# ABSTRACTS

## VII ANNUAL SCIENTIFIC MEETING OF THE EUROPEAN ASSOCIATION FOR CONSULTATION LIAISON PSYCHIATRY AND PSYCHOSOMATICS (EACLPP)
## "Future developments in Consultation-Liaison Psychiatry and Psychosomatics"

**Berlin, June 23-24, 2004**

**PLENARY SESSION: CONSULTATION-LIAISON PSYCHIATRY AND PSYCHOSOMATICS AND INTEGRATION OF CARE**
Chair: F. Creed, Manchester, W. Söllner, Nuremberg — Wednesday, June 23, 1.30-3.00 pm, Room: Saphir

**MENTAL DISORDERS AND PSYCHOLOGICAL PROBLEMS IN THE SOMATICALLY ILL – WE HAVE LEARNED A LOT ALREADY, BUT WHO CARES?** Arolt V. Dept. of Psychiatry, University of Muenster, Germany.

Throughout the last decades we have learned that mental disorders and psychological problems are highly prevalent in the somatically ill, deteriorate the quality of life, and negatively influence the outcome of somatic diseases. About 35% of co-morbid patients need some kind of qualified intervention, due to suffering from depression, alcoholism, psycho-organic syndromes, somatoform disorders or adaptation/ psychosocial problems. On the basis of well conducted clinical research, we have also gained an extensive knowledge about successful treatments of most of these disorders. However, only in a few places these achievements can be transferred into practical patient care. There seems to be a large gap between our possibilities on the one hand and common patient care on the other. Overall, less than 20% of the patients in need are seen by a specialist, and although we can principally assume high efficacy of interventions, their effectiveness in real life is often low, due to numerous reasons. This situation is not going to be changed easily - on the contrary. Under increasing pressure by the burden of costs, the dominance of impact factor - driven research, and political decision making that is limited to narrow perspectives, we seem to face challenging times.

**RETHINKING THE APPROACH TO COMPREHENSIVE MEDICAL AND BEHAVIORAL HEALTHCARE.** Kathol RG**.** Cartesian Solutions/University of Minnesota, Burnsville, USA.

When medical, pharmacy, and behavioral health service use expenditures are totaled for those who use behavioral health services and compared to those who don't, the total cost of care is double and accounts for over 20% of annual health care claims expenditures, up to 80% of which is for medical and pharmacy, not for behavioral health, services. Despite this fact, nearly three quarters of those with behavioral health disorders go untreated even though symptom reduction is associated with decreased service use, largely because they never reach the independently managed behavioral health setting. Analysis of existing administrative practices found in the clinical and health policy literature suggests that this adverse interaction between general medical and behavioral health service use is fueled by independent behavioral health management. Reversal of these negative outcomes requires the integration of general medical and behavioral health treatment, including case and disease management This cannot be achieved if the independent business practices for general medical and behavioral health management are retained. Integration, in the context of this presentation, means "handling the assessment, treatment, and reimbursement for psychiatric illness the same way that other general medical and surgical illnesses are handled". Core components of health care integration at the purchaser, health plan, hospital and clinic, and provider levels will be described.

*The lecture of. R. Kathol is supported by Lundbeck, sanofi cynthelabo, and Janssen Austria.*

**FROM CONSULTATION TO COMPLEXITY OF CARE PREDICTION AND HEALTH SERVICE NEEDS ASSESSEMNT.** Huyse FJ, University Hospital Groningen, The Netherlands.

Psychiatric consultservices are basically reactive and primarily geared towards the needs of doctors and nurses (1). In the last decade a European group of C-L psychiatrists and other professional have developed a method –the INTERMED (IM)-method) which can be applied by non-psychiatric providers in the general health care system in order to detect and treat complex patients (2). Patients seen in consult services are prototypical for complex hospital patients. Complex patients are patient with multi-morbidity, including psychiatric, and those patients who somatize. Available publications are summerized on the website www.vumc.nl/INTERMED. During the presentation a short overview of the method is provided. Yet the focus of the presentation is a video fragment in which both the integration in the clinical process as well as a part of the interview and the dataentery module for the hospital computersystem is demonstrated. The goal of the presentation is to make consultants aware of a practical clinical tool which can be trained to non-mental health professionals who work in populations with many complex patients in order to enhance the quality of their care and the quality of their referral and collaboration with mental health professionals.

(1) Huyse FJ, Herzog T, Lobo A, Malt UF, Opmeer BC, Stein B, de Jonge P, van Dijck R, Creed F, Crespo MD, Cardoso G, Guimareas-Lopes R, Mayou R, van Moffaert M, Rigatelli M, Sakkas P and Tienari P: Consultation-liaison psychiatric service delivery: results from a European study. Gen Hosp Psychiatry 23(3):124-132, 2001.

(2) Huyse FJ, Lyons JS, Stiefel FC, Slaets JPJ, de Jonge P, Latour C: Operationalizing the Biopsychosocial Model. The INTERMED. Editorial. Psychosomatics 42-1:5-13, 2001

**SYMPOSIUM 1: RECOGNITION AND TREATMENT OF PSYCHIATRIC DISORDERS IN THE MEDICALLY ILL, PART I**

Chair: G. Lloyd, London, U. Malt, Oslo — Wednesday, June 23, 3.15-4.45 pm, Room: Saphir

**MAJOR DEPRESSION AT THE GENERAL HOSPITAL: PREVALENCE, MULTI-DISCIPLINARY ASSESSMENT AND CO-MORBIDITY.** Andreoli A, Dumont P, de Tonnac N, Borgacci S, Carbaillera Y, Rentsch D. Service d'accueil, urgences et liaison, Departement de psychiatrie, Hopitaux Universitaires de Genève, Switzerland.

Careful diagnosis and treatment innovation for medical patients referred to general hospital with major depression is a major mental health issue with significant relevance to contemporary liaison psychiatry. To better to respond these needs, a DSM IV-derived questionnaire was utilised from a well trained clinical psychologist in order to assess DSM IV diagnostic criteria for Major Depression in 250 consecutive subjects who had been admitted to a non psychiatric university service (Département de Médecine Interne, HUG, Geneva). Then, an attendant psychiatrist performed a reliable, blind assessment of each subject on presence and severity (HDRS) of this illness. First step of data analysis was to compute prevalence rates, second was to investigate the comparative diagnostic power of every day medical assessment, self report supported evaluation and psychiatric examination. Finally, we estimated the effect of presence and subtype of additional non psychiatric disorder, depression severity and psychiatric co-morbidity to the observed differences. The main results of this ongoing project will be reported and comment will be provided.

**DEPRESSION IN MEDICAL INPATIENTS AND THERAPEUTIC IMPLICATIONS.** Lobo A and the REPEP Workgroup, Hospital Clínico Universitario de Zaragoza, Spain.

**Objective:** To document the prevalence of depression at the time of discharge of medical inpatients, the outcome at six months after discharge and the implications for treatment. Methods: A multi-centre research project in Spain has been designed in each participating hospital with the following methodology: **Sample:** Consecutive adult patients, hospitalised in IM and fulfilling inclusion and exclusion criteria of depression or controls. Sample size has been calculated after a pilot study (types I and II errors, potency): 100 cases of depression and 100 controls (850 patients will be examined, elderly 45% approximately). **Instruments:** Standardised Spanish versions of HADS, MMSE, ARSI/COMPRI, CAGE, y drug screening, Karnofski and Duke scales, SF36, EuroQuol, Client Service Receipt Interview (CSRI). Psychiatric interview: Standardized Polivalent Psychiatric Interview (SPPI). Diagnostic criteria ICD-10 research, medical patients version (psychiatric) and WONCA (medical). Procedure: Hospital phase (screening by lay interviewers, assessment of "probable cases" by standardised clinicians (SPPI); blind procedures). Follow-up phase in PC (six months): same procedure and administration in "cases" and "controls" of specific instruments (Duke and Karnofski scales, HADS, MMSE, EuroQual, SF36, CSRI). The statistical analysis includes specialised techniques. **Results:** Seven hospitals across Spain participate, and preliminary results have been computed. Close to two thirds the sample of depressed patients have been recruited in the co-ordinating hospital, but only 10% approximately in other hospitals. The working hypotheses tends to be confirmed. The prevalence of depression at the time of discharge varies across hospitals, but is approximately 20%. Most depressions are considered to be adjustment disorders. A considerable proportion of patients is still depressed at the 6-month follow-up in Primary Care. Compared to controls, the depressed patients tend to have poor quality of life, a higher use of medical services and an increased mortality. **Conclusions:** Depression in medical inpatients requires the testing of case-finding and treatment interventions based on the available empirical data.

**DEVELOPMENT OF GUIDELINES ON THE MANAGEMENT OF DELIRIUM: A FORMALIZED EXPERTS' CONSULTATION.** Michaud L. Institute of Social & Preventive Medicine, Lausanne, Switzerland.

**Introduction:** Guidelines for the management of delirium in the general hospital are currently being developed by a multidisciplinary group of psychiatrists and physicians from different somatic specialities. Based on a systematic review of the literature, a formalised consensus was organised to determine the appropriateness of different interventions concerning risk factors, prevention, screening and diagnosis of delirium. The objective of the study is to confront evidence-based knowledge on delirium with expert ratings, as well as to examine the level of consensus between experts from different fields. **Methods:** An exhaustive synthesis of the literature detailing the different levels of evidence was conducted and submitted to the experts. Based on this literature review and their clinical experience, experts were invited to grade the appropriateness of 248 statements on risk factors, prevention, screening and diagnosis of delirium. This proceeding was derived from the validated RAND appropriateness method (1) and consisted of two grading rounds with an intermediate discussion of topics for which votes were heterogeneous between experts. Agreement between experts on appropriateness of each topic was calculated and a qualitative analysis of the verbatim of the discussion was performed. Further analysis will evaluate differences between ratings of physicians from different specialities. **Results:** Quantitative analysis revealed an agreement between experts on 84% of the statements, which seemed to be moderately correlated with the levels of evidence in the literature. It also showed high levels of appropriateness of interventions to prevent delirium (95% of interventions considered appropriate), while feasibility of the interventions was lower (79% of them considered feasible). Qualitative analysis identified usefulness of screening and the role of physical restraints in the development of delirium as the most debated topics in the discussion. **Conclusion:** A broad consensus existed between experts. However, some topics emerged as non consensual even when supported by scientific evidences. It may be interesting to address them in future research projects.

[1] Fitch K et al. The RAND/UCLA appropriateness method user's manual. Santa Monica, 2001.

**NEUROPSYCHIATRIC OUTCOME AFTER EXTRA-CORPOREAL MEMBRANE OXYGENATION (ECMO) TREATMENT.** Risnes I, Jensen J, Hynås IJ, Heldal A, Svennevig J, Malt UF. Rikshospitalet, Univ. of Oslo, Norway.

**Background:** Extracorporeal membrane oxygenation (ECMO) is an established treatment in management of persons with severe cardiopulmonary failure with an established mortality > 80% with conventional treatment (respirator-high frequency ventilation, NO gas support) the time of onset of ECMO. No study has looked at the neuropsychiatric outcome among those who survived such treatment. **Methods:** A follow-up cohort study of 17 adults surviving ECMO treatment (survival rate 53%) were conducted. Assessments included somatic outcome, EEG and MR of the brain, MINI neuropsychiatric interview, MADRS, neuropsychological assessment and General Health Questionnaire-30 (GHQ-30) and Hospital Anxiety Depression Rating Scale (HAD). **Results:** About 1/3 of the ECMO-treated adults had physical sequelae, four motor delay, two kidney disabilities, two hearing problems, one vascular diseases and distal necrosis, reduced sight and vocal cord paralysis. Ten patients had EEG-pathology and 7 pathological MR. Eleven had psychiatric disorders dominated by symptoms such as fear, lack of ability to concentrate, insomnia, failing memory, aggressive outburst. Neuropsychological impairment was detected in 9 subjects. However, the qualitative clinical interviews and psychometric tests suggested satisfaction with the treatment outcome in comparison to the severe prognosis of their disease prior to treatment. **Conclusions:** ECMO treatment saves lives of patients with acute cardiac or pulmonary failure in a variety of clinical settings. Most patients are satisfied with the long-term outcome. However, the prevalence of neuropsychiatric complications is high. Patients surviving ECMO treatment should be offered a psychiatric evaluation in order to detect and treat neuropsychiatric disorders.

## SYMPOSIUM 2: UNEXPLAINED MEDICAL SYMPTOMS / SOMATOFORM DISORDERS

Chair: S. Özkan, Istanbul, M. Rigatelli, Modena — Wednesday, June 23, 3.15-4.45 pm, Room: Rubin

**DIAGNOSTIC PROBLEMS ABOUT SOMATOFORM DISORDERS.** Rigatelli M, Ferrari S. Consultation-Liaison Psychiatry Service, Department of Psychiatry and Mental Health, University of Modena & Reggio Emilia, Modena, Italy.

"Is this patient somatizing?" is one of the most common questions asked by the internist or the GP to the psychiatrist. Somatization is such a frequent phenomenon that the risk, for the internist, is even the opposite: to quickly categorize as psychogenic a case that afterwards may show organic bases. Patients with Medically Unexplained Symptoms (MUS) are up to a quarter of the average attenders at a GP clinic and up to 40-50% at outpatient clinics in general hospitals [1]. At the same time, borderline medical-psychiatric diagnoses such as fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, non-cardiac chest pain are becoming more and more numerous in types and prevalence. Nevertheless, full-blown somatoform disorders, the diagnostic category that is naturally expected to include the majority of such demanding and frequent cases, are not so much frequent in the general population and in medical settings, with prevalence rates up to 2%. Somatoform disorders were only 5.3% of total psychiatric disorders diagnosed in Europe by the ECLW study [3]. Our Service's data also confirm this trend: in a 40-month period of activity, 287 patients were referred for MUS (7.98% of total referred patients) but only 44 were diagnosed to be suffering from a somatoform disorder (1.22% of total referred patients and 15.33% of patients referred for MUS). Many authors have attributed the contrast to the insufficiency or inefficiency of traditional diagnostic instruments in such a complex and "slippery" field as that of MUS. Examples of this criticism are the huge international work on DCPR [4] or the accumulating literature on sub-threshold somatoform disorders. Consultation-Liaison Psychiatry daily operates within these difficulties: theoretical speculations have to lead the way towards the development of positive diagnostic tools, that are understood by and can be shared with colleagues from other medical specialties.

[1] Royal College of Physicians, Royal College of Psychiatrists: The psychological care of medical patients. A practical guide. Report of a joint working party. 2nd edition. 2003.
[2] Huyse FJ et al: Consultation-liaison psychiatric service delivery: results from a European study. Gen Hosp Psychiatry 23: 124-132, 2001.
[3] Fava GA et al: Diagnostic criteria for use in psychosomatic research. Psychother Psychosom 63:1-8, 1995.

**TRANSCULTURAL ASPECTS OF SOMATIZATION IN TURKEY: A STUDY OF 70 CASES.** Ozkan M, Ozkan S, Istanbul Faculty of Medicine, Department of Consultation-Liaison Psychiatry, Istanbul, Turkey.

Somatization in its various forms is extremely common and poorly recognized problem in all aspects of medical practice in Turkey thus leads to mistreatment and excess morbidity and chronicity. The setting of Consultation Liaison Psychiatry makes possible to early reach to these people and to study general characteristics. The presented study is conducted at the CLP department of Istanbul Faculty of Medicine . This study is conducted with 70 patients diagnosed as somatization disorder (DSM-IV) from among those referred from the other various clinics of the hospital. All of these cases are referred from outpatient clinics and were followed at CLP outpatient clinic. This study aimed to understand the main features of somatization disorder, level of alexytymia and correlating factors with alexytymia. A semi structured interview form pertaining questions on sociodemographics, illness behavior and illness cognition was applied. The degree of alexhtimia was measured with Toronto Alexytymia Scale. Somatization was meaningfully more prevalent in females, housewives and married. A high level of alexytymia among the cases was found. Somatization appears to be a mode of communication and an expression of emotional strain and psychological distress in symbolic body language. Psychiatry should penetrate developmental and societal processes in health and diseases and should bridge itself to medicine to reach and recognize these people thus, in time those cases of somatization will properly be handled and general well-being in psychological terms will develop.

**CHILDHOOD ADVERSITY AND FREQUENT MEDICAL CONSULTATIONS.** Jackson J, Fiddler M, Kapur N, Wells A, Creed F. Psychological Medicine, University of Manchester, UK.

**Background**: We assessed possible psychological mediators of the relationship between childhood adversity and frequent medical consultations among new out-patients at neurology, cardiology and gastroenterology clinics. We assessed whether these differed in patients with and without organic disease that explained their symptoms. **Method:** At first clinic visit we recorded: Hospital Anxiety and Depression scale (HADS – anxiety and depression subscale scores), Illness Perception Questionnaire (IPQ – 4 subscales: consequences, cure, identity, timeline), Health Anxiety Questionnaire (total score) and Symptom Amplification Scale (total score). Subjects were divided into 2 groups according to whether they had experienced any type of childhood adversity using the Childhood Experience of Care and Abuse Schedule. Outcome was the (log) number of medical consultations for 12 months before and 6 months after the index clinic visits. Multiple regression analysis was used to determine mediators; this was performed separately for patients with symptoms explained and not explained by organic disease. **Results:** 129 patients (61% response) were interviewed. Fifty two (40.3%) had experienced childhood adversity; they made a median of 16 doctor visits compared to 10 for those without adversity (adjusted $p = 0.026$). IPQ identity score (number of symptoms attributed to the illness) and HAD depression scores were significantly associated with both childhood adversity and number of medical consultations and these variables acted as mediators between childhood adversity and frequency of consultation in the multiple regression analyses. This association was limited to patients with medically unexplained symptoms.. Sexual abuse and overt neglect were the adversities most closely associated with frequent consultations. **Conclusion:** In patients with medically unexplained symptoms the association between childhood adversity and frequent medical consultations is mediated by the number of bodily symptoms attributed to the illness and depression severity. Psychological treatments should be targeted at these patients with a view to reducing their frequent doctor visits.

**FREQUENT ATTENDERS OF PRIMARY CARE: GETTING TO KNOW THEM** Ferrari S, Galeazzi GM, Rigatelli M. Consultation-Liaison Psychiatry Service, Department of Psychiatry and Mental Health, University of Modena and Reggio Emilia, Modena, Italy.

**Introduction:** Minor psychiatric problems such as anxiety, mild depression and somatization are common in non-specialised medical settings, particularly in primary care: they affect up to 60% of patients in a GP clinic [1]. Several previous studies have suggested that they may play a role in causing a disproportionally high use of health care services, especially when they are combined to medical morbidity [2-3]. **Methods:** The 50 top most Frequent Attenders (FAs) at a GP clinic in the north of Italy were compared to 50 randomly selected normal attenders. Socio-demographic and medical data were collected from GP files. The SCID-brief version for research and the Diagnostic Criteria for use in Psychosomatic Research (DCPR [4]) were administered to both patient groups. Quality of life was also evaluated. **Results:** Among FAs, 98% suffered from at least one medical disorder and 68% from at least one psychiatric disorder, versus 54% and 6% respectively in the control group. Medical-psychiatric co-morbidity was more frequent in the FA group, 66% of whom gave positive results to all three diagnostic fields (medical, psychiatric and psychosomatic), versus 4% of controls. **Conclusions:** Data from the present study confirm the association between medical-psychiatric co-morbidity and frequent attendance and excessive utilisation of primary care resources; they also suggest the need to develop effective diagnostic and therapeutic tools able to address concurrent psychological distress which may not be recognised as such using established diagnostic techniques.

## SYMPOSIUM 3: C-L INTERVENTIONS IN ONCOLOGY

Chair: M. Keller, Heidelberg, A. Kiss, Basel — Wednesday, June 23, 3.15-4.45 pm, Room: Jade

**RECOGNITION OF DISTRESS IN CANCER PATIENTS IN ROUTINE CLINICAL CARE.** Keller M, Brechtel A, Fischer C, Knight L, Otteni, M., Sommerfeldt S. Psychosocial Care Unit & Dept. of Surgery, University Heidelberg, Germany.

