the dimensional vantage point, careful neuropsychiatric diagnostic procedures remain mandatory.

(1) Verhoeven WMA, Tuinier S. The effect of buspirone on challenging behaviour in mentally retarded patients: an open prospective multiple-case study. Journal of Intellectual Disability Research, 40: 502–508; 1996.

SEC25-2
STRESS HORMONES AND IMPULSE REGULATION

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The precise nature of impulsive behavior and some of its consequences such as aggression, self-injurious behavior or challenging behavior and other types of behavioral disinhibition is not well understood. In the case of outward directed aggressive behavior several clinical studies suggest an involvement of central serotonergic activity in subgroups of patients (Tuinier et al. 1996). The nature of aggressive behavior in mentally retarded subjects has been far less studied with respect to its biological background. Frequent manifestations of disordered behavioral control include self-injurious behavior and stereotyped movement disorder, that has been linked to disturbances in the availability of endogenous opioids, dopamine hypersensitivity and central serotonergic dysfunction. Since these biological parameters are also closely linked to the functional status of the stress system, we studied basal levels of the stress hormonal parameters ACTH, beta-endorphin, prolactin, cortisol, free cortisol and transcortin in 64 mentally retarded subjects with either self-injurious behavior and/or stereotyped behavior or without these phenomena. We found major effects on stress parameters of concomitantly prescribed anticonvulsants and oral contraceptives, no indication that beta-endorphin is related to these behavioral disorders and some support for the hypothesis that stereotyped behavior and self-injurious behavior are related to disordered stress homeostasis. This finding is also supported by the observation that mentally retarded subjects as a group might be more vulnerable to develop pathological states of arousal and might also possess less capacity to counteract deviations from their emotional and behavioral set point with serotonergic mechanisms.

(1) Tuinier S, Verhoeven WMA, Van Praag HM. Serotonin and disruptive behavior; A critical evaluation of the clinical data. Human Psychopharmacology 11; 469–482: 1996.

SEC25-3
BEHAVIORAL PHENOTYPE AND DISTURBED IMPULSE CONTROL

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Behavioral phenotypes are recognizable characteristic patterns of behavior associated with genetically determined disorders. For some of the so called genetically determined syndromes associated with mental retardation the characteristic pattern includes oppositional, explosive and at times aggressive behavioral features.

One of our behavioral phenotype research projects was aimed at clarifying and documenting these manifestations of disturbed impulse control behavior. These distinctive behavior characteristics for the demarcation of some of the genetically determined syndromes associated with mental retardation are reviewed for Prader-Willi syndrome, Velo-Cardio Facial syndrome, Smith-Magenis syndrome and a syndrome caused by a terminal deletion on chromosome 8p. Our experience indicates that patients with the association of mental subnormal development and disturbed impulse control should be examined by an experienced clinical geneticist.

SEC25-4
DIFFERENT DIAGNOSTIC SYSTEMS IN DESCRIBING AGGRESSION IN MENTAL RETARDATION

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There is no diagnostic entity of aggression in either of the two major classificatory schedules in psychiatry, DSM-IV and ICD-10. Although aggressive behaviour is common in many mental illnesses and personality disorders it has not been considered that any one psychiatric illness or personality disorder is defined by abnormal control of aggression. These two schedules recognise the existence of disorders of control of impulsivity as discreet diagnostic entities, depicted by the terms emotionally labile personality disorder and intermittent explosive disorder in DSM-IV. Within a sample of people with mental retardation it is only the rare chronic aggressive subject that falls into either of these two categories.

Thirty chronically aggressive mentally retarded subjects in hospital were examined closely according to ICD-10 and DSM-IV schedules. An attempt was also made to classify each patient according to Sovner's four domain classification of behaviour disturbance.

The results showed that only a few patients could be adequately classified under the heading of impulsive or antisocial personality disorders. The majority of patients showed irritability and aggression related to environmental changes. Most of the patients were only satisfactorily classified under the heading of organic personality disorder or syndrome on the basis of pre-existing brain damage responsible for the degree of intellectual impairment.

In the classification of aggression it may be more heuristically valuable to describe aggression according to the nature of the aggressive act, e.g. verbal, physical, destructive, self-harming.

S26. The impact of schizophrenia on the patient's life

Chairs: H Häfner (D), D Naber (D)

S26-1
HISTORY OF TREATMENT SYSTEMS AND THEIR CONSEQUENCES FOR THE LIFE OF SCHIZOPHRENICS

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In the course of this century, treatment systems in psychiatry have underwent dramatic changes. From the asylum era of the first half of this century, there has been a sometimes gradual, sometimes irregular move in the direction of a community-based system of care delivered to geographically delimited catchment areas. People suffering from schizophrenia have been the main

recipients and the priority target of this significant change. While the fate of a person with schizophrenia was almost unavoidably a long-term instituzionalization, nowadays the bulk of care to patients with this disorder is provided, inter alia, in a variety of outpatient and non-hospital settings. In parallel with the institutional change, our knowledge of the disorder and of the effectiveness of different treatment options has dramatically improved. All these transformations are reflected in substantial changes in several indicators affecting the life of people of schizophrenia: general mortality rates, suicide rates, life expectancy, comorbidity rates, average length of hospitalizations, quality of life, employment opportunities, etc. All these changes on turn have challenged the 'social' (as opposed to the 'natural') history to the disorder. This paper will provide an overview of the main institutional changes occurred in the course of this century, will show how they have affected the life of people with schizophrenia and will point to the most sensible and reliable indicators of this global transformation.

