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Symposia

Sunday, April 18, 2004

S29. Symposium: Delusions - New Trends in Diagnosis and Treament

(Organised by the AEP Section on Psychopathology)

Chairpersons: Michael Musalek (Vienna, Austria), Giovanni Stanghellini (Florence, Italy)
08:30 – 10:00, Hall A

S29.01

Definitions and diagnosis of delusions

P. Berner*. *Paris, France*

No abstract received.

S29.02

Delusions: A dimensional view

S. Opjordsmoen*, N. Retterstøl. *Department Of Psychiatry, Ullevål University Hospital, Oslo, Norway*

Even though delusions have been defined and are categorised in clinical practice, clinicians often have difficulties in describing what a delusion (false belief) is. Neither are delusions rigidly fixed, but fluctuate in intensity over time. They are better conceptualised as continuous from normal to pathological on a number of dimensions. Several rating scales based on a dimensional view have been worked out the last twenty years, and factor analyses of those have revealed the following factors: conviction, construct, preoccupation, distress and behaviour. Out of 180 first-break psychotic patients who had been personally followed up after 30 years, a subsample of 41 was randomly drawn. They represented three different groups - a good outcome (n=17), an intermediate outcome (n=12), and a bad outcome (n=12) group according to GAS scores. Based on case histories at first presentation the Dimensions of Delusional Experience Scale was scored without knowledge of outcome. Poor compared to good outcome patients had delusions at first presentation characterised by more conviction, extension, disorganisation, bizarreness and pressure. Intermediate outcome patients had scores in between, but closer to poor outcome patients. This means that rating scales based on a multidimensional view of delusions might have predictive power and consequently should be used to a larger extent in research as well as in clinical practice.

S29.03

Delusions: Cognitive or emotional disorders

M. Musalek*. *Anton Proksch Institute, Vienna, Austria*

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For the last century research on delusion focused primarily on examining cognitive disorders (e.g. formal thought disorders) as possible causes of delusional syndromes. But as it could be shown by the results of a psychopathological study on 60 patients suffering from DSM-IV schizophrenia carried out in Vienna delusions are not closely connected to thought disorders. In other recent studies on the pathogenesis of delusional syndromes it has been concentrated on the role of affective alterations. Summarizing these studies - results we may conclude that emotions play a major role in the pathogenesis of delusions whereat the relations between delusions and affects are of multiple nature: on the one hand affects play an important role in the development of delusional convictions; on the other hand delusional ideas and the problems resulting from them for the patient and the social environment may serve as a trigger for affects and emotions, which as a consequence of the delusion may become a constituting and maintaining element of it. Therefore delusions have to be considered not only as a cognitive but primarily as an emotional phenomenon.

S29.04

Anthropological aspects of delusions

G. Stanghellini*. *OSPSM Annunziata, Florence, Italy*

No abstract received.

S29.05

Psychological treatments of delusions

C. Mundt*. *Department Of Psychiatry, Psychiatric University Hospital, Heidelberg, Germany*

This presentation will point out the psychopathological prerogatives of psychotherapy, necessary to clarify before making up a treatment program. Aspects which belong to these prerogatives are the affective dynamism of delusion, the framing and communicative function, the covert message, and the cognitive style of gaining and avoiding information. After the psychopathological clarification as prerogative for psychotherapeutic treatment the presentation will describe the characteristics of a treatment manual which addresses the psychopathological pathogenetic lines which are most promising for amelioration of delusional experience and deluded behaviour.

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S15. Symposium: Schizophrenia and Depression

Chairpersons: Heinz Häfner (Mannheim, Germany), Hans-Jürgen Möller (Munich, Germany)
08:30 – 10:00, Hall B

S15.01

Depression as a co-existing factor from psychotic symptoms to psychosis with need for treatment

L. Krabbendam[1,*], I. Myin-Germeys[1], M. Hanssen[1], R. de Graaf[2], W. Vollebergh[2], M. Bak[1], J. van Os[1,2]. *[1]EURON, Department of Psychiatry and Neuropsychology, Maastricht University, The Netherlands Institute of Mental Health and Addiction, Utrecht, The Netherlands. [2]Division of Psychological Medicine, Institute of Psychiatry, London, UK*

Objectives: Current psychological theories state that the clinical outcome of hallucinatory experiences is dependent on the degree of associated distress, anxiety and depression. This study examined the hypothesis that the risk for onset of psychotic disorder in individuals with self-reported hallucinatory experiences would be higher in those who subsequently developed depressed mood than in those who did not.

Methods: A general population sample of 4670 individuals with no lifetime evidence of any psychotic disorder were interviewed with the Composite International Diagnostic Interview Schedule (CIDI) at baseline and 1 and 3 years later. At year 3, individuals with CIDI evidence of psychotic symptoms were interviewed by clinicians to identify onset of psychotic disorder. Psychotic disorder was specified at three levels, 2 involving severity of positive symptoms of psychosis and one using additional clinical judgement of need for care.

Results: Given the presence of hallucinatory experiences at baseline, the increase in risk of having the psychosis outcome at year 3 was higher in the group with depressed mood at year 1 than in the group without depressed mood at year 1 (any level of psychotic symptoms: risk difference 17.0%, 95% CI -1.7, 35.7; severe level of psychotic symptoms: risk difference 21.7%, 95% CI 3.2, 40.2; needs-based diagnosis of psychotic disorder: risk difference 16.8%, 95% CI 0.4, 33.3).

Conclusion: The results are in line with current psychological models of psychosis that emphasize the role of secondary appraisals of psychotic experiences in the onset of clinical disorder.

S15.02

Schizophrenia and depression - two stages of one process or two disorders?

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

Starting with Kraepelin's (1889) assumption that 'dementia praecox' is a disease entity clearly distinguishable from other disease entities, e.g. affective psychosis, demographic variables, psychopathology, social behaviour, functional impairment and illness course are compared in a sample of 130 first hospitalised schizophrenic patients and 130 age and gender matched controls, firstly hospitalised for unipolar depression. A milder syndrome of depression together with negative symptoms and functional impairment occurs at the earliest prodromal stage of both disorders increasing and decreasing with psychotic episodes, but basically persisting as core syndrome of the illness. Unipolar depression and schizophrenia are distinguishable by the specific symptoms of psychosis, which emerge at the final stage of the prodromal phase. But the closer the look at how the two syndromes evolve, the greater is the overlap between the disorders. Concerning prior medication, comparable proportions of 19% patients with schizophrenia and 21% patients with depression had been on psychoactive medication before the first admission. In conclusion, depression and schizophrenia are closely associated at various levels, e.g. on the genetic and the neurodevelopmental level and in relation to morphological brain anomalies. But the aetiological risk factors seem to be milder in depression. Also in relation to the social development, depressive patients are located in between people from the healthy population and patients with schizophrenia, who are characterised by the most severe social disadvantages already in the early illness course.

S15.03

Depression in the long-term course of schizophrenia

W. An Der Heiden*, H. Häfner, K. Maurer. *Schizophrenia Research Group, Central Institute of Mental Health, Mannheim, Germany*

Depressive symptoms are very common in schizophrenia. In the ABC Schizophrenia Study 83% of the first-episode sample (n=232) suffered from depressive mood for at least two weeks before first hospital admission. 39% showed a continuous presence of depressive symptoms, 34% recurring depressive episodes and 8% only one depressive episode. Compared to healthy controls schizophrenic patients showed a 3 to almost 5 times higher cumulative prevalence of depressive symptoms. Attempted suicide with a 40% access pointed to an early suicide risk before the first treatment contact. Looking at the illness course during five years after first hospital admission the prevalence of depressive episodes remains fairly stable. We also found that early depression predicted neither positive nor non-specific symptoms, but it did predict negative symptoms by exerting a significantly negative effect particularly on affective flattening up to a one-year and a five-year assessment. In our contribution we will present data on the prevalence and course of depressive symptoms in schizophrenia in 107 patients of the ABC sample followed up until 12 years after index admission. Particularly we are looking at the predictive power of depressive symptoms for the long-term course and outcome of schizophrenia.

S15.04

Depression as a predictor of 15-year outcome in schizophrenia

R. Bottlender*, H.-J. Möller. *Department of Psychiatry, Ludwig Maximilians University, Munich, Germany*

Schizophrenia is a heterogeneous disorder with a plethora of psychopathological features, including positive, negative and also affective symptoms. Despite differences concerning the prevalence rates of depressive symptoms between different studies, it is now generally accepted that depressive symptoms in schizophrenia are

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common and often severe. Depressive symptoms can occur during all stages of the schizophrenic illness. Etiological theories about depression in schizophrenia are controversial and include effects of neuroleptics, psychoreactive and other secondary causes. Some recent evidence also supports the hypothesis that depressive symptoms are an integral part of the schizophrenic symptomatology. The prognostic significance of depressive symptoms for the longer term course and outcome in schizophrenia is still controversially discussed. Although some earlier authors pointed out that depression during the acute phase of schizophrenia may be associated with a more favorable prognosis and remission, more recent studies indicated the opposite and revealed that depression appears to be an unfavourable prognostic sign which has been associated with a greater risk for suicide and relapse. On that background, data of a 15-year follow-up study on schizophrenic patients are presented. The patients of the study were standardized assessed at their first psychiatric admission and reassessed after a 15-year course of their illness. Prevalence rates of depression at the different stages of the schizophrenic illness as well as data concerning the impact of depressive symptoms on the 15-year outcome are presented.

S15.05

The treatment of psychosis and depression with novel neuroleptics - treating a common pathophysiological mechanism or two illnesses?

H.-J. Möller*. *Psychiatric Department, University of Munich, Germany*

Depressive symptoms, especially of a subsyndromal type which do not reach the magnitude of a full depressive episode, have been known for a long time to be part of the clinical phenomenology of not only acute schizophrenic episodes but also prodromal and post-psychotic states. Only recently several newer, standardised evaluations have again provided data to support this. In this respect the newer/atypical neuroleptics are of special therapeutic relevance since several control group studies with various novel neuroleptics have shown that they have a greater influence on depressive symptoms as part of a schizophrenic disorder than classical neuroleptics. This hypothesis is being tested and evaluated in more detail based on the results of some studies. The fact that pharmacogenic depression has been described as a side effect of classical neuroleptics, particularly the highly potent dopamine D2 blockers, is of particular relevance in this context. Clinical experience to date has shown that this side effect does not occur, or only rarely, during treatment with novel neuroleptics. The better efficacy in treating depressive symptoms as part of a schizophrenic disorder, together with the lower risk of inducing pharmacogenic depression, leads to the expectation that the use of novel neuroleptics can possibly also reduce the suicidality that occurs during schizophrenic disorders. Newer long-term studies, particularly those with clozapine, have indicated that this may well be the case.