**Purpose:** Timely and valid identification of psychosocially distressed patients in acute hospitals gaines increasing importance. This study aimed to determine the prevalence of psychological morbidity among cancer patients treated in a university surgical setting as well as the doctors' and nurses' ability to reliably diagnose patients' distress and need for psychosocial intervention. **Methods:** In a cross-sectional design 189 consecutively recruited patients were included and preoperatively assessed. Based on a multi-level approach distress was measured by patients' self-report (HADS) and rated by surgical residents and nursing staff. The Structured Clinical Interview (SCID-I for DSM-IV, gold standard) was administered to a randomised sub-sample of 78 patients. Referrals to a psychosocial liaison service initiated by the medical staff were analysed. **Results:** We found 24 current psychiatric DSM-IV diagnoses in 22 of the patients (28%). According to HADS (cut-off ?16) 26% of the patients were highly distressed. Surgeons and nurses judged about 50% of the patients as distressed and/or in need of psychosocial support. Surgeons correctly recognised marked distress in 77% of patients, nurses reached 75% sensitivity. Because of low specificity, the positive predictive value was only 39% in surgeons and 40% in nurses. One third of the patients diagnosed with a psychiatric disorder were eventually referred to the psychosocial liaison service. **Conclusions:** Distressed cancer in- patients remain undiagnosed and untreated, when relying on medical staff's perception solely. This indicates the need for implementing adequate screening procedures. Results from a screening project that is currently being established within routine care will be presented.

**CONSULTATION-LIAISON SERVICE FOR WOMEN WITH CANCER: IDENTIFYING NEEDS FOR SPECIFIC PSYCHOONCOLOGICAL**

**INTERVENTIONS.** Sperner-Unterweger B. Division of Biological Psychiatry, Innsbruck University, Austria.

**Background:** Prerequisites for a well functioning consultation liaison (CL) service have been studied and are well described. Despite this, an ongoing quality assessment and scientific evaluation of CL-services have rarely been established on routine clinical care conditions. Quality can be assessed via different parameters including internally defined quality criteria, the assessment of subjective satisfaction of patients and the care team and the identification of specific necessities of certain psycho-oncological interventions. We have conducted three studies to evaluate the need of specific interventions in the context of psycho-oncological CL-services. **Methods:** In the first study we have investigated 98 outpatients suffering from ovarian cancer, focusing on anxiety, depression, fatigue and quality of life. The second evaluation dealt with 108 women following breast cancer surgery, who were investigated with respect to psychosocial stress and quality of life during aftercare. The third study also dealt with breast cancer patients. Sixty women were asked about their satisfaction with the aesthetic outcome of breast reconstruction and various aspects of psychosocial wellbeing. **Results and discussion:** The most obvious finding in patients with ovarian cancer was the high incidence of fatigue: despite stable somatic health 32.7 % of the women suffered from clear cut symptoms of fatigue. These patients also displayed a higher level of anxiety and depression and a considerable impairment of quality of life. This underlines the necessity to put considerable emphasis on the diagnosis and management of fatigue in psycho-oncological aftercare. In the group of breast cancer patients we found on the one hand an increased need for psychological interventions in patients with advanced stages of the illness and on the other hand a number of treatment relevant deficits in social relations and sexuality in patients without relapse of cancer over 5 years. In the third investigation we found that 75 % of patients with breast reconstruction were satisfied with the cosmetic result of this intervention, but those who had their reconstruction done immediately suffered from significantly more psychosocial impairment than patients with breast reconstruction at later stages.

**FOUNDING A NEW MULTIDISCIPLINARY CONSULTATION FOR PHEOCHROMO-CYTOMAS AND PARAGANGLIOMAS.** Lahlou-Laforêt K, Gimenez-Roqueplo KP, Plouin PF, Jeunemaître X, Consoli SM. Dept. of C-L Psychiatry, Dept. of Genetics and Dept. of Hypertension, Georges Pompidou European Hospital, Paris, France.

Paragangliomas are highly vascularized tumors. Inherited paragangliomas are commonly multiple, bilateral, present at an earlier age and more often functional (pheochromocytomas). Recent genetic studies have shown that paragangliomas are caused by mutations in SDHD, SDHB, SDHC genes. Furthermore, recent data suggested that germline mutations in the SDHs, VHL and RET genes may be detected in 24% of nonsyndromic pheochromocytomas.

A multidisciplinary consultation has been founded in Georges Pompidou European Hospital (Paris) in order to propose to each patient with a paraganglioma and/or pheochromocytoma, the possibility of a genetic information and testing. This co-operation between Genetic team and Consultation-Liaison team was aimed at preventing negative emotional reactions in patients receiving a genetic diagnosis. The organisation of this consultation will be described, particularly the meetings between the patient and the psychiatrist (one before the genetic test, one after the result of the test). The role of the psychologist or the psychiatrist in this co-operation will be analysed. Ethical questions will be raised. Several clinical examples will illustrate these topics.

**PSYCHODYNAMIC INTERVENTIONS WITH CANCER PATIENTS.** Stiefel F. Psychiatry Service, University Hospital of Lausanne, Switzerland.

Psychodynamic psychotherapy with cancer patients is based on the theoretical concepts of psychodynamic understanding and follows the its established rules. However, differences exist between psychodynamic psychotherapy in healthy individuals and cancer patients. These differences mainly concern: the conscious and unconscious reasons for engaging in therapy; role and rigidity of the setting; technical aspects, such as the degree of confrontation of defenses, interpretation, transference and counter-transference, acting and abstinence; therapeutic goals; and termination of psychotherapy. The specific aspects of psychodynamic psychotherapy with cancer patients will be reviewed, followed by a short overview of the different challenges a malignant disease represents for different types of personality organisations.

**COMMUNICATION SKILLS TRAINING FOR ONCOLOGISTS AND ONCOLOGY NURSES.** Kiss A. Psychosomatic Division, University Hospital Basel, Switzerland.

Communication with patients and relatives is one of the core clinical skills in daily practice. In contrast to other clinical skills there is little training in this area. Communication in oncology involves breaking bad news, giving complex information, shared decision making, including patients in clinical trials, and end-of-life communication. Communication skills training in oncology was pioneered by Peter Maguire, Lesley Fallowfield, and Darius Razavi. The efficacy of such a training has recently been demonstrated by a randomised controlled trial[1]. In the lecture the tools of such a training will be described as well as the importance of "booster sessions" in the follow-up[2]. The pros and contras of joint training for physicians and nurses will be elucidated. The implementation of such a training, which is mandatory to become a licensed oncologist in Switzerland, will be presented[3]. It is of interest for the future that professional associations such as the European School of Haematology (ESH) or the American Society for Clinical Oncology (ASCO) are on the way of establishing communication skills training for their members.

[1] Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled trial. Lancet 2002;359:650-6.

[2] Razavi D, Merckaert I, Marchal S, et al. How to optimise physicians' communication skills in cancer care: results of a randomised study assessing the usefulness of posttraining consolidation workshops. J Clin Oncol 2003;21:3141-9.

[3] Kiss A. Communication skills training in oncology: a position paper. Ann Oncol 1999;10:899-901.

**SYMPOSIUM 4: C-L INTERVENTIONS IN GERIATRICS**
Chair: J. Slaets, Groningen, G. Stoppe, Basel Wednesday, June 23, 3.15-4.45 pm, Room: Opal

**TOOLS FOR CASE FINDING AND CARE COORDINATION IN A CONSULTATION-LIAISON SERVICE FOR ELDERLY.** Slaets JPJ. Dept. of Internal Medicine, Groningen University Hospital, Netherlands.

In this presentation I will address two common problems in geriatric consultation-liaison services and the solutions we have implemented in our geriatric department where medicine and psychiatry are fully integrated. How to select elderly people who need geriatric interventions and how to make accurate treatment decisions are recurring problems in geriatrics. Chronological age, though often used, seems not the best selection criterion. Instead, the concept of frailty can be used, which indicates a bundle of losses in resources. As expected, frailty relates more strongly to a decline in self-management abilities and case complexity than chronological age. Therefore, using frailty to select older people at risk is an improvement compared to selecting people for interventions only by their chronological age, because it is likely to yield a more accurate selection. As the instrument we developed to measure frailty (the Groningen Frailty Indicator) is short and easy to use, it seems a reasonable and manageable alternative for using chronological age as selection criterion for interventions. The GFI screens for the loss of functions and resources in 4 domains of functioning: physical (mobility functions, multiple health problems, physical fatigue, vision, hearing), cognitive (cognitive functioning), social (emotional isolation), and psychological (depressed mood and feelings of anxiety). The second problem in dealing with so-called complex patients, especially the frail elderly, the chronically ill and patients with somatic and psychiatric co-morbidities, lies in the need of coordination of fragmented care. Coordination, which integrates the different medical, including psychiatry, and paramedical disciplines and guarantees communication between health care professionals. To achieve this goal we have implemented the INTERMED, a method developed over the last decade by an international group of general hospital psychiatrists and geriatricians, to assess the bio-psycho-social care needs of complex patients. I will present data on screening elderly at risk with the Groningen Frailty Indicator (GFI) as well as the practical implications of using the intermed in an integrated geriatric consultation-liaison service.

**THE NEECHAM CONFUSION SCALE AND THE DELIRIUM OBSERVATION SCREENING SCALE: COMPARISON ON PREDICTIVE VALUE.** van Gemert EAM, Schuurmans MJ. Free University Medical Centre, Amsterdam, Netherlands.

**Introduction:** Delirium, a frequent form of psychopathology in older hospitalised patients, is associated with high morbidity and mortality. Early recognition of symptoms enables diagnosis and treatment of the underlying cause and can prevent negative outcomes. Nurses are in a strategic position to observe behavioural changes, however, are not well trained in recognition of delirium. For successful implementation of delirium screening, nurses need instruments that are based on observation, that allow bedside use during regular care, repetitively and without respondent burden. Two scales are developed that meet these criteria: the NEECHAM Confusion Scale and the Delirium Observation Screening (DOS) Scale. Both scales are tested in several samples with good results. The scales, however, were never tested in one study. In order to decide which instrument we would implement in our hospital we designed this comparative study. Aim of the study was to test sensitivity and specificity of both scales as well as their ease of use in daily care. The question was which scale gives the best predictive value and is most practical for daily use. **Methods:** The project was conducted on a general medical and three surgical wards of a university hospital. 93 patients were included. During 3 shifts (evening, night, day) these patients were observed for symptoms of delirium, the symptoms were rated on both scales by nurses. The DSM-IV diagnosis of delirium was made or rejected by a geriatrician at the end of the dayshift based on psychiatric assessment. Nurses were asked to rate practical value of both scales on a structured questionnaire. **Results:** In 10.3% the diagnosis delirium was made. The sensitivity and specificity of the NEECHAM scale (1.00 – 0.86) and DOS scale (0.89 – 0.88) were both high. Rating time of the NEECHAM was 8 minutes, of the DOS Scale 5 minutes per shift. The NEECHAM needs to be rated once, the DOS needs to be rated in 3 consecutive shifts to come to a diagnosis. Nurses were positive about both instruments; however, they rated the DOS scale ease of use and relevance for their practice significantly more positive. **Conclusions:** Successful implementation of standardised observation depends largely on consent and acceptation of a scale by professionals. Based on the results of this study we implemented the DOS scale in our hospital.

**PSYCHOTHERAPY WITH THE ELDERLY.** Stoppe G, Basel, Switzerland.

**INTEGRATED PSYCHOSOMATIC SERVICE IN A GERIATRIC DAY HOSPITAL.** Adler C, Sieber C, Söllner W, Depts. of Psychosomatics & Psychotherapy and Internal Medicine (Geriatrics), General Hospital Nuremberg and University of Erlangen, Germany.

The geriatric day hospital at the General Hospital Nuremberg offers diagnostics and treatment for older patients suffering from typical geriatric diseases and symptoms like stroke, diabetes, pain, dementia or depression. The psychosomatic consultant is not only part of the multidisciplinary staff but also a member of the steering committee of the day hospital, co-developing integrated service packages and public relations strategies. About 500 patients are treated a year. They attend the day hospital daily for 10 to 25 days. Every third patient is presented to the psychologist by the geriatrician, especially mourning or depressive patients, patients with inadequate coping strategies after stroke or with other disabilities, patients with memory disabilities, patients with probably somatoform disorder and patients with conflicts with their spouse or their adult children. The main tasks of the psychosomatic consultant are diagnostics of early dementia, differential diagnosis between dementia and depression, psychodiagnostics and brief psychotherapy, as well as consultation of family caregivers. Every patient takes part in one of three groups for cognitive training . There is a special group for demented patients based on a biographical approach. Most patients with depression or somatoform disorders

take part in a group for relaxation therapy and a discussion group. The consultant takes part in a daily team meeting where all staff members report about the treatment outcome and discuss the further therapeutic approaches. She also helps to understand the psychodynamics of an ill person, enables colleagues to talk about their countertransferences and supports them to cope with so-called difficult patients. Psychosomatic has proved in this setting to present a cornerstone in a multidisciplinary approach to these frail and multimorbid patient group. A case report finally illustrates the integration of psychosomatics in holistic therapeutic framework. For better understanding of what integrated psychosomatic treatment means, a case report will be presented.

**POSTER SESSION 1**
Chair: A. Diefenbacher and R. Burian, Berlin Wednesday, June 23, 5.15-6.00 pm, Hall

**PREVALENCE OF DEPRESSION AMONG INTERNAL MEDICINE INPATIENTS AT A GENERAL HOSPITAL - PRELIMINARY RESULTS.** Cordero A, Conejo A, Lozano M, Ramos-Brieva J, Ochoa E, Saiz J, Saban J. Services of Psychiatry and Internal Medicine, Ramon y Cajal Hospital, Alcala University, Madrid.

**Introduction:** According to different epidemiological studies, depression is a frequent disorder among internal medicine inpatients. We hypothesised that a high proportion of these patients are discharged without their depression being identified. The presence of this disorder negatively affects the course of their somatic disease and increases health care costs. **Material and methods:** Randomly selected internal medicine inpatients hospitalised for at least five days in a period from November 2003 to February 2004 were interviewed at the time of discharge. During the screening phase we used the Mini-Mental State Examination to exclude cognitive disorders, the CAGE questionnaire to discard alcoholism and the Hospital Scale for Depression and Anxiety to identify possible affective cases. Patients with other psychiatric disorders were excluded from the study. During the second phase, we used the Standardized Polyvalent Psychiatric Interview (SPPI). This well-established structured clinical interview uses ICD-10 to diagnose depressive disorders and others. Consequently, two groups are formed: one of depressive disorder and the other of the control group therefore facilitating the appropriate comparisons. Both groups will be re-evaluated 6 months after the five assessment. **Results and discussion:** During this period, 264 patients were hospitalised for more than five days. 31 (12%) died before opportunity for interview. 105 patients were selected among the rest by using the "catch as can catch" method, very close to random. We excluded 42 patients (40%) due to the presence of cognitive disorders, 5 patients (5%) because of alcoholism and 7 (7%) delirium sufferers. Finally, 7 patients (7%) met some of the ICD-10 criteria for a depressive disorder: 3 depression episodes, 1 dysthymia and 3 moderate adaptive depressive disorders. No psychiatric consultation had been requested for any of these patients by their attending physicians. 18 patients (17%) did not show any psychiatric disorder. These results are further discussed with relation to the current literature on this topic and the goals of the investigation.

**USING NEW PSYCHOACTIVE DRUGS AND PROMOTING PSYCHOTHERAPY IN A PSYCHOSOMATIC C-L SERVICE.** Leiberich P, Tritt K, Hesse A, Laahmann C, Loew T, Nickel M. Dept. of Psychosomatics, University of Regensburg, Germany.

**Background:** In 2001 a psychosomatic consultation-liaison service was set up in a general university hospital; since, there has been increasing demand whenever the somatic origin of a complaint was not found or patients were not able to cope with a serious disease. Which therapies did psychosomatic specialists recommend? **Methods:** Physicians' demands for psychosomatic consultations were met on the same or next day. CL doctors informed their colleagues directly or by PC network about diagnosis, psychic state, ways of therapy. **Results:** Per year about 900 patients were examined. The sample of 400 elected cases from 2003 consists of 60% women, mostly 40-70 years old. 41,3% were treated in the internal ward, 12,1% in ICU (e.g. CHD, renal failure, irritable colon), 19,4% in surgery (accidents, attempted suicides, cancer), 6,9% in dermatology (pruritus, eczema). The most frequent diagnoses are adjustment and affective disorders, somatoform function or pain disorders, alcohol or drug addiction, neuropsychologic disorders, coping problems. Due to patients' short stay, 85% of the consultations took place only once. The most important advice is the prescription of psychoactive drugs (69%): antidepressants like TCA amitryptiline, sNSRI mirtazapine, SSRI citalopram; classic and atypical neuroleptics haloperidol and risperidone; tranquilizers against agonising anxiety. Other recommendations: 12,1% continued somatic diagnostics, 38,4% psychotherapy, 5,6% relaxation technique, 4,3% counselling with relatives. **Conclusions:** Counselling patients with psychic problems or with psychosomatic symptoms and offering them explanations and access to psychotherapy is a real chance to stop psychosomatic chronification and to prevent doctor shopping. Unfortunately, the small number of staff in most cases even precludes short-time therapies.

**THE ASSOCIATIONS OF PSYCHOLOGICAL FACTORS WITH POOR TREATMENT COMPLIANCE IN TUBERCULOSIS PATIENTS.** Dickens C, Psychological Medicine, Manchester University, UK.

**Introduction:** Non-compliance is a principal reason for treatment failure in patients with Tuberculosis (TB) yet the factors that determine who complies with anti-TB treatment regimes are not well understood. **Methods:** We have examined the associations of depression and negative illness beliefs with treatment compliance in consecutive Mycobacterium tuberculosis culture positive patients attending a TB outpatients clinic the UK. Patients recorded demographic information and details about their TB (site of infection, duration of treatment). Subjects also completed the Hospital Anxiety and Depression (HAD) Scale and the Illness Perception Questionnaire (IPQ). In addition, patients were visited at home each month by a specialist nurse who assessed compliance with anti-TB medication using tablet counts. **Results:** Thirty- five subjects (33.7%) were rated as poorly compliant (missing > 3 daily doses in one month). Poorly compliant patients were more depressed, more anxious, reported greater symptoms load, anticipated more negative outcome and perceived that they had a reduced likelihood of controlling/curing their TB. On logistic regression poor compliance was independently associated with depression (Odds ratio=1.8) and the perception of poor control over their TB (Odds ratio=4.7). **Conclusion:** Depression and pessimistic views about TB were prevalent in our subjects, and were associated with non-compliance with treatment. Addressing these psychological problems offers an alternative to increasingly assertive community monitoring such as directly observed therapy, which is expensive and of unproven efficacy.

**PSYCHOSOCIAL BURDEN IN PATIENTS IN THE SENIOR RENAL TRANSPLANT PROGRAM AND THOSE IN THE STANDARD TRANSPLANT PROGRAM.** Ludwig G[1], Nonnast-Daniel B[2], deZwaan M[3], deJonge P[4], Stiefel F[5], Söllner W[1]. Depts. of [1]Psychosomatics and Psychotherapy, and [2]Nephrology, General Hospital Nuremberg, [3]Dept. of Psychosomatics &Psychotherapy, Univ. of Erlangen, Germany, [4]Groningen University Hospital, NL, [5]Service de Psychiatrie de Liaison, Lausanne, Switzerland.

**Introduction:** Investigations in survival rate and quality of life among patients in the Eurotransplant Senior Program (ESP) present promising results. Some clinicians raised doubt about the psychosocial burden these elderly patients experience before and after renal transplantation (RTX). Therefore we conducted this exploratory study to find out if ESP patients differ with patients listed for standard cadaveric RTX on this point. **Methods:** We base this preliminary report on the collected data of 18 consecutive patients listed for standard RTX and 15 patients included in the ESP, 9 of whom being candidates for senior TX and 6 being followed up one year after the operation. The biopsychosocial profiles were assessed using the INTERMED (Huyse et al. 2001) before and one year after RTX. This observer-rated instrument classifies information from a structured interview and estimates the patient's vulnerability in the biological, psychological and social domain and the complexity of his health care. Non-parametric tests were used to test the differences in means of continuous variables. **Results:** Neither the INTERMED total score nor the single outcomes for the four domains revealed significant differences between the ESP candidates and the group awaiting standard TX. The groups only differed regarding the psychological distress experienced at present (p=0.011, M* 0.89, M** 1.56). The difference in the total score between ESP patients awaiting TX and the 6 patients who have already undergone the operation was not significant. However, a significant difference appeared when comparing their sum scores in the psychological domain (p=0.047, M* 2.33, M*** 0.83). A highly significant difference emerged comparing their present need for health care (p=0.007, M* 1.22, M*** 0.33). We plan to present the analysed data of a larger sample at the Congress. **Conclusions:** The fact of the ESP candidates standing out as less stressed in the psychological domain than the younger RTX-patients underlines our hypothesis: prior to transplantation ESP patients seem to be psychologically more stable and equilibrated than patients in the standard allocation program. Maybe the reduced waiting time for a new organ make elderly patients emotionally more balanced. **Legend:** M=Mean on a Likert scale from 0 to 4 *ESP before RTX **standard RTX *** ESP post TX

**BODY IMAGE AND SEXUAL FUNCTIONING IN PATIENTS HAVING GASTRIC BYPASS SURGERY FOR OBESITY.** Vaidya V, Director Consultation Liaison Psychiatry, Assistant Professor of Psychiatry and Internal Medicine, Johns Hopkins University School of Medicine, USA.

