Furthermore, the relationship between sexual dysfunction and other psychiatric symptoms in SZ is still unclear. Our aim was to describe the sexual dysfunction in chronic patients with SZ and its relation to negative, positive and depressive symptoms.

**Methods:** A convenience and exploratory sample of 57 patients (age 43.75±10.38, 69% men, 86.2% single) were recruited from an university outpatient schizophrenia clinic, in Porto Alegre – Brazil. Participants were assessed using Arizona Sexual Experience Scale (ASEX), Medication Adherence Rating Scale (MARS), Positive and Negative Syndrome Scale (PANSS), Calgary Depression Inventory and demographic information.

Sexual dysfunction was considered following the ASEX scoring criteria. **Results:** Sexual dysfunction was present in 51.8% of the patients, assessed by ASEX. Women showed increased sexual dysfunction than men (χ²=22.727, p < .001). There were no differences between patients that reported sexual dysfunction and the ones who did not regarding age, duration of illness and medication adherence assessed by MARS (p > .05). Additionally, there were no differences between groups on positive and negative symptoms assessed by PANSS. Interestingly, patients with sexual dysfunction had increased depressive symptoms compared to patients with a good perceived sexual function (t(54) = −3.326, p = .002). Calgary total scores were positively correlated with ASEX total scores (r = .369, p = .005).

Nevertheless, we did not find significant correlations between ASEX total scores and other scales. Scores found on MARS (8.07±1.5) suggest that this sample is highly adherent to prescribed treatment.

**Discussion:** This is an exploratory and preliminary study that shows and reinforces the idea that sexual dysfunction is importantly prevalent and remains as a neglected issue in individuals with schizophrenia, as are the depressive symptoms. We showed that there is an association between these two domains, which might indicate a need for change of perspective for the pharmacological and psychosocial approaches currently used. In addition to the dopaminergic blockage by antipsychotics that lead to reduction in positive symptoms, we believe there is a need to look for depression symptoms to access, prevent and treat sexual dysfunction. Inattention to this may result in abrupt treatment discontinuation and relapse. Curiously, the fact that we did not find any correlations between sexual evaluations and PANSS scores would suggest that sexual dysfunction in chronic patients could differ from others stages of the disease. The size of our sample and the fact that we did not access hormones and prolactin levels are important limitations of this study. However this is an exploratory study that provided clues on the subject, allowing to address further investigation taking into account the limitations.

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**S235. COGNITION AND SOCIAL BEHAVIORS IN SPORTS FOR PATIENTS WITH SCHIZOPHRENIA ENGAGED IN SPORTS HABITS**

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**Background:** Several studies have reported that team sports are effective for maintaining and improving mental health among patients with schizophrenia. Social behavior, such as adjusting an individual’s motion while reading others’ intentions and predicting others’ motion in team sports, is considered to improve related cognitive characteristics. However, the quantitative evaluation of social behaviors during sports, and the cognitive characteristics of patients with schizophrenia engaging in team sports habits remain unclear. In this study, we aimed to clarify these behaviors and cognitions quantitatively.

**Methods:** Twelve male patients with schizophrenia and 15 male healthy controls with experience playing football participated in this study. We used a 3-vs-1 ball possession task. Three-dimensional coordinates of the landmark points were acquired using a 3D optical motion capture system with 16 cameras (OptiTrack, USA). First, we evaluated group coordination in a previous study using three inner angles of the three attackers’ triangle. Second, we computed four variables for evaluating individual performance: pass-miss rate, pass angle, angular displacement, and additional distance. Third, we used a slalom dribble test to evaluate individual football skill. Meanwhile, we used three cognitive tasks: the Rey-Osterrieth Complex Figure test (ROCFCT), Trail Making Test A and B (TMT), as well as RTI (reaction time), IED (intra-extra dimensional set shift) and SWM (spatial working memory) in the Cambridge Neuropsychological Test Automated Battery (CANTAB). For statistical analysis, we used the Mann-Whitney U-test to compare the variables between groups. We used Spearman’s rank correlation coefficient between the variables in 3-vs-1 and cognitive tasks. In addition, we conducted partial correlation analysis between these variables using recent football experience per month and duration of illness as covariates.

