The mechanism role and future development of cognitive behaviour approaches to chronic fatigue syndrome is discussed.

S9-6
No abstract received

S10. Suicide prevention

Chairs: D de Leo (I), R Jenkins (UK)

S10-1
EFFECTS OF ADEQUATE LITHIUM PROPHYLAXIS ON SUICIDALITY AND MORTALITY OF PATIENTS WITH AFFECTIVE DISORDERS: RETROSPECTIVE AND PROSPECTIVE STUDIES

B. Muller-Oerlinghausen*, B. Ahrens. *Research Group Clinical Psychopharmacology and Lithium Clinic Berlin; Dept. of Psychiatry, Freie Universitat Berlin, Germany*

Based on serotonin-agonistic and antiaggressive effects of lithium, both well-documented in animals and humans, we hypothesized that properly performed lithium long-term medication might have specific antisuicidal effects. Support for this assumption came from our findings that in a high risk group of the Berlin lithium clinic suicidal behaviour was significantly higher in patients having discontinued lithium than in those with regular uninterrupted medication. In the context of a large prospective multi-centre German study (MAP), in which patients were allocated at random to either lithium, carbamazepine or amitriptylin long-term treatment, it could be demonstrated that suicides and parasuicides occurred exclusively in the non-lithium groups.

Since death due to suicide is the most important cause of the 2–3 times elevated mortality of patients with affective disorders, a reduction of suicidal behaviour should result in a lowering of the excess mortality. Such an effect of lithium long-term treatment could be shown by various groups, e.g. Coppen in the U.K. and Nilsson in Sweden, but has been particularly demonstrated by the large collaborative study of IGSLi. It could be shown in a large international patient group equalling 5,600 patient years that the mortality during lithium long-term treatment is normalized, i.e. is no more different from the normal population, and that it rises again when lithium is discontinued. Such an effect has not been demonstrated so far for any other alternative prophylactic treatment in affective disorders.

It is concluded that lithium should remain the prophylactic agent of first choice, particularly in patients with a history of suicide attempts and that doctors should be extremely cautious when considering a discontinuation of lithium in alleged non-responders.

S10-2
WHO PROGRAMME ON THE PREVENTION OF SUICIDE: A GLOBAL INFORMATION NETWORK FOR MONITORING SUICIDE TRENDS

J.M. Bertolote. *Mental Disorders Control, Division of Mental Health and Prevention of Substance Abuse, World Health Organization, Geneva, Switzerland*

This paper will describe the WHO global information network for monitoring suicide trends, as part of its programme on the prevention of suicide. The components and procedures will be described in detail, as well as the way of accessing the appropriate information through the internet.

Updated information obtained and provided by the network will be presented and discussed.

S10-3
ARE THERE BIOLOGICAL PREDICTORS OF SUICIDE?

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Studies of biological factors related to suicidal behaviour have so far revealed two current lines of correlational evidence: monoamines and other factors related with the hypothalamic-pituitary-adrenal (HPA) axis. When evaluating biochemical studies, there are several confounding factors to be considered. Apart from questions dealing with definitions of suicidal behaviour, suicidality needs to be disentangled from diagnostic issues. Original findings of high cortisol levels in body fluids or low concentrations of the serotonin metabolite 5-hydroxyindoleacetic acid (5-HIAA) in cerebrospinal fluid (CSF) were shown in studies of patients with depressive disorders. The most marked deviances of serotonergic measures have since then been found in depressed patients with recent suicide attempts or who later presented with suicidal behaviour. It is self-evident that monoamines are affected by psychotropic drugs. Hence, study populations should be drug-free. This in turn leads to extremely selected patient materials, from which it becomes difficult to draw general conclusions. In our view, the very issue of wash-outperiods therefore needs to be studied.

Biological parameters vary during the day, month (menstrual period) and season. Also there could be correlates with sex and body height. Furthermore, being aware of the impact of diet on monoamine metabolism, researchers run into apparent problems when interpreting their results. A careful approach is thus needed when searching for biological markers predicting suicidal behaviour.

Evidently, we have not yet reached the stage for introducing biological factors in clinical routines for evaluation of suicidal behaviour. Bearing in our minds that there are indeed markers for different phenomena in somatic illnesses, we hopefully will find markers in psychiatry. Maybe by use of challenge paradigms or brain imageing we will be successful.

S10-4
THE FALL DOWNS OF THE WHO/EURO MULTICENTRE STUDY ON PARASUICIDE

A. Schmidtke[1,2]*, D. De Leo[2], U. Bille-Brahe[2], P. Crepet, H. Hjemeland, A. Kerkhof[2], K. Michel, I. Querejeta, B. Temesvary, E. Salander-Renberg, J. Sampaio-Faria, D. Wasserman. [1]*Dept. Psychiatry, University Wurzburg;* [2]*Steering Group of the WHO/EURO Multicentre Study on Parasuicide, Germany*

The WHO/EURO Multicentre Study on Parasuicide was introduced in the frame of the WHO programme "Health for all by the year 2000". In this programme the European region of WHO identified the prevention of suicidal behaviour as a main target. As part of the action in the implementation of target 12 of the WHO European strategy the project was designed to collect comparative data on rates and trends in attempted suicide in various European countries; epidemiological data, data about special risk groups, data about precipitating and causal factors as well as the use of services. In 1989, 16 centres in 13 European countries started to assess "real" suicide attempt rates and trends as well as the epidemiology of suicide attempts. The study as a whole increased the awareness

of the problem in many European countries and directly created a network of researchers and suicide research centres. The knowledge of risk groups was also increased. In some countries, in the context of the study, suicide prevention programmes for the whole country or specific groups were introduced, or suicide was acknowledged by the governments as a major health problem. Due to the benefits of these fall downs, the study is now expanding in more countries (Eastern and Southern countries as well as in some countries in other parts of the world).