**Introduction:** The increasing prevalence of obesity in the USA, and its medical, social, and economic implications have made it a national health crisis. Severe obesity (body mass index BMI of greater than or equal to 40kg/meter sq.) is associated with increased risk of hypertension, cardiac and pulmonary insufficiency, DJD, Diabetes, socioeconomic and psychosocial impairment. Bariatric surgery has been shown to be the most effective means to manage obesity and its comorbidities. Patients tend to lose 50-70% of their excess weight within a year post-operatively. Although these patients have reported body image problems and sexual problems, to the best of my knowledge, there has been no systematic study of these attributes in this population. Surgeons now require that patients have a psychiatric evaluation prior to surgery. **Aim of the study:** We have studied 250 patients who were evaluated prior to gastric bypass surgery for obesity. The aim is to study the body image disorders and sexual functioning of these patients. The vulnerable group of patients thus identified could be offered additional help in-groups or individually, thereby optimizing the outcome of surgery. **Method:** We evaluated 250 patients prior to Gastric bypass surgery, each patient had the following: Psychiatric Evaluation (Axis I- V), Derogatis Inventory of Sexual Functioning, Body Image Questionnaire. **Results:** The data was analyzed to study the trends for body image problems and sexual difficulties in this population. Both men and women scored almost 2 standard deviations below the norms. Women tended to have more significant correlation with body image and several domains of the sexual questionnaire. **Conclusion:** Identifying vulnerable groups and offering them targeted help, we feel would optimize outcomes of surgery for this population. This is an ongoing study and patients are currently being followed up after surgery.

**DEPRESSIVE, PANIC AND NEURASTHENIC DISORDERS PREDICT POOR OUTCOME IN SEVERE IRRITABLE BOWEL SYNDROME.**

Guthrie E, on behalf of the North of England IBS Research Group; University of Manchester: School of Psychiatry and Behavioural Science and Section of Gastrointestinal Science, University of Sheffield: Centre for Integrated Medicine, Institute of General Practice, Northern General Hospital, University of York: Centre for Health Economics, UK

**Background:** We identified the psychiatric disorders that commonly accompany severe irritable bowel syndrome and assessed their contribution to impaired outcome. **Method:** 257 patients with severe irritable bowel syndrome entering a psychological treatment trial were interviewed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Outcome measures were: number of days of restricted activity, role limitation (physical) score of SF36 and total costs. Analyses controlled for age, sex, number of other medical disorders, abdominal pain and treatment group. **Results:** At baseline depressive disorder (29% of patients), panic (12%) and neurasthenia (35%) were all associated with impaired health-related quality of life after controlling for confounders. Only depressive disorder was associated with increased costs. Number of psychiatric disorders was associated in a dose-response fashion (p=0.005). At follow-up depressive disorder and neurasthenia were associated with role limitation score (p<0.0005) but not costs. Reduction of depressive symptoms (Hamilton depression score 10 or less) was associated with improved role functioning and fewer days restricted activity but nor reduction in costs. **Conclusions:** Depressive, panic and neurasthenic disorders contribute to poor outcomes in severe irritable bowel syndrome and appropriate psychological or psychiatric treatment should be available to these patients.

**VALIDATION OF THE DANISH PSYCHIC VULNERABILITY SCALE.**

Eplov LF[1], Petersen J[1], Jørgensen T[1], Birket-Smith M[2], Johansen C[3], Osler M[4], Mortensen EL[4]. [1]Copenhagen County Research Centre for Prevention and Health, Glostrup University Hospital, [2]Liaison Psychiatric Unit, Bispebjerg University Hospital, [3]The Danish Cancer Society, Institute of Cancer Epidemiology, [4]Institute of Public Health, University of Copenhagen, Denmark.

**Background:** In the present context psychic vulnerability is defined as a tendency to experience psychosomatic symptoms or inadequate interpersonal reactions. A national Danish study has demonstrated that psychic vulnerable persons compared with non-vulnerable individuals report more diseases and symptoms, use health services more often, and have an unhealthier lifestyle. In other studies psychic vulnerability has be associated with upper dyspepsia, irritable bowel syndrome, peptic ulcer, ischaemic heart disease, premature mortality, but not with cancer. Furthermore, in other studies psychic vulnerability predicted persistent pain after lumbar spine surgery and cholecystectomy. The scale is based on a questionnaire constructed by the Military Psychological Services in Denmark. In the 1970s The Danish National Institute of Social Research used 22 of the original 27 items on a random sample of 10,753 Danes, and in this sample 12 of the 22 questions were found to fit a Rasch-model and thus to constitute a one-dimensional scale. **Objective:** Further validation of the scale. **Method:** Data from Copenhagen County Research Centre for Prevention and Health will be used. The data are collected in connection with population studies conducted through the period 1976-1999, and among other the data consists of answers on the 22 version of the Psychic Vulnerability Scale for more than 100.000 person-years. The content validity will be examined by conducting a) Item response analysis, b) Rasch analysis and c) item bias analysis. The scale will be tested against well-known scales, among others Neo-Pi-R, EPI-Q and MMPI. The stability of the scale will be examined among cohorts that have been re-examined. **Results and conclusion:** The study is in the planning phase.

**AN EXAMINATION OF THE CONNECTION BETWEEN STRESS-MARKERS AND SCORING ON THE DANISH PSYCHIC VULNERABILITY SCALE.**

Eplov LF[1], Jørgensen T[1], Birket-Smith M[2], Johansen C[3], Osler M[4], Mortensen EL[4]. [1]Copenhagen County Research Centre for Prevention and Health, Glostrup Univ. Hospital, [2]Liaison Psychiatric Unit, Bispebjerg Univ. Hospital, [3]The Danish Cancer Society, Institute of Cancer Epidemiology, [4]Institute of Public Health, Copenhagen, Denmark.

**Background:** In the present context psychic vulnerability is defined as a tendency to experience psychosomatic symptoms or inadequate interpersonal reactions. Studies have shown that around 10 % of the Danish population can be defined as psychic vulnerable. In earlier studies psychic vulnerability has be associated with upper dyspepsia, irritable bowel syndrome, peptic ulcer, ischemic heart disease, premature mortality, but not with cancer. An explanation for the association may be that psychic vulnerability is associated with a high level of chronic physiological stress, since psychic vulnerable individuals not only more often react with bodily distress, but may also create distressful situations because of their negative reactions in interpersonal interactions. This high level of chronic psychological stress may lead then to diseases and early mortality. **Objective:** The objective of this study is to examine the association between psychic vulnerability and some stress markers. **Method:** Data from Copenhagen County Research Centre for Prevention and Health will be used. The data are collected in connection with population studies conducted through the period 1976-1999, and among other the data consists of answers on the 22 version of the Psychic Vulnerability Scale for more than 100.000 person-years. The association between psychic vulnerability and the following stress markers a) pulse at rest, b) heart-rate variability, c) hypogonadic index, d) HbA1c, e) insulin/glucose ratio and f) self-rated stress will be tested. When testing for an association linear and logistic regression models will be used, controlling for gender, age and social status. **Results and conclusion:** The study is in the planning phase.

**PSYCHIC VULNERABILITY AS A GENETIC SUSCEPTIBILITY TOO STRESS.** Eplov LF[1], Erling Mellerup[2], Birket-Smith M[3], Jørgensen T[1]. [1]County Research Centre for Prevention and Health, Glostrup University Hospital, [2]Laboratory of Neuropsychiatry, Righospitalet, [3]Liaison Psychiatric Unit, Bispebjerg University Hospital, Copenhagen, Denmark

**Background:** In the present context psychic vulnerability is defined as a tendency to experience psychosomatic symptoms or inadequate interpersonal reactions. Studies have shown that around 10 % of the Danish population can be defined as psychic vulnerable. In earlier studies psychic vulnerability has be associated with upper dyspepsia, irritable bowel syndrome, peptic ulcer, ischaemic heart disease, premature mortality, but not with cancer. An explanation for the found association may be that psychic vulnerability has a genetic susceptibility to stress, since high level of chronic psychological stress may lead to diseases and early mortality. In a recent study a functional polymorphism in the promoter region of the serotonin transporter (5-HTT) gene was found to moderate the influence of stressful life events on depression. Thus, the study provided evidence of a gene-by-environment interaction, in which an individual's response to environmental events is moderated by her genetic makeup*. **Objective:** The objective of this study is to examine whether psychic vulnerable persons significantly more often have the genotype on the functional polymorphism leading to a higher genetic susceptibility to stress. **Methods:** Data from Copenhagen County Research Centre for Prevention and Health will be used. The data are collected in connection with a population study conducted in 1999. The genotype regarding the polymorphism of the serotonin promoter region on 1000 non vulnerable persons and 500 vulnerable persons will be compared to establish an association between genetic susceptibility to stress and the score on the Psychic Vulnerability Scale in a regression model with gender and age as covariate. **Results and conclusion:** The study is in the planning phase. **Caspi A, Sugden K, Moffitt TE et al. Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science, 301: 386- 389, 2003.*

**THE MEASUREMENT OF SOMATIC COMPLAINTS USING THE GIESSEN SUBJECTIVE COMPLAINTS LIST IN A PSYCHOSOMATIC OUTPATIENT SAMPLE.** Schlagenhauf F, Schmitz N. Dept. of Psychosomatic Medicine, University of Duesseldorf, Germany.

**Background:** The Giessen Subjective Complaints List (GBB), is a widely used German self-report instrument for the measurement of somatic complaints, the latter being measured on four scales: exhaustion, gastrointestinal, cardiovascular and musculoskeletal complaints. **Methods:** In the paper submitted the properties of the GBB were studied in a large psychosomatic outpatient sample (N=1107, age 38 +/- 12 years) and its relationship to other psychometric instruments (IIP, BSS, NEO-FFI, SCL-90) was analysed. **Results:** In comparison to a representative German community sample, psychosomatic patients reported significantly more somatic complaints in all scales. The most frequent symptoms reported were fatigue, exhaustion and head-ache, neck pain and lower-back pain. In accordance with previous studies, women reported more somatic complaints than men and older patients more than younger patients. Overall, the factor structure and internal consistency of the GBB scales were satisfactory. There were significant differences between the ICD-10 diagnosis groups. Interpersonal problems measured using the IIP had little influence on somatic complaints. We found a significant relationship between the personality dimension neuroticism (NEO-FFI) and all GBB scales. Expert ratings of the severity of somatic symptoms measured using the BSS exhibited a surprisingly weak correlation to subjective complaints. Significant relationships were found between the GBB and the Symptom Checklist SCL-90-R. The GBB revealed more somatic complaints than the SCL-90 particularly in the area of somatoform disorders. **Conclusions:** The GBB was demonstrated as a reliable instrument for the measurement of somatic complaints and may serve as an additional diagnostic tool in psychotherapy and psychosomatics.

**FACTORS LINKING SOMA AND PSYCHE? PSYCHO-SOMATIC INTERACTIONS IN CHRONIC LOW BACK PAIN.** Schreiber B, Bandemer-Greulich U, Bahrke U, Müller K, Fikentscher E. Dept. of Psychosomatics, University Halle, Germany.

**Background:** Back pain syndroms are a wide-spread phenomenon usually remitting. Despite the small amount of patients taking a chronic course this group causes immense costs. Yet the process of pain chronification is still not sufficiently clarified. Despite the established biopsychosocial model, interaction between somatic and psychosocial factors is still vague and hypothetical, which makes a genuine integrative treatment difficult. Aim of the study was to investigate risk factors for pain chronification, focussing on psychosomatic factors resp. factors possibly linking psychological and somatic aspects (self- and body concept, body image) as well as impact on treatment(-success). **Methods:** Data were collected on CLBP patients within 2 studies in rehabilitation and ambulant settings. (1)To clarify the relevance of these factors, patients taking part in an ambulant treatment group were tested for aspects of pain/pain coping, self-/body concepts, body image and compared to pain free persons. (2) Within a BMBF-sponsored project, somatic and psychosocial parameters were investigated at an orthopaedic rehabilitation clinic before/ after rehabilitation, 6 and 12 months follow-up. Treatment success was compared between an experimental group (EG, treatment focussing on modules connecting physiotherapy and psychological therapy and including pain behaviour and body image) and a control group (CG, usual treatment). **Results:** 350 persons (22-58, m:f 59%:41%) were included. First results revealed from the ambulant group are presented and point out a high relevance of body image and body concepts within pain (shiftet body sensation focus, decreased awareness of body signals. Corresponding to this, the EG (rehabilitation program) shows increased treatment success, e.g. for pain intensity (EG: Ø6.0 to 4.0, CG: 6.3 to 5.9**), well-being (EG: BDI Ø11,5 to 8.3, CG: 11.3 to 10.1**) and reduction of muscular dysbalance. **Conclusions:** Deficiencies in body image and body awareness seem to affect different types of pain treatment modules (physiotherapy/ sensomotoric treatment, relaxation training) and thereby treatment success. Therapy programs should therefore include enhancement of body awareness and connect somatic and psychosocial therapy instead of working out parallel.

**JOINT HYPERMOBILITY SYNDROME AS A NEW BIOLOGICAL MARKER OF FEAR.** Bulbena A, Sperry L. Psychiatry Department, Hospital del Mar, Barcelona, Spain.

**Objective:** The purpose of this study was to evaluate fears according to the intensity of presentation and frequency in a sample of hypermobile and non-hypermobile subjects from a rural population. Design: Community cross-sectional study conducted in a rural town. **Subjects and Methods:** A sample consisting of 1305 subjects selected from the municipal registry of a Catalan rural town were assessed for Joint Hypermobility Syndrome using Beighton's criteria and for fear intensity and frequency by the self- administered modified Wolpe Fear Scale (100 items). Prominent fears defined as scoring "very" or "extremely" intense were compared between hypermobile and non-hypermobile subjects. The analysis was carried out separately for men and women. Non parametric analysis (Mann-Whitney) was applied throughout. **Results:** Joint hypermobility Syndrome was found in 19.9% of women and 6.9% of men. 87% of subjects referred one or more prominent fears (scores of "very" or "extremely" intense). 36 fears out of the 100 fears evaluated scored as prominent for men and women together, being 44 items in women and 39 in men separately. 43 out of the 44 prominent fears in women and 36 out of 39 in men scored significantly higher in the hypermobile group compared to the non-hypermobile group. Comparison of the total score of the Wolpe Fear Scale between the hypermobile and non- hypermobile groups (both in men and women) also showed significant differences, therefore reinforcing the hypothesis that intensity of fears is greater in subjects with Joint Hypermobility Syndrome. **Conclusion:** Previous research has indicated that anxiety disorders are more prevalent in hypermobile subjects both in a clinical population and the general population. The number and intensity of fears has also shown to be significantly higher in the hypermobiles for both men and women. The already defined genetic predisposition as well as the greater vegetative vulnerability could explain these differences. The Joint Hypermobility Syndrome is clearing a new path to further understand the relationship between somatic and psychological symptomatology.

**THE LUNAR PHASES' INFLUENCE ON BEHAVIOUR: STILL A MYTH?** Bulbena A, Sperry L. Psychiatry Department, Hospital del Mar. IMAS. Barcelona, Spain.

**Objective:** The influence of the moon on human and animal behaviour has been a common belief throughout the history of humankind that has shaped many myths and cultural traditions. Throughout the past years many researchers have pursued gaining empirical data to assess whether the lunar phases do enhance psychiatric disturbance, despite increasing evidence that such association is not significant. This study assesses the moon's influence on behaviour further by analysing psychiatric emergencies and animal bites according to the lunar phase. **Design:** Retrospective observational analysis of hospital admission records compared with lunar phase records during the period of time reviewed. Analysis of variance for independent groups was used throughout. **Main outcome measures:** Total number of emergencies (N*f*-10704; 1999-2001) in a district psychiatric hospital, number of emergencies due to panic attacks (N*f*- 145; 2002) in a general hospital, and number of animal bites (N*f*-1203; 1995- 1998) collected at the Regional Register in a community hospital were analysed and compared with the corresponding lunar phases. **Results:** No significant differences were found for psychiatric emergencies ($F=1.5$; $p=0.2$), panic attacks ($F=1.15$; $p=0.28$) or animal bites ($F=1.3$; $p=0.2$) comparing with days of full moon and all other lunar phases. **Conclusion:** Psychiatric disturbance and animal bites do not seem to be more frequent on full moons than at any other lunar phase. However, a positive trend was appreciated in panic episodes in females during full moon ($F=2.3$; $p=0.13$) despite not reaching statistical significance. Regardless of folkloric belief and some positive results in previous studies, the myth seems to remain a myth.

**FACTITIOUS DISORDERS IN GENERAL MEDICINE: A CASE STUDY.** Ozkan M, Istanbul University, Faculty of Medicine Çapa, Turkey.

Factitious disorders though rare if unrecognised may cause serious morbidity and waste of time in general hospital settings. Factitious disorders are characterised by repeated and conscious stimulation of an illness, feigning symptoms suggestive of a disorder. These patients initiate the production of symptoms through self mutilation or interference with diagnostic procedures. A case of factitious disorder with physical symptoms is presented in this study. Definition clinical characteristics, diagnostic principles and treatment approaches of factitious disorders are reviewed. The psychological theories and connections, in this regard are studied. The psychopathological and clinical aspects in this regard are reviewed.

**SEASONAL AND CIRCADIAN TIME PATTERNS OF RAILWAY SUICIDES: AN ANALYSIS OF 4003 CASES.** Erazo N, Baumert J, Ladwig KH. Institute of Psychosomatic Medicine, Psychotherapy and Medical Psychology, University of Munich, Germany.

**Aim** of the study was to examine sex specific time patterns of suicidal behaviour on tracks as basis of suicide preventive strategies. **Methods:** Cases were derived from the national central registry of all passenger accidents on the German railway net between 1997 and 2002 satisfying the operational definition of suicidal behaviour and included sex, age, date, clock time and outcome of the incidence. Over a 6-year observation period, a total of 4,003 fatal and non-fatal suicidal incidences on German railways were documented. **Results:** Male to female ratio was 2.70:1 ($p<0.001$). The female subgroup was significantly older than the male subgroup ($p<0.001$). The monthly distribution revealed a bimodal pattern, particularly in men younger than 65 years, with a seasonal excess risk in April and September. The significant circannual pattern, however, attenuated in the second half of the observation period. Monday and Tuesday proved to be high risk days for both sexes. Overall, the diurnal distribution pattern peaked between >18.00 and 21.00 hr, whereas female suicides occurred significantly more often during daytime compared to male suicides and peaked between >9.00 and 12.00 hr. A seasonal variation of the diurnal pattern was found with a bimodal distribution in the winter half year (peaks: >6.00 - 9.00 hr and >18.00 – 21.00 hr) and a unimodal distribution in the summer half year (peak: >21.00 – 24.00 hr). On the contrary, females

exhibited solely a morning peak (>9.00 – 12.00 hr) in the summer half year. **Conclusions:** The analysis reveals marked seasonal, weekly and diurnal peaks of railway suicide intensity. Differences between men and women indicate sex-specific processes underlying their suicidal behaviour. The findings may increase alertness of railway and security personal for particular vulnerable time windows of excess risk for railway suicides.

**SEX SPECIFIC TIME PATTERNS OF SUICIDAL ACTS ON THE GERMAN RAILWAY SYSTEM.** Ladwig KH. Institute of Psychosomatic Medicine, Psychotherapy and Medical Psychology, Techn. University Munich, Germany.

**Background:** To examine sex specific time patterns of suicidal behaviour on tracks as basis of suicide preventive strategies. **Methods:** Cases were derived from the national central registry of all passenger accidents on the German railway net between 1997 and 2002 satisfying the operational definition of suicidal behaviour and included sex, age, date, clock time and outcome of the incidence. **Results:** Over a 6-year observation period, a total of 4,003 fatal and non-fatal suicidal incidences on German railways were documented. Male to female ratio was 2.70:1 ($p<0.001$). The female subgroup was significantly older than the male subgroup ($p<0.001$). The monthly distribution revealed a bimodal pattern, particularly in men younger than 65 years, with a seasonal excess risk in April and September. The significant circannual pattern, however, attenuated in the second half of the observation period. Monday and Tuesday proved to be high risk days for both sexes. Overall, the diurnal distribution pattern peaked between >18.00 and 21.00 hr, whereas female suicides occurred significantly more often during daytime compared to male suicides and peaked between >9.00 and 12.00 hr. A seasonal variation of the diurnal pattern was found with a bimodal distribution in the winter half year (peaks: >6.00 - 9.00 hr and >18.00 – 21.00 hr) and a unimodal distribution in the summer half year (peak: >21.00– 4.00 hr). On the contrary, females exhibited solely a morning peak (>9.00–12.00 hr) in the summer half year. **Conclusions:** The analysis reveals marked seasonal, weekly and diurnal peaks of railway suicide intensity. Differences between men and women indicate sex-specific processes underlying their suicidal behaviour. The findings may increase alertness of railway and security personal for particular vulnerable time windows of excess risk for railway suicides.

