Objective: Impairments in affect recognition are well known in schizophrenia. Such impairments are known to be a trait-like characteristic in schizophrenia mostly unaffected by traditional treatment. Moreover they seem to play a crucial role in patients' poor social functioning. The present study should contribute to the still open question of treatment options for these impairments.

Methods: A special Training of Affect Recognition (TAR) was evaluated using a pre-post-control group design with three groups of about n=25 partly remitted schizophrenia patients each. To control for nonspecific effects of implicit cognitive training, TAR was compared with a Cognitive Remediation Training (CRT) aiming at improvement of basic neurocognitive functioning. To control for nonspecific effects the two active training groups were compared with a control group without additional training (CG).

Results: Patients under TAR showed an improvement in facial affect recognition, with recognition performance after training approaching the level of healthy controls from former studies. Patients under CRT and those without training (CG) did not show improvements in affect recognition, though patients under CRT improved in some memory functions.

Conclusions: Improvements in disturbed facial affect recognition in schizophrenia patients is not obtainable with a traditional cognitive remediation program like CRT, but needs a functional specific training like the newly developed TAR.

S07.03

Therapy of social cognition: Overview and empirical results

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Social cognition appears to be an important mediating factor between cognitive and social functioning in schizophrenia which may increase the efficacy of different cognitive-behavioural therapies. In fact, social cognition is becoming a specific target of these interventions, including psychoeducation, cognitive remediation, social skills training and cognitive therapy for positive symptoms. By means of a systematic literature review, main publications about possible efficacy of social cognition in four major languages (English, Spanish, French, and German) are selected. According to this review, main empirical results concerning therapy of social cognition in schizophrenia, both in research and clinical settings, are shown in this presentation. Finally, some practical recommendations about these therapies are provided.

S07.04

Social cognition scale (SCS): A newly developed assessment instrument

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There is general consensus that social cognition is a key cognitive dysfunction in schizophrenia. At the same time, the hypothesis that social cognition is an aspect of cognition that determines social functioning has been receiving more and more empirical support since it was first proposed a few years ago.

However, the actual definition of ''social cognition'' can be a confounding factor in this framework. The definition has been a matter of debate in literature and only recently has some consensus emerged about the aspects that constitute ''social cognition'' (emotion perception, theory of mind, social perception, attributional style, social scheme). As a consequence, most of the time research in this area only considers some of these aspects, probably because the instruments available to measure social cognition measure these aspects individually and not social cognition globally.

The SCS (social cognition scale) is an instrument under development with the goal of measuring together some of the components of social cognition, specifically: identification of stimuli, emotion perception, and social perception. Results show that the social perception of the patients who participated in the social perception program has improved. Patients that have received training in social perception learn to gather more information from an image, and to make more adequate interpretations.

S07.05

Integrated neurocognitive therapy for schizophrenia patients (INT)

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During the past two years we designed a cognitive-behavioural group therapy program (INT) as further development of the cognitive part of Integrated Psychological Therapy (IPT). INT is partly computer based and intends to restitute and compensate neuro- and social cognitive (dys-)functions. The program is embedded in the daily living context of the patients and starts from their resources with a special focus on facilitating intrinsic motivation. The INT-manual contains exercises to improve the following (MATRICS) areas: Speed of processing, attention/vigilance, verbal and visual learning and memory, working memory, reasoning and problem solving, emotional and social perception, social schema and emotion regulation.

Currently we evaluate INT in a randomized multi-centre study in Switzerland and Germany. INT is compared with TAU. Outpatients with a diagnosis of schizophrenia (DSM-IV) are included. Assessments are applied before and after therapy with a 1 year follow-up. Additionally the therapy process is evaluated. Assessment instruments measure neuro- and social cognition, psychopathology, social functioning, quality of life, expectation of self-efficacy and therapy motivation. Patients receive 30 therapy sessions each lasting 90 minutes for 15 weeks. During the first study year 44 patients participated (23 for INT and 21 for TAU groups). First results (pre- post assessments) show better outcome of INT patients in neurocognitive variables, emotion perception, self-rated motivation and self-efficacy. Up to now we didn't find a significant influence on social functioning and on psychopathology. Further results, especially data of the follow-up have to confirm the significance of the newly developed therapy program within other rehabilitation approaches.

W01.Workshop: PROBLEMS IN THE PROVISION OF PSYCHIATRIC SERVICES IN EUROPE (Organized by the European Division of the Royal College of Psychiatrists)

W01

Problems in the provision of psychiatric services in Europe

G. Christodoulou [1], H. Sass [2]. [1] *Department of Psychiatry, University of Athens, Athens, Greece* [2] *University Hospital Aachen, Aachen, Germany*

The workshop deals with various aspects of the provision of psychiatric services in Europe in general and in selected European countries.

The differences in the provision of psychiatric care between East and West will be highlighted and the need to channel the recommended action

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in an appropriate need – centered way is emphasized. Other challenges in the provision of psychiatric services will also be dealt with.

