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Background: Although the clinical high risk (CHR) for psychosis paradigm has become well-established over the past two decades, one key component has received surprisingly little direct investigative attention: the validity of the conversion to psychosis or transition criteria. This lack of evidence is surprising because many CHR treatment and prediction studies rely on the conversion measure as an outcome. In the absence of such evidence, some observers have raised the possibility that conversions from CHR may be trivial.

The aim of this study is to evaluate the predictive validity of the transition to psychosis as measured by the Structured Interview for Psychosis-Risk Syndromes (SIPS) in CHR individuals. To our knowledge, this is the first study to examine the CHR conversion to psychosis at one-year follow-up. It is hypothesized that CHR participants whose conversion to frank psychosis was ascertained by SIPS (SIPS CV) will show similar diagnostic stability and severity of illness compared to the FEP sample and will differ significantly from SIPS Non-Converters (NCV) on clinical severity.

Methods: Participants included 33 SIPS Converters (CV) (met criteria for conversion to frank psychosis (COPS) on SIPS) and 399 CHR NCV both from the North American Prodromal Longitudinal Study (NAPLS) 2, as well as a sample of 67 separately-ascertained first-episode psychosis (FEP) patients from the STEP Coordinated Specialty Care (CSC) program in New Haven, CT. Comparisons using Chi-square and ANOVA were made at baseline and one-year follow-up on variables from demographic, diagnostic stability (SCID) and available measurement domains relating to severity of illness (psychotropic medication and resource utilization).

Results: The principal findings of the present study are: 1) large majority of cases in both SIPS CV (n=27/33, 81.8%) and FEP (n=57/67, 85.1%) samples continued to have current psychosis diagnoses at one year follow up, 2) exposure to antipsychotic medication was higher in SIPS CVs (n=17/32, 53.1%) compared to SIPS NCVs (n=81/397, 20.4%), and similar as compared to FEP cases (n=39/65, 60%), 3) at follow up, SIPS CV had higher rates of resource utilization (any psychiatric hospitalizations, day hospital admissions, and ER visits) than SIPS-NCV and were similar to FEP in most categories.

Discussion: The results suggest that the SIPS definition of psychosis onset carries substantial validity in that those with SIPS-defined psychosis demonstrate similar diagnostic stability and severity of illness at one-year follow as a first episode sample and greater severity of illness as compared to a SIPS-defined CHR non-converting sample. Limitations include the lack of functional assessments at follow-up in the SIPS-CV. Additional studies are needed to further validate the CHR vs transition to psychosis distinction. Since many patients who come to baseline evaluation for CHR are discovered to have previously unrecognized frank psychosis, future studies should aim to obtain additional evidence by following this important group.

F62. EVOLUTION OF ANTI-NMDA RECEPTOR ENCEPHALITIS CLINICAL FEATURES IN ADULTS

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Background: Autoimmune encephalitis is a recently discovered illness caused by antibodies against neuronal cell-surface or synaptic proteins. Of the 11 immunologically distinct varieties currently known, anti-NMDA receptor (NMDAr) encephalitis is second in frequency only to acute disseminated encephalomyelitis, which primarily affects children. Early symptoms of NMDAr encephalitis can mimic psychiatric disorders, including schizophrenia, and most patients are initially referred to a psychiatrist and misdiagnosed, further delaying treatment. Autoimmune encephalitis can develop rapidly over days or weeks, sometimes beginning with a prodrome of headache, mild hyperthermia or symptoms of a viral illness. Observed mortality rates range from 4–10%, and the recovery course is often protracted with substantial disability, but a full recovery can be achieved in 50% or more of patients with prompt and effective treatment. This study focuses on the frequency and chronological sequencing of signs and symptoms in adults with anti-NMDAr encephalitis who are likely to be evaluated first by a psychiatrist, with the aim of identifying patterns of clinical features that should prompt active consideration of this diagnosis early in the illness course.

