Background: Cognitive insight represents the ability to question and criticize the validity of one’s beliefs, to recognize when beliefs may be faulty, and to then rely on external feedback to make correct assessments of a situation. Cognitive insight is characteristically impaired in persons with schizophrenia and related psychoses. The Beck Cognitive Insight Scale (BCIS) is the most widely used tool to assess cognitive insight, yet there is no consensus regarding clinical cutoff values. Cognitive insight is predictive of better response to psychosocial treatment and the ability to accept critical feedback from treatment teams, thus cutoffs are an important next step needed to facilitate the clinical interpretation of the BCIS. Some studies have attempted to develop diagnostic cutoffs, yet no study has proposed clinical cutoffs to differentiate levels of cognitive insight between patients with schizophrenia.

Methods: Three hundred and eighty-five English or French-speaking patients with a schizophrenia spectrum disorder (203 first-episode and 182 multiple-episode psychosis patients) and 185 healthy controls completed a battery of clinical and neuropsychological tests, including the BCIS. Patients and controls were matched on age, sex, level of education, and socio-economic-status. Correlations were calculated between the composite index and previously identified correlates of cognitive insight. Variables significantly correlating with the BCIS composite index were then included in a clustering analysis to classify patients according to their clinical profile. Two clinical profiles representing low and high cognitive insight were identified, and were based on global functioning and IQ. Composite index scores at the 33rd percentile in the low cognitive insight cluster and the 66th percentile in the high cognitive insight cluster were calculated.

Results: Functioning and IQ significantly correlated with the BCIS composite index and were included in a clustering analysis, using a pre-determined number of two clusters. Independent samples t-tests revealed that the 2 clusters differed significantly on the BCIS self-reflexiveness score (t(372) = -3.93, p < .001) and on the composite index (t(372) = -3.17, p = .002). There was no difference between clusters on self-certainty (t(372) = .31, p = .76). Patients in cluster A had a mean SR, SC, and composite index of 12.65 (SD = 4.3, Range = 2 to 26), 7.78 (SD = 3.3, Range = 0 to 18) and 4.87 (SD = 5.8, Range = -11 to 20), respectively, while mean scores for patients in cluster B were 15.11 (SD = 4.1, Range = 3 to 25), 7.64 (SD = 2.9, Range = 1 to 15) and 7.47 (SD = 4.8, Range = -3 to 22). In cluster A, the values of the 33rd and 66th percentiles were 2.6 and 9. Respectively. In cluster B, these values were 5 and 9. We are proposing that 33% of patients with the lowest composite index scores in cluster A represent those with low cognitive insight. Accordingly, 33% of patients with the highest composite index scores classified in cluster B represent those with high cognitive insight. Low cognitive insight is thus represented by a score of 3 or below, borderline scores range from 4 to 9, and high cognitive insight is represented by a score of 10 or above.

Discussion: We proposed clinical cutoffs for the BCIS with a theoretical basis anchored in patient clinical profiles (functioning and IQ). Clinical cutoffs will facilitate and better orient treatment teams in the clinical interpretation of the BCIS and ergo to patients’ level of cognitive insight. The development of such cutoffs will help to reduce heterogeneity in psychosocial group intervention, will facilitate interventions aimed at increasing cognitive insight, and improve communication between patients and their treatment teams.
with relatively normal cognitive performance. However, the prevalence and implications of these subgroups for understanding schizophrenia are unclear because “normality” criteria vary. Estimates of the frequency of normal range performance in the patient population are as low as 0% and as high as 89%. This study examines the relation between different normality criteria and normality prevalence. It also assesses functional outcome and symptom severity in cognitively normal and impaired subgroups.

**Methods:** “Narrow” (IQ) and “broad” (MATRICS Consensus Cognitive Battery; MCCB) cognitive normality criteria were applied to data from schizophrenia (n = 99) and healthy control samples (n = 80). Functional outcome was assessed with the Multidimensional Scale of Independent Functioning (MSIF). The Positive and Negative Syndrome Scale (PANSS) was administered to measure symptom severity.

**Results:** Cognitive normality ranged from 13% (broad criterion) to 47% (narrow criterion) among patients. Patients meeting both broad (MCCB) and narrow (IQ) definitions were functionally disadvantaged compared to cognitively normal controls (t(63) = 7.05, p < .01; t(72) = 9.97, p < .01, respectively). However, cognitively normal patients showed no functional (MCCB) advantage relative to cognitively impaired patients based on both broad and narrow definitions of cognitive normality (t(95) = .43, p = .67; t(74) = -1.04, p = .30, respectively). Functioning did not differ between IQ and MCCB based cognitively normal patients (t(51) = .61, p = .55). Moreover, broad and narrow definitions of cognitive normality were not associated with differences in symptom severities relative to cognitively impaired patients. This held true for both positive (t(97) = 1.39, p = .17; t(76) = -7.2, p = .47, broad and narrow definitions, respectively) and negative (t(97) = .98, p = .33; t(76) = -1.07, p = .29, broad and narrow definitions, respectively) symptom severity on the PANSS.

