Discussion: Cannabis use is not related to an ameliorated or improved neurocognitive functioning in patients with a first episode psychosis. This is consistent with previous studies which showed absence of differences in the neurocognitive functioning between FEP cannabis users and non-users (Burgra et al., 2013). However, it has been demonstrated that continued cannabis intake worsens cognitive performance although some of the FEP patients had better premorbid capacities (González-Pinto, 2016). Moreover, the doses and the different types of cannabis preparations may interfere the present results. Meta-analysis on longitudinal studies which include these potential moderator variables may be performed in the future.

F93. SUBCLINICAL PSYCHOSIS COMPONENTS MAKE DIRECT AND INDIRECT CONTRIBUTIONS TO ACTIVE SUICIDE IDEATION IN ADOLESCENTS

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Background: Subclinical psychosis predicts concurrent and future suicidal ideation and attempts. A key account of this relationship is that it is spurious—that suicidality and subclinical psychosis are both products of a common confounding factor such as environmental risk exposures (e.g., neglect or abuse) or the burden of general psychopathology. This account is unsatisfactory for several reasons, including that subclinical psychosis may be especially predictive of more lethal forms of suicidal behaviour. Moreover, few have considered the relationship in light of contemporary accounts of suicide. Therefore, we sought to better understand the link between subclinical psychosis and suicidality using a contemporary ideation–action framework in which perceived burden and thwarted belonging are distinguished as proximal pathways to suicidal ideation. We tested whether this framework fully mediates the relationship of subclinical psychosis with suicidal ideation, consistent with a common confounding factor account.
Methods: Randomly sampled 15- to 18-year-olds from a socio-economically representative high school were invited to participate anonymously. Of those invited (n = 300), 59% provided informed consent and completed self-report measures of positive, negative, and disorganised components of subclinical psychosis (Schizotypal Personality Questionnaire [SPQ]), thwarted belonging and perceived burden (Interpersonal Needs Questionnaire), and passive and active suicidal ideation (Beck Scale for Suicide Ideation [BSS]). Participants were classified using BSS responses as non-ideators, passive ideators, or active ideators. In regression modelling (maximum likelihood estimation with bias-corrected bootstrapping), direct and indirect effects of SPQ components on ideator classifications were obtained. Mediators were perceived burden, thwarted belonging, and their interaction term. Sex and migrant status were entered as covariates.
Results: Of those with complete data (n = 156), 69.9% were non-ideators, 12.8% were passive ideators, and 17.3% were active ideators. In bivariate analyses, SPQ positive scores predicted passive ideation ($r = .24$, $p < .001$) but negative ($r = .13$, $p > .05$) and disorganised scores ($r = .14$, $p > .05$) did not. In contrast, active ideation was strongly predicted by negative ($r = .39$, $p < .001$) and disorganised scores ($r = .34$, $p < .001$) and less strongly predicted by positive scores ($r = .19$, $p < .05$). Mediation models predicted passive ($R2 = .29$, $p < .05$) and active ideation ($R2 = .65$, $p < .001$). Passive ideation was sensitive only to indirect effects of SPQ scores: negative ($\beta = .14$, $p < .01$) and disorganised SPQ scores ($\beta = .11$, $p < .05$) were mediated by perceived burden. For active ideation, negative ($\beta = .17$, $p < .05$) and disorganised scores ($\beta = .14$, $p < .05$) had similar indirect effects mediated by perceived burden but there were also direct effects of positive ($\beta = -.44$, $p < .01$) and negative SPQ scores ($\beta = .37$, $p < .05$). Thwarted belonging did not mediate the effects of SPQ scores on ideator status.
Discussion: A contemporary ideation–action model of suicide did not fully account for the relationship between subclinical psychosis and suicidal ideation. Instead, some components of subclinical psychosis directly influenced suicidal ideation status: Positive subclinical psychosis components protected against active suicidal ideation whereas negative components increased the risk of active ideation. Negative and disorganised components of subclinical psychosis also increased the risk of ideation by increasing the perception of self-hate and liability on others. Subclinical psychosis makes a unique contribution to the prediction of suicidal ideation.

F94. A PREVALENCE PILOT STUDY FOR OBSTRUCTIVE SLEEP APNEA SYNDROME IN CLOZAPINE USERS

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Background: Obstructive Sleep Apnea Syndrome (OSAS) is a frequent and common disorder. Estimated 50.000 persons in the Netherlands suffer from this disorder. Clozapine is known for its efficacy in treatment resistant schizophrenia. Frequent side effects of clozapine are weight gain, fatigue, sleepiness and metabolic syndrome. Similar symptoms occur in the course a OSAS. The Dutch pharmacovigilance centre LAREB (LAREB 2012) proposed an association between OSAS and clozapine usage, independent of confounding factors as obesity, smoking and glucose intolerance. Although clozapine is much used in the treatment of schizophrenia, OSAS prevalence studies in the clozapine treatment group are scarce. Research is needed to elucidate the relationship between clozapine use and OSAS. Identifying OSAS and treatment with continuous positive airway pressure (CPAP) could possibly (Galletly te al, 2016), through reduction in cardiovascular risk factors, have a favorable effect on mortality and possibly have a positive effect on daytime sleepiness, fatigue and daytime functioning.
Primary goal of this study is discovering the prevalence of OSAS in clozapine using schizophrenic spectrum disorder patients. The secondary goal is discovering how willing schizophrenic spectrum disorder patient are in undergoing a polysomnography.
Hypothesis: Many patients with schizophrenia spectrum disorder have multiple OSAS risk factors: obesity, presence of metabolic syndrome, frequent usage of benzodiazepines, male sex, older age. OSAS prevalence is estimated to be much higher than in the general population because of these risk factors. Atypical antipsychotics are an independent risk factor for the development of OSAS. Polysomnographically diagnosed OSAS will even be higher in the clozapine treatment group estimated to be present in 30% percent of the patients.
Methods: Research design: prospective observational and cross-sectional study in a group of stable adult patients with DSM IV schizophrenia spectrum disorder treated with clozapine in an outpatient community mental health service. Estimated study group consists of 30–50 patients. Exclusion criteria: unwillingness to undergo a polysomnography, inability to give informed consent, insufficient understanding of the Dutch language, severe cardiac failure, a history a cerebrovascular accidents and alcohol abuse.
Method: screening on the presence of OSAS symptoms and risk factors associated with OSAS through: Epworth Sleepiness Scale for daytime sleepiness (Johns, 1991), STOP-BANG Questionaire ((SBQ: Chung 2012) when there is a high risk for OSAS followed by an ambulatory polysomnography including heart rate/ECG, respiratory measures with nasal flow canule and thermistor flow inductive respiratory movements, oximetry, and snoaring noises through sensory measurements (AASAM, 2009). OSAS is considered to be present in the presence of daytime sleepiness and if the Apnea Hypopnea Index (AHI) is larger than 5.0 obstructive or mixed type respiratory events per hour (AASM, 2009: Berry et. al, 2015: NVALT & CBO, 2009).
Statistical analysis: polysomnography: descriptive and univariate analysis. Presence of OSAS will be dichomotized (1 =OSAS present; 0 = OSAS absent) Summation of the amount of positive results will be presented as percentage of the total study population. Chi- squared test for considering of the height of the results on the ESS test and the STOP-Bang test and the prevalence of OSAS. Statistical significance: $p < 0.05$.