amygdala. Among regulated genes are both systems previously implicated in alcoholism, e.g. several glutamatergic genes and manoamine oxidase, as well as interesting novel candidates, such as the cannabinoid CB1 receptor, and several kinases in the mitogen-activated protein (MAP) kinase pathway. Our findings illustrate that this strategy has an ability to identify targets which are not only correlative but may also be causally related to the alcoholic phenotype: both acamprosate, a partial agonist at glutamatergic NMDA-receptors, and a CB1 antagonist suppress alcohol drinking in subjects with a history of dependence, but not in regular laboratory rats. The application of this strategy promises to provide attractive targets for future drug developments efforts.

S22. Nosology, epidemiology and biology of somatoform disorders – Part I

Chairs: A. Janca (AUS), M. Maes (NL)

S22.1

Measurement of somatisation: a cross-cultural perspective

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Objectives: To develop and evaluate cross-cultural applicability and reliability of instruments for the assessment of medically unexplained somatic symptoms in different cultures.

Method: A set of assessment instruments based on ICD-10 and DSM-IV criteria for somatoform disorders was developed and evaluated in the context of the WHO International Study of Somatoform Disorders, which included 11 countries and 1200 patients presenting with medically unexplained somatic symptoms in primary care and general medical settings.

Results: WHO instruments for the assessment of somatoform disorders were found to be suitable and reliable tolls for the assessment of medically unexplained somatic symptoms in different cultures. Patients with somatoform disorders were found in all cultures. However, there was a significant difference in the prevalence of specific diagnostic categories of somatoform disorders across cultures.

Conclusions: Somatisation is a universal phenomenon and the most frequent symptoms of somatisation are multiple and medically unexplained aches and pains. A number of culture-specific symptoms of somatisation have to be taken into account in order make diagnosis of somatisation in specific cultures, which may explain the difference in prevalence rates of somatoform disorders across cultures.

S22.2

The epidemiology of somatization

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The essential feature of somatization is that the patients present physical complaints suggesting a physical disease that cannot be adequately explained on the basis of any known organic pathology or pathophysiological mechanism.

Physical symptoms and sensations are extremely common in the general population and a high proportion of patients seeking health care present with medically unexplained physical symptoms. About $\frac{1}{4}$ of the patients in various medical settings including primary care fulfil the diagnostic criteria for an ICD-10 or a DSM-IV somatoform disorder. Somatization may thus be considered as a spectrum of severity ranging from a normal reaction to very severe illness.

Somatization is associated with a wide range of other mental disorders.

Medically unexplained symptoms and somatoform disorders are more prevalent in females than males. As females more often seek health care than males, the gender difference might be due to likelihood of presentation to health care rather than real prevalence differences in the general population.

Beside the suffering that somatoform disorders cause the individual patient, the patient group poses a considerable financial burden to health and social service provision due to the high prevalence figures and their high health care utilization.

A major problem in the studies on the somatoform disorders is that the area is dogged by terminological confusion and the validity of the current ICD-10 and DSM-IV classifications of somatoform disorders are dubious.

S22.3

The significance of stress in the development of fibromyalgia syndrome

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About 7% of all women in industrial countries are struck by fibromyalgia syndrome (FMS). Ninety percent of the patients are women. Recent studies have found that long lasting stress in one form or another often precedes the onset of this disorder and that stress also may worsen and maintain the symptoms.

In our studies, we have found that 65% of the patients with FMS have had some kind of stressful life events that affected them emotionally very negatively in relation to the onset of the FMS. Also in child-hood and adolescence the patients had more stressful events compared to healthy controls. Many patients also developed the disorder close to physical stress such as long-standing infections, low back pain and accidents. Others have developed the disorder after sudden changes in the sex hormones as at postpartum and after abortion. Forty-four percent of the patients also had co-morbidity with the premenstrual dysphoric disorder (PDD), and the same proportion also had some kind of affective disorder. The influence of the sex hormones on the symptomathology was illustrated with significantly higher scores on pain, stress, physical and psychological symptoms perimenstrually compared to in the ovulatory phase of the menstrual cycle, beside perturbed neuropeptide levels. Furthermore, in a personality study, 82% of the patients scored high on the temperament variable "harm avoidance", which means that these patients get easily anxious/distressed.

The results are interpreted as a vulnerability in women in general for developing stress related disorders and that FMS may be a late phase in a continuum of a chronic stress states. Women with stressful life events, earlier depressions and an anxious personality with high ambition, loyalty and a stressful every day life, are probably more likely for developing the FMS or other stress related disorders. Highly qualified care-givers focused on psychosocial and individual interventions, stress-reducing treatments and education are needed to help high risk women from developing the FMS and to help those of them who already are struck by the disorder.

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