process or narcissistic fixation. If in psychotherapeutic contacts there are elements of autism, it is often a transfer of symbiotic dependence on the therapeutist. The group therapeutic process leads through interactions and the interpersonal process to interpersonal change, personal autonomy is strengthened and the ultimate objective is extemalization towards the world. Continuing Sullivan's concept on psychopathology originating in the interpersonal matrix and Alexander's postulate on correctional emotional experiences, Yalom developed his observation on "interpersonal learning as the essence of the group therapeutic process". Only observation and consensual validation lead to interpersonal self-cognition. Yalom takes interpersonal learning to mean both transfer and insight. In the group therapy of schizophrenic patients in addition to nonverbal communications, verbal communications should be brought close to all members of the group. We could not say that it is justified to speak about the interpretation of conflicts and symbols in the therapy of schizophrenia. It seems that the synthesis of the dissociated patient's personality is primary. The therapist who tries to involve himself in the patient's world to bring the patient gradually back to the world of objects, realities, should in a certain way understand the language of his patients. By using the chronogram according to Murray Cox, the author follows the interpersonal process and interpersonal changes in a small therapeutic group.

P45.23

How psychotic are non-psychotic patients?

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Background: The objective of this study was to investigate the psychosis continuum hypothesis in patients of an ambulant mental health service and in the general population.

Method: 695 patients and 215 controls filled in the Community Assessment of Psychic Experiences (CAPE). The following DSM-IV categories were used in the analyses: 1. Schizophrenia and Other Psychotic Disorders (n=72), 2. Mood Disorders (n=214), 3. Anxiety Disorders (n=63). Patients and controls were compared on the positive, negative and depressive factor of the CAPE with regression analysis.

Results: Patients with schizophrenia had the greatest differences in positive psychosis items compared to controls (B= 0.48, 95% CI: 0.37–0.58), whereas patients with depression and anxiety had the highest depression symptom scores, and positive symptom scores that were intermediate to that of controls and schizophrenia patients (depression: B= 0.26, 95% CI: 0.18–0.33; anxiety: B= 0.25, CI 95%: 0.14–0.36).

Discussion: Patients scored highest on the factor score that was pathognomic for their diagnosis. However, non-psychotic patients had elevated scores on positive psychosis items, suggesting that the dimension of positive psychotic symptoms varies quantitatively across DSM-IV categories.

P45.24

Social functioning and neurocognitive deficit in schizophrenia

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Objectives: To determine correlations between neurocognitive deficit and social functioning in schizophrenia and schizoaffective disorder patients and to reveal the possible differences of cognitive profiles of recent-onset and chronically ill patients.

Methods: 52 patients diagnosed with schizophrenia or schizoaffective disorder were included in the study. Neuropsychological assessment was conducted by using a scale based on Luria's approach. PANSS was applied for the symptomatology evaluation and an original questionnaire was used to assess social functioning.

Summary of the results obtained: Recent-onset patients performed better on the majority of the cognitive tests. Correlations were revealed between neurocognitive and social functioning the patients have shown. Verbal memory was related to all social functioning items examined. The relationships were exposed between cognitive functioning and negative and positive symptoms.

Conclusions: The obtained results could be used as a basis for further research and for elaboration of more precise cognitive rehabilitation programmes.

P45.25

Psychiatric comorbidity in schizophrenia with obsessive compulsive disorder

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Although a schizo-obsessive subgroup was included in the spectrum of obsessive compulsive (OC)-related disorders, to date there is no study examining the rate of obsessive compulsive disorder (OCD)-related co-morbidity in schizophrenia patients with and without OCD.

Methods: We compared first-and recurrent episode schizophrenia patients (43 male 12 female mean age 31.2+ 9.4 years, mean no. of hospitalizations 2.9 + 1.5) with a comparative group (n=55) of non-OCD schizophrenia patients, matched for gender, age and number of hospitalizations. Diagnosis of schizophrenia, OCD, and psychiatric comorbidity was reached by the best estimate approach including SCID-P.

Results: 46.7% of the total sample met DSM-IV criteria for at least 1 comorbid disorder. OCD-schizophrenia patients had significantly more OCD-spectrum disorders (body dysmorphobic disorder, hypochondriasis, anorexia/bulimia nervosa) than the non-OCD schizophrenia group [10 (18.2%) vs 2(3.6%), respectively,chi square = 4.95, p-value = 0.03]. Inclusion of tic disorders in the analysis, significantly increased between group differences [14 (25.4%) vs. 2(3.6%), chi square = 8.19, p=0.004].

Conclusion: Increased OCD-related comorbidity in the schizo-obsessive subgroup may provide additional validation for the OCD-schizophrenia diagnostic entity.

P45.26

QLIS – a new schizophrenia-specific quality of life scale

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In the face of an increasing use of quality-of-life (QoL) scales in schizophrenia outcome research there is a pressing need for well-developed, reliable and valid instruments specific to schizophrenic life circumstances and experiences.

Based upon open-ended interviews in 268 patients from different care settings (community, hospital, long-term wards) important components of QoL in schizophrenia were identified. On this qualitative basis items were generated and submitted to a Delphi approach with professional carers of schizophrenic patients.

