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of two randomized placebo controlled trials with acamprosate (Sass et al 1996, Arch Gen Psychiat) and tiapride (unpublished) with a prospective study of patients who received only group psychotherapy.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.