

increased risk of PE. However, in a multivariate analysis only verbal bullying was independently associated with an increased risk of psychotic experiences (OR: 1.56, CI: 1.27–1.93; adjusted for bullying at 13: OR: 1.47, CI: 1.19–1.82). There was a linear relationship between the number of different methods of bullying experienced at 9 and the risk of PEs at 13 (continuous OR: 1.24, CI: 1.14–1.34). Of the reasons for bullying given by the PCG, only ethnicity (OR: 2.36, CI: 1.46–3.80), being a teacher's pet (OR: 2.09, CI: 1.17–3.73) and jealously (OR: 2.28, CI: 1.5–3.39) were significantly associated with PEs. Persistent bullying was associated with a higher risk of PEs relative to their peers (never bullied OR: 2.31, CI: 1.73–3.08; and bullied at one-time point: OR: 1.49, CI: 1.10–2.03).

Based on the child's account, the vast majority of those who report being a bully (13.87%) at age 9 were also bullied (76.48%, OR: 7.04, 5.97–8.31). Both being a bully and being bullied at age 9 were associated with an increased risk of PEs (16.91%, OR: 1.34, CI: 1.09–1.64; and 50.48% OR: 1.71, CI: 1.48–1.98, respectively). In a multivariate analysis only being bullied was independently associated with PEs (OR: 1.68, CI: 1.44–1.96; adjusted for bullying at 13: OR: 1.57, CI: 1.34–1.83). Verbally bullying another was the only method of bullying associated with an increased risk of PEs at 13 (OR: 1.59, CI: 1.06–2.39). Of those reporting being bullied, verbal and written bullying at age 9 were associated with an increased risk of PEs at age 13 (OR: 1.25, CI: 0.97–1.6; and OR: 1.44, CI: 1.05–1.97, respectively). In a multivariate analysis only written bullying was associated with an increased risk of PEs (OR: 1.47, CI: 1.05–2.06; adjusted for bullying at 13: OR: 1.41, CI: 1.01–1.99). The impact of the bullying on well-being was also associated with an increased risk of PEs at 13 (OR: 1.36, CI: 1.09–1.72; adjusted for bullying at 13: OR: 1.30, CI: 1.04–1.63). Persistent bullying was associated with a vastly higher risk of PEs relative to their peers (never bullied: OR: 4.42, CI: 3.44–5.69; and bullied at one time point OR: 2.71, CI: 2.10–3.50).

Discussion: Bullying is pervasive in the childhood of those who subsequent report PE. Bullying at age 9, particularly verbal and written bullying methods are risk factors for PEs in adolescence even when controlling for adolescent bullying. Persistent bullying was associated with a vastly higher risk of PEs. Reducing the rates of bullying in childhood may moderate the likelihood of PEs in adolescents.

O12.3. PROTECTIVE FACTORS FOR PSYCHOTIC EXPERIENCES AMONGST ADOLESCENTS EXPOSED TO MULTIPLE FORMS OF VICTIMIZATION

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Background: Experiencing multiple types of victimization (poly-victimization) during adolescence is associated with onset of psychotic experiences. However, many poly-victimized adolescents will not develop such subclinical phenomena and the factors that protect them are unknown. This study investigated whether individual, family, or community-level characteristics were associated with an absence of psychotic experiences amongst poly-victimized adolescents.

Methods: Participants were from the Environmental Risk (E-Risk) Longitudinal Twin Study, a nationally-representative cohort of 2232 UK-born twins. Exposure to seven different types of victimization between ages 12–18 was ascertained using a modified Juvenile Victimization Questionnaire at age 18. Adolescents were also interviewed about psychotic experiences at age 18. Protective factors were measured at ages 12 and 18.

Results: Exposure to poly-victimization during adolescence was associated with age-18 psychotic experiences (OR=4.62, 95% CI 3.59–5.94, P<0.001), but more than a third of the poly-victimized adolescents reported having no psychotic experiences (40.1%). Greater social support was found to be protective against adolescent psychotic experiences amongst those exposed to

poly-victimization. Notably, social support was also generally associated with a reduced likelihood of age-18 psychotic experiences in the whole sample (along with engaging in physical activity and greater neighborhood social cohesion).

Discussion: Increasing social support from friends and family appears to be an important area for preventive interventions targeting adolescent psychotic experiences. Such prevention efforts would be most effectively targeted at poly-victimized adolescents who are at high-risk of developing psychotic phenomena.

O12.4. SOME OF THE INDIVIDUAL DIFFERENCES IN RISK TO DEVELOP PSYCHOSIS AMONG CANNABIS USERS CAN BE EXPLAINED BY WHERE THEY LIVE AND BY THEIR AGE AT FIRST USE

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Background: Cannabis use remains the most widely used recreational drug worldwide. Following from several USA states legalisation policies, European countries are reconsidering their cannabis laws. While a significant amount of Epidemiological evidence has reported that cannabis use increases the risk of psychosis it is still unclear: 1) what underpins individual differences in developing a psychotic disorder following cannabis use; 2) if variations in availability of cannabis have affected rate of Psychotic disorders across Europe.

Methods: Using detailed data on lifetime pattern of cannabis use from the EUGEI first episode case-control study (N=2300) and the available Incidence rates of Psychosis calculated for each European site of the same study, we aim 1) to estimate if differences in age at first use, especially of high potency cannabis among cannabis users resulted in differences in their probability to develop psychosis across the study sites; 2) to calculate the proportion of new cases of psychosis attributable to early adolescence-high Potency cannabis in the 5 countries; 3) to relate data on prevalence of cannabis use in each study site with the corresponding Incidence rates for psychotic disorders.

Results: Cannabis users starting using cannabis at age 15 and younger who live in those EU countries where high potency cannabis is available have the highest probability to develop psychosis, compared to never users (Adj ORs from 2.6–5.9; p<0.01). Moreover, the proportion of new cases of Psychosis attributable to heavy use started in adolescence was between 20% and 37%. Finally, the correlation between lifetime use of cannabis in population controls from the study sites was significantly correlated with the corresponding incidence rates for Psychosis (r=0.6; p<0.001)

Discussion: Before Europe rushes into the USA legalisation “moda” more public education effort might need to be invested in reducing the use of high potency type of cannabis among young adolescents. The latter could lead to a significant reduction in the proportion of new cases of psychosis across Europe.

O12.5. GENETIC AND ENVIRONMENTAL PREDICTORS OF MAIN OUTCOMES IN THE DANISH HIGH RISK AND RESILIENCE STUDY - VIA 7. A STUDY OF 522 7-YEAR-OLD CHILDREN OF PARENTS WITH SCHIZOPHRENIA, BIPOLAR DISORDER OR NEITHER OF THESE DISORDERS

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