that eating disorder patients have a reputation for being difficult to treat. The aims of this paper are: (1) to discuss the different motivational challenges presented by different types of eating disorders (anorexia nervosa, bulimia nervosa and binge eating disorder); (2) to review what we know about the use of motivational techniques in the treatment of eating disorders (Treasure and Schmidt, 2000), (3) to present data from ongoing trials at the Maudsley Hospital using these techniques in anorexia nervosa, bulimia nervosa (Treasure et al., 1999) and binge eating disorder (Schmidt et al., 1999) and (4) to discuss limitations of motivational approaches to treatment.

S41.03
DIAGNOSTIC SUBGROUPS IN EATING DISORDERS RELATED TO PAIN THRESHOLD

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We studied a relation between pain perception and diagnostic subgroups of eating disorders (ED). The pain threshold latencies on thermal stimuli were measured under rest and stress conditions in 37 DSM-IV diagnosed anorexia nervosa (AN) and bulimia nervosa (BN) patients (15 BN, 22 AN – 11 restricting and 11 nonrestricting type) and in 34 healthy controls. In AN restricting type we showed a higher pain threshold when compared with controls, AN nonrestricting type and BN. Pain thesholds were negatively correlated with BMI and illness duration. In controls all stressors increase the pain threshold while in ED the pain responses vary with the type of stressor. Major differences were observed between mental (MS) and alimentary stress (AS). The MS increased the pain threshold in all ED groups with exception of AN nonrestricting type. During AS the pain threshold in both groups of AN remained unchanged while in BN decreased. The pain sensitivity decreases by stress via antinociceptive mechanism, analgesic-like effect of sweet nutrients or stress anticipation. The inverse reaction of pain threshold during AS was typical for ED with shortest duration of illness. We are suggesting that the "alimentary pain test" might be used as a state marker and differentiate the diagnostic subgroups. This phenomenon may reflect more general psychopathological pattern explaining both continuum and differences in eating disorders pathology.

S41.04
WHEN THE BODY SPEAKS: THE CULTURAL CONTEXT OF EATING DISORDERS

M. Katzman

No abstract was available at the time of printing.

S41.05
GUIDELINES FOR PHARMACOTHERAPY

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Pharmacotherapy is not the first choice in the treatment of eating disorders. Behavioral and cognitive behavioral therapy are usually preferred.

As for Anorexia Nervosa only a few controlled studies of different treatment methodes have been conducted. There are some promising results in relation to the use of SSRI'-s in preventing relapse of anorexia nervosa and reducing obsessionality. In small open trials some cases with severe anorexia nervosa were successfully treated with atypical antipsychotics like Olanzapine.

As for bulimia nervosa more then 15 controlled studies have been done on the effect of antidepressants. Nearly all antidepressants have been shown to be effective treatments in reducing binge eating and purging behaviour in bulimia nervosa. Especially fluoxetine 60 mg/day has been effective in large controlled trials. However based on evidence from randomized trials and clinical experience most experts prefer cognitive behavioral or interpersonal psychotherapy as the therapy of first choice.

Binge eating disorder seems to be a more mild disorder in which the prescription of antidepressants can have its value.

A review will be given of the work done in this field. Guidelines will be presented and recommendations will be made for further research.

C02. Interpersonal psychotherapy for depression

Chair: L. Schramm (D)

C02.01
INTERPERSONAL PSYCHOTHERAPY (IPT)

E. Schramm

Interpersonal Psychotherapy (IPT) is a short-term model for the treatment of outpatients with major depression. It was developed by Klerman and Weissman over a twenty year period. Based on the ideas of the interpersonal school according to Sullivan, the treatment focus is on dealing with interpersonal stress related to the current depression. Examples are: marital disputes, loss of a significant other, loneliness, role transitions by retiring, job promotion, moving, etc. IPT attempts to intervene in symptom formation and psychosocial problems rather than personality structure. It is also used as a maintenance treatment in a modified format.

The workshop focuses on the theoretical and empirical basis for IPT and the discussion of the course of treatment within the IPT model. Clinical illustration (videotaped cases) is used.

C06. Development of programmes combating stigma and discrimination because of schizophrenia

Chair: N. Sartorius (CH)

C06.01
DEVELOPING PROGRAMMES AGAINST STIGMA AND DISCRIMINATION BECAUSE OF SCHIZOPHRENIA

N. Sartorius, J.J. Lopez-Ibor, W. Gaebel, W. Schöny, G. Rossi

The World Psychiatric Association, aware that stigma and discrimination related to schizophrenia present a major obstacle to the provision of care for people suffering from the disease, has initiated an educational programme that is to help its member societies to undertake relevant action at national or regional level. The programme, which started in 1996, quickly grew and was declared an institutional programme of the World Psychiatric Association

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in 1999. Now under way in twelve countries in different parts of the world the programme has assembled sufficient knowledge and experience about the ways of dealing with stigma and discrimination because of schizophrenia to be able to offer training about the programme to teams from other countries.