**DELIBERATE SELF-HARM AND CAPACITY: IMPLICATIONS FOR EMERGENCY MANAGEMENT.** Jacob R, Holland A, Clare I, Maimaris C, Gunn M, Watson P. Cambridgeshire & Peterborough Mental Health NHS Trust, Dept. of Psychiatry, University of Cambridge, Emergency Dept., Addenbrooke's Hospital NHS Trust, Cambridge, Dept. of Law, Nottingham Trent University, and MRC Cognition and Brain Sciences Unit, Cambridge, UK.

**Aims:** In many democratic countries, an adults' ability, or 'capacity', is pivotal in resolving the dilemma between respect for their right to make decisions for themselves and their need for care and protection from harm. To inform everyday practice, an exploratory study was carried out to (i) examine capacity to make treatment decisions among men and women needing emergency medical treatment following deliberate self-harm; and (ii) assess the impact on capacity of cognitive functioning, psychiatric disorder, suicidal intent, and alcohol abuse. **Methods:** Seventy-one patients (63% women) were interviewed after an initial clinical review by Emergency Department staff, but prior to any clinical intervention. Each provided an account of the proposed intervention(s) using a standardised semi-structured interview devised to assess capacity to consent. Next, written information relating to the specific form of self-harm was presented and explained. Then, capacity to consent was again assessed using the semi-structured questionnaire. Finally, standardised measures were used to assess cognitive functioning, psychiatric disorder, suicidal intent, and alcohol dependence, whilst current blood alcohol levels were measured with a breathalyser. **Results:** Using accepted legal criteria, clinical judgements were made about each patient's capacity to consent to the proposed intervention(s). Initially, only 39% (21/71) patients had capacity to consent to their proposed treatment. However, after the information was explained to them, this proportion increased significantly ($p \leq 0.01$) to 63% (45/71). Whilst a number of participants were unable to complete all the assessments, the only variables significantly related to incapacity were impaired cognitive functioning and severe mental disorder. **Conclusions:** Though patients who have engaged in deliberate self-harm are a very vulnerable group, a simple intervention, which is not time-consuming, can be used to enhance capacity to consent to treatment. The clinical, ethical, and legal implications of the findings of this study for practice in Emergency Departments will be presented.

**THE MORNING SALIVARY CORTISOL RESPONSE IN BURNOUT.** Grossi G, Perski A, Ekstedt M, Johansson T. Institute of Psychosocial Medicine, Univ. Stockholm, Sweden.

**Objectives:** The aim of the present study was to examine the free salivary cortisol response to awakening in men and women reporting low, moderate and high levels of burnout. **Methods:** Twenty-two patients with chronic burnout were compared with 22 participants with low and 20 participants with intermediate scores on the Shirom- Melamed Burnout Measure, with regard to the free salivary cortisol response to awakening. Saliva samples were collected upon awakening and at +15, +30, and +60 minutes thereafter. **Results:** The patients with burnout had higher cortisol levels than the group with low burnout at awakening, and at +15, and +60 minutes after awakening. The Area Under the Curve (AUC) for salivary cortisol was also greater in the group with high burnout scores in comparison with the one with low scores. The mean increases in cortisol, however, tended to be smaller in the group with high burnout. **Conclusions:** The results of the present study indicate a dysregulation in HPA-axis activity in chronic burnout as shown by elevated morning salivary cortisol levels.

**SPOUSES OF PATIENTS SUFFERING FROM CANCER EXPRESS HIGHER LEVELS OF PSYCHOSOCIAL DISTRESS THAN THOSE OF RENAL TRANSPLANT OR DIABETIC PATIENTS.**
Consoli S[1], Seigneur E[1], Levacher C[1], Duboust A[2], Altman JJ[3], Andrieu JM[4]. [1]Dept of C-L Psychiatry, [2]Dept of Nephrology, [3]Dept of Diabetology, [4]Dept of Oncology, G. Pompidou European Hospital, Paris

**Background:** Spouses of patients suffering from cancer undergo the impact of cancer on family circle as well and can considerably suffer without expressing their own need for help. **Objective:** To assess psychosocial distress in spouses of patients followed up for cancer (C-sp), compared with two control groups, respectively spouses of renal transplant patients (RT-sp) and insuline dependant diabetics (IDD-sp). **Methods:** 14 patients followed-up for a cancer (C), 10 who benefited from a renal transplant (RT) and 10 insulin dependent diabetics (IDD) where invited to fill out a quality of live questionnaire (MOS SF-36). Their spouses (13 C-sp, 9 RT-sp, 7 IDD-sp) filled out the GHQ-28. **Results:** Spouses' GHQ-28 total score and sub-scores (anxiety, depression, somatisation, social dysfunction) were not linked with gender, neither with age. Higher scores were found in C-sp, for total GHQ-28 score (C-sp > RT-sp) and anxiety sub-score (C-sp > RT-sp and C-sp > IDD-sp). Total spouses' GHQ score and anxiety sub-score were negatively correlated with physical capacity SF-36 sub-score describing the ill patient's quality of life (respectively r = -0.40 and r = -0.50), whereas GHQ anxiety sub-score was negatively correlated with emotional role SF-36 sub-score and Mental Component Summary, derived from ill patient's SF-36 (both r = -0.41). **Conclusion:** These results confirm the presence of higher psychosocial distress levels among spouses of patients followed up for a cancer, compared with control groups, and suggest that different factors determine the anxiety level and the depressive mood level of a spouse living with a patient followed up for a severe physical illness.

**A SUPPORT GROUP FOR PATIENTS WHO UNDERWENT LARYNGECTOMY FOR CANCER.**
Dolleans MC, Teissier C, Hans S, Brasnu D, Consoli SM. Dpt of C-L Psychiatry and Dpt of ENT, Georges Pompidou European Hospital, Paris, France.

Different kinds of psychological help groups are offered to cancer patients, but few concern ENT pathologies and more specifically patients who underwent laryngectomy. Representing 25% of ENT cancers and 2-5% of all cancers, larynx cancer occurs particularly in men (97 %), aged 45 to70, with a history of heavy smoking and alcohol abuse. Patients generally come from a disadvantaged social and economic background. These patients often stigmatised as “alcoholics and/or smokers”, have major difficulties in expressing their needs due to their fear of being rejected, whilst in an extremely fragile state. Surgery destabilises them even more. Not very communicative and/or not given the appropriate care by health care workers, they remain uncomfortable in communicating with their new voice, resulting from the laryngectomy. This treatment involves other physiological stigmas than the altered voice, and requires a painful psychological work for adjusting to the new image offered to oneself and to others. Our support group led by a psychologist and a speech therapist offers an therapeutic interesting alternative to those patients for whom access to psychotherapy is a problem, as they have difficulties conversing with another. This group began at the Georges Pompidou European Hospital in February 2001 ; it opened to patients having had a full laryngectomy and in the process of voice rehabilitation. We will describe the steps allowing these patients to appropriate this new voice and to restore a self-image and a self-esteem unsettled by the illness and the mutilating surgery.

**ADJUSTMENT TO INVASIVE PROCEDURES IN CHILDREN WITH CANCER: COGNITIVE-BEHAVIORAL INTERVENTION.**
Silvares E, Bernardes Rosa L. Instituto de Psicologia da Universidade de SãoPaulo, Brazil.

**Objectives:** The aim of this study was to evaluate the efficacy of a cognitive-behavioural intervention program for oncological children with six psychological strategies (Super QT, Relaxation, Magical cotton, Cognitive Distraction with music and without and Visualization Training). The authors objectives were to help the adjustment of children with cancer to invasive procedures and to the disease. **Methods:** Five Brazilian children (Mean age=7,8, Sd=2,2) and their mothers were participants in the program and were evaluated in the beginning and at the end of medical treatment. Behavioural observation scales were used to evaluate the child’s and the mother’s behaviours during the following situations: before the appointment, when called for it, during the appointment and during aversive procedures of medical treatment. Behavioural data were taken as soon as the child arrived for the medical appointment, and through a multiple base design while children received the cognitive-behavioural intervention programme. Other assessment instruments were used at the beginning and at the end of medical treatment: scale of the child’s and mother’s behaviour judgement, CDI, BDI, CBCL. All mothers gave informed consent to psychological intervention. **Results:** Children benefited from the intervention, like relaxing during the medical examination and following instructions throughout the aversive procedures. Interventions that brought more benefits for the children were: magic cotton and the training of progressive relaxation. Using these methods, childrens’ adequate behaviours increased and inadequate behaviours decreased immediately after they were applied. However, the mothers did not show beneficial behavioural changes with the psychological programme. **Conclusions:** The learning of cognitive and behavioural facing strategies help children to adjust to the disease. However, more attention should be paid to mothers’ behaviours in order to get them better adapted to the procedures and suffering less during their childrens’ treatment.

**LIAISON WITH HEPATOLOGY: MANAGING PSYCHIATRIC SIDE EFFECTS INDUCED BY INTERFERON THERAPY IN HEPATITIS B AND C**
Becker U. Charité - Campus B. Franklin, Psychiatric C-L Service, Dept. of Psychiatry & Psychotherapy, Berlin, Germany.

The combination of Interferon (IFN) and Ribavirin is used today in the successful treatment of hepatitis B and C. 20 – 40 % of these treated patients, however, develop psychiatric side effects: especially depressive and dysphoric syndromes and suicidal ideations. This is why, we established a Liaison project between hepatology and the psychiatric Consultation- and Liaison Service. Patients are seen by the psychiatrist (a) for screening, before beginning IFN, to rule out psychiatric contraindications, (b) so called "risk patients" with present or passed depressive episodes in order to begin a prophylactic antidepressant treatment before IFN and (c) patients, who develop psychiatric side effects while under IFN treatment. Under close psychiatric co-treatment (pharmacologically and psychotherapeutic) IFN Therapy is effective and safe, even in "risk patients" and those, who develop side effects. Results of the investigation will be presented.

**EFFECTIVENESS OF POST-ABORTION SYNDROME COUNSELLING IN NEW YORK AREA.** Wierzbicka E, Sokolowska J, Versailles N. Expectant Mother Care, Jamaica, N.Y., USA.

The survey was conducted by a volunteer researcher to look at the efficiency of counseling services in preventing abortion among pregnant women, who considered such an action. The data was collected in several pregnancy centers in New York City area from community sample of women age 16-28 at their very early stages of pregnancy. All of the surveyed women from 2002-2003 received one-on-one counseling session explaining medical aspects of different procedures, as well as, physical, psychological and spiritual consequences of abortion. As a result, approximately 50-60% of women decided not to have an abortion, 40-50% regardless of counseling session went on to have an abortion or left the agency undecided. Out of those who decided to keep the pregnancy, there were women who after all decided to be parents themselves, while others considered giving up the baby for adoption. There were four groups of women: who had never had an abortion, one abortion, two abortions, and three or more abortions. According to the number of previous abortions their decisions may be influenced by Post- Abortion Syndrome (PAS), which causes inability to deal with many feelings and reactions, affects their ability to maintain healthy relationships and also changes their attitude toward the next child. (PAS is often related to Post- Traumatic Stress Disorder). Among demographic factors influencing their decision to have an abortion or keep the pregnancy were age, parent/partner support, on-going education, financial situation, housing facilities. There is no data telling how many women left the agencies without counseling, as they had already decided to terminate their pregnancies and were not interested in getting more information regarding the subject. Nevertheless the results show that counseling is beneficial and very effective especially in case of young women who do not have sufficient knowledge regarding abortion procedures, but also come from poor or neglectful family environments. In many cases counselors from pregnancy centers were able to resolve family problems like housing, unemployment or lack of medical insurance, but also overcome fears and possible effects of PAS.

**HOW IT BEGINS: CHILD AND ADOLESCENT PSYCHIATRIC CONSULTATION IN A CHILDREN'S HOSPITAL.** Schäfert R, Frank R. Bürgerhospital Stuttgart, Psychosomatic and Internal Medicine, and Institute for Child & Adolescent Psychiatry and Psychotherapy, University Hospital Munich, Germany

**Objective:** To characterise a psychiatric and psychosomatic consultation service in a children's hospital. **Method:** The notes of all consultations delivered by the "Institute for Child and Adolescent Psychiatry" to the "Dr. von Hauner Children's Hospital" of the Ludwig-Maximilians-University of Munich between 1986 and 1997 were coded retrospectively. For comparison, data of the overall hospital population were available. **Results:** 521 consultations were documented. The referral rate was 1,4%. Significantly more referrals came from medical-paediatric wards (71%) than from paediatric surgery (29%). Girls (53%) prevailed, especially in view of a predominance of boys in the hospital population (63%, n = 797). Compared to the age distribution of the hospital population, which showed a continuous decline from the 1st year of life towards adulthood, in the consultation group infancy and preschool age were underrepresented, school age and adolescence were over-represented. The leading reasons for referral were: Psychosomatic disease (33%), chronic disease (29%), parent-child-problems (28%), child abuse (21%), abnormal behaviour (21%), developmental disorders (21%), coping problems (18%), suicide attempts (10%), sexual abuse (9%), feeding / eating disorders (9%). Among the consultant's statements, identifying problems (73%) leads over therapy planning (55%), recommendations for non-medical measures (47%) and transfer (19%). In the 521 consultation cases, 1699 contacts took place with the following distribution: 1 contact in 48% of the consultations, 2 – 4 in 32% and 5 or more in 20%. The most frequent performed services were: dialogue with the referring physician (89%), assessment of the child (65%), writing the report (63%), talking with the parents (49%), dialogue with social workers, nurses etc. (47%), dialogue with the psychologist (29%). **Conclusion:** Child and adolescent psychiatric and psychosomatic consultation in a children's hospital gives us an idea, how patients' careers can begin. Most problems are connected to the parent-child-interaction; therefore family orientation plays a central role. A preventive attitude should gain more importance; in that context it is worth thinking, that in adult medicine we are often treating the parents of the next generation.

**ELDERMEN-I-STUDY: IS THERE A CORRELATION BETWEEN BIOGRAPHIC TRAUMATISATION AND PSYCHOGENIC SYMPTOMS IN OLDER AGE?** Driesch G[1], Schneider G[1], Heuft G[1], Kruse A[2], Nehen HG[3], [1]Dept. of Psychosomatics & Psychotherapy, University of Münster, [2]Department of Gerontology, University of Heidelberg, [3]Geriatric Dept., Elisabeth-Hospital Essen, Germany.

**Objective:** Is there a correlation between biographic burdening and supporting experiences and the current psychogenic impairment in people older than sixty years? **Methods:** In this study, which was supported by the DFG, 156 geriatric patients over sixty years of age (105 women and 51 men) underwent an extensive psychosomatic-psychotherapeutical examination at the end of their in-patient, internal-geriatric treatment. Patients with dementia or psychotic disorders were excluded as were patients with severe medical diseases or addictive disorders. In addition to an extensive questionnaire, psychiatrically and psychotherapeutically trained doctors carried out a semistructured biographic interview. The interviews lasted on average 2.5 hours and were tape-recorded for later consensus rating. In these biographic interviews, important biographic subjects (father, mother, siblings, school, teachers, occupation, sport, friendship, marriage, financial situation, children etc.) were quantified with regard to their subjective burden or support and their objective burden on a scale from zero (no burden / no support) to four (strong burden / strong support). A traumatisation as defined in the ICD-10 was always estimated as an objective burden of four. The assessment of the recurrent psychogenic impairment was carried out with the Impairment Score (IS; german: Beeinträchtigungs-Schwere-Score (BSS) (Schepank, 1995)), which had been adapted in co-operation with the team in Mannheim for use with over sixty-years-old persons (Schneider et al. 1997). The IS (BSS) measures the impairment by a psychogenic disease in terms of the three dimensions: somatic, psychic and social-communicative. On these three dimensions, results from zero (none) to four (extreme) were assessed by an expert-rating. The total score of twelve corresponded with a worst-case psychogenic impairment. A total score of ? five plus an ICD-10 diagnosis (Chapter F) was defined as a „case“ of a psychogenic disorder. Age and the ADL (Activities of daily living; Lawton & Brody 1969) were considered as factors, which could influence psychogenic impairment. **Results:** The results of the investigation are summarized in four tables and exemplified by a case report. The results of the investigation are: (1) Objective burden/trauma in earlier phases in life are more closely associated with a psychogenic impairment in older age than traumatisation in later phases in life. (2) High subjective support in a burdensome/traumatic phase of life is positively correlated with a lower psychogenic impairment in older age. *The study is supported by the DFG (German Research Association) He 1898/2-1; 1898/2-2.*

**NEUROPSYCHOLOGICAL ASPECTS IN DELIRIUM.** Gabriel A[1], Diefenbacher A[2], Reischies FM[3], [1]Dept. of Psychiatry & Psychotherapy, Charité-Mitte, [2]Dept. of Psychiatry & Psychotherapy, Königin Elisabeth Krankenhaus Herzberge, [3]Dept. of Psychiatry & Psychotherapy, Charité-B. Franklin, Berlin, Germany.

**Objective:** Few investigations exist that analyse neuropsychiatric deficits in delirium. The symptomatology is described rather homogeneously, due to the belief that delirium cannot be investigated because of the disturbance of consciousness. **Methods:** Using an extensive battery of tests we examined the cognitive status of 94 successively diagnosed delirious patients. According to the aetiology three groups were assigned: 50 patients with a delirium in dementia (*dd*), 23 patients with an alcohol withdrawal delirium (*awd*) and 21 patients with a delirium due to other causes (*doc*). **Results:** There was a large neuropsychological heterogeneity among the three groups: the cognitive impairment of the *dd* patients differed significantly from the awd patients ($p<0.001$ by ANOVA). One possible explanation could be the underlying dementia. In addition, different cognitive deficits could be demonstrated in *awd* and *doc* patients using the verbal fluency and short time memory tests like repeating 10 words ($p<0.01$ by ANOVA). Finally the testing of *dd* and *doc* patients yielded equal results in incrementally addition and orientation scores. These observations point to the possibility that differences in the cognitive functions of delirious patients are also due to dementia independent factors. **Conclusions:** Neuropsychological testing in delirium seems possible. Following the findings we are discussing the use of different neuropsychological tests helping to distinguish delirium according to its specific aetiology.

**A REPROSPECTIVE STUDY ON THE ACTIVITY OF CONSULTATION-LIAISON PSYCHIATRY WITHIN A GERIATRIC HOSPITAL.** Cante T, Celentano I, Ciliberti C, Cimmino C, Foggia G, Mauro E, Rocco A, Riccio D. Psychiatry Dept, Hospital San Giovanni di Dio, Frattaminore-Napoli, Italy.

**Introduction:** The activity of consultation-liaison psychiatry within the different departments of the geriatric hospital consists of patient care, preventive activities, and research on disability. **Methods:** Our study focused on the characteristics of the referred patients and the kind of interventions carried out by the consultation-liaison service in the Emergency Unit and the departments of Frattaminore Hospital (Napoli) during a 4-months period (January 2004- April 2004). C-L activity and its development is described qualitatively and quantitatively by means of a retrospective collection of information, and a comparison with previously collected data in the same setting. **Results:** Referrals to the C-L service increased by 21% from January to April 2004. The most frequent reasons for referral have been depressive disorders with cognitive impairment (working memory) and disability as well as crisis interventions. Physicians‘ concordance with consultants‘ recommendations for psychotropic medication was 45%. **Conclusion:** C-L psychiatry plays a major part in the treatment of patients in our geriatric hospital.

**SYMPTOMATIC PSYCHOSIS IN ELDERLY PATIENTS AND CONSULTATION- LIAISON PSYCHIATRY.** Cante T, Celentano I, Ciliberti C, Cimmino C, Foggia G, Mauro E, Rocco A, Riccio D. Psychiatry Dept., Hospital San Giovanni di Dio, Frattaminore-Napoli, Italy.

**Introduction:** Symptomatic psychosis is an important event in the general hospital. It is associated with significant cognitive impairment, disability and mortality. Most patients with symptomatic psychosis recover fully; however, when left untreated, symptomatic

psychosis may progress to aggressive behaviour or death. Symptomatic psychosis is less likely to resolve completely in elderly patients in whom persistent cognitive deficits commonly occur. **Methods:** A total of 22 patients with symptomatic psychosis who were referred to consultation-liaison psychiatry were assessed using standardised measures. Medical services completed discharge summaries on these patients; a chart review captured the extent to which the diagnosis of depressive disorder with symptomatic psychosis and the involvement of psychiatry was recorded in the discharge summaries. **Results:** In structured discharge summaries, a reference to the occurrence of symptomatic psychosis was found in 35% of cases. In unstructured discharge summaries, the reporting of this diagnosis was much lower (24% of cases). Symptomatic psychosis was more likely to be reported in women than in men, when it was more severe, or when it was the principal reason for admission. **Conclusions:** Symptomatic psychoses that occur for the first time during a period of hospitalisation for treatment of any medical disorder are underreported, even when they have been diagnosed by a C-L service.

