duration of sedentary bouts and frequency of varying sedentary bout lengths. Pearson correlations were calculated between sedentary behavior and health variables for the full sample, and stratified by sex. Hierarchical regression models were calculated for WC and BMI, first controlling for age, sex, and chlorapromazine equivalents, followed by moderate to vigorous physical activity (MVPA) and accelerometer wear time, and finally sedentary variables.

Results: One hundred thirty participants enrolled in the study, of which 113 completed the study and 101 wore their accelerometers for a sufficient amount of time. Mean (SD) daily sedentary time was 455.8 (125.3) minutes, or 53% of daily accelerometer wear time. Sedentary time was broken up by 79.6 (17.4) breaks in sedentary time. The average bout of sedentary behavior lasted 5.9 (1.7) minutes. Sedentary bouts under 5 minutes were most common across the sample, mean (SD) = 53.57 (15.5) per day, followed by bouts lasting 5 to <10 minutes, 13.49 (4.5) per day. Sedentary bouts longer than an hour occurred, on average, .4 (.4) times per day. WC was significantly related to total sedentary breaks $r = .20$, $P = .04$, and average sedentary bout length $r = .25$, $P = .015$, however BMI was not. When stratified by sex, WC was only related to the average sedentary bout length in men, $r = .40$, $P = .002$, whereas there was no relationship in women. However, in the regression models no sedentary behavior variable was associated with WC or BMI after controlling for other variables such as MVPA.

Conclusion: To date, this is the largest reported sample of objectively measured sedentary behavior data among people with schizophrenia we are aware of. This study provides a comprehensive profile of sedentary behavior patterns in this sample. Overall sedentary time in this sample was lower than what has been previously reported by studies using other objective measures. There was little evidence that sedentary behavior was associated with measures of adiposity. Further assessment of sedentary behavior and its relationship with other metabolic and cardiovascular health outcomes is warranted.

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M60. EXAMINING THE ROLE OF CULTURAL DISTANCE AND PSYCHOSOCIAL DISEMPOWERMENT IN HIGHER RATES OF PSYCHOTIC DISORDERS IN ETHNIC MINORITY GROUPS: A MULTI-NATIONAL CASE-CONTROL STUDY

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Background: Ethnic minorities have an increased risk of developing psychotic disorders, but the causes remain largely unknown. Theories such as social defeat have been suggested as possible explanatory frameworks, but empirical evidence is lacking. Here, we investigated whether psychosocial disempowerment (a perceived lack of control over one's life), and cultural distance from the majority ethnic group accounted for the excess psychosis risk in ethnic minority groups.

Methods: We used case-control data from the EU-GEI study, a 16-centre case-control study in 6 countries (England, France, the Netherlands, Italy, Spain and Brazil). Within defined epidemiological catchment areas, incidence cases with an OPCRIT-confirmed first episode of ICD-10 psychotic disorder (F10-33) were invited to participate. Population-based controls were sampled via primary care. We created a binary measure of psychosocial disempowerment, using a self-perceived discrimination questionnaire, where participants were asked if they had ever felt unfairly treated in 12 situations. We approximated cultural distance using the linguistic distance of a participant's primary language from the majority language in each setting, informed by linguistic decision trees. Age and sex were included as confounders. Following multiple imputation to account for missing data we used logistic regression to investigate whether our exposures explained any increased psychosis risk in ethnic minority groups.

Results: We recruited 1168 cases and 1498 controls, who were representative of the population at-risk. Ethnic minority status was associated with increased odds of psychotic disorder after controlling for age and sex (OR: 1.66; 95% CI: 1.59–1.73). Inclusion of psychosocial disempowerment and cultural distance in the model did not attenuate risk in ethnic minority groups (OR: 1.63; 95% CI: 1.54–1.72), despite greater exposure to psychosocial disempowerment (OR: 1.54; 95% CI: 1.47–1.62) and cultural distance (OR: 3.99; 95% CI: 3.83–4.17). Both psychosocial disempowerment (OR: 1.16; 95% CI: 1.13–1.19) and cultural distance (OR: 1.17; 95% CI: 1.14–1.22) independently predicted psychosis risk, after control for age, sex and minority status.

Conclusion: Ethnic minorities had a higher risk of developing a psychotic disorder. Psychosocial disempowerment and cultural distance did not explain this risk, but had independent additional effects which appeared to follow dose-response relationships. These preliminary analyses suggest the social environment of ethnic minorities might be a significant predictor of psychosis risk, independent of ethnic minority status.

M61. DATA-DRIVEN APPROACH IDENTIFIED FUNCTIONALLY AND PHYSIOLOGICALLY DISTINCT PSYCHOSIS SUBTYPES

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Background: Unlike diagnoses in other branches of medicine, current classification of psychiatric disorders relies on phenomenological observations, despite the increasing evidence pointing to superior characterization by physiological-based markers. Common risk genes, symptoms, and medications had been found between patients traditionally diagnosed with schizophrenia, schizoaffective, and bipolar disorder with psychosis. To address this issue, and to ultimately achieve customizable treatment plans for illnesses with psychotic features, identification of biomarkers for psychosis and their criteria is essential.

Methods: Part of Bipolar-Schizophrenia Network on Intermediate Phenotypes (B-SNIP), the present study was conducted in continuation of previous work that identified psychosis Biotypes (Clementz et al., 2016), and it included 709 probands with psychotic features and 342 control subjects. In addition to the biomarker panel used in Clementz et al. (2016), this iteration included additional biomarkers capturing variance in ocular motor performance, inhibition, and cognitive control. Similar multivariate analysis procedures were used. Birchwood Social Functioning Scale and structural MRI characteristics from Freesurfer analyses were used as validators of cluster membership.

Results: On average, probands showed lower cognitive performance, lower accuracy to motor tasks, and lower EEG power to auditory stimuli than controls. Interestingly, these anomalies were not ubiquitous among the probands. From within-task principle component analysis (PCA) and k-means clustering, 4 (rather than 3 as previously reported by Clementz et al.) phenotypically distinct proband groups emerged: Group 4 had hyperactive motor response and low cognitive control; Group 3 showed normal cognition and motor control but abnormally low EEG amplitude in response to auditory stimuli; Group 2 was slow in motor tasks combined with poor cognitive control, and Group 1 performed more similarly to controls across