual is now both in Europe and the US in a systematic improvement process. Research has revealed complex ethical responsibilities: infant assessment is also an intervention.

S36.2
CLASSIFYING THE DISORDERS OF ATTENTION AND ACTIVITY CONTROL

Taylor, Eric, Institute of Psychiatry, Kings College London, United Kingdom

The current taxon of hyperkinetic disorder has some predictive and discriminative validity, but its boundaries are in dispute and give rise to clinical and research misunderstandings. The current status of understanding on some key issues will be reviewed:

1. The current diagnostic criteria refer to traits of behaviour: do they adequately capture the concepts of disorder? Some criterion overlap may exist between the currently defined items of impulsiveness and those of oppositionality.
2. The number and type of behavioural items required for the diagnosis needs research in part to clarify the relationship between the broader criteria of "ADHD" in DSM (validated against current U.S. diagnostic practice) and the narrower subtype of "hyperkinetic disorder" (validated against neuro-developmental associations and drug response). The "subthreshold" conditions of inattentiveness and overactivity may require more explicit recognition to support current practice.
3. Coexistence of other disorders is very common; the establishment of their proper place in classification requires an understanding of the various developmental tracks that can lead to "comorbidity".
4. The mapping of clinical nosology on to genetic influences is complex, and current knowledge of heritability favours neither the concept of ADHD nor that of hyperkinetic disorder. A separate axis of classification may ultimately be required.
5. Classifications embody theories about the nature of the disorder. A better understanding is therefore needed of how far the disorders represent specific developmental delays (and therefore should go on a separate axis), or a neurological abnormality, or a deviation from the normal course of mental development. Further, information is needed concerning the extent to which problems should be subclassified according to significant sources of heterogeneity such as IQ, motor coordination, gender, situational expression or cognitive endophenotype.

S36.3
MORE VALID PROGNOSES OF CONDUCT DISORDER BY BETTER CLASSIFICATION?

Schmidt, Martin H., Klinik für Psychiatrie und Psychotherapie des Kindes- und Jugendalters am Zentralinstitut für Seelische Gesundheit Klinikum, Mannheim, Germany

ICD-10 and DSM-IV categories mostly differ concerning conduct disorder. Two subcategories of F91 in ICD-10 are said to be uncertain, too. Moreover, there is a debate on oppositional or conduct disorder as comorbid to hyperkinetic disorder. Distinctions between reactive and instrumental aggressiveness, and between avoiding and offending aggressiveness have to be considered in order to make proposals concerning further classification. Of more interest is the natural course of early and late starting conduct problems, of conduct disorder with antecedent or simultaneous (arising) hyperkinetic or attention deficit syndromes, of oppositional-defiant disorder and of conduct problems (yet) limited to the family. Experiences concerning treatment effects could also be taken into consideration. As far as data are available, information leads to four proposals:

- Further development of ICD should differentiate oppositional-defiant disorder and conduct disorder giving up the former DSM subcategory of conduct disorder;
- Skip the category of family limited conduct disorder from F91;
- Take over the distinction between early and late starting conduct disorder from DSM-IV;
- Keep the combined category of hyperkinetic and conduct disorder.

Thus, oppositional defiant disorder and late starting conduct disorder due to their course could be seen as more developmental/temporary disorders whereas early starting conduct disorder (with or without hyperkinetic disorder) should be considered as a mostly long lasting problem with a more unfavourable course and urgent need for early treatment. The rare cases of conduct disorder confined to the family context could probably be seen as a special kind of social function disorder more prone to the ICD-10 category of F94.

S36.4
ON CLASSIFICATION OF DEPRESSION IN CHILD AND ADOLESCENT PSYCHIATRY

von Knorring, Anne-Liis, Child and Adolescent Psychiatry University Hospital, Uppsala, Sweden

Classification of depression is not part of the F9 section in ICD-10 (behavioural and emotional disorders with onset usually occurring in childhood and adolescence) and similar in the DSM system. Results of research studies allow some careful considerations for both the diversity of depression and its usual onset.

S36.5
THE DIAGNOSIS OF SUICIDE IN ADOLESCENCE: DIMENSIONAL DIAGNOSIS: THE CASE OF SEROTONIN AND SUICIDALITY

Apter, Alan, Schneiders Childrens Medical Center, Peyah Tikva, Israel

For many years, psychiatry has been devoted to nosology. This disease model conceives psychiatric conditions as discrete entities with a particular pathophysiology and predictable relations between phenomenology and outcome. This model is personified by the DSM and ICD. This model has many drawbacks. There is a magnification of comorbidity, border problems and neglect of a developmental perspective. One particular problem in this regard has been the proliferation of disorders which seem to be based on a dysregulation of serotonin metabolism. This has led to the notion that the actions of serotonin on behavior are non-specific. An alternative approach propagated by Herman van Praag has been a classification based on psychopathological dimensions both on a biological basis and on a psychological basis. One of the most fruitful areas of research in this field has been on the serotonin-anger-anxiety-depression-suicidality axis. This axis cuts across othodox nosological borders and has considerable theoretical and practical interest. For example the association between serotonin and suicidal behavior is the most consistent finding in biological psychiatry. Numerous studies using neuroendocrine challenges, studies of monoamine metabolites in cerebrospinal fluid (CSF), or more recently PET studies, have demonstrated altered central serotonergic neurotransmission associated with attempted suicide. Moreover, these studies have shown associations between suicidal behavior and serotonin neurotransmission regardless of psychiatric diagnosis, in such diverse diagnostic groups as depression, borderline disorder, schizophrenia, alcoholism, and substance abuse.

S36.6
PERVASIVE DEVELOPMENTAL DISORDERS: PLEASING TO HUG ON MULTIAXIALITY?

Poustka, Fritz, Department of Child and Adolescent Psychiatry, Goethe University Frankfurt, Frankfurt, Germany

Beside the unifying concepts in the ICD-10 and DSM-IV for PDD there exists some controversy in using Autism Spectrum (AS) definitions (e.g "High Functioning Autism" (HF) vs. Asperger Syndrome: whether "Asperger's syndrome" or HF is a specific, clearly distinguishable disorder, within the autistic spectrum, or whether it represents a milder phenotypical variation of autism). The effect of the variables language delay (currently or ever) and level of intelligence on the amount of autistic symptoms especially are debatable in respect to impairments in the reciprocal interaction in the sense of a lesser degree of severity and in results of formal genetic studies. Findings support the assumption that within AS "extreme points" on a continuum of severity are represented, and lead to the suggestion that the classification of different subtypes of autism could be abandoned in favor to a dimensional (multi-axial) approach.

SYMPOSIUM S37
The Meaning of Classification Systems for Transcultural Psychiatry
WPA Section "Transcultural Psychiatry"

Chairs: Thomas Stompe - Sergio Villaseñor-Bayardo

Saturday, 21 June, 4.00-5.30 pm - Radetzky Appartement

S37.1
DIFFERENT CLASSIFICATION SYSTEMS IN COMPARATIVE PSYCHIATRY

Ortwein-Swoboda, Gerhard, High Security Hospital Göllersdorf, Göllersdorf, Austria; Stompe, T.; Marquart, B.; Ascoli, M.

Classification of schizophrenia relies on widely different criteria, depending on the diagnostic system used. These systems are different not only in their view of schizophrenia either as a peculiar form of delusional-hallucinatory syndrome or as a group of disorders which share an unfavorable course but also differ in their logical structure. First rank syndromes, for example, create asymmetric relations between the term "schizophrenia" and each first rank symptom, in the sense that each first rank symptom is a sufficient condition for schizophrenia, while on the other hand, no first rank symptom is a necessary condition. Criterial diagnostic systems on the other hand conceive "schizophrenia" as a cluster term in which a single psychopathological symptom is neither a necessary nor sufficient condition. This leads to the need for arbitrary cut-off scores, and the use of non-psychopathological items and categorical confusion. In fact, categorical systems, in which necessary and sufficient conditions can be stated, seem to be the best solution to avoid those epistemological problems. But there also are limitations: Leonhard's efforts show that, even in trying to reach such a classification, it is not possible to give both necessary and sufficient conditions for all psycho-pathological entities. The choice of the classification system does not only pose a theoretical problem but is also relevant for empirical research. This can be shown by the distribution of schizophrenic subtypes in comparative psychiatry: changes in subtypes over time and culture seem to depend largely on this choice. There is not only the danger to take an epistemological problem for a result, but also, that discrete changes in the composition of subtypes are concealed by a classification bias, even if the system itself shows good reliability.

S37.2
THE DISAPPEARANCE OF CATATONIC AND HEBEPHRENIC SUBTYPES OF SCHIZOPHRENIA - FACTS AND FICTIONS

Stompe, Thomas, University Clinic of Psychiatry Vienna, Vienna, Austria; Ortwein-Swoboda, G.; Marquart, B.; Ritter, K.

The decline of the frequency of catatonic and hebephrenic subtypes among schizophrenic disorders during the last 50 years is a well established topos in clinical and transcultural psychiatry. Until now the factors that could be responsible for this development are under discussion. We wanted to estimate the influence of the interaction of different classification systems and sociocultural patterns on the results of epidemiological and comparative studies. First we classified a sample

of 220 consecutively admitted schizophrenic patients from three different psychiatric institutions with a polydiagnostic design using DSM-IV, ICD-10 and Leonhard´s criteria. It turned out that the frequency of catatonic (10-22%) and hebephrenic (5-20%) schizophrenia varies in a broad range – depending on the diagnostic system applied. As the classification of Karl Leonhard exists stable since more than 60 years we compared the two original Leonhard-cohorts (1938-68, 1969-86) with our own one (1994-99). It turned out that the chronic forms of catatonic schizophrenia slightly declined, indicating a confounding cultural factor, while the rates of hebephrenia remained stable.

S37.3
THE "CULTURE BOUND SYNDROMES": THEIR IMPORTANCE WITHIN THE INTERNATIONAL CLASSIFICATION SYSTEM IN PSYCHIATRY

Villaseñor-Bayardo, Sergio, University of Guadalajara, Guadalajara, Mexico; Rojas-Malpica, C.

The ICD-10 Classification of Mental and Behavioral Disorders is being accepted by most countries and by the World Psychiatric Association as the international standard in the field of statistical reporting and for clinical care and research. Emerging now is the need to harmonize international communication with recognition of cultural diversity and specific local requirements. Latin American psychiatrists hold a long standing commitment to the formulation of a reliable and valid diagnostic system in international psychiatry. Some classes of Latin American cultural syndromes are showed here.

S37.4
THE CHINESE CLASSIFICATION OF PSYCHIATRY AND ITS CONTRIBUTION TO INTERNATIONAL DIAGNOSTIC SYSTEMS - THE PROSPECTIVE FIELD TRIALS OF MENTAL DISORDERS

Chen, Yanfang, Shandong Mental Health Center, China; *Xiao, C.*

Objective: The aim of this study was to resolve the controversy existing on CCMD-2R, and to integrate it with international classification and diagnostic systems, particularly the ICD-10, and also to enhance the reliability and validity of the classification and diagnostic criteria of mental disorders in China. A prospective study of the 17 categories of adult mental disorders in CCMD-2R was conducted. **Methods:** From 1996 to 2000, a total of 1538 adult subjects were recruited from inpatient and outpatient units, and other subjects (e.g. homosexuality) from community sites. All these subjects were evaluated mainly with RTHD (Rating Test for Health problems and Diseases) according to CCMD-2R by 67 doctors from 24 mental health agencies. Of the 1538 subjects, 775 (50.4%) were involved in a prospective follow-up study for 1 to 3 years. **Results**: Interrater agreement was high for most categories of mental disorders, with kappa from 0.73 to 1.00. Most of the patients retained the same diagnosis when they were rediagnosed after one year. **Conclusions:** The results provided scientific data for CCMD-3 and also suggested that the use of a standard rating scale could enhance the reliability of CCMD-3. Mainly based on the data of the prospective field trials, the CCMD-3 was proved to be explicit and easy to implement.

S37.5
THE IMPACT OF CULTURAL FACTORS ON THE DIAGNOSIS OF SUBSTANCE-RELATED DISORDERS

Haasen, Christian, University of Hamburg, Hamburg, Germany; *Kleinemeier, E.; Krausz, M.*

The diagnostic process of mental disorders for persons of other ethnic background is affected by cultural factors, which can lead to misdiagnosis. The factors that will affect the process of diagnosis include differences in the type of substance used, in the patterns of use and in associated psychosocial stressors. With respect to the substance, persons of other cultural background may develop a substance use disorder with substances that are not common in the host society. Examples are khat for migrants from Yemen, mescal for Mexican migrants and opium for Iranian migrants. Patterns of use may differ by showing excessive binges followed by short phases of abstinence instead of regular daily use. Psychosocial factors affecting the presentation of substance use disorders are a different interaction between family problems and the disorder, the correlation with discrimination and negative correlation with degree of acculturation. These factors and other will be discussed.

SYMPOSIUM S38
Gay Affirmative Psychiatry: Diagnostic Controversies and Treatment Issues

Chairs: Gene Nakajima - Reidar Kjaer

Saturday, 21 June, 4.00-5.30 pm - Künstlerzimmer

S38.1
HOMOSEXUALITY AROUND THE POLAR CIRCLE. GAY ISSUES, DIAGNOSIS, AND MENTAL HEALTH IN NORWAY

Kjaer, Reidar, Oslo, Norway

This presentation addresses the origin of the current theoretical framework for Norwegian psychiatry's understanding of homosexuality. It points to the influence in Norway of German academic psychiatry and the impact of both pre- and post- World War II psychoanalytic theories. In Norway today, the prevailing attitude is a non-psychopathological understanding of homosexuality based on a generally vague psychosocial and biological understanding of mental health problems and illnesses. Following the American Psychiatric Association resolution of 1973 that removed the DSM diagnosis of homosexuality, the Norwegian Psychiatric Association followed suit in 1977 and recommended that the ICD diagnosis of homosexuality should no longer be used. After that, the professional interest in the mental health of gays and lesbians was neglected until recently. Little research has been done in this field of Norwegian psychiatry. Firm knowledge is scarce, and there is a demand for establishing a special competence center. This vacuum allowed psychoanalysts to neglect modern theories while religious groups imported the reparative therapy movement. This talk emphasizes the discrepancy between the Norwegian pro-gay legislation, the removal of the diagnosis of homosexuality and the lack of development in Norwegian psychiatry.

S38.2
CASE STUDY OF A GAY MAN WITH RAPIDLY CYCLING BIPOLAR DISORDER

Rubin, Howard, South of Market Mental Health Clinic, San Francisco, CA, United States

Through a presentation of the course of psychotherapeutic and psychopharmacologic treatment of a gay man with bipolar disorder, I will explore the rich and challenging diagnostic and clinical issues that arise during treatments that combine medication and talk therapies. The patient has been in once-a-week psychodynamic psychotherapy for the past three years. Co-morbid Axis I illnesses, including alcohol abuse and post traumatic stress disorder, complicate his treatment course. Despite a chaotic external environment and cycles of depression, hypo-mania and mania lasting one to two weeks, he manages to pursue a college degree in film and attend sessions consistently. The role of the therapist's office as a safe and stable holding environment will be discussed. When the patient was diagnosed with HIV, the therapy took on greater urgency. Often, my role as physician became as prominent as my role as therapist. I will demonstrate how transference and counter-transference inform the pace and tenor of the treatment and guide therapeutic decision-making. As an openly gay therapist working with this patient, I will confront prominent issues regarding appropriate disclosure and boundaries. Working with a patient who considers personal creativity and art as the loci of meaning in his life has been difficult at times because his symptoms often preclude his ability to be creative. Therapy often focuses on existential issues relating to the creation and appreciation of meaning amongst a world he often perceives as erratic, unforgiving and hostile.

