Disclosure of interest AM received honoraria or advisory board/consulting fees from the following companies: Janssen Pharmaceuticals, Otsuka, Pfizer and Pierre Fabre.
SG received honoraria or advisory board/consulting fees from the following companies: Lundbeck, Janssen Pharmaceuticals, Hoffman-La Roche, Angelini-Acraf, Otsuka, Pierre Fabre and Gedeon-Richter.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.096

S023

Progressive brain changes associated with persistent negative symptoms following a first episode of psychosis

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Early persistent negative symptoms (ePNS) refer to the presence of potentially idiopathic or primary negative symptoms and have been observed following a first episode of psychosis (FEP). There is evidence for cortical changes associated with ePNS and given that a FEP often occurs during a period of ongoing brain development and maturation, neuroanatomical changes may have a specific age related component. The current study examined cortical thickness (CT), hippocampal/amygdala volume and shape as a function of clinical trajectories and age using longitudinal structural imaging in FEP. T1-MRI scans were acquired for early ($n = 21$), secondary ($n = 30$), non-($n = 44$) PNS patients with a FEP, and controls ($n = 44$). Cortical thickness and amygdalar–hippocampal volumes and surface area (SA) metrics were extracted from three time points over a two-year period. Linear mixed models were applied to test for a main effect of group, and age group interactions. Relative to the other groups**,** ePNS patients showed cortical thinning over time in temporal regions and a thickening with age primarily in prefrontal areas. They also exhibited reduced left amygdalar and right hippocampal volumes. Morphometry revealed decreased surface area in ePNS compared to other groups in left central amygdala. The current study demonstrates that FEP patients with ePNS show significantly different CT trajectories with age. Increased CT may be indicative of disruptions in cortical maturation processes within higher-order brain regions. Amygdalar-hippocampal changes with age are also linked to ePNS with converging results from volumetric and morphometric analyses. Taken together, these results could represent dynamic endophenotypes setting these ePNS patients apart from their non-symptomatic peers.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.097

Symposium: New avenues in the management of bipolar disorder

S024

Mania and depression: What's new?

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Despite the high burden of bipolar disorder and the noticeable progress in its treatment, the disorder still goes frequently misdiagnosed, unrecognized, or not optimally treated. To date, no medication has been specifically developed on the basis of a precise understanding of the pathophysiology of the disorder, or based on the unique characteristics of several subtypes of bipolar disorder or on the medication mechanism of action. Lithium remains on of the gold standard treatments for bipolar disorder. Its mood-stabilizing properties are thought to occur via specific cellular signaling pathways, such as inhibition of glycogen synthase kinase 3, which is considered to regulate cellular apoptosis. Divalproex, carbamazepine and several atypical antipsychotics are also approved for bipolar disease Evidence also suggests that antipsychotics show the ability to treat and prevent mania and/or depression but are often burdened by side effects such as sedation, hortostatic hypotension and weight gain. Hence, while it is clear that there still are several unmet needs especially for what pertains tolerability, efficacy for specific subtypes, and predictability. Novel and more effective treatments are needed and researchers are currently engaging in targeted drug development for bipolar illness, aimed at improving pharmacological strategies with marked and sustained effects. A variety of newer medications are being tested. Some of these drugs target pathways that are similar to those targeted by lithium, while others focus on newer targets, such as opiate receptor and *N*-methyl-D-aspartate (NMDA) receptors. Newer and older treatment strategies for bipolar disorder will be presented and critically reviewed.
Disclosure of interest Andrea Fagiolini is/has been a consultant and/or a speaker and/or has received research grants from Allergan, Angelini, Astra Zeneca, Boehringer Ingelheim, Pfizer, Eli Lilly, Ferrer, Janssen, Lundbeck, Novartis, Otsuka, Roche.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.098

S025

The role of long acting antipsychotics in bipolar disorder

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Antipsychotics are widely used for the short and long-term treatment of bipolar disorder. Depot and long-acting injectable formulations (LAIs) can be particularly useful for certain subgroups of patients. This lecture will discuss the available data from randomized controlled trials of LAIs in bipolar disorder. A recently published meta-analysis and individual studies assessing depot medications, as well as modern LAIs such as risperidone, paliperidone and aripiprazole, will be reviewed, looking carefully into the prevention of either pole of illness and tolerability. Potential indications and patient profile, based on data and clinical experience, will be discussed.
Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.099

S026

Managing cognitive dysfunction in bipolar disorder

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Cognitive dysfunction, including memory and concentration difficulty, is an emerging treatment target in bipolar disorder. However, a key challenge in the management of these cognitive deficits is the lack of treatments with robust effects on cognition. Further, it is unclear how cognitive dysfunction should be assessed and addressed in the clinical treatment of the disorder. This talk will review the evidence for cognitive impairment in bipolar disorder, including its severity, persistence and impact on patients'

functional recovery. It will then discuss when and how to assess cognition and present some new feasible screening tools for cognitive dysfunction. Finally, it will highlight some novel candidate cognition treatments.

