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 ($ß = 0.31$, $P < 0.05$).
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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