

**Background & Aims:** The Mirror System (MS) subserves imitation and may facilitate emotional processing. We explored the possibility that this system is dysfunctional in schizophrenia. Schizophrenic patients and controls completed an imitation task to test basic MS function, and an affective startle paradigm to investigate the MS for emotional processing.

**Methods:** Imitation task: reaction time to initiate finger movement in response to (1) observation of finger movement and (2) a numerical cue was recorded (Brass et al, 2001).

**Affective startle:** participants viewed pictures that were divided into emotionally positive, neutral and negative categories. Pictures were preceded by emotionally congruent primes: half the primes consisted of a videoclip showing hand-object interaction and half consisted of a control sequence showing static images of the interaction. Acoustic startle probes were presented during picture viewing and startle eyeblink amplitude was recorded.

**Results:** There were no differences between groups on either task.

Imitation task: observation of biological motion facilitated motor responses compared to a numerical cue.

Affective startle: startle amplitude was inhibited during positive picture viewing and potentiated during negative picture viewing when pictures were primed with moving videoclips compared to static controls.

**Conclusions:** Our results suggest that the MS functions normally in schizophrenia. Both patients and controls exhibited comparable facilitation of movement responses when observing biological motion, reflecting recruitment of the basic motor MS during imitation. Furthermore, both groups showed enhanced startle reactivity to pictures primed with moving videoclips designed to recruit the MS, reflecting involvement of the MS in emotional processing.

## P0148

Refusal to eat, as a symptom of schizophrenia, can result in cachexia, phenomenologically resembling comorbid anorexia nervosa

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Refuse to eat, resembling eating disorders, may be related to overvalued ideas; beginning during prodrome and transforming into delusions throughout psychosis.(2,3) Clarifying the reason is crucial, as antipsychotics' side effects can aggravate comorbid eating disorder.(1)

Female, age 16. Referred to our inpatient psychiatry clinic first, by an internist, for her refusal to eat. Height:155cm, Weight:26.3kg, BMI:10.95; was on wheelchair. She had primary amenorrhea. Complained about her fear of eating, excessive need to smoke, insomnia. 3 years ago, she began to refuse eating, reporting foods being fatty. After 6 months, persecutory delusions (being poisoned) and her unique auditory hallucination (“Don’t eat, otherwise we’ll kill you”) began. She was taken to practitioners and internists repeatedly, was hospitalized but didn’t mention her psychotic symptoms. 2 years ago, she noticed that auditory hallucinations reduced when smoking; then became a heavy smoker. Her food intake had reduced in the last year and she had eaten nothing during last 2 months. Alimentation and Risperidone 1.5-3mg/day was administered via nasogastric tube. 3 weeks later; delusions and hallucinations remitted, eating behaviour normalized, smoking reduced explicitly. At 5th and 9th week of medication, weight/BMI were, 34kg/14.15 and 44.5kg/18.52 respectively. Except negative symptoms; she had no positive symptom,

no fat phobia and no disturbed body perception. Eating behaviour was normal.

Smoking may be a self-medication in Schizophrenia.(5) Cognitive and emotional component of eating refusal, like fat phobia and disturbed body perception, should be searched carefully after remission of positive symptoms, to exclude comorbid eating disorder.(4)

(1) *Amer.J.Psych.*(1992);149:1408-9

(2) *Br.J.Psych.*(1999);174:558-66

(3) *Int.J.Eat.Disor.*(1988);7:343-52

(4) *Int.J.Eat.Disor.*(1996);22:101-5

(5) *Neuropsychophar.*(2000);22:451-65

## P0149

Place and clinical features of schizotypal personality disorders in schizophrenic spectrum

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**Background:** Schizotypal personality disorder is situated in the middle of a spectrum of related disorders, with schizoid personality disorder on the milder end and schizophrenia on the more severe end. It is inserted to schizotypal disorders (F21), but not to personality disorders (F60). Clinical definitions of this disorder correspond to common definitions of all schizotypal disorders, but there is not integral conception of schizotypal personality and its place in “schizophrenic spectrum”.

**Aim of the study:** To define clinical features and a place of schizotypal personality disorder among disorders of schizophrenic spectrum.

**Material and Methods:** Cohort of 35 patients with schizotypal disorders were studied by clinical psychopathological and experimental psychological methods.

**Results:** We found that schizotypal personality disorder takes an intermediate storage between personality disorder and schizophrenia as it includes some special features of schizophrenia. But it has stable character without typical for schizophrenia course and moulds by ways distinguishing from personality disorder.

**Conclusion:** The results let us guess that we can consider schizotypal personality disorder as acquired personality peculiarities in the result of schizophrenic process in continuum of mild states not reached to residual schizophrenia with distinct deficit symptoms (20.5)

## P0150

The Danish national schizophrenia project: Response to clinical treatment according to gender in first episode psychosis

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**Background:** Gender differences are often ignored in clinical research and as such undervalued as a treatment factor. In FEP-patients, female gender is associated with better social function and a higher degree of compliance, while males seem to exhibit more negative symptoms and a higher degree of abuse.

