in patients suffering from affective disorder or neurosis. The presentation summarizes most recent findings discussing functional and clinical implications.

THE ORIGIN OF SCHNEIDERIAN FIRST-RANK SYMPTOMS AND THE EVOLUTION OF LANGUAGE

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First-rank symptoms were proposed by K Schneider as pathognomonic for schizophrenia although he disavowed any pathophysiological interpretation. More recently the incidence of schizophrenia (defined by the presence of first-rank symptoms) has been demonstrated to be relatively constant across cultures in the WHO Ten Country Study.

In morphologic and functional studies [1] there is evidence in schizophrenia of a loss or diminution of cerebral asymmetry. It will be argued that this is consistent with a failure to establish dominance for language unequivocally in one or other cerebral hemisphere, and that the peculiar nature of first-rank symptoms arises from an abnormal interaction between dominant and non-dominant hemispheres. This theory is consistent with the view of Trimble [2] that such symptoms relate to the dominant temporal lobe; and of Nasrallah [3] that they arise as intrusions from the non-dominant hemisphere. According to this concept schizophrenia has its origin in the variation generated in the evolution of the homo-sapiens' specific capacity for language [4]).

[1] Crow, T.J. (1995) The relationship between morphologic and genetic findings in schizophrenia: An evolutionary perspective. In: Schizophrenia, Alfred Benzon Symposium 38, edited by Fog, R. & Gerlach, J. Munksgaard, Copenhagen, p. 15–25.
[2] Trimble, M.R. (1990) First-rank symptoms of Schneider: a new perspective? Br J Psychiatry 156, 195–200.
[3] Nasrallah, H.A. (1985) The unintegrated right cerebral hemispheric consciousness as alien intruder: a possible mechanism for Schneiderian delusions in schizophrenia. Compr Psychiatry 26, 273.
[4] Crow, T.J. (1995) Constraints on concepts of pathogenesis: Language and the speciation process as the key to the etiology of schizophrenia. Arch Gen Psychiatry 52, 1011–1014.

PATTERNS OF HEMISPHERE SPECIALIZATION AS INDICATORS OF VULNERABILITY TO SCHIZOPHRENIA

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Human brains reveal neuroanatomic asymmetry and hemisphere-specific involvement in particular processes and tasks. Schizophrenia is characterized by deviations from the physiological cerebral asymmetry and hemisphere-specific deficits in size of brain areas, function and blood flow. It has been proposed that the association with laterality-specific patterns present a cue to the etiology of schizophrenia. The origins of the physiological asymmetry and of deviations from asymmetry remain obscur; a codetermination by genetic factors is discussed.

Hemisphere specialization and asymmetry scores were shown to be attenuated in first episode schizophrenics of medication as compared to controls in a first study. We subsequently explored two putative determinants (sizes of hemisphere-specific brain areas and genetic factors) of the deviation of cerebral functional asymmetry in schizophrenia by a series of studies:

1. Hemisphere-specific sizes of brain areas and neuroanatomic asymmetry scores were related to functional specialization in first episode schizophrenics off medication and controls.

2. Functional hemisphere specialization was compared between healthy siblings of schizophrenics and of controls.

3. Genetic determination of patterns of functional hemisphere specialization, of other indicators of laterality and sizes of hemisphere-specific brain areas was assessed in a series of healthy twins.

Although deviant patterns of functional hemisphere specialization cosegregated with schizophrenia in families, evidence for a genetic link was not found. However, inconsistencies between indicators of laterality and hemisphere specialization is also cosegregating with schizophrenia; inconsistency between these indicators demonstrates a substantial determination by genetic factors which might also contribute to schizophrenia.

NEUROPSYCHOLOGICAL AND CLINICAL CORRELATES OF STRIATAL ASYMMETRY IN SCHIZOPHRENIA

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Research literature consistently suggests that anatomical abnormalities in schizophrenia are asymmetric, and more marked in the left hemisphere. Findings from neuromorphological, neurophysiological and neuropsychological studies support the hypothesis that the striatum could play a key role in the pathophysiology and in the production of symptoms and signs in schizophrenia.

We used an inversion recovery magnetic resonance protocol with the assistance of the Talairach atlas to identify striatal structures in thirty-five schizophrenic patients and twenty-four healthy controls. Patients also underwent a neuropsychological evaluation of executive functions by Wisconsin Card Sorting Test (WCST) and clinical assessment by standardized rating scales (Krawiecka-Manchester Rating Scale and Outcome Scale).

Results show that poor WCST performers have a reduction of the striatum complex and caudate nucleus bilaterally, and the left putamen with respect to controls. Significant correlations were only seen between neuropsychological indexes and left striatal measures. Left striatal structures also show negative correlations with positive and negative symptoms, suggesting that schizophrenic patients with more severe symptoms have more lateralized morphological anomalies. On the contrary, WCST indexes do not correlate with symptomatology but with the outcome measure.

The evidence for a lateralized dysfunction is strongly suggestive of hypotheses regarding the relationship of hemispheric asymmetries of function and schizophrenia.

