

attending to the Early Intervention Program of the Institut Pere Mata, in Reus. At study entry participants underwent to a comprehensive clinical, biometric and cognitive assessment by standardized neurocognitive battery (MATRICS Consensus Cognitive Battery; MCCB). T scores were converted to standard equivalents (z-scores) based on data from a healthy control group from the same geographical area.

Overweight was defined as BMI ≥ 25 according to WHO standards. Two-way ANCOVAs were performed to determine the interaction effect between overweight and sex on the cognitive tests. Ethical approval was obtained by the Committee for Ethical Clinical and Pharmacological Investigation of the Pere Virgili Research Institute. **Results:** At study entry 85% of participants were on antipsychotics for less than 6 months with a median dose of 300 (200-450) chlorpromazine equivalents (CPMZ) in mg/day. 37.7 % of participants were overweight without differences between men (41.5%) and women (30.2%) ($X^2 = 1.47$; $p = 0.22$). There were no clinical and treatment differences between overweight and normal weight participants. With regards sex differences, females presented statistically significant higher scores in Calgary depression scale and lower doses of antipsychotics. No differences were found in cognitive performance regarding weight status but we found a significant interaction between sex and overweight in verbal learning memory ($F = 6.09$; $p = 0.01$). When controlled for depressive symptoms and CPZM equivalents differences continued to be significant. Overweight females performed worse -1.09 (SD 1.18) than normal weight females -0.23 (SD 1.10); ($t = 2.57$; $p = 0.02$) in verbal learning memory whereas that difference was not found among overweight and normal weight males ($t = -1.10$; $p = 0.27$).

Conclusions: Our results provide evidence for sex-differences on cognitive function depending on weight status. Advances in the study of sex differences in FEP would help to target specific treatment strategies

Disclosure of Interest: None Declared

EPP0767

An influence of family history and season of birth on clinical characteristics of schizophrenia

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Introduction: A large body of evidence shows that both genetic and environmental factors play an important role in the etiology of schizophrenia. There is also growing evidence of an interaction between these factors.

Objectives: To investigate the influence of family history of schizophrenia, which reflects the contribution of genetic factors, and birth in the winter months, considered as an important environmental risk factor for this disease, on the clinical characteristics of schizophrenia.

Methods: The results of a clinical examination of 1590 inpatients with schizophrenia (F20.0 ICD-10) were analyzed. The analysis included clinical characteristics of the disease (age of onset of the disease, severity of symptoms, which were assessed by PANSS),

information about the family history of schizophrenia, and the season of birth (SOB) of the patient. Data analysis was carried out using multivariate analysis of variance, in which clinical characteristics were used as a dependent variable, and the presence/absence of schizophrenia in first-degree relatives of the patient, patient's birth in the winter months/birth in other months of the year, sex were independent factors.

Results: The study group included 1153 women and 437 men. Family history was present in 569 patients (427 women) and absent in 1021 (726 women). In 415 (26.1%) cases, patients born in the winter months. In the group without family history, the percentage of births in the winter months did not differ from that in the group with family history. There was an effect of sex on the age of onset of the disease as well as on the severity of positive symptoms, which were higher in women ($p = 0.0000$). Family history of schizophrenia had a significant, sex-independent effect on the age of onset. The disease manifested at an earlier age in patients with family history. Being born in the winter months was not associated with either age of onset or positive symptoms. There were significant main effects of family history ($p = 0.018$) and birth in the winter months ($p = 0.044$) on negative and general psychopathological symptoms, which were not mediated by sex. The additive effect of these factors was found at the trend level ($p = 0.08$), while the greatest severity of negative symptoms was observed in the group with a family history and birth in the winter months ($p = 0.02$). A significant additive effect ($p = 0.012$) of family history and birth in the winter months on general psychopathological symptoms was found. As in the case of negative symptoms, the greatest severity was noted in the presence of both factors.

Conclusions: Family history and birth in the winter months are not only risk factors for the development of schizophrenia, but also affect the severity of the disease. The results indicate the feasibility of further molecular genetic studies on this sample, both using candidate gene analysis and genome-wide analysis with polygenic risk assessment.

Disclosure of Interest: None Declared

EPP0768

The assessment of self-stigmatization of patients with schizophrenia and complex approach to reduce it

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Introduction: The negative consequences of the stigmatization of mental illness significantly impair health care system, society, patients and their families. It has been established, that more than 40% of patients with schizophrenia suffer from self-stigmatization (E. Brohan et al., 2010), what determines the relevance of research aimed at its reduction.

Objectives: To assess the level, components of self-stigmatization and associated with it factors in patients with schizophrenia, receiving psychosocial treatment in the community; to propose and implement a complex of interventions for destigmatization.

Methods: The battery of instruments was used: Self-stigmatization questionnaire (V.S. Yastrebov, I.I. Mikhailova et al., 2005), revealing the patient's tendency to explain their problems in the main areas of psychosocial functioning as manifestations of the disease or the prejudice against them; Emotional intelligence questionnaire (D.V. Lyusin, 2006); Quality of life questionnaire (J.E. Ware et al., 1995); Montreal Cognitive Assessment (Z.S. Nasreddine, 1996). 40 patients with schizophrenia (ICD-10 F.20), receiving psychosocial treatment in a non-profit organization in community, were examined.

