Conclusion: ECT is not useful in the therapy of obsessive-compulsive disorder.

(1) Reuven D. *Treatment of obsessive-compulsive disorder.* Current Opinion in Psychiatry 1996, 9:125–128
(2) Dolberg OT et al. *Treatment duration of obsessive compulsive disorder.* Eur Psychiatry 1996; 11:403–406

Mon-P36

CLINICAL VARIANTS OF OBSESSIVE-COMPULSIVE DISORDERS OF ORGANIC GENESIS

A. Maksoutova[1] *, E. Jeleznova[1], L. Sokolova[1]. [1] *Moscow Research Institute of Psychiatry, Ministry of Health, Russia*

We analysed the group of patients (N = 44) of specialized hospital of exogenous-organic psychical disorders and epilepsy. These patients were suffering from the consequences of the organic decease of brain with different genesis including neonatal pathology, repeated brain injures, neuroinfections etc. In the status of 26 patients we diagnosed paroxysmal disorders. The control group included patients with the same psychical disorders suffering from schizophrenia. Comparative clinical and psychopathological analysis of obsessive - compulsive disorders in both groups demonstrated some specialities of structure and dynamics of the following syndromes, determined by the organic brain decease including secondary neurotic mechanisms. Compulsive ideatoral and motoric disorders appeared in patients with the different range of psycho-organic syndrome including mnemic and intellectual, paroxysmal disorders and psychopathic behaviour. Affective disorders also frequently accompanied or preceded obsessive and compulsive syndromes, such as anxious depression, dysphoria. The contents of impulsive-compulsive syndromes were simple, without tendency to complication. Also some obsessions stereotyped, frequently repeated, but symbolic actions we observed seldom. In dependence with the dominating components of obsessive-compulsive syndrome we can distinguish the following variants: 1. motoric (simplex and complex compulsive disorders); 2. ideatoric obsessions; 3. mixed disorders with the symptoms of 1 and 2 variants.

Mon-P37

PHENOMENOLOGY OF OBSESSIVE-COMPULSIVE SYMPTOMS IN NON-REFERRED POLISH ADOLESCENTS

A. Bryńska, T. Wolańczyk *, B. Goszczyńska. *Department of Child Psychiatry, Warsaw Medical Academy, 00-576 Warszawa, Poland*

Obssesive-Compulsive Disorder (OCD) is a debilitating problem for many patient who suffer from it. Phenomenology of OCD is well described, however in referred patients. There are a few studies concerning the obsessive-compulsive symptomatology in non-referred child and adolescent population. In practically all studies, obsessions regarding dirt and contaminations, as well as compulsive washing rituals, are described as the most common symptoms.

Objective: To assess the phenomenology and severity of obsessions and compulsions in a nonclinical adolescents population.

Method: In the second part of a two-stage epidemiological study of obsessive-compulsive (OC) symptoms in non-referred adolescents, clinicians interviewed 148 primary schools pupils selected based on the Leyton Obsessional Inventory-Child Version administered in the first stage: 96 subjects reflecting possible subclinical or clinical OCD and 52 from control cohort. Severity of OC symptoms was assessed with the Children's Yale-Brown Obsessive-Compulsive Scale.

Results: The OCD cases identified (10 from high-risk cohort and 1 from control cohort) had characteristics similar to those of clinical cases. Of special interest is that none of these children were under the professional care. The were no significant differences between prevalence of subclinical OCD in these both cohorts.

Mon-P38

CREATIVE THERAPY AND SOCIAL PHOBIA. A NATURALISTIC CASE-STUDY

C. Gois. *Department of Psychiatry. Hospital Santa Maria. Lisbon, Portugal*

A twenty-two years-old female with social phobia (DSM IV) was in treatment for five mounths in a weekly consultation basis with a creative therapy technique, without any psychopharmacologic medication, and with total symptomatic remission. Drawing, painting and storymaking with pictures aid, were used to achieve meaningfull representations of emotionally charged past and present situations. Memory for visual information is sometimes greater than for verbal information and what we tend to remember is the picture's meaning, not its physical appearance. As past recollections often become distorted by the "misinformation effect", even when they produce "catarsis", the present case-study discusses the results not on a reupdating conflicting memories basis, but within a cognitive changing life-narrative framework and a modified systematic desensitization approach, using a imagining creative technique as a facilitator. As social phobia is usually rooted in a very strong imagery, when assotiated with specific personality traits, the author thinks that this kind of creative and integrative therapy could represent a good tool for this particular pathological situation, what needs obviously replication with a representative sample.

