Conclusion: Our results underline the hypothesis that NSS are associated with chronicity of the disorder as indicated by the correlations between NSS and duration of illness and apathy, which is defined as a much broader concept than negative symptoms are. The correlations between NSS and SAPS/BPRS “thought disturbance” correspond to the fluctuation of positive symptoms during the course of the disorder. This interpretation is indirectly facilitated by the clinical observation of a decline of positive symptoms with aging.


M56. FAMILY HISTORY WITH SOMATIC DISEASES AS A RISK FACTOR FOR SEVERE MENTAL DISORDERS

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Background: People with severe mental disorders have in numerous studies been shown to have an excess somatic comorbidity compared to the general population. Furthermore, individuals with somatic diseases also have an increased comorbidity of mental disorders. A possible contributing factor could be shared genetic risk factors explaining part of the excess co-occurrence of somatic diseases and mental disorders. Previous studies have mainly investigated comorbidity in the individual, which makes it difficult to disentangle the genetic contribution vs the influence of medication and lifestyle factors. Consequently, we aimed to utilize the extensive nationwide Danish registers to study if a family history with somatic diseases increases the risk of severe mental disorders.

Methods: We utilized the extensive nationwide Danish registers to identify any somatic diseases in the parents. The outcome was diagnosis in the offspring with severe mental disorders (schizophrenia, bipolar disorder, and unipolar disorder). We compared the incidence of getting one of the severe mental disorders if there was a somatic disorder in the parents compared to those without parents with somatic diseases. The main outcome measures were incidence rate ratios (IRR) estimated with Poisson regression analysis. All analyses were adjusted for the age, calendar time, and gender.

Results: We found a higher risk for schizophrenia with an IRR of 1.28 (95% CI: 1.23–1.32) if a parent had a somatic disorder, compared to individuals whose parents did not have a somatic disease. It was slightly attenuated when we additionally adjusted for socioeconomic status in the parents (highest education), psychiatric disorder in the parents, and somatic disorders in the proband, IRR = 1.11 (95% CI: 1.07–1.15). The risk for unipolar depression was increased with an IRR of 1.23 (95% CI: 1.21–1.25), also with a slight attenuation in the fully adjusted model. The risk for bipolar disorder was only slightly increased with an IRR of 1.11 (95% CI: 1.06–1.17), with no significant effect after full adjustment.

Conclusion: Severe psychiatric disorders are very heritable disorders clearly demonstrated in twin studies, genetic studies, and large scale population based studies. The results presented in this study could suggest that there is also heritability between severe somatic diseases and severe psychiatric disorders. This could add to the explanation of the excess somatic comorbidity leading to early mortality found in persons with severe mental disorder.

M57. GASTROINTESTINAL DISEASE IMPACT ON ANTIPSYCHOTIC INDUCED WEIGHT GAIN IN SCHIZOPHRENIA: ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

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Background: Although atypical antipsychotics have been effective at treating psychotic symptoms, secondary effects including weight gain contribute to the development and exacerbation of chronic disease leading to poor outcomes and attenuated lifespan in schizophrenia. The aim of this study was to estimate the overall incidence of gastrointestinal disorders for people with schizophrenia actively participating in antipsychotic medication trials in order to determine the relationship between gastrointestinal disorders and antipsychotic induced weight gain.

Methods: Randomized, doubleblind, placebo and active comparator antipsychotic monotherapy trial data from the NIMH CATIE Schizophrenia Distribution 15 has been obtained for subsequent analyses as part of the Open Translational Science in Schizophrenia (OPTICS) project. The participants included in these initial analyses were individuals diagnosed with schizophrenia or schizoaffective disorder from the CATIE phase 1 trials with baseline and post treatment outcome measures available. The primary outcome measure for these analyses was change in weight after accounting for sociodemographic factors.

Results: Preliminary analyses suggest that 7.5% of the study participants spontaneously reported a gastrointestinal (GI) disorder before study randomization. Of those with a GI disorder, 70.9% reported experiencing gastro-oesophageal reflux disease (GERD), followed by 7.9% reporting history of irritable bowel syndrome (IBS). The overall incidence of GI disorder remained the same at the end of the Phase 1/1a. As previously reported, there was a significant increase in weight gain at the end of Phase 1, P = .014. Gastrointestinal disease did not independently contribute to antipsychotic induced weight gain, P = .891.

Conclusion: Further examination with additional schizophrenia case-control data sets will help determine whether there is increased prevalence of individual GI disorders in schizophrenia. Inclusion of additional antipsychotic medication trials are necessary to replicate and determine the generalizability of these findings. Future studies that include systematic assessment of gastrointestinal diseases and medical records that corroborate incidence of gastrointestinal disorders, will also be needed to confirm these preliminary findings.

M58. SEDENTARY BEHAVIOR PROFILES AND OBESITY AMONG PEOPLE WITH SCHIZOPHRENIA

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Background: Sedentary behavior has been identified as a risk factor for cardiovascular disease and mortality independent of physical activity; the purpose of this study was to profile sedentary behavior in a sample of people with schizophrenia and identify relationships between patterns of sedentary behavior and measures of adiposity.

Methods: Participant waist circumference (WC) and body mass index (BMI) were measured at intake. Participants subsequently wore accelerometers for 7 days. Valid wear time was considered to be 10 hours or more on at least 4 days. Sedentary behavior was considered any period with less than 100 counts per minute, for at least 1 minute. A profile of sedentary behavior was assessed to identify volume of sedentary time, the daily average

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