S57. Symposium: Liaison Psychiatry in the Care for the Elderly

(Organised by the AEP Section of Geronto-Psychiatry)

Chairpersons: Florin Tudose (Bucharest, Romania), Margda Waern (Göteborg, Sweden)
08:30 – 10:00, Hall C

S57.01

Consultation Liaison Psychiatry - Old-Age Psychiatry: Specific aspects in diagnosis of comorbidity and the management of care in a general hospital

F.D. Tudose*. *University Emergency Hospital, Bucharest, Romania*

The paper presents the Consultation-Liaison-Psychiatry Department in the biggest emergency hospital from Romania, which has more than 40 000 admittances yearly. An important percentage - 41% from the patients that are examined in the psychiatric department are old persons (above 65 years). The most frequent diagnostics are: mood disorders, various cognitive deficits, somatoform disorders. There have been diagnosed more than 100 cases with Alzheimer disease in patients hospitalized for other medical conditions. The psychiatric diagnostic was difficult to be done, because the somatic comorbidity is rich in the elderly and there is also an important psychiatric symptomatology related with the medication recommended especially for cardiac and respiratory diseases. It is also discussed the difficulty of adding a psychiatric treatment to the medical or surgical one that the patient has to make. On the other hand there is a high resistance on behalf of elderly patients in receiving psychotropic medication. The study is also showing that many of the elderly patients are coming for the first time in contact with a psychiatric facility being referred to the liaison psychiatric department, even if they needed an examination much time before the admittance in the general hospital.

S57.02

Suicidal ideation and completed suicide in patients with dementia

J. Leszek*. *Department of Psychiatry, Medical University, Wroclaw, Poland*

Suicidal ideation and completed suicide in elderly (age 65 or older) in patients with dementia are the major health problem in Eastern and Central European countries. Available data suggest that social isolation, loneliness, somatic illness and male gender are an important risk factors of suicide but not always related to depression. Basic on our epidemiological data, we statement that active and passive suicidal ideas are from 200 to 400 times more prevalent than suicidal deaths among elderly patients with dementia. The frequency of suicidal ideation in this group of patients suggest that epidemiological study can realistically advance suicide prevention from clinic-based to population -based approaches. GPs have an important role to play in reducing elderly suicide with most contact with the health service in elderly suicide being with them. Specific postgraduate teaching designed to help detection and treatment dementia and depression have been shown to reduce elderly suicide and may be use in this situation. According to our experiences, especially widowed men and childless woman should be high priorities for both GPs and identification programmes focused on this category of patients.

S57.03

Delirium in the elderly

N. Tataru*, O. Laza. *Neuropsychiatry Hospital, Oradea, Romania*

Delirium is a serious disorder of late life whose poor outcomes include increased number of hospital complications, increased

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lengths of stay and death rates, increased cognitive impairment and risk of dementia. Dementia is also a risk factor for delirium. Delirium in the elderly is an acute and reversible disturbance of brain functioning resulted of an interaction between external insults (physical illness, medication, sensory deprivation) and individual vulnerability (brain disease, malnutrition, inactivity). Diagnosis can be difficult in elderly patients. There is two-stage process: diagnose delirium and identify the cause. The aim of this study is to investigate the incidence, predisposing and precipitating factors, clinical profile and outcome of delirium in older patients admitted to a general hospital (internal medicine and surgery) and in a psychiatric one in district Bihor. Delirium was diagnosed according ICD-10 and DSM-IV criteria. We noticed that patients with delirium had significantly longer hospital stay and higher mortality than those who were not delirious. Because the predisposing and precipitating factors for delirium were easy identified and delirium was one of the most important prognostic factors, we think that we have to give more attention to prevention and treatment. Prevention of delirium is very important and address to underlying causes, complications, vulnerability and optimize function.

S57.04

Suicide risk evaluation in elderly suicide attempters

M. Waern*. *Section of Psychiatry, Sahlgrenska University Hospital, Göteborg, Sweden*

Elderly persons who attempt suicide appear to be at greater risk of completed suicide than their younger counterparts. While the ratio of attempted to completed suicide in the general population is estimated at 8-20:1, the corresponding figure for the elderly is 4:1. Among suicide attempters, degree of suicidal intent and premeditation has been found to increase with age. Elderly persons who are admitted to the general hospital in connection with a suicide attempt constitute a high risk group for future suicide. The consultation-liaison psychiatrist is often the elderly patient's first contact with psychiatry. Evaluation of suicide risk may be difficult because the elderly patient may suffer from guilt feelings. Seriousness of the attempt may be underrated. Evaluation of depressive symptoms can be problematic due to somatic comorbidity. Rating scales for suicide risk assessment and for the detection of depression will be discussed, and preliminary results from the Sahlgrenska Suicide Studies presented.

Free Communications: Affective Disorders II

08:30 – 10:00, Hall D

Genetic association analysis of HPA axis related genes in major depression

S.J. Claes[1,2,*], J. Del-Favero[1], D. Van West[1,2,3], F. Van Den Eede[1,2], J. Mendlewicz[4], R. Adolfsson[5], C. Van Broeckhoven[1]. *[1]Department of Molecular Genetics, Flanders Interuniversity Institute for Biotechnology. [2]Collaborative Antwerp Psychiatric Research Institute (CAPRI), University of Antwerp. [3]University Centre of Child and Adolescent Psychiatry Antwerp (UCKJA). [4]Department of Psychiatry, Erasme Hospital, University of Brussels (ULB), Belgium. [5]Department of Clinical Sciences and Psychiatry, Umeå University, Sweden*

An increasing amount of data suggests that affective disorders might be related to dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, one of the stress-response systems. Preclinical genetic studies have demonstrated that a number of functional candidate genes are important in HPA axis regulation. However, the possible role of these genes in the pathogenesis of major depression is still unclear. We present a haplotype-based association study of 4 genes important in HPA axis function: the CRH receptor 2 (CRHR2) gene, the CRH binding protein (CRHBP) gene, the glucocorticoid receptor (GCR) gene and the AVP receptor 1b (AVPR1B) gene. In these 4 genes, 5-7 single nucleotide ploymorphisms were identified and genotyped in two clinically well-define samples, one from Belgian and one from Swedish origin. Both samples consisted of patients with recurrent major depression (n=92) and matched controls (n=92). Subsequent association analysis at the haplotype level showed an association between a specific haplotype of the CRHBP gene and major depression in the Swedish population. Carrying this haplotype more than doubles the risk to develop major depression. In the AVPR1B gene study, a frequent haplotype was found to protect against developing major depression in both populations. No association was detected between major depression and the GCR or CRHR2 genes. This ongoing study is instrumental in determining which genetic factors may lead to the HPA axis dysregulation seen in major depression and in some other psychiatric disorders.

Personality structure and affect regulation in female in-patients with self-destructive behaviour: Investigations by means of Operationalised Psychodynamic Diagnostics (OPD)

H. Boeker*, C. Schopper, M. Straub, B. Kuechenhoff, H. Himmighoffen, R. Gramigna, H.P. Graf, D. Hell. *Department of Clinical Psychiatry and Experimental Psychopathology, Psychiatric University Hospital, Zurich, Switzerland*

Self-destructive behavior often is connected with personality disorders and has to be differentiated from suicidal behavior in the acute depressive state of patients with affective disorders. Aim of the study is to investigate psychotherapeutically and psychodynamically relevant dimensions of personality (personality traits) and of affect regulation. It can be hypothesized that self-destructive behavior is correlated with a higher amount of disturbances of interpersonal relationships, conflicts, and personality structure. These dimensions are operationalized and investigated by means of the Operationalized Psychodynamic Diagnostics (OPD). The sample includes 20 female patients with depressive disorders showing automutilistic behavior (AMB) and 20 female depressive patients without automutilistic behavior (controls). HAMD-score <15.

Results: The AMB-group differed significantly in all categories of the OPD-dimension 'Structure' from the controls. Patients with AMB experienced themselves as isolated and disclosed; furthermore the negative self-perception in the AMB-group correlated with the negative counter transference of the therapists. There were no significant differences in the OPD-dimension 'Conflict'.

Conclusion: OPD open's up therapeutically relevant dimensions of personality for empirical research.

Self-concept and partner relationships of patients with bipolar disorders. An empirical study in the symptom-free Interval with the Giessen-Test

H. Himmighoffen[1,*], K. Budischewski[2], F. Härtling[3], D. Hell[1], H. Böker[1]. *[1]University Psychiatric Hospital, Zurich, Switzerland.*

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[2]*Department of Medical Psychology and Medical Sociology, Johannes Gutenberg University, Mainz.* [3]*Clinic of Childhood Psychiatry and Psychotherapy, Johann Wolfgang Goethe University Clinic, Frankfurt am Main, Germany*

Objectives and methods: Against the background of the existing empirical studies investigating the personality of patients with bipolar affective disorders in remission an own study was carried out. This study was investigating the self-concept and the partner relationships of patients with bipolar disorders in remission (n=34) by means of the Giessen-Test (Beckmann et al) in comparison with those of patients with unipolar depression in remission (n=32), a control group of orthopedic patients without psychiatric disorder (n=45) and the standard sample of the Giessen-Test (n=1546).

Results: Bipolar patients in remission showed a self-assessment with low self-esteem, depressive basic mood, retention, great distance to others and low social resonance which differed significantly with the self-assessment of the standard sample and the control group. The bipolar and unipolar depressive patients showed no significant differences in their self-concept. Concerning the partner relationships the results of the patients with bipolar disorders and unipolar depression were largely congruent with those of the control group. However in contrast to the control group the patients with the affective disorders showed a prominent attribution of positive aspects to their partners which differed significantly from their negative self-concept. There was also a greater mutual confirmation of the own self-assessment by the patient and the partner respectively in the control group.

Conclusions: Patients with bipolar disorders in remission have – just like unipolar depressive patients – a relevant negative self-concept with low self-esteem and influence on their partner relationships, that should be included into therapeutic considerations.

Treatment motivation, modalities and preferences in relation to depressive symptoms in a general population sample

M.M. Berner*, L. Kriston, M. Haerter. *Department of Psychiatry and Psychotherapy, Freiburg University Hospital, Freiburg im Breisgau, Germany*

Objective: This nationwide representative survey was conducted to examine treatment motivation, modalities as well as preferences in relation to the severity of depressive symptoms.

