behaviour in schizophrenic patients and possible interventions. These include: discussion of suicidality in treatment, psycho-education, continuity of care, work on grief and losses, attention to suffering and not only symptoms, adapted living — and work environment, adequate treatment of psychosis and depression.

LONG-TERM OUTCOME OF SCHIZOPHRENIA

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The WHO International Study of the Determinants of Outcome of Severe Mental Disorders (DOSNMeD) identified inception cohorts of psychotic patients in ten countries including both 'developing' and 'developed' cultural settings. The International Study of Schizophrenia (ISoS) is a 13 year WHO co-ordinated follow-up of these and similar samples. We report data from the UK (Nottingham) field center. Ninety-six percent of the original psychosis cohort (n = 99) were traced to residence or point of death (n = 9). None were found homeless or in prison and only two patients were in residential accommodation. Of those assigned a project diagnosis of schizophrenia at onset, 55% showed good or fair social functioning and over 50% were free of psychotic symptoms over the last two years. However, only 17% of the cohort were alive, completely free of symptoms and receiving no treatment. Predictors of long-term outcome were early (2 yr) course type, female gender, age, marital status and acuteness of onset, accounting for over 40% of variance in disability and symptoms. Analysis of course types produced no evidence of progressive deterioration or amelioration, and there was no evidence of 'late recovery' at this stage of follow-up. These findings will be compared and contrasted with preliminary data from other ISoS collaborating centers.

PREDICTORS OF LONG-TERM COURSE IN DEPRESSIVE ILLNESS

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In 1988 we published an 18 year outcome study of depressed inpatients from the Maudsley Hospital, London. 89 consecutive admissions with primary major depressive episodes had been prospectively ascertained and interviewed by R E Kendell in 1965–66. Follow-up was by a trained psychiatrist using standardised instruments who interviewed 94% of the survivors, and was blind to the index data. Over one third suffered unnatural death or severe chronic distress and handicap. Less than one fifth of the survivors had remained well. Similar results from other modern follow-up studies have led to a new focus on the long-term risks of a severe depressive illness. Since depressive disorders are common whilst resources are limited, there is an urgent need to predict at an early stage which patients will develop recurrent, resistant and complicated illnesses, to aid the targeting of preventative strategies.

We have now completed a family study of the Maudsley series. A trained psychiatrist blind to all proband data has used standardised interviews to determine the psychiatric histories of 519 first degree relatives. We present the results of this study together with predictors derived from the index admission. Three predictors of poor global outcome have emerged. 1) A family history of in-patient treatment for depressive disorder, a psychotic episode, or suicide. 2) High (psychotic) scores on Kendell's neurotic-psychotic index, or DSM III melancholia. 3) High neuroticism scores on recovery.

Family history was a strong predictor. Of 24 patients with a family history, none had a good outcome and 20 (83%) were readmitted. The three predictive factors together were multiplicative, so that patients with a family history, and melancholia, and high neuroticism were 15 times more likely to have a very poor outcome.

We have found risk factors in each of the domains of family history, phenomenology and personality. Their predictive power over 18 years, despite many intervening variables, is strong evidence for their importance in causal models. They await replication, but are clinically useful hypotheses to help target biomedical and cognitive prophylaxis.

LONG-TERM PROGNOSIS OF UNI- AND BIPOLAR DISORDERS

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A dichotomy of schizoaffective disorders into unipolar and bipolar schizoaffective disorders, analogous to the dichotomy of unipolar and bipolar affective disorders, seems to be justified in that the differences between the former resemble those between the latter. The most important differences between unipolar and bipolar schizoaffective disorders were found regarding gender, premorbid personality, occupation at onset, social class at onset, number and frequency of episodes and cycles, mean length of cycles, length of intervals and inactivity period. Unipolar affective disorders differ from bipolar affective disorders in the following parameters: age at onset, occupation at onset, premorbid personality, stable heterosexual relationship, family members with schizophrenia, frequency of long-lasting preepisodic alterations, number and frequency of episodes of illness, mean length of cycles and length of intervals. The most important differences between the unipolar forms of the two disorders (affective and schizoaffective) were in age at first manifestation, which was lower in unipolar schizoaffective patients than in unipolar affective patients, and in outcome, more favourable in the unipolar affective than in the unipolar schizoaffective disorders. Between the bipolar forms of the two disorders (affective and schizoaffective) only small differences were found, regarding some more favourable social aspects of outcome. Building a voluminous group of unipolar disorders and a voluminous group of bipolar disorders similarities and differences remain stable, as between the unipolar and bipolar forms of affective and schizoaffective disorders separately.

A THIRTY YEAR FOLLOW-UP OF THE NEWCASTLE AFFECTIVE DISORDERS COHORT

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A sample of 154 patients with affective and anxiety disorders who were admitted to Newcastle psychiatric units between 1963–5 was followed-up by an independent assessor, blind to the original diagnosis, at 30 years. No data was available on 12 patients and only limited follow-up information was available on 16 survivors. Of the other 126 patients it was possible to assess survival rates, outcome according to Lee and Murray's criteria (1988) and change in diagnosis over time. Five diagnostic subgroups had been identified originally: reactive depression (n = 42); endogenous depression (n = 30); phobic anxiety depersonalisation syndrome (n = 40); simple anxiety (n = 16); and other diagnoses (n = 14). At thirty years, 46% sample survived with the lowest survival rate (20%) in endogenous depressives and the highest (65%) in the phobic anxiety depersonalisation syndrome group. Only 10% sample had a very good outcome according to Lee and Murray's criteria. Few of the depressives were rediagnosed during the follow-up, but the majority of individuals with phobic anxiety depersonalisation syndrome went on to experience at least one episode of major depression.