of the patient's prognosis. It helps to reduce the whole family burden represented by the illness. Basic questions are: How can we measure these effects? Are there any differences among different types of programs?

To measure the effects of psychoeducation in terms of the quality of life improvement the Czech version (SQUALA-CZ) of the French instrument SQUALA (Subjective Quality of Life Analysis) was used (Zannotti 1992). This questionnaire was selected for this study for several reasons: (1) it is well theoretically based on a definition very similar to our concept; (2) it measures subjective quality of life defined as the difference between the wish and expectations on one side and the person's situation on the other, taking into account the individual hierarchy of values and (3) it includes 23 domains of life functioning, covering the health status, everyday activities, social interactions and inner reality. Respondents were asked to use a five-level scale to assess subjective importance (0 = irrelevant; 4 = essential) and personal satisfaction (1 = disappointed; 5 = completely satisfied) with each of the 23 life domains. Patients with schizophrenia and their relatives were randomized into one of the two parallel group programs (relatives and patients participating in programs separately): (1) 8 weeks program, two hours sessions once in a 14 days for relatives and one hour session once a week for patients and (2) one day 8 hours program. Until now we have data from 30 participants, 20 relatives and 10 patients. They completed SQUALA questionnaire before the entry into the study and 3 months later. First preliminary data analysis showed that there is a significant improvement of satisfaction with the domain "Family" (p<0.05). During the next course/duration of the program we are expecting more answers about relevant methods of "measuring" the effects of psychoeducation, advantages and disadvantages of the both types of programs, relaps frequency and duration of possible re-hospitalization in comparison with noneducated control groups of patients and their relatives.

YRP.14
Service and non-service costs of psychiatric patients attending a community mental health centre in Italy

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Objective: This study estimated service and non-service costs in a random sample of patients attending a community psychiatric mental health centre (CMHC) in Italy. Costs of different diagnostic subgroups and variables associated with service and non-service costs were calculated.

Methods: A randomly selected sample of patients identified during one week of routine clinical activity of the Magenta CMHC. Information was collected using the Economic Questionnaire for routine clinical practice of Psychiatric Services (QESP). The QESP includes the following domains and variables: sociodemographic data, information related to the psychiatric illness, accommodation, employment and income, caregiver, service receipt and patient / caregiver burden. Costs were classified in two categories: service costs (from the provision of services) and non-service costs (loss of productivity and informal care)

Results: One hundred-twenty patients were included. In patients suffering from schizophrenia service cost per month per patient was nearly double than for patients with other diagnoses. Non-service costs associated with patient's lack of job opportunities were more than three times higher in patients with schizophrenia, accounting for an overall non-service cost per month per patient more than three times higher than that for patients with other diagnoses. Non-service costs associated with patient's and caregivers' time off work were similar in the two groups. In the multivariate analysis length of illness and being not employed, but not diagnosis, were associated with higher service costs. Young age and length of illness were determinants of higher non-service costs. The latter two independent variables resulted in addition associated with overall (service and non-service) costs.

Conclusion: This study of an Italian community psychiatric service showed that monitoring within routine conditions was successful and could generate useful information on the costs to psychiatric services, patients and care-givers.

YRP.15
Depression, anxiety, aggression, impulsivity and suicidal behavior

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Objectives: The study of clinical suicide risk factors should involve the simultaneous assessment of dimensions such as depression, anxiety, aggression, and impulsivity that should be integrated in the relatively large concept of comorbidity. The purpose of the study was: 1) to assess the interrelations between all these factors in a sample of affective disorder patients; 2) to test the hypothesis that a high level of anxiety could be a protective factor against suicide acts; 3) to further assess the validity and clinical interest of the Suicide Risk Scale (SRS) of Plutchik.

Methods: We assessed a sample of 49 inpatients with an axis I diagnosis of affective disorder (major depression, dysthymia, adjustment disorder). Patients were subgrouped into suicide attempters (SA, n = 25) and non-attempters (NSA, n = 24). Both groups were compared on measures of depression, impulsivity (Impulsivity scale, Plutchik), anxiety (State and trait anxiety scale of Spielberger), aggressiveness (Buss-Durkee Hostility Inventory and suicide risk (SRS).

Results: SA and NSA differed significantly on the suicide risk scale (p<0.00005) and the impulsivity scale (p<0.001). We did not observe any differences in BDHI scale scores, and state or trait anxiety scores between SA and NSA. However, several aspects of agressiveness were correlated with the current suicide risk. Our results did not confirm the protective value of a high anxiety level.

Conclusions: Taking account of some methodological limitations, we can considere that impulsivity is an important risk factor (a trait factor) of suicidal behavior in patients suffering from an affective disorder. Dimensions such as aggressiveness, anxiety and severity of depression tend to play a more minor role. Our results also suggest the potential interest of the suicide risk scale of Plutchik in clinical practice.