**DISORDERS OF RENAL FUNCTION AND ELECTROLYTE BALANCE IN PSYCHIATRIC PATIENTS.** Hewer W, Stark HW, Dept. of Psychiatry, Vinzenz von Paul Hospital Rottweil, Germany.

**Objective:** Assessment of frequency and clinical relevance of disorders of renal function and electrolyte balance in newly admitted patients of a regional mental hospital. **Methods:** Evaluation of routine laboratory screening at admission in 3644 consecutively treated patients, diagnosed according to ICD-10 (50.6 % male patients, mean age: 51.3 +/- 18.8 years). Distribution of main diagnoses: substance-related disorders 30.0 %, affective disorders 23.4 %, schizophrenia and other psychotic disorders 19.8 %, organic mental disorders 12.3 %, other psychiatric disorders 14.5 %. For 5 biochemical parameters (urea, creatinine, sodium, potassium, calcium) all deviations from the normal range were recorded, additionally we defined thresholds for marked abnormalities, usually indicating a necessity of substantial and rapid clinical action. **Results:** 86.9 % of the tests were within the normal range, in 10.9 % we found mild, and in 1.0 % marked abnormalities (1.2 % missing data). The rate of abnormalities was lowest for urea (8.7 %) and highest for creatinine (18.8 %). In 4.1 % of patients at least one marked abormality was detectable. The frequency of abnormal biochemical values was raised in patients with substance-related disorders (electrolytes) and in those with organic mental disorders (renal function and electrolytes). Main causes for pathologic laboratory values are in addition to comorbid general medical conditions (including comedication) related to behavioural problems associated with specific psychiatric disorders (e.g. lack of drinking, polydipsia, malnutrition). **Discussion:** In newly admitted psychiatric inpatients we found abnormalities relating to renal function and electrolyte balance in substantial frequency. Marked pathology was detected in 1 of 25 admissions. For that reason, laboratory evaluation should be performed promptly after admission to inpatient treatment. This applies especially to specific risik groups (psychogeriatric patients, patients with substance-related disorders, and those with medical comorbidity).

**BIOCHEMICAL ABNORMALITIES IN PSYCHOGERIATRIC PATIENTS.** Hewer W, Stark HW, Vinzenz von Paul Hospital Rottweil, Germany.

**Objective:** Evaluation of the diagnostic yield of routine laboratory screening in newly admitted psychogeriatric patients of a regional mental hospital. **Methods:** Recording of selected parameters of laboratory testing at admission in 154 consecutively treated patients, diagnosed according to ICD-10 (64.3 % female, mean age 77.1 +/- 8.3 years). 55.9 % of the patients suffered from organic mental disorder, in 27.9 % an affective disorder was present, and in 16.2 % other mental disorders were diagnosed. For 10 biochemical and hematologic tests all deviations from the range of normal were recorded, and we defined for each parameter a threshold for marked abnormalities, usually indicating necessity of substantial and rapid clinical action. **Results:** 61.1 % of the tests were within the limits of normal, in 28,1 % a mild, and in 4.4 % a marked abnormality was found (6.4 % missing data). Abnormalities were most frequently present for parameters of renal and liver function (44.8 % and 41.0 %, respectively), and with regard to total protein (36.4 %). Marked abnormalities related especially to thyroid function (13.6 %), electrolytes (7.1 %), and to C-reactive protein (4.5 %). In 64.9 % of patients 3 ore more parameters were out of normal range, and in 31.8 % at least one marked abnormality was present. **Discussion:** In psychogeriatric inpatients we found abnormalities in common laboratory tests in high frequency, requiring acute medical interventions in many cases. For that reason, laboratory screening is an essential element of assessment of newly admitted inpatients which should be performed without delay. Our results underscore the importance of general medical comorbidity in psychogeriatric patients many of whom are of very advanced age. In our view it is essential to consider this fact with further development of psychogeriatric institutions.

**MEDICAL INTERVENTIONS IN PATIENTS WITH DEMENTIA.** Hewer W, Psychiatry Dept., Rottweil, Germany.

**Objective:** A high proportion of patients with dementia is affected by comorbid general medical conditions. In our sample of patients of a regional mental hospital we investigated the frequency of interventions relating to comorbid medical conditions in the course of psychogeriatric treatment. **Methods:** Retrospective study of the course of inpatient treatment in 50 consecutive patients with dementia, who were diagnosed by ICD-10, including brain imaging by CT-scanning (66 % female, mean age 79.3 +/- 7.2 years). 48 % of the patients were admitted from their home, 28 % from general hospitals, and 24 % from nursing homes. We recorded all interventions in the field of general medicine initiated or significantly modified during the stay of the patients in mental hospital, with confirmation of the diagnoses by a physician certified in internal medicine. **Results:** In 72 % of the patients dementia of Alzheimer type was diagnosed, in 22 % vascular dementia, and in 6 % dementia of other etiology. In 90 % of the patients we diagnosed a dementia syndrome in a moderate or severe stage. With a length of stay of 38.8 +/- 20.0 days in 78 % of cases at least one medical intervention was required in the course of inpatient treatment (mean: 1.5 interventions per patient). Most frequently infections, mainly of the respiratory and the urinary tract, had to be treated (36 %

of the interventions), followed by interventions relating to cardiovascular (27 %) and metabolic disorders (14 %). 12 % of the patients had to be transferred to general hospital. Interventions were required more frequently in patients with vascular dementia, a finding which failed – with a low number of cases – to reach statistical significance. **Discussion:** In addition to psychiatric treatment and a high level of nursing care patients with advanced dementia require very frequently interventions relating to comorbid general medical conditions. With regard to the increasing prevalence of dementia in our populations this aspect should be accurately considered with further development of psychogeriatric institutions.

**NEUROTOXIC SYNDROME INDUCED BY THE CONCOMITANT USE OF PAROXETINE AND OLANZAPINE:A REPORTED CASE.** Sangines M, Cejas R, Soto R, Martín E, Rubio B, Paz M. Hospital Universitario de Canarias, La Laguna. Tenerife, Spain.

**Objective:** To report the development of a possible serotonine syndrome in a patient taking Paroxetine and concomitant use of Olanzapine. **Case Report:** A 31 year-old man taking Paroxetine 20 mg/d for generalized anxiety disorder developed confusion, diaphoresis, coordination problems, fever, and myoclonus a few days after treatment and worsened with the concomitant use of Olanzapine. CSF examination, MRI of the brain, laboratory investigations, except for serum CK, glycaemia, and WBC, were normal. **Discussion:** Serotonine syndrome is a potentially lethal condition of serotonine hyperstimulation, which may develop rapidly or over the course of several weeks. Symptoms of serotonine syndrome typically occur following additions or increases of serotonine-enhancing drugs. Olanzapine has variable effects on 5-HT2A receptors that may enhance the risk of serotonine syndrome when administered with other serotoninergic drugs. **Conclusion:** Symptoms consistent with serotonine syndrome may develop with the concurrent administration of Paroxetine and Olanzapine. Prevention, early recognition of the clinical presentation, identification and removal of the offending agents, supportive care, and specific pharmacological therapy are all important to the successful management of serotonine syndrome.

**EFFECTS OF A HERBAL MEDICATION ON THE DELAY OF COGNITIVE DEGENERATION IN DEMENTIA OF ALZHEIMER TYPE.** Weiwan Whang[1], Jongwoo Kim[1], Sunyong Chung[1], Hyuntaek Kim[2], Sunyoung Cho[2]. [1]Dept. of Oriental Neuropsychiatry Kyunghee University, [2]Dept. of Psychology, Chungbuk University, Seoul, Korea

**Background:** There have been few reports on the Alzheimer disease with natural products. In this study, we investigated the clinical efficacy of herbal medication(HH343) which consists of Polygala tenuifolia and Acorus gramineus on the cognitive function in patients with mild Dementia of Alzheimer Type(DAT). **Methods:** Twenty outpatients with mild DAT at the department of Oriental Neuropsychiatry Kyunghee medical center were selected for this study. Their ages ranged from 62 to 86 years with an average of 70.4 years. We used the Clinical Dementia Rating and Korean-Dementia Rating Scale(K-DRS) to confirm the mild DAT, and the Brain- MRI to exclude the vascular dementia. Patients were treated with HH343 four times a day for 6 months and evaluated with K-DRS, Korean version of Mini Mental State Examination (MMSE-K) and Korean Instrumental Activities of Daily Living (K-IADL). **Results:** 1. Total score of K-DRS was 119.55¡¾ 7.112 at baseline and 120.25¡¾10.341 at 6-month. There was no significant difference between before and at the end of treatment (p=.689). 2. Memory score of K-DRS was 10.900¡¾ 2.713 at baseline and 13.400¡¾3.719 at 6-month. That was significantly improved after the treatment (p=.006). 3. MMSE-K score was 20.50¡¾3.869 at baseline and 20.89¡¾4.128 at 6-month. There was no significant difference between before and at the end of treatment (p=.506) 4. K-IADL score was 1.024¡¾0.636 at baseline and 1.403¡¾0.949 at 6-month. That was significantly progressed after the treatment (p=.026). **Conclusion:** Treatment with HH343 for 6- month prevented patients with mild DAT from declining the cognitive function, especially memory function in spite of deterioration of daily life. These results imply that HH343 could not only protect the deterioration of other cognitive function of the mild Alzheimer dementia patients but also improve the memory. And there might be possibilities that anti-dementia drug could be developed by using natural products.

**A TANNED, DEPRESSIVE FEMALE ANORECTIC – A CASE REPORT.** Schneider J, Zajontz H, Baumann B. Dept. of Psychiatry, Psychotherapy and Psychosomatics, Magdeburg University, Germany.

A 31 year old woman presented, accompanied by her family members, at the central emergency admission of our clinic, because she vomited several times daily and suffered from pronounced weight loss over a period of two weeks. She felt weak, her mood was depressed and she had increased need to sleep. She reported that her symptoms had increased, since she had experienced problems at work because of a new chief. The patient was well-groomed, made up and had a "tanned" skin coloration. According to the primary treating internist, there was suspicion of an eating disorder and depression; so the patient was referred to our psychiatric clinic. As to the past medical history it is remarkable that there was no previous psychiatric treatment. The patient did, however, report that over the past approximately 10 years she had recurrent phases, during which she intentionally ate less in order to lose weight; she denied self-induced vomiting. In the past, she also considered a career as a "model." At the time of review of routine laboratory values at our division, a suppressed TSH was found; the T3 level indicated a hyperthyroid metabolic situation. Thyroid sonography and auto-antibody assays (anti-TPO, anti-thyroglobuline, anti-TSH receptor) were performed. The findings indicated the presence of a Hashimoto's thyroiditis. In addition, in the further course, laboratory tests demonstrated recurrent hyponatremia in the presence of concomitant hyperkalemia. The patient was questioned about her skin coloration but was unable to determine any change. Her husband, however, reported that he had previously noticed the increased browning; it had remained unchanged for several months (since summer of last year), although there was no further exposure to UV light. Our suspicion of Addison's disease was confirmed by determination of cortisol, ACTH and auto-antibodies (anti-adrenal IgG, anti-21-hydroxylase). After conclusion of the studies, our diagnosis was "type 2 polyglandular autoimmune syndrome with Addison's disease and Hashimoto thyroiditis with accompanying

hyperthyreosis" (ICD-10 : E31.0). Under antithyroid treatment with thiamazole, parenteral fluids, electrolyte replacement and therapy with hydrocortisone and fludrocortisone there was rapid improvement in concentration, psychomotor drive mood and appetite within one week, so that the patient could be discharged. In the present case report important differential features of an eating disorder (anorexia, bulimia) in comparison with Addison's disease are illustrated, because the knowledge of typical signs and symptoms is very important for prompt initiation of adequate treatment.

**POSTER SESSION 3**
Chair: A. Riessland-Seifert, Vienna Wednesday, June 23, 5.15-6.00 pm, Hall.

**EVALUATION OF THE CHANGING PATTERNS OF PSYCHIATRIC REFERRALS IN A 5 YEAR PERIOD IN A LARGE UNIVERSITY.** Özkan M, Kaçmaz N. Dept. of Consultation-Liaison Psychiatry, Istanbul University, Turkey.

**Objectives:** The aim of this study was to compare two 1 year psychiatric surveys 5-years apart in order to understand the patterns of referral, reasons of referral, method of interventions and spectrum of psychiatric diagnoses in time. **Methods:** Using a chart review, we retrospectively examined consultations referred to an adult consultation liaison service at a university hospital in the 1998 (N=1035) and 2003 (N=1609). All the consultations were evaluated with regard to demographic characteristics, the source of referral, reason for referral, medical diagnoses, psychiatric diagnoses (according to DSM-IV), and suggested treatment modalities. **Results:** As the escalation in the consultation request continues according to years quantitatively and qualitatively, the most frequent requests come from internal medicine, general surgery and emergency units. When the psychiatric diagnoses are evaluated, it is viewed that consultation need is not limited with major psychiatric diseases. In the years it is distinctive that not only major psychiatric situations but emotional, behavioural and adjustment related problems which do not satisfy diagnostic criteria are being referral to our CLP department. Besides, apart from patient-centred referral more and more treatment team-centred psychiatric referrals are requested. **Discussion:** The factors leading to the changes in psychiatric consultation and the implications are discussed. Our findings are compared with the findings in the literature within the context of the development of psychiatric medicine of our faculty, rational utilisation of psychiatric services in general hospitals, and effort of educational standards.

**ANALYSIS OF THE REASONS FOR REFERRALS TO THE C-L PSYCHIATRIC UNIT AT THE RAMÓN Y CAJAL HOSPITAL, MADRID.** Vázquez JJ, Lozano M, Ramos-Brieva J, Ochoa E. Service of Psychiatry, Ramon y Cajal Hospital, Alcala University, Madrid, Spain.

**Introduction:** One of the distinguishing characteristics of C-L Psychiatry is that the request for attention does not come directly from the patient, but from the medical team responsible for the patient's care. The psychiatry consultant deal with also the psychological difficulties encountered in the patient-health worker relationship. In this communication some of the variables that constitute C-L psychiatry practices will be analysed. **Methods:** All requests made between May 1997 and June 1998 at Ramón y Cajal Hospital are evaluated. The sample was made up of 808 patients. The average stay of these patients is compared with the general average stay in the hospital. The time between admittance and request for psychiatric attention is also considered. The urgency of the request and the reasons behind it are given equal importance. These variables are analysed in the five areas with most frequent requests for attention: infectious diseases, traumatology, internal medicine, gastroenterology and general surgery. **Results:** The average stay in the hospital is of 10.9 days; the time between admittance and request for psychiatric attention is 12.15 days. 9.8% of requests were asked for urgently. The main reason for request were psychiatric symptoms detected in 39.5% and, in second place, substance abuse found in 24.7%. The differences between the areas and the different needs are commented on.

**WHEN IS PSYCHOSOMATIC SUPPORT REQUESTED, ACCEPTED, OR REFUSED?**
Weidner K, Dept. of Psychosomatics & Psychotherapy, University Dresden, Germany

**Background:** Mental condition and quality-of-life can be influenced by acute gynaecological illness. On the other hand, mental disorders can also cause gynaecological symptoms. Thus, diagnosis and recognition of the mental condition of women is required to offer adequate help. This, however, is a challenge due to the daily routine in gynaecological clinics. In order to improve service and treatment, factors, which influence the acceptance of psychosomatic support, need to by identified and analysed. **Methods:** All women, hospitalised at the gynaecological clinic, are screened for depression, anxiety (HADS), physical complaints (GBB) and health-related quality-of-life (SF-12). In addition, the request for psychosomatic support is registered. Women showing psychosomatic symptoms during the initial screening are especially interviewed in order to verify psychosomatic disorders, therapy requirement, and therapy motivation. **Results:** Initial results of this study will be presented with emphasis on the request for support and therapy motivation of the women. Influencing factors, such as anxiety, depression, quality-of-life, physical complaints and gynaecological diagnoses are analysed. **Conclusion:** To avoid chronification of psychosomatic disorders, disturbances of the mental status need to be detected early and intervened immediately with psychotherapeutic methods tailored to the individual needs. The consideration of motivational aspects in interventions can influence the therapeutic success positively.

**EVALUATION OF SCREENING INSTRUMENTS IN THE SET UP OF A PSYCHOSOMATIC C-L SERVICE IN A GENERAL HOSPITAL.** Monhof M[1], Schmitz N[2]. [1]Dept. of Psychosomatic Medicine, Sana-Hospital Remscheid, [2]Dept. of Psychosomatic Medicine, University of Düsseldorf, Germany.

**Objective:** Psychosomatic and psychiatric consultation - liaison - services exist in Germany in 10% of general hospitals only. The in-house integration and organisation of a psychosomatic ward in a general hospital presents an ideal background to facilitate appropriate diagnosis and treatment of patients whose illness is both mental and somatic. Apart from describing the clinical characteristics of the referred patients it was an objective of this study to develop and evaluate a suitable combination of instruments for the screening and assessment of these patients and especially for those with somatoform disorders. **Methods:** We examined 275 patients under standardised conditions. Apart from the basic documentation to establish the socio-demographic data the Giessen Complaint List (GBB), the Symptom-Check-List (SLC90R) and the Inventory of Interpersonal Problems (IIP) were implemented to evaluate the psychosomatic factors. Psychiatric and psychosomatic diagnoses were carried out on each patient according to the ICD10- Classification. **Results:** The majority of the patients (93%) suffered from a somatic illness and psychological or psychiatric co-morbidity. The most prevalent psychiatric diagnoses were somatoform disorders (F45) and adjustment disorders (F43) .Even when a significant number of psychosomatic complaints and greater psychosomatic pressure were evident in the "SCL-90- R" and the "GBB" a conspicuously, less pronounced assessment showed up in the "IIP" – in fact lower than the assessment in a healthy reference sample. The GBB scores and the severity of physical illness had no significant relation. **Conclusions:** The psychosomatic consultation- liaison service in a general hospital provides a good and necessary framework for an early diagnosis of patients with psychological disturbances who otherwise would not receive adequate treatment and who would cause elevated health care costs .The results of this study suggest to chose screening instruments, which take into consideration the patients' explanatory models and their fixation on physical complaints. The lower IIP scores in the patients' group may relate to underreporting as well as to the difficulty to realise emotional reactions. The patient's approach to a biopsychosocial model of disease may be supported by presenting the IIP after the diagnostic interview.

**INTERMED AND MULTIDISCIPLINARY ASSESSMENT OF MEDICAL INPATIENTS' COMPLEXITY IN SPAIN.** Lobo E & the REPEP Workgroup, Hospital Clínico Universitario, Zaragoza, Spain.

**Objective:** To document complexity of care in medical patients admitted to a University hospital in Spain, assessed by a medical team by means of INTERMED. **Methods:** Consecutive patients admitted to the Pneumology ward in the Hospital Clínico Universitario of Zaragoza, Spain, were initially selected to participate in the study. Patients giving informed consent were to be assessed by means of INTERMED. The validity of the Spanish version of this interview was previously documented by the same team. A standardised nurse administered this novel method of assessment, the information coming both, from patients (and/or relatives) and the medical team. The interviews were conducted in the first three days of hospitalisation. **Results:** Two hundred and forty patients were invited to participate, and 210 completed the assessment procedure. Problems in the "biological" area (scores above the threshold point) were documented in close to 90% of patients, problems in both the "psychological" and "social" areas in close to two thirds of patients and problems in the "health services" area in approximately 80% of patients. Close to one third of the sample had problems in all four areas investigated. **Conclusions:** A multidisciplinary assessment of pneumological inpatients by means of the Spanish version of INTERMED documents an important proportion of "complex" cases. The clinical implications are clear, but also the implications for the organisation of multidisciplinary medical teams.

**ASSESSMENT OF CASE COMPLEXITY BY MEANS OF THE INTERMED: THE USERS' POINT OF VIEW.** Guitteny-Collas M[1], Vanelle JM[1], Bydlowski S[2], Stiefel F[3], Consoli SM[2], Vénisse JL[1]. [1]Service Hospitalo-Universitaire de Psychiatrie et Psychologie Médicale, Hôpital Saint-Jacques, C.H.U. Nantes, France, [2]Service de Psychologie Clinique et de Psychiatrie de Liaison, Hôpital Européen G. Pompidou, Paris, [3]Service de Psychiatrie de Liaison, Universitée Lausanne, Switzerland.

