guaranteed to all people included in the Convention. However, even in signatory states, violations often occur behind "closed or open doors" and go unreported and consequently unprevented. The growing number of people with mental health conditions in the world has further contributed to a level of attention paid to quality and human rights conditions in both outpatient and inpatient facilities, which has never been greater. Persons with mental health conditions need both de jure human rights protection and de facto human rights practices.

Seven years after the CRPD came into force the care available in many mental health facilities around Europe is still not only of poor quality but in many instances hinders recovery. The level of knowledge and understanding by staff of the rights of people with mental disabilities is very poor. It is still common for people to be locked away or to be chained to their beds, unable to move. Inhuman and degrading treatment is common, and people in facilities are often stripped of their dignity and treated with contempt. Violations are not restricted to inpatient and residential facilities; many people seeking care from outpatient and community care services are disempowered and also experience extensive restrictions to their basic human rights.

In the wider community, many people with mental disabilities are still denied many basic rights that most people take for granted. For example, they are denied opportunities to live where they choose, marry, have families, attend school and seek employment. There is a commonly held, yet false, assumption that people with mental health conditions lack the capacity to assume responsibility, manage their affairs and make decisions about their lives. These misconceptions contribute to the ongoing marginalization, disenfranchisement and invisibility of this group of people in their communities.

One of the underlying reasons it is difficult to move through the obstacles to fully embrace the CRPD, is that discrimination continues to affect people with mental health conditions on many levels. Changing laws is only a partial solution. We have to change the ways that we relate to each other at every level, and to offer people information and tools to make the transition to a more equitable social reality.

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Promoting stigma coping and empowerment: Results from the multi-center clinical trial STEM

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Introduction The stigma of mental illness is still a major challenge for psychiatry. For patients, stigma experiences and self-stigma are associated with reduced quality of life and increased vulnerability to a more chronicle illness course. Nevertheless, there is a scarcity of validated therapeutic approaches addressing strategies for coping with stigma.

Objectives and aims A manualized psycho-educational group therapy for stigma coping and empowerment (STEM) should be tested for efficacy in patients with depression and schizophrenia. The study was funded by a research grant of the Federal Ministry of Education and Research.

Methods A cluster-randomized RCT with two arms including 30 mental health care services (psychiatric inpatient services, day-units, and outpatient services, as well as inpatient psychiatric rehabilitation services) was conducted. The intervention consisted of 8 sessions regular psycho-education group therapy and 3 sessions addressing stigma coping and empowerment. Controls received 11 sessions regular psycho-education. Primary outcome variable was quality of life (WHO-QOL). Assessments were conducted directly before and after the intervention, and at 3, 6 and 12 months follow-ups.

Results A total of 469 patients participated and more than 300 participants (approx. 65%) completed the 12-month follow-up. First results of the analysis will be presented at the conference.

Conclusions Since the statistical analysis is currently in progress, no conclusions concerning the efficacy of the tested therapeutic approach can be done by now. Nevertheless there is a strong need for supporting patients in developing positive stigma coping strategies. STEM is the first therapeutic approach to our knowledge tested for efficacy in a RCT.

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Phenomenology of anxiety

S70

Temporality and spatiality of anxious experience

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Since the first descriptions of anxiety, it has been related with temporality and in particular with the dimension of future. Thus, we already find anxiety defined as a general feeling of threatening (from the future) in the German mystic Jakob Boehme (1575–1634). He also used the image of "the wheel of anxiety", with which he refers to its probable origin in a conflict between two forces which tend to separate themselves and are not able to do it, as a result from this centrifugal rotation movement of a wheel. This image also has a temporal character. In Kierkegaard, we read that "anxiety is always related with the future. . . and when we are disturbed by the past we are basically projecting toward the future. . ." In Heidegger's masterpiece, "Being and Time", there is a chapter dedicated to the temporality of Befindlichkeit, and in particular to anxiety. Fear and anxiety have their roots, according to Heidegger, in the past, but their relation with the future makes them different: anxiety arises from the future as possibility, while fear arises from the lost present. In this paper, we try to make a contribution to the phenomenology of temporality (and of spatiality) of anxiety in relation with the analysis of a concrete anxiety experience: flight phobia. The analysis allows us to show both the desolation and narrowing of anxiety space, and with respect to temporality, the disappearance of every plan (the future), of every history (the past), and the reduction of the present to a succession of mere punctualities, behind which there arises, threatening, the nothingness itself.

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Being on the edge: The psychopathology of the accelerated, agitated and anxious subject

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