Table 2 Description of using coping strategies and quality of life in schizophrenic outpatients.

COPING STRATEGIES	T-score mean	QUALITY OF LIFE	Points
Underestimation	47.77 ± 12.87	Physical health (max 65p)	41.81 ± 9.74
Guilt denial	54.35 ± 12.2	Feelings (max 70p)	46.33 ± 10.63
Diversion	50.88 ± 9.88	Work (max 65p)	27.82 ± 18.13
Compensatory satisfaction	55.57 ± 10.2	Household (max 50p)	34.99 ± 9.04
Situation control	44.95 ± 11.08	School / study (max 50p)	13.47 ± 8.77
Reaction control	47.76 ± 10.8	Leisure (max 30p)	20.15 ± 5.42
Positive self-instruction	41.37 ± 11.95	Social activities (max 55p)	35.69 ± 9.22
Need for social support	50.98 ± 11.02	General (max 80p)	51.49 ± 12.08
Active avoidance	55.76 ± 8.9	SUMA Q-LES-Q (max 465p)	271.5 ± 12.47
Escape tendency	61.82 ± 9.42	Q-LES-Q in percent	58.42 ± 12.47 %
Perseveration	49.9 ± 12.5		
Resignation	60.44 ± 10.95		
Self-accusation	53.29 ± 12.61		
Using negative coping	59.04 ± 11.24		
Using positive coping	49.5 ± 11.8		

Abbreviations: Average use of coping 40-60 T-score, more than 60 overusing, less than 40 reduced using of coping strategy

Average use of coping 40-60 T-score, more than 60 overusing, less than 40 reduced use of coping strategy.

Table 3 Correlations between quality of life and coping strategies.

Coping / Domain	Total Q-LES-Q	Physical health	Feelings	Work	House-hold	School	Leisure	Soc.activities	General
Underestimation	0.466***	0.318**	0.477***	0.269**	0.322***	0.098	0.332**	0.328**	0.473***
Guilt denial	0.246*	0.256**	0.348***	0.145	0.085	-0.093	0.182	0.136	0.292**
Diversion	0.486***	0.417***	0.444***	0.297**	0.360***	0.134	0.285**	0.291**	0.444***
Compensatory satisfaction	0.283**	0.305**	0.310**	0.147	0.181	0.004	0.251*	0.184	0.250**
Situation control	0.284**	0.180	0.272**	0.141	0.322**	0.030	0.226*	0.260**	0.218*
Reaction control	0.477***	0.366***	0.473***	0.247*	0.359**	0.153	0.299**	0.354***	0.434***
Positive self-instruction	0.639***	0.505***	0.667***	0.356***	0.503***	0.148	0.419***	0.430***	0.563***
Need for social support	0.019	0.056	0.001	-0.050	0.097	-0.188	0.026	0.133	0.051
Active avoidance	-0.034	0.027	0.013	-0.051	0.008	-0.220**	0.020	0.025	-0.002
Escape tendency	-0.274**	-0.133	-0.275**	-0.236*	-0.172	-0.228*	-0.146	-0.148	-0.158
Perseveration	-0.397***	-0.305**	-0.454***	-0.163	-0.194	-0.150	-0.369***	-0.266**	-0.415***
Resignation	-0.518***	-0.467***	-0.613***	-0.244*	-0.377***	-0.133	-0.353***	-0.319**	-0.455***
Self-accusation	-0.319**	-0.283**	-0.397***	-0.262**	-0.140	-0.028	-0.201**	-0.069	-0.322**
Negative coping	-0.468***	-0.364***	-0.543***	-0.267**	-0.275**	-0.153	-0.344***	-0.264**	-0.434***
Positive coping	0.588***	0.481***	0.615***	0.323**	0.438***	0.085	0.417***	0.407***	0.547***

Abbreviations: * p<0.05; ** p<0.01; *** p<0.001

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

sion analysis showed that symptoms severity (subjCGI), Positive coping strategies (especially Positive Self-instruction), Difference between the objCGI and subjCGI and Negative coping strategies explain totally 53.8% of variance of the QoL (Tables 1–3).

Conclusions Our study suggests the importance of utilizing the Positive coping strategies in improving the quality of life in patients with psychotic disorders.

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

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EW524

Self-stigma and quality of life in Psychopharmacs treated outpatients with schizophrenia and related disorders - A cross-sectional study

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Introduction Self-stigma is a maladaptive psychosocial phenomenon that can disturb self-image and quality of life in psychiatric outpatients and may lead to dysphoria, social isolation and reduced adherence to treatment.

Objectives Self-stigma and QoL could be reflected as important factors for patients, who suffer from schizophrenia spectrum disorders, their caregivers and mental health specialists. Focus on reducing the self-stigma in supportive and educational therapy could be an important factor in promoting a higher QoL.