Methods: PubMed and EMBASE databases were searched systematically to identify published reports of anti-NMDAr encephalitis that were associated with prominent behavioral or psychiatric symptoms. This search strategy was designed to identify any report in which the clinical presentation was likely to have resulted in a psychiatric evaluation, rather than those with more typical neurological presentations such as delirium. The search yielded 354 PubMed citations and 78 EMBASE citations, and additional reports were found by manually searching bibliographies of the computerized search results; 385 distinct citations remained after eliminating duplicates. The frequencies of clinical features in 7 major symptom domains were tabulated, and temporal ranks were assigned to these features based on their order of first appearance relative to one another in each patient. Median ranks were used to sequence the clinical symptom domains.

Results: A total of 230 unique cases (185 female) met inclusion criteria, which included age 19 years or older. The most frequent features were seizures (60.4%), disorientation/confusion (42.6%), orofacial dyskinesias (39.1%), mutism or staring (37.4%), dyskinesias involving other body parts (36.1%), and memory disturbance (34.8%). Auditory hallucinations were common but often atypical for psychiatric disorders. Median temporal ranks for symptom domains indicated the following temporal sequence: behavioral/psychiatric, fever, seizures, catatonic features, cognitive dysfunction, motor dysfunction (including dyskinesias), and autonomic dysfunction.

Discussion: Anti-NMDAr encephalitis is uncommon, but every psychiatrist is likely to encounter these patients in clinical practice. Prompt and effective treatment is associated with much better outcomes, so early recognition is crucial. The best strategy for recognizing this disorder is to have a high index of suspicion when an individual develops new psychiatric symptoms in the context of a recent viral prodrome (malaise, headache, loss of appetite), when accompanied by seizures or unexplained fever, or when the quality of the psychiatric symptoms is unusual (e.g., non-verbal auditory hallucinations). Orofacial dyskinesias are distinctive for this disorder, but this feature often emerges relatively late, so relying on its presence to make a diagnosis may lead to unnecessary treatment delays.

F63. INHIBITED TEMPERAMENT IS A TRANSDIAGNOSTIC FACTOR ACROSS SCHIZOPHRENIA, PSYCHOTIC BIPOLAR DISORDER, AND MAJOR DEPRESSIVE DISORDER

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Background: Diagnostic categories are a fundamental piece of psychiatric disorders; however, a patient’s symptoms and behaviors seldom fit under...
one diagnosis. Transdiagnostic approaches have been proposed with a goal of identifying mechanisms that share commonalities across diagnoses, instead of identifying differences. Transdiagnostic vulnerability factors are early-emerging patterns of behavior, thought, or emotions that confer risk for multiple different psychiatric disorders. One potential transdiagnostic vulnerability factor is childhood inhibited temperament, defined as the biologically-based predisposition to respond to novelty with wariness, fear, or caution. Substantial evidence demonstrates that early childhood temperament significantly increases the risk for developing anxiety and depressive disorders. Emerging data suggests that inhibited temperament may also be associated with schizophrenia, raising the possibility that inhibited temperament is transdiagnostic. The current study tested the hypothesis that inhibited temperament would be equally high in patients with schizophrenia, psychotic bipolar disorder, and major depressive disorder and would account for variability in anxiety, mood, cognition, and personality across disorders.

Methods: Participants were patients with schizophrenia (N = 184, 66.8% male), psychotic bipolar disorder (N = 62, 55.6% male), major depressive disorder (N = 53, 30.2% male) and healthy controls (N = 192, 59.1% male). Temperament was assessed by a validated self-report measure, the Retrospective Self Report of Inhibition. Patients completed clinical interviews, cognitive assessments, and self-report questions to assess clinical characteristics (anxiety, mood) personality (NEO five factors, schizotypal personality questionnaire), and cognition (premorbid, current). ANOVAs were used to test whether inhibited temperament was higher in patients relative to controls and whether inhibited temperament differed between disorders. Regression analyses were performed to test for associations between inhibited temperament and clinical characteristics, cognition, and personality and whether the associations differed between disorders.

