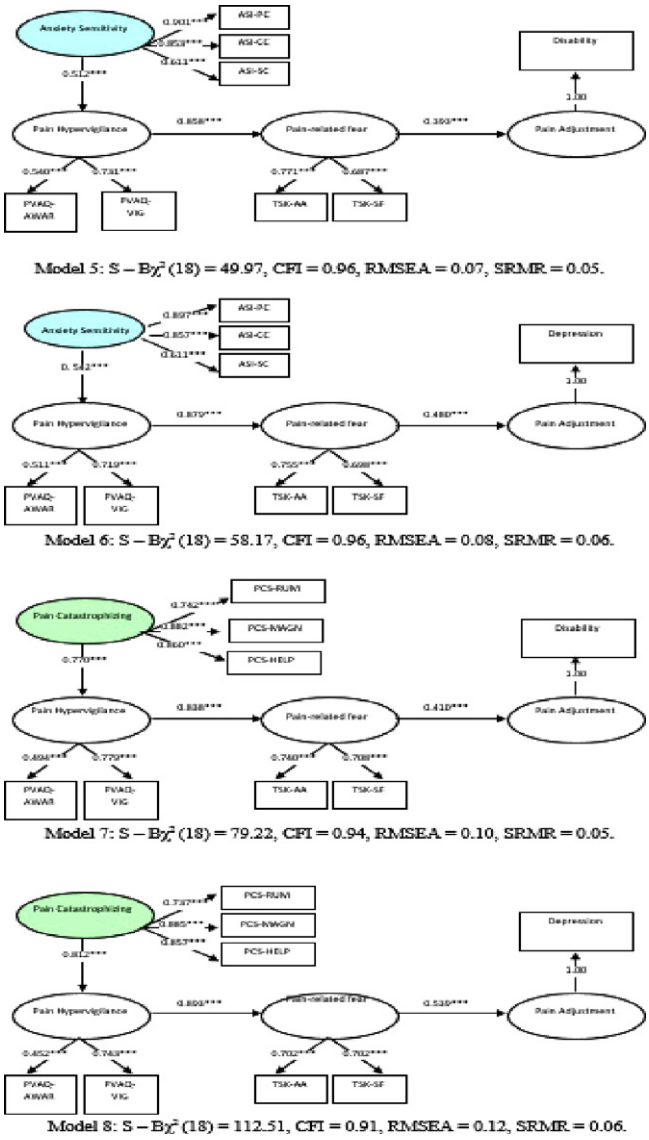

Fig. 1 Simple models testing the mediating role of pain hypervigilance in the link between anxiety sensitivity and pain-related fear (Models 7 and 8) predicting disability and depression. Anxiety Sensitivity was indexed by the Anxiety Sensitivity Index (ASI). PC: ASI Physiological Concerns subscale; CC: ASI Physiological Concerns subscale; SC: ASI Social Concerns subscale. Pain catastrophizing was indexed by the Pain Catastrophizing scale (PCS). RUM: PCS Rumination subscale; MAGN: PCS Magnification subscale; HELP: PCS Helplessness subscale. Pain hypervigilance was indexed by the Pain Vigilance and Awareness Questionnaire (PVAQ). AWAR: PVAQ Passive Awareness subscale; VIG: PVAQ Active Vigilance subscale. Pain-related fear was indexed by the Tampa Scale for Kinesiophobia (TSK). AA: TSK Activity Avoidance subscale; SF: TSK Somatic Focus. Disability was indexed by the Chronic Pain Grade Disability score. Depression was indexed by the Depression subscale of the Hospital Anxiety and Depression scale. S–$B_X{}^2$: Satorra and Bentler scaled Chi^2 statistic; CFI: comparative fit index; RMSEA: root mean square error of approximation; SRMR: standardized root mean square residual. $^{***}P < 0.001$.

Table 1 Multivariate regression analyses of the relationships between pain hypervigilance, anxiety sensitivity, pain-related fear.