The advances, the challenges and the problems in mental health provision in selected European countries in East and West (Serbia, Germany and France) will be presented under the light of recent developments in these Countries (e.g. the new French Mental Health Plan).

Special emphasis will be given to the difficulties in the transition from Mental Hospital Psychiatry to community care and to the ethical aspects of this transition.

W02.Workshop: IMAGINATIVE DEATH EXPERIENCE IN HYPOCONDRIASIS

W02

Imaginative death experience in hypochondriasis

J. Prasko [1,2,3], H. Praskova [4]. [1] *Prague Psychiatric Centre, Prague, Czech Republic* [2] *3rd Medical Faculty of Charles University, Prague, Czech Republic* [3] *Centre of Neuropsychiatric Studies, Prague, Czech Republic* [4] *Out-Patients Psychiatric Clinic, Horni Palata, Czech Republic*

Patients with health-anxiety are very often unable to describe concrete consequences of their putative somatic diseases. They block their thoughts due to anxiety attended this thoughts. The health-anxious patients try not to think about illness at all, by attempting to control their thoughts or by distraction. Our method is based on therapeutic dialogue, using Socratic questioning, and inductive methods which force patient to think beyond actual blocks.

In second step, patients are asked to think out all other possibilities of newly discovered future. They are forced to imagine the worse consequences of all dread situations. Dialogue is led through one's serious illness status, with its somatic, psychological and social consequences, and the dying experience to the moment of death, which has to be described with all related emotions and details. Further, we ask patients to fantasize and constellate possible ''after death experiences''. In the next session the patient brings a written conception of the redoubtable situation previously discussed. Than we work with this text as in imaginative exposure therapy.

This method seems to be quite effective and not too time-consuming. Several patients with health-anxiety underwent this exposure in our therapeutical groups. All of these patients profited from this therapy, as confirmed by follow-up data.

Participants will learn:

- conceptualization of health anxiety with the patient;
- Socratic questioning with the hypochondriacal patient;
- how to apply the exposure to the imaginative death experience.

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PL01. PLENARY LECTURE

PL01

Placebo and nocebo effects: how the doctor's words affect the patient's brain

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The administration of inert treatments along with verbal suggestions of either clinical improvement (placebo) or worsening (nocebo) are known to powerfully affect the course of some symptoms and diseases. In fact, placebos and nocebos have been found to affect the brain in different conditions, like pain, motor disorders and depression. It has also been shown that this may occur through both cognitive factors, like expectation, and conditioning mechanisms. In recent years, placebo- and nocebo-induced expectations have been analyzed with sophisticated neurobiological tools that have uncovered specific mechanisms at both the biochemical and cellular level. For example, positive expectations (placebos) have been found to activate endogenous opioids whereas negative expectations activate cholecystokinin. Placebos have also been found to induce a release of dopamine in the striatum and to affect the activity of single neurons in the subthalamic nucleus in Parkinson patients. There is also experimental evidence that different serotonin-related brain regions are involved in the placebo response in depression. Recently, the placebo effect has been studied with a different experimental approach, in which hidden (unexpected) medical treatments were carried out and compared with open (expected) ones. In all cases, the hidden medical treatments were less effective than the open ones. These findings show that the patient's awareness about a therapy is of crucial importance in the therapeutic outcome. Overall, all these studies show that the psychosocial context around the therapy, particularly the doctor's words, may induce changes in the patient's brain that, in turn, may affect the course of a disease.

SOA1. STATE-OF-THE-ART LECTURE

SOA1

Advances in pain research and therapy

H. Flor. *Department of Clinical and Cognitive Neuroscience, University of Heidelberg, Central Institute of Mental Health, Mannheim, Germany*

Recent neuroscientific evidence has revealed that the adult brain is capable of substantial plastic change in areas that were formerly thought to be modifiable only during early experience. These findings have implications for our understanding of chronic pain. Functional reorganization in several brain areas related to the processing of pain was observed in neuropathic and musculoskeletal pain. In chronic low back pain and fibromyalgia patients the amount of reorganizational change increases with chronicity, in phantom limb pain and other neuropathic pain syndromes cortical reorganization is correlated with the amount of pain. These central alterations may be viewed as pain memories that influence the processing of both painful and nonpainful input to the brain. Learning processes that contribute to the development of pain-related memory traces are predominantly implicit and involve processes such as sensitization, operant and classical conditioning or priming. Cortical plasticity related to chronic pain can be modified by behavioral interventions that provide feedback to the brain areas that were altered by pain memories. These behavioral interventions can be enhanced by pharmacological agents that prevent or reverse maladaptive memory formation.

PR01. PRESIDENTIAL FORUM ON EUROPEAN STRATEGY FOR MENTAL HEALTH

PR01.01

WHO European office's views and the European mental health plan

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