chotherapy are of major interest. We compared all male patients of two randomized placebo controlled trials with acamprosate (Sass et al 1996, Arch Gen Psychiat) and tiapride (unpublished) with a prospective study of patients who received only group psychotherapy. Patients were treated for 6 months (tiapride) or for one year.

Data of 823 male patients were available: acamprosate (103), placebo A (108), tiapride 109, placebo T (110), psychotherapy (237). Patients were matched for variables of proven predictive validity (Küfner and Feuerlein, 1989), e.g. age, civil status, living status, unemployment rate, previous treatment episodes, and suicide attempts. After matching more than 300 patients were available for analysis.

Results: Percentage of continuous abstinence after 6 (12) months differed significantly between the groups: placebo 32% (28%), acamprosate 46% (41%), psychotherapy 61% (49%). Tiapride figures will be presented.

Conclusion: Although "high dose" psychotherapy does significantly better, the results of only 9–12 treatment sessions as outpatients are remarkable, especially when treatment is combined with pharmacotherapy.

S19-5

METHODOLOGY OF THE U.S. MULTICENTER STUDY OF ACAMPROSATE IN ALCOHOL DEPENDENCE

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Acamprosate (calcium acetylhomotaurine; CA), a synthetic derivative of homotaurine, has been shown to have a specific effect on decreasing voluntary alcohol intake in animal and human studies. Ten of 11 double-blind, placebo-controlled European multicenter trials found greater latency to first drink, cumulative abstinence duration and retention in treatment with CA than with placebo in alcohol-dependent patients. The FDA has granted an IND for CA 500 mg oral tablets, and a 21-site (n = 446) six-month double-blind, placebo-controlled multicenter trial has been initiated to determine safety and efficacy of CA in U.S. alcoholics. Novel research design decisions were informed by basic science and European clinical studies and include: 1.) an exploratory study of a 3 gram dosing condition based on the absence of rate-limiting side effects in a standard 2 gram dose; 2.) a 500 mg dosage strength, with a b.i.d. dosing schedule (1,000 mg b.i.d. or 1,500 mg b.i.d.); 3.) randomization as early as two days post-detox based on no evidence of pharmacological interaction with alcohol, anxiolytics, hypnotics, etc.; 4.) no upper age limit, as CA is not metabolized, there is no pharmacologic rationale for excluding healthy older adults, and there is a need to treat this subgroup; and 5.) secondary measures of use of nicotine and illicit drugs; and 6.) manualized brief intervention and medication compliance enhancing procedures to reduce the influence of diverse clinical settings. A synopsis of the manualized behavioral treatment will be presented.

S20. Eating disorders

Chairs: H-C Steinhausen (CH), D Sampaio (P)

S20-1

THE EPIDEMIOLOGY AND COMORBIDITY OF EATING DISORDERS

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The authors will review the findings of epidemiological studies on the incidence and prevalence rates of the eating disorders (ED) over time and in different populations, on identified risk factors, and on the significance of comorbid psychopathology.

Anorexia nervosa (AN) and bulimia nervosa (BN) typically affect women during late adolescence and early adulthood, with prevalence rates estimated at 0.5–1% for AN and 1–2% for BN. The male/female ratio is about 1/10. Although long considered as disorders affecting almost exclusively western, white, high sociecomomic populations, more and more reports are emerging from other racial, ethnic and cultural backgrounds.

Much recent debate has centered around an apparent increase in the incidence of AN, and further controversy exists as to whether the emergence of BN in the 1980s reflects the development of a new disorder, the current recognition of an older one, or the transformation of the clinical expression of AN.

Among suggested risk factors, cultural pressures and vocational requirements for a low weight or a slim shape, some chronic physical illnesses, and child abuse, have received some empirical support, but the relationship between full and partial syndromes need to be more readily clarified. Data from family and twin studies suggest the importance of genetic risk factors, but molecular genetic studies are only begining.

There has been growing interest for the comorbidity between ED and affective disorders. Potential links between ED and mood disorders have been suggested on the basis on a high personal and family comorbidity, on similar neuroendocrine and biochemical evidence of serotonergic dysregulation, and on some efficacy of antidepressant agents in the treatment of ED. Although the comorbidity between ED and anxiety disorders has been less investigated, social phobia and other anxiety disorders might predate the onset of an ED in many cases and contribute to its development.

Future directions for epidemiological studies should include careful case-control studies, as well as groups of subjects with less common presentation, to further elucidate etiopathogenic mechanisms underlying the clinical presentations of the ED.

S20-2

ANOREXIA NERVOSA: INDIVIDUAL AND FAMILY ASSESSMENT

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Anorexia nervosa is a challenging disease to many health professionals and sometimes becomes a chronic and devastating condition.

