OBSESSIONAL SYMPTOMS IN PATIENTS WITH EATING DISORDERS AND THEIR RELATIONSHIP TO OUTCOME

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Eating disorders have been linked to obsessive compulsive disorder (OCD) because of similarities in phenomenology, individual and family comorbidity, reports of high obsessional symptom scores among eating disordered patients, and their response to specific serotonin reuptake inhibitors.

The study measured obsessional symptoms prospectively in 101 consecutive new female patients referred to a national centre for eating disorders over one year, compared to age matched control women. The patients were reassessed at three months and one year. Diagnoses were made according to DSM III R criteria.

37 patients had anorexia nervosa, 40 bulimia nervosa and 24 eating disorder not otherwise specified. The mean obsessional symptom score (Maudsley Obsessive Compulsive Scale (MOCI)) was significantly higher in patients (11.1 sd 5.7) than in controls (4.2 sd. 3.5) at initial referral ($p < 0.001$, Wilcoxon signed ranks). At three months, of 80 responders, those who had an initial MOCI score of 7 or above had significantly higher Eating Attitudes Test (EAT) ($p < 0.05$) and Bulimic Investigatory Test, Edinburg (BITE) ($p < 0.05$) scores. Of 55 responders at one year, those patients with a good or moderate outcome had a significant reduction in their mean MOCI score compared to those who showed no change or disimproved, who showed a mean increase in MOCI Score ($p = 0.01$, Mann Whitney U = 218.0). There was also a significant association between outcome at 3 months and outcome at one year ($p < 0.01$, $X^1 = 10.6$, df = 1). Treatment duration, location, type of eating disorder, history of childhood abuse, impulsivity and referral agent were not significantly associated with outcome.

This study supports the view that eating disorders may be a gender specific OCD.

PREDICTION OF COURSE AND MORTALITY OF EATING DISORDERS IN DENMARK, 1970–93. A NATIONAL CASE REGISTER STUDY

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Follow-up studies of eating disorders have shown a tendency to high mortality and many chronic courses. Up to now most of these follow-up studies included patient populations that were too small to document prognostic factors.

The present record-linkage study includes all patients diagnosed as suffering from an eating disorder according to the ICD-8 classification system during the period 1970–93 at any Danish psychiatric (since 1970) and somatic department (since 1977).

By linking three national case registers, the Psychiatric Case Register, the Danish National Patient Register (covering all somatic admissions) and the Central Death Register, we describe mortality and prognostic factors with regard to death and chronic courses for patients with eating disorders. The study includes 2763 cases, of which 237 are males. Mean follow-up time is 10.3 years. A significant excess mortality is demonstrated, as the SMR of the total patient population is 5.7, and the highest SMR of 14 relates to women aged 25–29. Patients only admitted to psychiatric departments have the lowest SMR and these patients show a marked preponderance of suicide as death cause. The study shows that patients with an eating disorder first admitted to somatic departments are at an increased risk of death and chronic course. Alcohol and drug abuse at index admission for eating disorder has special importance with regard to excess mortality. Attempted suicide and compulsory admission at index admission for eating disorder are significantly related to an increased risk of a chronic course. Gender is not a predictor for mortality, but females are at an increased risk of running a chronic course measured by their frequency of contact with the treatment system. This study finds neither period effects nor rural-urban differences concerning the course of eating disorders.

