Objective In this case report we aim to describe the clinical characteristics and manifestation of Capgras syndrome in a female patient with schizophrenia, perform a literature search on the topic and compare our report to literature findings.
Results and discussion A 50-year-old female patient was verbally and physically aggressive to her family members upon admission to our center. The onset of disease was marked 2 years ago when she first started feeling deserted and isolated and had a prescribed therapy for her condition which she did not follow. During the current admission a psychiatric assessment was performed. Delusional misidentification of her family members was observed and consequent food and sleep self-deprivation due to psychosis was noted. The patient denied being suicidal but was intense and psychotic, and reported different objects to have started disappearing mysteriously from her home. The patient was diagnosed with schizophrenia and was treated with haloperidol, olanzapine, chlorpromazine, and biperiden. The patient was discharged in an improved condition, without episodes of obsessive delusions and improved communication with her relatives.
Conclusion Although according to the literature organic substrate may be found in some patients with Capgras syndrome, in the case presented here it is the dominant psychotic theme, which determined the content of the disease.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV1164

The cremation of care ritual: Burning of effigies or human sacrifice murder? The importance of differentiating complex trauma from schizophrenia in extreme abuse settings

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Introduction This session explores Human Sacrifice killings in extreme abuse cult settings disclosure of which often leads to a misdiagnosis of 'Schizophrenia'.
Objectives The purpose of the paper is to raise awareness and signpost professional development resources regarding extreme abuse 'Death Cults' that operate largely with impunity across the world.
Aims Case study materials and documentary evidence will be utilised to illustrate criminal practices and the impact on survivors.
Method Accounts of extreme abuse and ritual violence were identified in the context of an adult survivor assessment intervention.
Results There are supporters of abuse survivors who bore witness to and believe disclosures of extreme abuse and ritual violence, and 'False Memory' adherents who consider Ritual Abuse an unfounded 'moral panic'. Survivors provide chilling accounts of ritual killings in Scott (2001), Becker, Karriker, Overkamp and Rutz (2008) and Epstein, Schwartz and Schwartz (2011). In the wake of institutional abuse enquiries and the 'unbelievable' child abuse perpetrated by celebrities like Jimmy Saville and Ian Watkins, a 'new reality' is setting in that child abuse is pervasive and knows no limits. Reports of elaborate rituals with 'mock' human sacrifices at the highly secretive annual 'Bohemian Grove' summer festival point towards a pervasive interest in the occult in high society.
Conclusion Mental health professionals have a 'duty of care' towards their service users. Unless clear and irrefutable counter-evidence is available it is inappropriate to claim that disclosures of extreme abuse and/or human sacrifice rituals are 'delusions' and indicative of Schizophrenia.
Disclosure of interest The author has not supplied his/her declaration of competing interest.

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EV1167

Risk-taking and self-medicating contribute to the association between psychometric risk for schizophrenia and smoking

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Background There is a robust association between positive symptoms of schizophrenia and smoking. This relationship extends to psychometric risk for schizophrenia (schizotypy). We sought to determine whether smoking in schizotypy is best understood in terms of self-medicating or risk-taking behaviour. The self-medication perspective holds that individuals with schizophrenia smoke to relieve stress. By smoking, cortisol levels increase, stimulating negative feedback circuits that reduce the hypothalamic-pituitary-adrenal (HPA) axis stress response. Increased HPA activation also stimulates dopamine release, promoting the expression of positive schizotypal experiences. In contrast, the risk-taking perspective holds that elevated dopamine promotes risk-taking behaviour, including substance misuse, by reducing reward sensitivity and increasing sensation-seeking.
Method Undergraduates ($n = 230$) reported current and past nicotine use and completed the Schizotypal Personality Questionnaire and a self-report measure of stress sensitivity.
Results Consistent with risk-taking, positive features of schizotypy predicted having ever smoked (OR = 1.02, $P < 0.05$) but did not distinguish current smoking from non-smoking (OR = 0.99). The self-medication hypothesis was examined in two ways. When smoking status was regressed onto positive schizotypy and stress, stress was found to predict current smoking (OR = 1.08, $P < 0.05$) but not having ever smoked (OR = 1.09). Secondly, stress and current smoking interacted to predict positive schizotypy ($\beta = 0.31$, $P < 0.05$).
Conclusions Risk-taking and self-medicating each contributed to the relation between smoking and schizotypy, but in different ways. Risk-taking seems to contribute to having ever smoked whereas current smoking seems to reflect self-medicating behaviour.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV1169

Specifics of communication with schizophrenic patient

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The precondition of communication with schizophrenics is knowing and understanding of their fragmented and chaotic world. Communication with the schizophrenics should respect their fear of fusion and disintegration, as well as the fear of abandoning. In communication with the schizophrenic two facts are important: the real support is accepting the bizarre existence of the patient, and the other side of the support is the capacity of the psychiatrist to understand and withstand the patient. This capacity is determined through the consistency of therapist's behavior, possibility to accept the patient's right on regression, but also the ability to offer the constancy of himself, too. The therapist is the representative of the reality whose consequence and constant presence

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enables him to grow up from the internal mixture of the mental presentations into an authentic, independent person, dedicated to the patient. The therapist is expected to tolerate the patient's alienation due to the fears from fusion or disintegration. A constant activity of reestablishing of contact and respect of a specific cognitive style are needed. Communication with the schizophrenics implies an explicit calling to a verbal communication that has to be understandable, and searching for the conceptual framework, which provides understanding. Basic characteristics of the adequate communication are persistence, consequence and simplicity of instructions with the norm of behavior control, as well as the clarity of the "here-and-now" situation. The therapist's understanding of the schizophrenics justifies his actions and allows taking the psychotherapeutic attitude.

