EAT and assessed correlations among the EAT and three other commonly used empathy tasks.
Methods: Patients (n=92) and healthy controls (n=42) matched for age and education, completed the EAT, the Interpersonal Reactivity Index, the Questionnaire of Cognitive and Affective Empathy and the Faux Pas task. Differences between groups were analyzed and correlations were calculated between empathy measurement instruments.
Results: The groups differed in EAT performance, with controls outperforming patients. A moderating effect was found for the emotional expressivity of the target: while both patients and controls scored low when judging targets with low expressivity, controls performed better than patients with more expressive targets. Though there were also group differences on the cognitive and affective empathy questionnaires (with lower scores for patients in comparison to controls), EAT performance did not correlate with questionnaire scores. Reduced empathy performance did not seem to be part of a generalized cognitive deficit, as differences between patients and controls on general cognition was not significant.
Discussion: Individuals with schizophrenia benefit less from the emotional expressivity of other people than controls, which contributes to their impaired empathic accuracy. The lack of correlation between the EAT and the questionnaires suggests a distinction between self-report empathy and actual empathy performance. To explore empathic difficulties in real life, it is important to use instruments that take the interpersonal perspective into account.

F106. STATE AND TRAIT RELATED NATURE OF INSIGHT IMPAIRMENT IN SCHIZOPHRENIA

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Background: Impairment of insight is a prominent feature of schizophrenia and is associated with poor adherence and poor outcomes. While many studies have investigated the nature of insight impairment in schizophrenia, few have charted its course longitudinally. In this study we investigated changes in different components of insight during the first 12 months of antipsychotic treatment.
Methods: The sample comprised 107 never or minimally treated patients with a first episode of schizophrenia, schizophreiform or schizoaffective disorder. They were treated according to a fixed protocol with flupenthixol decanoate. Insight was assessed with the self-rating Birchwood Insight Scale and the investigator rated global insight item of the PANSS scale.Psychopathology was assessed with the PANSS and CDSS. Cognitive performance was assessed with the MATRICS. We performed evaluations at baseline, month 6 and month 12. Linear mixed effects mixed models for repeated measures were conducted to assess changes over time, adjusting for age, gender and educational status.
Results: There were no significant changes in the BIS subscales of symptom awareness, awareness of illness or total BIS score. The need for treatment subscale improved slightly (p=0.02) while the PANSS global insight improved considerably (p<0.0001). Degree of insight impairment was only weakly correlated with psychopathology and cognition
Discussion: Insight impairment is common in schizophrenia and displays trait-like rather than state-like features. These findings have important clinical implications.