Model	β	SE	95% CI	P value
Model 1ª: Anxiety sensitivity → Pain hypervigilance → Pain-related fear				
Anxiety sensitivity (Predictor) → Pain hypervigilance (Mediator)	0.25	0.04	0.17, 0.34	<0.001
Pain hypervigilance (Mediator) → Pain-related fear (Outcome)	0.19	0.02	0.15, 0.23	<0.001
Anxiety sensitivity (Predictor) → Pain-related fear (Outcome)	0.15	0.02	0.12, 0.18	<0.001
Anxiety sensitivity (Predictor) → Pain-related fear (Outcome) | Pain hypervigilance (Mediator)ᵇ	0.11	0.02	0.08, 0.14	<0.001
Sobel test	$Z = 4.86$		$P < 0.001$	
Model 2ª: (Anxiety sensitivity × Pain hypervigilance) → Pain-related fear				
Anxiety sensitivity (Predictor)	0.12	0.02	0.09, 0.15	<0.001
Pain hypervigilance (Moderator)	0.15	0.02	0.11, 0.18	<0.001
Anxiety sensitivity (Predictor) × Pain hypervigilance (Moderator)	-0.00	0.00	-0.00, 0.00	0.186
Model 3ª: Pain catastrophizing → Pain hypervigilance → Pain-related fear				
Pain catastrophizing (Predictor) → Pain hypervigilance (Mediator)	0.47	0.05	0.38, 0.57	<0.001
Pain hypervigilance (Mediator) → Pain-related fear (Outcome)	0.18	0.02	0.15, 0.22	<0.001
Pain catastrophizing (Predictor) → Pain-related fear (Outcome)	0.21	0.02	0.17, 0.24	<0.001
Pain catastrophizing (Predictor) → Pain-related fear (Outcome) | Pain hypervigilance (Mediator)ᵇ	0.15	0.02	0.11, 0.19	<0.001
Sobel test	$Z = 5.08$		$P < 0.001$	
Model 4ª: (Pain catstrophizing × Pain hypervigilance) → Pain-related fear				
Pain catastrophizing (Predictor)	0.15	0.02	0.11, 0.19	<0.001
Pain hypervigilance (Moderator)	0.11	0.02	0.07, 0.15	<0.001
Pain catastrophizing (Predictor) × Pain hypervigilance (Moderator)	-0.00	0.00	-0.01, 0.00	0.068

Note. β: Unstandardized beta coefficient; SE: standard error; CI: confidence interval; NS: non-significant P value at 0.05 level. All regression equations were controlled for age, sex, number of pain site, and pain duration. The total scores of the measurement scale of anxiety sensitivity, pain hypervigilance and pain-related fear were used in all regression models.
ªFour separate regression models were generated to test the mediation pathway of pain hypervigilance on the link between anxiety sensitivity and pain-related fear (Model 1) and the link between pain catastrophizing and pain-related fear (Model 3).
ᵇPain hypervigilance, as mediator, was controlled in the regression equation.
ᶜUsing pain-related fear as dependent variable, one regression model was generated to test the moderation pathway of pain hypervigilance on the link between anxiety sensitivity and pain-related fear (Model 2) and the link between pain catastrophizing and pain-related fear (Model 4).

Table 2 Results of SEM testing the relationships between anxiety sensitivity, pain catastrophizing, and pain hypervigilance for two pain adjustment outcomes.

Model	S–$B\chi^2$	*df*	CFI	NNFI	RMSEA	90% CI	SRMR
Simple model: Anxiety sensitivity → Pain hypervigilance → Pain-related fear → Adjustment outcome							
Model 5: Disability	49.97	18	0.96	0.94	0.07	0.05, 0.10	0.05
Model 6: Depression	58.17	18	0.96	0.93	0.08	0.06, 0.10	0.06
Simple model: Pain catastrophizing → Pain hypervigilance → Pain-related fear → Adjustment outcome							
Model 7: Disability	79.22	18	0.94	0.91	0.10	0.08, 0.12	0.05
Model 8: Depression	112.51	18	0.91	0.96	0.12	0.10, 0.15	0.06
Full model							
Model 9: Disability	122.24	40	0.95	0.93	0.08	0.06, 0.09	0.05
Model 10: Depression	154.49	40	0.93	0.91	0.09	0.08, 0.11	0.06