**Introduction:** The INTERMED is a reliable and validated scoring instrument to assess biopsychosocial case complexity. The study « Assessment of consultation-liaison psychiatry needs with the INTERMED in 3 medical and surgical units » (presented as a Poster at the EACLPP conference in Zaragoza, September 2003) included 194 patients and demonstrated that high-complexity patients (INTERMED total score ≥ 21) are frequent in these wards (60%), and for only 11% of high-complexity patients a consultation-liaison psychiatry was requested. **Objectives:** This second study was aimed to collect the point of view concerning the INTERMED of the involved actors (patients, C-L psychiatry staffs, medical and surgical staffs). **Methods:** The patients' point of view was collected after each INTERMED assessment by asking their opinion about the interview. The point of view of the staffs was collected during 4 focus group meetings, 7 months after the INTERMED interview period. **Results:** A majority of patients (79%) replied that they had a positive opinion about the assessment with the INTERMED. Medical and surgical staffs emphasised the utility of INTERMED to document integrated information of patients' needs, to describe case complexity and to define a treatment plan. Psychiatric staffs underlined the usefulness of INTERMED as a tool to "liaise" between medical staff and psychiatric staff. **Conclusions:** While social desirability may have influenced the results, this feedback can be considered as favourable for the INTERMED method. The INTERMED probably requires a thoughtful preparation and a conceptual framework when implemented in medical units of the general hospital. Further research should better evaluate the clinical utility of a routine use of the INTERMED in C-L psychiatry practice.

[1] Huyse FJ, Lyons JS, Stiefel FC, Slaets JPJ, Lobo A, Guex P, de Jonge P. INTERMED : A Method To Assess Health Service Needs : Development And First Results On Its Reliability. General Hospital Psychiatry 1999 ; 21 : 39-48.

[2] Stiefel FC, de Jonge P, Huyse FJ, Vannotti M, Spagnoli J. INTERMED : An Assessment System for Case Complexity and Health Care Needs : Results on its Validity and Clinical Use. General Hospital Psychiatry 1999 ; 21 : 49-56.

**A PSYCHOSOMATIC "FAST-TRACK" WARD – A MODEL FOR INTEGRATING A PSYCHOSOMATIC CONSULTATION-LIAISON SERVICE AND PSYCHOSOMATIC IN-PATIENT TREATMENT.** Eisenberg A, Söllner W, Dept. of Psychosomatics and Psychotherapy. General Hospital Nuremberg, Germany.

In the summer of 2003 we started a new project to improve the co-operation of the psychosomatic consultation-liaison service with other medical departments. A psychosomatic "fast-track" ward has been established. It offers treatment for patients, who have originally been treated in medical/surgical wards, but are identified as patients with psychosomatic disorders or with somatic disorders and psychiatric co-morbidity. The C-L team is responsible for their identification in the medical/surgical ward. Patients can be transferred to this psychosomatic ward within one or two days. In the mean, patients stay there for 1 to 14 days. There are two main groups of patients in this special psychosomatic ward. The first group consists of patients in an acute crisis situation, e. g. after a failed suicide attempt. Some of them have psychosocial problems in their environment; some have difficulties to accept the diagnosis of a severe somatic illness. The second group consists of patients with typical psychosomatic diseases (predominantly somatoform disorders) but who are still unsympathetic towards any intensive psychotherapeutic treatment. According to their problems treatment strategies focus on stabilisation, support, relaxation, psycho-education and motivation for further psychotherapeutic treatment.

**CONSULTATION-LIAISON SERVICES AND ACTIVE CO-OPERATION: MODELS OF GOOD PRACTICE** Fazekas C[1], Stelzig M[2], Jandl-Jager E[3], Suchar G[1], Rothenhäusler HB[4], Kapfhammer HP[4], Bergmann G[5], Stix P[1], Pieringer W[1]. [1]Dept. of Medical Psychology & Psychotherapy, University Graz, [2]Dept. of Psychosomatics, General Hospital Salzburg, [3]Dept. of Psychotherapy, University Vienna, [4]Dept. of Psychiatry, and [5]Medical Director, University of Graz, Austria.

In all fields of medicine there is a tendency that patients are hospitalised for an increasingly shorter time period than in previous years. This trend has a dramatic effect on the functions of consultation–liaison (CL) services. One consequence is that CL services need to intensify their efforts to build up co-operations within the hospital as well as concerning post-treatment care. In our contribution we present the basic concepts and our first experiences with the following innovative models of internal and external co-operation. These are first, the internal bio-psycho-social case conferences, second, regional networks of psychosomatic quality circles for post-treatment care, and third, a national network for psychosomatics in Austria. It is our ultimate goal to develop these approaches into models of good practice.

**THE SPANISH NETWORK OF LIAISON PSYCHIATRY AND PSYCHOSOMATICS (REPEP).** Sarasola A, Lobo A, Saz P, Barcones MF, Cazcarra R, Larraga L, Roy F and REPEP Group. Psychosomatic Service and Departments of Medicine and Psychiatry. Universidad de Zaragoza, Spain.

**Background:** In the context of the interphase between liaison Psychiatry and other medical disciplines, the Spanish Network of Liaison Psychiatry and Psychosomatics (REPEP) was created, which brought together 11 Hospitals co-ordinated by the Service of Psychosomatics and Liaison Psychiatry of the University Clinic Hospital of Zaragoza. The aim is to create frameworks of scientific co-operation which will impact on clinical and preventive practice and it is financed by the Instituto de Salud [Health Institute] Carlos III (ISCiii) and the Fondo de Investigación Sanitaria [Health Research Fund] (FIS). **Aims:** To co-ordinate research of the different nodes To promote the complementarity of activities To take advantage of the existing synergies and the previous structure of the group network To initiate new projects of co- operative research To create more powerful frameworks of scientific co-operation Strategies: **Methods:** Impact of depressive co-morbidity and the acute deterioration of cognitive functions in hospitalised patients (total: 4000 patients). Follow-up in Primary Care sets out to verify the hypothesis as to the medical costs of depressive co- morbidity. A plan of research personnel training and of researcher mobility. A research result transfer plan. **Results:** The most relevant results obtained by the group during this first year are presented: Recognition of the scientific work: three prizes Training: 24 researchers in Doctoral Courses, 23 Doctoral Theses in preparation, 1 Doctoral Thesis completed. Co-operation activities: preparation and adaptation of 9 instruments, design of a new instrument, co- operation with at least 20 medical services, design of informed consent form Activities of diffusion: 37 Oral communications at congresses, 11 articles published in journals, 8 chapters published in books, one book published. **Conclusions:** The aims are being fulfilled. Based on the work carried out, the Instituto de Salud Carlos Tercero has decided in favour of the continuity and financing of the work of the Network. The work which is being performed is establishing the bases for ambitious intervention studies.

**CURRENT STATUS OF CONSULTATION-LIAISON PSYCHIATRY IN SWITZERLAND.** Caduff F, Georgescu D, Swiss Society of C-L Psychiatry, Thun, Switzerland.

We present a map of the psychiatric consultation and liaison services in Switzerland and an overview of the ongoing efforts to enhance the identity of the C+L Psychiatry as an important speciality of clinical psychiatry in our country. Our survey is based on a inquiry, that we performed in 2000. To collect the data we have developed a 24-item questionnaire covering various areas (among others C+L model, provided services, areas of responsibility, demand and utilisation of service, personnel and institutional characteristics, financing, teaching, research, communication, development plans) of C+L activity. We contacted 88 services, institutions, hospitals or individuals covering all regions of the country; 72 delivered sufficient data to be included in our survey, among them all C+L services of university, big and medium hospitals. We present the most important results of this survey. As a consequence of this study a Swiss Society of Consultation-Liaison Psychiatry (SSCLP) was founded in 2001; the Society itself became member of the Swiss Society of Psychiatry.

Beside other activities (contact, teaching, homepage (www.ssclp.ch), organisation of symposia) we plan to establish the C+L psychiatry as an official sub-specialisation of psychiatry in our country.

**EVALUATING THE PSYCHIATRIC CONSULTATION IN A UNIVERSITY HOSPITAL OF THE CANARIAS.** Cejas MR, Souto R, Martin E, Sanginés M, Paz M, Gracia R. Dept. of Psychiatry Hospital Univ. de Canarias. Tenerife. Spain.

**Objective:** The purpose of this study was to ascertain whether there has been any change made on the demands in the psychiatric consultation in our hospital in the past ten years. **Method:** We studied all 165 psychiatric consultations made in the last 3 months (from October through January 2004) and compared them with 60 consultations made ten years ago in the same time period. **Results:** There has been no significant differences in the demographic aspects. The median age was around 50 years old, no difference in sexes, most of the patients were singles, working active, and with elementary studies in both periods analysed. The most demanded department was internal medicine with were then the 50% of the consultations. It was also noted that the surgical departments increased their petitions. The grade of the psychiatric consultation made was 75% of cases considered urgent or preferential by the demanded department. In most of the cases the patient was not informed about the psychiatric consultation. By the psychiatric point of view only 25% of those were considered urgent; only 8,4% had suicidal behaviour, 4,8% were agitated and 10% were confusional syndromes. **Conclusions:** We consider that the principal cause of the urgent consultations in most of the cases was to relief the doctor's anxiety and his difficulties to treat the anxiety symptoms associated with the sickness. We propose training programs in these aspects, directed to the personnel that have to deal with these kinds of patients.

**PSYCHOLOGICAL DISTRESS AMONG PATIENTS ATTENDING A GENERAL MEDICAL OUT PATIENT CLINIC IN PAKISTAN.** Husain N, Chaudhry I, Afsar S, Creed F. Dept. of Psychiatry, Manchester Royal Infirmary, U.K.

**Background:** Depressive disorder is one of the most common disabling conditions worldwide. It is not known whether the pattern of depression in medical out-patients in Pakistan is similar to that observed in the West. **Method:** Consecutive medical out-patients attending 4 half-day clinics at Civil Hospital, Karachi completed the Self- report questionnaire (SRQ) to detect probable psychiatric disorder. The usual cut-off score of 8/9 was used as we had previously validated the SRQ in a population-based sample[1]. The clinic doctor rated the medical diagnoses as *physical* (symptom(s) explained by organic disorder) or *medically unexplained* (commonly: widespread bodily symptoms, neurological and gastrointestinal symptoms). The results were analysed by sex separately. **Results:** 1069 patients completed the SRQ (84% response rate). 22% of men and 60% of women presented with medically unexplained symptoms. In *men* 85% of patients with medically unexplained symptoms had probable depressive disorder compared to 36% of those with symptoms caused by recognised physical illness ($p<0.0005$). In *women* the respective proportions were 55.4% and 49.6% ($p=0.34$). In 4 clinic sessions, approximately 207 men and 317 females with probable depressive disorder attended the clinic. **Conclusions:** Depressive disorder is very common in medical out-patients in Pakistan, especially in men with medically unexplained symptoms. Systematic attempts to initiate antidepressant treatment in this setting should be attempted.

[1] Husain N, Creed F & Tomenson B. Depression and social stress in Pakistan.*Psychological Medicine* 2000:30;395-402.

**COMPARISON OF CONSULTATION-LIAISON-SERVICES BEFORE AND AFTER THE INTRODUCTION OF A DRG SYSTEM IN GERMANY.** Kinzel U, Thuberg HC, Weig W. Dept. of Psychiatry, Hospital Osnabrück, Germany

**Introduction:** In 2003 a DRG system was introduced in Germany with the exception of psychiatry and psychosomatic medicine. US-American research showed that the introduction of a DRG system lead to an increase of patients to be seen by consultation-liaison psychiatrists. **Methods:** We compared two one-year intervals of consultation-liaison psychiatry in general hospitals in Osnabrück, Germany. The research was done on a retrospective basis and the following parameters have been assessed: gender, age, reason for referral, referring department, ICD-10 diagnoses, kind of therapy, time consumed for each consultation, interval between admission to hospital and psychiatric consultation, and psychiatric advice concerning therapy. **Results:** The results show an increase of referrals to consultation-liaison psychiatry after the installation of a DRG system in the somatic departments corresponding to previous US-American findings.

**QUALITY MANAGEMENT SYSTEM IN THE SPANISH NETWORK OF LIAISON PSYCHIATRY AND PSYCHOSOMATICS (REPEP)** Sarasola A, Lobo A, Saz P, Carreras S, Feijoo J, Ibáñez O, Lobo E and REPEP Group. Psychosomatic Service and Depts. of Medicine and Psychiatry, University of Zaragoza, Spain.

**Aim:** In the context of the Spanish Network of Liaison Psychiatry and Psychosomatics (REPEP), financed by the Instituto de Salud [Health Institute] Carlos III (ISCiii) and the Fondo de Investigación Sanitaria [Health Research Fund] (FIS). it has been developed a Quality Management Plan, which promotes in each group a culture of participation and continuous improvement. **Methods:** It has been set up a schedule that includes different steps of the plan: 1/ Policy: Mission, Vision, Values, Main Principles and Main Strategies. 2/ Plan: Design of the different processes, temporary objectives and levels of organising responsibility. 3/ Annual Program: Development and assessment of the established targets in the frame of the PDCA (Planning, Doing, Checking, Acting) of Deming. **Results:** The Quality Management System that has been developed will be presented in the congress. The most relevant markers and Standards obtained by group agreement will also be presented. **Conclusions:** The Quality Management System will contribute to: 1/ Decrease the processes variability 2/ Improve the team efficiency 3/ Promote a work culture that includes the systematic evaluation and the continuous improvement.

**DO QUALITY CIRCLES DIMINISH COSTS OF CARE? ACCOUNTING DATA ANALYSIS OF PRIMARY CARE PHYSICIANS IN A QUALITY**

**ASSURANCE STUDY.** Glaesmer H, Maschewsky-Schneider U, Deter HC. Institute of Clin. Psychology & Psychotherapy, Berlin University, Germany.

**Background:** Increasing costs and quality deficits in health care are requiring efficient strategies to both improve quality of care and to control the increase in costs. On the basis of the available studies it is impossible to determine to what extent the different quality assurance instruments are useful. Since there is no comprehensive evaluation of quality circles in Germany, it is difficult to make a general statement about their impact on quality and costs of care. **Methods:** Between 1994 and 1997 the Ministry-of-Health-Project "Quality Assurance in Psychosomatics" was realised at the Free University of Berlin. Primary Care Physicians in Berlin were taking part in quality circles for psychosomatic basic care. The prescribing costs of 16 physicians of the quality circles and 12 physicians of a control group were analysed for 13 quarters. **Results:** The physicians of the quality-circles had significantly fewer patients than the physicians in the control group. In the whole period (1994-1997) as well as in several time segments no significant differences in the prescribing costs between quality circle- and control-group-physicians could be proved because of the large differences in the means. First of all, it is an effect of the large variance in the groups and the small sample size. In the beginning of the quality assurance project in the second quarter of 1994 the two groups did not differ. Whereas over the period of the quality circles in the control group the share of patients with prescriptions is rising, in the quality circle-group it is decreasing. **Conclusions:** The analysis could not prove the expected cost-diminishing effect of quality circles. However it is ambiguous, if it is a problem of the study sample or if this effect is not existent. Nor could two current studies not prove these effects and thus support the impression that there are no economic effects of quality circles. For a convincing statement about the effects of quality circles it seems to be important to implement evaluation as an integral part of quality circles and to thus gain better data.

**ASAMANS: ASKING STUDENTS ABOUT MEDICINE AND NATIONAL SOCIALISM.** Langkafel P, Charité, Medical Faculty of the Humboldt-University, Berlin.

We conducted a representative survey on medicine under National Socialism at the Charite, questioning 332 medical students (1st, 5th, and 10th semester) about their outlook and knowledge in regard to this topic. Apart from a historical part, we included questions touching the currently hotly debated discussion on the relationship of medicine and ethics. We also asked whether in the student's view these topics are represented in their curriculum and what their motivation is to deal with this subject matter. The results are unambiguous: students know very little about the history of the medical profession under National Socialism, saying that it is their poor education that is to blame. At the same time, a great majority wants to learn more about this subject as they rate it as highly important for their later medical practice. As a consequence of the survey, the Charité started to support different activities (e.g. excursions to historical sites, discussion rounds, documentary films…) to sensitize students to this topics. You can find all informations at www.asamans.de.

## SPECIAL SESSION: GERMAN VERSION OF "MICROCARES" – STATE OF PROGRESS

Chair: J. Strain; New York, A. Diefenbacher, Berlin, W. Reichwaldt (Janssen Cilag) Wednesday, June 23, 5.15-6.00 pm, Opal

**USING THE PDA AS A DATA COLLECTION DEVISE FOR AN ELECTRONIC RECORD IN C-L PSYCHIATRY.** Strain JJ, Strain JJ jun., Mount Sinai Medical Center, New York City, USA.

**Introduction:** The authors have been developing computer software for C-L psychiatry since 1986. Programs have offered several types of data entry: scanner sheets, pen-entry computer notebooks, and computer entry. This is the first time a PDA (PalmTungsten E) has been available for clinical data collection for one time data entry. **Method:** A standardized clinical database with 132 variables in five domains have been developed for the PDA Tungsten E (32mb). The data screens are organized in six categories: demographic, reasons for consultation, diagnoses, psychosocial/psychotropic interventions, administrative issues, and narrative formulation. Predetermined patient variables use. *The session is supported by Janssen Cilag.*

## SYMPOSIUM 5: RECOGNITION AND TREATMENT OF PSYCHIATRIC DISORDERS IN THE MEDICALLY ILL, PART II

Chair: A. Diefenbacher, Berlin, A. Riessland-Seifert, Vienna Wednesday, June 23, 6.00 – 7.30 pm, Room: Saphir

**A PSYCHOSOMATIC SCREENING IN PATIENTS WITH CHEST PAIN.** Einsle F, Nitschke M, Pollack K, Petrovski K, Strasser RH, Joraschky P. Dept. of Psychosomatics and Psychotherapy; University of Technology Dresden, Germany.

**Purpose:** Patients reporting chest pain often show psychological comorbidity. The lack of time in cardiological outpatient units makes it difficult to detect psychological disorders. The goal of our study was to implement a screening in a cardiological outpatient setting and validate it for patients with psychological disorders. **Methods:** Between February and November 2003 all patients reporting with acute or chronic chest pain to the outpatient clinic received the standard cardiological diagnostic and were screened for inclusion. Eligible patients got the Hospital Anxiety and Depression Scale (HADS-D), the Zerssen somatic symptom list, and the Cardiac Anxiety Questionnaire. Patients with a positive cut-off of the HADS scales and the somatic symptom list were notified along with their general physician. They were offered the opportunity to report to the psychosomatic outpatient clinic on their own demand. **Results:** A total of 407 patients were included in the study (58% male), 383 (94%) answered the questionnaire. 145 patients (38%) reached the cut-off and were subsequently referred to an exploration by a psychologist. 45 of these patients (31%) reported to the

psychosomatic outpatient clinic. 41 took part in a interview about their symptoms and psychological problems. The majority (n = 39) fulfilled the criteria of one or more psychological disorders according to ICD-10. Out of these patients 38% had an affective disorder, another 38% showed problems in coping; 33% reported an anxiety disorder, and 23% showed a somatoform disorder. To most of the patients an outpatient psychotherapy was recommended (n = 15). The remaining patients was either offered a participation in our relaxation group (n = 6) or an in-patient psychosomatic treatment (n = 9). Two patients showed not motivation for implementing our recommendation. **Conclusions:** Our results demonstrate that an implementation of a screening in the stressful daily routine of a cardiological outpatient clinic is not only possible but also necessary. Based on our results, however, the question arose why 70% of the conspicuous patients did not participate in the psychosomatic interview and will be discussed in our presentation.

**IMPLEMENTING AN EFFECTIVE INTERVENTION FOR PROBLEM DRINKERS ON MEDICAL WARDS.** Fiddler M, Mcmanus S, Hipkins J, Haddad P, Guthrie E, Creed F. School of Psychiatry and Behavioural Science, University of Manchester, UK.

**Background:** Many medical inpatients have alcohol related problems but evidence of the feasibility of instituting a brief intervention is incomplete. **Method:** An alcohol counsellor trained nurses on five general medical wards to screen patients routinely for alcohol problems. She counselled appropriate patients using one or two counselling sessions. She also worked closely with nursing staff to change attitudes towards people with problem drinking and encourage routine assessment of alcohol consumption. Efficacy of the counselling was assessed by interview six months following the admission. The extent of attitude change in nursing staff used the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ). **Results:** 19.6% of male and 4.8% of female medical patients were drinking more than 50 units per week (male) or 35 units (female). Counselling, with one or two sessions led to a reduction from a median of 74 units (49 drinks) per week at admission to 26 units (17 drinks) per week at six months follow-up. A second counselling session after discharge showed no advantage over a single one administered while the patient was in the ward. There was a significant positive change in attitude of the nursing staff working on the intervention wards (median score changed +11) compared to a negative change score in nurses on comparison wards (median = -6) $p<0.0005$. **Conclusion:** The barriers to developing a successful an alcohol screening and counselling service in medical wards can be overcome provided there is also adequate support and training of the ward nursing staff.

