## S56-4

NEW FINDINGS IN THE PHARMACOLOGICAL TREATMENT OF PANIC DISORDER

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Clinical efficacy has been found for a variety of drugs in controlled clinical trials of panic disorder, including benzodiazepines (especially alprazolam and clonazepam), tricyclic antidepressants (especially clomipramine and imipramine), classical monoamine oxidase inhibitors (e.g. phenelzine) and Serotonin Specific Reuptake Inhibitors (SSRIs). Controlled clinical trials on all SSRIs on the marked (citalopram, fluvoxamine, fluoxetine, paroxetin and sertraline) have been published in the litterature or presented at international meetings indicating significant efficacy in panic disorder. Both short and long-term studies have been performed. Thus, extensive data on important variables with respect to drug treatment of panic disorder are available, including time course of improvement, overall efficacy of drug treatment, spectrum of side effects and comorbidity.

The studies on drug efficacy on panic disorder have great importance for the theoretical conception of the disorder. Several new antidepressants with a different pharmacodynamic profiles have recently been introduced. Venlafaxine, a specific noradrenalin and serotonin receptor uptake inhibitor, and mirtazapine, a drug which via a blockade of the noradrenaline $\alpha_2$-autoreceptors enhances noradrenergic and serotonergic neurotransmission, but apparantly without stimulating postsynaptic 5-$HT_2$ and 5-$HT_3$ receptors. Their roles in the treatment of panic disorders await future studies. However, there is some evidence that velafaxine has anti-panic properties. Moclobemide, a reversible monoamine oxidase A inhibitors can be prescribed without the dietary restrictions needed for the classical irreversible monoamine oxidase inhibitor. However, controlled clinical trials are few.

Fragments of the neuropeptid cholecystokinin have anxiogenic properties, and the tetrapeptide $CCK_4$, a selective cholecystokinin receptor B agonist, induces panic-like symptoms in normals and in panic patients, A $CCK_B$ receptor antagonist is available, and preliminary evidence may suggest a role for drugs interacting with the CCK-system.

## S56-5

PSYCHOLOGICAL AND BIOLOGICAL RESPONSE PREDICTION TO PHARMACOTHERAPY IN PANIC DISORDER?

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In Panic Disorder (PD) pharmacotherapy, with compounds like tricyclic antidepressants, selective serotonin reuptake inhibitors, high-potency benzodiazepines and monoamine oxidase inhibitors, has proven to be effective in reducing anxiety and the number of panic attacks. Since not all patients respond to treatment, and because of the delayed onset of most of these drugs and the occurrence of side effects, it would be very welcome if response could be predicted. Until now quite a number of studies have investigated predictors of response to pharmacotherapy in PD, enabling us to draw some conclusions on factors which may obstruct effective therapy.

For this exploration all studies have been included which investigated baseline predictors of nonresponse to pharmacotherapy and used at least DSM-III criteria. Both short term studies (2–32 weeks) and long term studies (1–7 years) will be discussed.

Variables measuring severity of illness and the presence of comorbid disorders seem to be the most robust predictors of response.

Furthermore it appears that some predictors gain importance when patients are studied for a longer period. Duration of illness, agoraphobic avoidance and a comorbid depression predicted nonresponse especially in long term studies.

A few studies have investigated biological predictors of nonresponse. Mean 24-hour cortisol levels, plasma MHPG and heart rate were found to be predictors of response to pharmacotherapy.

Nonresponders to pharmacotherapy appear to be characterised by a greater illness severity and comorbid disorders. Standard treatment is not efficient for this subgroup of patients, which is about 20 to 40% of all patients treated.

## S56-6

COMORBIDITY AND ITS CLINICAL RELEVANCE IN PANIC DISORDER

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Available data from the literature supporting the hypothesis that partial manifestations of the panic-agoraphobic spectrum may be as clinically relevant as a full-fledge syndrome were reviewed. These partial expressions of disorder may occur singly or in connection with other mental disorders. In particular, we have examined evidences indicating relationships of panic-agoraphobic spectrum with other mental disorders in childhood and adolescence and with psychotic disorders. Their importance in childhood and adolescence is important because we believe that these symptoms influence adult behavior and are viewed, at that later time, as atypical symptoms. Panic-agoraphobic spectrum syndromes, both in their full-fledged and partial manifestations frequently co-occur with other mental disorders and are likely to be associated with significant impairment either when occurring singly, partially or comorbidly. Several conditions typical of childhood, such as separation anxiety, school phobia and other symptoms related to the concept of 'behavioral inhibition' seem to be connected with the panic-agoraphobic spectrum and deserve attention in relation to the development of different anxiety and mood disorders in subsequent phases of the life cycle. Identification of panic-agoraphobic spectrum features is also important within the realm of psychoses where they may substantially affect phenomenology, course of illness and treatment response.

