later, in relation to subsequent research on schizophrenia, and certain other concepts — cycloid, paranoid, puerperal and psychogenic psychosis.

ICD-10, EXPERIENCES IN WESTERN EUROPE

J.J. Lopez-Ibor. *Clinica Lopez-Ibor, Av. Nueva Zelanda 44, E-28035 Madrid 38, Spain*

Since the beginning of 1994, an increasing number of Western European countries officially have taken ICD-10 in use, and in other countries preparing to do so, extensive introduction and training in use of the psychiatric part of ICD-10 has taken place. In this way, experience with the use of ICD-10 has amounted. As expected, the use of ICD-10, Chapter V has contributed to increased diagnostic reliability leading to improved professional training and heightened quality of diagnosis and treatment in psychiatry. Following a short period of transition, the ICD-10 has been found easy to use, and adequate for the majority of the disorders met in the psychiatric in- and out-patient clinics. Some Western European countries still adhere to the DSM-system, in case the latest revision, DSM-IV, which, in spite of many and profound differences in practice, for the main categories overlap with ICD-10 in most cases. Further experiences including validity studies comparing the two systems will help to point out categories to be considered for the next revision.

INTRODUCTION TO THE ICD-10 COURSE

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The ICD-10 chapter dealing with mental disorders has been produced through an intensive process of collaboration between experts in more than 30 countries. The proposals have been translated into numerous languages and tested worldwide. The process of production of the ICD-10 Chapter V have probably been the largest international collaborative project ever.

The presentation will give a brief description of the process and of its main products, thus serving as an introduction for the course.

EXPERIENCES IN CENTRAL AND EASTERN EUROPE

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First information regarding the progress in cooperation between psychiatrists of the former "Eastern Block" and their western colleagues was given at the 6th AEP Congress in Barcelona, 1992. Authors have continued in their efforts to create the basic semantic tool compatible enough with the western psychiatrists in the sphere of the psychiatric classification. E.g. special courses on ICD-10 and DSM-IV classifications have been organized in Czech Republic and the basic materials of WHO have been translated into Czech. Authors have contacted actually Psychiatric Associations of the Central and some Eastern European countries to reach basic information about their experiences in the application into the practice the new psychiatric classification. The changes of information has been valuable in many cases. The main common problem seems to be difficulties in the development of informational systems which could be sufficient enough to link Eastern and Western informational data bases. The creating of these systems depends first of all on the economical possibilities. Even if the macroeconomical data could give evidences of the substantial changes and improvements, the health systems in the countries of the former "Eastern Block" have suffered from radical reduction of financial meets actually. In spite of these problems, first successful steps have been achieved in the mutual cooperation thanks to the help of the WHO Division of Mental Health, WPA and many institutions and colleagues of the West European countries, U.S.A., Canada and others.

S5. New developments in child and adolescent psychiatry

Chairmen: M Schmidt, RC Harrington

THE OUTCOME OF HOME-TREATMENT COMPARED TO INPATIENT TREATMENT OF CHILDREN WITH PSYCHIATRIC DISORDERS

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Earlier studies have demonstrated that home-treatment and inpatient treatment of psychiatric disorders in children and adolescents is comparable with regard to the outcome of psychopathological, behavioural and psychosocial factors. The aim of the present study is to replicate these treatment effects when home-treatment is performed by a registered nurse with special experience in child and adolescent psychiatry supervised by a child and adolescent psychiatrist. In the home-treatment group children aged 6 to 16 years with need of inpatient treatment are treated two times a week for three months. Control group is an inpatient treated sample of children matched for age, sex, diagnosis, severity of disorder, and psychosocial background. Treatment evaluation includes multi-modal assessments by patient, parents and therapist (self rating scales, structured interviews, performance tests) before, during and after treatment. Treatment effects are evaluated by comparing the home-treatment group with the control group. Furthermore long-term effects will be assessed one year after the end of the treatment. Results are reported for 40 children of each group. Preliminary results reveal that home-treatment is as effective as inpatient treatment and that the effects of the home-treatment are long-lasting.

EARLY ONSET BULIMIA NERVOSA: LIFE EVENTS, DEPRESSIVE FEATURES AND TWO-YEAR FOLLOW-UP

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Typically, bulimia nervosa (BN) begins around 18 years of age and is thought to be related to difficulties in autonomisation and separation from family.

In a French multicenter study including 358 consecutive female outpatients with a DSM-IV diagnosis of BN, 69 subjects (19%) had had onset of their disorder between 10 and 15 years of age. At time of evaluation, they were aged 15 to 46 years.

Compared to patients with a classical late adolescent onset of BN, those with early onset came more often from disrupted families, they had an earlier age of menarche and reported more often a pronounced weight gain at puberty. Other factors cited as possible precipitating events included death of a parent or grandparent, conflict with parents, somatic illness of a parent, change in family composition, and difficulty adjusting to a new school.

