W11.03
PRACTICAL DEMONSTRATION AND GROUP INDUCTION

U. James

No abstract was available at the time of printing.

W11.04
STRUCTURE AND FUNCTIONS OF BRITISH HYPNOTHERAPY EXAMINATIONS BOARD

L. Mathew

No abstract was available at the time of printing.

FC09. Schizophrenia I

Chairs: N. Lindefors (S), C. Höschl (CZ)

FC09.01
BINOCULAR RIVALRY IS SLOW IN BIPOLAR DISORDER BUT NOT IN SCHIZOPHRENIA OR MAJOR DEPRESSION

S.M. Miller*, G.B. Liu, T.T. Ngo, L.B. Geffen[1], B.D. Gynther, P.B. Mitchell[2], J.D. Pettigrew. *Vision Touch and Hearing Research Centre, Department of Physiology and Pharmacology; [1]Cognitive Psychophysiology Laboratory, University of Queensland; [2]Mood Disorders Unit, University of New South Wales, Australia*

Binocular rivalry refers to the perceptual alternations that occur when different images such as orthogonal gratings, are presented simultaneously, one to each eye. We have demonstrated that the rate of rivalry with drifting, high-spatial frequency (h.s.f.) gratings is slow in bipolar subjects (median = 0.27 Hz) compared with controls (median = 0.60 Hz) (1). Here we used stationary gratings with a low-spatial frequency (l.s.f.) to assess rivalry rates in a different group of bipolars and controls, and in schizophrenia and major depression.

We report that rivalry rate in bipolar subjects (n′, mean = 0.28 Hz) was again significantly slower than in controls (n), mean = 0.40 Hz, $t(54) = -3.72$, $p < 0.001$). Fourteen subjects with schizophrenia (mean = 0.37 Hz) did not differ significantly from controls ($t(41) = 0.85$, $p = 0.40$), and 16 subjects with major depression (mean = 0.37 Hz) also did not differ significantly from controls ($t(43) = 0.72$, $p = 0.48$).

The data replicate our original finding and suggest that drifting, h.s.f. gratings separate bipolar from control groups more effectively than stationary, l.s.f. gratings, and that rivalry rates in schizophrenia and major depression are not slow. In light of our results, sensitivity and specificity data necessary to assess the clinical utility of the slow rivalry marker should be collected using drifting, h.s.f. gratings.

(1) Pettigrew JD, Miller SM: Proc R Soc Lond B 1998, 265: 2141–2148.

FC09.02
THE CALGARY DEPRESSION RATING SCALE FOR SCHIZOPHRENIA (CDSS): RELIABILITY AND VALIDITY DATA OF A GERMAN VERSION

M.J. Müller*, O. Benkert. *Department of Psychiatry, University of Mainz, Mainz, Germany*

Background: The CDSS is a semi-standardized interview (9 items, scaled 0–3) for the assessment of depressive symptoms with high sensitivity and specificity in schizophrenia. We recently developed a German CDSS version in collaboration with the author of the source version and we carried out reliability studies. The scale is currently available in 19 languages including Czech, Danish, Dutch, Finish, French, German, Greek, Hungarian, Italian, Polish, Portuguese, Romanian, Russian, Spanish, and Swedish. In an ongoing study we investigate the validity of the CDSS.

Methods: Interrater reliability was assessed by intraclass correlations and Cohen's coefficient kappa. So far, 65 inpatients with a diagnosis of schizophrenia or schizoaffective disorder have been investigated after admission. The CDSS and additional scales (HAMD, BRMES, PANSS, SAS, BARS, AIMS) were used for the present analyses.

Results: The reliability studies revealed ICC > 0.7 for single items, and ICC > 0.9 for the total scale. Preliminary results of the ongoing study show a correlation between CDSS and HAMD or BRMES sum scores of $r > 0.70$ ($P < 0.0005$). No substantial correlation was found between CDSS scores and measures of EPS ($P > 0.05$). CDSS sum scores were moderately ($P < 0.05$) related to PANSS general psychopathology and negative symptoms. No substantial relationship emerged between CDSS and PANSS positive symptoms.

Conclusions: The results suggest that the CDSS (German version) is suitable to assess depressive symptoms in schizophrenia within reliably, rather specifically, and economically. No substantial overlap between CDSS scores and assessments of positive, negative, and EPS symptoms, and a rather high correlation with other depression assessments (HAMD, MADRS) underline the discriminant and converging validity of the CDSS. The careful development of a number of language versions of the CDSS now available on the Interact (http://www.ucalgary.ca/cdss/) make the scale very useful for European and international collaboration.

FC09.03
ESTABILISHING ONSET IN FIRST-EPISODE PSYCHOSIS: THE NOTTINGHAM ONSET SCHEDULE (NOS)

S.P. Singh*, J.E. Cooper, C.J. Tarrant, H. Bagalkote, P.B. Jones. *University Department of Psychiatry, Duncan Macmillan House, Nottingham NG3 6AA, UK*

Background: Most ratings of onset of psychosis use a single global measure. There are few structured instruments to study the phenomenon of onset itself. The Nottingham Onset Schedule is a short guided interviewing and rating schedule to measure onset in psychosis. Onset is defined as the time between the first reported/observed change in mental state/behaviour to the development of psychotic symptoms. Onset is conceptualised as comprising of (i) a prodrome of two parts: a period of 'unease' followed by 'non-diagnostic' symptoms; (ii) appearance of psychotic symptoms; and (iii) a build-up of diagnostic symptoms leading to a definite diagnosis. The schedule was piloted in a sample of first-episode psychosis patients.

Methodology: Consecutive cases of first-episode psychosis were administered the schedule, blind to diagnosis. A consensus ICD-10 diagnosis was made using all available information.

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