Note: The full models include both anxiety sensitivity and pain catastrophizing, and specify that pain hypervigilance mediates the link of both anxiety sensitivity and catastrophizing with pain-related fear, which in turn predicts adjustment outcomes. Disability was indexed by the Chronic Pain Grade Disability score; Depression was indexed by the Depression subscale of the Hospital Anxiety and Depression Scale; S–$B\chi^2$ = Satorra & Bentler scaled chi-square statistics; *df* = degrees of freedom; CFI = comparative fit index; NNFI = non-normed fit index; RMSEA = root mean square error of approximation; CI = confidence interval; SRMR = standardized root mean square residual.

Disclosure of interest The authors have not supplied their declaration of competing interest.

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Personality and personality disorders

FC50

Prevalence, mortality and healthcare utilization of cluster B personality disorders in Quebec: A province cohort study, 2001–2012

L. Cailhol[1,*], E. Pelletier[2], L. Rochette[3], E. Villeneuve[4], L. Laporte[5], P. David[6], A. Lesage[7]
[1] *Montreal, Canada*
[2] *INSPQ, Surveillance des troubles mentaux, Quebec, Canada*
[3] *INSPQ, Statistique, Quebec, Canada*
[4] *CIUSS-Capitale-Nationale Institut universitaire en santé mentale de Québec, Département de psychiatrie, Quebec, Canada*
[5] *Université McGill, CUSM, Montreal, Canada*
[6] *IUSMM, PTRP, Montreal, Canada*
[7] *IUSMM, Psychiatrie, Montreal, Canada*
* *Corresponding author.*

Background Cluster B personality disorder (PD) is a highly prevalent mental health condition in general population (1 to 6% depending on the subtype and study). Patients affected are known to be heavier users of both mental and medical healthcare than other clinical conditions such as depression. Few studies have highlighted their elevated mortality rate compared to general population.

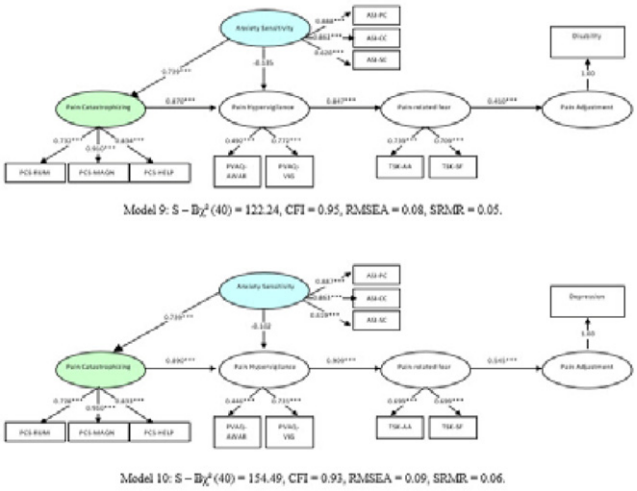

Fig. 2 Full models testing pain hypervigilance as a mediator in the link of both anxiety sensitivity and pain catastrophizing with pain-related fear which predicts disability (Model 9) and depression. Anxiety Sensitivity was indexed by the Anxiety Sensitivity Index (ASI). PC: ASI Physiological Concerns subscale; CC: ASI Physiological Concerns subscale; SC: ASI Social Concerns subscale. Pain catastrophizing was indexed by the Pain Catastrophizing scale (PCS). RUM: PCS Rumination subscale; MAGN: PCS Magnification subscale; HELP: PCS Helplessness subscale. Pain hypervigilance was indexed by the Pain Vigilance and Awareness Questionnaire (PVAQ). AWAR: PVAQ Passive Awareness subscale; VIG: PVAQ Active Vigilance subscale. Pain-related fear was indexed by the Tampa Scale for Kinesiophobia (TSK). AA: TSK Activity Avoidance subscale; SF: TSK Somatic Focus. Disability was indexed by the Chronic Pain Grade Disability score. Depression was indexed by the Depression subscale of the Hospital Anxiety and Depression scale. S–B$_X^2$: Satorra and Bentler scaled Chi^2 statistic; CFI: comparative fit index; RMSEA: root mean square error of approximation; SRMR: standardized root mean square residual. $^{***}P < 0.001$.