Aims Current research moved attention to the relationship between demographic data, the severity of symptoms, self-stigma and quality of life in schizophrenic outpatients compared to the QoL in healthy controls.

Methods Patients who met ICD-10 criteria for schizophrenia spectrum disorder were recruited in the study. The Quality of Life Satisfaction and Enjoyment questionnaire (Q-LES-Q), Internalized Stigma of Mental Illness (ISMI) and severity of the disorder measured by objective and subjective Clinical Global Impression severity scales (CGI) were assessed.

Results One hundred and nine psychotic patients and 91 healthy controls participated in the study. Compared to the control group, there was a lower QoL and a higher score of self-stigma in psychotic patients. We found the correlation between the self-stigma, duration of disorder and QoL. The level of self-stigma correlated positively with total symptom severity score and negatively with the QoL. Stepwise regression analysis revealed that the objective severity and self-stigma score were significantly associated with the quality of life (Tables 1 and 2, Fig. 1).

Conclusions Our study suggests a negative impact of self-stigma level on the quality of life in patients suffering from schizophrenia spectrum disorders.
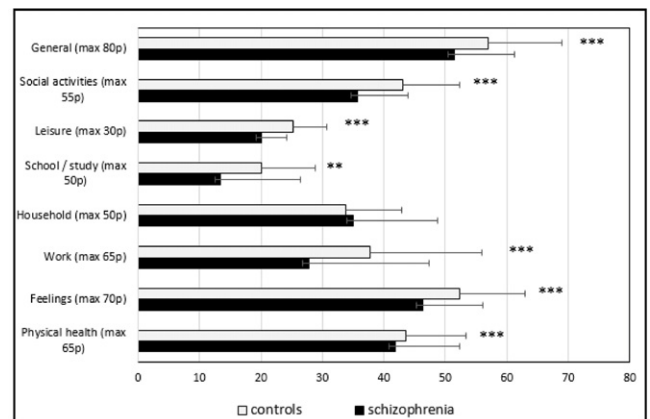
Fig. 1 Q-les-Q domains in the controls and the patients. Statistically significant relation was marked by *. *$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

Table 1   Description of the sample, demographic and clinical data.

Table 1: Description of the sample, demographic and clinical data

VARIABLE	PATIENTS (n=103)	CONTROLS (n=91)	STATISTICS
Age	41.96 ± 10.231	36.23 ± 13.40	Mann Whitney test; MW U= 3519; p<0.0005
Gender (M: F)	41:62	36:55	Fisher exact test; ns.
Age of disease onset	26.12 ± 8.974		
Lifetime duration of treatment	15.38 ± 9.519		
Number of hospitalizations	4.13 ± 3.968		
Psychiatric heredity			
Same disorder	15 (14.6%)		
Other disorder	39 (37.9%)		
Without	47 (45.6%)		
Education:			
elementary	9 (8.7%)	1 (0.9%)	
vocational training	25 (24.3%)	3 (2.8%)	
secondary school	52 (50.5%)	38 (34.9%)	Pearson chi-square; ns.
university	16 (15.5%)	9 (8.3%)	
not completed	1	40	
Marital Status:			
single	61 (59.0%)	28 (25.7%)	
married	24 (23.1%)	21 (19.3%)	
divorced	15 (14.3%)	1 (0.9%)	Pearson chi-square; ns.
widowed	1 (0.9%)	1 (0.9%)	
not completed	3 (2.7%)	40	
Employment Yes/No	33/70		
objCGI severity	4.14 ± 0.971		
subCGI severity	2.75 ± 1.392		
objCGI-subCGI severity	1.67 ± 1.56		
Q-LES-Q			
Physical health (max 65p)	41.81 ± 9.74	43.53 ± 10.43	unpaired t-test: t=4.098 df=180; p<0.0001
Feelings (max 70p)	46.33 ± 10.63	52.36 ± 9.70	unpaired t-test: t=4.107 df=192; p<0.0001
Work (max 65p)	27.82 ± 18.13	37.78 ± 19.47	Mann Whitney test: MW U= 3377; p<0.001
Household (max 50p)	34.99 ± 9.04	33.84 ± 13.72	unpaired t-test: t=0.6997 df=192; ns.
School / study (max 50p)	13.47 ± 8.77	20.05 ± 12.97	Mann Whitney test: MW U= 3451; p<0.005
Leisure (max 30p)	20.15 ± 5.42	25.22 ± 4.05	unpaired t-test: t=7.290 df=191; p<0.0001
Social activities (max 55p)	35.69 ± 9.22	43.02 ± 8.24	unpaired t-test: t=5.808 df=192; p<0.0001
General (max 80p)	51.49 ± 12.08	56.88 ± 9.69	unpaired t-test: t=3.400 df=192; p<0.001
SUM O-LES-Q (max 465p)	271.5 ± 58.03	312.68 ± 46.11	unpaired t-test: t=5.419 df=192; p<0.0001
SUM Q-LES-Q in percent	58.42 ± 12.47 %	67.24 ± 9.91 %	unpaired t-test: t=5.401 df=192; p<0.0001
ISMI			
Alienation	13.31 ± 3.89		
Stereotype agreement	14.01 ± 3.42		
Perceived discrimination	11.01 ± 3.30		
Social withdrawal	13.03 ± 3.77		
Stigma resistance	12.63 ± 2.34		
Overall score	63.98 ± 13.74		