S38.3
THE NOSOLOGY OF SUBSTANCE USE DISORDERS AND ABSTINENCE-BASED TREATMENTS IN THE GAY MALE COMMUNITY

Levounis, Petros, Columbia University College of Physicians and Surgeons, New York, NY, United States

Over the past ten years, the nosology of substance use disorders has been instrumental in clarifying treatment options for addicted patients. A patient's transition from a diagnosis of *substance abuse* to a more serious diagnosis of *substance dependence* is typically accompanied by persistent neurobiological changes in the brain pleasure/reward dopaminergic circuitry, indicating the individual's loss of control. Consequently, only abstinence models are indicated for the optimal treatment of *substance dependence*, while both abstinence models and harm reduction models may be appropriate for the treatment of *substance abuse*. In the gay male community, however, the word "abstinence" has a negative connotation. It primarily suggests abstinence from sex, either in the context of an anti-gay morality campaign or in the context of a conservative (and often anti-gay) HIV prevention campaign. Either way, the majority of gay men, along with most health care professionals, advocate safer sex rather than abstinence as the most effective path to physical and mental health. Unfortunately, the rejection of the "abstinence from sex" recommendation, while legitimate, often leads to the erroneous rejection of an "abstinence from drugs" recommendation as well. Gay men seem to have generalized the now infamous slogan "Just say no!" (first introduced by Nancy Reagan, an anti-drug advocate from the 1980s with a dismal record on gay issues) to encompass both sex and drugs. "Abstinence" has come to signify all that is uninformed, outdated, biased, and despised in the gay community. Sometimes, it is even hard to remember whether Ms. Reagan was referring to sex or drugs. (It was drugs.)

S38.4
DIAGNOSTIC DISCREPANCIES BETWEEN DSM-IV AND ICD-10 RELATING TO EGODYSTONIC SEXUAL ORIENTATION

Nakajima, Gene, Center for Special Problems, United States

In 1973, the American Psychiatric Association (APA) was the first psychiatric organization to declare that homosexuality was not a mental illness. However, the APA added a new category, sexual orientation disturbance to DSM-II. In 1980, egodystonic homosexuality replaced sexual orientation disturbance in DSM-III, but the APA deleted it in DSM-IIIR in 1987, because there was no supportive empirical research, and the diagnosis was rarely used clinically. In 1992, the WHO deleted homosexuality as a mental illness following the practice in many countries, which had already deleted homosexuality as an illness in their versions of ICD-9. In ICD-10, three new diagnoses were added: egodystonic sexual orientation, 1) heterosexual (F66.10), 2) homosexual (F66.11), and 3) bisexual (F66.12). These diagnoses were probably added for political rather than scientific reasons. A search of Medline and Psychinfo, two major databases of worldwide medical and psychological journals, produced no research or clinical reports using egodystonic sexual orientation since 1992. An article from 1987 describes a single case report of egodystonic heterosexuality, but it was written largely to demonstrate the invalidity of the diagnosis. Because of the potential stigmatization caused by the inclusion of diagnoses related to sexual orientation, countries should consider deleting egodystonic sexual orientation from their versions of ICD-10. Hopefully, ICD-11 will follow DSM-IIIR by deleting egodystonic sexual orientation. DSM-IV continues to include "persistent and marked distress about one's sexual orientation" as an example of sexual disorder, not otherwise specified (NOS). Some therapists use this diagnosis when conducting unethical attempts to change gay men and lesbians into heterosexuals. In DSM-V, this misuse of sexual disorder NOS should be addressed.

SYMPOSIUM S39
Diagnosis in Early Psychosis: Past, Present and Future

Chairs: William G. Honer - Peter Falkai

Saturday, 21 June, 4.00-5.30 pm - Schatzkammersaal

S39.1
DIAGNOSIS OF FIRST-EPISODE PSYCHOSIS IN A HISTORICAL SAMPLE

Smith, Geoffrey N., University of British Columbia, Canada

Between 1872 and 1950, all psychiatric hospital care in British Columbia (B.C.) was provided by one of three public mental hospitals. No other psychiatric care was available in B.C. during this time. Records contain detailed clinical and personal information and over 98% have been preserved. Previous reports suggest the nearly 100% of those with schizophrenia were hospitalized during this era suggesting that this data set contains a nearly complete record of major psychiatric illness in B.C.. Of the 24,982 patients who were admitted, 13,520 were diagnosed with a functional psychosis. The files of these 13,520 patients are currently being reviewed. For approximately

12,500 patients, this was their first psychiatric hospitalization. A DSM-IV diagnosis was made from the records of 500 of these patients using a structured inventory of symptoms. Good agreement (81%) was found between a DSM-IV diagnosis of schizophrenia and historic diagnoses of terminal dementia, delusional insanity, dementia praecox, and schizophrenia. This was the case for each decade between 1895 and 1950. Substantial diagnostic variability was found for manic depression throughout the study period and only 20% would receive a DSM-IV diagnosis of bipolar disorder. These historical records suggest an increasing incidence of schizophrenia. A search of archival records failed to reveal any changes to psychiatric services that could explain the increased incidence. The relative risk of schizophrenia was significantly greater in immigrants than in those born in Canada.

S39.2
FIRST-EPISODE PSYCHOSIS TODAY: FROM SCHIZOPHRENIA TO AFFECTIVE DISORDERS

MacEwan, G. William, University of British Columbia, Canada

The specific diagnosis of the cause of a psychosis is important in determining appropriate treatment, rehabilitation and prognostication. Early Psychosis Programs face a number of unique challenges in making an appropriate clinical diagnosis. Often clinicians are presented with durations of untreated psychosis that are extremely brief and the psychosis may be mixed in with clusters of mood symptoms and substance abuse. Also these individuals are early on in the course of their illness' evolution so that there is also no documented past psychiatric history which can be so helpful in determining a definitive diagnosis. The South Fraser Early Psychosis Initiative (EPI) Program is a case finding clinical program serving a catchment population of 600,000. The program assesses, diagnoses, treats and follows any case of first episode psychosis, which has never been treated, in people between the ages of 13-35 in our region. This program, in its third year, is seeing 130 new cases of psychosis a year. Our program diagnoses the cause of psychosis using a DSM-IV symptom and syndrome checklist. Of the initial 250 cases of first episode psychosis the diagnostic percentages were Psychosis Not Otherwise Specified (PNOS) 35%, Schizophreniform 25%, Bipolar Disorder 11%, Major Depression with Psychosis 10%, Schizophrenia 12%, and Substance Induced Psychosis 7%. In this presentation the variables duration of untreated psychosis, hospital versus community referrals, pathway into care and cognition will be discussed. We will also present strategies to improve diagnostic reliability and stability in these clinical populations.

S39.3
EARLY INTERVENTION FOR PSYCHOSIS IN HONG KONG: INITIAL EXPERIENCE OF THE EASY PROGRAMME

Chen, Erik Y. H., University of Hongkong, Hongkong, China

In mid 2001, a comprehensive programme for early intervention for psychosis was launched in Hong Kong. The Early Assessment Service for Young people with Psychosis (EASY) is based on three key components. An active media campaign aims to promote awareness in the general public as well as front line professionals concerning the features of psychosis and the referral pathway. A responsive open referral system aims to provide prompt assessment in a non-stigmatizing setting. Finally, for identified cases, a comprehensive intervention package integrates optimal pharmacotherapy with intensive psychosocial intervention. Initial evaluation of the programme was conducted on EASY patients (n=836) using a historical comparison group of first episode psychosis patients assessed before the launching of the EASY programme (n=131). Mean Duration of Untreated Psychosis (DUP) was significantly reduced from 513 days (sd 890) to 296 days (sd 505). Median DUP was reduced from 150 days to 105 days. Longitudinal changes in symptom profile over 1 year was available in 175 EASY patients and compared with 115 patients in the historical control group. There was no difference in PANSS total score, negative symptoms, and general psychopathology upon presentation, but PANSS positive symptoms was lower in EASY patients. 4 months into treatment EASY patients had significantly more positive symptoms compared with control patients. However, at 12 months, there was no difference in positive symptoms among the two groups. Notably, negative symptoms were lower in EASY patients compared with historical control patients at one year follow-up. The EASY programme has within the first 18 months successfully reduced the DUP in early psychosis patients in Hong Kong. Profiles of EASY patients are similar to patients presenting prior to the inception of the EASY service, apart from lower positive symptomatology. EASY patients appear to make a slower recovery from positive symptoms and this may reflect more cautious use of antipsychotic medication. At one year follow-up both groups made substantial recovery from positive symptoms. EASY patients exhibit less negative symptoms compared with those in the historical control group.

S39.4
DIFFERENTIAL DIAGNOSIS OF FIRST EPISODE BIPOLAR DISORDERS

Scherk, Harald, Department of Psychiatry and Psychotherapy, University of Saarland, Germany

Around 20% of patients later developing schizophrenia have only a single psychotic episode in their lifetime. Descriptions of these psychotic episodes clearly document a considerable number and severity of affective symptoms. Furthermore, bipolar disorders are often misdiagnosed in the beginning, which means that a proper treatment only starts years after the onset of the illness. Therefore clinical diagnosis of first episode psychosis needs to take in account the affective symptoms that might be part of the broader spectrum of bipolar disorders. Furthermore biological markers need to be tested, which could help to distinguish between schizophreniform and affective psychotic syndromes. Cortical abnormalities in schizophrenia and endocrine dysfunction in affective disorders might be useful candidates along these lines.

S39.5
ROLE OF BRAIN IMAGING IN THE DIAGNOSIS OF FIRST EPISODE PSYCHOSIS

Falkai, Peter, Department of Psychiatry and Psychotherapy, University of Saarland, Germany

Brain imaging studies in the last two centuries support the notion that schizophrenia is a brain disorder. Meta-analyses have demonstrated reduced whole brain volume, increased ventricular size and bilateral reduction of the hippocampal formation in schizophrenia. Furthermore 3-5% of patients diagnosed as having a first episode of schizophrenia reveal organic brain lesions such as a tumour, bleeding or encephalitis. Therefore brain imaging in first episode psychosis currently, and in the future will have several important roles: 1) Diagnosis: from most guidelines it is clear that first episode psychosis needs a thorough physical work-up including brain imaging, such as

CT-scan. 2) Prognosis: long term follow-up studies are needed to judge the implications of morphological and/or functional abnormalities for the short and long term outcome of schizophrenia. Brain imaging may play a crucial role in this respect. As an example, several current studies seem to support progressive changes over time at least in a subgroup of first episode psychosis.

SYMPOSIUM S40
Sleep Disorders: Diagnosis and Therapeutic Consequences

WPA Section "Psychiatry & Sleep Wakefulness Disorders"

Chairs: Constantin R. Soldatos - Gerda Saletu-Zyhlarz

Saturday, 21 June, 4.00-5.30 pm - Erzherzog Karl Saal

S40.1
NONORGANIC INSOMNIA IN AFFECTIVE DISORDERS: DIAGNOSIS AND TREATMENT

Kupfer, David, University of Pittsburgh School for Medicine, Department of Psychiatry, Pittsburgh, United States

Sleep disturbance has represented one of the cardinal symptoms of mood disorders in most classificatory schemes in affective disorders. In this presentation, a review of the role of sleep changes in the specific subtypes of affective disorders and their treatment will be discussed. Newer strategies characterizing sleep in affective disorder patients using spectral analysis and neuroimaging suggest novel ways in characterizing sleep disturbances as a manifestation during the course of affective mood disorders. These changes can occur prior to an episode or even following a successful initial treatment response for the affective disorder as a residual symptom.

S40.2
SLEEP DISORDERS IN SCHIZOPHRENIA PATIENTS AND THE EFFECTS OF ANTIPSYCHOTIC DRUGS

Monti, Jaime M., Clinic Hospital Montevideo, Department of Pharmacology and Therapeutics, Uruguay; Monti, D.

Although the sleep disturbances in schizophrenia could be sufficiently severe to warrant independent clinical attention, they seldom are the predominant complaint. Nevertheless, severe insomnia is often seen during exacerbations of schizophrenia, and may actually precede the appearance of other symptoms of relapse. Less frequently, severe sleep disruption may complicate schizophrenia to the degree that patients can become suicidal. The sleep disturbances of either never-medicated or previously treated schizophrenia patients are characterized by a sleep-onset and maintenance insomnia. In addition, stage 4 sleep, slow wave sleep (stages 3 and 4), non-REM (NREM) sleep in minutes and REM latency are decreased. Moreover, the duration of visually scored stage 4 sleep or slow wave sleep has been shown to be inversely correlated with the severity of negative symptoms. Automated delta sleep measures revealed that total and average delta wave counts were also inversely associated with negative symptoms. It should be mentioned that controversy still exists about EEG sleep in schizophrenia. Discrepancies may be related to: 1) the differing definitions of schizophrenia; 2) the inclusion of patients over a wide range of ages, in different phases of their illness (acute vs. chronic), and with varied subtypes of schizophrenia; 3) the lack of screening for obstructive sleep apnea and periodic limbic movement disorder, which are prevalent in older people; 4) the inclusion of patients who had been taking antipsychotic drugs. The atypical antipsychotics olanzapine, risperidone, and clozapine significantly increase total sleep time and stage 2 sleep. Moreover, olanzapine and risperidone enhance slow wave sleep. On the other hand, the typical antipsychotics haloperidol, thiothixene, and flupentixol significantly reduce stage 2 sleep latency and increase sleep efficiency.

S40.3
ON THE KEY-LOCK PRINCIPLE IN DIAGNOSIS AND TREATMENT OF INSOMNIA RELATED TO ANXIETY DISORDERS

Saletu-Zyhlarz, Gerda Maria, University of Vienna, Department of Psychiatry, Vienna, Austria; Anderer, P.; Saletu, B.

Nonorganic insomnia is a frequent sleep disorder which has a high comorbidity with other psychiatric illnesses. In our sleep outpatient clinic, 41% of the patients showed neurotic, stress-related and somatoform disorders, 31% affective disorders and 1.6% schizophrenia. Sleep laboratory investigations in patients for diagnostic purposes and in normals for the evaluation of drug effects suggest that changes in the sleep architecture of patients with nonorganic insomnia due to psychiatric disorders as compared with normal controls are opposite to alterations induced by psychotropic drugs intended for their treatment as compared with placebo ("key-lock principle"). Evidence for this principle was found regarding nonorganic insomnia related to generalized anxiety disorder (GAD) or panic disorders and benzodiazepines, nonorganic insomnia related to depressive episodes, recurrent depression or dysthymia and sedative antidepressants and finally schizophrenia and sedative neuroleptics. Nonorganic insomnia related to GAD demonstrated significantly increased wake-time during the total sleep period (TSP), more early morning awakenings, decreased total sleep time (TST) and sleep efficiency as compared with normals. In regard to sleep architecture, decreased S2% and increased S1, S3+S4 % were observed, but there were no differences in REM measures. Subjective sleep quality was deteriorated as well, as were thymopsychic measures in the morning. Concerning noopsychic performance, GAD patients did rather well. Benzodiazepine therapy, including triazolam, quazepam, lorazepam and Somnium (lorazepam + diphenhydramine), generally induced opposite changes. In nonorganic insomnia related to panic disorder, polysomnography demonstrated decreased sleep efficiency, TST and S2 as well as increased middle and late insomnia (S1, S3+S4), snoring and periodic leg movements as compared with controls. There were no inter-group differences in REM variables. Subjective sleep quality was deteriorated, as were drive and fine motor activity in the morning. Blood pressure in the evening and morning and pulse rate in the evening were elevated. As compared with placebo, alprazolam 0.5 mg induced changes that were opposite to the differences observed between patients and controls before treatment, thereby normalizing sleep and awakening quality. The above-described studies point to a key-lock principle in the treatment of insomnia due to anxiety disorders and neurophysiologically visualize processes at the receptor level (e.g. benzodiazepine agonists vs. inverse agonists).