The initial consultation and first assessment are most important for the treatment of AN and should be done with careful understanding of the patient and her family.

Individual assessment includes a clinical interview, a carefully selected battery of questionnaires and eating diaries, other than a detailed history of weight and weight control measures.

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Family assessment includes a joint family interview in all patients less than 18 years old and in most of the elder patients. A detailed history of family eating habits and psychpathology is mandatory.

Medical assessment includes physical examination and a battery of laboratory studies.

S20-3
NEUROBIOLOGICAL FINDINGS IN THE EATING DISORDERS

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Almost all neurobiological systems studied in patients with anorexia nervosa and bulimia nervosa were found to be disturbed. The alterations of the sympathetic nervous system are the main topic of this contribution. Clinical findings like low blood presure, bradycardia and low body temperature indicate an impaired function of the sympathetic nervous system. Norepinephrine metabolites were found to be reduced in cerebrospinal fluid and in urine. Resting norepinephrine concentrations in blood were low in anorectic and bulimic patients. The effects were more pronounced in anorectic than in bulimic subjects. Challenges of the sympathetic nervous system like orthostatic tests, exercice and test meals resulted in impaired increases of plasma norepinephrine. As expected Alpha-2-adrenoceptor capacity on platelets was significantly increased in both eating disorders. Post receptor mechanism as studied by invitro experiments adding different doses of receptor agonists and antagonists revealed an increased sensitivity of the post receptor mechanism. However receptor upregulation was not able to compensate for the reduced norepinephrine secretion. Studies in long term recovered anorectics showed persistence of the reduced norepinephrine secretion. It therefore remains unclear whether the disturbance is state or trait dependend.

S20-4
WHAT'S NEW IN THE TREATMENT OF BULIMIA NERVOSA?

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The starting point for this paper is a brief description of the 'status quo' of bulimia treatment research. Treatment of bulimia nervosa has been well researched, especially if one bears in mind the recency of its first description. Yet, we cannot afford to be complacent, as the best psychological treatments (cognitive-behavioural therapy, interpersonal therapy) lead to symptom resolution in only 40 to 60% of patients with uncomplicated bulimia nervosa. The success rates with pharmacological treatments are lower.

In the second part of the paper new developments in the treatment of bulimia nervosa will be presented, in particular ultrabrief manual-based traeatments, motivational enhancement therapy, schema-focused cognitive-behavioural therapy and dialectical behaviour therapy. The question of where and how these treatments might fit into our therapeutic armamentarium will also be addressed.

S20-5
THE LONG-TERM OUTCOME OF EATING DISORDERED PATIENTS

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The objective of the study was to review a total of 108 outcome studies on anorexia nervosa that were published between 1953 and 1996 and a total of 24 outcome studies on bulimia nervosa that were published between 1983 and 1996. Findings will be reported on mortality rates, general and specific outcome data of the eating disorders, other psychiatric disorders at follow-up, and prognostics factors. The long-term outcome indicates that, both for anorexia and bulimia nervosa, less than half of the patients recover from their eating disorder completely, whereas 20% of the anorectic patients and a quarter of the bulimic patients have a chronic eating disorder. Various other psychiatric disorders are very common. Although prognostic factors have been found in empirical studies, there is no way of defining the prognosis of individual patients.

FC21. Measuring psychopathology and hospital treatment

Chairs: VN Krasnov (RUS), R Heun (D)

FC21-1
SOMATOFORM DISORDERS IN A MEDICAL DEPARTMENT

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Objectives: 1) To determinate the prevalence of somatoform disorders in an internal medical ward. 2) External validation of Whitely-index and Hopkins Symptom Checklist for somatization (SCL-12) as screening interviews for somatization. 3) Estimation of doctors ability to diagnose somatization. 4) To estimate the effects of somatization on length of stay.

Material and Methods: Ninety-five patients were randomly selected in an internal medical ward. All were interviewed with the screening instruments the day after admission, and with the semi-structured interview SCAN (Schedules for Clinical Assessment in Neuropsychiatry) at discharge. The day after admission the doctor responsible for the patient answered two questions in a self-administered interview on whether, in his opinion, the patient was a somatizer or not. By means of SCAN and additional information obtained from medical records somatoform diagnoses were made.

Results: Prevalence of somatoform disorders was 33.7%. The medical doctors estimated that 25.8% of the patients were somatizers, but the sensitivity was only 28.6% using SCAN as gold standard.

The external validation of the screening instruments were tested at different cut-points. All showed bad to moderate results. Somatization patients were not hospitalized for a longer period than non-somatizers.

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