YRP.16
Brain glucose metabolism after dextromethorphan challenge in alcohol dependent males and controls

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Introduction: Pre-clinical studies indicate that acute and chronic effects of alcohol are mediated by NMDA receptor. NMDA re-

ceptors have been suggested to be the primary target of alcohol.[1] We have demonstrated alcohol-like effects in healthy controls and blunted effects in recently detoxified alcoholics when challenged with 2.0 mg/kg Dextromethorphan a non-competitive NMDA antagonist. Induction of craving effect was recorded in patients only.[2]

Main Objective is to compare brain glucose metabolism profiles of alcohol dependent males and healthy controls induced by blocking NMDA receptors with dextromethorphan.

Methods: We compared regional metabolism using [18F] fluorodeoxyglucose (FDG) positron emission tomography (PET) in recently detoxified alcoholic patient and controls (double blind, double dummy, placebo controlled) after challenge with 2.0 mg/kg Dextromethorphan. Controls were additionally challenged with alcohol (0.6 g/kg). Subjects were being assessed with standard measurements.

Results: based on preliminary statistical analyses (so far 5 patients and 10 controls, aim 12/12) indicate:

1. Lower metabolism rate in all brain regions among recently detoxified alcohol dependent males under placebo condition. Alcohol globally reduces regional brain glucose metabolism in controls. (consistent with published findings)
2. In alcohol dependent males dextromethorphan challenge led to no changes, or small reduction in brain glucose metabolism, most pronounced in the cerebellum (-4.9%).
3. In controls dextrometorphan challenge was associated with a small, non-significant increases in metabolism, most pronounced in the frontal region (6.1%), and least pronounced in the cerebellum (2.2%). This finding of "hyperfrontality" is consistent with reported findings from ketamine challenge.[3]

Changes in regional metabolism seem to be different in alcohol dependent males and controls.

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YRP.17

Th1 and Th2 relationship in schizophrenia – immunological, immunogenetic and therapeutic investigations

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We have hypothesised immunological abnormalities characterised by a decreased Th1 and an increased Th2 immune response in a distinct group of schizophrenic patients. To prove this hypothesis we performed biochemical, immunogenetic, and clinical investigations: Cytokine production by in-vitro stimulated lymphocytes; Molecular genetics of candidate Th1/Th2-related genes: IFN-gamma, IL-4, IL-12, IL-13 (patients/controls n=170 each); Clinical study using a COX2 inhibitor added to an antipsychotic medication (n=50 patients).

Our results suggest a subgroup of schizophrenic patients with reduced IFN-gamma production and increased IL-4/IL-13 production. The IL-13 gene A1082G promotor polymorphism, accompanied with more pronounced Th2 response, was more frequent in patients. Patients receiving the COX2 inhibitor showed a markedly faster reduction of psychotic symptoms, than patients of the placebo group.

Our complex but systematic results may have great impact for the identification of a subgroup of schizophrenia with immune-related pathophysiology and for the development of an immune-mediated therapy strategy in schizophrenia.

YRP.18

The candidate gene approach in affective disorder: the European Collaborative Project on Affective Disorders

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No abstract was available at the time of printing.

YRP.19

Lithium augmentation in venlafaxine non-responders: an open study

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Thirteen major depressive patients not responding (less than 50% decrease of their baseline MADRS score) to a four-week venlafaxine 300mg treatment were eligible for a four-week open trial of lithium addition. These patients were part of an initial group of 50 patients. If the patients had an insomnia resistant to the allowed sedatives (zopiclone, clorazepate), trazodone could be added to venlafaxine at bedtime during the prelithium phase: 7 of the 13 patients received trazodone. Lithium dose was individually determined according to 24 hrs single dose plasma level: the mean steady state plasma levels ranged between 0.75 and 0.81 mmol/L. Two patients had to stop lithium before the end of the study. Among the 11 other subjects, five patients became responders, including one patient with a dramatic response (dropping of the MADRS score from 40 to 14 in four days) and two patients had a semi-rapid response (within two weeks). The two patients who dropped out did so for similar reasons involving a mixed-manic switch, nausea and trembling. Retrospectively we believe that these may have been moderate cases of serotonin syndrome.

YRP.20

Childhood routines and obsessive–compulsive disorder in a community sample

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Goals: Obsessive–compulsive behavior appears as a part of normal repertoire in young children, and it appears to fade out in a majority, while persisting into school age and further in some.

The study aimed to document the prevalence of compulsive behavior in young children's routines in a community sample, and establish its cross-sectional correlates in demographic, individual and parental behavior characteristics.

Method: 1169 families of children between 9–72 months from a community sample in Istanbul were interviewed about the child's behavior, using Childhood Routines Inventory-Turkish version by Evans et al. Age-specific average scores were calculated. The upper-, middle-, and lower- 5-percentile were selected for further detailed interviews about OC behavior /disorder and related problems.

Results: OC behavior described as "childhood routines" is common in all age groups, however, the peak is at around 36–47