S40.4
SLEEP DISTURBANCES AND PSYCHOSOMATIC STATUS IN PATIENTS WITH CORONARY ARTERY DISEASE

Varoneckas, Giedrius, Institute for Psychophysiology and Rehabilitation, Palanga, Lithuania

Sleep quality was found disturbed in cardiac pathology, while disturbed sleep has a negative impact on the development of the latter. On the other hand, depression has a negative impact on sleep as well as on development of cardiac pathology. The relation among sleep disturbances, psychoemotional status and cardiac pathology is discussed. Data of 50 healthy subjects and 1086 CAD patients who underwent polysomnography, Pittsburgh sleep quality index, Hospital Anxiety and Depression Scale, SF-36, and cardiovascular testing were used. NYHA functional class was I in 49 patients, II in 627 patients, and III in 405 patients. 465 patients were without anxiety and depression, 229 with anxiety, 64 with depression, and 171 with both anxiety and depression. CAD patients, as compared with healthy subjects, had significantly reduced TST, SE, SWS, and REM sleep and increased WASO. Subjective sleep quality was worse for CAD patients. Disturbed sleep was paralleled by worsening of functional class as well as by complications such as heart failure, hypertension or diabetes. Worsening of objective sleep quality paralleled an increase of PSQI. Objective sleep quality was worse in cardiac patients with depression while subjective sleep quality was worse in patients with anxiety or both anxiety and depression. Worsening of functional class of CAD patients was paralleled by decreased quality of sleep. Anxiety was related more to decreased subjective sleep quality, while depression was related more to decreased objective sleep quality measured by polysomnography. Quality of life, especially mental one, was reduced in patients with anxiety, as compared with patients having depression or with both anxiety and depression.

SYMPOSIUM S41
Schizoaffective Disorder: An Entity or a Diagnostic Loophole

Chairs: Mario Maj - Andreas Marneros
Sunday, 22 June, 8.30-10.00 am - Zeremoniensaal

S41.1
CONCEPTS OF SCHIZOAFFECTIVE DISORDERS

Marneros, Andreas, University of Halle, Halle, Germany

The interest of clinicians and researchers in the field of schizoaffective disorders, which arose in the last decades, is mainly an indirect result of the psychopharmacological revolution, although the origins of schizoaffective disorders are very old, and can be found in the concept of Kahlbaum of "vesania typica circularis". They were as "cases-in-between" (Kurt Schneider) only of theoretical interest. Even after the descriptions of Kasanin, showing a prognostic relevance of the diagnosis "schizo-affective", they remained mainly of theoretical interest. But after the establishment of psychopharmacology, especially of the prophylaxis with mood stabilizers, more intensive research on the topic began. But the concepts of schizoaffective disorders are still controversial. Both the ICD-10 and the DSM-IV defined schizoaffective disorders as having three kinds of episodes: schizodepressive, schizomanic and mixed schizoaffective episodes. But the concepts underlying the definitions of both systems are insufficient to assess the whole spectrum of schizoaffective disorders. The main reason is that diagnoses of schizoaffective disorders in both systems are mainly based on cross-sectional criteria, which are somewhat sufficient to define episodes but insufficient to define diseases under longitudinal considerations. The DSM-IV definition is more problematic than that of ICD-10 mainly because of the chronological limitations regarding the occurrence of special symptoms. Concepts considering both cross-sectional and sequential manifestations of symptoms and episode types may be more appropriate to deal with schizoaffective disorders both for clinical and for research purposes. In spite of the uncertainties regarding nosological categorisation of schizoaffective disorders, they are an everyday clinical reality having relevant consequences for treatment, prognosis and rehabilitation of patients. They are also theoretical keys to understand "typical" psychoses and the bridges between them.

S41.2
RELATIONSHIP BETWEEN SCHIZOPHRENIA AND AFFECTIVE DISORDERS

Maier, Wolfgang, University of Bonn, Department of Psychiatry, Bonn, Germany

The relationship between schizophrenia and affective disorders is a core issue of clinical psychiatry since more than 100 years. Classical family studies tried to establish a distinct boundary between these conditions. These attempts were partly successful, at least with regard to the relationship between chronic schizophrenia and non-psychotic bipolar disorder. However, cases in-between, the schizoaffective disorders, define a broad area of overlap. This topic received renewed attention because of recent results of linkage studies, and subsequent fine and linkage disequilibrium mapping. Substantial overlap of candidate regions for both disorders did not occur just by chance but instead for about half of the identified intervals on the genome. Identified susceptibility genes will offer a new approach to the test of the classical Kraepelin's dichotomy.

S41.3
POSTPARTUM PSYCHOSES

Brockington, Ian, University of Birmingham, Bredenbury, Bromyard, United Kingdom

The sudden onset of psychosis after childbirth has intrigued medical practitioners for centuries. Over 2,000 papers have been published. This is a diverse group, which includes psychogenic, organic and affective or cycloid psychoses. The psychogenic group include morbid jealousy, querulant reactions, dysmorphophobia, and psychoses in adoptive mothers and fathers. The organic group include infective delirium, post-eclamptic psychosis, delirium tremens, confusion and stupor following parturition, and cerebral venous thrombosis. Only one form of postpartum psychosis is commonly seen in nations with modern obstetrics. This is often called "puerperal psychosis" and takes the form of mania, severe depression (with delusions, confusion or stupor) or acute polymorphic ("cycloid") psychosis. It was first fully described by Osiander in 1797. Record linkage studies give an incidence of slightly below 1/1,000 births. There is much evidence for a close link between puerperal and manic depressive psychosis, and with cycloid (acute polymorphic) psychosis. Childbirth, abortion, late pregnancy, bromocriptine treatment, weaning and menstruation are among the triggers of bipolar episodes in susceptible women. Puerperal psychosis has a high and specific heritability, which may involve the serotonin transporter gene. Its recurrence rate is about one in four pregnancies. These patients are best referred to specialist care. Neuroleptics, especially haloperidol, should be used

with caution, because dangerous side effects, including neuroleptic malignant syndrome, occur. Electroconvulsive treatment is useful in all forms (including mania), and lithium may be an effective prophylaxis.

S41.4
EVIDENCE AND EXPERIENCE IN THE TREATMENT OF SCHIZOAFFECTIVE DISORDERS

Vieta, Eduard, Hospital Clinic, University of Barcelona, Spain

Schizoaffective disorder is a common, severe, and lifelong illness; however, little is known about the specific pharmacologic treatment of this disorder. Different combinations of antipsychotics, mood stabilisers, and antidepressants have been tried, but well-designed, randomised clinical trials are scant. During the last years an emerging body of data has supported the use of atypical antipsychotics in this condition. While these trials were methodologically good, unfortunately schizoaffective patients represented only a fraction of the total sample, which mostly consisted of schizophrenic subjects, and often the lack of statistical power did not allow for particular subanalysis on the schizoaffective population. The combination of long-term atypical antipsychotic and mood-stabilising therapy would likely be the first-line treatment at present time for schizoaffective disorder, bipolar type, whereas the combination of an atypical antipsychotic and an antidepressant seems the most suitable for schizoaffective disorder, depressive type. Electroconvulsive therapy has still an important role in refractory cases. In coming years, research should focus on which specific combinations of treatments are the most efficacious and safe, and on the role of novel putative antipsychotic and mood-stabilising drugs. Psychoeducation and cognitive-behavioral approaches should be studied as adjuncts to pharmacotherapy in order to improve the outcome of this long-lasting and disabling condition.

SYMPOSIUM S42
Bipolar Depression - Clinical Challenge and Pharmacological Treatment

Chairs: Heinz Grunze - Gary Sachs

Sunday, 22 June, 8.30-10.00 am - Rittersaal

S42.1
BIPOLAR DEPRESSION: WHICH ANTIDEPRESSANTS AND FOR HOW LONG?

Nolen, Willem, University of Utrecht, Utrecht, Netherlands

In a recent Cochrane systematic review including 4 trials comparing antidepressants with placebo (total participants, n=323), 3 trials comparing an antidepressant with another type of drug (n=73), and 4 studies comparing two different antidepressants (n=236), we concluded that antidepressants are effective in bipolar depression (Gijsman et al, in press). In one of these studies tranylcypromine was found more effective than imipramine. There is no evidence that switching to mania is a common early complication of treatment with antidepressants, but the risk may be higher for TCAs than for other antidepressants, especially SSRIs. Therefore, it may be prudent to start with a SSRI as first-line treatment and to also use a MAOI rather than a TCA. There is no consensus in guidelines on how long to continue antidepressants after remission. Recently we examined the effect of antidepressant discontinuation or continuation on risk for relapse, in a sample of 84 patients with bipolar depression who had obtained remission from depression with the addition of an antidepressant to an ongoing mood stabilizer (Altshuler et al, in press). In a naturalistic design, the risk of depressive relapse was significantly associated with discontinuing antidepressants soon after remission. The risk of manic relapse was not significantly associated with continuing use of antidepressant medication and, overall, was substantially less than the risk of depressive relapse. In conclusion, long term treatment with the combination of a mood stabilizer and an antidepressant may be safe and even warranted in some patients with bipolar disorder.

S42.2
BIPOLAR DEPRESSION: TREATMENT WITH MOOD STABILIZERS

Sachs, Gary, Harvard University, Massachusetts General Hospital, Boston, United States; Iosifescu, D.

Among recovered bipolar patients enrolled in the systematic treatment program for bipolar disorder (STEP-BD) about 4% suffer a new episode of major depression each month. There are no medications approved specifically for the treatment of bipolar depression and little data is available to guide clinical management. Several studies report the efficacy of lithium to be superior to placebo. However, Nemeroff and colleagues found adding paroxetine or imipramine to ongoing treatment with lithium conferred no significant advantage. This presentation reviews preliminary results from a STEP-BD controlled naturalistic comparison of the outcomes following treatment for new onset episodes of bipolar depression. Outcomes are based on standardized prospective ratings completed at routine clinical visits. The analysis was carried out on 93 new episodes of bipolar depression. Comparisons groups were constructed on the basis of the clinical record indicating treatment with (n=44) versus without (n=49) a standard antidepressant medication within three weeks of diagnosis. At the episode onset, depression and mania severity scores were equivalent. The primary outcome criterion, a sustained "recovery" (>8 weeks) was seldom acheived (25% versus 26%). For these recovered subjects, time to onset of recovery was not significantly different. A trend for more switch into hypomania, mania or mixed episodes in those receiving antidepressant medication (18% versus 11%) did not reach statistical significance. In conclusion, this open controlled comparison of treatment for bipolar depression found low recovery rates and no advantage for adjunctive use of standard antidepressants over mood stabilizers alone.

S42.3
THE ROLE OF ANTIDEPRESSANTS IN BIPOLAR DEPRESSION – CORNERSTONE OR ELECTIVE TREATMENT?

Grunze, Heinz, LMU Munich, Department of Psychiatry, Munich, Germany; Moeller, H.-J.

The depressive episode appears to be the more refractory and difficult-to-treat pole of bipolar disorder. Bipolar depression is usually treated with a combination of a mood stabilizer and an antidepressant. Although the antidepressant efficacy of most mood stabilizers has so far not been proven in a satisfactory way, it seems sensible that a mood stabilizer should at least accompany treatment in any phase of the illness. As far as bipolar depression is concerned, mood stabilizers make sense to achieve long-term stabilization without a switch into hypomania or mania. The role of antidepressants, however, has been disputed for a long time. A potential switch induced by an antidepressant was balanced against the negative impact of insufficiently

treated depression, including chronification and suicidality. Additionally, unambiguous scientific evidence for their efficacy in bipolar depression is still far less than that available for unipolar depression. However, over recent years we have learned more about the usefulness of antidepressants in bipolar patients, regarding both their efficacy and their safety of use, and long-term continuation. Especially SSRIs and bupropion appear to be safe and efficacious in treating bipolar depression. Additionally, some atypical antipsychotics exhibit intrinsic antidepressant properties which may be useful as an augmentative treatment approach. Considering all pros and cons, at least some modern antidepressants should always be considered for the treatment portfolio in the majority of bipolar depressed patients.

S42.4
EXPERTS OPINION AND EVIDENCE-BASED MEDICINE – CURRENT TREATMENT ALGORITHMS AND GUIDELINES FOR BIPOLAR DEPRESSION

Kasper, Siegfried, Deaprtment of General Psychiatry, University of Vienna, Vienna, Austria

Bipolar disorder is not sufficiently diagnosed and if so current treatment guidelines are not reflected in everyday clinical practice sufficiently. Recent guidelines published by the American Psychiatric Association (APA) as well as from the World Federation of Societies of Biological Psychiatry (WFSBP) lay ground for evidence-based medicine. Based on these guidelines different phases within the bipolar disorder need to be considered, e.g. the individual is either in a depressed or manic state or suffers from a mixed mania-depression or rapid cycling. Mood stabilisers, including novel ones like the recently introduced lamotrigine, have their place in the different phases. Atypical antipsychotics on the other hand have been recently studied thoroughly for various indications within bipolar disorder. The broadening of bipolar disorder to the bipolar spectrum and the increasing awareness of the limitations not only of lithium but also of our current treatment portfolio gave rise to the development of new treatment strategies. These new strategies are encompassed in the newly developed guidelines and will help the clinicians to guide their everyday work based on data derived from evidence-based medicine.

SYMPOSIUM S43
Psychiatric Diagnosis in the Treatment of Cancer and Organ Transplantation Patients

Chairs: Barbara Sperner-Unterweger - Reinhold Schwarz
Sunday, 22 June, 8.30-10.00 am - Geheime Ratsstube

S43.1
THE RANGE OF PSYCHOLOGICAL REACTIONS AND PSYCHIATRIC SYMPTOMS IN PATIENTS WITH CANCER

Schwarz, Reinhold, Universität Leipzig, Institut für Arbeits- und Sozialmedizin, Leipzig, Germany; Krauß, O.