F107. CSF ABNORMALITIES IN SCHIZOPHRENIA AND DEPRESSION: PRELIMINARY RESULTS FROM A LARGE SCALE COHORT

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Background: CSF abnormalities and a neuroinflammatory pathophysiology have been discussed for affective and non-affective psychosis for more than 30-years. Recent studies pointed towards a specific phenotype of autoimmune-antibody mediated psychosis, but evidence is still sparse. Especially CSF data investigating autoimmune antibodies in large-scale CSF cohorts of affective and non-affective psychoses are lacking.
Methods: We analyzed a retrospective naturalistic cohort of 592 patients with A) schizophrenia-spectrum disorders (N = 330) or B) depressive disorders (N = 262) who underwent a lumbar puncture as part of the clinical routine in the Department of Psychiatry and Psychotherapy at the Ludwig-Maximilians University Munich between July 2012 and May 2017. We used a predefined systematic algorithm for the database search in the clinical documentation system and data was extracted by TO and AG. The study was approved by the local ethics committee.
Results: We identified 592 patients with standard CSF parameters. Schizophrenia spectrum patients did not differ from depressive patients with regard to the white blood cell count (cells/µl) (p = 0.774) or albumin quotient (p = 0.663). The general prevalence of oligoclonal bands did not differ between groups (schizophrenia: 37.0%, depression: 37.8%; p = 0.838). However, schizophrenia patients showed higher frequencies for intrathecal oligoclonal bands (32% of all oligoclonal bands) compared to depressive patients (19.1% of all oligoclonal bands. (p = 0.034). 124 schizophrenia-spectrum patients (54 first-episode patients) received CSF analyses for neural antibodies. None of the patients showed positive CSF results in any of the tested autoimmune-encephalitis panel (NMDA(N=119), AMPA-1(N=114), AMPA-2(N=114), CASPR(N=111), LGI-1(N=110) and GABA-B(N=112)-Antibodies) in CSF. The results for the intracellular onconeuronal and synaptic antibodies were also negative (Amphyphysin(N=93), Yo(N=58), Hu(N=94), Ri(N=94), CV2(N=93), Ma1(N=93) and Ma2(N=93)-Antibodies). Three of these patients with negative CSF titers did have low-titer neuronal antibodies in serum: CASPR-2-AB: 1:10, CASPR-2-AB: 1:50, Yo-AB: low band-intensity. 36 depression patients were also tested for autoimmune antibodies and again no positive reports could be identified in CSF.
Discussion: This is the first analyses of autoimmune antibodies in first-episode and recurrent schizophrenia and depressive mood disorder showing no positive CSF titers. However, schizophrenia patients have a higher prevalence of intrathecal oligoclonal bands compared to affective patients pointing towards more immunological disturbances in this population. The here presented analyses are exploratory and need to undergo confirmatory analyses and quality control.

F108. PSYCHOTIC EXPERIENCES IN A NORWEGIAN SAMPLE - TENTATIVE RESULTS OF A QUESTIONNAIRE VALIDATION

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Background: Auditory verbal hallucinations are a major symptom in schizophrenia but also affect patients with other diagnoses and healthy people without any pathology. This applies also to delusions and hallucinations of other sensory modalities. Since most questionnaires that assess hallucinations focus on one particular disorder, the Questionnaire for Psychotic Experiences (QPE) was created to provide an instrument that is applicable independently of clinical status.

The QPE is a semi-structured interview consisting of 50 items that are categorized into four subscales (visual, auditory, other hallucinations and delusions). Each subscale starts with a screening question to indicate if a symptom is present, followed by questions regarding specific characteristics. We translated the QPE into Norwegian (bokmål) and distributed the screening questions online with the aims (1) to validate the Norwegian version of the screener QPE and (2) to assess the prevalence of hallucinations and delusions in the Norwegian population independently of the clinical status.

Methods: We conducted an online survey using a test/re-test design, which comprised the 13 screening questions of the QPE as well as demographic and clinical questions. Seven days after initial completion of the QPE participants received a link for the second round. For test/re-test reliability, we calculated concordance rates (i.e., percentage rates of how many participants gave the same response at the first and second measurement). Internal consistency is indicated with Cronbach's alpha. Finally, we calculated a principal component analysis (PCA) for the QPE items to identify the QPE's item structure. The study was approved by the regional ethics committee.

Results: Until now, 407 individuals (304 females, 103 males) with an age range of 18 to 78 (mean = 32.7) participated in the first part of the online survey, of whom 185 also took part in the re-test.

Twenty-eight % of all participants had at least one psychiatric diagnosis. Among the healthy participants alone, 35% reported auditory hallucinations, 26% visual hallucinations, 40% tactile hallucinations and 28% olfactory hallucinations. Around 68% of all healthy participants reported at least one delusional experience.

Cronbach's alpha across all 13 items for the entire sample was 0.772 in the first round and 0.765 in the second round. Test/re-test reliability was between 79% and 99%. The PCA, also based on the entire sample, revealed one dimension, with high loadings especially on delusion-related questions (range: 0.488–0.697).

Discussion: The distribution of different modalities of hallucinations and delusions in the healthy sample suggests that psychotic experiences are not necessarily connected to diagnoses. This finding is in accordance with other studies and supports the hypothesis that psychotic experiences are independent of the clinical status.

