a cross-cultural perspective and to examine the hypothesis that economic development is not associated with fatigue.

b) Design: We carried out a secondary analysis of the WHO Collaborative Study of Psychological Problems in General Health Care (5438 patients in 14 countries). The assessment included questions on the basic sociodemographic variables, a primary health care version of CIDI and the 28 item general health questionnaire (GHQ 28).

c) Results: The weighted prevalence of unexplained chronic fatigue was 7.99% (95% CI 7.13%–8.85%). Before adjusting for cross-cultural differences, the score on the GHQ-28 (Odds Ratio 1.14, [95% CI 1.12–1.16]), female subjects (1.78, [1.35–2.33]), the unemployed (1.55, [1.04–2.32]), having 7–12 years of education (2.26, [1.66–3.07], having more than 12 years of education (1.81, [1.24–2.63]), and suffering from any chronic physical disease (1.72, [1.32–2.25]) were positively associated with unexplained fatigue. Adjusting for inter-center variability had a minor effect in these associations. Compared to poor countries (Gross National Product[GNP]per head < 1000 US$), there was a trend for increasing rates of fatigue according to GNP.

d) Conclusions: Unexplained chronic fatigue is a common condition in primary care with sociodemographic associations which are independent of cross-cultural influences. The prevalence however of fatigue is higher in countries with higher income.

PS04. Treatment update 2000 – schizophrenia

Chair: W. Gaebel (D)

PS04.01

PHARMACOLOGICAL TREATMENT OF SCHIZOPHRENIA

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The past decade has seen a number of significant advances in the knowledge about the pharmacological treatment of patients with schizophrenia. These include sophisticated dose response studies, long-term studies that include psychosocial reintegration and quality of life as outcome variables, definitive answers on the debate on continuous versus intermittent treatment, suggestions on how to enhance compliance, a substantial body of new evidence concerning drug safety, a new emphasis on symptoms beyond the positive domain, including negative, affective and cognitive symptoms, and, of course, the development of second generation antipsychotic drugs. All this evidence taken together has led to the development of treatment guidelines in many countries. Disregarding local differences, most of these guidelines agree on the basic treatment principles of treating patients with schizophrenia with antipsychotics as early as possible (many guidelines, especially the more recently published ones, favor second generation antipsychotics over traditional neuroleptics). Monotherapy is generally recommended, maintenance treatment suggested to last between one and two years for patients with first-episode schizophrenia and considerably longer in patients with recurrent presentations of the disorder. Combining pharmacological with psychosocial interventions is stressed, especially during long-term treatment. At this point in time it is not easy to suggest differential indications for the second generation drugs, as only very few studies comparing the new agents to each other are available. The individual tolerance of a drug is still very much a decisive factor. The next decade will be needed to study the new medications in more detail and to gather data in larger and less selected samples of patients in order to gain information that will eventually allow to tailor pharmacological treatment to patients' individual needs.

PS04.02

PSYCHOSOCIAL TREATMENT

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While the Decade of the Brain has produced no new biological treatments for schizophrenia, during this period there have been major advances in the introduction and development of psychosocial treatments. Working with families has been evaluated in a number of controlled trials with very consistent results. These have included studies in China, indicating that this approach is effective regardless of cultural variations in family structure and function. A cognitive behavioural approach to persistent delusions and hallucinations has been pioneered in the UK and has been shown to improve psychotic symptoms in up to half the patients receiving it. Furthermore, the beneficial effects seem to persist over a long period of time. These striking findings must cause us to re-examine our concepts of psychotic symptoms. The success of these novel interventions in experimental trials has not led to their widespread use in clinical practice. The problems in disseminating the essential skills and integrating them into clinical services will be addressed.

PS04.03

REHABILITATION

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The goal of psychiatric rehabilitation is to help disabled individuals to live, learn and work in the community with the least amount of professional support. Enabling disabled people to live a normal life in the community causes a shift away from a focus on an illness model towards a model of functional disability. Social role functioning including social relationship, work and leisure as well as quality of life and family burden are of major interest for the people affected living in the community.

The overall philosophy of psychiatric rehabilitation comprises two intervention strategies. The first strategy is individual-centered and aims at developing the patient's skill to interact with a stressful environment. The second strategy has an ecological approach and is directed towards developing environmental resources to reduce potential stressors. Most disabled people need a combination of both approaches. As such, effective psychiatric rehabilitation requires tailored and specialised treatment which has to be embedded in a comprehensive and coordinated system of rehabilitative services.

In contrast with acute treatment there are almost no legal powers to enforce rehabilitation. Thus, the patient's autonomy concerning treatment decisions has to be respected. Within this framework, the refinement of psychiatric rehabilitation has achieved a level where it should be made readily available for every disabled person.

https://doi.org/10.1016/S0924-9338(00)94379-7 Published online by Cambridge University Press