S56. Evaluations in functional psychiatric illness

Chairmen: M Philpot, L Gustafson

DEPRESSION, PHYSICAL HEALTH AND DISABILITY IN LATER LIFE: A PRAGMATIC APPROACH BASED ON THE FINDINGS OF THE LONGITUDINAL AGING STUDY AMSTERDAM (LASA)

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The contribution of depression to disability and impaired well-being has been studied primarily in younger adults. In a random community-based sample of older inhabitants of the Netherlands (55–85 years), which was stratified for age and sex, associations of major and minor depression with well-being and disability were studied. Major depression was diagnosed in a two stage screening procedure, using the Center for Epidemiologic Studies Depression Scale as the screenings instrument (n = 3056), and the Diagnostic Interview Schedule as the criterion (study sample, n = 646). Minor depression was defined as all depressive syndromes, not fulfilling diagnostic criteria for major depression. The results suggest that major and minor depression are both associated with well-being and disability, but through different pathways. Although closely related to physical health at all stages of the disablement process, *minor depression* had important independent associations with both disability and well-being. The findings suggest a reciprocal causal model for the contributions of minor depression and physical impairment to disability, leading to a variety of potential intervention strategies. In contrast, *major depression* appears to be quite independent of physical health in its associations with disability and well-being. This suggests that primary treatment of major depression in later life should not be delayed, regardless the presence of comorbid physical conditions.

SHORT EVALUATIONS OF DEPRESSION IN THE ELDERLY: ISSUES FOR GENERAL PRACTICE

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Despite a significant prevalence, doctors in general have a poor knowledge of depression in the elderly and are not skilled in its identification. So depression in the elderly is underdiagnosed and undertreated, particularly in general practice. Explanations for non-recognition might be that many of the symptoms characteristic of a major depressive syndrome according to DSM III-R may have been seen as due to a coexistent physical disorder or because any of the symptoms present in a depressive disorder might have been attributed to ageing itself. Most of the authors consider that the most useful diagnostic tests are screening assessments. The use of assessment scales is not common in general practice. According to the GP's activity, there is a need for brief and easy to administer scales. Some rating scales for depression have been validated in general population then secondarily in the elderly (HDRS, MADRS, BDI, CES-D), but on the other hand, some screening scales are specific of depression in the elderly taking into account biases linked to age and more particularly to somatic items. The Geriatric Depression Scale (GDS) has received increased usage, mainly with the aim of detection, since the 30-item original version was developed (Yesavage et al, 1983). 15-item shortened version was proposed (Sheikh & Yesavage, 1986). Several other short scales are already validated or in progress such as BASDEC, short Zung IDS, 13-item BDI, DGDS and more recently, a 4-item GDS for primary case attenders was developed (D'ath et al, 1994).

French elderly depressives (179) and controls (66) were asked to complete the 30-item GDS (french version) and an other french self-rating scale, the QD2A (Pichot, 1986). In an attempt to devise a french short scale, the data were subjected to logistic regression analysis, multiple regression analysis, item-total Spearman's rank correlation coefficients and finally to mean choice ranks combination method. A 4-item version was generated. This GDS 4 was found to be highly correlated with GDS 30 ($r = 0.84$, $p < 0.0001$) and with QD2A ($r = 0.64$, $p < 0.0001$) and had a high level of internal consistency (KR20 = 0.66). The sensivity and specificity of the GDS 4 were 69% and 80% (cut-off 0/1) and against QD2A were 75% and 75% (cut-off 0/1). Out of the four items, two were common with the D'Ath's 4-item version.

It is concluded that this short scale may be useful in helping GPs and practice staff to identify elderly patients with significant depressive symptoms.

S57. The treatment of sexual abusers

Chairmen: F Beyaert, P Cosyns

TREATMENT OF CHILD-ABUSE IN GERMANY AND AUSTRIA

W. Berner.

Sexual abuse can be a symptom of very different conditions, reaching from pure disregard of impulse-control, to conditions of mental and psychical disorders, like retardation, brain-injuries, antisocial personality disorders and paraphilia proper. Treatment programs and reports on treatment-programs very rarely take these different conditions as limiting factors for follow-up results into consideration. Treatment-follow-up results will be compared with a greater study on recidivism of child-molestation in Canada (Hanson et al. 1993).

Reports on existing programs for child-abusers in forensic departments in Germany will be presented.

TREATMENT OF SEXUAL ABUSERS IN BELGIUM

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Sexual violence against woman (rape) and children (pedophilia), be it in intrafamilial or extrafamilial, is a matter of major concern in Belgium. The public opinion pressure for more harsh punishment of sexual abusers became reality in new laws on rape, pornography and pedophilia. The health care system underwent a parallel evolution stressing the importance of a more human and concerned approach of victims of sexual violence. Only in the nineties sexual offender treatment became acknowledged by the Belgian government as a policy priority. According to the law of April 13th '95, each offender for pedosexual activities is obliged to follow a therapy in case of parole.

There is no evidence that the prevalence of sex offences significantly increased or decreased during the last 15 years.

