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**Keywords:** Suicide; major depressive disorder; Psychiatric emergencies; MDD

## Schizophrenia and other Psychotic Disorders 2

### O0131

#### Clinical Indicators of Symptom Dimensions and Cognitive Ability in Schizophrenia

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**Introduction:** Schizophrenia is a heterogeneous disorder and it is unknown what causes individual variability in symptoms and cognitive ability.

**Objectives:** To examine the association between nine clinical predictors measurable at the onset of schizophrenia and five phenotype dimensions: positive, negative (diminished expressivity), negative (motivation and pleasure), disorganised symptoms and cognitive ability.

**Methods:** 852 participants (mean age 49 years old) with a diagnosis of schizophrenia or schizoaffective depression were included from the CardiffCOGS cross-sectional sample. Phenotype dimensions were created using confirmatory factor analysis and a 5-factor model. Associations were tested using linear regression, adjusting for age and sex. A Bonferroni correction was applied for ( $p < 1.1 \times 10^{-3}$ ) for multiple testing.

**Results:** Age of onset of psychosis was significantly associated with positive symptoms ( $\beta = -0.18$ ,  $p = 4.0 \times 10^{-6}$ ). Lower premorbid IQ was associated with diminished expressivity ( $\beta = -0.25$ ,  $p = 7.0 \times 10^{-13}$ ), reduced motivation and pleasure ( $\beta = -0.23$ ,  $p = 4.3 \times 10^{-11}$ ), disorganised symptoms ( $\beta = -0.14$ ,  $p = 7.6 \times 10^{-5}$ ) and reduced cognition ( $\beta = 0.54$ ,  $p = 4.8 \times 10^{-77}$ ). Poor premorbid social adjustment held associations with all except positive. Developmental delay was associated with reduced cognition ( $\beta = -0.35$ ,  $p = 4.3 \times 10^{-5}$ ). Cannabis use (year before onset), psychosocial stressors (within 6 months), childhood abuse and family history of schizophrenia held no associations.

**Conclusions:** Clinical indicators measurable at schizophrenia onset are associated with lifetime symptom variability. A younger psychosis onset is associated with more severe positive symptoms, suggesting possible age-targeted management. Pre-established links of lower premorbid IQ with poor premorbid social adjustment and negative symptom severity with cognition are strengthened. Further investigation could potentially improve diagnosis and guide treatment choice for aspects of schizophrenia with poor outcomes.

**Disclosure:** No significant relationships.

**Keywords:** Clinical indicators; Phenotype dimensions; Aetiology; schizophrenia

### O0132

#### Patient violence towards their family carers: A qualitative exploration of carers' experiences in psychosis

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**Introduction:** Compared to the general population, people living with schizophrenia spectrum disorders (SSD) are more likely to perpetrate acts of violence. When this happens, family members (informal carers) are most commonly the victims. However, family violence by people with SSD is often a taboo topic and largely neglected within public discourse, research, and clinical domains. Consequently, our understanding of families' experiences and support needs are limited.

**Objectives:** To develop a detailed understanding of the subjective experiences, and impact, of patient violence towards family carers.

**Methods:** Individual semi-structured interviews were held with family carers of adults with SSD and a history of violence perpetration towards their family carer. Interview data were subject to thematic analyses using NVivo software.

**Results:** Twenty-one UK based carers that were predominately White British (90%) and female (81%) were interviewed. Key themes highlight the range of physical and mental injuries endured by carers following patient violence, and speak to carers' experiences of suffering, living in a constant state of hypervigilance, as well as social isolation in the context of shame, stigma, and an absence of professional and informal support.

**Conclusions:** Family violence by people living with SSD can and does happen. Yet, too often, carers are left with no option but to continue supporting their relative in the absence of support, even in contexts where this compromises their own safety. The devastating impact of violence is far-reaching, across all levels of the family-system. The findings highlight the danger of neglecting family violence by people with SSD in research and clinical fields.

**Disclosure:** No significant relationships.

**Keywords:** Carers; violence; aggression; Psychosis

### O0133

#### A systematic review and meta-analysis of implicit Theory of Mind in schizophrenia

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**Introduction:** Everyday social interactions are based on Theory of Mind (ToM) or mentalizing, whose complex processes are involved in understanding, representing one's own and other people's mental states. ToM is supposed to have two systems. The implicit ToM seems to be a fast, automatic, non-verbal processing. The explicit ToM is characterized by a slower, but more flexible processing, which is mostly verbal, interpretative. Several studies have described explicit ToM deficit in schizophrenic patients. Less research has investigated implicit ToM in patients, however recently, there has been a growing number of articles examining implicit ToM of patients with schizophrenia.