S26-2

WHEN AND HOW DOES SCHIZOPHRENIA LEAD TO SOCIAL DEFICITS?

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We studied the course of schizophrenia in a population-based sample: 1) 232 first episodes of schizophrenia of a broad diagnosis retrospectively from onset to first admission, 2) in a representative subsample of 115 first episodes prospectively from first admission on at 5 cross-sections over 5 years. 3/4 of the cases began with a prodromal phase lasting 5 years on average and free of positive symptoms. Only 18% had an acute onset within 4 weeks before first admission, and only 7% began with purely positive symptoms. In 57% of the sample social disability (Disability Assessment Schedule score ≥ 2) emerged before first admission (on average 2 to 4 years before). Schizophrenics at onset did not differ significantly from healthy controls in social status. Before first admission, however, they suffered considerable deficits in social ascent.

75% of schizophrenics fell ill before age 30, men 3 to 4 years earlier than women. The proxy variables of the disorder – initial symptoms, type of onset etc., showed no significant sex differences. Socially negative behaviour and substance abuse were considerably more frequent among schizophrenic men than women. Even the sex difference in age of onset meant slightly better social conditions at onset for women than men. By logistic regression we could show that an earlier age of onset and socially negative behaviour of young men at the time of the first episode had a significantly unfavourable impact on 5-year social outcome.

The symptom-related course showed great interindividual variability, but stability without any clear-cut improvement or deterioration of group means. As a whole, social outcome was clearly better for schizophrenic women than men because of women's slightly higher level of social development at onset and better adjusted illness behaviour. Considering their high level of social development at onset, late-onset patients, however, showed considerable downward drift. Nevertheless, their social outcome was better than in the early-onset group. The most important implication of these findings is a need for early detection and intervention.

S26-3

THE INFLUENCE OF DISCRIMINATION AND STIGMA ON THE LIFE OF PATIENTS AND THEIR RELATIVES

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The heavy stigma attached to mental illness, particularly schizophrenia, by the public affects patients and their families. Patients find it very hard to gain employment once their history of illness is known. They also meet difficulties in being accepted in social situations. Relatives feel embarrassed to reveal the illness to other family members and friends, and as a result they lose the support of their natural social networks.

Two surveys of neighbours in streets with sheltered housing for the mentally ill showed that there was a great deal of ignorance about schizophrenia. In particular people confused mental illness and learning difficulties. They saw the mentally ill as being unpredictable, difficult to communicate with, and dangerous, although the latter was mentioned by less than a quarter of the respondents.

An encouraging feature was that there was a great deal of goodwill expressed towards the mentally ill and a desire for information.

These surveys were followed by a controlled trial of a campaign to educate the neighbours in one of the streets. The campaign included an educational meeting with a video and leaflets, social activities in the sheltered house, and door-to-door discussions with the residents. Compared to residents in the control street, neighbours exposed to the campaign showed a reduction in fear of the mentally ill, an increase in intentions to socialize with the patients, and a fair amount of social contact with them. Experimental patients had significantly more contact with their neighbours than control patients.

S26-4

DO MODERN CARE AND TREATMENT IMPROVE THE QUALITY OF LIFE OF SCHIZOPHRENICS AND THEIR RELATIVES?

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Background: This paper reports the impact on the quality of life (QOL) of patients with psychosis of an intensive compared to a standard model of community care.

Method: An epidemiologically representative sample of 514 patients was identified all of whom had an ICD 10 diagnosis of psychosis, and were living in two geographical sectors in South East London. A random sample of these from each sector were interviewed with a variety of research measures at baseline, and at a two year follow up point. Between baseline and follow up services within the intervention sector were reorganised. Quality of life was measured using the Lancashire Quality of Life Profile. 138 patients had QOL data at both time points.

Results: The two overall QOL measures - global QOL and the average of the domain specific scores, were remarkably stable over time. There were no within sector significant changes on these overall measures, nor was there any evidence of an effect of the intervention of these QOL measures. For individual QOL domains there was weak evidence for an improvement in living situation domain in the intensive sector, and it is suggested that this may be accounted for by the large drop in inpatient admissions in the intensive sector. In both sectors objective QOL was poor, and there was little change over time in any of the objective indicators except

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