**DESCRIPTIVE STUDY OF THE PSYCHOSOCIAL PROFILE OF PATIENTS SEEKING COSMETIC SURGERY AT ST. THOMAS' HOSPITAL DURING 1996 –2000.** Valsraj K, Hodgkiss A, Dept of Liaison Psychiatry St. Thomas' Hospital, London, UK.

**Aims:** To describe the psychosocial status of all patients requesting cosmetic surgery at St. Thomas' hospital who were referred on for psychiatric assessment during 1996 to 2000. **Method:** A retrospective case note review of all new patient referrals. Cases were ascertained by hand searching. The new patient assessment recorded detailed psychiatric assessment including the diagnostic criteria of body dysmorphic disorder. A proforma was devised to capture relevant psychosocial variables. We identified 36 cases. **Results:** The cases consisted of 33 females, 3 males and the mean age was 32years(range 24-47). The majority were either single (47%) or divorced (16%). Regarding the cosmetic surgery: 67% sought breast augmentation, 8% rhinoplasty, 3% breast reduction, 3% pinnoplasty, 3% liposuctions. 17% had had previous cosmetic surgery. All the patients had visible defects that were potentially amenable to surgical correction. 54% reported physical or sexual abuse in childhood or domestic violence in adulthood. 50% reported a past psychiatric history, typically depression and associated deliberate self-harm. 27% had features of body dysmorphic disorder. 54% of women seeking breast augmentation mentioned breast-feeding as an issue. 87% of the women had children, most during their teens. **Comments:** This case series obviously reflects local referral patterns but confirms existing knowledge of the epidemiology of Body Dysmorphic Disorder. However it may have heuristic value in that it points to a group of women seeking cosmetic surgery as part of an explicit project of self-improvement in their early thirties. We need to learn whether breast augmentation benefits the mental health of this group of single or divorced women from the lower social classes who suffered abuse, had children young, lost breast volume after breast feeding and then suffered depression and subsequently self harmed. The request for cosmetic surgery is perceived by them as part of a process of recovery, a fresh start.

**THE INFLUENCE OF PRENATAL DIAGNOSIS OF CONGENITAL MALFORMATIONS ON POSTNATAL PARENTAL PSYCHOLOGICAL WELL-BEING.** Skari H, Malt UF, Bjørnland K, Egeland T, Haugen G, Østensen AB, Skreden M, Emblem R. Rikshospitalet, Univ. of Oslo, Norway.

**Background:** Prenatal diagnosis of congenital malformations has been suggested to reduce parental psychological distress compared to postnatal diagnosis. The aim of the study was to explore this relationship. **Methods:** A prospective longitudinal study including 293 parents of 148 consecutive neonates with congenital malformations admitted for surgery (1997 – 1999) was conducted. A prenatal diagnosis of malformation was made in 55 (37.2%) and postnatal in 93 (62.8%) of the cases. Neonatal and 6 month-mortality were 9.5% and 12.2%, respectively. Self-reported anxiety, depression, intrusive and avoidance stress, and psychological distress were measured by standardised psychometric instruments (GHQ-28, STAI-X1, and IES) acutely; six weeks; and six months after the initial admission. Multiple linear regression analysis controlling for other predictors of psychological distress was performed. **Results:** Statistical significant increased psychological distress (total GHQ score) was reported by parents with prenatal diagnosis compared to parents with postnatal diagnosis both acutely, at 6 weeks and at 6 months. Mothers consistently scored higher than fathers. Multiple linear regression analysis controlling for parental gender, 6 month mortality, and associated malformations showed that prenatal diagnosis was a significant independent predictor of acute psychological distress. **Conclusions:** Increased levels of psychological distress were reported

among by parents with prenatal diagnosis of congenital malformations. This finding raises important ethical and management questions.

**SYMPOSIUM 6: MANAGING DELIBERATE SELF-HARM IN THE GENERAL HOSPITAL**
Chair: A. Lundin, Stockholm, G. Niklewski, Nuremberg Wednesday, June 23, 6.00 – 7.30 pm, Room: Rubin

**FACTORS ASSOCIATED WITH SUICIDAL RISK AMONG CONSULTING YOUNG PEOPLE IN A PREVENTIVE HEALTH CENTER.** La Rosa E, Hubert-Vadenay T, Le Clésiau H, Consoli SM. Centre de Prévention Sanitaire et Sociale de la CPAM de la Seine-Saint-Denis and Dept. of C-L Psychiatry, G. Pompidou European Hospital Paris, France.

**Objective:** To explore the role of stressful life events or contexts during childhood or the recent past in teenagers presenting with a high suicidal risk. **Methods:** Individuals aged 16 to 25 who consecutively consulted in a preventive health centre on the occasion of a free work up were invited to fill out several self-administered questionnaires, aimed at assessing especially the level of psychosocial distress (GHQ-28) and of hopelessness (Beck's scale). They were also invited to meet a psychologist for a semi-structured interview, to collect biographical information and determine the level of suicidal risk, on the basis of a scale of suicidal ideation (ERSD score = 4). **Results:** 1004 self-administered questionnaires (61.3 % of females) and 576 interviews could be analysed. GHQ-28 global score and sub-scores were all higher in women (all the $p < 0.001$). A high suicidal risk was found in 24.1% of the studied population. This subgroup was characterised by higher levels of GHQ-28 scores and sub-scores as well as hopelessness (all the $p < 0.001$), and by several biographical antecedents: unknown father, death of parents, separation from parents, severe quarrel between parents, money problems within the family, disorders related with alcohol consumption in parents, drug addiction within the family. Other predictors were: recent violence within the family, social isolation, lack of self-esteem, school difficulties, educational failure, consumption of drugs, neuroleptics, antidepressants, and tranquillisers (all the p from 0.02 to 0.001). In a final multiple regression analysis, five variables continued to independently predict a high suicidal risk : hopelessness (Odds Ratio (OR) = 4.09), depressive mood at GHQ-28 (OR=3.75), the notion of an unknown father (OR=2.95), the notion of a recent destabilising event other than a school problem or an aggression (OR=1.90) and the notion of an educational failure (OR=1.78). **Conclusion:** These results confirm previous scientific data on this topic and underline that childhood context, educational course, psychological vulnerability and the occurrence of recent stressful life events combine their effect, enhancing the risk of a suicidal attempt. They can be useful for settling more efficient screening and preventive programs.

**ASSESSMENTS OF PATIENTS AFTER ATTEMPTED SUICIDE MADE BY THE PSYCHIATRIC AND THE PSYCHOSOMATIC C-L-SERVICES.** Lehfeld H[1], Simen S[1], Niklewski G[1], Wentzlaff E[2], Gutberlet S[2], Söllner W[2]. Depts. of [1]Psychiatry and [2]Psychosomatics, Nuremberg, Germany.

**Objectives:** The "Nuremberg Alliance against Depression" is an intensive awareness programme on depression which is carried out in the city of Nuremberg within the framework of the "German Research Network on Depression". The aim of this programme is to improve diagnosis, therapy and care for patients suffering from depression. The project is scheduled for a total duration of five years. The reduction of the number of suicide attempts serves as one important criterion for the evaluation of the success of the campaign. **Methods:** The Psychiatric and the Psychosomatic C-L-Services in Nuremberg General Hospital, one of Europe's largest hospitals, assesses nearly all patients hospitalised after attempted suicide. Each parasuicidal episode is registered using a standardised documentation sheet covering variables such as socio-demographic data, methods of parasuicidal action, former suicide attempts, diagnosis or recommended therapy after dismissal. Altogether, 1,327 suicidal episodes have been documented within the time period 2000 to 2002, mostly by staff of the two hospital C-L-Services. To minimise inter-rater effects, assessments by 5 raters from both C-L-Services were compared with regard to similarities and differences between patients seen by the two services. **Results:** 316 episodes were documented by two physicians of the Psychiatric C-L service and 309 episodes by three members of the Psychosomatic C-L service. Differences between the two services were found, for example, on assessments of the underlying motivation of the suicidal action as perceived by the consultant, on diagnoses (psychosomatic consultants prefer F4 diagnoses whereas affective disorders (F3) were most often diagnosed by psychiatrists) or on recommended therapeutic interventions after dismissal. An explanation for these findings could partly be seen in the fact that psychiatric consultants tend to see patients after more severe suicide attempts than their psychosomatic colleagues.

**MANAGING DELIBERATE SELF-HARM IN THE GENERAL HOSPITAL.** Rigatelli M., Palmieri G., Ferrari S. Consultation-liaison Psychiatry Service, University of Modena and Reggio Emilia, Modena, Italy.

Suicidal and self harm behaviours in General Hospital (GH) inpatients are important reasons for referral to a CL-Psychiatry Service. Unlike many patients with medical-psychiatric comorbidity, those who talk about killing themselves receive prompt psychiatric attention. The suicide rate in GH patients has been found three fold higher than in the general population [1]. Jumping from the window is the most common reported mean of suicide in the GH [2]. This group of patients usually includes those admitted after suicide attempts and the chronically medically ill with co-morbid depression, especially in cases of severe pain, alcoholism, transient confusion, poor prognosis, or after recent adverse news. Physical disease is an independent risk factor present in a high proportion of people who commit suicide or parasuicide [3]. The collaboration between the medical staff and the CL-Psychiatry Service is fundamental to achieve an effective treatment for these patients and for suicide prevention. In this view, we developed an integrated pathway for the GH inpatient with self harm risk, which includes: stabilisation of medical conditions; rapid referral to our service by medical staff previously

trained in the recognition of the suicidal risk, psychiatric consultation within an hour with risk assessment [4]; analysis of the therapeutic-caring strategies. The latter consists of: pharmacologic treatment, daily follow-up psychiatric consultations by a multidisciplinary team, special monitoring of the patient by the ward staff, liaison with Community Mental Health Team, GP and social services when needed, environmental restraints, up to the rare necessity of admission to the psychiatric ward.

[1] Dhossche DM, Ulusarac A, Syed W: A retrospective study of general hospital patients who commit suicide shortly after being discharged from the hospital. Arch Intern Med 161:991-4; 2001.
[2] White MB, et al: Jumping from a General Hospital. Gen Hosp Psych, 17; 208-15; 1995.
[3] Harris EC, Barraclough BM: Suicide as an outcome for medical disorders. Medicine (Baltimore), 73: 281-96; 1994.
[4] Montgomery SA, Smeyatsky N, de Ruiter M, Montgomery DB: Profiles of antidepressant activity with the Montgomery-Asberg Depression Rating Scale. Acta Psychiatr Scand 320:38-42; 1985.

**THE NUREMBERG ALLIANCE AGAINST DEPRESSION: RESULTS ON THE EFFECTS ON SUICIDALITY AFTER TWO YEARS OF INTERVENTION.** Niklewski G, Lehfeld H, Hegerl U. Depts. of Psychiatry, General Hospital Nuremberg and University of Munich, Germany.

**Objective:** The "Nuremberg Alliance against Depression" is an intensive awareness campaign which aims at improving the quality of care for patients suffering from depression. **Methods:** A multilevel action programme was set up in the city of Nuremberg (480,000 inhabitants) to improve current deficits in the diagnosis and therapy of depressive disorders. The total duration of the programme will be five years. The numbers of completed suicides and suicide attempts are the main outcome criteria for the success of the campaign. With the year 2000 serving as the baseline, the awareness campaign was launched in January 2001 and faded out by the end of 2002. Suicides and suicide attempts will be analysed until the end of the year 2004. The two-year intervention programme especially addressed general practitioners (GPs), the public, multipliers in contact with depressed patients (e.g., teachers, geriatric nurses) and patients and their relatives. **Results:** In the present analyses, data from the two years of intervention (i.e., 2001 and 2002) are compared to baseline (i.e., the year 2000) and a control region (Wuerzburg, 270,000 inhabitants). During the two-year intervention period, a statistically significant reduction of suicide attempts could be observed in Nuremberg as compared to the control region. Between 2000 and 2002, the numbers of attempted suicides dropped by 26.5% from 520 at baseline to 382 in the second year of intervention ($p < 0.001$). The reduction was most pronounced for "hard" methods (e.g. hanging, jumping, shooting). Furthermore, there is evidence that younger patients could be addressed more efficiently than elderly persons by the awareness campaign. Concerning the number of completed suicides, the drop recorded in Nuremberg did not reach the level of significance when compared to the control region. **Conclusion:** The "Nuremberg Alliance against Depression" appears to be an effective programme for reducing suicidality. It provides a concept as well as many materials, which are presently implemented in several other intervention regions in Germany and other countries.

## SYMPOSIUM 7: WHAT IS THE BEST WAY TO LIAISE? MODELS OF INTEGRATED CARE

Chair: A. Boenink, Amsterdam, W. Söllner, Nuremberg — Wednesday, June 23, 6.00 – 7.30 pm, Room: Jade

**A RANDOMIZED PSYCHIATRIC INTERVENTION IN COMPLEX MEDICAL PATIENTS: EFFECTS ON DEPRESSION.** Stiefel F[1], Bel Hadj F[1], Zdrojewski C[1], Boffa D[1], deJonge P[4], Dorogi Y[1], Miéville JC[1], Ruiz J[2], So A[3]. [1]Psychiatry Service, [2]Division of Diabetology, [3]Rheumatology Service, University Hospital of Lausanne, Switzerland, [4]Psychiatry Service, University of Groningen, NL.

**Aims of the study:** This study evaluates a psychiatric intervention targeted on complex medical patients identified by means of the INTERMED, a reliable and valid case-finder for bio-psycho-social case complexity (1,2). **Methods:** Complex patients are identified with the INTERMED in a rheumatology inpatient clinic and a diabetes outpatient unit. Patients with INTERMED cut-off scores >20 identified as complex are included and randomised into "care as usual" or intervention groups. The intervention consists of (i) a multidisciplinary team conference or (ii) one or more psychiatry and/or liaison nurse consultations. Follow up is scheduled every three months for a year and assesses quality of life, anxiety and depression, medical outcome and health care utilisation. **Results:** After 12 months study period, 550 patients have been approached and 130 patients have been included in the study (66 attributed to the intervention, 64 to care as usual). While one third of exclusion was related to exclusion criteria, such as hospitalisation of less than 3 days, cognitive failure or advanced disease, two thirds were excluded because they did not qualify as complex patients (INTERMED scores < 20). A preliminary analysis of some of the outcome measures showed that the percentages of major depressive episodes (as measured with the MINI) at baseline was about 40% in both group; this percentage slightly raised in the care as usual group, but diminished to 30% at 3 months and to 10% at 6 months follow up in the intervention group. Total INTERMED scores predicted the number of depressive symptoms at 3 months ($r=0.34$; $p < 0.01$) and 6 months follow up ($r=0.53$; $p < 0.01$). **Conclusions:** The percentage of patients suffering from major depressive episode is high in complex medical patients. Total INTERMED scores predicted the number of depressive symptoms during follow up. Case complexity as measured by means of the INTERMED may be responsible for the persistence of depressive states, while early identification and intervention by liaison psychiatry decreases the number of depressive episodes. Further inclusion will allow to evaluate significances and other outcome measures.

**PREVENTION OF RE-ADMISSION BY AN AMBULATORY CASE MANAGER.** Latour HM, Huyse FJ, de Vos R, van Gemert EAS, de Jonge P, Boenink AD, Stalman WAB. Free University Medical Centre, Amsterdam, NL.

**Objectives:** To evaluate whether the addition of an ambulatory case-manager to standard care after discharge

will result in a reduction of unplanned re-admissions during 24 weeks , a reduction of the medical consumption, and an increase of the functional status and psychological functioning. **Methods:** Randomised open label trial. Included were adult patients admitted for at least 2 days, 18 years or older, at least 1 admission during the last 5 years. Excluded were patients with memory problems and no help from a care giver, or discharge to an other hospital or nursing home. The primary outcome was unplanned re-admission rate, at 12- and 24 weeks. Secondary outcomes were: quality of life (SF-36), psychological functioning (HADS) and medical consumption at 12- and 24 weeks. **Intervention:** Patients received standard care or care of an ambulatory case- manager according to protocol. The case-manager visited the patient at home and assesses the complexity of the patient using an INTERMED interview. Based on the INTERMED an inventory of care-needs was made, this was discussed with the patient, the family doctor and other specialist. The case-manager visited the patient at least every two months, and adjusted the care plan, if necessary. **Results:** Patients in the intervention group were more frequent admitted than in the usual care group (RR 1.29, 95% CI 0.64; 2.58). In the group of patients with a complete follow-up patients in the usual care group felt less anxious and depressed. They experienced less pain and over all their mental condition seemed to be better. The average total costs for the intervention group were EUR 6212 and for the usual care group EUR 3118, with an average difference of EUR 3093 (CI 95% 182 ; 5192). Patients of the usual care group were more frequently admitted to an nursing home, but used less home-care facilities. **Conclusion:** We found no significant difference to the benefit of the intervention group as where it concerns the unplanned re-admissions, quality of life, psychological functioning and costs. Patients receiving co-ordination of care possibly stay longer in their home situation than patients not receiving this care. The trend to worse outcomes in the intervention group may be related to selective drop-out.

**A STEP TOWARDS INTEGRATIVE CARE: LIAISON SERVICES WITH MEDICAL AND SURGICAL DEPARTMENTS.** Maislinger S[1], Söllner W[2], Kantner-Rumplmair W[1], Rumpold G[1], Schüssler G[1]. [1]Dept.of Medical Psychology & Psychotherapy, University of Innsbruck, Austria, [2]Dept. of Psychotherapy & Psychosomatics, Nuremberg, Germany

In our workgroup we run consultation as well as liaison services for different clinical departments. A well-functioning liaison service needs a certain extent of structure and timetable and includes a relatively high extent of team-oriented interventions in comparison to the consultation service, which is clearly case-oriented. Taking part in ward rounds, initiating case conferences, Balint groups and training courses in communication skills are important parts of this work, meaning also support for the clinical teams. Being to a certain extent part of the team of the medical department, makes it easier for patients to accept the consultation. Even more, if infrastructure, like an own office within the department, document this integration. What makes a CL-service successful for patients, physicians and consultants; Easily accessible support for patients as well as for their relatives, a well-functioning network between physicians and consultants and the possibility that chronically ill patients are accompanied by the same consultant for a longer period The results of a survey our workgroup(asking the users for their satisfaction or dissatisfaction with the liaison service) strongly support these key-points To keep up such a quality the consultant needs the support of an own psychosocial team . Taken together a higher amount of time and energy is necessary for a CL service compared to a pure consultation service. Being part of the medical team can provoke conflicts or unclear tasks, we will report some of the negative experiences we made. Positive and negative aspects of liaison services, considering different tasks in various clinical departments as well as the results of the survey will be described.

**THE GERMAN MODEL OF INTEGRATED PSYCHOSOMATIC CARE.** Müller-Tasch T, Herzog W, Dept. of General Internal and Psychosomatic Medicine, University Hospital Heidelberg, Germany.

In many hospitals, the psychosomatic care of internal medicine patients is organized via a consultation or liaison service. Care for these patients then is separated from the internistic care, which can be difficult especially in patients with severe somatic diseases. To allow for an integrated medical care for these patients, a setting with incorporation of a bio-psycho-social perspective has been implemented in some places in Germany. As an example for such integrated models of care the structure of the Department of General Internal and Psychosomatic Medicine as an embedded part of the Medical University Hospital of Heidelberg is depicted. Its general internistic and psychosomatic outpatient units cooperate closely. A consultation service cares for patients of the Medical Hospital on demand. In its two internistic-psychosomatic wards, an internistic care with the diagnostic and therapeutic spectrum of a University Hospital is provided with the simultaneous possibility of psychic diagnostic and therapeutic care for patients in need of it. If the psychic problems are the focus of further treatment, patients can be treated in our psychotherapeutic ward. In the symposium our model of integrated care with its advantages and disadvantages will be discussed.

