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

Sidney Bloch. *Department of Psychiatry, University of Melbourne St. Vincent's Hospital, Melbourne, Victoria 3065, Australia*

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

Jeremy Holmes. *Department of Psychiatry, North Devon District Hospital, Barnstaple, Devon EX31 4JB, England*

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

Frits J. Huyse. *Psychiatric Consultation Service University Hospital Vrije Universiteit Amsterdam The Netherlands*

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

https://doi.org/10.1016/0924-9338(96)88487-2 Published online by Cambridge University Press

described and a small number of studies examining attempts to reduce these have been reported. These will be reviewed together with a study carried out by the author involving a randomised controlled trial of a six-session, home-based family intervention aimed at reducing the negative aspects of caregiving and psychological morbidity, as well as improving coping and well-being.

It is concluded that short-term interventions, whether mainly educational or more ambitious in scope, have a modest impact on carers' understanding of the illness and the development of positive attitudes to the patient. Reducing caregiver distress or psychological morbidity is more difficult, as is changing coping styles.

The nature of work with carers is discussed, including aspects of the helping relationship which differ from conventional psychological therapies. Approaches which promise a greater impact on caregiver distress and coping will be considered.

PSYCHOLOGICAL TREATMENT OF MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS IN A MEDICAL OUTPATIENT CLINIC

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Unexplained physical symptoms are common, both in general practice and in the general hospital setting. It is often claimed that the outcome of these symptoms in terms of recovery and medical care utilisation is poor. Patients with unexplained symptoms are considered to benefit from psychological therapy but may be reluctant to accept referral to a psychiatrist or psychologist.

We compared the efficacy of cognitive behavioural therapy and optimised medical care in 79 general medical outpatients with persistent unexplained physical symptoms. The study was introduced to the patients by their attending physician and the treatment took place in the medical clinic. This therapy comprised identifying and modifying dysfunctional automatic thoughts and offering behavioural treatment to break the vicious cycle of the symptoms and their consequences.

Cognitive behavioural therapy seemed to be feasible and effective in reducing both the severity of the symptoms and the accompanying functional limitations. Basic principles of cognitive behavioural therapy could probably be incorporated in routine clinical care.

S23. WHO ICD-10: Evaluation and evolution

Chairmen: JE Cooper, A Bertelsen

ICD-10 CHAPTER V AND DSM-IV: RELATIONSHIPS BETWEEN THEM, AND COMMENTS UPON SIMILARITIES AND DIFFERENCES

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In spite of their different origins and purposes (one international and one national) these classifications are more remarkable for their similarities of content than for their differences. This is because a) they both reflect the same body of internationally available descriptive knowledge about psychiatric disorders, and b) a series of meetings was held between the WHO advisers on ICD-10 and members of the Task Forces developing DSM-IV, with the shared purpose of removing unnecessary differences between the two emerging classifications. The most obvious differences are in presentation rather than content: because of its responsibility to different types of mental health workers in different countries across the world, the WHO adopted a strategy of "different versions for different purposes" (e.g. clinical psychiatry, primary care, and research).

Some of the remaining differences in content, such as the differences in the criteria for schizophrenia, will be examined, and some unsolved problems shared by the two classifications will be identified.

WHO ICD-10 EVALUATION AND EVOLUTION: FORENSIC IMPLICATIONS

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Forensic psychiatry is situated at the interface between Law and Psychiatry. The communication gap between the 2 disciplines rests on the differences of their basic paradigma. Law focus on social deviance and has to dispense justice. Psychiatry focus on psychopathology and has to treat persons affected by psychiatric disorders. The concept of "(ir-) responsibility" is a third dimension to be evaluated separately besides "social deviance" and "psychopathology".

European forensic psychiatry presents at least a double heterogeneity: that of national legal systems and that of psychiatric nosologies. ICD-10 improves substantially the heterogeneity of psychiatric taxonomies, but, in forensic psychiatry, the influence of the legal system is prominent and this "sets the rules of the game" within which forensic psychiatrists work. Legal requirements however, should not dictate psychiatric response, which should be guided by scientific knowledge and ethical concerns.

ICD-10 states in his introduction that "social deviance or social conflict alone, without personal dysfunction, should not be included in mental disorder as defined here". Can ICD-10 help the forensic psychiatrist in distinguishing social deviance with and without psychiatric disorder?

The correct use and advantage of ICD-10 in forensic psychiatry will be reviewed. We will focus on the most prominent ICD-10 diagnosis for civil and penal law.

Each instrument has however his own "instructions of use" and can consequently be "misused". Recommendations will be made in an European perspective on:

- elaboration of an European Glossary of Forensic Psychiatric Technical terms.
- educational programs in Forensic Psychiatry
- fixation of minimal standard requirements for the qualification of an expert and the content of the report
- an ethical code for psychiatric experts.

ICD-10 CHAPTER V (F): DIFFICULTIES AND DEFICIENCIES

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Chapter V (F) of ICD-10 has been used in many psychiatric institutions for several years and is used in many scientific studies often in parallel to DSM-III-R and DSM-IV. There is no doubt that ICD-10 diagnoses are judged to be superior compared to ICD-8 and ICD-9. Operationalized, criteria oriented diagnoses show a high interrater reliability, a high reliability between different institutions and a good international comparability.

As points of criticism are mentioned loss of local psychiatric

https://doi.org/10.1016/0924-9338(96)88487-2 Published online by Cambridge University Press