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A 130-item pilot-version of the QoL instrument in schizophrenia (QLIS) was analysed in 203 schizophrenics. Items were selected according to psychometric properties and content.

In a validation study the resulting questionnaire was completed by n=136 schizophrenic patients along with the WHOQOL-Bref, SWN-K and the German Version of the LQLP, and by n=49 in a test-retest design. Reliability coefficients for the 10 subscales were satisfactory to good (median of retest-coefficients: r=.80, median of internal consistencies: a =.75). Validity coefficients show that QLIS-scales differ empirically from present QoL instruments.

QLIS, therefore, offers an opportunity for specific, comprehensive and reliable self-reported evaluation of QoL in schizophrenia.

P45.27

The subjective/objective dichotomy in schizophrenia-data from Striatal Dopamine Depletion Study

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The commendable efforts to objectify observations and standardize diagnosis has,unfortunately,left out a big chunk of psychiatric phenomenon as being subjective, i.e. not reliable and mostly non-measureable. It is our thesis that the Subjective/Objective dichotomy is rather false; being not completely understandable is not a good reason to ignore it. Over the years, we demonstrated the importance of subjective experiences on antipscyhotic medications for management and outcomes. We have developed appropriate methodologies for measuring and quantifying subjective phenomena, related to the effects of antipsychotics. Using a dopamine depletion SPECT design, we recently demonstrated the significant inverse correlation of subjective responses on medications to striatal dopamine receptor binding ratio. This is an example where the subjective and objective blend together. In essence, we demonstrated that once appropriate methodologies to assess subjective phenomena and relate it to specific brain function exists, the dichotomy becomes a non-issue. It is our belief that classificatory multiaxial systems need to consider adding a subjective axis. For that to become useful, further research is needed.

P45.28

Cognitive dysfunctions in prepsychosis

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Introduction: Psychotic episodes in patients are often proceeded by a prepsychotic period with several symptoms: isolated psychotic symptoms and anxiety, anhedonia, apathy, irritability, sleep disturbances, etc. However, little information is available about the cognitive dysfunctions during this stage of psychotic disorders. Our aim was to characterize the cognitive dysfunctions in patients during prepsychotic period by neurocognitive tests.

Patients and Method: Ten patients fulfilling the criteria for prepsychotic symptoms of psychosis were studied. All patients had no history of psychotic episode or severe mental disorder. Cognitive functions were measured by the computerized Cambridge Neuropsychological Test Automated Battery (CANTAB). Thirteen tests covering various aspects of cognitive functions were evaluated.

Results and Conclusions: In prepsychotic period impaired cognitive functions were found in new information learning (Paired Associated Learning, PAL), in spatial recognition memory (SRM), sustained attention (Rapid Visual Information Processing, RVIP), and spatial working memory (SWM) compared to a standard healthy control group. Visual memory and executive functions were in the normal range. The results show that marked cognitive impairments are present at the prepsychotic period in patients.

P45.29

Reduced energy metabolism in schizophrenia

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Objectives: An altered membrane phospholipid composition have been shown in schizophrenia. Such a disturbance may effect integral proteins and energy demanding processes as ion transport. This motivates exploration of overall energy metabolism and simultaneous determination of polyunsaturated fatty acids (PUFA).

Method: Basal metabolic rate (BMR) was measured with indirect calorimetry in 22 patients with schizophrenia and 16 controls. Measured BMR was compared with a predicted level for each individual by use of anthropometry-related equations (FAO/WHO/UNU). PUFA in plasma were determined with gas chromatography.

Results: Patients with schizophrenia showed a significantly lowered BMR compared with the expected level. There was a slight nonsignificant decrease also in the control group. The mean reduction of BMR was −172,8 kcal/d in the patients and −50,1 kcal/day in the controls, (p=0,01). A tendency towards lowered levels of PUFA in plasma was seen in patients compared to healthy controls, (p=0,052 for eicosapentaenoic acid).

Conclusion: Reduced BMR was shown in patients with schizophrenia. The changes were so pronounced that the finding can not be explained by deviations in diet or physical activity. The effect of neuroleptics has however not been elucidated.

P45.30

Acceptance of pharmacological treatment by schizophrenic patients

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The aim of the study was to assess clinical and demographic factors associated with the acceptance of pharmacological treatment in schizophrenic patients.

Method: Forty inpatients with schizophrenia (20 male, 20 female, mean age 42,2 years) were studied. Acceptance of the necessity of medication and awareness of its effects were assessed by means of Insight into Illness Scale and semi-structured questionnaire. Intensity of symptoms of schizophrenia (using PANSS), depressive symptoms (HDRS), extrapyramidal symptoms (Simpson scale) and quality of life (WHO Bref) were also evaluated.

Results: Only 14 patients (35%) acknowledged the necessity of pharmacological treatment. Acceptance of treatment correlated with other dimensions of insight into illness and compliance in ambulatory treatment. Inverse correlation between treatment acceptance and negative symptoms severity and extrapyramidal symptoms intensity was also found. Patients accepting treatment were significantly less frequently hospitalized in "chronic wards" than non-accepting, despite similar duration of illness, number of previous hospitalisations and age of onset of illness.

Conclusions: The results point to the low percentage of patients accepting treatment and suggest the role of treatment acceptance in the social outcome of schizophrenia.

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