Mon-P39

PAROXETINE IN SEVERE SOCIAL PHOBIA

S.A. Montgomery[1] *, C. Pitts[2], R. Oakes[2], B. Hunter[3], I. Gergel[2]. [1] *Imperial College School of Medicine, St Mary's Hospital, London;* [3] *SmithKline Beecham Pharmaceuticals, Harlow, Essex, UK* [2] *SmithKline Beecham Pharmaceuticals, Collegeville, PA 19426, USA*

Social phobia is a common and treatable condition. However, sufferers are reluctant to request medical help and by the time they present for treatment, the condition may have developed into a severe form associated with secondary comorbidity and maladaptive behaviour. Both patient disability and the most serious consequence of severe social phobia, suicidality, are increased with disease severity and the presence of comorbidity. Clearly, treatment of social phobia must be shown to be effective in patients with the most severe disorder and, ideally, should also be effective in common comorbid conditions, such as depression.

The SSRI paroxetine has previously been shown to be effective in a large randomised trial in patients with social phobia. The efficacy of paroxetine in severe social phobia was examined in a post hoc analysis of this 12-week, placebo-controlled trial. Severity of social phobia was defined as severe (Liebowitz Social Anxiety Scale (LSAS) total score $\geq$ 82; n = 85), moderate (LSAS total score 52–81; n = 78) or mild (LSAS total score $\leq$51; n = 19). At the end of treatment, the paroxetine-placebo difference in mean LSAS total score was greater in the severely affected patients (20.0; p = 0.001) than those with moderate disease (13.7; p = 0.02). Similarly, the paroxetine-placebo difference in percentage of patients rated as 'very much' or 'much' improved, as rated by Clinical Global Impression global improvement scores, was greater in the severe

group (34.2%; p = 0.0001) than in the moderate group (29.1%; p = 0.02). Clearly, paroxetine has been shown to be effective in treating both moderate and severe social phobia and the response is more distinct in patients with severe symptoms.

Mon-P40

THE SYMPTOM STRUCTURE OF GENERALIZED ANXIETY DISORDER REVISITED

V. Starcevic[1,2]*, G. Bogojevic[1]. [1]*Institute of Mental Health, Belgrade;* [2]*University of Belgrade School of Medicine, Belgrade, Yugoslavia*

Objective: To re-examine the symptom structure of generalized anxiety disorder (GAD) and significance of each symptom as diagnostic criterion for GAD in view of the large difference in the conceptualization of GAD between DSM-IV (too narrow) and ICD-10 (too wide).

Method: The Structured Clinical Interview for DSM-III-R (SCID), modified for DSM-IV and ICD-10 Diagnostic Criteria for Research (ICD-10-DCR), was administered to 76 consecutive patients with agoraphobia/panic disorder, many of whom had a comorbid GAD. Patients diagnosed with GAD on the basis of DSM-IV (N = 44) and ICD-10-DCR (N = 45) were compared in terms of the GAD symptom endorsement. Considering high comorbidity rates of GAD with other mental disorders, the ICD-10-DCR diagnostic hierarchy rules were disregarded, because very few, if any patients, would have been diagnosed with GAD if these rules had been followed.

Results: The diagnostic agreement between DSM-IV and ICD-10-DCR for GAD was high (kappa = 0.86). The analysis of frequency of GAD symptoms in 47 patients suggests that there are three groups of GAD symptoms in DSM-IV and ICD-10-DCR: seven "first-rank" symptoms (inability to relax, restlessness, feeling keyed up or on edge or mentally tense as one symptom, easy fatigability, exaggerated startle response, muscle tension, sleep disturbance, difficulty in concentrating, and irritability), five "second-rank" symptoms (nausea or abdominal distress, sweating, dry mouth, palpitations/tachycardia, and trembling/shaking), and the remaining ten ICD-10-DCR symptoms - to be excluded as diagnostic criteria both because of their relatively low frequency and low specificity for GAD. Thus, a diagnostic conceptualization of GAD may be improved with the requirement of a minimum of four of the seven "first-rank" symptoms and one of the five "second-rank" symptoms.

