S48-3

RECOGNITION OF AND EARLY INTERVENTION IN ALCOHOL ABUSERS IN GENERAL HOSPITAL AND PRIVATE PRACTICES IN GERMANY

U. John[1]*, H.J. Rumpf[2], U. Hapke[2], A. Hill[2], C. Veltrup[3]. [1]*University of Greifswald, Institute of Epidemiology and Social Medicine;* [2]*Medical University of Lübeck, Department of Psychiatry, Lübeck;* [3]*Klinik Lindow, Lindow, Germany*

High prevalence rates of alcohol abuse and dependence are well known for patients in general and psychiatric hospitals as well as general practices. The patients in many cases do not get adequate care. We conducted two studies. In the first one we made a prevalence estimation of alcohol abusers or dependents in a municipal general hospital with a medical and a surgical department (n = 1309) as well as in a random sample of 12 general practices (n = 960). 17.5% were alcohol abusers or dependents according to the two step diagnostic procedure (1. screening, 2. diagnosis on grounds of SCAN). Those detected as alcohol abusers or dependents according to DSM-IV or ICD-10 were offered counsellling based on the principles of the stages of change model of Prochaska & DiClemente. Follow-up interviews 1 year after hospital discharge show a significant increase in utilization of alcohol-related care (self-help groups, counselling, treatment). In the second study we conducted a randomized controlled trial with a sample of alcohol dependent in-patients in a detoxification treatment in a psychiatric clinic. 161 patients with 3 30 minute counselling sessions were compared to 161 patients with a two week motivational treatment. Results show that the two intervention groups do not differ in utilization of further help as well as drinking behavior 12 months after discharge. It is concluded that counselling according to the stages of change model is a fruitful secondary prevention approach.

S48-4

OUTCOME OF BRIEF INTERVENTION FOR ALCOHOL PROBLEMS IN PRIMARY CARE: A CRITICAL REVIEW

Jonathan Chick. *Royal Edinburgh Hospital, UK*

Of the randomised controlled trials of brief intervention for alcohol problems in primary care, a majority have demonstrated efficacy. Screening procedures, and consent to participate, mean that the proportion of problem drinkers eligible who actually participate in the study is often low. Results cannot therefore be extrapolated to wider populations without caveats. This is, however, only one reason which can be offered to explain negative results in some controlled studies.

S48-5

COMORBIDITY PROBLEMS AND ADDICTION; IMPLICATION FOR DETECTION AND TREATMENT

P.J. Geerlings*, W. van den Brink. [1]*Jellinek Institute & University of Amsterdam;* [2]*Amsterdam Institute Addiction Research, Netherlands*

During the last decades different Dutch studies determine the psychiatric (co)-morbidity among adults in the population and in primary care. Examinations were carried out with different instruments. The P.S.E. in Groningen, the DIS in Amsterdam and diagnoses of GP in the "monitoring" and in the "transitie"-project.

In the Netherlands Mental Health Survey and Incidence Study (NEMESIS) 7076 adults have been interviewed with the CIDI.

About 25% of the interviewed people in the different studies had a mental disorder in the last year and more than one third had at least two disorders Almost 50% of the patients in primary care in Groningen with an ICD-10 diagnosis had more than one ICD-10 disorder. In the Amsterdam study a mood disorder with comorbidity of alcohol dependence and use of medication, mostly benzodiazepines had a higher risk to become a chronic mental disorder. The NEMESIS study found high comorbidity in mood and anxiety disorders and in drug dependence.

Patients with addictive disorders and psychiatric comorbidity have a high utilization of health care faclities and use of medication.

Extensive existing of comorbidity challenges the concept of specifity of recognition and treatment of the different 400 diseases in primary care. Patterns of combinations of substance use, mental and somatic disorders with high utilization of health care facilities and frequent use of psycho-pharmacological agents, especially sedatives need combined comprehensive treatment programmes with general practioners.