Methods The estimates were produced using data from the integrated monitoring system for chronic disease of Quebec. It provides annual and life prevalence, mortality rate, years of and healthcare utilization profile Quebec inhabitants.
Results A total of 7,995,963 people were included in the study. The life prevalence of cluster B PD is 2.6%. The mean years of lost life is 13 for men and 9 for women when they are compared to general population. The 3 most important causes of death are: suicide (20.4%), cardiovascular diseases (19.1%) and cancers (18.6%). The standardized mortality ratio (SMR) for each medical condition is superior in cluster B personality disorders than general population. The most important SMR is for suicide (male: 10.2 and female: 21). In the year 2011–2012, 78% had consulted a general practitioner, 62% a psychiatrist, 41% were admitted in an emergency department and 21% were hospitalized.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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FC51

Correlation between attachment and personality dimensions and their association to the catechol-O-methyltransferase Val158Met polimorphism

L. Erkoreka [1,*], M.I. Macías [2], A. Arrue [2], N. Basterreche [2], A. Arnaiz [2], E. Gordo [2], O. Olivas [3], B. Santos [4], M.I. Zamalloa [2], M. Zumárraga [2], M.A. González-Torres [5]
[1] *Mental Health Network of Biscay, Centro Salud Mental Barakaldo, Barakaldo, Spain*
[2] *Mental Health Network of Biscay, Hospital de Zamudio, Zamudio, Spain*
[3] *Mental Health Network of Biscay, Centro Salud Mental Gernika, Gernika, Spain*
[4] *Universidad del País Vasco, Neurociencias, Leioa, Spain*
[5] *Hospital Universitario de Basurto, Servicio de Psiquiatría, Bilbao, Spain*
[*] *Corresponding author.*

Introduction Both attachment style and personality traits are closely related to individual's interpersonal patterns. Association between these constructs has been widely studied, but variability in results makes it difficult to reach definite conclusions. Similarly, dopaminergic pathways are considered to underlie some personality traits and to be related to attachment styles, but evidence, hitherto, remain inconclusive.
Aims To assess the correlation between personality and attachment dimensions and to study whether a common association to the catechol-O-methyltransferase (COMT) Val158Met polymorphism exists.
Methods One hundred and three Caucasian controls (mean age 39.6 ± 6.4; 65% women) were recruited in the province of Biscay, Spain. DAPP-BQ and ECR-Spanish scales were administered to assess personality and attachment dimensions respectively. DNA was obtained from saliva and the COMT Val158Met polymorphism was determined. Pearson's correlation coefficient and ANOVA were calculated using R statistical software.
Results High positive correlation is observed between inhibition personality dimension and attachment avoidance ($r = 0.75$). Besides, both inhibition and avoidance dimensions' scores are significantly higher in the COMT ValMet genotype than in the other genotypes. MetMet: 63.1 ± 13.6; ValMet: 71.0 ± 13.9; ValVal: 63.0 ± 16.7 (ANOVA $F = 3.75$, $P = 0.027$) for inhibition and MetMet: 3.44 ± 0.17; ValMet: 3.82 ± 0.2; ValVal: 3.33 ± 0.23 (ANOVA $F = 3.83$, $P = 0.025$) for avoidance.
Conclusions Attachment patterns are rooted in early interactions with parental figures, and according to our results they could be linked to self-perceived personality traits in adulthood. Our study also suggests that genetics may predispose individuals to certain interaction styles. Our findings, linking ValMet individuals to avoidant attachment, are similar to Luijk's (2011) results, and would support a genetic-environmental model of both attachment and personality.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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