care should be carried out and should integrate quantitative and qualitative variables, including measures such as quality of life, unmet needs, satisfaction with services and costs. In the last few years we developed an integrated model for assessing the outcome of care *routinely:* the South-Verona Outcome Project (OUT-*pro*). According to this model, variables belonging to four main dimensions are considered: clinical variables, social variables, variables concerning the interaction with services (specifically, needs for care, satisfaction with services, family burden) and data on service utilisation and costs. Most of the assessments are actually completed, after a short training, by the clinicians themselves, some other assessments are made by the patients, with the help of research workers. A comparison of results obtained in the group of psychotic patients (those with a diagnosis of schizophrenia, schizotypal and delusional disorder; affective disorder and organic psychosis) and non-psychotic patients will be presented. These data indicate that in South-Verona the diagnosis of psychosis is not necessarily a marker for unfavourable life conditions and that the South-Verona CPS meets the demands of psychotic patients. Moreover, they indicate that the perspective of patients and professionals convey complementary point of views.

TRUE VERSUS TREATED PREVALENCE OF PSYCHOSIS — THE PRISM CASE IDENTIFICATION STUDY

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In a defined population of 47, 800 for one mental health sector in the Camberwell Health Authority in South London, a comprehensive case identification study was carried out. There were two aims. First, to establish baseline service contact for a prospective study of the outcomes of introducing community mental health teams. Second, to establish more precise data on true one year prevalence of psychosis in the community. The method used was to find possible cases from contacts within the index year with mental health, general health and primary care and social services. In addition, church ministers, probation officers, users groups and a wide range of housing, voluntary and homeless agencies were contacted. Possible cases were screened using the OPCRIT system [1] to define ICD-10 and DSM IIIR cases. From 718 initial possible cases, less than half were confirmed, using this research diagnostic procedure, as having a functional psychosis. The characteristics of the social and demographic patients will be described, along with their history of psychiatric service contact, with particular reference to differences between the three main patient groups: current-contacts (mental health services), past-contacts, and never-contacts. The implications of these results for data from other studies, based only upon current secondary service level contacts, will be discussed.

[1] McGuffin P, Farmer A. And Harvey I. (1991). A Polydiagnostic Application of Operation Criteria in Studies of Psychotic Illness. Arch. Gen. Psychiatry, 48, 764–771.

S29. Conceptual obstacles to research progress in affective disorders

Chairmen: GA Fava, P Bebbington

THE CONCEPT OF RECOVERY IN AFFECTIVE DISORDERS

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The definition of recovery is a current pressing need of psychiatric research and practice. It is hindered by conceptual and methodological problems and by the relative paucity of studies on the psychobiological assessment of patients judged to be remitted, particularly in affective disorders. Only a very small percentage of patients, regardless of the affective disorder (bipolar illness, unipolar depression, panic, agoraphobia, social phobia and obsessive-compulsive disorder) and the therapy involved (whether psychotherapeutic or pharmacological or both), appears to be fully asymptomatic after treatment. The majority of patients experience residual symptoms, which are among the most powerful predictors of relapse or recurrence. There is preliminary evidence suggesting a relationship between prodromal and residual symptoms in affective disorders (the rollback phenomenon) and that improving these subclinical symptoms may ameliorate outcome. Clinicians treating patients with affective disorders often have partial therapeutic targets, neglect residual symptomatology and equate therapeutic response with full remission. A reassessment of the concept of recovery, which may provide new directions for therapeutic efforts specifically directed to residual symptomatology, is presented. Examples of such novel strategies are provided.

PSYCHOTHERAPY AND PHARMACOTHERAPY IN ANXIETY DISORDERS

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Many myths stand in the way of advancing treatments for anxiety disorders. Evidence will be presented against common illusions that:

1. treatment can be matched tightly to diagnosis;
2. disorders with physical bases require physical treatment (usually meaning medication) and disorders with psychological causes need psychotherapy;
3. brief, appropriate and effective psychotherapy is less cost-effective than medication;
4. it is hard to learn to do brief effective psychotherapy;
5. years of ongoing treatment can be justified from brief trials lasting a few weeks or months (the idea that chronic treatment need not to be based on results from chronic trials);
6. results from randomised controlled trials are always a reliable basis for clinical decisions;
7. patient satisfaction is unimportant in deciding which treatment to give.

RELAPSE AND CHRONICITY IN DEPRESSION

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In the last ten years it has become clear that, although with modern treatment the immediate outcome of depression is generally good, on longer term follow up there are high rates of symptom return.

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We have been carrying out a series of studies into this problem. In this presentation questions will be addressed about the nature of outcomes after acute treatment and factors contributing to them. In a prospective longitudinal study, predominantly of inpatients, remission below major depression was achieved within 15 months in all but 6%. However, 40% relapsed in the next 15 months. An important finding was the presence of residual symptoms reaching 8 or more on the Hamilton Scale in 29% of remitted subjects, 78% of whom subsequently relapsed. Residual symptoms are an important outcome in depression which has received insufficient attention. In a second follow up study at 18 months of a new sample, aftercare received following discharge from hospital has been examined. Data obtained include full details of medication prescribed and taken, all other forms of treatment and care, compliance, attitudes and satisfaction.

