therapeutic effects against all domains of schizophrenic morbidity; 3) they have an extensive side effect profile. The thrust of new drug development has been to identify new compounds that have enhanced antipsychotic efficacy and reduced side effects as compared to standard neuroleptic compounds. Toward this end, drug development strategies have been employed which depart from the standard approaches which pursued D-2 receptor antagonism as the "Holy Grail" of antipsychotic activity to produce novel compounds instead of "me too" neuroleptics.

Several lines of research have been pursued which can be summarized as follows: 1) selective dopamine receptor (D-1, D-2, D-3, D-4) antagonists; 2) serotonin receptor (5-HT-1a, 1c, 2, 3, 6, 7) or mixed 5-HT2/D-2 receptor antagonists; 3) selective dopamine agonists or partial agonists; 4) mixed neuroreceptor antagonists that combine multiple pharmacologic properties, e.g, DA, 5-HT, adrenergic, etc; 5) sigma site antagonists; 6) neuropeptide agonist/antagonists. In addition to more favorable side effect profiles, a typical antipsychotic drugs offer the promise of superior efficacy that may be reflected in various measures of disease morbidity as well as provide new insights into the pathophysiological basis of schizophrenia. Clozapine, remoxipride and risperidone are the first atypical antipsychotic drugs to become available for clinical use. Other compounds, including olanzapine, sertindole, seroquel, iloperidone and ziprasidone among others, are in development many of which should become available between now and the end of this century.

HOPE FOR A NEW BEGINNING

Lori Schiller, Nancy Schiller.

There is hope for the mentally ill. We know it. We have experienced the emergence from the hell of madness to a life where pleasure and tranquillity are the true reality. We use the plural "we" because mental illness is not the problem of an individual but the concern of family and friends as well. We suffer together.

Lori Schiller was an exceptionally bright, achieving and socially adept youngster who seemed to excel in everything she did. Suddenly, however, she began to experience the symptoms of a severely mentally ill teenager. She had visual and auditory hallucinations, had trouble concentrating in school, had thoughts of self-destruction, and felt out of control in her social and work relationships. She kept these thoughts and feelings hidden for several years, but ultimately was hospitalized after a suicide attempt at age 21. It was only then that the family became aware that a significant problem existed.

During the nearly nine years of psychiatric hospitalization that followed, she had 21 electric shock treatments, was given dozens of different forms of medication (both neuroleptic drugs as well as those to counteract their side effects), had several psychotherapists and was subject to various demeaning "therapies" that serve to quiet rather than resolve the turbulence of the helpless patient. Diagnosed initially as having a "schizoaffective disorder," she was so sick at one point that an attendant was prescribed to be within arms length at all times, 24 hours a day.

The private hospital where she had been "housed" for a number of years decided they could help her no further and suggested that she be placed in a state institution for the remainder of her life with little hope for improvement, let alone recovery. Fortunately, Lori heard about an experimental drug, Clozaril, that was being considered for certain patients. The staff was hesitant to include Lori in the experimental group because of potentially serious side effects of the medication. Nevertheless, we insisted and thus embarked on the road to recovery.

Lori is out of the hospital for more than six years. She has her own apartment, drives her own car, has an active social life and works as a management case worker with the recovering mentally ill and substance abusers. She has co-authored a book, "The Quiet Room", published by Warner Books and translated into more than seven languages. The book details her illness, the impact it has had on her family and friends, and her escape from schizophrenia. She now travels the world with her mother. Nancy, giving a message of hope to patients, their families and the mental health workers who too often give up prematurely. They are now collaborating on a monograph for families of the mentally ill, giving them hope and guiding them on how to deal with the multi-faceted issues involved with schizophrenia.

Their presentations will include Lori's personal story of hope and recovery, while Nancy will address issues of stigma, guilt and the interaction with physicians and other mental health workers.

THE USE OF COGNITIVE BEHAVIOUR THERAPY IN THE TREATMENT OF SCHIZOPHRENIA

Nicholas Tarrier. *Professor of Clinical Psychology University of Manchester*

This paper will discuss the recent developments in the use of cognitive behaviour therapy in the treatment of schizophrenia. A number of approaches have been developed simultaneously in the UK and this paper will focus mainly on that developed in Manchester. The literature suggests that a significant group of patients who suffer from schizophrenia will continue to experience persistent hallucinations and delusions despite the use of neuroleptic medication. These persistent symptoms are frequently distressing and interfere with the patient's ability to function. A number of researchers have noted that many patients who do experience such persistent symptoms make active attempts to cope, master or overcome these psychotic symptoms and the emotions that they evoke. From this finding we devised a treatment approach that was designed to enhance a patient's ability to cope with their psychotic symptoms by systematically training them in coping strategies. In our first trial we compared this coping training with another cognitive behavioural approach, problem solving. We predicted that coping training would significantly reduce positive psychotic symptoms and would also result in an improvement in the patient's level of social functioning. The problem solving treatment, however, should have no affect on psychotic symptoms but should improve functioning. The results showed that both coping and problem solving resulted in a decrease in psychotic symptoms compared to waiting time, during which there was no improvement. There was some evidence suggesting greater benefit from coping training compared to problem solving. Both treatments were well received by the patients. However, neither treatment resulted in any improvements in negative symptoms or in social functioning. In our second trial an extended treatment was devised that combined coping training, problem solving and relapse prevention strategies. This treatment was compared to supportive psychotherapy and to routine care. The preliminary results from this trial will be discussed. These initial trials have been addressing the problems of patients with persistent drug-resistant psychotic symptoms there is now preliminary evidence that cognitive behaviour therapy can be used effectively with patients admitted to hospital for an acute episode and results in speeded recovery and decreased time in hospital. The results of our pilot study in Manchester will be described along with a multi-site inpatient study funded by the MRC which has just started.

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