The objectives of the course are: (1) to make participants aware of possible ways of fighting stigma and discrimination because of schizophrenia; (2) to enable them to use the WPA instruction manuals describing the steps necessary to build up a programme in their country; and (3) to establish working relationships between the participants in the course and teams fighting stigma and discrimination because of schizophrenia in the framework of the WPA programme.

The faculty of the course will be composed of representatives of centres that are carrying out anti-stigma programmes in their countries. Participants: (1) psychiatrists and other mental health workers from settings in which preliminary action concerning the development of antistigma programmes has been carried out. Such groups will be given priority for inscription at the course; (2) others engaged or likely to become engaged in teaching or other action related to stigma and discrimination because of mental illness.

FC11. Schizophrenia II

Chairs: M. Kirsten-Krüger (CH), J. Libiger (CZ)

FC11.01

PHENOMENOLOGY OF SCHIZOPHRENIA IN DIFFERENT GENDER

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Schizophrenia still poses controversy regarding its different dimensions. The difference of opinion varies across a number of parameters ranging from aetiology to treatment, causes to manifestations and treatment to outcome. When it comes to the issue of gender, schizophrenia also plays a different role. It not only strikes men and women at different ages, but, it follows a different course and displays a significant gender difference in phenomenology. This paper describes the data from a study which has been completed at a local psychiatric facility in the UK looking at different aspects of this illness. The information was collected from a cohort of schizophrenic patients diagnosed as per I.C.D. 10 using BPRS and PANSS. The results support the findings suggesting a different clinical picture with reference to gender. Significant differences were observed among male and female patients in many symptoms. Female patients showed more affective symptoms, somatic concern, anxiety, tension and depressed mood as compared to male patients. The results are discussed with reference to the practical implications of this difference. An attempt is also made to argue whether we are dealing with two distinct types of schizophrenia or there is only one disorder with variations in it presentation and occurrence in different sexes.

FC11.02

THE LANGUAGE OF SCHIZOPHRENIA IN XXTH CENTURY: FROM PHENOMENOLOGICAL TO ILLOCUTIONARY APPROACH

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As strange as it may seem, psychiatrists contrary to psychoanalytic have seldom made attempts to analyze the significance of language in mental illness. This is particularly surprising in view of the fact that language is their principal instrument in attempting to assess the condition of patients. Psychiatrists tend to interpret language in a phenomenological manner. But here the following should be noted: when language is looked upon as an instrument/symptom the linguo-philosophic principle is being ignored. Clearly, another approach to the understanding of psychotic speech is needed, one that takes into account the role of language in the generation of psychosis. Our idea that the speech act theory makes it possible to realize it. According to the illocutionary acts theory (J. Austin), a distinction should be made between utterances that constitute statements or descriptions, and utterances that constitute acts of creation. It is assumed here that psychotic discourse should be viewed as an illocutionary act and that language itself is able to create a new psychotic reality. The peculiarities of this approach are the following: a) Psychotic discourse can be defined ignoring true-false dichotomy. b) In the frame of the theory a new vision of the thought – language – reality triad language itself has the power to create a new psychotic reality.

FC11.03

FOUR-YEAR STABILITY OF POSITIVE AND NEGATIVE SCHIZOTYPAL TRAITS IN NORMAL ADOLESCENTS FROM THE GENERAL POPULATION

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Background: Schizotypal traits are considered risk markers for schizophrenia spectrum disorders. One study (Champan et al., 1994) has so far shown their predictive value. However, little is known about their stabilility and even less at an early age such as adolescence. It is important to know of their stability 1) to be able to properly conceptualise them as 'risk markers', and 2) since adolescence is an important stage in which to assess 'trait-like' risk indicators.

Methods: We initiated a biobehavioural high-risk study for schizophrenia spectrum disorders in 1993 with adolescents from the general population. We did an initial screening with the sustained attention measure CPT-IP with 1498 subjects. We then chose 301 subjects, half poor and half normal CPT-IP performers (T1). After 4 years, in 1998, we re-assessed the working sample (T2). We were left with 138 subjects. In T1 we assessed schizotypal personality with 3 of the Chapman scales: Perceptual Aberration, Physical Anhedonia, Social Anhedonia Scale. In T2 we did a multidimensional assessment with the O-LIFE, which also taps positive and negative factors and contains an important number of items from the Chapman scales.

Results: Pearson correlations between T1 and T2 schizotypal traits were significant for the total sample and both groups separately. However, subjects with attentional deficit present more negative traits than control subjects 4 years later. The pattern of associations is the expected one between positive and negative dimensions.

Conclusions: These data point to the reliability of schizotypal traits measurement at 13 and 17 years old. Furthermore, our

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