The diagnosis and treatment of cancer carries a high risk of psychiatric co-morbidity, which impedes the treatment of cancer and of associated physical symptoms, and worsens the quality of life of patients. Reliable and valid epidemiological data on the prevalence of mental co-morbidity are lacking and the nature of co-morbid mental disorders remains unknown. Research is needed to identify patterns of distributions by cancer site, treatment, and stage. To fill this gap we are performing an epidemiological study about the various aspects of mental co-morbidity in cancer patients and the identification of mental illness by health professionals. To examine the mental health of cancer patients we differentiate between patients with little symptoms, sub-threshold cases, and cases who meet the DSM IV/ICD 10 criteria. 200 patients consecutively admitted to the oncology units of the University Hospital at Leipzig were asked to complete the following check-lists: EORTC-QLQ-C30, HADS, and MFI. Additionally the Structured Clinical Interview (SKID) was performed. Furthermore we asked nurses and oncologists to give their evaluation of the psychiatric status of the patients. About 30% of the patients were found to have a psychiatric disorder, and ca. 20% suffered from sub-threshold impairments. Less than one third of the psychiatric cases were identified by the oncologists and/or the nurses. These findings demonstrate the high incidence of mental co-morbidity in cancer patients and the poor detection rate by health professionals.

S43.2
VALUE OF SELF-RATING QUESTIONNAIRES IN RESEARCH OF MENTAL HEALTH CARE IN ONCOLOGY

Effiace, Fabio, EORTC, Brüssel, Belgium

Over the last twenty years a large number of questionnaires have been developed to assess cancer patient's well-being. Some of these measures strictly focused on specific aspects measuring, for example, anxiety or depression. Other measures, more widely used at present time with cancer patients, are aimed at assessing a broader concept that is health-related quality of life (HRQOL). Whilst there is not yet a single accepted definition of the term HRQOL, there is a wide agreement on its multidimensional features. HRQOL is a construct that includes, but is not limited to, the patient's physical health status, psychological well-being, social and cognitive functioning and the impact of illness and treatment on patient's experience of life. As it is also recognized that patients represent the most appropriate source of information for their own HRQOL, the use of patient self-reported questionnaires is widely recommended as compared to proxy administered questionnaires. HRQOL measures are potentially useful in clinical practice for screening and for monitoring disease or treatment and may also contribute to improve doctor-patient communication. Moreover, HRQOL assessment is also an important aspect in cancer research as it is increasingly used as an endpoint to determine the whole treatment benefit of a new given therapy. At present time, several HRQOL measures are available that vary widely in their methods of development, content (e.g. focusing on physical symptoms rather than psychological aspects), breadth of use and psychometric robustness. Given this, careful attention has to be paid to the selection criteria when using a specific HRQOL questionnaire.

S43.3
PSYCHIATRIC DIAGNOSIS IN CANCER PATIENTS: IMPLICATIONS FOR TREATMENT

Grassi, Luigi, University of Ferrara, Ferrara, Italy

A number of studies have shown that 25-35% cancer patients report symptoms indicating a psychiatric diagnosis, particularly adjustment, depressive and anxiety disorders. Psychosocial morbidity secondary to cancer causes remarkable consequences to the patients and the family, but it is often un-recognized by health professionals. In a multicenter study carried out in Mediterranean countries, namely Italy, Spain and Portugal (Southern European Psycho-Oncology Study - SEPO-S) we have confirmed the high prevalence of both sub-thresh-

old and complete depressive and anxiety disorders among cancer patients, with significant correlations with cancer-related worries and poor social support. Appropriate recognition and referral of patients presenting psychosocial disorders can facilitate the development of programs in the community services with the aims of favoring adjustment to cancer and improving quality of life. Group psychotherapy, such as Supportive-Expressive Group Therapy (SEGT), represents a possible clinical tool to deal with psychiatric morbidity in an integrated way. Results of a study carried out on 161 breast cancer patients indicated that 62.1% had no ICD-10 diagnosis ("non-cases") while 37.9% received a psychiatric diagnosis ("cases"). Those who took part in 16-18 week SEGT showed a significant improvement in several dimensions of psychosocial morbidity, including depression, anxiety, hostility, global stress index, and maladaptive coping styles (e.g. hopelessness and anxious preoccupation). A sub-group of patients (11.9%) remained "cases" after the SEGT, while of patients who were "non-cases" on the screening phase and were re-evaluated at 6-month follow-up (n=85), 8.2% developed symptoms indicating an ICD-10 diagnosis. These effects were maintained at a 1-year follow-up. Implications for the organization of services in specific cultural contexts, such as Southern Europe, are discussed. **Acknowledgements**: The research presented here has been supported by funds from the University of Ferrara, the Italian Institute of Health – Mental Health Project, the Italian National Research Council and the European Commission Health and Consumer Protection – Commission on Cancer (agreement University of Ferrara)

S43.4
PSYCHOPATHOLOGICAL SYMPTOMS AND SYNDROMES IN PATIENTS BEFORE AND AFTER LIVER TRANSPLANTATION

Sperner-Unterweger, Barbara, Innsbruck University Clinics, Department of Biological Psychiatry, Austria; *Kohl, C.; Köss, G.*

Psychiatric co-morbidity in patients before and after liver transplantation is an important issue in liaison-psychiatry. It reflects the complexity of the field of interactions between somatic diseases and psychiatric disorders or symptoms and corresponding therapeutic strategies. Assessing psychopathological symptoms and syndromes during different stages of liver disease requires the use of a comprehensive diagnostic battery consisting of a structured psychiatric interview as well as psychometric self rating instruments. Before liver transplantation it is necessary to focus on pre-morbid psychiatric disorders which have caused or at least contributed to the liver disease, like alcohol and drug dependence. Furthermore primary psychiatric diagnoses unrelated to the liver disease such as affective disorders, schizophrenia, anxiety disorders etc. must not be neglected. Another important diagnostic problem is represented by different kinds of organic brain disorders induced by progressive liver disease. Special attention also needs to be given to psychological symptoms caused by the burden of a chronic disease or by chronic psychic stress induced by waiting for a liver transplantation. After liver transplantation, acute organic brain disorders, acute and/or chronic adjustment disorders, relapse of substance abuse and psychiatric side effects of immunosuppressive medication must be considered. Reliable psychiatric diagnoses are of utmost importance to provide appropriate liaison/counselling services for patients before and after liver transplantation.

SYMPOSIUM S44
Thought Disorder in Childhood - From Disorder to Classification
WPA Section "Child and Adolescent Psychiatry"

Chairs: Rochelle Caplan - Sam Tyano

Sunday, 22 June, 8.30-10.00 am - Trabantenstube

S44.1
THOUGHT DISORDER IN PEDIATRIC NEUROBEHAVIORAL DISORDER

Caplan, Rochelle, Department of Psychiatry and Biobehavioral Sciences UCLA, Los Angeles, United States; *Siddarth, P.; Asarnow, R.*

Background: Thought disorder is considered a core symptom of schizophrenia in adults and children with this disorder. However, several studies have found similar thought disorder findings in adolescents with affective and schizophrenic psychosis and in children with schizophrenia, attention-deficit hyperactivity disorder (ADHD), and epilepsy. There have been no studies to date on the developmental and cognitive profiles of thought disorder in children with these disorders. **Objectives:** The study presented in this abstract compared the thought disorder manifestations and associated developmental and cognitive correlates in children with schizophrenia, ADHD, complex partial seizure disorder (CPS), and petit mal (PM). **Methods:** Speech samples elicited with the Story Game (Caplan et al, 1989) were coded for thought disorder in 88 schizophrenic, 115 ADHD, 91 CPS, 51 PM, and 190 normal children, aged 7 – 15 years, according to Caplan et al, 1996, 2000. The Wechsler Intelligence Scale – Revised, Span of Apprehension, and Continuous Performance Tests were also administered to all the children. **Results:** The younger normal, schizophrenic, ADHD, CPS, and PM subjects had significantly more thought disorder than the older children with these diagnoses. Using a score derived from a discriminant analysis, the propensity towards having schizophrenia-like thought disorder, the schizophrenic, ADHD, CPS, and PM groups had different profiles of thought disorder correlates. Thought disorder was unrelated to IQ, working memory, and information processing measures in the schizophrenic group, but significantly related to these measures in the ADHD group. IQ and verbal working memory in the CPS group and IQ in the PGE group were significant correlates of thought disorder. **Conclusions:** Thought disorder, found in normal young children, is a developmental disability that occurs as a primary manifestation unrelated to the cognitive deficits found in childhood schizophrenia. In contrast, thought disorder is a developmental disability reflecting different aspects of the cognitive dysfunction found in children with ADHD, CPS, and PM.

S44.2
INFORMATION PROCESSING IMPAIRMENT IN CHILDREN WITH CONDUCT DISORDER AND SCHIZOPHRENIA

Mozes, Tamar, Child Psychiatry Department, Ness Ziona Mental Health Center, Ness-Ziona, Israel; Kertzman, S.; Verkslerchic, M.; Maman, Z.; Ben-Nachum, Z.

Objective: To assess which stages of information processing (IP) and which type of attention or memory is impaired in Conduct Disorder patients compared with schizophrenic and healthy children. **Methods:** 32 patients suffering from Conduct Disorder according to DSM-IV criteria (C) were included in the pilot. Two control groups were used: 15 early onset schizophrenic (S) patients, and 47 healthy chil-

dren of same age and gender. Tools were the computerized neurocognitive battery "CogScan" which included 14 real-time subtest of IP/attention and memory performance test. Statistical analysis was performed using ANOVA. **Results:** Significant differences between C and S versus healthy children were found in all subtests of information processing, selective and sustained attention, and working memory. Recall for pictures and faces were intact in both C and S groups. C patients were more impaired than S patients in picture recognition, word recall, and sustained attention in boring situations. S patients were more impaired than C patients in finger tapping test, simple reaction time, selective attention, and sustained attention in loading situation. **Conclusions:** Schizophrenic and conduct disorder children have distinct patterns of information processing impairments. Generally, schizophrenic children are more impaired, and conduct disorder children are less impaired. The differences between the latter groups can be partially explained by use of antipsychotic agents in schizophrenic patients, which causes slowness in output (motor slowness). Nevertheless, conduct patients are impaired in comparison with healthy children. Results suggest further investigation of impairment in information processing in conduct patients.

S44.3
MCDD – A SUB-CATEGORY WITHIN AUTISM SPECTRUM OR PRECURSOR OF SCHIZOPHRENIA?

Van Der Gaag, Rutger Jan, Department of Child and Adolescent Psychiatry, Netherlands

In 1986 the regretted late Donald Cohen proposed a heuristic category McDD for inclusion within DSM IV in order to foster studies on children frequently seen in clinical practice yet difficult to classify properly. They share the problems in the development of reciprocal social relations with children and adolescents with PDD/ASD. Yet they are also characterized by their severe problems in regulating affective states and thought disorders. In a series of studies (Towbin, 1993; Van der Gaag, 1995; Paul, 1999) the face validity of the concept was underscored. Follow up studies have given support both to the hypothesis that McDD is comparable to Asperger's disease, a persistent condition within Autism Spectrum Disorders, but also showed an incidence of psychotic episodes in more than 10% of the adult follow up cases, a sign that McDD has a risk comparable to schizotypal personality disorder vis à vis schizophrenia. In this presentation these data will be presented and critically discussed.

S44.4
COGNITIVE EXECUTIVE FUNCTIONS IN ADOLESCENT SCHIZOPHRENIA

Tyano, Sam, Geha Psychiatric Hospital, Israel; Zalsman G., Shvartzbord M., Weizman A.

The existence of deficits in executive functions (EF) among adult patients with Schizophrenia (SCZ) is well known. It was found that the cognitive deficit caused by SCZ is more pervasive and severe among adolescents than among adults. The scarce research evidence on adolescents with early onset SCZ also emphasizes their severe psychosocial deficits. The relationship between EF and social skills was examined from only few aspects and through the use of measures that do not significantly reflect the function in everyday life. The aim of this research is to discover a link between EF and interpersonal relations among adolescents with SCZ. The research took place at the Geha Mental Health Center, Israel. The participants were adolescents aged 16 – 19 years who were diagnosed as suffering from Adolescence Onset Schizophrenia. The sample included 30 adolescent inpatients. The research measures were: Positive and Negative Syndrome Scale (PANSS), Behavioral Assessment of the Dysexecutive Syndrome (BADS), Patient Competency Rating Scale (PCRS), Awareness questionnaire, Assessment of Interpersonal Relations (AIR). The preliminary results show association between low EF as measured by BADS and negative interpersonal relationships as measured by the AIR. All patients were lower than normal controls by all measures.

SYMPOSIUM S45
Cultural Factors in the Diagnosis of Mental Disorders

Chairs: Wielant Machleidt - Juan E. Mezzich

Sunday, 22 June, 8.30-10.00 am - Radetzky Appartement

S45.1
CULTURAL ASPECTS IN THE DIAGNOSIS OF NEUROTIC DISORDERS IN MIGRANTS

Machleidt, Wielant, Medizinische Hochschule Hannover, Abteilung Sozial-psychiatrie und Psychotherapie, Hannover, Germany; *Calliess, I.*

Migration processes go hand in hand with considerable mental stress. Whereas approx. two thirds of all migrants cope with this stress in a positive manner, supported by their social surroundings and families, approx. one third of all migrants get mental problems which have to be treated by experts. These mental disorders are mainly so called "stress disorders". These symptoms have a neurotic character, including mainly fear, latent and manifest aggression and also depressive moods. Comparing the subjective experience of migrants with experiences from patients coming from central Europe, who tend to introspectively psychologize their mental conflicts, migrants explain their disorders in a kind of "body language". This means, the disorders are projected onto organs of the body and are expressed by symptoms respectively. The transcultural subjective experience and the use of a symbolic "body language" explaining the disorder make it difficult to diagnose neurotic mental disorders with migrants. A similar difficulty, however in a different way, arises in making a diagnosis about personality disorders with migrants. For a valid diagnostic process the psychiatrists need a minimum of cultural competence and migration sensitivity.

S45.2
A US PERSPECTIVE ON CULTURE AND DIAGNOSIS: FROM IDENTIFYING DISORDERS TO THE CULTURAL FORMULATION

Mezzich, Juan E., International Center for Mental Health, Mount Sinai School of Medicine, New York, United States

The presence of culture in DSM-IV included the following components:

- An orientative statement for the Manual introduction;
- Cultural considerations for specific mental disorders and the use of diagnostic criteria;
- Culture-bound syndromes and idioms of distress;
- The Cultural Formulation.

The presentation will review recent efforts to study and facilitate a competent use of the Cultural Formulation.

S45.3
CULTURAL ASPECTS IN THE DIAGNOSIS OF PSYCHOTIC DISORDERS AMONG MIGRANTS

Haasen, Christian, Klinik für Psychiatrie und Psychotherapie, Universitäts-Klinikum Eppendorf, Hamburg, Germany; Yagdiran, O.; Kleinemeier, E.; Krausz, M.

Several studies in the past have implied cultural differences in the psychopathology of schizophrenia between migrants and natives, leading to problems in diagnosis. It has been hypothesised that misdiagnoses are frequent due to language problems. However, in a strictly controlled study, including comparison of diagnosis with a migrant and native speaking psychiatrist, results showed that the rate of potential misdiagnosis is higher among Turkish migrants in Germany, yet not strongly correlated to poor second language proficiency. Paranoid ideation had the lowest correlation between the two interviewers, while in a regression analysis poor correlation also was associated with late age of migration. Analysing only those cases where diagnosis agreed, migrants sample showed higher depression and hostile excitement, and no differences in positive, negative or cognitive symptoms. The similarities concerning core symptoms reflect evidence from cross-cultural studies on schizophrenia. This study therefore shows that differences in psychopathology between psychotic migrants and natives may be mainly due to diagnostic differences.

