95% CI: 1.9–4.2). This association remained after adjustment for age, sex, minority status, urban residence, level of CIDI paranoid symptoms at baseline, level of education, unemployment and single marital status (OR: 2.3, 95% CI: 1.5–3.5). Minority status increased the risk for psychosis (OR adjusted for age and sex=2.1; 95% CI: 0.8, 5.6); this effect was largely confined to young men (OR men aged 18–34 years=6.3, 95% CI: 1.04, 38.5). Entering minority status and discrimination jointly in the equation attenuated the effect size of minority status much more (28%) than that of discrimination (8%), leaving only discrimination as significant independent predictor.

Interpretation: Experience of discrimination is robustly associated with onset of psychotic symptoms and may explain in part the high observed rates of schizophrenia in some minority populations.

S54.3

Migration and schizophrenia: a Danish population-based cohort study

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[2]*Aarhus University, Denmark*

Migration is increasingly implicated as a risk factor for schizophrenia, yet the mechanism underlying this association remains obscure. We studied immigrant background and history of foreign residence (among persons with Danish background) as potential risk factors for schizophrenia, utilizing a novel approach that would minimize the influence of selection factors. Using data from the Danish Civil Registration System, we established a population-based cohort of 2.14 million people resident in Denmark by their 15th birthday. Schizophrenia in cohort members and psychiatric disorder in a parent were identified by cross-linkage with the Danish Psychiatric Case Register. First- and second-generation immigrants had significantly increased risk for schizophrenia compared to persons with Danish background. Age at first residence in Denmark and the accumulated number of years lived in Denmark had no impact after adjusting for these factors. Among persons with Danish background, history of foreign residence significantly increased the risk for developing schizophrenia. Our findings provide compelling support for an association between migration and schizophrenia that is not solely attributable to selective migration and that may possibly also be independent of foreign birth.

S54.4

Does racial discrimination cause mental illness?

K.J. McKenzie*. *Royal Free and University College Medical School, London, UK*

Differences in incidence of mental illness between some immigrant groups and indigenous populations cannot be explained by traditional risk factors such as genetic and socio-economic differences. Important risk factors include the reasons for migration and the host population's response to newcomers.

One such response is racial discrimination. Though it has been considered a possible risk factor for some time, there has been little systematic evidence to support or refute such claims. An increasing body of literature now suggests that racial discrimination is in fact an important risk factor for mental illness. These include a cross-sectional association between reported racial discrimination and psychosis in a national sample, demonstration of a longitudinal association between reported racial discrimination at baseline and incident psychosis three years later and evidence that rates of psychosis, suicide and presentation for parasuicide are higher in an ethnic minority group when it makes up a lower proportion of the local population.

The author will review these recent developments and the wider literature to answer the question; "Does racism discrimination cause mental illness?".

S54.5

Social isolation and high rates of psychosis among migrant groups

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Objectives: Social isolation is likely to be one of the major problems of migrant communities. We sought to test whether this applied to the patients of Caribbean origin in Britain experiencing a first onset of psychosis.

Methods: A first onset sample of patients in London was compared with a similar group in the Caribbean and healthy controls using socio-demographics, perceptions of disadvantage and contact with non- psychiatric medical services prior to presentation.

Results: The British Caribbeans were more socially isolated (lived alone and had fewer social contacts), more Rely to be unemployed and had greater perceptions of being disadvantaged than their white counterparts in both the psychotic and the healthy controls and even more so than the Caribbean cohort. They also had a longer duration of untreated symptoms and less interaction with the non-psychiatric medical services.

Conclusions: These findings support the hypothesis that higher rates of psychotic illness may occur in the context of increased social isolation, perceptions of disadvantage and may be compounded by a tendency to not engage in appropriate help seeking behaviour.

S55. Personality disorders: new issues in diagnosis, etiology and therapy

Chairs: H. Sass (D), C.B. Pull (L)

S55.1

Experimental psychopathology in personality disorders

S.C. Herpertz*, B. Wenning, K. Schnell, T. Dietrich, H. Saß. *University of Technology Aachen, Department of Psychiatry and Psychotherapy, Germany*

Alterations of emotional responses are one of the main features in cluster B personality disorders: borderline personality disorder (BPD) is generally thought to be associated with emotional hyperresponsiveness while antisocial personality disorder appears to be characterized by emotional detachment.

Method: In a first step, psychophysiological measures and functional magnetic resonance imaging (fMRI) were used to identify neurobiological correlates of abnormal emotional processing. In a second step, the influence of emotions on inhibitory attentional functioning was focused on, using neuropsychological tasks.