DEPRESSION, FAMILY ENVIRONMENT AND ADOLESCENT SUICIDAL BEHAVIOUR

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Objective: To assess the specific influence of family relationship difficulties, over and above the effect of depression, on the risk of adolescent suicidal behaviour. *Method:* The study was based on the clinical data summaries, "item sheets", of children and adolescents who attended the Maudsley Hospital during the 1970s and 1980s. Two hundred and eighty-four cases of suicidal behaviour, defined as suicidal ideas, attempts or threats (mean age 13.9 years SD 2.6), were compared with 3,054 non-suicidal controls, using stepwise logistic regression controlling for age and sex. *Results:* The following variables were each independently associated with suicidal behaviour: an operationally defined depressive syndrome, odds ratio (OR) = 1.5 (95% CI 1.1–6.3), family discord, OR = 1.5 (95% CI 1.1–2.0), disturbed mother-child relationship, OR = 1.5 (95% CI 1.1–2.0), and familial lack of warmth, OR = 1.4 (95% CI 1.1–2.3). Twenty-seven percent of the suicidal cases met operational criteria for depression. In a separate analysis of nondepressed cases (n = 198), female gender, OR = 2.4 (95% CI 1.7–3.2), and conduct symptoms, OR 1.4 (95% CI 1.02–1.95), were independent risk factors for suicidal behaviour. Among the depressed cases (n = 73), gender and conduct symptoms did not affect the risk of suicidal behaviour. *Conclusions:* Although depression is the largest single risk factor for teenage suicidal behaviour, family relationship difficulties make a significant independent contribution to this risk. Depression also interacts with gender, so that the excess risk of suicidal behaviour in young females is confined to nondepressed cases.

ETUDE SUR LE DEVENIR Á LONG TERME DES ADOLESCENTS SUICIDANTS

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Objectif: Il s'agit d'une enquête catamnestique sur le devenir social, médical et psychologique de 552 enfants et adolescents hospitalisés au CHU de Grenoble, suite à une tentative de suicide, entre le 1/1/1982 et le 31/7/1992.

Matériel et méthode: Le taux de mortalité a été obtenu directement auprés des services de l'état civil et le devenir social, médical et psychologique par des autoquestionnaires adressés par courrier à l'adolescent, à ses parents et au médecin généraliste. Les résultats ont été comparés à ceux d'une population témoin (N = 273) constituée par des patients non suicidants hospitalisés en pédiatrie et en stomatologie. Les réponses des deux populations ont été appariées pour l'âge, le sexe et l'année d'hospitalisation.

Résultats: Le taux de mortalité, déterminé à partir de 446 suicidants et de 223 témoins est respectivement de 2.2% et de 0.9%. Le taux de récidives suicidaires connu pour 282 suicidants est de 34%. Aprés appariement des deux populations, les paramétres sociaux, médicaux et psychologiques ont été étudiés pour 221 suicidants et 105 témoins. Leur âge moyen est respectivement de 14.8 ± 1.7

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et 14.4 ± 2 ans au moment de l'hospitalisation index et de 20 ± 3.4 et 20.2 ± 3.1 en 1993. Le recul moyen de l'étude est de 6 ans. Les paramétres pour lesquels une différence significative est mise en évidence entre les deux populations par le test du chi-carré concernent: la scolarité moins bonne chez les suicidants, leur consommation d'alcool plus importante, de même que leur nombre d'hospitalisation en psychiatrie et de suivi en consultation de santé mentale; la socialisation telle qu'elle a été étudiée est aussi moins bonne chez les suicidants. Par contre, aucune différence significative n'est mise en évidence en ce qui concerne les autres paramètres étudiés (vie familiale, emploi, pension d'invalidité, arrêts maladie et consommation de psychotropes).

Discussion et conclusion: Si certains résultats tendent à dédramatiser l'avenir des adolescents suicidants, d'autres sont par contre alarmants. Ces derniers justifient à eux seuls les efforts actuels pour mieux cerner les stratégies thérapeuthiques à court, moyen et long terme qui doivent être mises en place pour ces patients arrivant le plus souvent à l'hôpital dans un contexte d'urgence.

FORGIVENESS: AN COMPARISON BETWEEN PROSOCIAL AND AGGRESSIVE CHILDREN

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There has been surpassingly little research on how notions of vengeance and forgiveness develop and regulate behaviour. The proposed research examines how two group of children, prosocial and aggressive, resolve conflict raising issues of forgiveness. Understanding how they decide whether to retaliate, resent or forgive could be important for understanding the rising tide of youth violence and social maladjustment. Forgiveness may be a stable feature of children's socio-moral development, and therefore a solid base for social accepted behaviour.

