

the prevalence of bulimia nervosa in middle adolescence in both girls and boys. In School Health Study, a self-report questionnaire was administered on 8783 14–16 years old adolescents. The study was carried out in co-operation with secondary school. Pupils filled in the questionnaire during a lesson supervised by a teacher. All secondary schools in four different regions of Finland participated. Bulimia nervosa was detected in 2.3% of girls and 0.5% of boys. Bulimic eating behaviours were reported by 13.3%. Bulimic subjects had a higher BMI than others. Among girls, bulimia was associated to going to higher grade at school, in boys to recent unemployment in family. Bulimia seems to be common than thought in middle adolescence, and more common among boys than detected earlier. It is associated to increased weight and psychosocial stress. The high prevalence in this young age cohort suggests that bulimia may be increasing in frequency.

S67. Nicotine dependence

Chairs: J Costa e Silva (WHO, CH), N Collishaw (WHO, CH)

No abstracts received.

S69. Somatization and somatoform disorders

Chairs: M Ackenheil (D), N Sartorius (CH)

S69-1

CRITICAL ISSUES IN THE CLASSIFICATION OF SOMATOFORM DISORDERS

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The 'discovery' that people with mental disorders most often seek help in general health care services has led to an increase of interest in the form, course and classification of psychiatric problems that usually do not require inpatient treatment.

The characteristic feature of many of the disorders seen by general practitioners and specialists in disciplines other than psychiatry is their somatoform presentation, which is defying neat arrangement in classical psychiatric classifications. The way in which this problem was faced by the 10th Revision of the ICD will be described.

S69-2

"WHO STUDY: SOMATOFORM DISORDERS IN GENERAL PRACTICE, AN EPIDEMIOLOGICAL SURVEY"

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The PPGHC study was organised by WHO to describe the form and frequency of psychiatric disorders in primary care settings. This was a two-stage case finding study conducted in 26916 patients in 14 different countries. 5438 passed the second stage interview (CIDI diagnosis, disability assessment, health evaluation, treatment prescribed and consumed, physical diagnosis, reasons for contact).

In most domains, information was available from the doctor, the patient and a specialised-trained interviewer.

The prevalence of Somatization Disorder (SD) was 2.7% appearing as the 4th most common disorder.

More than 50% of patients with SD had a current comorbid condition. Among those, hypochondriasis, depression, GAD, and alcoholism show the highest odds ratio. In patients with a pure SD, the sex ratio is close to 1 while in comorbid patients females predominate. The age at onset of pure SD is also much earlier than that of patients with the comorbid condition. Suicide attempt history is rare in the pure condition (5%) but elevated when SD is associated with depression (26%) while this rate is 16% for pure depression. This may suggest that SD is not an homogenous single disorder.

The disability described by patients is high in SD whether patients present with the pure or with a comorbid condition.

On the contrary, when identifying all patients complaining of six or more current somatic symptoms, 31% suffered from major depression, 24% of GAD, overall, 45% had an ICD10 diagnosis. The number of somatic complains was higher in females and increased with age. These last figures underline the importance of integrating mental health care services in primary care.

S69-3

CHRONIC FATIGUE SYNDROME

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Patients with unexplained severe fatigue after minimal exertion, often accompanied by other symptoms such as myalgia, sleep disturbance and depression, are common in medical practice. Operationally defined, CFS is not unusual - between 1 to 2% of those attending primary care fulfil the criteria. It is also not a new illness.

There are no characteristic physical or laboratory findings, and it is defined solely in terms of symptoms. Although theories abound, no specific virological or immunological cause has been identified. Fatigue is of central, and not peripheral, origin. Psychological disorder is common, with rates in excess of those expected in physical illness. However, CFS cannot be explained simply as a misdiagnosed psychiatric illness. Recent research has suggested neuroendocrine changes in a subgroup of patients, characterised by reduced HPA activity and increased 5 HT transmission. These are more similar to those found in PTSD than classic depression.

Sufferers often make dramatic changes to their lifestyle, which can cause deconditioning and psychological avoidance. Many are told that the condition is incurable, and that the best treatment is rest, linked with dietary and lifestyle restriction. These beliefs are not supported by compelling evidence, and affect outcome. The prognosis for patients seen in specialist care is poor, associated with the strength of attribution to a solely physical cause, the presence of depression and continued behavioural avoidance.

Although a number of direct therapeutic agents have been tested, including anti viral or immunological agents none have been encouraging. Antidepressants have also not been found to be particularly effective. Considerable progress has been made in using rehabilitation techniques for CFS, including graded exercise programmes and CBT. Ensuring a good therapeutic alliance and a collaborative relationship between patient and doctor is also essential.