Background: The lifetime risk of suicide and suicide attempt in patients with schizophrenia are 5% and 25%–50%, respectively. Understanding the suicide risk factors is of great significance in research and clinical practice. The current systematic review is the first attempt to examine and demonstrate the associations between the core negative symptom of blunted affect and suicide in people with schizophrenia. We believe this review may have important implications for suicide epidemiology and helps us improve prevention tools.

Methods: A comprehensive search strategy using PRISMA guidelines was used to identify potential studies and data that met inclusion criteria. We searched original studies published since 2016 via MEDLINE (R) from 1946 to February 2016, EMBASE from 1947 to February 2016, and PsychINFO from 1806 to February 2016. Inclusion criteria were met if an article reported any kind of correlation between negative symptoms and suicide ideation, attempted suicide or completed suicide in patients with schizophrenia. The used search terms were: schizophrenia AND suicide* AND negative symptom* OR affective symptom* OR expressed emotion* OR emotional internal*. Studies with original data related to the blunted affect and suicide in schizophrenia were examined by manual reviewing.

Results: The initial search found 878 papers about negative symptoms and suicidal behaviour. From those only 12 papers fulfilled the inclusion criteria. Eight of twelve eligible papers found a positive association between blunted affect and suicide in schizophrenia indicating the link between social isolation and blunted affect with suicide (p<0.018), the impact blunted affect has on completed suicides on female population with schizophrenia (p<0.034) and the link between blunted affect and suicide in the stage of hospital admission (p<0.001). Two of twelve papers report no significance between blunted affect and suicide. One paper shows blunted affect did not have direct relation with suicide but can lead to the development of a suicidal behaviour. The last paper demonstrates blunted affect is important as suicide risk factor in schizoaffective disorder only.

Discussion: Based on the best available data, our results demonstrate a challenging link between blunted affect or related emotional disturbances and suicide in schizophrenia. Despite major suicide risk factors such as hopelessness, positive symptoms and depression, blunted affect is another factor we need to consider as it relates to social engagement and emotion regulation which are essential elements for eliminating suicides and improve interventions in psychiatry. Our outcomes may help with future development of preventive strategies and tools to combat suicide but also with gaining better understanding around what determines suicidal behaviour in schizophrenia.

Methods: We examined factor structure and internal reliability of a Romanian version of the Schizotypal Personality Questionnaire-Brief (SPQ-B), in a Likert format in a sample of 580 students of Universities of Bucharest, Craiova and Brasso, in Romania. 3 validity items and 5 items of social desirability were added to the 22-items SPQ-B. We investigated the dimensional structure of the Romanian version of the SPQ-B first in the entire sample, and then after eliminating “bad” responders (i.e. those with aberrant answers on the validity items). We used a Principal Components Analysis (PCA) followed by a promax rotation. Factor selection was based on eigenvalues over 1.0 (Kaiser’s criterion), Cattell’s scree plot test, and interpretability of the factors. We calculated Cronbach’s Alpha for total SPQ-B and for each dimension.

Results: Our sample was constituted of 433 women and 147 men. The mean age was 25.5 ± 4.5 years. SPQ-B Likert total scores ranged from 23 to 90 points (mean = 55 ± 12). 71 participants were excluded after taking account of validity questions. Factor analysis of the entire sample resulted in a 3-factor solution that explained 43.8% of the variance. Factor 1 (Cognitive-perceptual; 10 items) includes items related to “ideas of reference”, “magical thinking”, “unusual perceptual experiences” and “suspiciousness”. Factor 2 (Interpersonal; 5 items) includes items related to “social anxiety”, “no close friends”, and “constricted affect”. Factor 3 (Disorganized; 7 items) includes items related to “odd behavior” and “odd speech”. Coefficient Alpha for the three subscales and total scale, respectively, were 0.74, 0.78, 0.78 and 0.86. There were no significant differences when the analyses were conducted in the sample of 509 “good” responders students.

Discussion: Factor analysis of the Romanian version of the SPQ-B in a Likert format confirmed the three-factor structure of schizotypy. The SPQ-B and its subscales demonstrated good internal reliability. The use of items of validity and social desirability did not change significantly the results.
co-occurring affective disturbances, PEs, and HS (moderate psychosis [1–2 PEs]: relative risk ratio [RRR]=1.23, 95% CI 1.03 – 1.48, p=0.023; high psychosis [3 or more PEs or HS]: RRR=1.66, 95% CI 1.26 – 2.19, ρ<0.001) in models adjusted for socio-demographic characteristics and socio-environmental factors. However, when we additionally adjusted for working memory performance this association was attenuated (moderate psychosis: RRR=1.17, 95% CI 0.98 – 1.41, p=0.088; high psychosis: RRR=1.57, 95% CI 1.19 – 2.08, p=0.002). In line with previous findings, there was no evidence that JTC bias was more likely to occur in individuals with sole presence of affective disturbances (RRR=1.03, 95% CI 0.94 – 1.13, p=0.492). Further, there was some evidence of a dose-response relationship, as JTC bias was progressively more likely to occur in individuals with affective disturbances as the level of PEs increased or HS was reported (high vs. moderate psychosis: p=0.052). In contrast, compared to individuals with neither affective disturbances nor PEs, a decreased working memory performance was evident in all groups (i.e., affective disturbances only: RRR=0.94, 95% CI 0.90 – 0.98, p=0.006; PEs only: RRR=0.79, 95% CI 0.69 – 0.91, p=0.001; co-occurring affective disturbances and moderate psychosis: RRR=0.83, 95% CI 0.75 – 0.91, p<0.001; co-occurring affective disturbances and high psychosis: RRR=0.76, 95% CI 0.65 – 0.89, p=0.001).

