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 α_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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