Methods: A representative general population sample (n=2224) was interviewed employing a computer assisted personal interview regarding depressive symptoms, treatment modalities and motivation as well as preferences. Using a 14-item symptom checklist the degree of severity of depressive symptoms was estimated. Three groups were identified as minor (16,5%) moderate (7,5%) and severely (6,5%) affected by depressive symptoms.

Results: Within the most affected group only 25,7% were currently being treated, 40,7% rejecting treatment. Wish for treatment increased with symptom severity. 13,3% had initiated treatments by themselves. This led to any improvement in 56,6%. Patients with physician contact were more likely to have self initiated a treatment. Acceptance for chemically defined antidepressants and psychotherapy was low (7,6 and 9,8%) while relaxation techniques and especially phytopharmaceuticals were rated considerably higher (18,5% and 44,3%). However, the acceptance for all treatments increased with severity of symptoms. But even in the most affected group less than 30% accepted psychotherapy or chemically defined antidepressants.

Conclusion: The present study underlines the importance of education programmes regarding depression both for the general population and the practitioner. Self-initiation of a treatment was partially effective. The high acceptance for phytopharmaceuticals might facilitate an easier access to the initiation of an effective treatment. The lower acceptance for other treatments demonstrates the need for a thoroughly performed patient education and careful compliance monitoring.

How fast resolves depression with antidepressants as compared to placebo? A meta-analysis

A. Stevens*, R. Zarman. *Department of Psychiatry, University of Tübingen, Germany*

Background: The effectiveness of psychopharmacologic treatment may be assessed by a variety of statistical designs. In some psychiatric disorders, such as major depression, there are large placebo effects, which render the effect size of treatments sensitive to the interval begin onset of treatment and the time of assessment. Also, effect sizes for treatment have been shown to correlate with the size of placebo effects in individual trials.

Rationale: The study explores whether measuring the time course of symptom reduction offers advantages over the conventional methods.

Methods: A meta analysis of 21 published, placebo-controlled randomized studies of major depression is presented. Effect measures are the degree of symptom reduction (difference to baseline, conventional method) and the speed of symptom reduction as estimated by data modeling (novel method).

Results: The conventional statistical method seems to underestimate the effectiveness of antidepressants as compared to placebo, as symptom reduction occurs much faster with antidepressants than with placebo. Also, evidence is presented, that the onset of antidepressant action is immediate rather than delayed by 2-3 weeks. The notion of delayed onset of action may be a statistical artifact produced by comparison of group means.

Conclusion: It is concluded that dynamical assessment of improvement may offer a more informative approach to evaluate treatment vs. placebo effects.

Early onset of response to venlafaxine: Association with higher plasma level and increased exposure to the noradrenergic enantiomer

M. Gex-Fabry[1,*], A.E. Balant-Gorgia[1], L.P. Balant[1], S. Rudaz[2], J.L. Veuthey[2], G. Bertschy[1]. [1]*Department of Psychiatry, Geneva University Hospitals.* [2]*School of Pharmacy, Geneva University, Switzerland*

Objective: This study investigates the time course of response to venlafaxine and the relationship between plasma level and onset of response.

Methods: Thirty-five depressed inpatients received venlafaxine orally at a fixed 300 mg daily dose. Possible comedication included clorazepate, zopiclone and low dose trazodone. Severity of depression was assessed on days 0, 4, 7, 11, 14, 21 and 28 (Montgomery and Åsberg Depression Rating Scale). Blood samples were taken on days 14 and 28 and submitted to stereospecific determination of enantiomers V(+), V(-), ODV(+) and ODV(-) for venlafaxine and O-desmethylvenlafaxine, respectively.

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Results: Firstly, in a categorical perspective, patients displaying non-response, transient response, early persistent response and delayed persistent response were compared with respect to racemic concentrations and enantiomeric ratios. Whereas comparison of patients with and without persistent response did not reveal any significant difference, focus on patients with persistent response (n=19) indicated that early response, first observed before day 14, was associated with significantly higher V+ODV concentration than delayed response (median 725 vs 554 ng/ml, p=0.023). Shorter time to onset of response was significantly associated with lower V(+)/V(-) ratio (rs=0.48, p<0.05). Secondly, in a dimensional perspective, analysis of severity of depression versus time curves confirmed that higher V+ODV plasma level and lower V(+)/V(-) ratio were significantly associated with more rapid decrease of depression scores.

Conclusion: The hypothesis is raised that exposure to a more potent noradrenergic therapeutic moiety, as reflected by a lower V(+)/V(-) ratio, may be relevant to early improvement of depression.

S86. Symposium: Early Detection of Schizophrenia - Do We Need a Multilevel Approach?

Chairpersons: Anita Riecher-Rössler (Basel, Switzerland), Philip McGuire (London, UK)
08:30 – 10:00, Hall E

S86.01

Early detection of schizophrenia using a multilevel approach - The Basel FEPSY Study

A. Riecher-Roessler*, U. Gschwandtner, J. Aston, S.J. Borgwardt, M. Drewe, M. Pflueger, V. Exner, R.-D. Stieglitz. *Kantonsspital Basel, Psychiatrische Universitaetspoliklinik, Basel, Switzerland*

Early detection and therapy of schizophrenic psychoses has become a widely accepted goal in psychiatry. Whereas during earlier years, early diagnosis and intervention concentrated on clear-cut, full-blown schizophrenia, during the last years some centres have also started to treat patients even before a clear diagnosis could be established. However, reliable methods for an early detection already in this phase of beginning schizophrenia do not yet exist. The Basel FEPSY (Früherkennung von Psychosen) Study therefore aims at improving the empirical basis for the early detection of schizophrenic psychoses in the stage of beginning disease, even before clear-cut schizophrenic symptoms occur and at predicting psychotic breakdown. Patients potentially in an early stage of schizophrenia are identified by a screening procedure, which is based on the most important risk factors for schizophrenia and potential indicators of a beginning disease process. Each individual identified is then comprehensively examined in more detail and followed up over several years. By comparing those individuals at risk who in fact develop manifest psychosis during follow-up with those who do not, the study then seeks a post-hoc validation of the risk factors and indicators assumed a priori and tries to identify those signs and symptoms with the best predictive power. During three years we screened 206 individuals referred to our early detection clinic and could include 58 individuals at risk and 36 with first episode psychosis. A substantial promotion of individuals at risk have in the meantime made the transition to psychosis. First preliminary results will be presented.

S86.02

Clinical, neurocognitive and sociodemographic features of people with prodromal symptoms

P.K. McGuire[1,2,*], M. Broome[1,2], L. Johns[1,2], J. Woolley[1,2], E. Bramon[1,2], P. Tabraham[1,2], L. Valmaggia[1,2]. *[1]OASIS, South London and Maudsley NHS Trust. [2]Institute of Psychiatry, London, UK*

People with 'prodromal' symptoms appear to have a high risk of developing psychosis, but relatively little is known about the characteristics of this group. We studied referrals to OASIS, a clinical service for people with prodromal features in South London. Subjects were assessed in terms of psychopathology, cognitive function, structural and functional neuroimaging and electrophysiology. We have also examined their socio-demographic characteristics. These data will be presented, and the extent to which they can help predict subsequent transition to psychosis will be discussed.

S86.03

Younger age predicts progression to first-episode psychosis in individuals with subthreshold symptoms

G.P. Amminger[1,*], S. Leicester[2], A.R. Yung[2], H.-P. Yuen[2], P.D. McGorry[2]. *[1]University Clinic for Child and Adolescent Neuropsychiatry, Vienna, Austria. [2]ORYGEN Research Centre, PACE Clinic, Department Of Psychiatry, University of Melbourne, Australia*

Objective: The incidence of schizophrenia is highest in young males, but it is unknown if the risk of progression to first-episode psychosis in individuals with subthreshold symptoms varies with age or sex.

Methods: The sample comprised 92 individuals at ultra-high risk of psychosis through a combination of state and trait risk factors. All participants received treatment and monthly follow-up until transition to psychosis, or for 12 months if they had no symptom progression. Information on psychotic breakdowns after the initial 12 months was included and used for this analysis. Mean duration for follow-up in days was 759.38 (SD 577.97; range 4-2170). Survival analysis Cox regression was applied to compare progression rates in age groups (14-19, 20-30 years) with adjustment for sex, initial clinical presentation and treatment intervention.

Results: The transition rate to psychosis was significantly higher the younger age group (50%, 21 of 42 vs. 20%, 10 of 46; p<0.01). Hazard rate for developing psychosis decreased by 3.6 in the third life decade (p<0.01). The risk for transition was not significantly different in males and females.

Conclusions: Research investigating the biology of transition to psychosis or preventative interventions in putatively prodromal individuals should specifically consider 14-19 year olds as a subgroup of highest risk to manifest psychotic disorder.

S86.04

Fine motor function deficits and confounding factors in individuals at risk for schizophrenia (Basel FEPSY Study)

U. Gschwandtner*, M.O. Pflueger, J. Aston, S.J. Borgwardt, M. Drewe, R.D. Stieglitz, A. Riecher-Rössler. *Psychiatric Outpatient Department, University Hospital Basel, Switzerland*

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Introduction: Fine motor function deficits are suspected to be a risk factor for developing schizophrenia. However, up to now, they have not been systematically investigated with standardized methods. Within the Basel FEPSY-Study (early recognition of psychosis) we therefore investigate the question, if a respective computerized test battery is a promising contribution for early detection of schizophrenia.

Methods: Individuals at-risk for developing psychosis were recruited from the University Psychiatric Outpatient Department Basel and from referrals following information campaigns on early detection of psychosis. After screening, individuals at-risk who met inclusion criteria as well as a control group of healthy volunteers, were tested with the 'Motorische Leistungsserie' (Schuhfried and Hamster 1997), a computerized test battery comprising aiming, hand steadiness, line tracking, pin plugging and tapping. Both groups were compared controlling for the impact of the following factors: influence of medication, cannabis, age, gender and education.

Results: Significant differences between individuals at risk and healthy volunteers have been observed with respect to several subtest and factors of the MLS. However, after statistical control for influences of the above named factors, differences remained stable only in a few subtests.

Conclusions: Investigation of individuals at risk for psychosis with a standardized and computerized test battery could be helpful in detecting fine motor function deficits as risk-factors for schizophrenia, even when confounding factors are controlled for.