PRISE EN CHARGE HOSPITALIERE DE L'ANOREXIE: INTEGRATION DES DIFFERENTS ABORDS PSYCHOTHERAPIQUES

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La prise en charge des anorexiques restrictives ou boulimiques nécessite la plupart du temps une hospitalisation dans un service psychiatrique spécialisé dans les Troubles du Comportement Alimentaire (T.C.A.) et un abord intégrant différents modèles psychothérapiques de façon harmonieuse. Une prise en charge cognitivo-comportementale est fondée sur un contrat thérapeutique, qui constitue la base de cette hospitalisation. Ce contrat a pour but le rétablissement d'un comportement alimentaire adapté et la restauration du statut pondéral. Il se fonde sur les principes des conditionnements vicariant et opérant, utilisant des techniques de désensibilisation, de modeling, d'exposition in-vivo et de prévention de la réponse. L'abord cognitif vise à réduire les erreurs cognitives par l'éducation et à une restructuration cognitive globale inspirée des techniques de Beck.

L'anxiété généralisée est prise en charge par une relaxation de type Jacobson, et l'anxiété sociale, par les thérapies d'affirmation de soi.

Parallélement, d'autres abords psychothérapiques peuvent être proposés, suivant les caractéristiques et les affinités de chaque patient. Il s'agit de psychothérapies d'orientation analytique, en face à face ou avec médiation (arthérapie). Ces médiations sont, à la Clinique des Maladies Mentales et de l'Encéphale, la peinture, le modelage, le collage ou la musique.

Les problèmes posés par l'intégration de psychothérapies reposant sur des fondements théoriques extrêmement différents sont ici étudiés.

THE LONG-TERM COURSE OF CHILDHOOD OBSESSIVE-COMPULSIVE DISORDER

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A 6–22 year outcome study of 47 patients with childhood onset OCD is presented.

Phenomenological aspects at baseline did not differ from that seen in children and adults in other parts of the world. Compulsive handwashing and obsessions regarding dirt and contamination were the most frequent symptoms, seen approximately in half of the patients.

At follow-up, the course of OCD was described according to 4 groups of outcome. Approximately one fourth of the patients fell in each group:

1. No OCD in adulthood;
2. Subclinical OCD symptoms in adulthood;
3. An episodic course of OCD in adulthood;
4. Chronic OCD in adulthood.

In practically all cases where psychopathology was present, OCD was the main disorder. The intraindividual continuity of specific obsessive-compulsive symptoms was low.

Frequent comorbid symptoms at follow-up were depression and symptoms of anxiety.

Probands with OCD at follow-up had significantly lower social functioning than probands without OCD.

NR21. Biological and treatment issues in affective disorder — II

Chairmen: T Dinan, S Checkley

EPIDEMIOLOGY OF BIPOLAR DISORDER: NEW DATA

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12 modern epidemiological studies have been carried out worldwide, using the Diagnostic Interview Schedule [1]. These studies have identified DSM-III bipolar disorder in 0.5% (mean) of the population, with a range of 0.0 to 1.2%. A further 6 studies however, reported rates of the bipolar spectrum affecting 1.6 to 6.5% of the population. These studies largely used other interviewing methods, and to a varying extent included atypical bipolar disorder, cyclothymia and hypomania in the bipolar spectrum. Methodological difficulties occur due to the frequent absence of insight or feeling ill of hypomanics, due to shortcomings in interview questions, or of the definitions. Data of the Zurich cohort study, indicates the prevalence of DSM-IV hypomania/mania in 5.5%; in addition 2.2% of subjects were suffering from recurrent brief hypomania (RBM). RBM demonstrates good validity, shown by a positive family history for depression and by a high lifetime suicide attempt rate. RBM is strongly associated with major depressive episodes or other forms of depression. About 50% of RBM cases overlap with cyclothymia. The inclusion of RBM as a diagnostic category is suggested. The true

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