S49. Psychopathological assessment strategies and instruments in psychiatry

Chairs: H-J Möller (D), R-D Stieglitz (D)

S49-1

THE ASSESSMENT OF SYNDROMES IN SCHIZOPHRENIA: CURRENT STATUS AND FUTURE PERSPECTIVES

Hans-Jürgen Möller. *Psychiatric Department, Ludwig-Maximilian-University of Munich, Nussbaumstrasse 7, 80336 Munich, Germany*

For a long period of time the brief psychiatric rating scale was used as a gold standard for assessing schizophrenic symptoms, at least in clinical psychopharmacology. This scale covers predominantly positive symptoms of schizophrenia. With a growing interest for negative symptoms several specific scales were developed for this psychopathological domaine, among them the SANS reached a widespread use. The PANSS was designed to cover both, productive symptoms and negative symptoms. Starting with the Risperidone trials the scale was used in the clinical evaluation of most of the recently developed antipsychotics. However, the question remains, whether the scale is really satisfying to cover the whole symptom spectrum of schizophrenia in a sufficient manner. Data from our 15 years follow-up study, in which we used among other the SANS, the PANSS and the AMDP system suggest, that with respect to changes in negative symptoms the negative subscale of the AMDP system is more sensitive than the negative subscale of the PANSS. There is still also the question, whether under certain research questions a more comprehensive scale like the AMDP system gives the possibilities to a more differentiated inside into the phenomena under investigation than a scale restricted only to a very limited item pool.

S49-2

THE ASSESSMENT OF DEPRESSIVE SYNDROMES: CURRENT STATUS AND FUTURE PERSPECTIVES

Rolf-Dieter Stieglitz. *Department of Psychiatry and Psychotherapy, University of Freiburg, D-79104 Freiburg, Germany*

During the last 40 years a lot of instruments have been developed to assess the depressive syndrome. They were mainly used to select patients for clinical trials, as basis for therapeutic decisons and for the evaluation therapeutic interventions.

https://doi.org/10.1016/S0924-9338(99)80219-3 Published online by Cambridge University Press

In the first part of the paper an overview will be given of instruments and differences between them will demonstrate in relation to content as well as formal and methodological aspects. The general problems of syndrome scales will be demonstrated in relation to the Hamilton-Depression-Rating-Scale (HDRS), the most often used scale in this area. The following aspects will be critical discussed: methodological problems (for example reliability, validity) and problems in relation to the practical application. In the second part two specific problems of the assessment are presented in more detail: dimensionality and the relation between self- and observer rating scales.

In the third part current research activities are presented: the development of instrumentes for specific purposes in the area of depression, the development of interviews (computerized and not computerized) and the combination of a dimensional and categorial approach.

Finally deficits concerning the assessment of depression on the syndrome level will be summarized and future research perspectives will be demonstrated.

S49-3

THE AMDP-DEPRESSION-SCALE: A NEW COMPREHENSIVE RATING SCALE FOR THE ASSESSMENT OF DEPRESSIVE SYMPTOMATOLOGY

B. Ahrens. *Department of Psychiatry, Freie Universität Berlin, Germany*

In the AMDP-System, which is unique in the richness of its phenomenological description one hundred different psychopathological symptoms are described, as well as an additional forty somatic symptoms. Such a wealth of information is not artificial; it corresponds to the process of clinical assessment. However through the development of new psychotropic substances in the treatment of different psychiatric syndromes it is clinically relevant to assess and evaluate specific profiles of syndromes separately.

To archive this goal a specific AMDP-Depression-Scale has been developed, which is based on core symptoms relating to depressive symptomatology of the complete AMDP-System.

Furthermore the new scale covers the relevant symptoms for depressive disorders according to ICD-10 as well as the spectrum symptoms of the HAMD and MADRS. Although the AMDP-Scale belongs primarily to the group of observer based assessment and although the judgements of symptoms are based mostly on observations of the behaviour and descriptions of the experiences by the patients, nevertheless it was introduced to state whether it is a case of a purely observable symptom, or a self experienced and reported symptom or of a combination of both. Severity of symptoms refers to the degree of the presence of a symptom and is estimated as mild, moderate or severe. The judgement of severity is based on a combination of intensity, significance, and frequency.