**WORKGROUP: SERVICE DEVELOPMENT AND FUNDING OF C-L SERVICES - RECOMMENDATIONS FOR C-L SERVICES IN EUROPE**

Chair: F. Creed, Manchester, O. Ekeberg, Oslo, T. Herzog, Göppingen Wednesday, June 23, 6.00 – 7.30 pm, Room: Opal

Across Europe economic pressures on health services increase. European Union regulations play an ever increasing role in determining standards and regulations in health care. CL services are often poorly staffed and subject to insecure funding without a proper „power base“ of their own. Based on positive experiences with national guidelines and statements the workgroup aims at developing generic European guidelines, which can help at the local, regional and national levels to strengthen the quality and availability of CL service delivery. The workgroup will be introduced with 1.) a summary of the work in previous meetings, 2.) a synopsis of existing documents from Germany, the Netherlands and the UK and 3.) a survey of members of the workgroup. This introduction and the interactive part of the workgroup will focus the following issues: a) the definition of a series of clinical scenarios which require the expertise of a CL specialist (e.g. assessment of deliberate selfharm); b) the definition of the amount of clinical input these scenarios require (manpower). The goal is to develop recommendations which can be adapted to the various health care systems in their various stages of transition across Europe. In preparation of the session participants should consider issues like the following: what clinical situations most definitely require the skills of a CL specialist? How do you discriminate between those cases which require and those which do not require CL involvement (e.g. in somatic illness with comorbid depression)?

**CITATION POSTERS** These 5 posters have been selected by the Scientific Committee as best posters of the EACLPP meeting. They will be presented during the Welcome Reception. Wednesday, June 23, 7.30 pm, Hall

**CO-MORBID DEPRESSION IN MEDICAL IN-PATIENTS: RESULTS OF AN ONGOING PREVALENCE AND 6-MONTH FOLLOW-UP**

Barcones MF, Sarasola A, Saz P, Lobo A and the REPEP workgroup. Serv. Psicosomática, Hospital Clínico Universitario & University of Zaragoza, Spain

**Aims:** To report preliminary results of an ongoing study to test hypotheses about the high prevalence and poor prognosis of depression among medical in-patients at the time of discharge. **Sample:** Consecutive, adult patients hospitalised in medical wards. Sample size has been calculated (type I and II errors, potency), and 850 patients (predominantly elderly patients) should be examined to test hypotheses in 100 cases of depression and 100 controls. **Instruments:** Standardised Spanish versions of assessment instruments, including Hospital Anxiety and Depression Scale (HADS) and the Standardised Polivalent Psychiatric Interview (SPPI). ICD-10 Research criteria will be used for the psychiatric diagnosis. **Procedure:** Hospital phase (screening by lay interviewers, assessment of “probable cases” and “probable non cases” by standardised clinicians (SPPI). Follow-up phase in Primary Care (6 months): same procedure in “cases” and “controls”. Outcome, quality of life and costs of medical services will also be assessed with standardised instruments. The statistical analysis will include multiple regression techniques. **Results:** At the time of preliminary analysis, 592 patients have been included in the sample, but only 331 could be examined. Depression was detected at the time of discharge from medical ward in 57 patients (17,2%). 10 out of 30 depressed patients (33,3%) followed-up at the time of compiling these results were still depressed (2 of them were more severely depressed) and 12 had died ( 40%). Among the 55 non-cases followed- up, 2 were depressed (3,6%) and 12 had died (21,8%). **Conclusions:** These results tend to confirm the hypotheses about the rather high prevalence of depression in medical in-patients, and the poor prognosis in terms of chronicity and high mortality rate. A multi-centre national study (Red Temática de Investigación Cooperativa) has been planned to allow the generalisation of results.

**DEPRESSIVE SYMPTOMS ENSUING HERPES ENCEPHALITIS – AN UNDERESTIMATED PHENOMENON?**

Fazekas C[1], Enzinger C[2], Wallner M[2], Leonhardt S[1], Pieringer W[1], Fazekas F[2,3]. Depts. of [1]Medical Psychology and Psychotherapy, [2]Neurology, and [3]Neuroradiology, Medical University Graz, Austria.

**Background**. Cognitive deficits like amnesia and dementia are well known sequels of herpes simplex virus infection of the CNS (HSVI). Thus, previous long term follow-up studies predominantly focused on neurological and neuropsychological deficits, whereas residual affective symptoms have hardly been investigated. Given the neurotropism of the herpes virus for the limbic system and the temporal lobe we therefore aimed to further explore such a potential association using a screening test for depression in the long-term follow-up of HSVI. **Methods**. Selected from a retrospective study of 53 patients, who had been diagnosed with HSVI in the University Hospital of Graz over a period of 15 years, we contacted 26 subjects by telephone (10 females and 16 males, age 49.7+/-25.7 years) 5.1 +/-3.1 years after disease onset to obtain a structured interview including the „Well-Being-Five“ (WB5; a screening-instrument for depression) and the „Short-Form-12“ Test (SF-12; a health-related quality of life instrument). **Results.** In almost 40 percent of the interviewees (n= 10/26; 38.5%), there was evidence for depressive symptoms (WB5 < 13, median 13.4+/-5.8). In contrast, only four of them received adequate therapy. Concerning affective symptoms, the participants’ health-related quality of life was equally or even more affected than in serious chronic disorders (SF-12 score: 48.1+/-9.3; cancer: 49.6; chronic heart-failure: 47.8, diabetes: 50.1), although patients felt less impaired in terms of physical symptoms (51.9+/-9.6; cancer: 41.5, heart-failure: 36.8, diabetes: 38.9). Personal changes induced by the disease were perceived by 61% and 27 % felt that their life had changed due to the disease. Disease specific symptoms, such as impaired memory, speech disorders, ataxia, headache, sensorimotor deficits, and epilepsia were reported in 4, 3, 2, and 1 patient each, respectively. **Conclusion.** Our

results strongly suggest a surprisingly high prevalence of depressive symptoms associated with HSVI.. Neither patients nor physicians seem to be aware of this situation, although there are therapeutic options available. However, prospective studies with larger numbers of participants are required to confirm and further specify the assumed causal relationship between these findings.

**INTER-RATER RELIABILITY, PREVALENCE AND RELATION TO ICD-10 DIAGNOSES OF DIAGNOSTIC CRITERIA FOR PSYCHOSOMATIC RESEARCH IN CONSULTATION LIAISON PSYCHIATRY PATIENTS.** Galeazzi GM[1], Ferrari S[1], Mackinnon A[2], Rigatelli M[1]. [1]C-L Psychiatry Service, Dept. of Psychiatry & Mental Health, University of Modena, Italy, [2]Biostatistics & Psychometrics Unit, Mental Health Research Institute & Dept. of Psychol. Medicine, Monash University, Parkville, Australia

**Introduction:** The Diagnostic Criteria for Psychosomatic Research (DCPR) have been proposed by an international group of psychosomatic investigators as an operationalized tool for the assessment of psychological distress in medical patients, possibly able to overcome some of the limitations and rigidities of institutional diagnostic instruments. **Objectives:** The aim of this study was to evaluate the feasibility of the application of DCPR in the setting of Consultation-Liaison Psychiatry patients, to compare the distribution of ICD-10 psychiatric diagnoses with that of DCPR syndromes and to evaluate inter-rater reliability of the assessment of DCPR syndromes using a structured interview. **Methods:** One hundred consecutive patients referred for psychiatric consultation in a University General Hospital and fulfilling inclusion and exclusion criteria consented to assessment for DCPR syndromes and were jointly interviewed; clinical data from the psychiatric consultation, including a standardised ICD-10 diagnosis, were also collected. **Results** showed excellent inter-rater agreement with kappa values for the 11 DCPR syndromes ranging from 0.69 to 0.97. More patients met criteria for one or more of the DCPR (87%) than for a ICD-10 (75%) diagnosis. All but 13 patients (87%) met criteria for at least one of the 11 syndromes evaluated; in contrast, 25% failed to meet criteria for any ICD-10 psychiatric diagnosis. Four DCPR syndromes were particularly prevalent: demoralisation, alexithymia, illness denial and type A behaviour. **Conclusions:** DCPR criteria appear to be a useful, reliable and promising approach in the assessment and description of psychological distress coexisting with medical disease. They may serve as a focus of intervention studies in medical patients.

**PO-BADO (BASIC DOCUMENTATION IN PSYCHO-ONCOLOGY) – AN EXPERT RATING SCALE FOR THE ASSESSMENT OF THE PSYCHOSOCIAL CONDITION OF CANCER PATIENTS.** Knight L[1], Blettner G, Schneider E, Schumacher A, Strittmatter G, Brandl T[2], Herschbach P[2], Keller M[1]. [1]Psychosocial Care Unit, Dept. of Surgery, University of Heidelberg, [2]Institute of Psychosomatic Medicine, Technical University of Munich, Germany.

**Purpose:** As an alternative to self-administered questionnaires, the PO-Bado provides an expert rating scale for the reliable and valid assessment of the physical and psychosocial condition of cancer patients. A diagnostic tool especially developed for cancer patients is necessary, because psychiatric categories are often inadequate. **Methods:** In a multi-centric approach, over 1000 cancer patients were assessed in 70 institutions by over 100 professionals. The main criteria for item selection were clinical relevance and psychometric properties. The final version was applied routinely in 17 institutions to assess its practicability. A test of the sensitivity to change was carried out in a sample of 99 patients undergoing radiotherapy. **Results:** The PO-Bado contains 17 items, rated on a five-point Likert scale, and a section for the documentation of socio-demographic and medical factors. Its validity was tested in a sample of over 500 patients by concurrent administration of two psychometrically evaluated questionnaires (HADS and FBK). Only factors showing significant correlations of $r > .3$ with the questionnaire results were included. The inter-rater-reliability was tested based on 30 audio-taped interviews, comparing the ratings of three independent raters. The ICCs for the somatic and psychological total scores were .88 and .84 respectively. The sensitivity to change could be demonstrated assessing patients before and after radiotherapy. The standardised effect size for changes in patients' perceived somatic problems was .48. **Conclusions:** The PO-Bado provides the means for standardised psycho-oncological assessment. Its validity, reliability and sensitivity to change are established. *Supported by German Cancer Aid.*

**DOES DEPRESSION MODULATE AUTONOMIC CARDIAC CONTROL?** Siepmann M, Agelink M, Joraschky P, Rebensburg M, Poehlmann K, Mueck-Weymann M. Dept. of Psychosomatic Medicine, University of Dresden, Germany.

**Introduction:** Depressed patients have an increased risk of cardiovascular mortality which may be caused by impairment of psycho- neurocardiac control. Heart rate variability (HRV) can be employed as an indicator of psychoneurocardiac control. **Methods:** In the present study parameters of HRV such as root mean square of successive differences of RR intervals (RMSSD) were assessed in untreated outpatients with different degrees of depression during their first visit to our department by means of a standardised measurement device (ADI Inc., Australia). Patients were divided in two groups of 11 each by means of BDI scoring (BDI 9-19 minor to moderate depression and BDI 20-33 severe depression). Parameters of HRV of both patient groups were compared to those obtained from 11 sex and age matched healthy controls. **Results:** Subjects of the control group showed significantly higher RMSSD values as compared to those with slightly to moderately or markedly elevated BDI scores ($F=3.60$, $p=0.025$). **Conclusion:** Impaired autonomic cardiac control may link depressed mood with high risk cardiovascular by increasing the number of cardiac events.

**PLENARY SESSION: FUTURE DEVELOPMENTS IN CONSULTATION LIAISON PSYCHIATRY AND PSYCHOSOMATICS**
Chair: A. Lobo, Zaragoza — Thursday, June 24, 8.15 – 9.45, Saphir

**FUTURE DIRECTIONS IN CONSULTATION-LIAISON PSYCHIATRY.** Smith GC. University Dept. of Psychological Medicine, Monash Medical Centre, Clayton, Australia.

The results of the ECLW study suggest that developments in consultation-liaison (CL) psychiatry are likely to be heavily influenced by local culture and health service delivery funding structure. Nevertheless, certain developments in the professional organization of CL psychiatry and the evidence base on which it draws will be universal determinants of the future directions. CL psychiatrists are now well organized, with strong professional groups such as EACLPP in Europe and APM in North America, and similar groups in other countries, linked by the IOCLP. This considerable organizational force is a necessary part of future directions, because health service delivery funding bodies continue to deny the importance of physical/psychiatric co-morbidity and somatization. This is despite the fact that physical/psychiatric co-morbidity and somatization constitute the commonest forms of psychiatric presentation in the community, and are costly in terms of morbidity, mortality, health-care costs and the impact on family and health-care professionals. There is strong evidence emerging that psychiatric symptoms, particularly depression, even at sub-threshold levels, are major risk factors for the development of ischaemic heart disease, diabetes and stroke and for poor outcome in an even wider range of established illnesses. The neglect by funders is “epidemiologically unfair”. Lack of efficacy studies is often cited as justification for neglect. In many places, the absence of a seamless web of pre-admission/admission/post discharge functions prevents CL psychiatrists being able to audit outcome of their largely hospital-based practice. The difficulty in solving the methodological problems of researching complex medical illness is also a barrier to the establishment of a stronger evidence base. The future of CL psychiatry depends on successful addressing of these issues. That will require multidisciplinary research and political lobbying. In Australia, this has resulted in an acknowledgement of the importance of co-morbidity in the Third National Mental Health Plan. Proactive involvement with consumers is required; the success of schizophrenia support groups is a good example. The dilemma for CL psychiatry is that of how to move out of its inpatient hospital base and find a satisfying role in the community. This may involve a movement from primary to secondary and tertiary consultation; that would produce a very different type of CL psychiatrist, but it would mean that the large body of unmet need would be better addressed.

**THE SUB-SPECIALIZATION "PSYCHOSOMATIC MEDICINE" IN THE USA: FUTURE TASKS AND PRIORITIES.** Levenson JL, Dept. of Psychiatry; Virginia Commonwealth University, Richmond/VA, USA.

Psychosomatic Medicine (PM), also known as Consultation-Liaison (C-L) Psychiatry received approval as a Subspecialty field of psychiatry by the American Board of Medical Specialties in 2003, and the first certification examination will be in June, 2005. This represents the culmination of the development of the field of Psychosomatic Medicine in the U.S., and the recognition by leaders in the fields of medicine and psychiatry of its unique importance. The approval of subspecialty status for Psychosomatic Medicine will help promote the psychiatric care of patients with complex medical conditions, as well as foster further improvements in the quality of training and research in this important area, but our field has weaknesses as well as strengths, and faces threats as well as opportunities.

**RECOMMENDATIONS FOR THE DEVELOPMENT AND FUNDING OF C-L SERVICES IN EUROPE.** Herzog, T, Creed F, Dept. of Psychosomatics and Psychotherapy, Psychiatric Hospital Göppingen, Germany, and Dept. of Psychological Medicine, University of Manchester, UK.

**HOW TO OPERATIONALIZE THE BIO-PSYCHO-SOCIAL MODEL: THE INTERMED-METHOD - AN INTEGRATED CLINICAL RISK MANAGEMENT SYSTEM.** Huyse FJ[1], Stiefel F[2], [1]University Hospital Groningen, The Netherlands, [2]Psychiatry Service, University Hospital of Lausanne, Switzerland.

**Introduction:** In the last decade an international group of clinicians and researchers has developed and tested a risk management system. With this system the detection and analyses of patient's with multi-disease including psychiatric is facilitated to an empirical driven model allowing to initiate a multi-professional care trajectory for patients in need of it. Essential to the system is unity of information between healthcare professional of different professional backgrounds. One of the main advantages for C-L professionals is that departments or clinics who work with the system have more appropriate and timely referrals from a department who basically knows what is going on. These consults are more preventive. Therefore the method contributes to real operationalized liaison psychiatry. **Clinical implementation:** In addition to use in research projects to further validate the method, in the last years the system has been further developed for its use in clinical care. A DVD with 7 interviews to be used in training sessions and a software program has been developed. The software program is designed to be an integrated module of the doctors/nurses clinical working station, which allows. Part of the "poster" presentation is the presentation of the DVD showing the method including the clinical electronic module *Room Jade*

**HOW TO IMPLEMENT QUALITY MANAGEMENT IN C-L.** Herzog T[1], Stein B[2], [1]Dept. of Psychosomatics and Psychotherapy, Göppingen, [2]Dept. of Psychosomatic Medicine and Psychotherapy, University Hospital Freiburg, Germany.

Based on large scale experiences with the introduction of quality management (QM) in CL services across Europe a QM strategy developed for the specific needs of CL will be presented. This strategy focuses on internal quality management, but takes account of the increasing push towards external quality management (certification, accreditation etc.). Participants are requested to prepare lists of the most pressing quality issues in their local services or hospitals. This material will be used in the interactive part of the workshop. *Translation in German language if needed.* *Room Opal*

**PSYCHOPHARMACOTHERAPY IN SOMATICALLY ILL PATIENTS – PRINCIPLES, ITERACTIONS, RISKS.** Kapfhammer HP, Rothenhäusler HB. Psychiatric Department of Medical University, Graz, Austria.

Besides a supportive physician-patient relationship and symptom-/disorder-oriented psychotherapeutic approaches, pharmacological interventions play a major role in daily C-/L-activities. Substances of all major psychopharmacological classes may be used, antidepressants, however, being of superior relevance. As a basic rule, three pharmacological *principles* must be obeyed in using psychotropic drugs with somatically ill patients: (1) a detailed knowledge of possible adverse side effects of the major substance classes; (2) a survey on relevant interactions of psychotropic drugs with other drugs of clinical medicine, and (3) a thorough assessment of special pathophysiological processes in defined diseases and possible negative effects by a psychopharmacological intervention. These three principles have to be considered in a careful benefit-risk calculation for the individual patient. The workshop will deal mainly with two basic C-/L-psychiatric challenges in somatically ill patients: The pharmacological management of delirant patients on the one hand, of depressive-anxious patients on the other. The issue of *delirium* due to a general medical condition or due to multiple aetiologies will be dealt with in describing the clinical features, prevalence figures, clinical relevance, predisposing factors, major differential diagnoses, and use of neuroleptics. A proper neuroleptic treatment will be characterised in respect of side effects, interactions in hepatic metabolism, and possible negative effects on the pathophysiological process assumed to be causative. The issue of *depressive-anxious syndroms* due a general medical condition or due to multiple aetiologies will be dealt with in stressing diagnostic problems, and reporting on prevalence figures, clinical relevance and use of antidepressants. A proper pharmacological approach with antidepressants will be illustrated for special patients groups (e.g. cardiac and gastrointestinal diseases, liver and renal failure, malignant diseases, intensive care problems, defined neurological disorders) in respect of side effects, interactions in hepatic metabolism, and possible negative effects on the underlying pathophysiological processes.

*The workshop will be done in German language.*

*Room Turmalin*

**COMMON SYMPOSIA EACLPP AND ECPR**
Programme and abstracts see ECPR Thursday, June 24, 2004, 11.45 am – 1.30 pm

**Common Symposium 1: PSYCHOSOMATIC SERVICE SYSTEMS IN EUROPE** Room Saphir
Chair: K. D. Henke, Berlin, R. Kathol, Burnsville/MN

**Common Symposium 2: HEALTH AND SOCIAL ENVIRONMENT – SOCIAL DISADVANTAGE AND SOCIAL CAPITAL IN RELATION TO HEALTH** Room Rubin
Chair: A. Steptoe, London, P. Rosemeier, Berlin

**Common Symposium 2: DEPRESSIVE DISORDERS AND SOMATIZATION – PSYCHOTHERAPY OT PSYCHOPHARMACOTHERAPY?** Room Turmalin
Chair: J. Levenson, Richmond/VA, A. Lobo, Zaragoza

**BUSINESS MEETING – ANNUAL ASSEMBLY EACLPP**
Thursday, June 24, 2004, 1.30 – 2.30 pm, Room: Jade

**SPECIAL SESSION EACLPP AND ECPR "PSYCHIATRY IN NATIONAL SOCIALISM"**
Chair: A. Diefenbacher, Berlin, W. Söllner, Nuremberg Thursday, June 24, 2004, 7.30 – 9.00 pm; Room: Jade

**PSYCHIATRY AND PSYCHOTHERAPY IN NATIONAL SOCIALIST GERMANY.** Müller T, Beddies T, Center for the Humanities and Health Sciences, Institute for the History of Medicine, Benjamin Franklin Campus, Charité, Berlin, Germany.

In this mutual session of EACLPP and ECPR we will offer a medical historical contribution to this Berlin conference on psychosomatic research. Introducing into the issue of psychiatry and psychotherapy in National socialist Germany by sketching some of the preconditions and circumstances which led to the darkest chapter of German psychiatry, we will then focus on the years 1933-1945 by discussing the impact of Nazi ideology on this medical discipline, as well as portraying some of the crucial developments, political decisions and central personalities in psychiatry during this phase. Furthermore we will exemplify the harsh impact of political decisions on medical development by demonstrating the devastating consequences of these decisions on a singular form of psychiatric therapy and care. Psychiatry and Psychotherapy, for many reasons, cannot be considered seperately, during those years, although the different schools of psychotherapy and their representatives faced rather different situations once the Nazis were brought to power. After World War II, the Nuremberg trial on medical doctors marked a new step in the judgement of medical work, misconduct, of crime and murder initiated by medical doctors. We conclude by discussing the development of historiography on Nazi psychiatry as well as present forms of teaching the mentioned subjects to students in medical education in Germany.