S45.4
DIAGNOSTIC ISSUES FOR TRAUMATIZED REFUGEES

Kastrup, Marianne, Rehabilitation and Research Centre for Torture Victims, Copenhagen, Denmark

In the first half of the 20th century the prevailing thought was that traumatic life events per se did not leave lasting consequences for mental health but were a result of a premorbid vulnerability. Subsequently, the Second World War studies of concentration survivors and war sailors revealed that exposure to different forms of extreme stress may induce fairly comparable mental problems among previously well individuals. PTSD has been a nosological entity since DSM-III (1980) attempting to unite different stress responses. Later on, revisions of DSM have modified diagnostic criteria and ICD-10 has introduced two diagnostic categories (F43.1 and F62.0) covering consequences of traumatic stress. The tendency to inclusiveness of a biomedical paradigm has been criticized from several sources claiming that this is a Western trend that does not sufficiently take into consideration the socio-political context. The paper will discuss the advantages and shortcomings of current diagnostic categories vis-à-vis a reflection of the universe of traumatized refugees.

S45.5
AN ARAB PERSPECTIVE ON CULTURAL FACTORS IN THE DIAGNOSIS OF MENTAL DISORDERS

Okasha, Tarek, Ain Shams University, Cairo, Egypt

As our societies become more diverse and the world evolves into a global village, the need to integrate culture into medicine and psychiatry becomes more critically important. In Arab culture, the humanitarian interaction with a doctor is valued as much, if not more, than his or her technical ability or scientific knowledge. The humanitarian nature of this interaction depends on the way the doctor deals with the patient and his or her family and the extent to which the doctor expresses respect for and acceptance of local cultural and spiritual norms. There is no doubt that culture has a marked influence on the presentation of psychiatric symptoms, the understanding of these symptoms and the different methods of traditional therapies used in each culture. Understanding the presentation of the symptomatology is an essential and integral part of reaching a proper diagnosis. In this talk the main differences between traditional and western societies will be reviewed with special emphasis on the diagnosis of somatoform disorders in the Arab culture.

SYMPOSIUM S46
Is There any Link Between Psychiatric Nosology and Suicidology?
WPA Section "Suicidology"

Chairs: Jean Pierre Soubrier - Nicoleta Tataru
Sunday, 22 June, 8.30-10.00 am - Künstlerzimmer

S46.1
DEFINITIONS AND TENTATIVE CLASSIFICATION OF SUICIDAL BEHAVIOUR

Soubrier, Jean Pierre, Chair of the WPA Section on Suicidology, Paris, France

To have the first symposium of the WPA Section on Suicidology in Vienna is rather an historical opportunity. All of us remember the meeting of the Psychoanalytical Society organized by Sigmund Freud in 1910 on the theme "On Suicide". It is also in Vienna that Erwin Ringel opened the first Suicide Prevention Centre and after, in 1960 created the International Association for Suicide Prevention. However, definition of suicide and classification of destructive behaviours need to be discussed. The definition of suicide is still a major issue. Discussion is based more on interpretation of the suicide act or ideation than on definition (as it can be seen in clinical practice). Emile Durkheim, a French sociologist, in 1887 and Edwin Shneidman in 1985 have tried to do so but did not reach a consensus acceptable for the different cultures. Norman Farberow in 1980 proposed very astutely to discuss this topic by dividing it in two parts: direct and indirect self-destructive behaviour. More examples will be given taken from personal research. In everyday practice, wherever in private or in institutions and crisis centres, it is difficult if not impossible to use psychiatric diagnosis manuals since suicidal behaviour may be categorized as a syndrome or a symptom, never a specific illness, and is not always related to a mental illness. The WHO International Network for Suicide Prevention had to face this problem when launching the program SUPRE in 1999. This presentation will discuss the available terms used in clinical practice, including the question of adopting or not the term "parasuicide". The global wish is to improve research in suicidology and to prevent more suicides.

S46.2
SUICIDE AND ATTEMPTED SUICIDE IN THE ELDERLY

Tataru, Nicoleta, Neuropsychiatry Hospital, Oradea, Romania; Junker, R.

Suicide and attempted suicide are one of the major health problems in the world being a leading cause of morbidity and mortality among middle age and older adults. The authors present a study of suicidal behaviour in last 10 years in the elderly comparatively with other age groups in Romania and abroad. We have done a comparison of completed suicides and attempted ones with controls matched for age, gender, ethnicity, profession and community of residence. Rates in

elderly suicide in our district is not too high, there is a difference between the various districts. The authors studied also the risk factors for suicide and attempted suicide in the elderly. The majority of elderly who attempted suicide were widow, often living alone with low social support, who used - most of them - voluntary drug ingestion. This study indicates associations between suicide in later life and psychiatric illnesses, history of suicidal behaviour, fair and poor physical health status, functional status and social circumstances reducing social standing. There are not big differences for non-fatal behaviour in the elderly compared with younger subjects in suicide rates, but there are differences in motivations and clinical implications. Preliminary study revealed in most cases the presence of major affective illness, substance use disorders, severe physical illness and functional limitations, moderate and severe pain and little social support. The prevention of suicide in later life must include an educational program for primary care to enhance knowledge regarding the treatment of mental illness and recognize the hopelessness and suicidal ideation targets.

S46.3
BORDERLINE PERSONALITY DISORDER AND SUICIDAL BEHAVIOUR

Etzersdorfer, Elmar, Klinik für Psychiatrie und Psychotherapie, Stuttgart, Germany

The paper gives an outline of the current knowledge about the risk for suicidal behaviour in patients with borderline personality disorder (BPD). First different approaches to diagnose BPD are addressed. Then epidemiological data on suicides and suicide attempts of BPD patients are presented, showing that patients with BPD represent a high-risk group for suicidal behaviour. On the other hand it will be shown that particularly among those attempting suicide a huge amount of BPD patients can be found. It will be argued, however, that the definition of BPD used influences these results considerably. In the last part different approaches to explain the increased risk are described and discussed. Among them are the relationship with traumatic experiences and abuse, questions of co-morbidity, and biological as well as psychodynamic approaches. It will be argued that psychodynamic approaches, e.g. in the sense of Kernberg, describing identity diffusion with unstable and unintegrated inner object-relationships and more primitive defence mechanisms in BPD patients, offer a consistent explanation of the increased risk for suicidal behaviour, as well as a therapeutic strategy.

S46.4
SCHIZOPHRENIC SPECTRUM DISORDERS: PSYCHOLOGICAL AND PSYCHOPATHOLOGICAL DIMENSIONS AND SUICIDAL BEHAVIOUR

Botsis, Alexander, University Mental Health Research Institute, Suicide Research and Prevention Unit, Athens, Greece

Patients suffering from schizophrenic spectrum disorders have a high risk for suicidal behavior. In fact, 35-54% of these patients have at least one suicide attempt lifetime, and 10-12% of them commit suicide. The sex ratio for suicide attempts is totally different from the general population and it is estimated to be approximately m/f= 3/2.5, while the sex ratio for suicides is m/f = 3/1, similar to that of general population. It has been reported that 14% of the paranoid patients commit suicide, while non-paranoid have 2.5 times less risk for suicide, while patients with deficit syndrome have 8 times less probability to commit suicide than paranoid patients. The vast majority of patients commit suicide few days or weeks after hospitalization and only 20-25% of them commit suicide during their hospitalization. Besides the type of psychopathology, other psychopathological dimensions that are connected with high risk for suicide are depression, hopelessness, helplessness, and anxiety as well as aggression dysregulation. Psychological dimensions such as self-esteem regarding gender identity and role in males, impulse control, and pleasure capacity will be discussed.

S46.5
INTEGRATION OF SUICIDE PREVENTION PROGRAMS IN PSYCHIATRIC CLINICAL PRACTICE WHEN USING DIAGNOSIS GUIDELINES

Wasserman, Danuta, National Centre for Suicide Research - Karolinska Institute, Stockholm, Sweden

Suicide risk is particularly high among psychiatric patients characterised by simultaneous personality and somatic disorders, and poor psychosocial conditions. Adequate diagnostics and treatment both in psychiatric practice and in the general population are essential strategies for suicide prevention. Multi-level suicide-risk assessment should relate not only to patients, their families and social networks, but also to available treatment options and community resources for rehabilitation and prevention. Assessment of suicide risk touches both on patients' most pressing problems and on aspects of doctors' counter transference. Incorporating structured diagnostic clinical instruments into assessment interviews with suicidal individuals is therefore vital. Psychiatric diagnosis, the presence of personality and/or somatic disorders, social conditions and the influence of negative life events, such as losses, changes, traumas and narcissistic injuries, can be evaluated systematically in terms, for example, of Axes I–V according to the DSM-IV classification. Besides psychiatric interviews, various psychometric scales may be used to gauge suicide risk. The questions posed in a structured interview must feel natural both to the patient and doctor alike. During the clinical interview, it is essential to evaluate the development of the patient's suicidal process, suicidal communication, relationships, suicidal intentions and suicide in the family or among acquaintances (suicide model), if any. By means of careful diagnostic evaluation followed by adequate treatment, the risk both of suicide and of repeated suicide attempts can be significantly reduced. Integration of suicide-preventive programmes in psychiatric clinical practice is vital not only for patients, but also for the well being of psychiatric staff, to which a patient's suicide is highly distressing.

SYMPOSIUM S47
Diagnosis and Treatment of Psychiatric Comorbid Disorders in Children

Chairs: James M. Perel - Ruby Castilla

Sunday, 22 June, 8.30-10.00 am - Schatzkammersaal

S47.1
DIAGNOSIS AND TREATMENT OF PSYCHOSIS ASSOCIATED WITH DEPRESSION IN CHILDREN

Castilla, Ruby, Epidemiology Department,
University of Pittsburgh, Pittsburgh, United States; Perel, J.M.

Psychotic depression is defined as Major Depressive Disorder (MDD) associated with mood congruent or incongruent delusions and/or hallucinations. The face of depression in children is even more complicated when associated with psychotic features. This combination is frequently fatal due to suicidal behavior. However, the majority of psychotic depressive states are treatable. Proper psychiatric treatment of psychotic depression in children and adolescents necessitates the use of psychopharmacotherapy. Effective psychopharmacological intervention for psychotic depression is based on the appropriate psychiatric diagnosis and assessment of those domains of disturbance that will become the focus of treatment. The purpose of this presentation is to provide a clinically useful approach to using medications in the treatment of child and adolescent psychotic depression. The first part will focus on the revision of MDD, MDD associated to psychosis and additional disorders related with psychotic depression in children, and the second part will focus on the medications available for the treatment of them. Currently, the combinations of atypical antipsychotics, mood stabilizers and selective serotonin reuptake inhibitors (SSRIs) are the trial choice because of their efficacy, benign side effect profile, and ease of use. A combination of antidepressant, mood stabilizer, and antipsychotic medication is needed to effectively treat psychotic depression. Pharmacological treatment of MDD associated to psychosis in children and adolescents aims to achieve remission and prevent relapses and recurrences.

S47.2
ANXIETY AND DEPRESSION IN CHILDHOOD: EVOLUTION OR COMORBIDITY?

Grau, Arturo, Infant Psychiatry Division Calco Mackenna Hospital, Santiago de Chile, Chile

A prospective and retrospective study of children and adolescents diagnosed with Anxiety Disorder or Major Depression is discussed. A follow up study during the last ten years on a sample of 140 children with a precocious diagnosis of Anxiety Disorder allows us to conclude that it is more likely to find a developmental association than a comorbidity relationship by chance, between these disorders and Major Depression among adolescents. The suicide of five older patients (at least 15 years old) orientated a retrospective study in which a first correlation was found, that is, Anxious Disorder and family antecedents of coexisting or isolated Major Depression, Bipolar Disorder and Anxiety Disorder were present in all of these depressed and then suicidal patients from early stages of their development. From this finding, we decided to investigate personal and family background of anxiety and depression in every adolescent who consulted us due to a Major Depression and Dysthymic or Anxiety Disorder. We explored the reason why the adolescent consulted us, the symptoms, the personal and family background and the evolution from early anxious symptoms in childhood to later Major Depression in children more than 12 years old. This research emphasises the necessity of early diagnosis and treatment of childhood Anxious Disorders.

S47.3
ERP P300 AND RISK FOR SUBSTANCE USE DISORDER IN CHILDREN

Habeych, Miguel, University of Pittsburgh, School of Pharmacy, Pittsburgh, United States

Event related potentials (ERP) have been found altered in adults with a substance use disorder (SUD) as well as in their normal offspring. The most frequently reported and replicable findings pertain to deviations in the P300, a neurophysiological correlate of attentional control. Because offspring of men with SUD frequently manifest attentional problems which are also frequently concomitant to conduct disorder (CD), the question is raised regarding the specificity of the P300 deviations in relation to the risk for SUD. We will review the role of familial history of SUD for significant variance in P300 deviations in children; and the concept of inherited, developmental alteration of the function of the dorsal pre-frontal cortex as a biological correlate on the liability to SUD.

S47.4
PSYCHOTROPIC DRUG INTERACTIONS IN CHILDREN

Perel, James M., University of Pittsburgh,
Department of Psychiatry, Pittsburgh, United States

The application of multiple pharmacotherapies is often reserved for potentiation of a partial medication effect, to treat comorbid disorders and to reduce the side effects of a specific medication. The concurrent presence of several agents/metabolites increases the potential for drug interactions which are often caused by changes by one drug on the absorption, distribution, metabolism or excretion and intestinal/hepatic transport of another drug (pharmacokinetic). There could also be interactions at biologically active sites and signal transducers also resulting in changes in pharmacologic effects (pharmacodynamics). We will review the roles of cytochrome P-450 (CYP) enzymes, P-glycoproteins transporters and pharmacogenetics in conjunction with developmental and hormonal aspects of the juvenile population, with emphasis on interactions of $2^{nd}/3^{rd}$ generation antidepressants and atypical neuroleptics. There will be mechanistic interpretations and clinical applications of various pairs such as Fluvoxamine/Clozapine; R and S Citalopram/Fluvoxamine (Clomipramine); Nefazodone/immunosuppressants; Lithium and other forms of augmentation; Paroxetine/CYP2D6 substrates; Risperidone/CYP2D6/3A4 substrates.

S47.5
SCHIZOPHRENIA IN CHILDREN AND ADOLESCENTS: INTEGRATING DIAGNOSIS, PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY

Yunes, Roberto, Hospital Infanto Juvenil Carolina Tobar Garcis, Argentina

Studies suggest that atypical antipsychotics could be useful in treatment of adolescents with psychotic disorders; however, there are few studies made in Argentinean patients under 18 years old. This presentation examined the importance of early diagnosis and effectiveness and tolerability of both support therapy (ST) and psychotropic

drugs in the treatment of children and adolescents with psychotic disorders. We present the results of controlled clinical trials in children and adolescents with principal diagnosis (DSM-IV) of schizophrenia that were treated with atypical antipsychotics + ST. In our research we have studied in a retrospective way the efficacy and acceptability of atypical antipsychotics in patients of the Inpatient Unit of a Neuropsychiatric Hospital. This group of patients from 12 to 18 years old with catatonia, schizophrenia with negative symptoms or resistant schizophrenia, were previously treated with classical neuroleptics, used in adequate dose and periods of time without satisfactory results. We will discuss the impact of schizophrenia in children and adolescents. We also will recognize the potential role of diagnosis, psychopharmacological and psychotherapeutic approaches treatment in schizophrenic children and adolescents and the importance of evaluating the improvement, especially in positive symptoms, and side-effects during the first weeks of treatment. Integration of pharmacological treatments plus ST may be a promising combination for the treatment of schizophrenia in children and adolescents.