Disclosure of interest I have acted as a consultant and received honoraria from Lundbeck and Allergan.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.100

Symposium: Human based psychiatry: from theory to practice

S027

Evidence-based medicine - A critical review

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Evidence-based medicine is a method to establish best practice recommendations based on graded recommendations for diagnostic and therapeutic issues in health care. In mental healthcare, evidence-based medicine has shown that the therapeutic procedures are efficient and can help to not only ameliorate the symptoms of mental disorders, but also to improve the quality of life of those affected by mental disorders. Evidence-based medicine is not, however, cookbook medicine. While evidence is mostly generated in larger group trials and should be applicable to the majority of cases, aspects of the personal situation, social support systems and legal boundaries all affect mental healthcare and may modulate the interpretation of the findings of evidence-based medicine. A human-based psychiatry will therefore need to use the methods of evidence-based medicine as a basis for diagnostic and therapeutic recommendations, but will also need to extend into the acknowledgements of personal accounts, traditions and the cultural framework, in which mental healthcare is provided. This presentation will highlight some of the issues associated with the questions of the roles of evidence-based medicine in mental healthcare, and in a human-based approach towards mental healthcare.

Disclosure of interest Unterstützung bei Symposien/Symposia Support.
Janssen-Cilag GmbH, Neuss.
Aristo Pharma GmbH, Berlin.
Lilly Deutschland GmbH, Bad Homburg.
Servier Deutschland GmbH, München.
Fakultätsmitglied/Faculty Member.
Lundbeck International Neuroscience Foundation (LINF), Dänemark.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.101

S028

Theoretical background of human based psychiatry

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Every medical intervention is embedded in the prevailing spirit of its particular time. The world of modern medicine that is still shaped by positivism is often revered as a world of rational calculation and reason, a world in which mathematical calculation and so-called objectivity are prized above all else. Indeed, today's modern medicine in general and its battlewagon evidence-based medicine is a world of sober number games, reduction and fragmentation, of demystification and de-subjectification. As important and indispensable the achievements of EbM are, it nevertheless needs to be expanded by a medicine, which focuses not just on illness and its treatment but which places the concrete individual with all his or her sufferings and potentials. Such a human-based medicine (HbM) is no longer indebted to modern positivism, but seeks its foundations in the maxims of post-modernism. Moving away from classical "indication-based medicine" toward a medicine based on human sufferings and potentials necessarily requires a fundamental change in diagnostics and treatment.

Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.102

S029

Human based psychiatry in clinical practice

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World Psychiatric Association

Human based medicine and human based psychiatry are contemporary approaches to the theory and practice of medicine and psychiatry. It is a post-modern way of re-thinking psychiatry enriched by humanities, especially philosophy. In questioning the current research and praxis of psychiatry, it shares the statement by Wittgenstein, "what a curious attitude scientists have": 'We still don't know that; but it is knowable and it is only a matter of time before we get to know it as if that went without saying. So, here, our problematic is not only 'what and how much we do' but also 'how and why we do'. The clinician's main challenge is harmonizing the current available 'scientific universal knowledge' and the 'uniqueness' of that specific person in need of help. In achieving this task, the importance of the synthesis of the clinician's perspective and patient's perspective will be elaborated using depression as a case example. It will be stated that an empathetic understanding of depression, through a subjective, experiential and narrative-centered approach must become a primary concern by building a joint, ongoing, re-construction process of clinical assessment, formulation and treatment. There is no meta-theory explaining "the clinical truth". From the perspective of a human based psychiatric practice, in fact, we do not need such a meta-theory, but instead, we need multi-level/multi-dimensional approaches, also taking the narrative into consideration. We suggest the clinicians to be modest, honest and respectful towards "the clinical truth".

Disclosure of interest The author has not supplied his declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.01.103

S030

Current hot topics in working with service users and family carers towards a human based psychiatry

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Context The significant role of family as a resource for mental health, psychiatric care and recovery and rehabilitation is well documented. However, despite ongoing family advocacy the situation in most settings is still characterized by significant unmet needs and lack of resources and expertise in working with families.

Key messages This presentation will highlight pertinent issues and present data, concepts and experiences towards an improvement of partnership work with users of services and their families in a human based context.

Topics will include the needs of specific types of relatives, such as siblings, children, partners, grandparents, members of the peer group of friends as well as the need for support for families without patient consent. Recent developments with regard to individual