

cognitive conceptualisations of the processes which may be involved in these disorders and preliminary approaches to treatment. A welcome development is the application of CT to difficult, chronic cases with personality or characterological difficulties. Professor Beck's group described cognitive conceptualisations and treatment of DSM-III (American Psychiatric Association, 1980) personality disorders. The modifications of standard CT necessary to work with such cases were described. Controlled outcome studies are needed as treatment is likely to be prolonged and intensive.

Parallel to the clinical developments in CT, researchers are applying methods from cognitive psychology to investigate abnormalities of cognitive processing found in psychiatric disorders. The cognitive science symposium considered the theory of information processing and its applications in therapy. Other symposia examined intrusive cognitions and the relationship between emotion and cognition. Training courses were described and it was suggested that therapist competence can

be reliably measured and is related to successful outcome in therapy.

The congress was privileged to hear keynote addresses from Professors Beck, Ellis and Seligman, and particularly noted their views for the future of CT.

While more than one speaker suggested that in the future cognitive techniques may have a role in primary prevention, perhaps for now it will be sufficient to consolidate the role of CT as a standard treatment of depression and some anxiety-related disorders. The tradition of rigorous empirical evaluation of the efficacy of CT must be continued in the other disorders considered at this congress. The next World Congress has been preliminarily scheduled for Toronto in 1992; it is crucial for British psychiatrists to maintain their interest and skills in this expanding area.

Reference

AMERICAN PSYCHIATRIC ASSOCIATION (1980) *Diagnostic and Statistical Manual of Mental Disorders, 3rd ed.* Washington, DC: APA.

Advanced Summer School in Addictions*

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At its launch in April 1989 the new charity Action on Addiction declared its intention to support a National Summer School in Addictions. Following in the tradition of the Alcohol Summer Schools, this first conference took place in September 1989. At the opening, Professor Kendell, University of Edinburgh, described it as a somewhat autumnal summer school. Despite this it managed to attract 150 delegates from a wide range of disciplines. The conference aimed to provide an overview of the state of the art in treatment and research to people already working in the field of addictions. Considerable time was devoted to the issues of HIV and drug misuse. Don des Jarlais, New York, described the situation with HIV infected drug takers in New York and expressed optimism at drug takers' capacity to change their risk-taking behaviour. However, Dr Giel Van Brussell, Amsterdam, reviewed the Dutch response and was more pessimistic about future changes in behaviour. On aspects of the voluntary sector response Stuart Menzies, Frontliners support group, spoke about the difficulties encountered in trying to run voluntary support groups for HIV positive drug takers.

A session on the services patients have a right to expect was opened by Harriet Harman MP, shadow spokesperson on health, who described the difficulties her constituents experienced in getting help

for drinking and drug problems. She expressed particular concern for the impact of the White Paper on drug and alcohol services. Tim Cook, City Parochial Foundation, argued that the voluntary sector in the drug and alcohol field had an important role in providing innovative and flexible services and he felt that they were unwise in competing to provide mainstream services.

An afternoon was devoted to the detection of alcohol and drug problems in prisons, on the streets, in general practice and in general hospitals. This was followed by a session where the environmental influences were assessed. These ranged from family influences on drinking patterns with Jim Orford to Geoff Pearson on the influence of local policing on the availability of illicit drugs. The afternoon session looked at the influence of individual genetic, biochemical and personality factors on the predisposition to drug and alcohol use.

There were small group discussions on the concept of dependency and its usefulness, management issues in HIV positive drug users, the role of prescribing, drug users in prisons, the management of the pregnant drug user and cognitive behaviour treatment.

Dr Mark Gold, New Jersey, described the evolution of the cocaine problem in the US in the '80s, summarising prevention and treatment

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responses. The final session was chaired by Anthony Clare. Terry Sprately, Canterbury, described the challenges and conflicts of running a multidisciplinary team and this was complemented by Anthony Thorley's view of the application of

psychodynamic psychotherapy in the treatment of substance problems. A lively discussion on the role of general practitioners in the management of problem drug users rounded off an intensive week of lectures and small group discussions.

Behavioural family therapy: cost-effective schizophrenia care*

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The recent shift in emphasis from treatment in hospital to management in the community has led to patients with schizophrenia being cared for on a day-to-day basis not by trained staff but by relatives acting as non-professional carers. It has become evident that the outcome of this policy depends very much on the level and quality of support given to these carers. 'Community care' can be, and often is, no more than a burden for families to carry, but with effective family intervention, relapse of schizophrenic illness can be minimised while quality of life and level of functioning for both patient and family can be maximised.

Essentially, the aim of family intervention is to consider the family not as a problem which requires treatment but as a resource which, with training, can be utilised as the primary care team for the patient. Senior Clinical Psychologist Joanne Smith described a project in Worcester which has successfully involved relatives in the monitoring and early prediction of schizophrenic relapse. With most patients exhibiting one to two weeks of non-specific symptoms such as anxiety, mild depression and disinhibited behaviour immediately prior to relapse, family members are ideally placed to detect and report such symptoms, thus reducing the chance of hospital admission becoming necessary.

In terms of family therapy, the commonest basis is behavioural. A typical programme begins with the exchange of information by means of family sessions and written material. An assessment is made of the problems encountered by relatives and the ways in which they have been trying to overcome them; commonly, problems seem to stem from difficulties in coping with negative symptoms such as apathy, poor self-care and a lack of motivation and initiative. Clinical details such as the diagnosis and proposed

plan of management are discussed, along with aspects of aetiology and the likely course of the illness. Continuing sessions are designed to reduce the level of expressed emotion and to increase the patient's capacity for independence by adopting a positive, goal-directed, problem-solving approach.

Dr Ian Falloon reported that results from his project in Buckingham suggest that the entire service, including the management of acute schizophrenic episodes, can be run using an intensive family-based programme. However, the trend elsewhere will probably be for acute episodes to continue to be treated in hospital and the application of family behavioural therapy will be as a part of the overall management plan. As well as improving the quality of the service, the decrease in relapse rate and consequent hospital admission should eventually reduce the total cost of managing schizophrenia, perhaps by as much as 30% according to Ian Falloon's findings.

Costs in the first few years will however be higher for two main reasons. Firstly, there is the requirement for additional staff, facilities and training. Secondly, in the early years of establishing the service, the majority of the clientele will be the pre-existing pool of patients with schizophrenia and their families. In order to bring about the overall reduction in relapse rate necessary to achieve cost-effectiveness, it is essential that a sufficient proportion of the families in need are contacted and engaged. This can best be achieved by offering a service which is perceived by families as being appropriate and helpful and by promoting a public awareness that family behavioural therapy is an integral component of the management of schizophrenia, so that families will actively seek it as a matter of right in the same way in which they would seek medical treatment.

*National Schizophrenia Fellowship seminar held in Oxford, 10 October 1989.