

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.