The phenomenological and morpho-analytic methods are nonspecific but undoubtfully extremely important in approaching the symptoms of the pre-schizophrenia period. Because of the one side approach of these methods, the assistance of empathy, as used by Kohut, can provide more clinical information, but it is difficult to quantify in research.

Expanding on Kohut's views, psychotic states are primarily disorders of the self. The psychosis underpinnings are organically and attributionally experientially determined. Therefore, the self does not develop with a cohesive organized core of personality in these conditions.

Using empathy as an observational tool requires attunement to the patient emotional state. Empathy components are affective, as well cognitive, with brain metabolic correlates between interviewer and patient in an empathic interview. When two minds are connected, a state of alignment is created. In the pre-schizophrenia state that resonance, the alignment is missing. The reverberation of that empathic connection is replaced by the "œblack hole" that swallows resonance, and creates in the empathic examiner the frightful experience of being in the presence of someone whose humanity has now been hijacked, and only the opaqueness remains as sad reminder of a mind that was like ours. These observations need to correlates with clinical picture, as may also occur in other organic illnesses.

With the use of the methods available, the identification of the experiential changes can be delayed because of many factors. Using empathy as a tool, along with the existent methods, may bypass same of the difficulties of early identification of the prodromal symptoms.

P019

Induced 49 Hz gamma and event-related coherence in deficit and nondeficit schizophrenia

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A large body of literature supports the hypothesis that high frequency oscillations within the gamma band are involved in the integration of sensory information across different modalities and cortical areas. A reduction of gamma oscillations around 40 Hz has been reported in schizophrenic patients by several authors. This abnormality indicates a poor integration of the neuronal activity within distributed neural networks in schizophrenia, in line with modern conceptualizations of the disorder and its liability.

In the present study we investigated evoked and induced 40-Hz gamma power as well as fronto-parietal and fronto-temporal event-related coherence in patients with deficit and nondeficit schizophrenia and in matched healthy controls. In patients, correlations between gamma oscillations and psychopathological dimensions were also investigated.

We found that abnormalities of both induced gamma power and event-related coherence were present in patients with nondeficit schizophrenia, but not in those with deficit schizophrenia. These findings suggest that schizophrenia heterogeneity should be taken into account when dealing with indices of cortical functional connectivity.

In line with previous findings, in our study an excess of gamma oscillations has been found to correlate with reality distortion and other psychopathological dimensions, indicating that abnormal thoughts, behaviours and perceptions might be related to abnormal connectivity within distributed neural networks.

P020

Schizophrenia, structural violence and human rights

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The core phenomenon of schizophrenia is best conceived in terms of the Bleulerian concept of autistic alienation. The contributions of Heidegger, Merleau-Ponty and Wittgenstein allow us to arrive at a new 'philosophy of interpersonal relatedness', which better reflects the 'embodied mind' and signifies the end of Cartesian dualistic thinking. Patients with schizophrenia exhibit neurobiological and clinical evidence of social brain dysfunction. They find themselves seriously disadvantaged in the social arena and particularly vulnerable to the stresses of their complex social environments. Farmer (2005) has used the term 'structural violence' to describe the social, economic and political forces such as poverty, inequality, racism and discrimination that influence people's health. These forces shape both the landscape of risk for developing illness and the context in which health-care is provided. The concept of structural violence is relevant to schizophrenia since low socio-economic status, income inequality, urbanicity, homelessness and migration are factors that increase risk for the disorder. Furthermore, poverty and inequality are associated with earlier age of onset, longer duration of untreated psychosis, increased comorbidity and poorer access to services – all variables impacting negatively upon onset, course and outcome of schizophrenia. Taken together, these observations call for a human rights perspective on schizophrenia in society. At-risk individuals suffer increased alienation, more severe psychosis and greater disability in response to toxic social forces such as deprivation and exclusion. This constitutes a violation of the human rights of those predisposed to and suffering from serious mental disorders such as schizophrenia.

P021

Physical health monitoring in a scottish cohort of schizophrenia patients - the role of ECG and blood pressure monitoring

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Introduction: Schizophrenia patients have increased risk of cardiovascular disease (CVD) and mortality. Guidelines emphasise need for monitoring risk factors including ECG and blood pressure (BP). There is little naturalistic data on number and severity of categorical abnormalities detected.

Method: A global health clinic was set up in 2004 to undertake systematic physical health monitoring in all schizophrenia outpatients within Larkfield CMHT. Patients received 2 hour assessments from trained nurses. BMI, laboratory (non-fasting) parameters, ECG and BP performed.

Results: Since 2004 from 140 Schizophrenia outpatients 95 have been invited to attend screening of which 53 accepted (56%). An abnormal parameter was measured in 92% (n=49), 72% 2 abnormal findings (n=38) and 47% 3 or more. ECG abnormalities in 50% (n=26) of which 18 were significant findings (prior myocardial infarction and/or ischaemia, conduction blocks, right ventricular hypertrophy). Normal blood pressure using guidelines from British Hypertension Society (BHS) 2004 (<130/85) was determined in 36% (n=20), high-normal 11% (n=6) and varying grades of hypertension 53% (n=27). Grade 3 (severe) hypertension 8% (n=4). No patient had abnormal QTc >500 mscs. One male patient had QTc

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458msecs.In 18 patients (34%) the ECG analysis was determined by the analyser to be difficult to analyse due to significant baseline patient movement.

