Conclusions: For the schizophrenic patients, social problem-solving efficiency relies mostly upon attention and executive functions. This correlation is restricted to this group. The link between neurocognitive performances and social skills may be due to the impairment associated with the schizophrenic process, rather than to a non-specific relationship between cognitive variance and social competence. This issue is important regarding schizophrenia and its functional outcome. Also, support is given to the usefulness of the combination of neurocognitive training with social skills training in social rehabilitation, at least for the training of the kind of skills involved in social challenges as featured by the AIPSS.

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ANNOUCEMENT OF DIAGNOSIS OF SCHIZOPHRENIA

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The annoucement of diagnosis in psychiatry is more and more widespread. But in France, it still remains a controversal practice in the patient's care. Following the example of other medical disease, we hope that patients, knowing more about their illness, will better observe and participate to the medical attention. Consequently, a better observance and less frequent and less severe relapses are waited for. Clinically, the annoucemnt of diagnosis may come up against anognosia, which is an inherent symptom in the illness, and often a worsening factor, hindering the good proceed of care.

The annoucement can help the patient to limit the baneful effects of this symptom. This study proposes to evaluate the annoucement of diagnosis's impact, whose information elements will be formalised Day1, Day7, Day28 after on a population of 30 schizophrenic patients. 3 supervised interviews and evaluation of patients with avisual analogical scale will be performed. It will permit to appreciate the persistance of the given information about the illness and the potential psychopathological consequences on the short and middle-term.

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COMEDICATION IN PSYCHIATRIC ILLNESES

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Several reasons stand behind the rationale for the use of combination therapy. It has been hypothesised that this strategy likely target the different neurotrasmitter systems involved in the pathophysiology of psychiatric disorders. Indeed, neurotrasmitter imbalances in some areas of the CNS as well as neuroanatomical and neurophysiological abnormalities may coincide for different nosological entities and therefore, monotherapy is usually insufficient to adequately treat an individual nosological category. Additionally, augmentation strategies, when residual or recurring symptoms are not controlled with a single primary agent, or when the disease is resistant to one or more monotherapies has also been advocated. There are reports in the literature which associate combination therapy with better clinical outcome. However, controlled clinical trials with enough number of patients are lacking to support the use of this polypharmacy and the risk for the appearance of potential pharmacokinetic and pharmacodynamic drug interactions that frequently lead to the increase incidence of severe side effects is not mall. In our presentation the rationale behind the proposed combination therapies (especially in the treatment of schizophrenia, major depression and bipolar disorders), their clinical outcome and their potential for the development of side effects as reported in the literature will be reviewed.

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MENTAL HEALTH SUPPORT FOR WAR REFUGEES

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During spring 1999 more than a million had to flee from Kosovo. 300000 escaped to fYR Macedonia, 700000 to Albania. The influx of refugees was enormous, thousands crossed the border daily. This caused an enormous turbulence, because the refugees were continually transferred to other camps.

The refugees arrived scared and in chock after a few days of travel. The immediate needs were protection and shelter, the next food and information. After a few days the impact of the trauma became more obvious, with denials, repeating of memories, dissolving or hiding emotions and behavioral symptoms.

Medical services were arranged in the camps with mental health. The services were mostly individual visits to a health worker, usually a health worker among the refugees – hired by an organization. The patients sought relatively often help for somatization. The treatment was usually pharmacological.

The refugees shared their experiences first with their family, relatives or people from the same villages. The refugees searched very actively for people they knew from before, with the same cultural background. This network was clearly the most important source of comfort and support. Non therapeutic activities as sports or different leisure activities were important as also domestic tasks.

The coordination task of the organizations and activities in the camps was enormous. More than 100 different international organization participated. Local Macedonian and Albanian professionals were not properly involved in the services.

A guideline of the mental health and psychosocial services needed by war refugees in should be prepared. Local professionals should be involved. Other forms of support than individual visits must be arranged. The observations above were collected by WHO-EURO during the Kosovo crises 1999.

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COMPARISON OF THE TREATMENT OUTCOME MEASURES IN PANIC DISORDER

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Background and Objective: The monitoring of the outcome of treatment of panic disorder (PD) has recently been improved by introduction of Panic and Agoraphobia Scale (PAS) and Panic Disorder Severity Scale (PDSS). The goal of this study was to compare the efficiency of these instruments for measuring the outcome of treatment of PD.

Methods: 96 patients with PD were treated with cognitive-behaviour therapy (CBT) and pharmacotherapy. CBT was performed over the course of 16 sessions, followed by "booster" sessions once a month. Pharmacotherapy involved an 8-month course with an SSRI plus a 6-week initial treatment with a high-potency benzodiazepine. The scores on the PAS and PDSS were obtained at baseline and after 8 months of treatment.

Results: Patients showed a significant improvement on both the PAS and PDSS scores. However, the magnitude of the improvement ($p = 0.002$) was greater when the PAS scores at baseline and posttreatment were compared with the PDSS scores at baseline and posttreatment ($p = 0.03$). The improvement demonstrated by the PAS correlated more closely with clinical observations.

https://doi.org/10.1016/S0924-9338(00)94761-8 Published online by Cambridge University Press