Results: Inhibited temperament was higher in all three diagnostic groups compared to healthy controls (all p<0.001), with no between group differences between the patient groups (p=0.001). Inhibited temperament was significant associated with a set of clinical characteristics and personality traits similarly across all diagnostic groups. Specifically, inhibited temperament was positively correlated with anxiety, negative affect, schizotypal personality traits, and NEO neuroticism. Inhibited temperament was also negatively correlated with NEO extraversion, NEO conscientiousness, and quality of life (all p<0.01). However, while there were main effect of inhibited temperament and depression symptoms, NEO openness, and NEO agreeableness, the strength of the association differed across diagnoses. Inhibited temperament was not associated with cognitive function.

Discussion: The results of this study provide preliminary evidence for inhibited temperament as a transdiagnostic vulnerability. Early preventative interventions targeting inhibited temperament may reduce risk for the development of multiple different psychiatric disorders.

F65. AN INVESTIGATION OF TRANSDIAGNOSTIC PSYCHOSIS SUBGROUPS WITH PROGNOSTIC AND GENETIC VALIDATION

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Background: It is important to decompose the clinical heterogeneity of affective and non-affective psychoses into transdiagnostic subgroups that disentangle prognostic outcomes and inform aetiological understanding.

Methods: Participants were recruited from an Early Psychosis Program (n=245, ages 12–37, 72% male). Clinician ratings of symptoms (Brief Psychiatric Rating Scale; BPRS) and history of suicidal ideation, behavior and non-suicidal self-injurious behavior (NSSIB; Columbia-Suicide Severity Rating Scale) were obtained at baseline and 12 month follow up. A subset (n=78, ages 12–32, 62% male) completed self-report measures of emotion dysregulation (subset from Wender Utah Rating Scale) and impulsivity (Barrett Impulsiveness Scale). Regression analyses examined whether emotion dysregulation and impulsivity individually predicted suicidal behavior and ideation at baseline and follow up. Hierarchical cluster analyses of emotion dysregulation and impulsivity detected two distinct groups, and suicide variables were compared across groups.

Results: In the full sample (N = 245), 52% reported a history of suicidal ideation, 22% reported suicidal behavior and 18% reported NSSIB. In the subset, emotion dysregulation predicted history of suicidal ideation (R2 = .07, F (1,83) = 6.17, p = .02), behavior (R2 = .20, F (1,83) = 21.2, p < .01) and NSSIB (p = .05). When controlling for BPRS score, only the relationship with behavior remained significant. Attention impulsivity scores predicted suicidal ideation (R2 = .55, F (1,127) = 7.34, p = .01) and NSSIB (p = .04) but these were not significant when controlling for BPRS score. Motor and planning impulsivity scores were not related to suicidal ideation, behavior or NSSIB. Cluster analysis identified two groups: an emotionally dysregulated group with high impulsivity and inattention (N = 10), and a more regulated, less impulsive group (N = 68). The regulated group reported a history of higher ideation (R2 = .07, F (1,69) = 5.43, p = .03), suicidal behavior (R2 = .28, F (1,69) = 27.2, p < .01) and NSSIB (p = .04). Again, only the relationship with behavior remained significant controlling for BPRS score. In a preliminary outcome analysis, 122 individuals completed 12-month follow up, with 37% reporting ideation and 7% reporting suicidal behavior since baseline. History of depression, impulsivity, ideation and behavior did not predict 12-month ideation or behavior. Emotion dysregulation at baseline predicted suicidal behavior (R2 = .50, F (2,40) = 4.32, p < .01) but not ideation at 12 months.