**Discussion:** Our findings suggest that JTC bias and decreased working memory performance may contribute to a transdiagnostic phenotype of co-occurring affective disturbances and PEs. Further, findings support the notion that JTC bias may be specifically associated with psychosis, including in those presenting a transdiagnostic phenotype, while a lowered working memory performance may represent a more broadly distributed vulnerability factor across various symptom domains. Overall, results point to the need to further investigate whether established mechanism and risk factors, described to be involved in the development and maintenance of psychosis, extend to transdiagnostic phenotypes to further corroborate proposed aetiological models and overcome shortcomings of focussing only on specific domains of mental health.

**T116. CAFFEINE-INDUCED PSYCHIATRIC MANIFESTATIONS**

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**Background:** The association between caffeine consumption and various psychiatric manifestations has long been observed.

**Methods:** We present two cases that show the ability of caffeine to induce psychotic and manic symptoms, and we also review the extant literature on caffeine-induced psychiatric manifestations.

**Results:** On the basis of our own and others’ findings, we suggest that caffeine may be related to not only de-novo psychotic or mood symptoms but also to aggravation of pre-existing psychotic or mood disorders.

**Discussion:** We therefore suggest that caffeine consumption among patients with mood or psychotic symptoms should be assessed carefully in clinical practice as part of routine psychiatric evaluations.

**T117. INVESTIGATION OF FORMAL THOUGHT DISORDER AND RESPONSE TO TREATMENT IN SCHIZOPHRENIA**

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**Background:** Formal thought disorder (FTD) is a multidimensional dysfunction characterized by inability to maintain a coherent speech in spoken or written language, poor social cognition and disorganized thought itself. Presence of formal thought disorder has been associated with poor prognosis in schizophrenia, but the association with treatment response is yet to be determinate. Formal thought disorder has a close relation to disorganized symptoms in schizophrenia, which were independently associated with treatment resistance and poor response to standard antipsychotics. Formal thought disorder investigation could provide a clinical construct better delimited to assess disorganized symptoms in schizophrenia.

We investigated the association between FTD, remission and treatment resistance in patients with schizophrenia.

**Methods:** This study reunite a sample of 213 patients, between 14 and 69 years, who met DSM-IV criteria for schizophrenia.

The analyses were conducted in two samples conducted independently. In both samples, Diagnostic evaluation was performed with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), response to treatment was primarily assessed through PANSS, functional impairment was assessed by GAF and disease severity, by CGI. The first sample was a follow-up study that enrolled inpatients. Participants were rated at baseline and after four weeks of antipsychotic treatment. If the participant did not reduce a minimum of 40% of baseline PANSS, the antipsychotic was switched. If the participant did not reduce a minimum of 40% in total PANSS in the following antipsychotic trial, the participant was considered as treatment resistant schizophrenia (TRS) and clozapine, introduced. The second sample was enrolled in an outpatient clinic specialized in schizophrenia.

Illness remission was defined as a severity of mild (score of 3 on a scale of 1 to 7) or less for P1, P2, P3, G9, G5, N3, N1, N4 and N6 PANSS’s items. To establish FTD severity, PANSS items related to high scores at the Thought and Language Index (TLI) were considered: P2, P6, N1, N2, N5, N6, G7 and G9.

**Results:** Most subjects were male (56.8%) and the mean age was 34.42 (±12.33 SD).

The FTD Failed to associate with remission (t = 4.007, p = 0.491) or treatment resistance (t = -3.768, p = 0.988) in both samples.

FTD had a negative correlation with GAF (r = -0.473, p<0.01) and a positive correlation with CGI (r = 0.530, p<0.01).

**Discussion:** FTD had a stronger association with global functioning and severity measures, rather than treatment symptomatic outcomes. In future studies, we will investigate whether FTD show distinctive clinical features commonly related to disorganized syndrome, i.e. earlier age of onset.

**T118. IMPACT OF DYSFUNCTIONAL METACOGNITIONS AND WORRY ON DEVELOPMENT OF PARANOIA: A 1-YEAR LONGITUDINAL STUDY IN A NON-CLINICAL SAMPLE**

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**Background:** A worry thinking style has been identified as one of the proximal causal factors for paranoia (Freeman & Garety, 2014). This argument has been supported by the finding that patients with paranoia worry as much as patients with generalized anxiety disorder, and that worry predicts paranoia in non-clinical individuals. Wells (1995) argued that it is when metacognitions about worry (i.e. beliefs about worry and meta-worry) exaggerate worrying that anxiety disorders emerge. It was not clear how metacognitions interact with trait worry in the development of non-clinical paranoia.