**Objectives:** The aim of our systematic review and meta-analysis is to summarize the results of the implicit ToM in schizophrenia.

**Methods:** A systematic search was performed in four major databases. We included 11 publications. 7 studies; and 5 studies were included the quantitative synthesis and the qualitative synthesis, respectively.

**Results:** We found significant differences in accuracy, reaction time and brain activation patterns during implicit ToM between schizophrenic patients and controls. The systematic review revealed further alterations in visual scanning, cue fixation, face looking time, and difficulties in perspective taking.

**Conclusions:** Based on our results implicit ToM is affected in schizophrenia in addition to explicit ToM deficit. However, based on these results we cannot exclude the possibility, that implicit ToM or at least some elements of it might be relatively unaffected (e.g. detection of intentionality), however its effectiveness is limited by non-mentalizing deficits (e.g. certain neurocognitive impairments). Our results may have important implications for the remediation of mentalizing skills.

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**Keywords:** Theory of Mind; mentalizing; schizophrenia; implicit

## O0134

### Family aggregation of the Intelligence Quotient: understanding its role in first episode of psychosis

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**Introduction:** The familiarity of intelligence quotient (IQ), understood as its similarity among family members, might be related to different manifestations in first episode of psychosis (FEP) patients.

**Objectives:** To estimate the IQ familiarity through the intra-family resemblance score (IRS) in FEP patients and their unaffected first-

degree relatives; and to analyze if the deviation from the family-IQ is related to the patients' premorbid, clinical and cognitive characteristics.

**Methods:** Individuals from 129 families participated in this study (129 patients, 143 parents, 97 siblings). For each family, two values were estimated: the family-IQ, obtained by the mean IQ of the patient and his/her relatives (using the WAIS vocabulary subtest); and the IRS, an index previously reported that indicate intra-family heterogeneity (IRS<0) or homogeneity (IRS>0) for a given trait. According to the IRS and the family-IQ, patients were assigned to 6 groups (Figure 1).

**Results:** FEP patients in families with heterogeneous IQ (IRS<0) had a significantly lower IQ than their relatives (p<0.001). Also, those with low IQ and from heterogeneous families had poorer childhood adjustment (p=0.001). The patients with high IQ belonging to homogenous families showed less positive symptoms at baseline (p=0.009). FEP patients in homogenous families due to low IQ evidenced the lowest neuropsychological performance (Figure 2).

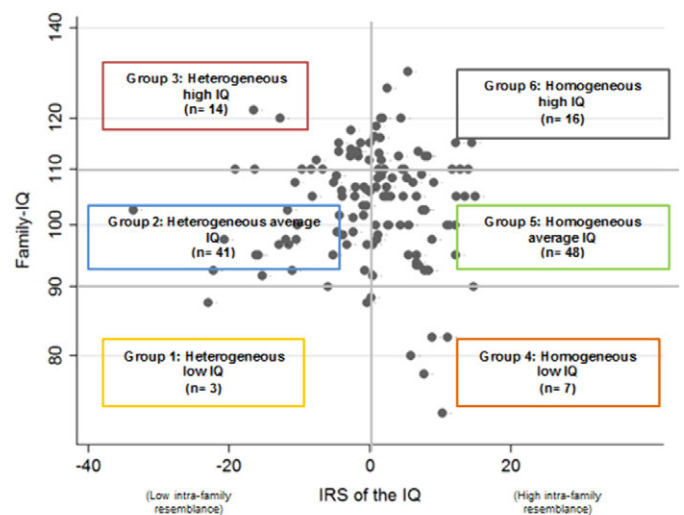


Figure 1. Distribution of FEP patients based on their IQ familiarity.

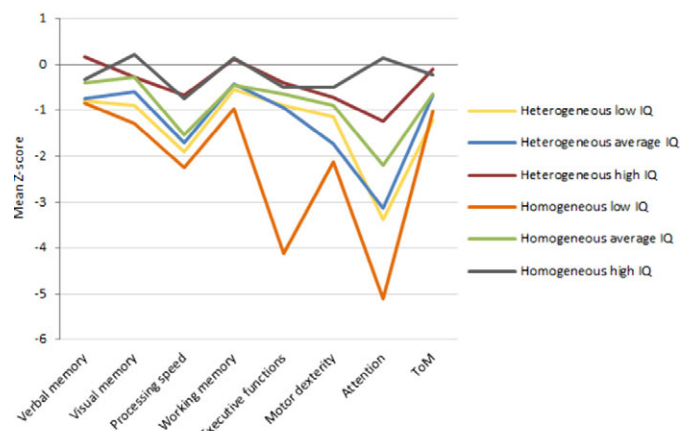


Figure 2. Neuropsychological comparisons of FEP patients