However, currently available studies in this area are not numerous, and often suffer from multiple methodological flaws. Furthermore, it is seldom realized that the assessment of "response" to lithium prophylaxis is a very complex task, for several reasons, including the irregularity of the natural course of bipolar disorder, the multiplicity of the dimensions on which "response" has to be evaluated, and the frequent inadequacy of the exposure of bipolar patients to lithium.

The present lecture, based on the 20 years of experience of the Naples group, aims to answer the following questions: a) how many bipolar patients started on lithium prophylaxis are still on treatment after five years? b) what are the most frequent causes of interruption of prophylaxis before that term? c) what are the patterns of outcome of prophylaxis which can be identified after five years? d) what are the most significant clinical and demographic correlates of those patterns? e) what are the prevalence and predictors of "late non-response" to prophylaxis (i.e., reappearance of multiple affective episodes after five years or more of completely successful treatment)? f) what are the prevalence and predictors of "lithium-discontinuation-induced refractoriness" (i.e., refractoriness to reinstituted lithium prophylaxis in bipolar patients who had relapsed after discontinuation of successful lithium treatment)?

PL8. Plenary Lecture — William Sargant lecture

DRUG TREATMENT FOR ANXIETY DISORDERS: A LEGACY OF WILLIAM SARGANT

M.G. Gelder. *Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX*

In 1962 Sargant and Dally published their seminal paper on "The treatment of anxiety states by antidepressant drugs". Since that time several kinds of progress have made on the basis of these original findings: (a) the classification of anxiety disorders has been extended and improved; (b) new antidepressant drugs have been introduced; (c) the original clinical observations have been followed by randomized controlled trials; and (d) new psychological treatments have been developed. These developments will be reviewed to determine the value of antidepressant treatment for the various anxiety disorders and how psychological and drug treatments can best be combined. The lecture will end with a reference to the implications of these findings about treatment for theories of the aetiology of anxiety disorders.

PL10. Plenary Lecture

NOSOLOGO-MANIA AND COMORBIDITY IN PSYCHIATRY

J. Angst. *Psychiatric University Hospital Zurich, P.O. Box 68, CH-8029 Zurich, Switzerland*

The term "Nosologo-mania" [1] signifies the inflation of psychiatric diagnostic categories as illustrated by the development from DSM I to DSM IV. In addition the modern non-hierarchical approach makes for a multitude of cross-sectional and longitudinal psychiatric diagnoses, and so for further complexity. What is the future of this development?

Given the low validity of the majority of diagnostic sub-categories, the spectrum concept suggested early on by Kety et al. [2] for schizophrenia and by Klerman [3] for mania is to be recommended. This synthetic view, which assumes homogeneity, simplifies the diagnostic complexity, and advocates of other concepts have the burden of proving heterogeneity. Further spectra worth considering are anxiety states including panic and social phobia including avoidant personality disorder.

Comorbidity between psychiatric syndromes is a frequent phenomenon, which can be highly specific, for instance mania plus depression, or very unspecific, for instance the association of recurrent brief spells of anxiety with GAD, panic disorder or OCD.

Whether two or more psychiatric diagnoses occur simultaneously or sequentially is of practical relevance for treatment and prognosis. From a theoretical point of view a clinical association needs to be studied through epidemiological samples, including family data, and data on the temporal sequence of syndromes. Retrospective data based on patients' recall of onset raise problems of reliability, which not even prospective studies can solve completely. Controversies around primary and secondary syndromes, for instance agoraphobia related to panic disorder, belong to this context. Our epidemiological data show that the age of onset of psychiatric syndromes is usually identical, whether they occur as pure or comorbid conditions, which questions the principle of the distinction between primary and secondary syndromes.

[1] van Praag HM (1995) Concerns about depression. Eur Psychiatry 10: 269–275.
[2] Kety SS, Rosenthal D, Wender PH, Schulsinger F (1968) The types and prevalence of mental illness in the biological and adoptive families of adopted schizophrenics. In: Rosenthal D, Kety SS (eds) The transmission of schizophrenia. Pergamon, Oxford, 345–362.
[3] Klerman GL (1981) The spectrum of mania. Compr Psychiatry 22: 11–20.

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