S86.05

Neuropsychological deficits in individuals at-risk for psychosis (the Basel FEPSY-Study)

M.O. Pflueger*, U. Gschwandtner, J. Aston, S.J. Borgwardt, M. Drewe, R.D. Stieglitz, A. Riecher-Rössler. *Psychiatric Outpatient Department, University Hospital Basel, Switzerland*

Introduction: Chronic as well as first episode Schizophrenia is sufficiently known to be associated with neuropsychological changes. However, its preclinical occurrence is not yet thoroughly investigated. To address this issue within the FEPSY-Study a comprehensive neuropsychological test battery is used to assess functional domains, such as attention, working memory, cognitive flexibility and planning.

Methods: Patients at risk for Schizophrenia have been consecutively recruited from the University Psychiatric Outpatient Department Basel and referrals following information campaigns on early detection of psychosis. All subjects at-risk were compared to healthy controls using the following test procedures: TAP (working memory), TAP (Go/NoGo), the Wisconsin Card Sorting Test (WCST), the Tower of Hanoi (ToH), the Continuous Performance Test (CPT) and an additional set of (non-) verbal intelligence tests.

Results: The analysis of co-variance, taking into account influences such as age, gender, education and medication, showed differences in vigilance, working memory and response inhibition due to the influence of risk for schizophrenia.

Conclusion: There were significant differences between the two groups. Only two measures of the capacity to process information (tapping vigilance and response inhibition) were not dependant on confounding variables.

W08. Workshop: How to prepare and make a Scientific Presentation

Chairperson: Cyril Höschl (Prague, Czech Republic)
08:30 – 10:00, Hall F

W08

How to prepare and make a scientific presentation

C. Höschl[1,2], N. Sartorius[3]. *[1]Director, Prague Psychiatric Center. [2]Vice-Dean, 3rd Faculty of Medicine, Charles University, Prague, Czech Republic. [3]University of Geneva, Switzerland*

Goal of the workshop is to gain or to improve skills of presentation of scientific material, particularly during international scientific events. The participants will learn the main principles of oral presentations and gain knowledge about communication skills, structure of a lecture, basic principles of a layout of slides, transparencies and power-point presentations etc. Written communication skills will also be addressed including aspects of correspondence (e.g. letters to the editor). The preparation of posters will be discussed.

Free Communications: Post Traumatic Stress Syndrome

08:30 – 10:00, Hall G

PTSD and mood disorders: Associations with types of traumatic exposure and comorbidity

C.L. Vandeleur[1,*], F. Ferrero[1], F. Borgeat[2], M. Preisig[2]. *[1]Department of Psychiatry, UREP, HUG, Geneva. [2]UREP, Site de Cery, Lausanne, Switzerland*

Objective: Several studies have revealed associations between PTSD and mood disorders. However, the impact of different types of exposure to trauma on the subsequent development of PTSD as well as the nature of the association between PTSD and mood disorders remains unclear. Consequently, our aims were to determine: 1) the association between the lifetime diagnosis of PTSD and types of traumatic events, such as experiencing accidents, violent crimes or witnessing death or injuries; 2) the association and temporal relationship between PTSD and unipolar and bipolar mood disorders; and 3) the association between types of traumatic events and unipolar and bipolar mood disorders.

Method: Our sample included 120 treated patients with bipolar disorder, 138 with MDD and 92 healthy controls. Diagnoses were made according to a best-estimate procedure based on a semi-structured interview (DIGS), medical records and family history information.

Results: 1) the risk of PTSD was associated with each type of traumatic exposure; 2) both unipolar and bipolar patients reported significantly higher rates of PTSD than controls and in comorbid patients, more than two thirds of MDD and bipolar patients reported PTSD to either precede or coincide with the onset of mood disorders; 3) patients with mood disorders experienced significantly more crime, and those with unipolar mood disorders also witnessed more crime/accidents than controls.

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Conclusion: Given the strong association and temporal relationship between PTSD and mood disorders, PTSD may be a vulnerability factor for the subsequent onset of both unipolar and bipolar mood disorders.

Determinants of posttraumatic symptoms in a sample of the Kosovan population more than two years after the war

A. Eytan[1,*], M. Gex-Fabry[1], L. Toscani[2], L. De Roo[2], L. Loutan[2], P.A. Bovier[2]. *[1]Department Of Psychiatry. [2]Department of Community Medicine, Geneva University Hospitals, Switzerland*

During the 1998-1999 period, over one million civilians from the province of Kosovo in the Balkans were displaced, as a consequence of war. The aim of the present study is to determine the prevalence of post-traumatic stress disorder (PTSD) in a sample of the Kosovan population more than two years after the end of the conflict. 340 households were randomly selected among 12'000 families returned from a country of asylum (Switzerland). All adults in each household were invited to participate (N=996). The following instruments were used: the Albanian translations of the PTSD section of the MINI, of the SF-36, and a list of traumatic events adapted from the Harvard Trauma Questionnaire (HTQ). The overall prevalence of PTSD was 23.5%. A strong cumulative effect of trauma was observed. Female gender, older age and having left Kosovo during the conflict were significantly associated with higher frequency of PTSD. Stratified analysis for people who stayed and left the province during the war suggested that different patterns of trauma may be relevant in the two subsamples, with forced separation and isolation strongly associated with PTSD in people who stayed in Kosovo. PTSD diagnosis was also significantly associated with lower scores on all dimensions of the SF-36, as well as lower economic status. The results suggest that responding to medium and long term mental health consequences of conflict is a necessary task for the global rehabilitation of health care systems in a war devastated country.

Traumatic bereavement and its relationship to posttraumatic stress disorder

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Most studies of bereavement neglected to assess the symptoms of posttraumatic stress disorder (PTSD). However, the traumatic mode which caused death of a close person influences the clinical presentation of subsequent bereavement.

Objective: The aim of this study was to evaluate clinical features of bereavement in a group of refugees whose close family member was killed during the war in ex-Yugoslavia.

Method: Thirty refugees that were referred for psychiatric help and who lost a close family member were included in the study. They have not experienced other trauma which would fulfill the DSM-IV criterion A for PTSD. The assessment consisted of a clinical semistructured interview based upon the DSM-IV criteria, Impact of Events Scale and Symptom Check List-90-Revised.

Results: 66.6% of the refugees had chronic PTSD symptoms.

Conclusions: Violent death often results in development of PTSD symptoms which are above the normal grief response. The concept of grief and trauma as separate and overlapping phenomena is discussed.

The role of religiosity in the prevention of pathological response to stress in war veterans

I. Pajevic[1], O. Sinanovic[2], M. Hasanovic[1,*]. *[1]Psychiatry Clinic. [2]Clinic for Neurology, University Clinical Centre, Tuzla, Bosnia and Herzegovina*

Physical, mental and spiritual potentials of personality are engaged in religious practice, both on individual and social level. Therefore, it is expected that religious practising has certain impact on level of predisposition for pathological response to stress. The aim of this paper is to evaluate salutary effect in regard to the response to stressfull situations in war veterans. The sample was made of 100 war veterans that are (controled variables): mentally healthy, of male gender, age between 20 to 40 years old, with an equate educational level. Experimental group (E) was made of subjects with high level of religiosity (N=50), and control group (C) of subjects with low level of religiousity (N=50). Standardized psychometric tests are used for the assessment of personality structure through three segments: neurotic profile (MMPI - Minessota Multiphase Personal Inventory), defensive mechanisms (OM - Questionnaire of Life Style), and emotional profile (PIE - Profile Index of Emotions). Questionnaires especially designed for this study are used to identify subjects in regard to their social status and level of religiosity. Statistical methods including t-test and CHI-test are used to determine the significance of differences gained among the sample groups. The results obtained indicate that religiosity strengthens psychological stability in human, and provides more successful strategies to cope with various stressors that war veterans face with. It also hightens fight readiness of soldiers to a higher level making them more willing to face with all hardships brought by war activities and destruction.

Prevalence of PTSD among the poulation of Chechen Republic in the war time conditions

K.A. Idrissov*. *Narcological Department, Grozny, Russia*

Since 1991 the population of the Chechen Republic has been living in the conditions of constant social-economic instability, including six years of full-scale military activities (war) that negatively resulted on the mental health of the majority of people. The main objective of the given research is to study the prevalence of non-psychotic psychiatric disorders, including PTSD among the local population in Chechnya under the influence of war related factors. A total of 1000 adults were questioned through the use of the door-to-door method with questionnaire for diagnosing PTSD based on the DSM-IV and ICD-10. The research took place in between October and December 2002. The results have shown that the population has been under the impact of lengthy, continuous and aggregative complex of psycho-traumatizing wartime factors, including life danger and unsuitable social-economic conditions that caused high rates of psychiatric disorders, predominantly of non psychotic nature. The analysis identified that 69,5% people have lived through one or more strong psycho-traumatizing events that resulted in the PTSD development among 31,2% of people. From the total number of questioned people PTSD detected 65,4% are women and 34,6% - men. Factors that contribute to the PTSD development are gender -

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women are more vulnerable to acquire PTSD, age – the frequency of PTSD increases upon the age increase, low income, destroyed housing, absence of adequate health assistance. The lengthy living in the war zone reduces the perceptivity level to psychotraumatizing events and increases the possibility of PTSD development.

Free Communications: Imaging

08:30 – 10:30, Hall H

Structural brain alteration in dyslexia: An MRI study

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Developmental dyslexia is a frequently diagnosed reading disorder, found in 4-10% of the population, characterized by reading difficulty despite normal intelligence and educational opportunities. Brain imaging studies have reported changes in task-related neural activity, mainly phonological processing as well as anatomic deviations that might underlie dyslexia. In this study, MRI brain scans of 14 men with dyslexia and 10 gender matched control subjects were compared using 1) a classic volumetric method and 2) a voxel-by-voxel based analysis. The volumetric method showed a reduced gray matter volume in both temporal lobes among the dyslexic subjects. The voxel-based analysis further localized the changes to the left temporal lobe, where the dyslexic experienced reduced gray matter density precisely in the middle end inferior temporal gyri. Conversely an increased gray matter density was found in the precentral gyri bilaterally. Lastly, looking for correlation between gray matter density and neuropsychological performances, the dyslexic subjects and the control subjects, taken as a whole group, demonstrated a positive correlation between the performance at rhyme judgment tasks and gray matter density in the middle and inferior frontal gyri, and in the middle temporal gyri bilaterally. In conclusion, dyslexia results from a structural deficit of gray matter tissue involving a complex fronto-temporal network implicated in phonological processing.

fMRI of amygdala activation during emotion processing in patients with schizophrenia

G. Sachs[1,*], S.D. Robinson[2], W. Gombas[1], R. Strobl[1], E. Moser[2,3], R.C. Gur[4], H. Katschnig[1]. [1]*Department of Psychiatry.* [2]*Institute for Medical Physics.* [3]*Department of Radiodiagnostics, University of Vienna, Austria.* [4]*Department of Psychiatry, University of Pennsylvania, Philadelphia, PA, USA*

Background: Facial expressions of emotion are increasingly being used in neuroscience as probes for emotion processing in functional magnetic resonance imaging (fMRI). Recent fMRI studies have indicated limbic activation in response to emotional stimuli, albeit with imaging methods which have recently been called into question. The present study employs a high resolution EPI protocol optimised for the amygdala and 3 T to investigate possible differences in emotion processing between patients with schizophrenia and healthy controls.