Discussion: Emotion dysregulation and impulsivity clustered together and high scores on both indicated past suicidal behavior, ideation and NSSIB. However, only the relationship with behavior was significant when accounting for psychiatric symptoms. Emotion dysregulation was the best predictor of behavior over 12 months. This suggests emotion dysregulation is a potential target for suicide prevention in early psychosis. Future directions include examining sex differences and using more targeted measures of emotion dysregulation to further distinguish the roles of impulsivity and emotion dysregulation on suicidal behavior.

F64. EXPLORING THE ROLE OF EMOTION DYSREGULATION AND IMPULSIVITY ON SUICIDAL IDEATION AND BEHAVIOR WITHIN AN EARLY PSYCHOSIS POPULATION

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Background: Suicide is a leading cause of death for young people and a challenging clinical issue across diagnostic categories. Historically suicide research has focused on specific diagnostic groups, rather than transdiagnostic risk factors. This has hindered prevention efforts and early identification of those at risk. Emotion dysregulation and impulsivity represent two transdiagnostic risk factors for suicide. While these constructs are often investigated separately, we hypothesized that emotion dysregulation and impulsivity cluster together, and that this combination increases suicidal behavior and ideation. This hypothesis was examined in an early psychosis population, a group at increased risk for suicide, comprised of affective and non-affective diagnoses.

Methods: Participants were recruited from an Early Psychosis Program (n=245, ages 12–37, 72% male). Clinician ratings of symptoms (Brief Psychiatric Rating Scale; BPRS) and history of suicidal ideation, behavior and non-suicidal self-injurious behavior (NSSIB; Columbia-Suicide Severity Rating Scale) were obtained at baseline and 12 month follow up. A subset (n=78, ages 12–32, 62% male) completed self-report measures of emotion dysregulation (subset from Wender Utah Rating Scale) and impulsivity (Barrett Impulsiveness Scale). Regression analyses examined whether emotion dysregulation and impulsivity individually predicted suicidal behavior and ideation at baseline and follow up. Hierarchical cluster analyses of emotion dysregulation and impulsivity detected two distinct groups, and suicide variables were compared across groups.

Results: In the full sample (N = 245), 52% reported a history of suicidal ideation, 22% reported suicidal behavior and 18% reported NSSIB. In the subset, emotion dysregulation predicted history of suicidal ideation (R2 = .07, F (1,83) = 6.17, p = .02), behavior (R2 = .20, F (1,83) = 21.2, p < .01) and NSSIB (p = .05). When controlling for BPRS score, only the relationship with behavior remained significant. Attention impulsivity scores predicted suicidal ideation (R2 = .55, F (1,127) = 7.34, p = .01) and NSSIB (p = .04) but these were not significant when controlling for BPRS score. Motor and planning impulsivity scores were not related to suicidal ideation, behavior or NSSIB. Cluster analysis identified two groups: an emotionally dysregulated group with high impulsivity and inattention (N = 10), and a more regulated, less impulsive group (N = 68). The regulated group reported a history of higher ideation (R2 = .07, F (1,69) = 5.43, p = .03), suicidal behavior (R2 = .28, F (1,69) = 27.2, p < .01) and NSSIB (p = .04). Again, only the relationship with behavior remained significant controlling for BPRS score. In a preliminary outcome analysis, 122 individuals completed 12-month follow up, with 37% reporting ideation and 7% reporting suicidal behavior since baseline. History of depression, impulsivity, ideation and behavior did not predict 12-month ideation or behavior. Emotion dysregulation at baseline predicted suicidal behavior (R2 = .50, F (2,40) = 4.32, p < .01) but not ideation at 12 months.

Discussion: Emotion dysregulation and impulsivity clustered together and high scores on both indicated past suicidal behavior, ideation and NSSIB. However, only the relationship with behavior was significant when accounting for psychiatric symptoms. Emotion dysregulation was the best predictor of behavior over 12 months. This suggests emotion dysregulation is a potential target for suicide prevention in early psychosis. Future directions include examining sex differences and using more targeted measures of emotion dysregulation to further distinguish the roles of impulsivity and emotion dysregulation on suicidal behavior.