Results: The overall level of self-stigmatization in the studied patients constituted 42.8% or an average level of self-stigmatization. Using Self-stigmatization questionnaire, nine components of self-stigmatization were revealed. The most pronounced indicators were in following components: "Reassessment of self-realization", "Readiness to distance from the mentally ill in the social sphere", "Reassessment of internal activity" (56.2%, 56.5%, 55.1% correspondingly). By the forms of self-stigmatization demonstrated that patients with autopsychic form (the justification of their failure by the disease) constituted the largest proportion or 41%. The compensatory form (denial of one's incompetence with its exaggeration in other mentally ill people) and socio-reversive form (explaining incompetence by the prejudice against them) had similar rates in 29% and 30% of patients, correspondingly. Inverse strong correlations with some of scales of the Emotional intelligence questionnaire, Cognitive scale and the Quality of life questionnaire were established. Destigmatization training for patients with schizophrenia based on cognitive behavioral psychotherapy was worked out. A set of destigmatization interventions was proposed and implemented.

Conclusions: A complex of different interventions taking into account the form of self-stigmatization and its main components, should be used. These interventions have to include psychoeducation, cognitive trainings, self-esteem trainings and special destigmatization trainings.

Keywords: schizophrenia, self-stigmatization, destigmatization trainings

Disclosure of Interest: None Declared

EPP0769

Cognitive and emotional-volitional disorders in patients with residual schizophrenia

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Introduction: Studies show that patients diagnosed with residual schizophrenia are characterized by cognitive and emotional-volitional disorders that increase with age. They can be the main barrier to treatment, psychosocial rehabilitation, and cause disability.

Objectives: To identify cognitive and emotional-volitional disorders in patients with residual schizophrenia.

Methods: The BACS and the abbreviated MMPI test were used; 20 patients with residual schizophrenia (ICD-10 F.20.5xx) receiving outpatient treatment (mean age 59.65 ± 14.24 years) were examined. Exclusion criterion: scores more 4 on at least one parameter of positive symptoms according to the PANSS.

Results: Patients with residual schizophrenia show an overall decline in cognitive function (BACS composite score =

31.56 ± 14.24) compared with healthy individuals, as well as compared with patients suffering from other forms of schizophrenia spectrum disorders. The greatest deficiency was revealed in the speed of information processing (subtests "Symbol Coding" = 28.01 ± 10.06 ; "Verbal Fluency" = 37.56 ± 11.57) and auditory-speech memory (subtest "Verbal Memory" = 33.25 ± 6.02). These parameters showed significant associations ($r=0.56$ at $p \leq 0.01$) with the disability of such patients. However, this deficit could be compensated by the relative preservation of planning processes and executive functioning (subtest "Tower of London" = 14.91 ± 4.57). Among the emotional and volitional disorders, the most important is the subjective feeling of low mood and paranoid tendencies (MMPI scales "Dp" = 56.38 ± 10.74 T, "Pa" = 59.06 ± 14.49 T), which can reduce the compliance of patients with residual schizophrenia.

Conclusions: Methods for leveling cognitive and emotional-volitional disorders should be included in programs of psychosocial rehabilitation of patients with residual schizophrenia.

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EPP0770

Posttraumatic growth in psychosis: Symptoms, meaning, and coping

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Introduction: Research suggested that psychosis and mental illness-related experiences can be extremely traumatic, and that psychosis could theoretically also lead to posttraumatic growth (Mazor et al., 2019; PTG). The promotion of PTG may contribute to the treatment of people who experienced massive traumas such as people with severe mental illness (SMI). Psychotic symptoms are a common feature of SMI, and individuals who have experienced psychosis are also more likely to have been exposed to trauma and are more vulnerable to developing posttraumatic symptomatology (Ng et al., 2021). Negative symptoms such as amotivation could also contribute to the traumatic experiencing of psychosis (Mazor et al., 2016). Amotivation is specifically relevant to the possible traumatic sequelae of psychosis (Mueser et al., 2010). Alongside the adverse consequences of psychopathological symptoms is the unique outcome of coping with adversity (Tedeschi & Calhoun, 1995)- PTG. Two important factors that contribute to PTG is coping self-efficacy (CSE), and meaning making (Mazor et al., 2018). We investigated the possibility of PTG in individuals with SMI, through the mediating effect of CSE and meaning making.

Objectives: Recent research has shown high rates of exposure to trauma among people with SMI, and that psychosis and mental illness-related experiences can be extremely traumatic. While some develop PTSD, it has been noted that some may also experience PTG. However, few studies have examined PTG in this population.

Methods: 121 participants were recruited from community mental health centers and administered trauma and psychiatric questionnaires. Study protocol was approved by the University of Haifa ethics board.

Results: High levels of traumatic exposure were found in the sample. Furthermore, we found that people who endured psychosis