Methods: 15 patients with schizophrenia (DSM-IV) and 15 age and sex-matched healthy controls viewed images of faces displaying happiness, sadness, anger, fear as well as neutral faces. FMRI was used to measure BOLD signal changes as subjects alternated between tasks requiring discrimination of emotional valence of the faces (positive or negative) and age (over 30 or under 30). All measurements were carried out using a 3 T Medspec S300 whole-body system. An optimised EPI protocol was employed; oblique axial slices of 2mm thickness, 128x128 matrix, TEeff=46ms, 12 axial slices in TR=2s.

Results: Activation in the amygdalae was detected in patients with schizophrenia and healthy subjects when both tasks (emotional and age discrimination) were considered in combination. Activation is also apparent in the fusiform gyrus as would be expected in response to facial recognition.

Conclusion: These results provide evidence for the involvement of limbic-structures during facial emotion processing in the patient and control groups. A high resolution EPI protocol combined with high field strength (3T) has proved capable of detecting robust activation in the amygdala and the fusiform gyrus.

The spatio-temporal cortical activity pattern of conscious decision-making as reflected by the haemodynamic response

E.R.M. Hülsmann[1,2,*], M. Erb[1], W. Grodd[1]. [1]*Section of Experimental Magnetic Resonance of the CNS, Department of Neuroradiology, University of Tübingen, Germany.* [2]*Hopital Psychiatrique Cantonal, Marsens, Switzerland*

The everyday situation in which a person knows what to do, but has the freedom to decide precisely when to do it is accompanied by cerebral activities in a characteristic temporal sequence. This succession of spatio-temporal activities has been imaged by functional magnetic resonance in 10 subjects as they performed 87 cycles of a delayed response task. The task consisted of responding to visual stimuli by self-paced motor responses (14 ± 2 sec. inter-stimulus interval). Statistical parametric evaluation of the data demonstrated neuronal activity during the whole inter-stimulus interval. The earliest activities (± 1 sec. signal) were seen in the visual perceptive and discriminative areas, followed (2 sec. post-signal) by the visual association areas (cuneus) and, finally (3 sec. post-signal) by the SMA. The cingulate gyrus was the first area to exhibit activity associated with the final decision (2 sec. prior to decision), followed by the SMA (1.5 sec. prior to the decision), and the motor-sensory areas (± 1 sec. decision). These spatio-temporal activity maps presumably reflect stable feedforward - feedbackward systems. The regions exhibiting activity in the time interval between the signal and the decision (i.e. the cuneus, cingulate cortex and SMA) are presumed to be related to a conscious state of mind. Two of these - the cuneus and cingulate cortex - are known to be disturbed in patients suffering from schizophrenia. We thus suggest that time-resolved efMRI has the potential of being used in the research and diagnosis of schizophrenia.

Pathological MRI brain scan and EEG findings in individuals at risk for schizophrenia (Basel FEPSY Study)

S.J. Borgwardt*, U. Gschwandtner, J. Aston, M. Drewe, M. Pflüger, W. Semenin, R.-D. Stieglitz, A. Riecher-Rössler. *Psychiatric University Outpatient Department, Kantonssspital Basel, Switzerland*

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Introduction: Various changes in brain structure and abnormal EEG findings have been described in patients with schizophrenia. It is to be expected that at-risk individuals show similar changes.

Methods: At the Psychiatic University Outpatient Department Basel, an early recognition clinic has been established. In a screening procedure, indicators and risk factors for schizophrenia (psychopathology, psychosocial factors and genetic risk) are assessed. Individuals identified as 'at-risk' as well as patients with first episode psychosis are then investigated comprehensively (extensive early recognition interview, neuropsychological tests, EEG, MRI brain scan and fMRI).

Results: Preliminary analyses of the EEG and MRI findings show a relatively high amount of pathological findings and norm variations in 'individuals at-risk' and in patients with a first episode of psychosis, e.g. fronto-temporal epileptiform potentials and focal slow waves, frontal brain atrophy and neuroepithelial cysts. Furthermore, coarse brain pathology such as chronic subdural haematoma or encephalitis could be detected in patients referred to our 'early detection of psychosis clinic'.

Conclusions: A substantial subgroup of individuals, referred to an early recognition clinic with suspected psychosis or suspected to be in a prodromal stage of schizophrenia, shows organic brain pathology. We conclude that in all such individuals diagnostic procedures should include EEG and MRI brain scan or CT in order to recognize comorbid brain disease and/or organic causes of psychosis.

The influence of expectancy on emotional pictures: A combined fMRI- Neuropsychology Study in depression

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Patients with major depression show often an expectancy bias; their emotional experience is biased by negative expectancy. We therefore investigated the influence of a preceding expectancy period on the neural correlates of emotional pictures using fMRI and neuropsychology. In a pilot study we investigated 14 healthy subjects in fMRI and neuropsychology (CANTAB). They viewed emotional pictures with and without preceding period of expectancy followed by a baseline while being scanned in fMRI. Preliminary analysis of results showed deactivation in pre/subgenual anterior cingulate (PAC/SAC) and posterior cingulate (PC) in pictures with preceding expectancy while the dorsomedial prefrontal cortex (DMPFC) showed activation. In contrast, pictures without preceding expectancy show a converse pattern with activation in PAC/SAC and PC and deactivation in DMPFC. These results will be correlated with the test scores from the neuropsychological test battery. In addition, patients with major depression will be investigated with the same paradigm; based on prior findings it is expected that they will show abnormalities in the PAC/SAC and the PC during modulation of the neural correlates of emotional expectancy by a preceding expectancy. This might account for what clinically may be described the negative expectancy bias.

Neuroradiological imaging and psychological testing: Useful and necessitive extensions of dementia-diagnostics?

M. Kreis[1,2,*], M. Damian[1,2], B. Krumm[1,3], F. Hentschel[1,2]. *[1]Central Institute of Mental Health, Faculty of Clinical Medicine, University of Heidelberg. [2]Division of Neuroradiolgy. [3]Division of Biostatistics, Central Institute of Mental Health, Mannheim, Germany*

Aims: The significance of extended diagnostics in dementia and vascular dementia has been discussed under the view of cost-effectiveness. The contribution of neuromaging and neuropsychological testing to diagnosis of vascular dementia is evaluated.

Methods: Of 215 patients of a memory clinic the first clinical diagnosis, the diagnosis of neuroimaging and of neuropsychology are registered under equal criterias and compared with the final clinical diagnosis. The radiological examination with magnetic resonance imaging (MRI) consists of standard sequences, a FLAIR-sequence, and a special Hippocampus-oriented sequence. Power- and Speed-Tests are used for the neuropsychological examination. A differentiation between demented vs. non-demented patients and vascular vs. neuro-degenerative dementia (e.g. Alzheimer's disease) is made.

Results: 205 of 215 patients are included to the study. Only 50,5% of 205 are demented patients. At 26% of 205 patients the results of extended clinical diagnostic are leading to changes of the final clinical diagnosis, compared with the first clinical examination. Under consideration of the final clinical diagnosis statistical coherences for the diagnostic criterias vascular dementia (VD), neuro-degenerative dementia (ND) vs. non-demented (XD) can be found: A specific contribution is given by neuropsychology to the diagnosis of dementia, and by neuroimaging for the differentiation of vascular (VD) vs. neuro-degenerative (ND) dementia.

Conclusion: The extended diagnostics contribute to correctness of the final diagnosis, the contribution is complementary. Even with regard to cost-effectiveness, early secondary prevention, and therapy of vascular dementia neuroimaging and neuropsychological testing are essential.

Special Event: Imposing Uniform Standards of Psychiatric Education in Europe: A blessing or a curse?

Chairperson: Henning Sass (Aachen, Germany)
10:30 – 12:00, Hall A

Special Event: Imposing Uniform Standards of Psychiatric Education in Europe: A Blessing or a Curse?

H. Sass*. *University Hospital Aachen, Germany*

Is a European harmonization of the training of medical specialists in psychiatry something we are looking for, or something we have to be afraid of? In 1995, the European Union of Medical Specialists (UEMS) has already published a European Training Charter for Medical Specialists defining the requirements for specialist training in psychiatry. Starting with a state of the art lecture the Special Event provides the opportunity to discuss this important issue in all its diversity. Discussants from different countries will present their point of view in this debate and open the discussion to the auditorium.

The experience in the United States has revealed that uniform standards improve the overall quality, and also improve the equivalency of experiences across multiple sites. However, questions arise

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regarding potential inhibition of creativity or new approaches to post graduate training, as well as determination of minimally acceptable numbers and interests of faculty, and diversity and quality of training facilities.

How shall we proceed in Europe with our specific tradition, i.e. the development of basic ideas in psychiatry and psychopathology represented by famous clinicians and conceptual authors like Kahlbaum, Maudsley, Kraepelin, Bleuler, Jaspers, Kurt Schneider or Ey? There are people supporting the idea that the vitality and fertility in Europe lies in its many distinct national elements and that we should better share educational strategies than to create a unitary system.

The Special Event gives opportunity to discuss all these items between the speakers and the auditorium.

