described and a small number of studies examining attempts to reduce these have been reported. These will be reviewed together with a study carried out by the author involving a randomised controlled trial of a six-session, home-based family intervention aimed at reducing the negative aspects of caregiving and psychological morbidity, as well as improving coping and well-being.

It is concluded that short-term interventions, whether mainly educational or more ambitious in scope, have a modest impact on carers' understanding of the illness and the development of positive attitudes to the patient. Reducing caregiver distress or psychological morbidity is more difficult, as is changing coping styles.

The nature of work with carers is discussed, including aspects of the helping relationship which differ from conventional psychological therapies. Approaches which promise a greater impact on caregiver distress and coping will be considered.

PSYCHOLOGICAL TREATMENT OF MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS IN A MEDICAL OUTPATIENT CLINIC

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Unexplained physical symptoms are common, both in general practice and in the general hospital setting. It is often claimed that the outcome of these symptoms in terms of recovery and medical care utilisation is poor. Patients with unexplained symptoms are considered to benefit from psychological therapy but may be reluctant to accept referral to a psychiatrist or psychologist.

We compared the efficacy of cognitive behavioural therapy and optimised medical care in 79 general medical outpatients with persistent unexplained physical symptoms. The study was introduced to the patients by their attending physician and the treatment took place in the medical clinic. This therapy comprised identifying and modifying dysfunctional automatic thoughts and offering behavioural treatment to break the vicious cycle of the symptoms and their consequences.

Cognitive behavioural therapy seemed to be feasible and effective in reducing both the severity of the symptoms and the accompanying functional limitations. Basic principles of cognitive behavioural therapy could probably be incorporated in routine clinical care.

S23. WHO ICD-10: Evaluation and evolution

Chairmen: JE Cooper, A Bertelsen

ICD-10 CHAPTER V AND DSM-IV: RELATIONSHIPS BETWEEN THEM, AND COMMENTS UPON SIMILARITIES AND DIFFERENCES

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In spite of their different origins and purposes (one international and one national) these classifications are more remarkable for their similarities of content than for their differences. This is because a) they both reflect the same body of internationally available descriptive knowledge about psychiatric disorders, and b) a series of meetings was held between the WHO advisers on ICD-10 and members of the Task Forces developing DSM-IV, with the shared purpose of removing unnecessary differences between the two emerging classifications. The most obvious differences are in presentation rather than content: because of its responsibility to different types of mental health workers in different countries across the world, the WHO adopted a strategy of "different versions for different purposes" (e.g. clinical psychiatry, primary care, and research).

Some of the remaining differences in content, such as the differences in the criteria for schizophrenia, will be examined, and some unsolved problems shared by the two classifications will be identified.

WHO ICD-10 EVALUATION AND EVOLUTION: FORENSIC IMPLICATIONS

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Forensic psychiatry is situated at the interface between Law and Psychiatry. The communication gap between the 2 disciplines rests on the differences of their basic paradigma. Law focus on social deviance and has to dispense justice. Psychiatry focus on psychopathology and has to treat persons affected by psychiatric disorders. The concept of "(ir-) responsibility" is a third dimension to be evaluated separately besides "social deviance" and "psychopathology".

European forensic psychiatry presents at least a double heterogeneity: that of national legal systems and that of psychiatric nosologies. ICD-10 improves substantially the heterogeneity of psychiatric taxonomies, but, in forensic psychiatry, the influence of the legal system is prominent and this "sets the rules of the game" within which forensic psychiatrists work. Legal requirements however, should not dictate psychiatric response, which should be guided by scientific knowledge and ethical concerns.

ICD-10 states in his introduction that "social deviance or social conflict alone, without personal dysfunction, should not be included in mental disorder as defined here". Can ICD-10 help the forensic psychiatrist in distinguishing social deviance with and without psychiatric disorder?

The correct use and advantage of ICD-10 in forensic psychiatry will be reviewed. We will focus on the most prominent ICD-10 diagnosis for civil and penal law.

Each instrument has however his own "instructions of use" and can consequently be "misused". Recommendations will be made in an European perspective on:

- elaboration of an European Glossary of Forensic Psychiatric Technical terms.
- educational programs in Forensic Psychiatry
- fixation of minimal standard requirements for the qualification of an expert and the content of the report
- an ethical code for psychiatric experts.

ICD-10 CHAPTER V (F): DIFFICULTIES AND DEFICIENCIES

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Chapter V (F) of ICD-10 has been used in many psychiatric institutions for several years and is used in many scientific studies often in parallel to DSM-III-R and DSM-IV. There is no doubt that ICD-10 diagnoses are judged to be superior compared to ICD-8 and ICD-9. Operationalized, criteria oriented diagnoses show a high interrater reliability, a high reliability between different institutions and a good international comparability.

As points of criticism are mentioned loss of local psychiatric

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culture, loss of transcultural elements, more social and especially more economical control by the insurance systems and governmental institutions.

Apart from these more global points of criticism there are some critical groups of diagnoses or single diagnoses like depressive disorders, eating disorders or some personality disorders, which are to be discussed critically, at some points in comparison to DSM-IV.