**Objectives:** To evaluate whether gender differences ought to result in gender specific treatment interventions.

**Methods:** A subgroup of 140 persons (93 men and 47 women) included in the DNS and received treatment as usual (TAU) plus individual or group psychotherapy intervention. This group was analyzed according to gender and possible variations in the expression of psychopathology, drug consumption and abuse. Results of treatment and social function expressed by PANSS, Strauss-Carpenter and GAF were compared.

**Results:** Data from baseline and 2 years follow-up of this group will be presented with focus on gender issues.

**Conclusions:** Various gender differences were confirmed in the study. As a consequence a number of gender specific interventions are suggested.

## P0151

Effect of schizotypy on hemispheric differences in language comprehension

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Formal thought disorder is one of the major symptoms of schizophrenia and may be related to abnormal pattern of hemispheric lateralization of language functions. In accordance with recent neurolinguistic models that focus on the unique contribution of each hemisphere during language comprehension, the aim of this study is to explore the effect of schizotypy on hemispheric differences in semantic context processing.

The task was a modified version of Federmeier and Kutas' paradigm (1999). Subjects heard pairs of sentences ending with an expected exemplar, an unexpected exemplar from the same category, or an unexpected exemplar from a different category. Pairs of sentences were presented binaurally while the last word (target) was presented either at the left or at the right ear (the reversed target was presented to the contralateral ear). The subjects performed a semantic judgment task. Reaction times (RTs) and percentage of correct responses were recorded. The schizotypy was assessed using the Schizotypal Personality Questionnaire (SPQ, Raine et al., 1991).

Results showed that although the two hemispheres were sensitive to semantic context, the left hemisphere strongly activated small semantic fields, whereas the right hemisphere weakly activated large semantic fields. The percentage of correct responses did not differ between the two hemispheres. In addition, subjects with higher SPQ scores demonstrated a lack of semantic context effect on the left hemisphere and a diffuse activation of concepts on the right hemisphere. The implication of these results in the understanding of the cognitive mechanisms of schizophrenic formal thought disorder is discussed.

## P0152

"Breakwater"- The preventive and therapeutic programme for the first degree relatives of schizophrenic patients

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Schizophrenia is today considered a neurodevelopmental disorder. It manifests itself early in life in the form of subtle neurological and psychopathological symptoms (e. g. cognitive deficits). The next stage of a pathological process can be "at risk mental state" with sub-threshold psychotic symptoms and deterioration in social and cognitive functioning. Referring to the neurodevelopmental model of

schizophrenia, our team has developed a preventive programme addressed to the persons who are already at higher risk for schizophrenia, i.e. the first degree relatives of schizophrenic patients. We would like to present the contents and methods of realisation of the programme. The programme is addressed to 12-18 years old children and siblings of schizophrenic patients. It will operate in 4 major areas:

1. Data collection and monitoring of selected parameters (socio-demographic and family data, obstetric history, childhood psychomotor development, level of psychosocial stress, schizoid-schizotypal personality traits, psychosocial and cognitive functioning)

2. Regular assessment of mental state (every 6 months) including screening towards "at risk mental state" for psychotic disorders

3. Prevention strategies (psychoeducation, stress management strategies, family therapy, drug misuse therapy, crisis intervention if needed)

4. Therapeutic interventions (CBT, cognitive remediation, pharmacological interventions)

The programme can be a source of information regarding risk factors for developing a psychotic disorder. It will also deliver data for estimating efficacy of different intervention strategies. For individuals "at risk" for psychosis participation in the programme may possibly prevent transition into psychotic disorder or give an opportunity for early intervention and reduction of DUP.

## P0153

Correlation of functioning and self feeling in schizophrenia

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**Background:** In the treatment of patients with schizophrenia one of the most important goals is achieving a proper quality of life. It is interesting what is the relation between the self-feeling of the patients in terms of their psychopathological symptoms, and the quality of their lives.

**Aims:** The purpose of our research was establishing the degree of satisfaction with their lives among patients suffering from schizophrenia. We have also analyzed correlation between the intensity of clinical symptoms and satisfaction with life.

**Methods used:** Fifteen patients participated in our research, among them 8 were male and 7 were females, the age scope was from 22 to 63 years old and the average age was 40.

The patients were asked to fill in the Quality of Life Scale (Q Scale). They filled in also the questionnaire of the Frankfurt Self-feeling Scale (FBS).

**Results:** Correlation between intensity of clinical symptoms and life quality: The patients assessed the intensity of each of 36 clinical symptoms on the scale from 0 to 3. The results varied from 1 to 108 with the middle score of 80. The correlation degrees between intensity of clinical symptoms and general satisfaction with life were calculated for every symptom. Strong negative correlation was observed between satisfaction with life and: emotional withdrawal, lack of emotion, losing one's self control, lack of concentration, oversensitivity and apathy.

**Conclusions:** It seems interesting that there is a strong correlation between satisfaction of life and those of the psychopathological symptoms, which are referred to as negative symptoms.