SYMPOSIUM S48
Adult Attention Deficit Hyperactivity Disorder

Chairs: David Baron - Karl Looper

Sunday, 22 June, 8.30-10.00 am - Erzherzog Karl Saal

S48.1
ADULT ADHD IN PRIMARY CARE

Fahrer, Rodolfo, Buenos Aires, Argentina; Baron, D.

The syndrome, now known as ADHD (Attention Deficit Hyperactivity Disorder), was first described in a poem by a German primary care physician, Heinrich Hoffman, in 1865. Dr. Hoffman's poem, *Fidgety Phil*, listed the core symptom presentation of children afflicted with the syndrome – hyperactivity, impulsivity and inattentiveness. It was not until 1902 that George Still, reporting in Lancet, focused serious scientific attention on this behavioral condition in children. He presented a series of three lectures to the Royal College of Physicians describing 43 children treated in his practice who were aggressive, defiant, and resistant to discipline, excessively emotional and displayed little inhibitory volition. Clearly, the history of the syndrome can be traced to astute clinical observations of primary care physicians. Adult ADHD was not seriously studied, or even acknowledged to exist until the late 1960's. Virtually all of the scientific investigations in Adult ADHD have been conducted by behavioral health specialists, and not primary care providers. Studies conducted over the past decade have demonstrated that 60%-70% of children with ADHD will continue to be symptomatic into adulthood. Given the limited number of clinical psychiatrists in many parts of the world, along with the very large number of patients with acute, severe psychopathology they must treat, the likelihood that these Adult ADHD patients are not being diagnosed and appropriately treated is high. These patients typically do not present with acute psychiatric symptoms, which might help initiate a psychiatric referral, but rather experience more chronic problems which are thought to be their "normal", character style. As leaders in world psychiatry, we must accept the challenge to educate ourselves in the proper diagnosis and treatment of this disorder, and then educate our primary care colleagues. As is the case in most forms of psychiatric diseases, primary care physicians are the first, and often the only, health care providers available to treat these patients and greatly improve their overall quality of life. Our efforts to increase awareness of Mood Disorders in the general public and with primary care providers have been successful. We need to seriously consider repeating this strategy with Adult ADHD. As always, it all begins with education.

S48.2
ASSESSMENT OF ADULT ADHD

Baron, David, Temple University, School of Medicine, Department of Psychiatry, Philadelphia, United States; *Lim, L.*

My colleagues have described the historical aspects of ADHD and the half-century gap in appreciating the existence of adult ADHD. Why did it take over 50 years to identify the clinical significance of this disorder when well over 60% of children with ADHD continue to be symptomatic as adults? The likely answer lies in the natural course of the illness. As ADHD patients age their most visible and clinically significant symptoms, disruptive behavior and hyperactivity, diminish. This predictable decrease in certain core symptoms resulted in the flawed assumption that the patient had outgrown the condition. Believing the condition to be restricted to children and young adolescents, no effort was made to seriously assess adults. In addition, there are no validated screening tools to make a diagnosis, as are available to assess depression. As in children, adult ADHD requires a longitudinal assessment. Most adult ADHD are able to function, albeit at a level well below their capacity. Children with ADHD are forced into situations where their symptoms are highly visible, school. The classroom environment requires the ability to sit still and pay attention. The inability to comply is quickly identified by teachers and parents. As adults, ADHD patients learn to adapt by avoiding situations which demand prolonged periods of focused attention. Adult ADHD patients do not pursue careers in accounting or become chess champions. The diagnosis of adult ADHD is based on a history of impairment of concentration, easy distractibility, and impulsivity in childhood. Documenting dysfunction of this type is, by definition, historical and dependent on retrospective data. Information is particularly vulnerable to distortion (a patient may remember being a poor student, but not recall why) and is often inaccurate and incomplete. The worldwide issue of the stigma associated with having a psychiatric diagnosis may result in patients' blaming their problems on being lazy, stupid, or unmotivated rather than be labeled with a mental disorder. In addition, adult ADHD patients are more likely to have co-morbid psychiatric problems, than children with the disorder. This may be the result of dealing with the core symptoms over a lifetime. An adult patient who presents with depressive or anxiety symptoms may not ever be worked up for ADHD. It is important for clinicians to consider ADHD in adult patients, even if a childhood diagnosis is not reported. The focus should be on symptom presentation and childhood functioning at school and at home. Adult ADHD requires a history of childhood ADHD. However, the patient may have had the condition and was never formally diagnosed.
The assessment of adult ADHD should include the following four questions at a minimum:

1) Is there reliable evidence that ADHD symptoms sufficient to cause impairment at school and home were present prior to mid-adolescence?
2) Do current ADHD symptoms cause impairment in social and occupational functioning?
3) Can the symptoms be explained by another cause, i.e., mental retardation, medical illness?
4) Does the patient have other psychiatric illnesses?

No single symptom will confirm the diagnosis and no psychometric tool can confirm the existence of ADHD. An accurate diagnosis is

dependent on a comprehensive psychiatric history and knowledge of ADHD symptom presentation.

S48.3
DEVELOPMENTS IN THE TREATMENT OF ADULT ADHD

Looper, Karl, Department of Psychiatry, McGill University, Montreal, Canada

The treatment of adults with attention-deficit/hyperactivity disorder (ADHD) is a relatively recent practice. Early research focussed on establishing the efficacy and safety of pharmacological interventions for the primary symptoms of ADHD. The use of psychostimulants and antidepressants as first line treatments is supported by randomized controlled trials, and other psychotropic medication may be of use in treatment resistant cases. Subsequent studies broadened the scope of investigation to address the complexity of clinical issues of adults with ADHD including associated symptoms not included in the formal diagnosis (eg: low self-esteem), complicating factors such as comorbid conditions, as well as the interpersonal, family, social and occupational dysfunction seen in this patient population. This has led to the development of psychosocial treatments that may be used alone or in combination with medications. The contemporary treatment of adults with ADHD requires a comprehensive approach including medication, psychological and social interventions. This presentation will review the important clinical considerations as well as the established and emerging treatments for adults with ADHD.

S48.4
ADULT ADHD: DIAGNOSIS AND TREATMENT FROM A MULTICULTURAL PERSPECTIVE

Lim, Leslie, Temple University, School of Medicine, Department of Psychiatry, Philadelphia, United States; Baron, D.

Attention Deficit Hyperactivity Disorder (ADHD) is defined as a disorder that presents with a persistent pattern of inattention and/or hyperactivity-impulsivity. The symptoms first present in childhood and interfere with normal functioning and psychosocial development. Core symptoms include low frustration tolerance, inability to stay focused, easy and frequent distractibility, poor organizational skills, frequent daydreaming, impaired work efficiency and academic and occupational underachievement. The syndrome was first described in the Western medical literature one hundred and fifty years ago and until 1934 was thought to only afflict children. Epidemiologic studies estimate that 2% to 10% of school age children are afflicted with the syndrome. In all studies the male to female ratio ranges from 3:1 to 6-10:1. Recent clinical research reports indicate that approximately 65% of children with ADHD will continue to be symptomatic into adulthood. It is estimated that between 1% and 6% of the general adult population experience ADHD symptoms. It is estimated that 85% of adult ADHD cases (~8.3 million American adults) are undiagnosed. The global impact is not yet known. The exact cause of ADHD is not yet known. However, definitive anatomic and functional changes in frontostriatal neuronal circuitry have demonstrated the condition is a neurobiological disorder influenced by genetic and neurochemical factors. ADHD appears to be a polygenic disorder affecting dopamine, norepinephrine and other catecholamine neurotransmitters. Genetic linkage studies have associated the dopamine transporter gene with ADHD, with the 7-repeat allele of DRD4 having a significant role in adult ADHD. ADHD is the most heritable psychiatric disorder.

SYMPOSIUM S49
Diagnosis in Psychiatry. The Historical Approach
WPA Section "History of Psychiatry"

Chairs: Paul Hoff - Eberhard Gabriel

Sunday, 22 June, 1.30-3.30 pm - Otto Wagner-Spital

S49.1
PSYCHIATRY IN VIENNA AROUND 1900: THE INSTITUTIONAL AND PSYCHOPATHOLOGICAL ASPECT

Gabriel, Eberhard, Sozialmedizinisches Zentrum Baumgartner Höhe, Vienna, Austria

The special event and the introductory remarks give the opportunity to focus on developments within the psychiatric field in Vienna around 1900 which turned out to be of ongoing impact. (1) The event takes place in a psychiatric institution opened in 1907 leaving space near the University hospital in the city center for the then designed university department of psychiatry and neurology in its former buildings. (2) In these institutions E. Stransky and J. Berze developed psychopathological concepts on the then new diagnostic category of dementia praecox (Kraepelin) which are connected with nowadays disorganization and negative factors in the symptomatology of schizophrenia. At the same time psychoanalysis both as a theory and a movement grew up.

S49.2
THE FUNCTION OF THE PSYCHOANALYTIC INTERVIEW IN IT'S HISTORICAL CONTEXT

Springer-Kremser, Marianne, University of Vienna Medical School, Vienna, Austria; Springer, A.

Beginning with S. Freud's 'Empfehlungen und Ratschläge für Indikation und Behandlung bei Psychoanalysen für Ärzte' from 1905, three phases of recommendations for diagnostic procedures can be distinguished, thus reflecting the state of the actual debate on psychoanalytic theories and technics. The first phase includes E. Jones, O. Fenichel and E. Bergler, who tried to attribute different prognoses to symptom neuroses, depending from the fixation to a certain psychosexual developmental phase. In 1918, at the fifth international psychoanalytic congress in Budapest, when S. Ferenczi, F. Alexander and others introduced the concept of short term psychoanalytic psychotherapy, the initial interview started to play a more prominent role. A second phase can be characterized by the assessment of the Ego functions as adaptive necessities, basing on the structural theory, which became the central point of reference for future diagnostic instruments, such as the Operationalized Psychodynamic Diagnosis (OPD), currently used in Germany. The assessment of certain Ego functions helps us to differentiate between neurotic, borderline and psychotic personality organization. At approximately the same time, psychoanalysts in Paris designed a special interview technique for psychosomatic patients. Finally, phase three can be defined by including Kleinian transference and counter transference concepts as diagnostically relevant, like projective identification.

S49.3
PSYCHIATRIC DIAGNOSIS BETWEEN KRAEPELIN AND ICD 10: CONTINUITY OR PARADIGM SHIFT?

Hoff, Paul, Universitätsklinikum RWTH Aachen, Psychiatry and Psychotherapy, Aachen, Germany

This presentation will outline the theoretical background of Kraepelinian psychiatry with special attention to his concept of mental illness and diagnosis. In a second step, the theoretical foundations of modern operational diagnostic procedures in psychiatry are discussed. Since many authors who contributed to the development of DSM-III, DSM-IV and ICD-10 would claim to be "neo-Kraepelinians", I will compare the two approaches which, indeed, have some aspects in common, but have also significant differences. These are usually underestimated. The practical relevance of this debate for psychiatric therapy and research will be shown.

SATELLITE SYMPOSIUM ISS1
Assuring Constant Coverage and Long-term Stability in Schizophrenia
(sponsored by Janssen-Cilag)

Chair: Ahmed Okasha

Friday, 20 June, 12.15 am-2.00 pm - Festsaal

ISS1.1
TREATMENT DISRUPTION AND RELAPSE IN SCHIZOPHRENIA: INEXTRICABLY LINKED?

Okasha, Ahmed, Ain Shams University, Egypt

Preventing relapse in schizophrenia continues to be a major challenge. Antipsychotics are effective for reducing relapse risk in studies, but in reality nearly all patients relapse many times during the course of their illness despite treatment. Why are relapse rates so high in clinical practice? Although continuous antipsychotic treatment is most effective for reducing relapse risk in schizophrenia, it is the exception rather than the rule in clinical practice. About two-thirds of schizophrenia patients are partially or fully non-compliant with medication, with some estimates reaching 81%. This means relatively few patients take their medication everyday. This problem is not unique to schizophrenia, but heightened by patients' poor judgement and lack of insight into their illness and medication benefits. Even occasional missed doses may lead to sub-therapeutic drug plasma levels, leaving patients vulnerable to symptom exacerbations. How do we make continuous treatment a reality? Conventional depots have fallen out of favour because of extrapyramidal symptoms and other side effects. Still, studies show that they may be more effective than oral administration for reducing relapse risk. A long-acting second-generation antipsychotic has been a significant need and would offer both second-generation efficacy and tolerability and assured medication delivery. Risperidone long-acting injection is the first agent to meet this need and offers psychiatrists and patients an opportunity to assure medication delivery, minimise therapy disruptions, reduce the risk of relapse, and optimise long-term outcomes.

ISS1.2
RISPERDAL® CONSTATM: THE FIRST LONG-ACTING NOVEL ANTIPSYCHOTIC

Fleischhacker, Wolfgang, Innsbruck University Clinics, Innsbruck, Austria

The efficacy, safety, and tolerability of risperidone long-acting injection have been evaluated in a 12-week, double-blind, placebo-controlled study and a 1-year, open-label study. The short-term study showed Positive and Negative Syndrome Scale (PANSS) total scores were significantly reduced by risperidone long-acting injection compared with placebo ($p<0.002$). In the long-term study, 'clinically stable' patients had continuous significant improvement in the range of symptoms over 1 year. Forty-five percent of patients given the recommended 25mg dose were not ill or only mildly ill (Clinical Global Impression scale) at endpoint compared with only 19% at baseline. The overall proportion of patients that discontinued treatment was 35%. Risperidone long-acting injection was well tolerated, with less than 5% of all patients discontinuing medication due to adverse events. In the 1-year safety study, severity of extrapyramidal symptoms (EPS) (Extrapyramidal Symptom Rating Scale [ESRS] total score) was low at baseline and remained so. Few patients (0.6%) had tardive dyskinesia. Mean weight gain over 1 year was 2.3 kg. Overall, there was little discomfort at the injection site. Patients were switched effectively and safely to risperidone long-acting injection from conventional depot antipsychotics or oral antipsychotics in two, 12-week, open-label trials. Mean total PANSS scores decreased despite stable dosing regimens before switching. The severity of EPS (ESRS total score) was low at baseline and unchanged or improved at endpoint in all patient groups. Risperidone long-acting injection provides effective and well-tolerated control of psychosis, which may help improve everyday functioning. It considerably enhances the options for long-term antipsychotic treatment.