DEVELOPMENTAL ASPECTS IN THE CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS

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Both DSM-IV and ICD-10 have included a somewhat greater developmental perspective than their predecessors, although several unresolved issues remain. Where there is demonstrated continuity between psychiatric conditions in childhood and in adult life, the same diagnostic code is used. This applies to a substantial range of conditions, but queries remain. New categories have been provided for a few disorders that are particularly important in early childhood (eg. attachment disorders) but this constitutes an age group for which the classification remains suboptimal. The same applies to disorders associated with severe mental retardation, apart from the progress in the field of pervasive developmental disorders and of specific disorders of psychological functions (such as language). The paper considers some of the key tasks remaining with respect to developmental issues in relation to the classification of psychiatric disorders.

S24. Recognition and treatment of depressive disorders in primary care

Chairmen: Y Lecrubier, M Ackenheil

THE UTILITY OF MEASURING PLASMA LEVELS OF ANTIDEPRESSANTS IN THE TREATMENT OF AFFECTIVE DISORDERS

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Steady state plasma levels (Css) are determined by different factors such as genetic variations in the P450 enzyme activity, gender, body habitus, smoking, food intake etc. The genotyping of eg. cytochrome CIP2D6 is associated with low or high metabolism. An additional phenotyping, e.g. dextromorphane challenge, includes additional factors.

Both, genotyping and phenotyping cannot totally predict Css plasma levels. The complexity of the interaction of the P450 and isoenzymes is not sufficiently clarified. Therefore, the measurement of plasma levels of antidepressants is necessary in therapeutic studies.

The rate of metabolism of the different antidepressants, which can vary depending on the substance and the individuum, is of therapeutic significance, because the pharmacological effects of metabolites are different as regards norepinephrine reuptake inhibitors. Furthermore, there are competitive interactions with co-medication.

With regard to the therapeutic effect, monitoring of plasma levels prevents non-compliance and side effects due to too high Css.

PSYCHIATRIC CLASSIFICATIONS AND DIAGNOSTIC INSTRUMENTS IN PRIMARY CARE SETTINGS

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More patients with mental disorders are cared for in the primary care sector than in the mental health sector. However primary care physicians in office settings fail to diagnose and treat 50% to 75% of patients suffering of common mental illnesses. In order to facilitate the rapid and accurate diagnosis of psychiatric disorders seen by general practitioners several standardized procedures (brief diagnostic interviews) have been developed during the last years. The structures of these different instruments (MINI, Prime-MD, SDDS) are quite comparable and consist in a self administered screen questionnaire (26 items for Prime-MD, 16 items for SDDS), followed by physician administered diagnostic modules. All of these modules are ICD-10, DSM IIR or IV based. Main disorders explored are the following: Mood Disorders, Anxiety Disorders, Somatoform Disorders, Alcoholism, Eating Disorders. Mean duration of administration of these instruments is approximately 10 mn; a longitudinal tracking form is added for some of them. Validation studies and practical use of these interviews will be discussed.

THE COPRESCRIPTION OF PSYCHOTROPIC AND SOMATIC DRUGS WITH ANTIDEPRESSANTS

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The coprescription of psychotropic and somatic drugs with antidepressants usually leads to clinical interactions. These interactions may account at either pharmacodynamic or pharmacokinetic levels. Pharmacodynamic interactions (the actions of the drug at the target, i.e. receptors) are possible when two or more drugs act in the same way or when two or more drugs act in different ways. The most important pharmacodynamic interactions reported with the different antidepressants are:

TCA's anticholinergics, antagonism of antihypertensive effects of guanetidine-like and clonidine-like agents, potentiation of catecholamines, MAO inhibitors, sympathomimetics, antiarrythmics and β-blockers.

MAO inhibitors: catecholamines and sympathomimetic amines, TCA's SSRI's reserpine, L-DOPA and meperidine.

SSRI: MAOI's, lithium, and L-tryptophan.

The pharmacokinetic interactions (the handling by the body and distribution to the target site: drug absorption, drug distribution and drug elimination) are more frequent and the most important are those that involve drug metabolism via the inhibition of different families of cytochrome P-450. The drugs interacting with antidepressants at drug metabolism level are amphetamines, antiarrythmics (type IC), astemizole, other antidepressants, β-blockers, benzodiazepines, carbamazepine, cimetidine, ciproheptadine, codeine, dextromethorphan, digoxin, nifedipine, pentazozine, prociclidine, phenobarbital, phenytoin, sodium valproate, terfenadine, theophyline, tolbutamide, verapamil, and warfarin.

Theoretical interactions do not mean clinical relevance but the practitioner should have special warnings with anticoagulants, antiarrythmics, antiepileptics, β-blockers, new antihistaminics, opiates, oral hypoglycemic drugs and psychotropic drugs.

THE IDENTIFICATION OF PSYCHIATRIC DISORDERS IN PRIMARY CARE

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The usual rate reported for depression in primary care is very high in western countries (10–20%). Similar figures were found in develop-

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