between suicidal ideation and psychotic experiences was mediated by depression as well (b= .3794, 95% BCa CI [.3431, .4150]). When the mediators were not included in the model, SI significantly predicted PE (b = 2.57, t = 26.45, p < 0.001). Both models exhibit robust and significant partial mediations.
Discussion: Our results indicate that depressive symptoms partially mediate the association between SI and PE. Moreover, either PE or SI could be outcome variables when depressive symptoms are mediators. This adds new evidence supporting that PE could consequential to SI as stated by the "suicidal drive hypothesis for psychosis". Our exploratory findings must be carefully interpreted, mainly because of our cross-sectional design, and the fact that there could be unmeasured or non-controlled psychopathological confounder variables in our models.

M29. SPECIFIC SYMPTOMS IN ADOLESCENCE PREDICT PSYCHOSIS IN THE NORTHERN FINLAND BIRTH COHORT 1986

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Background: A number of psychological symptoms have been found to predict psychosis. Many studies have found no specificity to separate symptoms predicting non-psychotic psychiatric disorders from those predicting psychotic disorders. Prodromal symptoms are non-specific problems often preceding frank psychosis. Previously prodromal symptoms have been studied mainly retrospectively or in high-risk clinical populations. We were able to conduct prospective study comparing adolescent symptoms predicting non-psychotic psychiatric disorders and psychotic psychiatric disorders.
Methods: Members of the Northern Finland Birth Cohort 1986 were asked to fill in PROD-screen questionnaire at age 15–16 years. PROD-screen includes 21 items both measuring positive prodromal symptoms, negative prodromal symptoms and general symptoms.
We were able to follow 5,368 participants using Finnish Hospital Discharge Register detecting new hospital treated mental disorders till 30 years.
Results: Subjects who developed psychosis had significantly more commonly positive and negative symptoms than subjects without psychiatric disorder or subjects who developed non-psychotic disorder.
When comparing separate symptoms in those having psychiatric hospital treatments, we found three positive symptoms and three negative symptoms predicting specifically psychotic disorders.
After adjusting for confounders, the symptoms predicting psychosis were: Difficulty in controlling one's speech, behavior or facial expression while communicating, Difficulties in understanding written text or speech heard, Feelings, thoughts or behaviors that could be considered weird or peculiar. Three of the negative symptoms also predicted psychosis: Difficulty or uncertainty in making contact with other people, Lack of initiative or difficulty in completing tasks, Difficulties in carrying out ordinary routine activities (at least one week).
Discussion: In this large prospective population sample both positive and negative symptoms in adolescence associated specifically with development of first episode psychosis compared to hospital treated non-psychotic disorders. This finding is in line with the other prospective general population follow-up studies. The main contribution of our study to the literature is that we had the possibility to compare the subjects who developed clinically real hospital-treated psychosis not only to healthy comparison subjects but also to subjects who developed non-psychotic psychiatric disorder.

M30. THE ASSOCIATION OF PEER-REPORTED BULLYING AND SOCIAL NETWORK CHARACTERISTICS WITH PSYCHOTIC EXPERIENCES IN CHILDHOOD

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Background: Psychotic experiences (PEs) are common in childhood and predictive of poor mental health outcomes, including psychosis, depression, and suicidal behavior. Prior studies indicate that bullying involvement and peer relationship difficulties may be linked to increased risk of PEs. However, most studies relied on self-report measures, while an approach including peer-report measures provides a more valid and comprehensive assessment of bullying and social relationships. This study aimed (1) to examine the prospective association of bullying perpetration and victimization with PEs in childhood, using a peer-nomination method complemented by ratings from mothers and teachers; (2) to investigate the prospective association between children's social positions within classroom peer networks and PEs in childhood.
Methods: This study was embedded in the population-based Generation R Study, a birth cohort from Rotterdam, the Netherlands. Peer-reported bullying as well as peer rejection, peer acceptance, and prosocial behavior were obtained using dyadic peer nominations in classrooms, victimization was reported by the child itself (n=925, age=7.5). Bullying involvement was additionally assessed by teacher-reported questionnaire (n=1565, age=7.2) and mother-reported questionnaire (n=3276, age=8.1). Using network analysis, we constructed classroom peer networks for peer rejection, peer acceptance, and prosocial behavior and estimated children's social positions within each network (i.e., degree centrality, closeness centrality and reciprocity). PEs were assessed at age 10 years with a self-report questionnaire. All analyses were adjusted for relevant potential confounders, including age, sex, ethnicity, and maternal education.
Results: After adjusting for sociodemographic covariates, higher bullying perpetration and higher victimization scores at 7–8 years were associated with increased risk of PEs at age 10 years for peer/self-report, teacher report, and mother report (bullying perpetration – peer report: OR=1.22, 95% CI 1.05–1.43, p=0.010, teacher report: OR=1.08, 95% CI 0.97–1.14, p=0.15, and mother report: OR=1.11, 95% CI 1.03–1.19, p=0.005; victimization – self report: OR=1.16, 95% CI 1.01–1.34, p=0.036, teacher report: OR=1.13, 95% CI 1.02–1.25, p=0.023, and mother report: OR=1.18, 95% CI 1.10–1.27, p<0.001). Unfavorable positions within the peer rejection network were associated with increased risk of PEs (OR degree centrality=1.25, 95% CI 1.07–1.45, p FDR-corrected =0.036). After correction for multiple testing, there were no significant associations between social positions and PEs within the peer acceptance and the prosocial behavior networks.
Discussion: This is the first study to demonstrate that peer-reported bullying and peer rejection are associated with increased risk of PEs in childhood. Our findings extend current knowledge of self-perceptions in the context of psychosis vulnerability by offering unique insight into peer perceptions of bullying and social relationships. The consistent findings across child, mother, and teacher ratings provide important support for the role of bullying victimization and perpetration in the development of PEs. In addition, our findings showed that children with negative peer perceptions, i.e., children who are rejected by their peers, were at increased risk of PEs. School-based interventions aimed at preventing and eliminating bullying and social exclusion may help to prevent the development of PEs, and, hence, prevent the onset of severe mental health outcomes.