SATELLITE SYMPOSIUM ISS2
Mania, Depression and Novel Antipsychotic Drugs: Key Issues and New Answers
(sponsored by Janssen-Cilag)

Chairs: Siegfried Kasper - Ahmed Okasha

Friday, 20 June, 5.45-7.15 pm - Festsaal

ISS2.1
MANIA, DEPRESSION: KEY ISSUES

Kasper, Siegfried, Department of General Psychiatry, Vienna, Austria

The lifetime prevalence of bipolar I disorder is approximately 1%, but the bipolar spectrum involves a range of conditions, including bipolar II and other presentations. Prevalence estimates have underestimated the impact of the disease; under-recognition and misdiagnosis exacerbate this problem. Recently, a large-scale community screen in the US reported a prevalence for bipolar I and II disorders alone of almost 4%. Of those identified with bipolar disorder, only a fifth had previously been diagnosed correctly, while one-third had a diagnosis of major depression. Around half had no previous diagnosis. Diagnosis of bipolar disorder is complex, due to the episodic nature of the condition, and the variability of symptoms among patients and across the course of illness. The overlap of symptoms with conditions such

as schizophrenia or unipolar depression adds to the difficulty. Comorbid psychiatric conditions such as substance abuse and anxiety disorders can mask bipolarity, further complicating the diagnosis. Inaccurate diagnosis leads to incorrect treatment. For example, a patient diagnosed with major depression is likely to be treated with an antidepressant, which might precipitate mania or hypomania or induce rapid cycling. Even when correctly diagnosed, patients may not receive adequate medication. For example, conventional antipsychotic drugs have historically been used in acute mania, but their efficacy is limited, and tolerability poor. Wider recognition of bipolar disorder will lead to more appropriate treatment. Our treatment strategies should be flexible, focusing on the pattern of symptoms in each patient. Successful management requires a long-term approach, which accommodates the changeable nature of the illness.

ISS2.2
NOVEL ANTIPSYCHOTIC DRUGS: NEW ANSWERS

Vieta, Eduard, University of Barcelona, Department of Psychiatry, Barcelona, Spain

The range of treatments available for patients with bipolar disorder is increasing. Novel (atypical) antipsychotic drugs offer a number of advantages compared with the conventional agents. This presentation focuses on encouraging new evidence on the use of risperidone for bipolar mania. The efficacy of risperidone against a broad range of symptoms in mania has now been demonstrated in double-blind, controlled trials involving more than 1250 patients, with risperidone monotherapy or added to a mood stabiliser. In a three-week trial conducted in the US, mania (YMRS) scores declined rapidly with risperidone monotherapy (mean modal dose 4.1mg) (Hirschfeld et al, 2002). The efficacy of risperidone was superior to placebo from as early as day 3 ($p<0.001$); this was sustained until endpoint. Twice as many patients were responders (reduction in YMRS score ≥50%) to risperidone than to placebo. Risperidone was well tolerated; the most common side effect was somnolence. Equally positive results have now been observed in a second 3-week placebo-controlled study, which also included haloperidol as an active comparator. The effect of risperidone plus mood stabiliser has also been found to be superior to that of mood stabiliser alone (Vieta et al, 2002). There is also evidence that the anti-manic effect of risperidone is maintained during longer-term treatment. A sustained reduction in symptoms (together with superior tolerability for risperidone versus haloperidol) has been shown in a 12-week double-blind study (Sachs et al, 2002). In longer-term open-label or naturalistic studies, progressive improvements have been observed, both in symptoms and overall functioning.

ISS2.3
NOVEL ANTIPSYCHOTIC DRUGS: WHICH PATIENTS BENEFIT?

Grunze, Heinz, Ludwig Maximillians-Universität, Department of Psychiatry, Germany

Mania is a heterogeneous condition. There is no ‘typical’ manic patient: differences in severity, the presence of psychotic or depressive symptoms, and medical or psychiatric co-morbidities all affect the presentation. Modern therapeutic strategies encompass all these therapeutic targets; treatments with broad efficacy are proving particularly valuable. In a study of severely ill patients (baseline YMRS mean score = 37), the anti-manic effect of risperidone was superior to placebo from week 1 ($p<0.001$); after 3 weeks of risperidone, the YMRS score was reduced by 22 points (Vieta et al, 2002). This study adds to our understanding of risperidone as an agent with broad-spectrum efficacy, with rapid onset of action, effective in both moderately and severely ill patients, with or without psychotic symptoms. Substantial remission rates have been achieved with risperidone, both add-on and monotherapy. There is also preliminary evidence that adjunctive risperidone may enhance the anti-manic and antidepressant effects of mood stabilisers in rapid cycling patients (Coconcea et al, 2002). Risperidone’s receptor occupancy profile supplies a biological rationale for its use for depressive and anxiety symptoms. There is preliminary evidence that risperidone can augment antidepressant response. In a study of 36 patients with major depression, risperidone plus fluvoxamine was well tolerated; 76% achieved remission (Hirose and Ashby, 2002). Risperidone augmentation may particularly benefit depressed patients who are resistant to standard antidepressants. Risperidone may also have potential as a treatment for anxiety disorders, such as post-traumatic stress disorder (Bartzokis et al, 2002) and obsessive-compulsive disorder (McDougle et al, 2002). This new evidence suggests that risperidone offers benefits to a range of patients with prominent affective and/or anxiety symptoms.

SATELLITE SYMPOSIUM ISS3
Shared Pathophysiology: From Gene Expression to Treatment
(sponsored by Eli Lilly & Company)

Chairs: Charles B. Nemeroff - David J. Kupfer

Saturday, 21 June, 12.15 am-2.00 pm - Festsaal

ISS3.1
OVERVIEW OF THE SYMPOSIUM

Kupfer, David J., Pittsburgh, United States

Although Kraepelin viewed them as completely different entities, the disease states of schizophrenia and bipolar disorder are proving to have much in common. Recent studies suggest that there are shared genetic risk factors for the two disease states, although it has not been determined if they share a common neuropathology. Treatment options and goals are shared between these disease states. Atypical antipsychotics are efficacious for the features presented in each disease. The clinical management of both conditions requires careful risk-benefit assessment in order to achieve satisfactory outcomes and reduce the risk of relapse. Data will be presented on treatment considerations and the therapeutic impact on patients with schizophrenia and bipolar disorder.

ISS3.2
PSYCHOPHARMACOLOGY UPDATE

Kupfer, David J., Pittsburgh, United States

Research continues to expand upon the demonstrated efficacy of atypical antipsychotics and mood stabilisers for the treatment of schizophrenia and bipolar disorders, including bipolar depression. More recently, atypical antipsychotics have fallen under the scrutiny of the medical media because of case reports suggesting that these agents may not be safe. Safety considerations such as weight gain and diabetes have been brought to public attention as medication-related rather than as possible predispositions of the disease states. The benefits of atypical agents, which provide a greater efficacy and freedom from side effects such as EPS and TD induced by conventional agents, have not been highlighted. This presentation will focus on the

current clinical information available to support the broad spectrum of efficacy and safety of treatment with the atypical antipsychotic agents. Over the past several years, remarkable advances have been made both in our understanding of the central nervous system (CNS) and in the pathophysiology of the major psychiatric disorders, resulting in major breakthroughs in our capacity to treat these devastating illnesses. Since the seminal work of Ramon y Cajal and Golgi at the turn of the century, new techniques such as fluorescence histochemistry have evolved into immunohistochemical and more recently in situ hybridisation. These techniques have permitted, for the first time, the elucidation of chemically defined neural circuits. Such advances in the mapping of neural systems and the visualisation of monoaminergic and peptidergic neurons and their receptors in tissue sections have provided the tools of the burgeoning field of neurochemical pathology of psychiatric disorders. Data provided from such studies has served as the basis for the development of novel pharmacological approaches to the treatment of affective and anxiety disorders, as well as schizophrenia. This review focuses on two major neural systems implicated in the pathophysiology of depression, serotonin and corticotropin-releasing factor (CRF). Development of novel agents is described, including selective serotonin receptor agonists, combined selective serotonin receptor antagonists and serotonin reuptake inhibitors, CRF receptor antagonists, and the use of an antisense strategy.

ISS3.3
LONGITUDINAL OUTCOMES IN SOHO

Knapp, Martin, London, United Kingdom

Atypical antipsychotic agents have been proven to have therapeutic efficacy on both positive and negative symptoms of schizophrenia and to have a lower incidence of extrapyramidal symptoms when compared to conventional antipsychotic agents. These proven therapeutic advances should correlate to an improvement in health outcomes. A recent study by Namjoshi et al assessed the clinical and quality of life outcomes associated with olanzapine, risperidone, and haloperidol treatment of patients with schizophrenia. The study concluded that olanzapine treatment was associated with better clinical and quality of life outcomes compared to haloperidol and risperidone treatment. Results of similar studies suggest that improvement in health outcomes may vary among the atypical agents. The Schizophrenia Outpatient Health Outcomes (SOHO) study is a 3-year, prospective, outpatient, Pan-European, observational study comparing patients treated with clozapine, olanzapine, risperidone, quetiapine, and atypicals. An early conclusion from this study indicates an ease of use with the initiation of olanzapine treatment in outpatients. The impact of this difference, and other differences from this study, on health outcomes requires further examination.

ISS3.4
BIPOLAR UPDATE

Goodwin, Guy, Oxford, United Kingdom

Bipolar disorder has been and remains a relatively neglected condition. This has two divergent consequences. First, there is a perception that treatment could and should be improved. Guidelines provide an opportunity to enhance the quality of care. Second, because of a relative dearth of high quality research, the confidence with which we can advocate particular treatments is limited. Guidelines are systematically derived statements that are aimed at helping individual patient and clinician decisions. The principle recommendations usually apply to the *average* patient. They need to be graded according to the strength of the evidence from appropriate, preferably randomised trials. The British Association of Psychopharmacology has now produced guidelines for the management of bipolar disorder. They specify the scope and target of treatment for bipolar disorder. They are based explicitly on the available evidence and presented as recommendations, graded on the basis of the evidence. A consensus meeting, involving experts in bipolar disorder and its treatment, reviewed key areas and considered the strength of evidence and clinical implications. The guidelines were drawn up after extensive feedback from participants and interested parties. The strength of supporting evidence was rated. The recommendations were supported by a more detailed review of the available evidence. The guidelines cover the diagnosis of bipolar disorder, clinical management, and strategies for the use of medicines in short-term treatment of episodes, relapse prevention, and stopping treatment.

SATELLITE SYMPOSIUM ISS4
Antipsychotics and the Treatment of Psychotic Disorders: New Insights, New Developments
(sponsored by Bristol-Myers Squibb Company & Otsuka Pharmaceuticals)

Chair: Siegfried Kasper

Saturday, 21 June, 12.15 am-2.00 pm - Zeremoniensaal

ISS4.1
PSYCHOTIC DISORDERS: CURRENT UNDERSTANDING AND TREATMENT APPROACHES

Peuskens, Joseph, The Catholic University of Leuven,
University Centre St. Josef, Kortenberg, Belgium

Psychotic impairment of reality testing, associated with symptoms such as hallucinations and delusions, is the central characteristic of psychotic disorders. Patients with these disorders need treatment that provides effective and sustained relief from psychotic symptoms, without imposing a burden of unwanted side effects. This presentation provides an overview of the current treatment options available for psychotic disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, and psychosis associated with Alzheimer's disease. The role of typical and atypical antipsychotic agents in the treatment of psychotic disorders will be discussed and their overall clinical effectiveness, in terms of clinical efficacy and safety/tolerability profiles, will be considered.

ISS4.2
SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDERS: IMPROVED PROSPECTS WITH NEW ANTIPSYCHOTIC THERAPY

Weiden, Peter, SUNY Downstate and Kings County Hospital
Center, Department of Psychiatry, New York, United States

Until clozapine, it was believed that virtually complete antagonism of dopamine activity was needed for antipsychotic efficacy. After clozapine, other antipsychotics were developed by adapting clozapine's weak D_2 affinity or serotonin antagonist activity. But, until aripiprazole, no antipsychotic was able to have dopamine agonist activity to help those symptoms of schizophrenia believed to arise from too little dopamine. Aripiprazole was developed to be a partial agonist for low-dopamine synaptic environments, and to antagonize dopamine in excess dopamine environments. Aripiprazole has shown that this

concept is successful in the clinic. Aripiprazole has an excellent short-term and long-term efficacy for positive, negative, and cognitive symptoms of schizophrenia, has an excellent side effect profile, and will expand treatment options for schizophrenia. The concept of dopamine partial agonism will be introduced and its implications for the clinical efficacy, safety and tolerability of the next-generation antipsychotics will be discussed. Data from short- and long-term clinical studies demonstrating the clinical efficacy of the next-generation antipsychotics in patients with schizophrenia or schizoaffective disorder will be presented. Some of the safety and tolerability issues that impact patient health and overall effectiveness of therapy will also be discussed.

ISS4.3
CHALLENGES IN MANAGING PSYCHOSIS IN THE ELDERLY: THE IMPACT OF SAFETY AND TOLERABILITY

Kasper, Siegfried, Department of General Psychiatry,
University of Vienna, Vienna, Austria

Several studies have investigated the clinical efficacy of the current generation antipsychotics in controlling or reducing psychotic symptoms in elderly patients with dementia. Given the increased susceptibility of elderly patients to adverse events, the presentation will place particular emphasis on the impact of the safety and tolerability profiles associated with individual antipsychotics. The role of next-generation antipsychotics in the treatment of patients with Alzheimer's disease will also be considered and data from recent clinical studies will be presented.

ISS4.4
THE EVOLVING ROLE OF NEW ANTIPSYCHOTICS IN THE PHARMACOTHERAPY OF ACUTE MANIA

Goodwin, Guy, Warneford Hospital, University Department, Oxford, United Kingdom

Comprehensive management of patients with bipolar disorder should ideally include the short-term control of acute episodes and maintenance of therapeutic effect, with a minimum of treatment-related adverse events. Current treatment options for patients with bipolar disorder include mood stabilizers such as lithium or valproate. However, response to these therapies is often suboptimal, with a high proportion of patients failing to respond to treatment or experiencing relapse subsequent to the initial response. This presentation will focus on the results of recent trials demonstrating clinical efficacy, safety and tolerability of the next-generation antipsychotics for both acute and maintenance treatment of manic episodes in patients with bipolar disorder. The challenge is to integrate these more acceptable medicines into new treatment strategies for short- and long-term treatment.

SATELLITE SYMPOSIUM ISS5
Treatment for Depression: Are Dual Mechanisms of Action Better than Single?
(sponsored by Eli Lilly & Company)

Chairs: Charles B. Nemeroff - Alan F. Schatzberg
Saturday, 21 June, 6.15 -8.00 pm - Festsaal

ISS5.1
OVERVIEW OF THE SYMPOSIUM

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It is well known that depression is a disease characterised by psychological, vegetative, and cognitive symptoms; it is becoming increasingly evident that somatic symptoms, especially pain, contribute to the substantial morbidity of this condition. This symposium will explore major depression as it resides at this interface, drawing on descriptive, epidemiologic, preclinical and clinical data sources. The somatic symptom presentation of depression will be reviewed, with an emphasis on the role of these symptoms in disease persistence and their implications for diagnosis and overall healthcare utilisation. The seminal role of norepinephrine and serotonin as key neurochemical mediators in the development of both depression and pain will be reviewed. Emerging data from animal models suggests an important role for these neurotransmitters in the process of central sensitisation, a central event in the development of chronic pain. Clinical data support the hypothesis that failure to resolve bodily symptoms may account for a substantial portion of those individuals who fail to fully remit from their depressive illness. Antidepressant therapies which act on both the serotonin and norepinephrine systems offer the potential to set a new standard toward obtaining complete relief of the symptom burden for patients with major depression.