S68. Symposium: Depression in Schizophrenia: from diagnosis to treatment

Chairpersons: Sonia Dollfus (Caen, France), Wolfgang W. Fleischhacker (Innsbruck, Austria)
08:30 – 10:00, Hall B

S68.01

Evaluation of depression in schizophrenic patients: Relationship with quality of life

C. Lançon[1,*], G. Reine[1], P. Reine[2]. [1]*Department of Psychiatry, CHU Sainte Marguerite.* [2]*Department of Public Health, School of Medicine, Marseille, France*

Depression is a frequent complication of schizophrenia. Evaluation of depressive manifestations is difficult. Calgary Depressive Scale for Schizophrenic (CDSS) is a useful scale to distinguish depressive symptoms, negative manifestations of schizophrenia and extrapyramidal symptoms. The impact of depressive manifestations of subjective quality of life is explored in a population of schizophrenic patients. Subjective quality of life is evaluating with the SQoL; a new quality of life scale especially developed for schizophrenic patients. Relationship between quality of life and depressive symptoms is exposed.

S68.02

Preliminary evidence for the validity of schizophrenia subtypes based on severity of illness, outcome and depressive symptoms

M.-A. Roy[1,2,*], M. Cayer[2], C. Lehoux[2], R. Palmour[3], J. Trépanier[2], L. René[2], S. Pelletier[2], P. Szatmari[4], R.-H. Bouchard[1,2], C. Mérette[1,2], M. Maziade[1,2]. [1]*Département de Psychiatrie, Faculté de Médecine.* [2]*Centre de Recherche Université Laval-Robert-Giffard, Quebec.* [3]*Department of Psychiatry, McGill Université, Montreal, QC.* [4]*Department of Psychiatry, McMaster University, Hamilton, ON, Canada*

Goal: To identify SZ subgroups using cluster analysis and to use preliminary diagnoses on relatives to test their validity.

Methods: 114 SZ subjects were sampled from 2 strata according to level of functioning. The lower functioning stratum came from long-term psychiatric wards or highly structured housing facilities. Higher functioning subjects living in the community without supervision. We entered severity of positive, negative and disorganization symptoms assessed during stabilized state, depressive symptoms assessed during acute episodes, premorbid adjustment and age of onset. Preliminary diagnoses on relatives were gathered from the probands' medical records.

Results: Our clusters were very consistent across 3 clustering techniques. Cluster I was characterized by less severe positive, disorganization and negative symptoms, more severe depressive symptoms, better premorbid and current functioning and later onset. Cluster II yielded characteristics opposite to those of Cluster I. Cluster III was characterized by prominent negative symptoms with less severe positive, disorganization and depressive symptoms. Preliminary diagnoses on relatives revealed a higher proportion of SZ in relatives of Cluster III compared to those of Cluster II subjects and a trend for relatives of Cluster I having a higher risk for mood disorders than relatives of Cluster II and III.

Discussion: These results suggest that: i) more than two subtypes are necessary to account for heterogeneity in SZ; ii) valid subtypes may be identified by non-linear analyses; iii) depressive symptoms are important to identify subtypes. Preliminary evidence for different rates of psychopathology in relatives have to be verified through our ongoing family study.

S68.03

Antipsychotics in the treatment of schizophrenic patients with a post-psychotic depression

S. Dollfus[1,*], P. Guillard[2], M. Cazenave[3], B. Chabot[4], C. Deal[5], V. Olivier[6]. [1]*Centre Esquirol, UMR 6095 CNRS, CHU Caen.* [2]*CHS Colson, Fort de France.* [3]*CHS Charles Perrens, Bordeaux.* [4]*CHS Bon Sauveur, Caen.* [5]*Clinical Operation Department.* [6]*Medical Department, Lilly France, Surresnes, France*

Depression is well known to occur during the course of schizophrenia. However, the symptoms of depression can overlap negative symptoms, extrapyramidal symptoms, dysphoria induced by neuroleptics, prodromes of psychotic relapse or acute distress reaction to life-events. Consequently, several therapeutic strategies can be considered. One of these can be the use of 'atypical' antipsychotics. Indeed, several controlled studies suggested a benefit for atypical antipsychotics in depressive symptoms in schizophrenia. However, no study has tested specifically an action of these drugs in post psychotic depression. Aim: the aim of this study was to compare, the efficacy of olanzapine (5 to 15 mg/d) and risperidone (4 to 8 mg/d) in patients with a postpsychotic depression (DSMIV).

Methods: the multicentric, randomized, double-blind study was interrupted after 36 and 40 patients were included in olanzapine and risperidone arms respectively. Patients were randomized after 1 week of placebo if they presented MADRS scores >=16 associated with positive PANSS scores <=28.

Results: there were significant decreases of MADRS scores in both groups after 2 and 8 weeks of treatment.

Discussion: both treatments improved depressive symptoms in residual schizophrenic patients with depression.

S68.04

Different pharmacological approaches to treat depressive symptoms in schizophrenia, depending on their relationship to the course of schizophrenia

W.W. Fleischhacker*. *Department of Biological Psychiatry, Innsbruck University Clinics, Austria*

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Although the evidence is still tentative, it appears to be current common practice for most psychiatrists, having ruled out confounding conditions such as extrapyramidal motor symptoms and negative symptoms, to prescribe antidepressant agents to patients with schizophrenia who show depressive symptoms. There are controlled clinical trials that have demonstrated that tricyclic antidepressants are effective in the treatment of depression in patients with schizophrenia. In contrast, the newer antidepressants have yet to be tested in large scale controlled studies. Monotherapy with novel antipsychotics may be a treatment option, as some such as zotepine, olanzapine and risperidone have shown advantages over traditional antipsychotics in reducing depressive symptoms in patients with schizophrenia. A treatment algorithm based on the differential diagnosis of depressive symptoms in schizophrenia patients will be presented.

S59. Symposium: Late Life Psychosis

(Organised by the AEP Section of Geronto-Psychiatry)

Chairperson: Nicoleta Tataru (Oradea, Romania)
10:30 – 12:00, Hall C

S59.01

Late-Life Schizophrenia

N. Tataru*. *Neuropsychiatry Hospital, Oradea, Romania*

Late-onset schizophrenia remains a controversial nosological entity. The 'Consensus Statement of International Late-onset Schizophrenia Group' has agreed on considering the schizophrenia with onset after the age of 40 years as Late onset schizophrenia, and schizophrenia with onset after the age of 60 as Very late onset schizophrenia-like psychosis. The evidence in support of the notion of late onset schizophrenia is not yet convincingly demonstrated and there are psychiatrists who do not agree that LOS is a different disease. Very late onset schizophrenia-like psychosis is associated with sensory impairment and social isolation Early and late onset psychosis are more similar than different in terms of symptoms. For the treatment of late-life psychosis is preferable to use the atypical antypsychotics in low doses if the compliance with neuroleptic medication can be established and maintained The place of non-pharmacological treatments has not been adequately investigated, however they are part of the 'complete management package' in the elderly psychosis.

S59.02

Prevalence of the depression in the elderly

J. Leszek*. *Department of Psychiatry, Medical University, Wroclaw, Poland*

Depression is one of the most common psychiatric conditions in late life. Some authors suggested that depressive illness in the elderly is often characterized by frequent and prolonged relapses, and that it is associated with greater mortality. They concluded that various factors can influence prognosis, such as severity, duration of depressive illness, biological aging factors in the brain, associated physical illness, and age at onset of the first depressive illness. The poor prognostic nature of depression in the elderly may have multiple adverse consequences such as poor quality of life, reduced compliance with other medical treatment, increased utilization of health care Services, cognitive impairment, and increased risk of mortality from suicide and other causes. This report presents the incidence of depression in Lower Silesian Province in period 1999- 2001 in population 65 yrs of age and older. We found that depressive illness were most prevalent in this range of age, increased with age and were higher in woman.

S59.03

Diagnosis particularities and efficient therapeutic strategies in BPSD

C.O. Tudose*. *Medicine University Carol Davila, Bucharest, Romania*

There is an increased number of sufferers of dementia and mainly of Senile Dementia of Alzheimer type who are quite early diagnosed nowadays and who receive specific cholinergic treatments as well as a diversified non-pharmacological care. These are the consequences of the higher interest of professionals as well as the increased awareness in dementia of the general public. The family members who previously recognized dementia only in the advanced phase of the disease - in the presence of important and disturbing psychological and behavioral changes are now beginning to be much more aware of the behavioral disturbances of dementia considered a distinct syndrome that is better understood and needs appropriate diagnosis and early interventions. The paper is making a review of the specific diagnostic criteria, therapeutically logarithms and strategies as well as particularly clinical aspects as a result of 3 years of activity of the Memory Centre from Bucharest.

S59.04

Particularities in treatment of late-life psychosis

V. Camus*. *Clinique Psychiatrique Universitaire, Centre Hospitalier Régional Universitaire, Tours, France*

Psychosis in late life may be underlain by several psychiatric conditions: schizophrenia, late paraphrenia, dementia, but is also associated with several medical co-morbid states. Elderly patients with psychosis are at high risk to have uncovered medical and social needs. Treatment of psychosis in late life requires to integrate specific medical, social, environmental interventions in addition to the administration of antipsychotic medications. The presentation will discuss the specificity of these different therapeutic means when used in the context of elderly and frail persons. It will emphasise that preventing drug induced parkinsonism and tardive dyskinesia is one of the main criteria for choosing pharmacological compound. The role of psychotherapeutic interventions and of the implication of informants and social environment will be discussed.

S43. Symposium: Nature and Narrative: Rediscovering Meaning in Neuroscience

(Organised by the AEP section on Philosophy and Psychiatry)

Chairpersons: Giovanni Stanghellini (Florence, Italy), Michael Musalek (Vienna, Austria)
10:30 – 12:00, Hall D

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S43.01

Introduction: The courage of philosophy

G. Stanghellini*. *OSP S M Annunziata, Florence, Italy*

No abstract received.

S43.02

Past Improbable, Future Possible: A hundred years of philosophy and psychiatry in twenty minutes

K.W.M. Fulford*. *Professor of Philosophy and Mental Health, University of Warwick, Honorary Consultant Psychiatrist, University of Oxford and Editor PPP, Oxford and Warwick, UK*

The 1990's, although anticipated as the 'decade of the brain', witnessed a remarkable explosion of work in the Philosophy of Psychiatry in many countries around the world. This paper outlines some of the main developments in Philosophy of Psychiatry and sets them in their historical context starting with the work of Karl Jaspers. Understood in this context, the 1990's 'decade of the mind' turns out to be not as improbable as it might have otherwise seemed to be. There is indeed a historical trajectory running through 20th Century psychiatry which points to a possible future of the subject in which, as in other complex sciences, philosophical and imperical methods are increasingly closely combined.

S43.03

The meaning of delusions as maintaining factor: The clinical evidence

M. Musalek*. *Anton Proksch Institute, Vienna, Austria*

No abstract received.