**Discussion:** Our data show that the prevalence of cognitive performance normality varies widely with the breadth of the normality criterion. However, regardless of the criterion applied, cognitively normal patients remain functionally disadvantaged relative to cognitively normal controls. Perhaps more importantly, however defined, cognitively normal patients demonstrate no advantage in functionality relative to cognitively impaired patients. Thus, patients meeting the broad definition of cognitive normality are not functionally advantageous relative to those meeting the narrow definition. We also found that varying definitions of cognitive normality/impairment have no implications for the severity of psychotic psychopathology in treated outpatients. Overall, the current study suggests that the reported prevalence of cognitive normality in schizophrenia is largely a product of definitional approaches. At the same time, the data cast doubt on the functional importance of preserved and proficient cognition regardless of definition and suggest that cognitive normality does not confer an advantage in terms of reduced symptom severity.

**T90. MEMBERSHIP IN A SCHIZOTYPY TAXON PREDICTS HOPELESSNESS AND THOUGHTS OF SELF-HARM 7 YEARS LATER**

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**Background:** Expressions of liability for schizophrenia are associated with suicidal thinking and behaviour. This relationship appears not to be specific to different expressions of suicide, although there is evidence suggesting that schizophrenia liability is associated with greater lethality. The relationship is evident among help-seeking and non-help-seeking volunteers and using measures of psychosis experience or self-reported schizotypy; it persists despite controlling for other psychopathologies. Given these observations, the link between suicide and schizophrenia liability may be rooted in shared pathogenic mechanisms. With this in mind, I tested whether stress sensitivity could contribute to the link between schizophrenia liability and suicidality in a prospective study.

**Methods:** At baseline (T1), n = 1074 undergraduates (M = 19.8 years, SD = 3.1; 30% male) completed the Schizotypy Personality Questionnaire (SPQ) and the Acute Hassles Scale (AHS), a self-report measure of stress sensitivity. Participants were classified as schizotypal or non-schizotypal by taxometric analyses of items for specific SPQ facets (cognitive-perceptual, interpersonal, and disorganization) and a general SPQ item set. Participants were classified as schizotypal (n = 43) if they were classified to the general schizotypy class to two or more specific-facet classes. At follow-up (T2) 7.8 years later (SD = 1.9, range = 5.5 to 10.5 years), the T1 schizotypy group (n = 43) and an age- and sex-matched control group (n = 216) were invited to participate in an online follow-up study. Of those invited, n = 84 (M = 27.7 years, SD = 3.3; 26% male; n = 15 schizotypal at T1) provided consent and completed the SPQ and AHS. At T2, hopelessness was assessed using 3 items from the Depression, Anxiety, and Stress Scales and thoughts of self-harm were assessed with one item from DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure for adults. The small n at T2 prevented taxometric analyses of SPQ ratings at T2.

**Results:** At T2, 9.5% of participants reported thoughts of self-harm and 17.8% hopelessness. Cross-sectional regression analyses of T2 data showed that the SPQ and AHS total scores each predicted concurrent self-harm thoughts (β = .52, p < .001, and β = .45, p < .001, respectively) and hopelessness (β = .43, p < .001, and β = .24, p < .05, respectively). When T2 SPQ and AHS were entered simultaneously, only SPQ scores predicted self-harm thoughts (β = .39, p = .001 for SPQ; β = .20, p = .10, for AHS) and hopelessness (β = .46, p < .001, for SPQ; β = .04, p = .74 for AHS). In longitudinal analyses, T1 taxon membership predicted T2 self-harm thoughts (β = .28, p = .011) and hopelessness (β = .33, p = .002) but T1 AHS did not (β = .09, p = .43, and β = .09, p = .40, respectively). T1 taxon membership remained a significant predictor of T2 self-harm thoughts (β = .28, p = .016) and hopelessness (β = .34, p = .004) when T1 AHS was entered as a concurrent predictor, whereas AHS predicted neither outcome (β = .01, p = .95, and β = .02, p = .84, respectively).

**Discussion:** Schizotypy classification during the late teens or early 20s predicted hopelessness and thoughts of self-harm 5 to 10 years later. Although stress sensitivity was correlated with concurrent thoughts or self-harm, stress sensitivity could not have accounted for the link between schizotypy and self-harm thoughts or hopelessness. The study is limited by the rudimentary nature of the assessment of self-harm thinking, the modest sample size, and the large rate of loss to follow-up.

**T91. DEVELOPMENT OF NOVEL BIS-AMIDINES FOR THE TREATMENT OF TOXOPLASMOsis**

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**Background:** Toxoplasma infections constitute a worldwide public health problem responsible for significant morbidity. Symptoms of acute infection by the agent, the apicomplexan parasite Toxoplasma gondii, can range from mild to life-threatening depending upon the immune status of the host. Toxoplasma infections are often unrecognized in immune competent hosts but infection can lead to the long-term establishment of cysts in the brain and thus a persistent infection. Such tissue cysts are associated with a wide range of neurological problems responsible for significant morbidity. Symptoms of acute infection by the agent, the apicomplexan parasite Toxoplasma gondii, can range from mild to life-threatening depending upon the immune status of the host. Toxoplasma infections are often unrecognized in immune competent hosts but infection can lead to the long-term establishment of cysts in the brain and thus a persistent infection. Such tissue cysts are associated with a wide range of neurological problems responsible for significant morbidity. Symptoms of acute infection by the agent, the apicomplexan parasite Toxoplasma gondii, can range from mild to life-threatening depending upon the immune status of the host. Toxoplasma infections are often unrecognized in immune competent hosts but infection can lead to the long-term establishment of cysts in the brain and thus a persistent infection. Such tissue cysts are associated with a wide range of neurological problems responsible for significant morbidity.

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