Sex offenders in prison are on remand, or condemned or "in-

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terned" (not guilty for reasons of insanity). Treatment possibilities inside the prison are very limited.

The residential Belgian psychiatric care is well organized, but the lack of medium security forensic units in psychiatric hospitals is a limitative factor.

The University Forensic Center of the University Hospital of Antwerp provides an exhaustive out-patient treatment program for sexual abusers. Data on the first 150 consecutive paraphiliac patients will be presented. We will focus on:

- inclusion/exclusion criteria for the treatment program
- the six steps of the cognitive-behavioural relapse prevention treatment program
- the role of coercion in the treatment
- the problem of the liability of therapists with this group of high-risk patients.

SEXUAL OFFENDERS: TREATMENT, PUNISHMENT OR BOTH?

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Sexual psychopath laws have a long history in the United States. Although details have varied over time and place, their intention is to detain those sex offenders who are assessed as being particularly dangerous for indefinite periods. In order to avoid this being prescribed as a cruel and unusual punishment, a treatment component is invariably attached to the indefinite detention. Poor assessment techniques, uncertainty in predicting sexual dangerousness, idiosyncratic and inconsistent treatment, and lack of resources have meant that clinical issues and empirical scrutiny have tended to be submerged beneath political and legal debate about the way society deals with men who sexually offend.

Although sexual psychopath laws per se do not exist in Europe, mental health legislation is sometimes used as a way to achieve a similar end. In addition, in the UK there is currently a debate about whether sexual offenders should be treated differently from men who offend in other ways. This paper will look at research that has taken place regarding the American legislation, and will discuss their meaning for European countries.

THE SLIDING SCALE: TREATMENT OF SEX OFFENDERS IN THE NETHERLANDS

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In Holland sex offenders are more likely to be assessed for a psychiatric diagnosis than other offenders because of their higher possibility of a psychiatric illness or a personality disorder, and therefor a diminished responsibility for their crime. The other reason is their high rate of recidivism, even after years of treatment, so all is tried to prevent relapses.

Being well diagnosed after having committed a crime sex offenders have a lot of legal possibilities to shorten their detention by doing ambulatory, dayclinical or clinical treatment. Partly their detention is left behind as a rod behind the door: to appear again when the conditional treatment is not followed. Partly the detention has been changed in TBS (terbeschikkingstelling): obligatory and controlled treatment in special clinics and hospitals, and in severe cases detention and treatment in one of the seven TBS maximum security hospitals.

So far a network has been established from ambulatory psychotherapy for incest perpetrators to long stay provisions for chronicle re-offending paedophiles or rapists. In fact these legal categories do not say anything about the treatment as psychiatric diagnoses and index crimes are not specific among one another. Important parameters for a certain kind of treatment are the presence of obsessional and compulsive symptoms, concordance of sexual and aggressive acts, perversive phantasies over a longer period, lack of empathy, motivation for treatment, symptoms of a extrovert or introvert personality disorder, and lessened ego-strength. These criteria will be worked out as indications for certain kinds of forensic treatment as the Dutch penal law provides the control.

S58. Membrane phospholipids in schizophrenia and other psychiatric disorders

Chairmen: I Glen, M Keshavan

MEMBRANES AND PSYCHIATRIC DISORDERS

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Phospholipids are essential for the structure of neuronal membranes and for normal development and functioning of the nervous system. There is growing evidence that one of the essential fatty acids in membrane phospholipids, arachidonic acid (AA), and its metabolites modulate neurotransmitter receptors and second-messenger systems. Evidence is accumulating that phospholipid metabolism in both brain and red blood cells may be disturbed in schizophrenia. In particular, in patients with negative symptoms, levels in the phospholipids of the essential fatty acids, AA and docosahexaenoic acid (DHA), in red blood cell membranes are severely abnormal. Cytosolic phospholipase A2, the enzyme that releases AA from membranes, shows increased activity in acute schizophrenia, and is downregulated by classical antipsychotic drugs. P-31 nuclear magnetic resonance spectroscopy of the brains of untreated patients shows increased levels of phosphodiesterase which are associated with increased lipid membrane breakdown. The membrane hypothesis of schizophrenia may represent a new and fruitful paradigm for research.

A GENETIC ABNORMALITY IN SCHIZOPHRENIA RELATED TO PHOSPHOLIPASE A2

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Direct and indirect measurements of PLA_2 activity demonstrate an increase in medication-free patients with schizophrenia compared to healthy controls. In addition, P^{31} NMR measurements of CNS phospholipid metabolism *in vivo* provide evidence consistent with increased CNS $cPLA_2$ activity in individuals with schizophrenia, including those who are neuroleptic naive.

Two studies were undertaken to determine a possible genetic basis for alterations in phospholipid synthesis and activity in schizophrenia. Initial results demonstrated an association in 65 schizophrenics compared with a matched normal control population. A follow up haplotype relative risk study of 44 triads (mother, father, affected offspring), confirmed the results seen in the association study. Results suggest that a genetic variant near the promotor region of the gene for cytosolic phospholipase A_2 ($cPLA_2$), the rate limiting enzyme

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