S43.04

Incomprehensibility: The limits of meaning in psychopathology

M.L.A. Heinimaa*. *Department of Psychiatry, University of Turku, Finland*

This presentation belongs to a series of papers that investigate the logic of some central psychiatric concepts like 'psychosis', 'delusion', 'insight', 'understanding' and 'incomprehensibility'. The key finding of these studies is the importance of the grammar of 'understanding' and concepts related to its demise (like 'incomprehensibility') in describing psychiatric concepts. Drawing on the analysis of the distinction between positive and negative conceptions of 'incomprehensibility', it can be shown that saying that something is incomprehensible is not giving and explanation, the reference of which would be the inconceivable state of affairs depicted, that is, 'incomprehensibility' is not a referential concept. In this presentation, I will go more into concrete investigation of the consequences of this analysis to understanding uses of psychiatric concepts like 'psychosis'. The question is: If defining psychoticism is dependent on a concept that in the end cannot be referred to, what are we doing when asserting psychosis as a nosological concept or as a determination of a nosological concept? And if the definition of delusion is dependent on evaluating the incomprehensibility of a certain though or reasoning, what are the consequences of finding that we are not in the position of saying what 'incomprehensibility' amounts to?

S43.05

Anxiety - Animal reactions and the embodiment of meaning

G. Glas[1,2,*]. *[1]Zwolse Poort, Zwolle. [2]Department of Philosophy, University of Leiden, The Netherlands*

In this presentation the question will be raised whether pathological forms of human anxiety are simply remnants of some archaic animal reaction or must be seen as distinct from animal physiology, for instance as bearer of existential meaning. I will explore a third position, which suggests that in the human world animal reactions can be enriched with 'or opened-up to' social, moral and even existential meanings. This position asks for a structural analysis of the various aspects of anxiety and their coherence. I will attempt to offer such a conceptual analysis. I will refer to and comment on recent work of neurologists and neuroscientists like LeDoux, Edelman, Damasio, Ramachandran. Putting the mind back in the brain, like they suggest, is indeed one important step. Opening-up the brain in such a way that brain functioning obeys to psychological regularities and is responsive to social norms and moral values, is another.

S76. Symposium: Management of Violent Patients on Psychiatric Wards

Chairpersons: Norbert Nedopil (Munich, Germany), Paul Cosyns (Antwerp, Belgium)
10:30 – 12:00, Hall E

S76.01

Inpatient violence - Epidemiological data

T. Steinert*. *Department of Psychiatry, Centre of Psychiatry Weissenau, University of Ulm, Germany*

Data concerning the incidence of inpatient violence is influenced by numerous factors such as definitions of violence, reporting procedures, and characteristics of patients, staff, ward organisation, hospital organisation, catchment area and health policies. Though there are plenty of studies from many regions across the world, both cross-sectional comparisons of representative hospital populations in different countries and longitudinal studies are scarcely available. There are some hints that violence is more frequent in Northern America and has been increasing within the last two decades due to bed reduction policies. The findings concerning characteristics of violent patients are largely inconsistent, probably due to sample selection bias. The most robust predictor is a history of violent behaviour, followed by general severity of psychopathological symptoms. Factors such as diagnosis, gender, age, substance abuse, and sociopathic personality traits play a minor role compared to their well-known importance for violence in the community. Intervention studies could confirm positive effects of staff training on violence management as well as the finding that the incidence of violence decreases if patients who are prone to violence are not concentrated on single units. Different causal relationships between inpatient violence and the frequency of coercive measures can be assumed but empirical data on the issue is missing.

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S76.02

Identifying factors predisposing to inpatient violence

M.J. Travis[1,*], Z. Atakan[2], M. Isaac[2], M. Isaac[3], D.L. Gilbert[3], M.J. Komeh[4], A. Shaw[2], C.A. Sweeney[1], R.W. Kerwin[1]. *[1]Institute of Psychiatry, Maudsley Hospital. [2]Institute of Psychiatry, Royal Bethlem Hospital. [3]Institute of Psychiatry Lewisham Hospital. [4]Institute of Psychiatry, Landor Road Hospital, London, UK*

The predication of violence in psychosis in acute ward settings has lacked a firm evidence base. This is primarily because of the inherent difficulties in studying such an acutely unwell population in a scientifically rigorous way. This lack of data has also hampered research into the effective management of such behaviour. Existing data has suggested that personal factors whish predict violence include; a previous history of violence; youth; male sex; a stated threat of violence and an association with a sub-culture prone to violence. Clinical Variables include; alcohol or other substance misuse; delusions or hallucinations which are focused on a particular person; a specific preoccupation with violence; delusions of control, particularly with a violent theme and agitation, excitement, overt hostility or suspiciousness. An increase in the risk of violence is also associated with a lack of collaboration with suggested treatments. We are in the process of conducting a naturalistic, prospective observation study over 12 months which will include all patients admitted to four inner city psychiatric intensive care units, (PICU), in the UK. The study is designed to collect data on subjects demographic details, previous violence and treatment experiences. These factors will then be related to violent incidents occurring during these PICU admissions and observational data collected on the response to interventions for violence. Preliminary data will be presented from this study and synthesised with other data from the literature to allow discussion of the primary factors which allow the prediction of violence.

S76.03

Seclusion and restraint - patients perspective

R. Kaltiala-Heino*. *Psychiatric Treatment and Research Unit for Adolescent Intensive Care (EVA), Tampere University Hospital, Finland*

Seclusion and restraint are widely used in psychiatric treatment to manage aggression and violent behaviour, but also to manage unspecific disoriented and disturbing behaviour. Literature mentions as main indications for these powerful coercive measures prevention violence to others and to the patient her/himself, and removing the patient from stimuli too intensive for her/him, implying that seclusion and restraint are not only for control, but also can have a therapeutic effect. Patient experiences have been studied very little. Mainly, patients have perceived these measures as frightening, irritating, insulting, anger-provoking, and alienating. They have reported increasing hallucinations in seclusion. Short term effects of the measures are good, usually the patient calms down, but long-term effects or optimal use are not known. Some patient populations can perceive these measures very differently from the majority. For example, forensic patients have in a preliminary study been exceptionally positive to seclusion. The patient's life history and experiences of services at large are likely to influence experiences of seclusion. A third physical violence management method is physical (manual) restraint of an escalating patient. Our experiences of this method in a Finnish adolescent forensic unit are good. Structured patient debriefing interviews also favour this method, which is carried out as part of a comprehensive aggression management programme.

S76.04

Ethical and legal issues pertaining to the management of inpatient violence

N. Nedopil*. *Department of Forensic Psychiatry, Psychiatric Hospital of the University of Munich, Germany*

During the last 30 years fundamental changes could be observed in the ethical and legal attitudes towards involuntary treatment and management of mentally disturbed patients in many parts of Europe. These changes can be summarized under the heading 'From paternalism to autonomy and partly back'. In many countries laws about guardianship, custody, involuntary commitment and the like have been changed to safeguard the previously not too well ob-served rights of psychiatric patients - not always for the benefit of all the patients, some of them were shifted from general psychiatry to forensic psychiatry - since general psychiatry was now unable or unwilling to manage these patients. The current state of political opinion and of court rulings has been summarized in the White Paper of the European Council. The main contents of this paper will be of outlined. They lead to the conclusion that 1) involuntary commitment be applied for no other reason than dangerousness because of mental illness and 2), that physical restraint is the last measure to avoid immediate danger after all other means including treatment have been unsuccessful; it does not mention medication exlicitly. Whether forced medication or physical restraint is considered as ultimate measure differs from country to country and in Germany even from State to State but there is general agreement that long acting or depot medication is not acceptable in emergency situations since the ultimate measure whatever it is only to applied to overcome the emergency situation, that is to avoid the immediate danger.

S76.05

Changes in the administrative management of violent mentally ill patients

H. Schanda[1,2,*]. *[1]JA Göllersdorf. [2]Psychiatric University Clinic, Vienna, Austria*

This contribution has to be understood as the interpretation of own results presented in the symposia S22 and S72: It were the United States, where deinstitutionalization started in the 50s of the 20th century. The rest of the Western world followed with more or less delay. The changes in the administrative management of mental patients in general were the same everywhere, modified only by differing legal and economic preconditions. This process brought the patients out of the hospitals and made them 'visible' in the community. The necessary changes in general mental health care were impaired by a lack of provision for a subgroup of severely ill subjects who could not accept the offers of modern community care or whose requirements were not met by the current developments. As these patients are disproportionately prone to violence, an increasing number of them again disappear in jails, prisons and special hospitals. The neglect of this problem is counterproductive with respect to the aims of psychiatry reforms and reinforces old prejudices against the mentally ill in general.

S76.06

The management of violence in psychiatric patients - from risk assessment to risk management

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H. Gordon*, S. Davison. *South London and Maudsley NHS Trust, London, UK*

There is increasing concern about protecting staff and patients within psychiatric units from violence. This session will provide an overview of the management of violent patients within healthcare settings. We will start with a brief overview of the association between violence and mental disorder and of what is known about the nature and circumstances of violence within healthcare settings. There will then be a presentation of the different methods for preventing and managing imminent violence and of the supporting literature. This will involve discussion of preventative measures such as talking down, behavioural management, boundary setting, environmental measures and tackling substance misuse and other relevant disorders. The talk will continue with a presentation of the relative risks and benefits of the different methods for containing violence in the acute situation: physical (control and restraint), geographical (seclusion) or chemical (sedation). Dr Gordon will review the issues pertaining to the use of mechanical restraint. There will be a discussion about the management of persistent aggression associated with mental disorder. We will conclude that there is no single correct way to manage violence. With the appropriate training and support, an appropriate care environment and with the full range of options at their disposal, staff can safely manage or prevent much of the violence within healthcare settings.

