S37. Treatments in consultation liaison psychiatry

Chairmen: S Wessely, M Musalek

THE ROLE OF PSYCHOPHARMACOLOGY IN LIAISON PSYCHIATRY

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Psychotropic drugs prescription is the most frequent therapeutic modality of consultation-liaison psychiatry in the general hospital setting. In many instances, it provides a substantial contribution to the management of acute psychiatric reactions and emergencies (e.g., delirium). These interventions are generally circumscribed and short-term. In other cases, however, the psychiatric consultant only starts a psychopharmacological treatment that should be continued once the patient is discharged from the hospital. The most important example is provided by use of antidepressants drugs in the medical patient. Psychotropic drug treatment in the setting of medical disease is a complex task that requires considerable skills and knowledge of specific interactions. The most viable approach in general psychiatric settings may not be the most suitable for medical patients. A few clinical examples are outlined. Long-term psychopharmacological strategies are likely to be successful as much as adequate follow up is provided. The clinical value of liaison outpatient clinics is underscored. Unfortunately, such services are currently neglected by consultation liaison psychiatry in Europe.

CONSULTATION LIAISON (CL) PSYCHIATRIC AND PSYCHOTHERAPY RESEARCH: TIME AS TREATMENT VARIABLE

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Objective: Time is a central but often neglected aspect of any psychological treatment and of particular importance under restricted conditions of psychiatric or psychosomatic consultations in the general hospital or practice. The following questions are being addressed: 1) How much time is realistically available under everyday practice conditions? 2) What are the kind of effects that we can (and cannot) expect given the time available? 3) What consequences does this have for CL treatment research and clinical practice?

Method: 1) Examination for CL patterns of the ECLW data base of 14,717 consecutive consultations across Europe [1]. 2) Review of psychotherapy research on the differential effect of time with special emphasis on de dose–effect paradigm [2] and the phase model [3].

Results: 1) Most consultations are restricted to little more than two contacts (M=2.5; SD=2.6) and the total time available for a given episode rarely exceeds two hours (M=121′,SD=160′). In more than 50% of all consultations the interventions are purely psychological. 2) Many patients already respond to a diagnostic assessment and some therapeutic effect can be expected for 50% of psychotherapy patients after eight sessions [2]. Treatment response may be in three phases, each dependent on the other: progressive improvement of subjectively experienced well-being, reduction in symptomatology, and enhancement of life functioning [3]. Chronic distress symptoms respond fastest and characterological symptoms slowest. Acute distress symptoms show the highest average of patients recovered across doses [4].

Discussion: Research on psychological treatments in CL and clinical practice must both take on the reality of service delivery and the time requirements for different therapeutic goals into account.

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[2] Howard KI, Kopta SM, Krause MS, Orlinsky DE (1986) The dose–effect relationship in psychotherapy. Am Psychol 41: 159–164.
[3] Howard KL, Lueger RJ, Maling MS, Martinovich Z (1993) A phase model of psychotherapy outcome: causal mediation of change. J. Consult Clin Psychol 61: 678–685.
[4] Kopta SM, Howard KI, Lowry JL, Beutler LE (1994) Patterns of symptomatic recovery in psychotherapy. J Consult Clin Psychol 62: 1009–101

PSYCHOTHERAPY IN LIAISON PSYCHIATRY

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The main clinical areas of concern to the general hospital liaison psychiatrist are those of medically unexplained symptoms, medical/psychiatric comorbidity and deliberate self harm. This presentation will focus particularly on the application of cognitive behaviour therapy to these problems. The cognitive behavioural conceptualisation offers an integrated approach ideally suited to liaison psychiatry. The strengths and weaknesses of cognitive behavioural therapy in the medical setting will be examined and the empirical evidence for its effectiveness reviewed. Finally the need for integrating psychotherapeutic approaches into general medical care and the obstacles encountered will be examined.

S38. Treating psychoses in the first half of the 20th century

Chairman: TH Turner

Abstracts not received.

S39. The long-term care and management of psychoses in the elderly

Chairmen: R Howard, B Lawlor

PSYCHOSIS AND BEHAVIOURAL DISTURBANCE IN THE ELDERLY: PREVALENCE, PHENOMENOLOGY, DIFFERENTIAL DIAGNOSIS

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The management of behavioural changes in elderly patients is one of the more difficult challenges in clinical medicine and calls on multiple skills in the practitioner. However, adequate description of symptoms, signs and comprehensive differential diagnosis must precede decisions regarding treatment intervention. Given the demo-

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