Table 2   Relation between Q-les-Q domains and facets of ISMI.

Domain	Overall score of ISMI	Alienation	Stereotype agreement	Perceived discrimination	Social withdrawal	Stigma resistance
Physical health	-0.496***	-0.397***	-0.509***	-0.372***	-0.454***	-0.349***
Feelings	-0.633***	-0.535***	-0.588***	-0.469***	-0.561***	-0.413***
Work	-0.261**	-0.202*	-0.246*	-0.141	-0.258**	-0.106
Household	-0.355***	-0.278**	-0.350***	-0.294**	-0.311***	-0.268**
School / study	-0.099	-0.069	-0.073	-0.078	-0.103	-0.100
Leisure	-0.457***	-0.430***	-0.411***	-0.347***	-0.410***	-0.293***
Social activities	-0.507***	-0.391***	-0.438***	-0.390***	-0.555***	-0.235*
General	-0.550***	-0.487***	-0.487***	-0.444***	-0.504***	-0.316***
SUMA O-LES-Q	-0.581***	-0.477***	-0.540***	-0.429***	-0.548***	-0.355***

*P < 0.05; **P < 0.01; ***P < 0.001.

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

EW525

Cognitive function in early psychosis patients from a low-income country

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Background   Cognitive impairments are well established findings in schizophrenia and are associated with significant impairment of social functioning. Episodic memory, working memory and executive function test scores are typically 1 standard deviation below healthy controls. There are reports suggesting the presence of neurocognitive deficits prior to illness onset, opening the possibility of using cognitive profiles as disease markers. Interest in exploring cognitive functioning in early stages schizophrenia has continued to grow, as earlier treatments could possibly lead to improved outcomes.

Methods   This is a cross-sectional assessment of cognitive profiles in patients with early psychosis. A total of 51 patients suffering from psychosis in the age group of 18–65 years were recruited and matched with 51 healthy controls. A wide range of neurocognitive domains were assessed using standardised neuropsychological tests.

Results   There was evidence of statistically significant impairments in cognitive functioning across a broad range of cognitive domains in early-psychosis patients, as compared to healthy controls. More pronounced deficits were seen in executive function tests.

Conclusions   To our knowledge, this is the first study to report cognitive deficits across a range of domains in patients with first episode psychosis from a low-income country. This study found deficits across multiple domains, including language, memory, attention, executive function, and visuospatial function in patients with early psychosis. Evidence of neuropsychological deficits in the early course of the disease may highlight crucial therapeutic windows for both pharmacological treatments and cognitive rehabilitation. This may improve functional outcomes in this patient group in the longer term.

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

EW526

Short-term compliance in first-episode psychosis

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Introduction   Non-compliance is a significant problem in patients with first-episode psychosis (FEP), representing a challenge for mental health professionals due to the heterogeneous course and functional outcomes.

Objectives   The aim was to describe the short-term compliance in FEP and analyze the demographics, clinical features, and management issues potentially associated with non-compliance.

Methods   This observational and retrospective study included all consecutive FEP admitted to our psychiatry unit from January to June 2015, belonging to our catchment area. To be categorized as compliant, patients had to attend month-1 and month-3 follow-up visits. Characteristics of compliant and non-compliant were compared using a bivariate analysis.

Results   We included 18 patients whose characteristics are shown in the table. Overall, 8 (44.4%) were non-compliant. Patients who were non-compliant had a significantly shorter length of stay (10.3 [6.3] vs. 18.5 [8.9] days). Most patients (66.7%) had cannabis abuse, being slightly more frequent among non-compliant (75% vs. 60%, *P* = NS); in addition, the diagnosis of substance-induced psychotic disorder was also more common among non-compliant (50% vs 20%, *P* = NS). There were 2 patients who were readmitted, both in the non-compliant group (Table 1).

Conclusions   Short-term non-compliance is high among patients with FEP. Despite the limitations of our study, our results suggest that, beside other factors (e.g. substance abuse), non-compliance could be associated with management-related factors.