W17. Workshop: Working Alliance with Suicide Attempters and Life Career Issues

Chairperson: Konrad Michel (Bern, Switzerland)
10:30 – 12:00, Hall F

W17

The working alliance with suicide attempters

K. Michel[1], L. Valach[2]. [1]*University Psychiatric Services, Bern.* [2]*Faculty of Philosophy, University of Zurich, Switzerland*

Suicide has to be properly conceptualized before we can prevent it. Attempted suicide is the main risk factor for suicide, but so far, there is little evidence that psychiatric aftercare reduces the risk. L. Valach and K. Michel developed a model of the suicidal process based on the notion that suicide and attempted suicide are actions. Action theory implies that a narrative interviewing style is more appropriate to understand a suicidal patient than a traditional clinical primarily diagnosis-driven approach. An interviewer who believes in the patients' ability to explain their actions will be able to develop an empathic and shared understanding of the importance of the emotional and deeply painful experiences in patients' lives. In our experience, an attitude in which the clinician particularly acknowledges the subjective meaning of life-career issues related to the patient's suicidality, strengthens the therapeutic relationship. The patient-oriented model of suicidal behaviour is the central issue of the Aeschi Working Group (www.aeschiconference.unibe.ch), of which K.M. is a member. Workshop participants will become familiar with an action theoretical model of suicidal behaviour and its implications for clinical practice. Educational means will include short theoretical presentations, discussions, video recorded patient interviews, and handouts. After the workshop, participants will be better able to join suicidal patients in their very individual experience of mental pain and suicidal thoughts.

Free Communications: Other Issues II

10:30 – 12:00, Hall G

Clinical aspects of transport phobias in schizotypal disorder

I.I. Sergeev, L.G. Borodina, O.V. Mikhalevskaya*. *Department of Psychiatry and Medical Psychology, Russian State Medical University, Moscow, Russia*

Clinical aspects of transport phobias in schizotypal disorder.

Objective: To investigate conditions of manifestation, clinical features, course and social functioning of patients with transport phobias in schizotypal disorder (ICD-10, F21).

Methods: 68 out- and inpatients aged 18 to 60 with predominant pathological fears of going by different means of transport living in the megapolis (Moscow) were studied. 38 patients with schizotypal disorder (main group) were compared to 30 subjects with neurotic disorder. Patients underwent psychopathological evaluation, follow-up and completed the original checklist for assessment of mental patients' social functioning and their quality of life (I.Y.Gurovich, A.B.Shmukler, 1993).

Results: The following differences were found between schizotypal transport phobias and neurotic ones: predominance of schizoid traits in premorbid personality (42,1%), spontaneous onset (28,9%), rapid progression from mono- to total fear of transport (52,6%). Besides, transport phobias developed on the basis of previous hypochondriac fears (cardio-, maniaphobia and etc.) or social phobia. Some patients had bizarre fears of accidents, speed with secondary importance in clinical picture. The structure of axial syndrome and consequence of joining transport fears were similar. However, with time different productive disorders such as depersonalization, senestopathias with odd localisation (brain, skeleton and etc.), other phobias, obsessive-compulsive disorders, severe depressive episodes, dissociative conversion symptoms and in single cases paranoid ideas and hallucinations occurred in main group. The course of transport phobia in schizotypal disorder had significantly greater tendency to progression. Patients with schizotypal disorder had statistically worse social functioning than subjects with neurotic problems.

Psychiatric comorbidity in gender identity disorder

U. Hepp*, B. Kraemer, U. Schnyder, A. Delsignore. *Psychiatric Department, University Hospital Zurich, Switzerland*

Objective: Despite being recognized as an important prognostic factor for the outcome in gender identity disorder (transsexualism) psychiatric comorbidity has rarely been assessed by means of standardized diagnostic instruments. The aim of this study was to assess current and lifetime psychiatric comorbidity in patients with gender identity disorder. Method: We collected a cross-sectional sample of 31 patients who were treated for gender identity disorder. Patients were diagnosed by structured clinical interview for Axis-I and Axis-II (SCID-I/II) and the Hospital Anxiety and Depression Scale (HADS).

Results: 29% of patients had no current or lifetime Axis-I disorder. 39% fulfilled the criteria for current and 71% for current and/or lifetime Axis-I diagnosis. The most common diagnoses at the time of the interview were anxiety disorders (26%, n=8), followed by mood disorders (13%, n=4), somatoform disorders (10%, n=3) and sub-

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stance abuse (10%). From a lifetime perspective, almost half of the patients met DSM-IV criteria for substance abuse or dependence (45%, n=14) and/or a mood disorder (45%, n=14). Lifetime anxiety disorders were identified in seven patients (23%). Some patients were diagnosed with more than one disorder. 42% of the patients were diagnosed with one or more personality disorders. 39% reported one or more suicide attempts, mainly before the onset of treatment.

Conclusions: Lifetime psychiatric comorbidity in gender identity disorder patients is high, and this should be taken into account in the assessment and treatment planning of transsexual patients.

Prevalence of eating disorders simultaneously using DSM-III-R and DSM-IV criteria

K.G. Götestam*, E. Kjelsås, E. Strøm. *Department of Neuroscience, Norwegian University of Science and Technology (NTNU), Division of Psychiatry Behavioral Medicine, Østmarka Hospital, Trondheim, Norway*

Most eating disorder research is usually reporting either version III-R or DSM-IV, but both sets of criteria simultaneously is very seldom used, why fair comparisons are difficult to perform. As far as we have seen no prevalence studies have been using both sets, in spite of rather large adjustments in the diagnostic system. Furthermore, few studies have been performed on ED prevalence in men, while the gender gap seems narrowing. Does it make any difference, which version is used? Prevalence of eating disorders, using a self report schedule (SEDs) was used. A total of 1687 university students participated. Total ED figures: Women: DSM-III-R 14.6% and DSM-IV 15.4%. Men: DSM-III-R 0.8% and DSM-IV 2.9%. Figures among women for AN: 3.2 and 2.4, BN 3.0 and 1.3, EDNOS 8.5 and 11.3. And for men: AN 0.1 and 0.1, BN 0.3 and 0.2, EDNOS 0.4 and 2.5. There are some differences in prevalence with the DSM III-R and IV, which mainly affects the detailed diagnoses. For women the sum of ED does not change. For men, however, there is a drastic threefold increase in ED. The severe diagnoses AN and BN give lower prevalence values for women, while the very low prevalence figures for men do not change substantially. The results with DSM-IV can give the impression that AN and BN has decreased over time, when different studies are compared, while the reason mainly could be the more conservative criteria used in DSM-IV. So, it really makes a difference, which version is used.

Cognitive behaviour therapy for psychiatric patients with comorbid personality disorder: Evaluation of a new treatment programme

V. Roder*, M. Lächler, P. Zorn, D.R. Müller, M. Thommen, W. Tschacher. *University Hospital of Social and Community Psychiatry, Bern, Switzerland*

Nowadays there are several well elaborated therapy approaches for patients with personality disorders available. Nevertheless there is a paucity of standardised cognitive behaviour group therapy formats targeting various kinds of personality disorders with comorbid psychiatric disorders. Against this background, we developed a cognitive behaviour therapy group programme ('Bern Integrative Therapy' [BIT]) for patients with personality disorders from all clusters (A to C; DSM-IV). BIT mainly focuses on clarification and modification of cognitive-emotional schemas, but integrates behavioural and coping-oriented therapeutic proceedings as well. In detail BIT comprises three steps for each personality style:

1. Psychoeducation
2. Clarifying social interactions and internal processes (dysfunctional feelings and cognitions)
3. Exercises of individual coping-oriented behaviour. An ongoing multi-centre study evaluates BIT based on a sample of 70 patients with personality disorders from all clusters.

The randomised design compares BIT with a group of patients (n=35) treated with 'classical' behaviour therapy (Social Skills Training). First results indicate, that BIT activates an examination of, and a coming to terms with individual dysfunctional schemas. Furthermore improvements in symptomatic impairments, interpersonal behaviour, emotional regulation and psychosocial functioning can be observed. Further data have to clarify a possible impact of these improvements on the psychiatric disorder. These preliminary results might indicate, that the developed therapy programme could be an additional significant approach for patients in psychiatric treatment.

Promoting wellbeing in physicians: From intervention programmes to preventive activities

A. Arteman[1,3,*], J. Padros[1,2,3], C. Bule[1,3], A. Calvo[1,3]. [1]*Galatea Foundation.* [2]*Barcelona Medical Council.* [3]*Integral Care Programme for Sick Physicians (PAIMM), Barcelona, Spain*

In 1998, the Barcelona Medical Council created, jointly with the Generalitat de Catalunya (Autonomous Government of Catalonia), the Integral Care Programme for Sick Physicians (PAIMM), devoted to delivering, specific and confidential, care services for physicians suffering from addictive behaviours and/or mental disorders. At first, the objective was to attend these cases and to respond to complaints and the malpractice suits that these cases grave rise to. Later, we perceived: a) that theses were more physicians affected by these factors than we had realized, b) that we needed to take preventive measures and c) that the general medical population is made up highly differentiated groups which needed different interventions. The purpose of this paper is to present the Galatea Foundation and its preventive and therapeutic programmes for sick physicians and nurses in Barcelona. The Foundation offers the following programmes: a) Integral care programme for sick physicians (PAIMM). b) The health of medical interns and residents. c) Health, gender and professional career. d) Preparation for retirement. e) The health of medical students. f) Prevention of and attention to the Burnout syndrome and g) Support to physicians in litigation.

DSM-IV self-report and subjective evaluation by psychiatrists in Israel

M. Weiss[1,2,*], R.D. Strous[1,2], R. Stryjer[1], D. Ofir[1], F. Bar[1,2], Y. Baruch[3], M. Kotler[1,2]. [1]*Beer Yaakov Mental Health Center, Beer Yaakov.* [2]*Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv.* [3]*Ministry of Health, Jerusalem, Israel*

Background: Psychiatric disorder, with the range of both subsyndromal and syndromal manifestation, is an important, yet often unrecognized and unacknowledged, problem amongst physicians. It is a subject that remains understudied, particularly amongst psychiatrists. The purpose of this study was to explore the subjective perception of mental illness amongst members of the psychiatric profession.

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Method: Psychiatrists attending an educational symposium completed anonymously a self-evaluation questionnaire in which they were asked to self-diagnose the presence of DSM-IV disorders.

Results: 110 responses were received (response rate: 52.1%). 90% of respondents indicated the presence of at least one syndrome or trait. The most common disorders on axis I and axis II were 'mood disorder' and 'narcissistic traits' respectively, with the least common being 'psychotic disorder' and 'schizotypal traits'. Female psychiatrists reported more impairment, particularly among axis I disorders. The reported number of axis I and II conditions decreased with subjects' age.

Conclusions: Manifestations of psychiatric conditions including the range of subthreshold phenomena, as self-diagnosed according to DSM-IV criteria, appear to be prominently reported, albeit with low severity, in a subjective manner by psychiatrists. Our findings may be of importance in encouraging the implementation of special programs in training and ongoing occupational support.

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