**Results:** In group coordination during the 3-vs-1 task, the patient group exhibited a slightly wider distribution in the contour plots in the phase plane than the control group. Next, in individual performance in motor tasks, the angular displacement in patients with schizophrenia was significantly smaller than that in the control group (p = 0.043, r = −0.39). Meanwhile, there were no significant differences in the slalom test, pass-miss rate, pass angle, and additional distances (p > 0.05). For cognitive tasks, the reproduction scores of ROCFT after 3-min and 30-min in patients with schizophrenia were significantly smaller than those in the control group (p < 0.006, r < −0.53). Patients’ scores on the TMT (A and B) were significantly lower than those in the control group (p < 0.004, r < −0.56). In RTI on the CANTAB, five-choice reaction time and movement time in the patients were longer than those in the control group (p < 0.049, r > 0.37). Meanwhile, other characteristics were not significantly different between the two groups.

In the correlation between 3-vs-1 variables and cognitive test performance, EDS errors in CANTAB IED and TMT A were negatively correlated with the pass angle (p = −0.62, p = 0.031 and p = −0.64, p = 0.026) in patients with schizophrenia. Additionally, the partial correlation in patients revealed that the negative partial correlation between EDS error in CANTAB IED and pass angle remained significant (p = −0.64, p = 0.046).

**Discussion:** The current results demonstrated that patients were not impaired in most domains of cognition and social behavior in the tasks. However, other types of cognition and social behavior for patients with schizophrenia and team sports habits were still likely to be impaired.

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**S236. QUALITY OF LIFE AND ASSOCIATION WITH SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA SIX YEARS AFTER FIRST EPISODE PSYCHOSES**

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**Background:** Quality of Life in patients with schizophrenia is an important part of successful treatment outcome. Our previous results showed, that despite symptomatic improvement after six weeks of antipsychotic treatment, the overall Quality of Life was not improved. The aim of the present study is to explore Quality of Life after six years, and the association with symptomatic remission or symptoms in general.
The following hypotheses were tested: Quality of life will be improved after six years, and patients in remission will report a better Quality of Life compared to patients not in remission. Further, low Quality of Life will be associated with high level of negative symptoms.

**Methods:** In this study 69 antipsychotic drug-naive, first episode patients with schizophrenia (ICD-10) were included between 2009–2013, and 31 patients where re-examined after 6.7 years (range 4.2–8.3).

Quality of Life was reported by answering a validated questionnaire counting 18 questions, divided into three domains: Housing Situation, Social Relations and Life Satisfaction. Higher scores indicate higher satisfaction within the domain.

Symptoms were assessed using Positive and Negative Syndrome Scale (PANSS) at baseline and follow up. Additionally, at follow up negative symptoms were assessed with Brief Negative Symptoms Scale (BNSS), focusing on three domains: Anhedonia, Asociality, and Avolition.

For statistical analysis, Spearman Rank, paired T-test and Mann-Whitney U-test were used.

**Results:** The overall Quality of Life was improved (p=0.013) after six years. The improvement was found in Housing Situation (p<0.001) and Social Relation (p<0.001) but not in Life Satisfaction (p=0.9).

Symptomatic remission was observed in 15 (48%) patients. Quality of Life in patients in remission did not differ from patients without remission (p=0.16).

Patients improved in PANSS total, positive, negative and general score (all p<0.001). A negative correlation was observed between Quality of Life (Social Relations) and PANSS-negative (r=-0.40, p<0.05), and PANSS-total score (r=-0.43, p<0.05), and between Quality of Life (Life Satisfaction) and PANSS-general (r=-0.53, p<0.01) and PANSS-total score (r=-0.44, p<0.05). There was no correlation between Quality of Life and positive symptoms.

All three Quality of Life subdomains correlated with BNSS total (p<0.05, r<0.42). This was driven by a high correlation with Anhedonia (all r<-0.55, all p<0.005) and Asociality (all r<-0.51, all p<0.005) but no correlation with Avolition.

**Discussion:** Patients in this study improved their subjective Quality of Life over a six-year period. This improvement was found within their Social Relations and an improved Housing Situation. In contrast, there was no improvement in patients’ Life Satisfaction.