Results: Psychophysiological data supported Cleckley's theory of emotional detachment in psychopaths. fMRI findings, using emotional paradigms showed intense amygdala activation in borderline subjects suggesting that limbic hyperreactivity may be a neurofunctional correlate of emotional dysregulation. Preliminary

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data indicate that emotions may deteriorate inhibitory functioning in BPD supporting a close interaction between emotional dysregulation and disinhibited behavior.

Conclusion: Experimental research enriches our understanding of personality disorders and their biological underpinnings.

S55.2

Neuropsychological measures in BPD patients and matched controls

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Objective: To further investigate executive functions in Borderline Personality Disorders.

Significance: Those aspects of the borderline syndrome that are associated with increased impulsivity, aggression and atypical depression may rely on neurological abnormalities. Neurocognitive studies of well selected borderline patients may be helpful to further define a research model aimed to investigate these alterations.

Methods: Forty patients with IPDE Borderline Personality Disorders and forty age, gender, nationality, social class and level of educated matched controls without DSM IV Axis I and Axis II Disorders were studied. After executive functions were assessed on several neuropsychological tests, ANOVA was utilized to compare the relationships between levels of executive function and group memberships as well as the interaction of the observed differences with IPDE Borderline Personality Disorder severity (total severity and emptiness, aggression, impulsivity subscores).

Results: There were significant severity dependent between group differences on the observed executive function after correcting for depression.

Comment: Is provided.

S55.3

The implications of behavioural genetic research for concepts and models of personality disorder

J. Livesley*. *University of British Columbia, Vancouver, Canada*

The results of twin studies indicate that all traits delineating personality disorder have as substantial heritable component and that a relatively large number of genetic dimensions contribute to personality phenotypes. They also suggest continuity between normal and disordered personality. These findings have major implications for theoretical models of personality disorder and psychiatric nosology.

Contemporary treatments are based on either a conflict or a deficit model of personality pathology. These models have lead to substantial differences in therapeutic approach. Recognition that personality has a substantial heritable component requires that these models be supplemented with a predisposition model that has somewhat different treatment implications.

Evidence of genetic and phenotypic continuity between normal and disordered personality suggests the need to modify current approaches to classification. If personality disorder is based a large number of genetic building blocks the occurrence of a relatively large number of discrete categories is unlikely. This suggests the need for alternative nosological approaches.

S55.4

Psychometric approaches in personality research

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Empirical evidence suggests that personality disorders (PD) are more appropriately represented by a dimensional model than by the categorical model used in the DSM- or ICD-systems. Several dimensional models have been suggested for the revision of the categorical system. The present study investigated the convergent and divergent aspects of the Five Factor model (Big Five), the psychobiological model proposed by Cloninger, and the 'Dimensional Assessment of Personality Pathology (DAPP)' model proposed by Livesley. Psychometric relationships between the different dimensional models and dimensional assessments of DSM-IV PD based on the SCID-II in N=165 general population subjects, and a sample of N=222 nonpsychotic psychiatric patients (including N=81 PD patients) were calculated. Differences and similarities in regard to convergent validity, discriminative and predictive power, and multivariate relationships will be summarized. Overall results support the assumption that there are basic convergent traits relevant for PD irrespective of the particular model they were derived from. PD can be represented by a dimensional system of personality traits with sufficient sensitivity and clinical specificity.

S55.5

Personality disorders in ICD-10 and DSM-IV

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The 10th Revision of the International Classification of Diseases (ICD-10) and the 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders both provide general criteria for the diagnosis of personality disorder as well as specific criteria for 8 (ICD-10) and 10 individual personalty disorders. The general criteria are essentially the same in both ICD-10 and DSM-IV. The two classification systems do, however, present a number of differences with regard to the number, the names, and the criteria that are provided for individual personality disorders.

Narcissistic personality disorder is listed among the "official" disorders in DSM-IV but not in ICD-10. Schizotypal disorder is listed among the personality diorders in DSM-IV, but among the psychotic disorders in ICD-10.

Three disorders have different names, i.e. antisocial (DSM-IV) and dissocial (ICD-10), avoidant (DSM-IV) and anxious (ICD-10), obsessive–compulsive and anankastic (ICD-10).

Major differences appear when ICD-10 and DSM-IV criteria are compared with regard to individual personality disorders. The authors will highlight major differences between ICD-10 and DSM-IV criteria and discuss the conceptual as well as potential practical implications of these differences.

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