of parents, health problems of one of the parents, reason of referral, behavioral problems during childhood, school functioning, options offered to the adolescents before referral by the community agents and the therapeutic approaches proposed by the clinicians.

It is as yet unclear whether these findings relate to differences in the clinical characteristics of the patients or to differences in environmental and cultural approaches.

S63. Generalised anxiety disorder: facts and controversies

Chairs: HGM Westenberg (NL), J-P Lépine (F)

S63-1
No abstract received

S63-2
No abstract received

S63-3
THE NEUROBIOLOGY OF ANXIETY DISORDERS

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Pathological anxiety can be defined as exaggerated normal fear characterized primarily by hypervigilance biased to aversive stimuli and emotions related to a sense of uncontrollability and uncertainty. Clinically, a number of separate anxiety disorders can be discerned. The distinctions between these conditions, presented in the DSM-IV and ICD-10, are primarily based on clinical features.

From a neurobiological perpective, the distinctions between these diagnostic entities are less clear. Thus, patients with anxiety disorders are, regardless of their diagnosis, more sensitive to the panicogenic properties of pentagastrin and sodium lactate than healthy controls. mCPP, a 5-HT_{2C} receptor agonist, elicites anxiety in patients with panic disorder (PD) and generalized anxiety disorders (GAD) to a higher degree than in controls. The growth hormone response to clonidine is blunted in all anxiety disorder patients and SSRI's have shown to be efficacious in patients with an anxiety disorder, irrespective of the diagnostic category. On the other hand, 5-HT_{1A} receptor agonists, such as buspirone and flesinoxan, but not in subjects who qualify for PD or social anxiety disorders. Preclinical data have revealed the amygdala and its connection to play a central role in normal and pathogical anxiety. This fear circuitry evaluates the degree of threat posed by internal and external cues and it adds to the emotional coloring of interoceptive, exteroceptive and proprioceptive cues. Therefore, hyperexcitability of the amygdala could be central in the development and maintenance of pathological anxiety. Serotonergic pathways to these structures play a role in the excitability of this circuitry. The global anxiolytic effects of SSRIs could be accounted for by an amplified inhibition of this fear circuitry. The differential effects of 5-HT selective compounds are more difficult to explain, but the fact that different 5-HT receptors with opposite effects on this fear-circuitry are implicated, could explain these paradoxical findings.

S63-4
THE TREATMENT OF GENERALIZED ANXIETY DISORDER

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Generalized Anxiety Disorder (GAD) was first delineated as a distinct syndrome in the DSM-III in 1980. The logic for the break up of the prior parent disorder anxiety neurosis into 2 entities-panic disorder and GAD-was fundamentally driven by a concept of pharmacological dissection. GAD was believed to be the benzodiazepine sensitive syndrome, and was probably not sensitive to antidepressants. Panic disorder was the antidepressant responsive syndrome and not thought at the time to be sensitive to benzodiazepines. A series of international studies in the 1980s demonstrated that panic disorder was responsive to benzodiazepines as well as tricyclic antidepressants and MAO inhibitors. GAD continued to be treated with benzodiazepines and 5HT1a agonists became the other widely adopted treatment.

Recently, as the range of indications for SSRIs and SNRIs grows, several large European and US studies have been conducted on their use in GAD. The most thoroughly studied of the newer medications is Venlafaxine-ER. Two double-blind, placebo controlled, 8 week outpatient studies using Venlafaxine-XR will be presented. In the first study 377 GAD patients were randomly assigned to either placebo, 75 mg, 150 mg or 225 mg per day in a fixed dose study design. The 225 mg/day dose was significantly superior to to placebo on all outcome measures, while the 150 mg/day dose was superior to placebo on several outcome measures. The 75 mg/day dose was not significantly superior to placebo. In the second study, 405 patients with GAD who did not have comorbid major depression were randomly assigned to either placebo, buspirone 10 mgs t.i.d., Venlafaxine-XR 75 mgs/day or Venlafaxine-XR 150 mgs/day. Both Venlafaxine-XR doses separated significantly from placebo on several outcome measures, while buspirone failed to separate from placebo on any outcome measure. The results suggest that the newer antidepressants like Venlafaxine-XR are effective in the treatment of GAD.

S63-5
No abstract received

S64. Consultation-liaison psychiatry

Chairs: P Fink (DK), R Mayou (UK)

S64-1
No abstract received

S64-2
PREVALENCE OF, SCREENIG FOR AND GPS' RECOGNITION OF SOMATOFORM DISORDER IN PRIMARY CARE

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The purposes of the study were to investigate the prevalence and nature of somatization illness in primary care, to assess the general practitioner's ability to recognize somatization, and to evaluate the Whiteley Index for Hypochondriasis as a screening tool.

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Method: A questionnaire including the SCL-25 was applied to patients (n = 191) consecutively consulting their family physician in a catchment area - a part of the City of Aarhus, Denmark. All patients with a high SCL-25 score (n = 44) and a random sample of the low score patients (n = 55) were interviewed by means of SCAN (Schedules for Clinical Assessment in Neuropsychiatry). Further, the Whiteley Index for Hypochondriasis was applied.