In order to provide operationalised descriptions of the symptoms covered a semi-structured interview and a manual has been produced following the structure of the revised manual of the original system (The AMDP-system, 6th edition, 1997).

The AMDP-system with its new syndrome scales serves to assist the necessary uniformity in the international assessment of psychopathological symptoms for diagnostic and research purposes.

S49-4

THE AMDP-OBSESSIVE-COMPULSIVE SCALE: A NEW INSTRUMENT TO ASSESS OCD-RELATED SYMPTOMS

H.-J. Grabe[1] *, A. Thiel[2], N. Kathmann[3], R. Boerner[3], P. Hoff[4], H.J. Freyberger[1]. [1]*Department of Psychiatry and Psychotherapy, University of Greifswald/Stralsund;* [3]*Department of Psychiatry, LMU Munich;* [4]*Department of Psychiatry and Psychotherapy, RWTH Aachen, Germany*
[2]*Department of Psychology and Psychotherapy, Innsbruck, Austria*

Results from epidemiology and from comorbidity studies have recently demonstrated the broad psychopathological relevance of obsessive-compulsive symptoms. Therefore the "Arbeitsgemeinschaft für Methodik und Diagnostik in der Psychiatrie" (AMDP) has started to develop a rating-scale for a quick and precise assessment of obsessive-compulsive symptoms. The item-selection and -definition were based on clinical and psychopathological considerations. The actual version of the scale comprises 20 items on the dimensions "description", "distress and impairment" and "emotion and cognition". The results of a first empirical study (n = 137, psychiatric in- and outpatients) demonstrated execellent internal consistency (Cronbach's $\alpha = 0.92$), a split-half reliability of 0.89 (Spearman-Brown), a test-retest reliability of $r = 0.86$ and good convergent validity with the Yale Brown Obsessive-Compulsive Scale (Y-BOCS) and the Hamburger Zwangsinventar (HZI). The factoranalytic distribution of the 20 items revealed a 4-factor structur of the scale. The items and results are presented and their implications on further steps of the development of the scale will be discussed.

S49-5

ASSESSMENT OF NONCOGNITIVE PSYCHOPATHOLOGY IN ALZHEIMER'S DEMENTIA

Michael Rösler. *Psychiatric Department, University of Würzburg, D-97080 Würzburg, Germany*

Background: Changes in behavior affecting social interactions, as well as psychiatric symptoms such as depression, anxiety, delusions, agitation, disorders of drive, affective lability, nuisance behaviors etc, are common in patients with Alzheimer's dementia (DAT). The significance of these psychopathological symptoms has been widely noted. They can place a severe burden on the caregivers and result in institutionalization and physical restraint. The investigation of noncognitive psychopathology may lead to a more detailed understanding of the nature of DAT in so far as little is known until now about the biological and psychological bases of this symptomatology. Furthermore we are not in the position to say, that we are able to understand the importance of noncognitive symptoms in terms of the course of DAT although we know several reports of an association of psychotic symptoms with more rapid progression of DAT. A further crucial point is the need for more effective treatments for managing nonkognitive psychopathology.

Objective: The purpose of the study was to develop a rating scale for the assessment of noncognitive psychopathology.

Method: We investigated 50 outpatients with mild to moderate DAT. The AMDP System with 140 psychopathological, behavioral and somatic symptoms, the Behavioral Rating Scale of CERAD and the BEHAVE-AD developed by the group of Reisberg were completed by two neuropsychiatrists.

Results: Our results are indicating, that the AMDP-System offers a wide range of assessment opportunities in noncognitive psychopathology, which exceeds the BEAVE-AD as well as the Behavioral Rating Scale (CERAD). Evaluations on the level of single psychopathological items and syndrome structures as well will be presented and discussed in terms of convergence validity between the three scales for the assessment of noncognitive psychopathology.

Conclusion: The Psychopathological Dementia Rating Scale (PDRS-AMDP) provides a standardized and reliable measure that can be applied to the demented patient and his caregiver.

https://doi.org/10.1016/S0924-9338(99)80219-3 Published online by Cambridge University Press