Conclusions: Our results suggest a potential usefulness of this ranking and combination of diagnostic criteria, because it might provide a more accurate description of GAD and its better differentiation from depression and other anxiety disorders. This effort might contribute to revisions of the existing GAD criteria in both diagnostic systems.

Mon-P41

ANXIETY DISORDERS AND SOMATIC ILLNESSES

E. Panagoulias*, P. Papadopoulos, D. Malidelis. *Mental Health Center of Peristeri, 121 35 Athens, Greece*

The aim of this study was to find the presence of possible differences, as far as the outcome is concerned between patients diagnosed as "anxiety disorders" (DSM-IV) with coexistence or not of somatic illnesses (not only symptoms).

Our material was the adults patients of our Center with the above-mentioned diagnostic category, who visited us within a period of one year. The total number was 76 persons, divided in two groups: anxiety disorders with somatic illnesses (group A, n = 23) and anxiety disorders without somatic illnesses (group B, n = 53). We examined parameters such as: age, marital status, previous contacts with psychiatric services, type of therapeutic intervention and outcome.

The different findings between two groups, are limited to age and marital status. More specifically, in group A the percentage of those aged 61 and above, is clearly higher (26.1%) than those in group B (5.7%). Similarly the percentage of the widows in group A is higher (21.7%) in comparison to group B (3.7%). Based on the outcome, we didn't find any differences between two groups.

In conclusion - and aware of the small number of patients- it seems that the existence of somatic illnesses did not affect the outcome as regards the psychopathology of the studied cases.

Mon-P42

ONCE-DAILY VENLAFAXINE XR VERSUS BUSPIRONE IN OUTPATIENTS WITH GENERALIZED ANXIETY DISORDER

L. Aguiar, J.T. Haskins, R. Rudolph*. *For the Venlafaxine XR 214 Study Group, Wyeth-Ayerst Research, Philadelphia, Pennsylvania, USA*

This was an 8-week, double-blind, placebo-controlled, randomized, parallel group study to compare the efficacy and tolerability of once-daily venlafaxine XR and buspirone in outpatients with generalized anxiety disorder (GAD). Outpatients satisfying DSM-IV criteria for GAD with a minimum score of 18 on the HAM-A total and scores of $\geq$ 2 on item 1 (anxious mood) and item 2 (tension), a Covi Anxiety Scale score higher than the Raskin Depression Scale score, and a Raskin score $\leq$ 9 were eligible. Patients with major depressive disorder were specifically excluded. Eligible patients were randomly assigned to treatment with placebo, once-daily venlafaxine XR 75 or 150 mg/day, or buspirone 30 mg/day. The primary efficacy variables were the final on-therapy scores for the HAM-A total and HAM-A psychic anxiety factor and the CGI scale. Data for 369 patients were analyzed on an intent-to-treat basis with the last-observation-carried-forward for dropouts. The venlafaxine XR 75 and 150 mg groups showed statistically significant greater improvement than the placebo group at various time points on the HAM-A psychic anxiety factor, anxious mood and tension items, and on the CGI scale. On the patient-rated HAD anxiety subscale, both venlafaxine XR groups showed statistically significant greater improvement than either placebo or buspirone. The safety profile was consistent with venlafaxine and venlafaxine XR use in depressed patients. These results demonstrate that once-daily venlafaxine XR is well tolerated and more effective than placebo for treatment of GAD in outpatients.

Mon-P43

DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY OF ONCE DAILY VENLAFAXINE XR IN OUTPATIENTS WITH GENERALIZED ANXIETY DISORDER

J.T. Haskins, R. Rudolph*, L. Aguiar. *For the Venlafaxine XR 210 Study Group, Wyeth-Ayerst Research, Philadelphia, Pennsylvania, USA*

This randomized, double-blind, placebo-controlled, 8-week study evaluated the safety and anxiolytic efficacy of once daily venlafaxine XR in outpatients with generalized anxiety disorder (GAD). Patients who met DSM-IV criteria for GAD could be enrolled in the study. Patients who had a recent diagnosis of major depression, had a Raskin Depression Scale (RDS) score greater than the Covi Anxiety Scale score, had a total RDS score greater than

https://doi.org/10.1016/S0924-9338(99)80376-9 Published online by Cambridge University Press