FUNCTIONAL PSYCHOPATHOLOGY AND THE DIAGNOSTIC PROCESS IN PSYCHIATRY

H.M. van Praag. *Academic Psychiatric Centre, University of Limburg, P.O. Box 616, 6200MD Maastricht, The Netherlands*

Functional psychopathology is an important though greatly neglected and underdeveloped component of the diagnostic process in psychiatry. The functional approach provides a much more precise and detailed picture of the psychopathology of a given patient than nosological and syndromal diagnoses can. Moreover, in this manner the unsurmountable problems caused by comorbidity in defining a mental condition, can be circumvented. Since many psychological dysfunctions are measurable, often in truly quantitative terms, functional psychopathology provides psychiatric diagnosing with a solid scientific foundation.

Functional psychopathology of a psychiatric condition is a prerequisite for, what I have called "verticalisation" of psychopathological phenomena, while "verticalisation", in its turn, is a prerequisite to target biological and psychopathological research much more accurately than has been possible so far.

Finally, the functional approach provides an opportunity to investigate the relative merits of the nosological disease model and the reaction form model of mental disorders for biological research in psychiatry. The latter model has been disregarded for a long time; I would rather say, for too long.

[1] Van Praag, H.M. (1995) Concerns about Depression. Eur. Psychiatry 10: 269–275.
[2] Van Praag, H.M. (1996) Over the mainstream — Diagnostic Requirements for Biological Psychiatric Research, Eur. Psychiatry, submitted.

S30. Gender and dementia

Chairman: L Whalley

OESTROGEN MAY AFFECT MOOD AND MENTAL STATE BY AN ACTION ON SEROTONIN$_{2A}$ RECEPTORS AND SEROTONIN TRANSPORTER

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Oestrogen exerts profound effects on mood and mental state. Low levels of oestrogen in women are associated with postmenopausal depression, postnatal depression and the depressive symptoms of the premenstrual syndrome. Sex differences in schizophrenia may also be related to oestrogen. Previous studies have shown that oestrogen stimulates a significant increase in dopamine$_2$ (D_2) receptors in the striatum and we have now shown that in the rat oestrogen stimulates a significant increase in the density of 5-hydroxytryptamine$_{2A}$ (5-HT$_{2A}$) binding sites in anterior frontal, cingulate and primary olfactory cortex and in the nucleus accumbens, areas of the brain concerned with the control of mood, mental state, cognition, emotion and behaviour. Our investigations have also demonstrated that oestrogen stimulates a relatively massive increase in the concentration of the serotonin transporter mRNA in dorsal raphe nucleus and that this corresponds with an increase in serotonin transporter binding sites in this nucleus as well as other areas of the rat brain concerned with behaviour. These findings provide a possible neuropharmacological explanation for the effect of oestrogen on mood and mental state, and the efficacy of oestrogen therapy or 5-HT uptake blockers, such as fluoxetine ("Prozac"), in treating major depression and the depressive symptoms of the premenstrual syndrome. Our findings also suggest that the psychoprotective effects of oestrogen in schizophrenia may be mediated by 5-HT$_{2A}$ as well as D_2 receptors.

Further molecular pharmacological studies are in progress to determine the precise mechanism of action of oestrogen, and neuroimaging studies are being carried out to determine whether oestrogen has similar effects on the serotonin transporter in the human brain.

S31. The long-term outcome of psychiatric disorders

Chairmen: J Angst, C Duggan

SUICIDE IN YOUNG SCHIZOPHRENIC PATIENTS, A CASE CONTROL STUDY

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Schizophrenia is a life-shortening disease and suicide turns out to be the major cause of death. The aim of our study is to identify possible risk factors for suicide in young schizophrenic patients.

We studied a large cohort of 870 DSM-III-R young schizophrenic patients (Age < 30 at index admission), consecutively admitted between 1973 and 1992. The mean duration of follow-up was 11 years and all patients were located. We adapted a matched case control design with matching for: sex, age and subtype. Lifetime psychiatric history was obtained for both cases and controls.

At follow-up 7.2% (N = 63) of all patients committed successful suicide, this is 9.1% for males and 4.2% for female patients. The S.M.R. for suicide is 39.7. 81% used a high-lethal mean and 52% died during an inpatient stay. 77% of the suicides were male. The mean age of suicide was 28.5 years.

Major risk factors are: N admissions > 4 ($p < 0.000$); short duration hospital stay ($p < 0.000$); past suicidal behaviour ($p < 0.000$) and attempts ($p < 0.000$); negative attitude towards treatment, fugues ($p < 0.000$), acting-out ($p < 0.000$), non compliance ($p < 0.000$); major loss ($p < 0.000$); psychosis ($p < 0.000$); depression ($p < 0.000$). Other risk factors are: IQ > 100; discharge against advice; use of antidepressants; living alone at index admission; residential psychiatric care. Odds Ratios are calculated for every risk factor.

Based on these risk factors we developed hypothesis on suicidal

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