At time of evaluation, patients with early onset BN had relatively less severe eating symptoms but more frequent impulsive disrupted

https://doi.org/10.1016/0924-9338(96)88416-1 Published online by Cambridge University Press

behaviors; their social life was relatively less impaired. Globally, both groups were equally depressed, but, for recent cases, depressive symptoms varied according to weight control strategies.

Fifty-eight per cent of the subjects with early onset BN could be reassessed two years after initial contact: 32% still had a DSM-IV diagnosis of BN, 28% had some, but not all, features of the disorder, and 40% were symptom-free. The specific clinical characteristics of the group were maintained.

In conclusion, risk factors for early onset BN are consistent with etiopathogenic factors for BN in general. Although the disorder can last for years, often untreated, BN does not appear more severe when it starts early during adolescence.

NEW DEVELOPMENTS IN THE STUDY OF AFFECTIVE DISORDERS IN YOUNG PEOPLE

Ian Goodyer. *Developmental Psychiatry Section, University of Cambridge, Douglas House, 18b Trumpington Road, Cambridge. CB2 2AH*

Major depressive disorders are relatively common in school-age children and adolescents. Epidemiological studies have delineated the six month prevalence rate of approximately 5%. New incidents occur with greatest frequency in middle adolescence with a slightly greater preponderance of females to males. In addition the clinical characteristics of major depression appear to vary with age. Studies on clinical populations suggest that as many as 45% of patients with major depressive disorder have alterations in selected adrenal steroid function. Evening cortisol hypersecretion and morning DHEA hyposecretion have both been described in this population. DHEA is a developmental steroid with circulating levels increasing markedly between the ages of 6 and 8 and again in mid adolescence. The implications of the developmental changes in steroid environment and their alterations during episodes of depression remain unclear. By contrast there is now considerable evidence that social adversities predict an increase in depressive symptoms in adolescence. There remains however no clear evidence that social adversities specifically provoke depressive episodes in this age range. Recent findings suggest that genetic factors contribute both to the risk for exposure to life events and difficulties and to the onset of depression, at least in adults. The role of genetic factors in the onset of depressive disorders in adolescence is less certain. Unlike adult studies however, child and adolescent psychopathologists have noted the high levels of comorbidity in depressive disorders in young people. Recent findings suggest that depressive conduct disorder may represent a specific and different sub-type from depression without conduct disorder. There is a need for interdisciplinary research to bring together these different strands of information on depression in young people. Study designs for the future should include family genetic designs so that the relative contributions of genetics, shared and non-shared environmental effects on some types of depressive disorders in this age range can be elucidated. The mechanisms and processes that lead to onset, relapse and recurrence represent the goals for future research. Short term longitudinal studies will enhance current longitudinal prospectives by a more systematic investigation of mechanisms and processes involved in the onset and cessation of episodes of disorder. A developmental approach should be maintained so that continuities and discontinuities between normal development and depressive disorders can be determined.

CONTROLLED TRIAL OF A BRIEF COGNITIVE-BEHAVIOURAL INTERVENTION IN ADOLESCENTS PARENTS WITH DEPRESSIVE DISORDERS

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Fifty-three child and adolescent psychiatric patients with depressive disorders were randomly allocated to brief cognitive-behaviour therapy (CBT) or to a control treatment, relaxation training. 48 patients completed the treatment phase of the trial, which comprised 5–8 treatment sessions. Post-treatment assessments showed a clear advantage of CBT over relaxation on measures of both depression and overall outcome. However, there were no significant differences between the treatments on comorbid anxiety and conduct symptoms. At follow-up, the differences between the groups were reduced, partly because of a high relapse rate in the DTP group and partly because subjects in the relaxation group continued to recover.

S6. A united Europe in psychiatry, too?

Chairmen: J Furedi, E Fombonne

Abstracts not received.

S7. Positive and negative symptoms in schizophrenia

Chairmen: Y Lecrubier, J Waddington

NEGATIVE AND DEPRESSIVE SYMPTOMS IN ACUTE SCHIZOPHRENIC EPISODES- DO THEY IMPROVE UNDER NEUROLEPTIC TREATMENT?

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There has been a continuing debate on the prevalence, association, specifity and development of negative and depressive symptoms in acute schizophrenia with productive symptoms and treatment outcome under antipsychotic drugs. In prospective investigations on the the concomittant occurrence and 5 years' course of negative and depressive symptomatology in schizophrenic and affective disorders we found that — apart from a substantial overlap of the symptomatologies — primary enduring negative symptoms are non-specific and were present in both diagnostic groups. Even in the longitudinal course of schizophrenia, this symptomatology was not more frequent than in affective disorders, and was observed in about 15% of both diagnostic groups.

In order to evaluate the efficacy of the mixed 5-HT_2-/D_2-like receptor antagonist risperidone vs. haloperidol and amitriptyline in a functionally defined combined psychotic and depressive syndrome, 123 patients suffering from either major depression with synthymic or mood-incongruent psychotic features, a depressive

https://doi.org/10.1016/0924-9338(96)88416-1 Published online by Cambridge University Press