Results: The SCAN interview showed that 60.6% of the 99 interviewed patients had at least one medically unexplained physical symptom and 24.2% fulfilled the diagnostic criteria for a ICD-10 somatoform disorder and 59.9% for a DSM-IV somatoform disorder, and 30.3% if excluding the DSM-IV Not Otherwwies Specificed (NOS) diagnostic group. Using ICD-10 criteria the prevalence of somatoform disorders among all the 191 screened patients was calculated to 22.3% (CI-95%: 16.4–28.1) and 57.5% (CI-95%: 50.5–64.5) using DSM-IV criteria and 30.3% (CI-95%: 23.8–36.9) excluding the NOS group. The internal and external validity of the Whiteley Index were tested by latent struc-ture analysis and ROC analysis, and a short 7-item version of the index including two subscales was developed. At a cut point of zero/one, the Whiteley-7 Scale detected all ICD-10 somatoform disorders and 71% of DSM-IV somatoform disorders

The GP's recognized about half of the patients with a somatoform disorder according to the SCAN interview. The GPs' ability to recognize other mental disorders was not significantly influenced by the presence of a somatoform disorder.

Patients with somatoform disorders used more non-psychiatric health care facilities than other patients ($p = 0.01$).

Conclusions: Somatization is very prevalent in primary care but frequently not recognized by the GP. The somatizing patients use more health resources than other patients. The Whiteley-7 questionnaire may be helpful for aided recognition.

S64-3
PSYCHIATRIC MORBIDITY IN A MEDICAL DEPARTMENT

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Objectives: To determine the prevalence and character of mental illness and symptoms in an internal medical department, and the association with the type and degree of somatic illness, length of stay, and complexity of care.

Material and Methods: Two hundred and ninety-four consecutive internal medical patients were interviewed the day after admission, at discharge, and by follow-up. A two-step design was employed for the investigation, using *ARSI,* a special interview form developed in connection with the Biomed1 Risk Factor Study in the frame of ECLW (European Consultation Liaison Workgroup), for screening, and *SCAN (Schedules for Clinical Assessment in Neuropsychiatry)* for case interviews.

By means of interviews with the patients and the medical and nursing staff, and from medical records, additional information was obtained on sociodemographic data, discharge diagnoses, health perception, compliance, health care utilisation, social support, somatic illness, and on the complexity of care, the concept of which is also developed within the Biomed1 Risk Factor Study.

Results: Preliminary results concerning the prevalence of mental illness in general, and of specific psychiatric diagnoses, will be presented. Comparisons regarding sociodemographics, somatic illness, length of stay, and complexity of care, will be made between the diseased group and the group identified as symptom-free.

S64-4
SCREENING FOR SOMATOFORM DISORDER IN MEDICAL OUTPATIENT CLINICS

R.C. Peveler. *Mental Health Group, Faculty of Medicine, University of Southampton, UK*

Objective: to test the ability of a screening questionnaire ("SQUASH"), completed by physicians, to predict the presence of somatoform disorder and other psychiatric disorder, clinical outcome, functional status, and healthcare costs in consecutive new patients attending medical outpatient clinics.

Design: Analysis of sensitivity, specificity and positive and negative predictive value of screening instrument compared with "gold standard" interview and outcome measures.

Main Outcome Measures: Screening instrument to identify somatoform disorder. Investigator-based research diagnostic psychiatric interview (SCAN/ICD-10). Functional status (SF-36). Healthcare utilization and costs.

Results: 344 eligible patients attended during the period of study. 249 subjects completed an interview (72%). 66% had clear-cut physical disease sufficient to explain their symptoms, whilst 34% had symptoms not explained fully by disease; 22% received a diagnosis of irritable bowel syndrome. 16% met criteria for a current depressive or anxiety disorder; 22% met criteria for somatoform disorder. Psychiatric disorder was much more common in patients with unexplained symptoms (83%) than in patients with clear-cut physical disease (20%).

The screening instrument was acceptable to and completed satisfactorily by the clinic physicians. Analysis of somatoform disorder prediction revealed that one questionnaire item, the physician's impression of the cause of the symptoms, correctly identified 85% of patients (sensitivity 62%, specificity 92%).

Discussion: The study confirms that medically unexplained physical symptoms are common in this setting, and are strongly associated with psychiatric disorder. The screening instrument enables physicians to identify somatoform disorder patients with a high degree of accuracy, although it requires further evaluation and development.

S64-5
PATIENTS PRESENTING TO CARDIOLIGISTS WITH THE COMPLAINT OF PALPITATIONS

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The symptom of palpitations is one of the commonest reasons for referral to cardiologists. We have conducted a study of 200 consecutive referrals from primary care to cardiologists providing a district service. Patients attended a research assessment 2–3 weeks before the clinic visit at which they completed questionnaires, were interviewed and underwent an assessment of heart rate. The cardiologist's assessment was coded and all patients were sent a postal questionnaire at three months. Eighty subjects with benign palpitations were recruited to an randomised controlled trial of a brief cognitive behavioural treatment-based intervention by a cardiac nurse and assessed in terms of symptomatic, psychological and quality of life outcome.

- Only 34% of subjects had evidence of medically significant arrhythmias, the others were assessed as being either abnormally aware of sinus tachycardia (23%) or of abnormalities of rhythm (such as extra beats) within normal limits (43%). Psychiatric disorder occurred in a minority of subjects and was most frequent in the sinus rhythm group (panic attacks 48%; panic