Conclusion: Significant BP and ECG abnormalities are common and require evaluation for treatment. QTc abnormalities are detected significantly less often than other important abnormalities. Using the most conservative definition of hypertension 53% of this cohort would be defined as needing antihypertensive treatments and lifestyle interventions in 64%.

P022

Categorical prevalence of hyperprolactinaemia in schizophrenia and bipolar outpatients in UK recieving antipsychotics

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Background: Increasing attention is paid to importance of hyperprolactinaemia. Sexual dysfunction and osteoporosis are reported in such patients. There is little naturalistic data showing prevalence and severity of hyperprolactinaemia in asymptomatic patients receiving antipsychotics.

Methods: All outpatients in a community mental health team in Halifax receiving antipsychotics with diagnosis of schizophrenia or bipolar disorder had prolactin measurements. Upper Limit of Normal (ULN) prolactin 500mIU/L (males) and 700mIU/L (females).

Results: Prolactin levels were obtained in 226 patients providing 253 incident cases as antipsychotic changes were made over 36-month period.

Abnormal values were found in 49% females and 29% males - 39% of the cohort. Levels >1000 mIU/L were seen in 23% (females 36%, males 10%). From the 61/125 females with abnormal levels, 74% of these had levels >1000 mIU/L and 16/125 (13%) >2000 mIU/L. Only 13/128 males had levels >1000 mIU/L. Prevalence of hyperprolactinaemia in those on antipsychotic monotherapy: olanzapine 7%, typicals 33%, amisulpride 92%, Clozapine 4%, risperidone oral 83%, and risperidone consta 65%. In Risperidone Consta patients, 15/23 (65%) had hyperprolactinaemia including 100% of females (10/10). Most females on oral risperidone (12/13) also had hyperprolactinaemia and had values >1000 mIU/L in11/12.

Conclusions: Routine prolactin screening showed abnormal values in 39% and significantly abnormal levels (>1000 mIU/L) that could lead to drug/dosage alterations in 23%. Exceptionally high levels >2000 mIU/L were found in 7%. Females on oral and consta risperidone may be particularly at risk of the effects of hyperprolactinaemia.

P023

Aripiprazole in schizophrenia: Dosing and switching in clinical practice

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This presentation will review the clinical evidence to date regarding the effective dose of oral aripiprazole and practical switching and administration regimens. Early and convenient dose optimization is a key determinant of treatment outcomes in patients with schizophrenia. Ease of dosing is essential to maintain compliance with antipsychotic agents, and rapid and sustained symptom relief will maximize treatment outcomes. Aripiprazole is the most recently available atypical antipsychotic, pharmacologically distinct from other antipsychotic agents. Clinical studies have demonstrated the rapid onset of symptom relief with a starting dose of aripiprazole 10 mg/day in patients with schizophrenia, and the effective dose range has been established with 10-30 mg/day. When switching to aripiprazole from another antipsychotic, this should be conducted according to good psychopharmacological principles. Clinical evidence with aripiprazole indicates that a favorable approach is to maintain the therapeutic dose of the previous antipsychotic in addition to aripiprazole 10 mg/day for at least two weeks. The previous antipsychotic can then be tapered off slowly. If necessary, benzodiazepines or antihistaminergic agents can be used with aripiprazole to treat potential sleep disturbances or to manage other transient emergent events that are most likely due to rebound effects and/or the differential pharmacological profiles of the previous antipsychotic versus aripiprazole. Concomitant anticholinergics can be used when switching from an antipsychotic with anticholinergic properties to smooth the transition between agents. Appropriate initiation and switching strategies should result in increased treatment successes with aripiprazole for short-term and long-term treatment goals.

P024

Analysis of the clinical profile of patients with schizophrenia and schizoaffective disorder at the acute care unit (profile 3 study)

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Background and aim: Characterizing the profile of schizophrenic patients with high hospitalization rates seems relevant. The aim of this study is to describe characteristics of patients with schizophrenia hospitalized at Acute Care Units, and identify clinical profiles associated to relapse.

Methodology: Observational retrospective study (case-control). Hospitalized patients diagnosed for schizophrenia or schizoaffective disorder for more than 2 years. Data related to the previous 3 years and current hospitalization were recorded: sociodemographics, diagnosis, CGI, reason for current/previous hospitalizations, life events, drug abuse, therapy prior and during hospitalization and compliance.

Results: Preliminary results from 1607 patients are presented: cases are patients with no hospitalization (No-HOSP) in the previous 3 years (N=508); controls are those who had some hospitalization (HOSP) during that period (N=1099). HOSP patients were significantly younger than No-HOSP ($p<0.0001$). 41% of HOSP and 28.4% of No-HOSP patients showed No-Low family support ($p<0.0001$). 55.9% of HOSP and 50.2% of No-HOSP patients showed some drug abuse close to current hospitalization ($p<0.05$). The most frequent factor for current hospitalization was relapse due to non-compliance in both HOSP (66.2%) and No-HOSP (59.4%; $p=0.0092$). Through artificial intelligence methods, fourteen variables are identified as related to relapse (Number of previous antipsychotics, Time of evolution, CGI, Age, Gender, Educational Level, Family support, Compliance, Heroine, Cocaine or Cannabis abuse, Stressing events, Diagnosis, Number of previous hospitalizations), which have permitted to develop a predictive model for relapse (PRECOG Project).

Conclusion: The main factor for hospitalization was non-compliance. Age, family support, drug abuse seem to be also related to hospitalization.

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