Disorder at the time of their death, 10 met criteria for a psychotic disorder and 13 met criteria for the presence of both depression and psychosis.
Measures:
Structured Clinical Interview for DSM-Disorders (SCID: First et al., 1994) used informant interviews to evaluate the presence of major mental illness in the adult who died by suicide. Interviews were conducted with family members, gathering detailed information about the duration and severity of major mental illness.
Suicidal Actions Checklist (Dejong, Overholser, & Stockmeier, 2010) was used to gather information about recent stressors, previous suicide attempts and past hospitalizations for psychiatric problems. Prior research (Dejong & Overholser, 2009) has documented an adequate level of agreement for the Suicidal Actions Checklist when collected from suicide attempters as compared to family member informants.
Procedures:
Assessment procedures followed the guidelines for psychological autopsy research (Hawton et al., 1998), whereby family members were interviewed two months after the death of their loved one. In order to determine the most accurate diagnosis for each case, all records were reviewed by a psychiatrist, a clinical psychologist, a social worker, and a neuroscientist.
Results: Because of the small number of patients with a psychotic disorder (with or without depression), these cases were combined into one group, and several non-significant trends are reported. As compared to suicide completers with a depressive disorder, the psychotic cases were more likely to be younger ($t = 2.18$, $p < .05$), unmarried ($\chi2 = 3.13$, $p < .08$), unemployed at the time of their death ($\chi2 = 9.75$, $p < .01$), and more likely to meet criteria for cannabis abuse ($\chi2 = 3.75$, $p < .06$). Suicide completers with nonpsychotic depression were more likely to meet criteria for a comorbid diagnosis of alcohol abuse ($\chi2 = 4.36$, $p < .05$) and often had alcohol in their system at the time of their death ($\chi2 = 4.35$, $p < .04$). Despite the higher rate of personality disorders among the depressed completers ($\chi2 = 3.14$, $p < .08$), the psychotic cases of suicide were more likely to have a chronic course to their symptoms ($\chi2 = 3.11$, $p < .08$) with a history of prior psychiatric hospitalization ($\chi2 = 18.22$, $p < .01$). Although not significant, when the three groups were examined separately, the depressed psychotic cases were more likely to have attempted suicide prior to the actual death by suicide (62%) compared to the depressed non-psychotic patients (37%) as well as the psychotic non-depressed cases (40%). Qualitative analyses will examine various patterns that may have direct links to suicidal urges.
Discussion: Adults with a psychotic disorder have a more chronic condition that appears difficult to treat and tends to impair work or home functioning. The psychotic patients were less likely to rely on alcohol to lower their inhibitions about committing a suicidal act, suggesting other factors need to be addressed in prevention efforts. Patients may allow their psychotic thinking to guide their behavior, and when combined with depression can result in self-destructive actions.

S128. CORRELATION OF DURATION OF UNTREATED PSYCHOSIS WITH TREATMENT RESPONSE ON THE SYMPTOM DIMENSIONS OF SCHIZOPHRENIA

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Background: Longer duration of untreated psychosis (DUP) predicts worse response to treatment and functional outcomes in first episode of schizophrenia (FES). Longer DUP also seem to particulary affect the severity of negative symptoms, but most studies enrolled previously medicated patients and did not focus on differential effects on schizophrenia symptomatic dimensions. This study investigates how DUP influences the five dimensions of symptoms of schizophrenia on antipsychotic naïve FEP patients before and after two months of treatment.
Methods: Drug-naïve patients at FES (n = 97) were recruited from the Inpatient Psychiatric Unit of Santa Casa de Misericórdia de São Paulo (Sao Paulo, Brazil), between 2011 and 2016. Subjects were assessed at hospital admission and after two months of follow up. All patients were treated with antipsychotics after the diagnosis was confirmed with the Structured Clinical Interview for DSM-IV (SCID-I). The Positive and Negative Syndrome Scale (PANSS) was administered at baseline and after two months of treatment. The PANSS items were grouped in five factors: positive, negative, disorganized/cognitive, mood/depression and excitement/hostility factors. The factors percentage reduction from baseline after treatment were correlated with the DUP, controlled for sex, age, years of education.
Results: The mean years of education of the sample was 9.2 (± 2.6 SD), mean age was 24.9 (± 7.0 SD), 62.9% were male and 42.7% were unemployed or had stopped their studies because of symptoms. Pearson correlation coefficients of the factors with DUP were: Positive = - 0.311 ($p < 0.001$); Negative= -0.340 ($p < 0.001$); Disorganized = -0.188 ($p = 0.033$); Hostility = -0.201 ($p= 0.023$); Depression = 0.030 ($p = 0.389$).
Discussion: Shorter DUP enhanced the early response to treatment in the positive, negative, disorganized and hostility dimensions. In line with the literature, our findings support that reducing the DUP may be one of the few interventions for a more favorable response to treatment on negative symptoms.

S129. DOES TREATMENT RESISTANT SCHIZOPHRENIA PRESENT A CHARACTERISTIC SYMPTOMATIC SIGNATURE?

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Background: Treatment-resistant schizophrenia (TRS) may underlie a specific biological signature among patients with schizophrenia. The main lines of evidence suggest a glutamatergic rather than dopaminergic dysfunction in TRS, with lower levels of striatal dopamine and higher levels of glutamate in anterior cingulate. Whether this biological signature relates to a distinct symptomatic profile remains unclear. Our objective is to define a symptom profile of patients with TRS.
Methods: We used two samples of patients with schizophrenia. First, we followed a discovery sample of inpatients (n=203) to prospectively identify TRS predictors, then we tested the predictors in a replication sample of outpatients (n=207). The samples were collected independently. All patients were assessed with the Positive and Negative Syndrome Scale (PANSS), the Clinical Global Impressions-Severity Scale (CGI-S) and the Global Assessment of Functioning Scale (GAF). Diagnosis was confirmed using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). TRS was defined according the criteria of the Schizophrenia Algorithm of the International Psychopharmacology Algorithm Project (IPAP). Initially, we tested if patients with disorganized subtype were more likely to be TRS, and grouped the patients into disorganized or non-disorganized schizophrenia according to SCID-I. Then, we checked which PANSS items at the baseline predicted TRS at the follow-up through multiple logistic regression analyses. A receiver operating characteristic (ROC) curve with the best items was performed at the follow-up.
Results: TRS was more common in disorganized schizophrenia in the inpatient sample (73.8% vs 22.4%, $P < 0.001$) and in the outpatient sample (68.2% vs 28.2%, $P < 0.001$) in comparison to non-disorganized schizophrenia. They also presented worse scores on PANSS, CGI-S and GAF ($P < 0.001$). In the second step, three PANSS items, P2 (conceptual disorganization), N5 (difficulty in abstract thinking) and G9 (unusual thought content), predicted TRS with 78.4% accuracy ($P = 0.011$, $P = 0.010$ and