S10-5
SUICIDE PREVENTION — AN ISSUE FOR THE WORLD BANK

R. Jenkins. *WHO Collaborating Centre, Institute of Psychiatry, London, UK*

This talk will present the burden of suicide in different regions of the World, the methodological problems of national suicide data collection, and the contribution of epidemiological suicide research to national policies for suicide prevention.

S10-6
IDENTIFYING AND TREATING DEPRESSION IN OLDER ADULTS: A KEY ISSUE IN SUICIDE PREVENTION

D. De Leo*, P. Scocco. *WHO Collaborating Centre for Suicide Prevention, Dept. Neurological and Psychiatric Sciences, University of Padua, Italy*

Data deriving from the WHO/EURO Multicentre Study on Parasuicide, for the period 1989–1993, indicate that depressive disorders are the most frequent diagnoses in non-fatal suicidal behaviour. In the elderly in particular, they represent the large majority of psychiatric diagnoses (those routinely performed). The study shows how their percentage rises through age-groups, whilst diagnoses such as personality disorders are most relevant in younger subjects and very infrequent in old age. Considering that the suicide/attempted suicide ratio in the European study in the elderly is 1:2 (almost 1:1 in men), correct identification and proper treatment of depressive disorders appears to be at the forefront of any preventive strategy in this age group. Better education of general practioners in this field also appears to be an absolute priority.

SEC11. Antecedents and early course of functional psychoses

Chairs: H Häfner (D), AH Mann (UK)

SEC11-1
EARLY ANTECEDENTS OF FUNCTIONAL PSYCHOSES

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Developmental precursors of schizophrenia suggest models of causes, mechanisms and preventive strategies. Specificity to subgroups of patients, or to schizophrenia itself amongst the psychoses is fundamental to such models. Developmental precursors of a range of adult psychiatric were studied in two longitudinal samples: the British 1946 (n = 5362), and the North Finland 1966 (n = 12058) birth cohorts. Motor and speech milestones, were later in children (n = 30 & 89, respectively) who developed DSM-III-R schizophrenia as adults. In the former, IQ at 8, 11 and 15 years was lower in these children by some 33% of a standard deviation. In the British cohort, these findings were also evident in 195 cases of childhood affective disturbance; most effects were more modest than in schizophrenia but the pattern was similar. The effects for IQ occurred across the whole population, the lower the IQ, the higher the subsequent risk of both disorders. In the Finnish cohort, motor effects were also seen in other DSM-III-R psychoses, neither were they confined to sub-groups. These overt effects are crude manifestations of underlying neural mechanisms which may differ in different disorders. Unknown factors, and/or gender, may determine outcome. Low specificity is an advantage for prevention strategies.

SEC11-2
THE EARLY COURSE OF SCHIZOPHRENIA FROM ONSET UNTIL FIRST ADMISSION

H. Häfner, K. Maurer*. *Central Institute of Mental Health, Mannheim, Germany*

Within the Mannheim ABC (age, beginning, course) study we analysed the development of schizophrenia in 232 first-episode cases with a broad schizophrenia diagnosis from onset until first hospital admission. Dates of onset and pattern of course (once, recurrent, continous) have been assessed for 66 non-specific, negative and positive symptoms by our standardised interview IRAOS.

In 3/4 of our sample schizophrenia began with a prodromal phase, lasting on average 5 years, but only in 7% it began directly with the manifestation of psychotic symptoms. 57% of the sample reported social disabilities during the early course, starting on average about 1 to 3 years before the first psychotic symptom, and 2 to 4 years prior to the first hospitalisation. The earliest positive symptoms were delusions of reference (52%), delusions of persecution (41%), and further delusions (39%). But among the 10 earliest symptoms, no positive symptom was identified. We found that schizophrenia most often begins with non-specific symptoms like tension (19%), depression (19%), anxiety (18%) and the negative symptom of impaired thinking/concentration (16%). Therefore, on average, the development of schizophrenia follows a characteristic sequence of depressive, dysphoric, and negative symptoms, and social disabilities, before the psychotic stage is reached.

Our study demonstrates a long, mostly untreated phase of early schizophrenia. As we know, that the duration of the untreated period is a predictor of an unfavorable course, early identification and early treatment is of increasing importance for schizophrenia research and clinical practice. As schizophrenia can be diagnosed only after the emergence of psychotic symptoms, early treatment has to avoid false positives, and therefore must be syndrome-related, e.g. specific for negative and depressive symptoms. Additionally, the early use of psychosocial techniques for the management of social disabilities and role deficits also is indicated.

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