S21. Towards standard European measures of outcome

Chairmen: I Marks, C Pull

TOWARDS STANDARD EUROPEAN MEASURES OF OUTCOME

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Europe-wide use and exchange of common measures of clinical outcome has come closer with computerisation e.g. of HoNOS (the UK's Health of the Nation Outcome Scale) and of patient-specific, syndrome-specific and generic ratings in systems such as CORM (Clinical Outcome and Resource Monitoring) which also measures

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the cost of treatment. Such computerisation makes it easier than before for clinics and countries to accumulate and exchange clinical outcome and cost data electronically within a *European Clearinghouse of Clinical Outcome and Cost.*

A barrier remains in the lack of agreed measures which are simple enough for clinicians to use in everyday practice as opposed to research; such measures must be 'cheap and cheerful' yet reliable and valid. Clinicians also lack incentive to spend even a few minutes rating outcome; fiscal incentives would expedite clinical audit. A European adoption of agreed simple measures of clinical outcome and the cost of obtaining it would allow the emergence of benefit-cost norms for different diagnoses, severity levels and treatments. That would improve the cost-efficiency of mental health care. In the Symposium the best way forward will be discussed with the audience by a European panel of experts.

S22. Old wine in new bottles: practising psychotherapy in diverse settings

Chairmen: S Bloch, J Holmes

GROUP THERAPY FOR WOMEN WITH EARLY STAGE BREAST CANCER

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With the increasing specialisation of cancer services, there is a need for greater emphasis on patients' psychological well-being and quality of life. Over 50% of cancer patients develop an anxiety or depressive disorder at some stage during their illness, while cancer survivors are challenged to cope with profound changes in multiple facets of their lives. Rather than waiting for psychological morbidity to develop, preventive interventions through group, family or individual therapies are desirable in a model closely integrated with chemotherapy, radiotherapy and surgical oncology.

The Melbourne Breast Cancer Psychological Therapies Project is an example of one effort to develop improved psychological care for one group of cancer patients. It is a multicentred study involving a randomised cohort of early stage breast cancer patients, in which we are assessing the effectiveness of an cognitive-existential model of group therapy in inducing positive changes in mental attitude to cancer, mood and quality of life.

Appreciating the importance of quality of life, the community has moved ahead of hospitals and cancer centres in developing an extensive network of self-help groups, which provide considerable support for many patients with cancer. We lack health professionals with skills to promote such group work in the clinical setting. A clear goal of the 1990s should be to see our hospitals develop the capacity to deliver appropriate psychosocial care to patients and families, and thus close the gap between current knowledge and actual clinical practice.

AN INTEGRATED PSYCHOLOGICAL TREATMENT SERVICE AS PART OF PSYCHIATRIC SERVICES IN A RURAL AREA

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The premise of the paper is that psychotherapy services, if they are to meet the needs of a population, must be integrated in two ways. First there must be integration among the psychotherapies. A generic psychotherapy service offering analytic psychotherapy, cognitive behavioural therapy, systemic therapies, and creative therapies is needed to meet the variety of needs of their clients. Secondly, such a psychotherapy service needs to be integrated into the work of general psychiatry. Patients suffering from schizophrenia can be offered cognitive and family therapy; patients with depressive illnesses appropriate cognitive therapy; and patients with personality disorders relevant analytic psychotherapy. Day to day ward management of patients needs to be informed by, and remain separate from, psychotherapy treatments.

The author describes the setting up of such a service in a rural area in the UK and presents preliminary findings evaluating impact of such a service, suggesting significant reductions in in-patient stay.

THE INTEGRAL DIAGNOSTIC AND INTERVENTION SCHEMA: IDIS. A SYSTEMATIC APPROACH TOWARDS CONSULTATIONS

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In the 60ties the *biopsychosocial model* was introduced. Although important, it lacked operationalisation resulting in a restricted operational application. Consultation-liaison psychiatrist, who do consults in the general hospital have been directly confronted with the complexity of the integration of physical- and psychiatric co-morbidity and its related psychosocial and health service delivery problems. This has resulted in the development of a practical operationalized model for integral assessment and treatment. This model is currently systematically used for clinical supervision of residents and as a structure to explain diagnostic and management considerations with medical-nurse staffs.

The primary goal of the integral diagnostic and intervention schema (IDIS) is to sort data obtained from the patients medical history and assessment. As such it facilitates the development of etiological hypotheses resulting in an intervention strategy. The IDIS has four rows representing the *biological (B)*, the *psychological (P)*, the *health care (HCS)* and the *social support system (SSS)*. In addition the IDIS has five columns representing data from the *long-term history*, the *recent history* and the *current state* belonging to the diagnostic part and the *diagnostic* and the *treatment* column both belonging to the intervention part of the IDIS. In addition to a generic IDIS there are specific schema's for patients who are confused, who are supposed to somatise or abuse. During the presentation the schema and it use will be presented.

	Long-term	Recent	Current	Diagnostics	Management
Biological (B)					
Psychological (P)					
Health care system (HCS)					
Social support system (SSS)					

HELPING CARERS OF PATIENTS WITH SEVERE MENTAL ILLNESS

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The role of informal carers, usually family members, in facilitating a policy of community care for patients with severe mental illness is increasingly acknowledged. An appreciation of their own needs, as distinct from family influences on the patient's illness, has only recently begun. High rates of psychological morbidity have been

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