stability of the relationship. Thus, the identification of contributing and maintaining factors of sexual problems as well as designing effective interventions is a primary concern of clinical psychiatry. Academic and clinical training within the field of psychiatry, and psychology, prepares a professional to "listen" to verbal and nonverbal communications of patients. The therapist is trained to "see" repetitive patterns of behavior and to associate current and historical information, permitting a more dynamic understanding of sexual and interpersonal problems. These skills facilitate the diagnostic evaluation. While patients may seek a "quick" fix for sexual problems, clinical experience supports the hypothesis of the importance of psychosocial, affective, cognitive, interpersonal and cultural variables in maintaining or exacerbating problems regardless of etiology. These variables are often not amenable to a "quick fix." Historically, major shifts in how sexual problems have been viewed and treated, demonstrates how sexuality is shaped by social and cultural expectations, (e.g. 100 years ago a sexually enthusiastic woman would likely have been pathologized as a "nymphomaniac" and hospitalized for insanity). The renaming of sexual problems also relates to the shifting norms and biases of society (e.g. frigidity and inhibited sexual desire, have a different emphasis then the use of desire disorder; impotence is more negative then the current term erectile disorder). Today, as new and effective pharmaceutical agents increase treatment options for sexual disorders, therapists have the opportunity to develop new psychological interventions designed to incorporate and potentiate the drug therapies. This presentation will focus on the importance of differential diagnosis and careful sexual history prior to treating sexual problems. I will demonstrate how information derived from the assessment process is translated into efficient interventions. Another purpose of this presentation is to increase the therapists awareness and sensitivity to overt and covert messages communicated to the patient during the evaluation and treatment process.

S20.04
BIOLOGICAL TREATMENTS OF PARAPHILIAS AND PREMATURE EJACULATION

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Pharmacotherapy of sexual dysfunction and sexual disorders is experiencing a renaissance. Even disorders which have been traditionally treated with various psychological and behavioral therapies, such as premature ejaculation (PE), and paraphilias, have reportedly been treated successfully with Pharmacotherapy. Premature ejaculation is the most prevalent type of sexual dysfunction among males with estimates of prevalence up to 40%. It is defined as persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes. The pause maneuver, pause-squeeze technique, and stop-start method have been standard treatments for PE for a long time. However, lately serotonergic antidepressants have emerged as an effective treatment for PE. Recent studies have demonstrated the efficacy and safety of clomipramine, fluoxetine, paroxetine, and sertraline in the treatment of PE. SSRI's seem to be the logical treatment of choice in cases of failed psychological treatment, when psychological treatments rejected, or the partner is unwilling to cooperate. The essential features of paraphilias are recurrent, intense sexually arousing fantasies and urges. Paraphilias have been described as impulse disorders, obsessive compulsive spectrum disorders, or affective spectrum disorders. Various hormones, antipsychotic drugs, lithium, buspirone and SSRI's, namely fluoxetine, have reportedly been successful in the treatment of paraphilias. This presentation will review the efficacy, management strategies, and advantages and disadvantages in the treatment of premature ejaculation with SSRIs, as well as in the treatment of paraphilias with various psychotropic drugs and hormones.

S20.05
TREATMENT OF SEXUAL DYSFUNCTION ASSOCIATED WITH MEDICATION

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Many commonly prescribed psychiatric medications are associated with sexual dysfunction. Antipsychotics affect sexual function, probably via dopamine D_2 receptor blockade and/or hyperprolactinemia. Antipsychotic treatment interferes with desire, arousal (erection) and satisfaction. The prevalence of sexual dysfunction in treated schizophrenics is 30–60%. Even novel atypical antipsychotics seem to cause sexual dysfunction. Attempts to treat the sexual dysfunction using dopaminergic drugs were disappointing. The addition of L-dopa may increase psychotic states. Apomorphine causes severe nausea and is not sufficiently effective, and the addition of 100 mg/day amantadine caused some improvement but was not clinically satisfactory. L-deprenyl, 15 mg/day, had no effect on sexual dysfunction. Viagra (sildenafil citrate), which acts locally on the penis, may be a new and promising treatment and the results for the first few patients are encouraging. Antidepressant drugs, including SSRIs, also affect sexual function; estimates vary from a small percentage to 96%. The most common sexual side effects are delayed ejaculation and anorgasmia; center dot desire and arousal are also olden affected. The hypothesized mechanisms of action are increased serotonergic activity at the $5\text{-}HT_2$ receptor, anticholinergic effects and inhibition of NO synthetase. A variety of strategies have been used in the management of SSRI-induced sexual dysfunction: waiting for tolerance to develop, dosage reduction, drug holidays, substitution with another drug, and augmentation strategies. Substitute antidepressants are bupropion, nephazodone and mirtazapine. Adjustive agents are $5HT_2$ antagonists (cyprobertadine, mianserin, mirtazapine), dopamine receptor agonists (psychostimulants, bupropion) and Viagra. Benzodiazepines and lithium are also not devoid of sexual side effects. Impairment in sexual function and quality of life may lead to noncompliance and relapse. Therefore, new strategies to overcome these adverse effects are of great importance.

S21. Neurocognitive dysfunctions in subjects with psychotic disorders: methodological issues and clinical relevance

Chairs: S. Galderisi (I), J. Gruzelier (UK)

S21.01
COGNITIVE REHABILITAITON IN PSYCHIATRIC PATIENTS

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Cognitive abnormalities in schizophrenia appear early in the course of the illness and seem to be enduring characteristics. They include deficits in attention, learning, memory and executive function. Studies of high-risk, first degree relatives of patients with schizophrenia provided evidence, that mild cognitive dysfunction may

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