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EV1170

Psychogenic polydipsia and schizophrenia

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Introduction Psychogenic Polydipsia is defined as the desire to drink liquid in big quantities with an inappropriate activation of the mechanisms of thirst without loss of liquid for urine. This disorder is frequent enough and can derive in a water poisoning, a clinical presentation of high mortality.

Objective Review of the Psychogenic Polydipsia in patients with schizophrenia and theoretical discussion of a case report.

Methods A case report of a 58-year-old male, admitted in hospital with a clinical presentation of hyponatremia with severe low serum osmolarity secondary to Psychogenic Polydipsia. As psychiatric history he has a diagnosis of Paranoid Schizophrenia for forty years in treatment with Paliperidone 6 mg: 1-0-0, Haloperidol 10 mg: 0-0-0.5, Quetiapina 300 mg: 0-0-1, Trazodona 100 mg: 0-0-1, Ketazolam 30 mg: 0-0-1, Diazepam 10 mg: 0-0-1.

Discussion Psychogenic Polydipsia is not included in any section of current psychiatric classifications as specific diagnosis. There are several psychiatric disorders that may present with psychogenic polydipsia; however, the most common cause appears to be schizophrenia.

Conclusions Mechanisms of hyponatremia in patients with schizophrenia are not well clarified; nevertheless, dopamine seems to be the common link between psychogenic polydipsia and schizophrenia.

Keywords Psychogenic Polydipsia; Hyponatremia; Schizophrenia

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EV1171

Treatment with intramuscular paliperidone palmitate in schizoaffective disorder

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Introduction Injectable formulations of long acting antipsychotic are a valuable treatment option for patients with psychotic disorders. Schizoaffective Disorder (SAD) is a complex disease; the optimal treatment is not well established yet.

Objective Answer the question about the effectiveness offered by intramuscular Paliperidone Palmitate in SAD versus other injectable antipsychotics. Keywords: schizoaffective disorder; paliperidone palmitate injection.

Methods A case report of a 35-year-old male diagnosed with Schizoaffective Disorder six years ago and with personal history of multiple manic decompensation after treatment discontinuation. Throughout his life he has been treated with intramuscular Risperidone 87.5 mg (50 + 37.5) every 14 days, Olanzapine flas 20 mg/day, Risperidone flas 3 mg, Amisulpride 600 mg/day, Valproic acid 1500 mg/day Clonazepam 2 mg/day and Lormetazepam 1 mg. In the last admission one year ago, he started treatment with intramuscular paliperidone palmitate up to 200 mg a month. Currently he receives a monthly dose of 100 mg and concomitant lithium 800 mg/day.

Discussion The use of intramuscular paliperidone palmitate in SAD and its effectiveness against other injectable antipsychotic is discussed.

Conclusions The use of intramuscular paliperidone palmitate appears to constitute an employment opportunity in the treatment of intramuscular maintenance in SAD. It could be effective in stabilizing episodes of acute exacerbation and remissions of psychotic, manic and depressive symptoms.

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EV1173

Battery of scales for comprehensive assessment of social cognition, neurocognition and motivation in patients with schizophrenia

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Introduction There has been a special interest in roles of neurocognition, social cognition and motivation impairments in patients with schizophrenia and possible approaches to remediating these deficits. Clinical practice lacks a comprehensive tool to measure those deficits.

Objective To build a comprehensive assessment battery to measure neurocognitive, social cognitive and motivational deficits in order to form targets for remediation programs and assess their efficiency.

Aims Translation and adaptation for Russian speaking subjects (if needed) of identified assessments upon authors' agreement.

Methods By consensus decision of 5 professionals in the field of clinical psychiatry, psychology and neuroscience a number of assessments were selected with the following criteria: 1. Relevance to domain assessed, 2. Appropriateness for Russian social context, 3. Reference rates in scientific papers, 4. Time consumed by each assessment.

Results Six measures reflecting main domains (neurocognition, Theory of Mind, attributional style, social perception, emotion processing, motivation) were selected: 1. BACS (Brief Assessment of Cognition in Schizophrenia) (R.S. Keefe et al., 2008), 2. Hinting Task (R. Corcoran 1995), 3. AIHQ (Ambiguous Intentions Hostility Questionnaire) (D.R. Combs et al., 2007), 4. RAD–15 (Relationships Across Domains) (M. Sergi et al., 2004), 5. Ekman–60 (P. Ekman et al., 1976), 6. AES (Apathy Evaluation Scale) (R.S. Marin et al., 1991).

Conclusions The battery built encompasses all targeted domains of neurocognition, social cognition and motivation. Time consumed by the battery estimates 130 ± 15 minutes, which is appropriate for clinical practice in a rehabilitation centre. Future research will