Remission was found in half of the patients. Although Quality of life was associated with total symptom severity, it seemed to be independent of symptomatic remission. Quality of life was most associated with the level of negative symptoms, especially with Anhedonia and Asociality. This is in line with previous findings of associations between negative symptoms and the ability to maintain social relations and to function in everyday life. The results underline the importance of increased focus on negative symptoms.

**S237. MODERATORS AND RELATIONSHIPS OF COGNITION AND SUBJECTIVE QUALITY OF LIFE IN SCHIZOPHRENIA**

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**Background:** The relationship between cognitive impairments and subjective quality of life (sQOL) in schizophrenia remains indeterminate, relative to studies of objective QOL (oQOL), despite much previous work. This study sought to better characterise the cognition-sQOL relationship in schizophrenia by 1) examining associations between factor analysis-derived cognitive domains and sQOL, 2) investigating if these domains predicted sQOL over other demographic and clinical variables, and 3) exploring if clinical, demographic and functional variables moderated the significant relationships.

**Methods:** 47 schizophrenia/schizoaffective disorder patients (age: M=43.72, SD=11.35) and 48 healthy controls (age: M=39.82, SD=13.89) were assessed. QOL was measured using the Lehman’s QOL Interview. Composite scores were created to represent oQOL and sQOL, and factor analysis (principal axis factoring with varimax rotation) assessed for latent domains within 14 cognitive tasks. Symptomatology was assessed using the PANSS and MADRS. Pearson’s correlations and a stepwise linear regression were conducted to examine the associations between cognition and sQOL before the moderation analyses.

**Results:** Three cognitive domains were derived: visuospatial planning, verbal linguistic and inhibition switching. Only tasks comprising the verbal linguistic cognitive domain were significantly associated with, and predicted, sQOL (p<0.05). Modulation analyses revealed that the direction of this relationship differed between patients and healthy controls (p<0.05), and was moderated in patients only by positive symptom severity (p<0.05).

**Discussion:** The relationship between cognition and sQOL in schizophrenia is determined by, and more associated with, meaning-based cognitions. It is affected by symptomatology, notably positive symptoms, which lead to worsening sQOL among those with more intact verbal linguistic processing.

**S238. PATIENT ENGAGEMENT TO EARLY INTERVENTION IN PSYCHOSIS SERVICES: RETROSPECTIVE ANALYSIS OF ENGAGEMENT PATTERNS**

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**Background:** Within outpatient mental health services there exists an important awareness of the difficulties in engaging and maintaining contact with patients, as well as the understanding of the negative effects of disengagement, including worse patient outcomes and increased healthcare burden. Despite the importance of engagement on service delivery and recovery outcomes, few studies have examined rates and predictors of engagement in the early phase psychosis population. Although better than community care, it has been reported that an average of 30% of patients disengage from specialized early intervention services for psychosis (EIS). We examined rates of disengagement to a 5 year EIS for psychosis, including potential individual risk factors for disengagement at entry to service.

**Methods:** This cross-sectional cohort study examined engagement to services to a single EIS site from November 2006 to November 2016. Disengagement was determined retrospectively on review of medical records, defined as not attending to clinic services despite repeated attempts by clinicians/clinic for a three month time frame. Gender, age at clinic entry, ethnicity, Positive and Negative Syndrome Scale (PANSS), Drug Attitude Inventory (DAI-30), General Assessment of Function (GAF), Social and Occupational Functioning Assessment Scale (SOFAS), WHO-ASSIST version 3.0, and the Psychological General Well Being (PGWB) scale at entry to service were examined between groups. Descriptive statistical and survival analyses for time to disengagement were conducted on the patient data set.

**Results:** 331 patient records were complete (with above scales) from entry to service to discharge or loss to follow-up. Patients were found to fall into 3 categories with regard to patterns of engagement. The first category we named “engagers” as they remained committed to their care throughout the program and comprised 50% of the sample. The second group were labeled the disengagers (20% of the group) and these were individuals who disengaged at some point in the program and did not return, in contrast to “intermittent engagers” who comprised 30% of the sample. Intermittent engagers were patients who at some point during their care would meet criteria for disengagement but would re-engage later (still within the 5 years from entry to EIS) and complete the program. Absolute disengagement by the disengager group was predominantly prior to 12 months of treatment (78% of the group) with a survival analysis showing a median time to absolute disengagement of 8 months. The groups though defined based on their engagement status, did not significantly differ in age, gender and...