The Cronbach's alpha suggests a good internal consistency at both time points, which stays stable over time and the test/re-test reliability shows a high accordance between the answers of round one and two. The PCA implies that the QPE screener is best characterized with a unidimensional structure, indicating that there is substantial overlap between hallucinations and delusions, even though factor loadings are particularly high for delusions. We conclude that the Norwegian version of the screener QPE is a viable tool for assessing psychotic experiences across both psychiatric and healthy populations.

F109. BOUNDARIES BETWEEN DEFICIT AND NONDEFICIT SCHIZOPHRENIA: LONG TERM STABILITY AND OUTCOMES

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Background: Negative symptoms of schizophrenia are admittedly associated with a poorer outcome regarding aspects such as functionality, quality of life and cognitive performance. Patients with prominent, persistent and primary negative symptoms have been considered to manifest a putative subtype called "Deficit schizophrenia" (DS). However, the boundaries of deficit and nondeficit forms were put in question since the publication of a study that considered separately a group of patients with persistent negative symptoms whose primary nature could not be asserted, the "ambiguous nondeficit" group, who would be otherwise categorized as nondefict according to the gold standard instrument: the Schedule for the Assessment of the Deficit Syndrome (SDS). Those patients presented psychopathological features, quality of life, insight and cognitive function quite different from the nondeficit group, and closer to the deficit group. The objectives of the present study are to investigate the stability of the categorization regarding the presence of DS in three groups: "deficit"(DS), "nondeficit" (ND) and "ambiguous nondeficit" (SND) over a long term follow-up and to evaluate clinical outcomes in the different groups.

Methods: We will contact 85 patients with schizophrenia, considered clinically stable in the previous year, who participated in a study about the DS in 2009/2010. Back then, they were recruited in two sites: an outpatient service of a university general hospital (49 patients) and a community-based mental health service (36 patients). Patients will be assessed with the same instruments adopted in the first study: a questionnaire for clinical and demographic information; BPRS, SAPS, SANS, Calgary Depression Scale, the SDS, QLS, and a battery of neurocognitive tests. We started the recruitment by the patients originally treated in the outpatient clinic.

Results: Here we present partial results. Of the 49 patients, 5 refused to participate in the follow-up study, 3 died prematurely, and 1 had the diagnostic changed for bipolar disorder. Assessment interval was 6.9 years ± 0.5 Among the 20 reassessed patients, mean age at baseline was 36.9 ± 8.9 years, mean duration of mental illness was 16 ± 10.1 years, and 75% were men. They had in mean, 10.7 ± 3.3 years of education, only 20% had any work activity, 15% were married and 55% had a low socioeconomic position. These demographic aspects slightly worsened: only 15% had an occupation at follow-up, and 60% fell in the lower socioeconomic position. Regarding the SDS classification, 4 of 9 ND patients at the baseline were reclassified as DS; 1 of 7 DS was reclassified as ND, the other 6 remained DS; from the AND, 3 were considered DS and 1 ND, from a total of 4. At the end, there were 13 DS and 7 ND, while at the baseline they were: 7 DS, 9 ND and 4 AND. Concerning psychopathology, 80% of the patients had an increase in SANS and the most expressive increase was in nondeficit group (an average of 5.4 points), although the average in DS group remained the higher (18.9 points). Still, SAPS and Calgary remained low in all three subgroups, with a mean of 6.20 and 2.20 points, respectively. As to medication, 70% of the baseline were in use of Clozapine (67% of ND, 57% of DS and 100% of the AND group) and that total number remained the same during the follow up.

Discussion: Our preliminary results are derived from a small sample. Although we cannot draw definite conclusion, these outcomes suggest trends that are worth observing: the worsening of negative symptoms among patients and the tendency of conversion to DS group, especially among the "ambiguous" group. This advocates against the dichotomous division of deficit and nondeficit schizophrenia and speaks in favor of a dimensional understanding of negative symptoms.

F110. THE BRIEF NEGATIVE SYMPTOM SCALE (BNSS): VALIDATION IN A MULTICENTER BRAZILIAN STUDY

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Background: Negative symptoms are a core feature of schizophrenia. The Brief Negative Symptom Scale (BNSS) is a new scale developed to assess negative symptoms in schizophrenia.