ISS5.2
PATIENT NEEDS ON THE PATHWAY TO RECOVERY: UNMET NEEDS IN DEPRESSION

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Depression is common, disabling, and potentially life threatening. It is estimated that by the year 2020, major depressive disorder will become the second leading cause of disability worldwide. Even with the availability of newer, safer classes of antidepressants, over 1/3 of the patients treated for depression may not achieve complete symptom resolution or remission. Factors contributing to this failure include inadequate dosing, patients and physicians giving up on a medication before an adequate trial, troublesome side effects, and possibly, the inability of the medication to alleviate both the emotional and physical symptoms of depression. Newer antidepressants on the horizon may prove to lessen the impact of these factors. Dual action antidepressants may offer benefit for treating physical symptoms and depression. Antidepressants providing improved efficacy as well as adherence to treatment could help fill the void in the available treatment and allow the over 1/3 of patients treated for depression to gain more complete symptom resolution.

ISS5.3
THE NEUROBIOLOGY OF DEPRESSION: THE ROLE OF SEROTONIN AND NOREPINEPHRINE

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Considerable research has demonstrated that alterations in both serotonin and norepinephrine containing neural circuits occur in patients with depression. Patients with depression can have psychological symptoms, such as sadness and anxiety, and vegetative symptoms, such as fatigue, sleep disturbance, and pain. The source of the 5-HT and NE projections to the forebrain are the raphe nucleus and locus coeruleus cell groups, respectively, found in the brain stem. Each of these monoamine pathways has not only an ascending forebrain projection, but a descending pathway. Dysregulation of 5-HT and NE in the forebrain is believed to be associated with many symptoms of depression, but the dysregulation of these neurotransmitters in the descending spinal cord pathway may be associated with altered pain perception. Antidepressants that selectively block 5-HT and NE reuptake may demonstrate efficacy for both the psychological and physical symptoms of depression, thereby improving remission rates for patients with depression.

ISS5.4
COMBINING SEROTONIN AND NOREPINEPHRINE MECHANISMS IN DEPRESSION

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Serotonin (5-HT) and norepinephrine (NE) both have been shown to mediate antidepressant response. While antidepressants with selective NE or 5-HT action appear to have equivalent efficacy, it is not known if agents with NE and 5-HT actions treat the same patients or the same symptoms. If the clinical effects differ, combining these actions may improve the speed of response or the final outcome. Two different approaches have been taken to achieve this end: the use of dual-action agents such as clomipramine, venlafaxine, mirtazapine, and duloxetine that appear to have greater efficacy than do selective drugs, and the combination of an NE agent with a 5-HT agent. These two strategies include the use of an SSRI with desipramine, bupropion, mirtazapine, or reboxetine. In this presentation, the efficacy data for dual-action agents and augmentation strategies that combine NE and 5-HT mechanisms with reference to whether NE/5-HT combinations are more effective than selective agents will be reviewed, as will issues related to dosing, drug interactions, and safety.

ISS5.5
SYMPTOM RESOLUTION IN DEPRESSION: STRATEGIES TO REACH REMISSION

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Major recurrent depression is one of the highest sources of lost disability adjusted life years (DALYs) worldwide, and constitutes a substantial and continually increasing burden on healthcare resources. Even among patients with a clear diagnosis of depression, current antidepressant treatments yield full remission in only about one third of depression cases. Alarmingly, 30-45% of patients show only partial response or no response at all. Remission failure is associated with increased relapse risk and healthcare costs. As a population, patients with depressive disorders experience an increased incidence of physical symptoms such as pain. When seen in a clinical setting, any patients presenting with pain symptoms will overlook or deny emotional symptoms. Recent epidemiological studies on the prevalence of pain and major depression point to high rates of comorbidity and follow-up studies suggest that poor resolution of physical symptoms is associated with continued depression. Serotonin (5-HT) and norepinephrine (NE) are neurotransmitters involved in both depression and pain. The role of 5-HT and NE in painful symptoms will be explored, as will the importance of addressing both the physical and emotional symptoms of depression to achieve remission.

SATELLITE SYMPOSIUM ISS6
Strategies for Achieving Positive Patient Outcomes in Schizophrenia
(sponsored by Pfizer)

Chair: Martina Hummer

Saturday, 21 June, 6.15 -8.00 pm - Zeremoniensaal

ISS6.1
STRATEGIES FOR ACHIEVING POSITIVE PATIENT OUTCOMES IN SCHIZOPHRENIA: THE EVIDENCE FROM CLINICAL TRIALS

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With increased understanding of schizophrenia and its core symptomatology, improvements in all symptom domains, including mood/anxiety symptoms and cognitive dysfunction, are now being routinely assessed in antipsychotic trials. The growing interest in subjective well-being and quality of life of patients with schizophrenia represents a conceptual shift in therapeutic outcome criteria, and is related to the introduction of atypical antipsychotics into clinical practice. Recent research indicates that subjective well-being and attitudes towards medication appear to be a major determinant of medication compliance in schizophrenia, and they are being increasingly regarded as an independent outcome variable. However, despite the fact that well-designed and meticulously executed controlled clinical trials are essential milestones in a drug's development, it is well recognised that the obtained results are not fully applicable to everyday clinical practice since strict definition and application of exclusion and inclusion criteria will inevitably lead to a selection of a subgroup amongst all potentially eligible patients. Consequently, the results of the randomised controlled trials should be interpreted critically. Recent research is also suggesting that results of methodologically well-performed open studies are valid and deserve more attention. Therefore a combination of data from randomised, controlled trials and from methodologically well-performed open clinical studies will provide comprehensive information that will ultimately serve as a guide to clinicians as to which patients may benefit the most from a particular drug. This information also enables prescribers to make informed decisions on which antipsychotic to choose for their individual patients to maximise the therapeutic success.

ISS6.2
STRATEGIES FOR ACHIEVING POSITIVE PATIENT OUTCOMES IN SCHIZOPHRENIA: CLINICAL PRACTICE PERSPECTIVE

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Switching of antipsychotics occurs frequently in everyday practice when the patient is in partial remission or is refractory to treatment, when current medication is poorly tolerated, in the presence of medical or psychiatric comorbidity, or when the patient or the caregiver requests a change in medication. Many patients who do not respond to one novel antipsychotic may do so to another, thus benefiting from a switch. However, as the transition could be associated with uncertainties, a clinical appraisal of the conditions under which switching of drugs occurs and evaluation of the appropriate strategy can help minimise the potential risks. Therefore the studies examining switching from one antipsychotic to another are providing valuable information, of particular importance to the practicing psychiatrist. For example, switching to ziprasidone from other antipsychotics has been examined in three identical open-label 6 week studies, using three different switch strategies. Switching from either the conventional antipsychotics, olanzapine or risperidone was associated with maintained symptom control, favourable overall tolerability, and improvements in several domains of cognitive function. Improvement in movement disorders and decrease in prolactin levels occurred after switching from conventional antipsychotics and risperidone, while switching from olanzapine resulted in mean body weight reduction. Another analysis has shown that making ziprasidone the preferred atypical antipsychotic in the formulary of a correctional inpatient psychiatric unit significantly reduced expenditures for atypical antipsychotics and decreased overall pharmacy costs, with projected annual savings of approximately 25% in this US setting. These studies showed that switching to ziprasidone was associated with clinical and pharmacoeconomic benefits.

INDEX OF CHAIRS AND SPEAKERS

Abraham S. 28,29
Ajdacic-Gross V. 17, 32
Akiskal H. 25
Akiyama T. 29
Alexandrowicz R. 17
Alezivos B. 38
Amering M. 25, 32, 33
Anderer P. 36, 47
Andrews G. 2
Angst J. 7, 11, 12, 17, 32
Apter A. 43
Arboleda-Florez J. 29
Asarnow R. 51
Ascoli M. 43
Bahbouh R. 12
Bailey R. 33
Banaschewski T. 23
Bandelow B. 39
Banzato C. 15
Barnes T. 4
Baron D. 56, 57
Beckmann H. 3
Belohlavek O. 13
Benda N. 17
Ben-Nachum Z. 51
Beranek M. 13
Berganza C. 10, 15, 24
Berner J. 35
Bianco F. 11
Bitter I. 39
Boening J. 19
Botsis A. 54
Boyd C. 28, 29
Braus D.F. 13
Brockington I. 48
Brook S. 63
Brugha T.S. 21, 22
Buitelaar J. 23
Burrows G. 37
Calliess I. 52
Cancro R. 34
Caplan R. 51
Castilla R. 55
Cervany P. 27
Charney D.S. 62
Chatterji S. 16, 24
Chen E.Y.H. 46
Chen Y. 44
Christodoulou G. 37, 38
Crow T. 7, 8
Czobor P. 40
Davenport T. 2
De Batista C. 14
De Bruijn H. 5
de Fuentes-Merillas L. 6
de Wildt W. 6
Dilling H. 11
Doerr O. 9, 10
Dvorak A. 5, 18, 19
Effiace F. 50
Eich-Höchli D. 17, 32
Etzersdorfer E. 54
Evans D.L. 13, 61
Fahrer R. 56
Falkai P. 23, 45, 46
Faravelli C. 38
Felder C. 27
Ferrero F. 18
First M.B. 39
Fleischhacker W. 3, 58
Flor H. 13
Flores B. 14
Fowler J. S. 27
Franck N. 9
Freidl H. 32, 35, 38
Gabriel E. 57
Gaebel W. 3, 22
Gamma A. 12, 17, 32
Gass P. 41
Gastpar M. 26
Gerlach A. 26, 28
Giannakopoulos P. 2
Goldberg T. 30
Goodwin G. 60, 61
Grassi L. 50
Grau A. 55
Grube M. 6
Gründer G. 15
Grunze H. 49, 59
Grüsser G. 13
Haasen C. 44, 53
Habeych M. 55
Hájek T. 12
Hanika H. 32, 38
Harrison G. 32
Hart S. 29
Heinimaa M. 8
Heinz A. 13
Henn F.A. 13, 41
Hermann D. 13
Hernandez-Serrano R. 10, 11
Hertling I. 5, 18, 19
Hickie I. 2
Hindmarch I. 35
Hitzemann R. J. 27
Hofer A. 4
Hoff P. 57, 58
Hoffmann H. 35
Honer W.G. 45
Horacek J. 12, 13
Höschl C. 12, 13
Hummer R. 4, 62
Huttunen J. 8
Ilonen T. 8
Inada T. 40
Iosifescu D. 49
Issakidis C. 2
Jablensky A. 22
Janovská D. 12
Junker R. 53
Kapfhammer H.P. 20, 21
Karlsson H. 8
Karwautz A. 28, 29
Kasper S. 30, 31, 50, 58, 60, 61
Kastrup M. 16, 53
Katschnig H. 4, 16, 26, 32, 38
Keefe R. 31

Kertzman S. 51
Kessler R.C. 22
King M. 7
Kjaer R. 11, 44
Klein S. 13
Kleinemeier E. 44, 53
Klosterkötter J. 26
Knapp M. 60
Koeter M.J.W. 6
Kohl C. 51
Kopecek M. 13
Kopp M. 17
Korkeila J. 8
Korzec A. 5
Köss G. 51
Kovács M. 17
Krauß O. 50
Krausz M. 44, 53
Krautgartner M. 32, 35, 38
Kuehner C. 17
Kuey L. 24
Kühn K.-U. 62
Kunze M. 5
Kupfer D.J. 13, 14, 47, 59
Kupper Z. 35
Kurz A. 3
Landgraf R. 41
Larach V. 22
Lehert P. 6
Lepine J.P. 30
Lesch O.M. 5, 18, 19
Levounis P. 45
Libiger J. 12
Lim R. 56, 57
Lipska B.K. 41
Looper K. 56, 57
López-Ibor A. 34
López-Ibor J.J. 30
Luscombe G. 28
Lykouras L. 37, 38
MacEwan G.W. 46
Machleidt W. 52
Mader R. 5
Maier W. 26, 31, 48
Maj M. 48
Malt U. 35, 36
Maman Z. 51
Margariti M.M. 37
Marksteiner J. 3
Marneros A. 22, 48
Marquart B. 37, 43
Martin A. 12
McGlashan T. 8
Meisenzahl E.M. 14
Meyer J.H. 15
Mezzich J. 15, 16, 24, 52
Moeller H.-J. 49
Montenegro R. 33, 34
Monti D. 47
Monti J.M. 47
Moran P. 20
Motorin A. 34
Moussaoui D. 6, 7, 29
Mozes T. 51
Müller E. 6
Murray R. 31
Nakajima G. 44, 45
Nemeroff C.B. 14, 59, 61, 62
Neuhaus C. 17
Neumeister A. 30
Niklewski K. 3
Nolen W. 49
Novell R. 20
Nowack C. 28
Okasha A. 29, 58
Okasha T. 53
Ortwein-Swoboda G. 37, 43
Pacheco-Palha A. 10
Papageorgiou C. 38
Pappas N.R. 27
Pascual-Marqui R.D. 36
Pasková B. 12
Pelegrina H. 10
Perel J.M. 55
Pettigrew B. 28
Peuskens J. 60
Poldrugo F. 19
Posener J. 14
Poustka F. 42, 43
Preisig M. 17, 18
Pull C. 23
Purebl G. 17
Ramskogler K. 5, 18, 19
Reker T. 35
Riecher-Rössler A. 11, 12
Rist F. 26, 28
Ristkari T. 8
Ritter K. 43
Rittmannsberger H. 35
Rojas-Malpica C. 44
Rössler W. 17, 32
Rózsa S. 17
Rubin H. 45
Ruhrmann S. 26
Ruiz P. 33
Russell J. 28
Sachs G. 49
Saletu B. 35, 36, 47
Saletu-Zyhlarz G. 5, 36, 47
Salokangas R. 7, 8
Salvador-Carulla L. 20
Sartorius N. 2, 32
Sayette M. 27
Schatzberg A. 13, 14, 61, 62
Scherbaum N. 26, 28
Scherk H. 46
Schippers G.M. 6
Schmidt L.G. 27
Schmidt M. 42
Schobersperger R. 5
Scholz H. 18
Schön S. 26
Schultze-Lutter F. 26
Schwartz M. 9
Schwarz R. 50
Scumaci S. 35
Seivewright H. 21
Shvartzbord M. 52
Siddarth P. 51
Smith G.N. 45
Soldatos C.R. 47
Solveson B. 14
Soubrier J.P. 53
Sperner-Unterweger B. 13, 50, 51
Springer A. 57
Springer-Kremser M. 57
Starcevic V. 39
Stompe T. 37, 43
Stoppe G. 12
Suomela T. 8
Szádóczcy E. 17
Tamminen T. 42
Tannock R. 23, 24
Tasman A. 25
Tataru N. 31
Tauscher J. 15, 30
Taylor E. 42
Treasure J.L. 29
Tyano S. 51
Tyrer P. 20, 21
Unbricht D. 36
Ustun B. 2, 16, 40
van den Brink W. 5, 6, 18
Van der Gaag R.J. 52
van Praag H.M. 6
Varoneckas G. 48
Verhagen P.J. 7
Verkslerchic M. 51
Vieta E. 49, 59
Villaseñor-Bayardo S. 43, 44
von Knorring A.-L. 43
Wancata J. 17, 34, 35
Walter H. 5, 18, 19
Wang G.J. 27
Wasserman D. 54
Weber G. 20
Wehrmann P. 6
Weiden P. 60
Weijers H.-G. 19
Weizman A. 52
Wessely S. 2
Wetterling T. 6
Weyrer S. 3
Wiesbeck G. 19
Wigger A. 41
Wiggins O.P. 9
Wilens T. 24
Wittchen H.-U. 21
Wong C.T. 27
Wrase J. 13
Xiao C. 44
Yagdiran O. 53
Yunes R. 55
Zalsman G. 52

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