# SEC57. Evaluation and treatment of juvenile delinquents

*Chairs*: P Cosyns (B), F Beyaert (NL)

## SEC57-1

RECENT CHANGES IN COERCIVE HELP OF MINORS IN FINLAND

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Involuntary hospitalisation of adolescents was widely discussed in the Finnish Parliament in the beginning of this decade. A new Mental Health Act entered into force in Finland in 1991. In addition to "mental illness" also a lighter criterion for commitment, "serious mental disorder" was included in the Act. When the Act was being discussed, also psychiatrists and child psychiatrists gave

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conflicting statements on the appropriateness of this provision. As a result of the discussion, the Ministry of Welfare and Health organised this study to assess the changes in practice due to the new Act. The study assesses coercive helping of minors in 1991–1993 and compared two groups of committed children ("serious mental disorder" and "mental illness") with children who were taken into care involuntarily on the basis of the Child Welfare Act and also with prisoners under the age of 18.

The first part of the study dealt with the documentary material of all persons under the age of 18 subjected to coercive measures in Finland (n = 434). The second part was based on interviews of 94 minors from the first part. It studied the relationship of minors who had been objects of coercive measures to social welfare and health care and their experiences and opinions about the coercive measures and their appropriateness.

The amount of involuntary care of minors almost doubled during the period studied. There were no changes in the number of commitment on the basis of mental illness. Instead, commitment on the basis of the new criterion, a serious mental disorder, increased yearly. Those committed on these grounds had more behaviour disorders and behaviour indicating risk of suicide than those committed because of mental illness. The change in involuntary psychiatric treatment was not reflected as changes in the coercive measures in child welfare nor the number of minor prisoners or the quality of the problems of the prisoners. The interviewed children experienced the coercion as confusing, unexpected and distressing. Those that had been in psychiatric treatment had the most positive attitude towards authorities. More than two thirds of them felt that they had benefited from the coercion.

One half of involuntarily committed minors were given treatment in units meant for adults. In this respect the Convention on the Rights of the Child was not observed in Finland. Since then new inpatient units have been opened, minors are more often treated in child and adolescent units and those treated among adults are most frequently 16 or 17 years of age.

## SEC57-2
### CASE FINDING IN ARRESTED JUVENILE DELINQUENTS

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In the Netherlands the public prosecutor is obliged to contact the Council of Child Protection. In case of a police-warrant the youngster involved is invited with his/her parents for an examining interview at the Council's office; in case of custody a social worker of the Council pays a visit to the youngster detained at the police office. In both cases a diagnostic screening is carried out. Authors developed a case finding instrument as a format for the early-help report for the judge and - secondly - to detect psychopathology in the young suspects. The Council may decide to do further examination of the person and/or of the family. Or to refer for diagnostic assessment. The instrument including indicators for psychopathology will be presented.

## SEC57-3
### JUVENILE SEXUAL DELINQUENTS

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**Objective:** This study compares adolescent sexual and adolescent assaultive offenders with regard to their personal development and their family characteristics.

**Method:** A defined sample of adolescents who had commited sexual offenses against female victims of their own age or older ("rapists", n = 38) and against child victims ("molesters", n = 36) were compared to adolescent assaultive offenders ("assaulters", n = 33) by means of questionnaires and intelligence tests during ongoing criminal proceedings.

**Results:** "Molesters" were most stressed regarding their physical and social development, several parent characteristics and family interactions. "Rapists" grew up under the best conditions up to the age of 14, but their integration into a peer group markedly worsened thereafter. "Assaulters" often experienced dissocial fathers and stood out with a higher incidence of conduct disorders in school.

**Conclusions:** The change in contact behavior of "rapists" towards peers may be the result of impaired intrafamilial relationships. The various stresses on the "molesters" may be responsible for considerably impaired attachment. In contrast, "assaulters" seek acknowledgement and recognition outside the family early on, although the peer group cannot always provide this.

## SEC57-4
### EVALUATION AND TREATMENT OF JUVENILE DELINQUENTS

Susan Bailey. *Consultant Adolescent Forensic Psychiatrist, Adolescent Forensic Service, Mental Health Services of Salford, Bury New Road, Prestwich, Manchester, M25 3BL, UK*

A study of the Demand and Need for Forensic Child and Adolescent Mental Health Services in England and Wales (Kurtz, Thornes, Bailey 1997 - DOH) revealed a group of adolescents with complex pathology, disturbance coexisting with other disabilities. They aroused major social concern because of violent, sexual fire-setting and multiple offending. In earlier childhood they suffered a range of difficulties, disturbance of temperament, intrafamilial discord, physical emotional and sexual abuse, multiple loss, global and specific developmental disorders and neuropsychiatric disorder. Current common relevant diagnoses were psychotic illness, conduct disorder, mixed disorder of conduct and emotion and substance abuse. Future concerns were of major psychosis, antisocial personality disorder and associated risk to others.

Combining the results of this study with clinical data on the series of adolescent offenders male and female (murder, violence, sex and arson) assessed and treated by the Adolescent Forensic Service (1983–1996) led to the development of the Salford Adolescent Forensic Inventory Assessment Schedule (SAFION 97) and parallel Adolescent Risk Assessment Schedule (ARAS 97) now being piloted for use by non health professionals - residential carers, youth justice workers, educationalists and prison officers.

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