49 adolescents meeting ICD 10 criteria for anorexia nervosa or atypical anorexia nervosa. The same diagnostic interview was administered twice, once via face-to-face and once as an online version, within a week. Method order was counterbalanced among participants and temporal stability was controlled. The Eating Disorder Inventory-2 (EDI-2) was used as a control variable.
Results: Both the equivalence test and the null hypothesis test were significant for the sum score of the EDE. Measures of psychopathology in eating disorders demonstrated equivalence across face-to-face and online format of the EDE.
Conclusions: The aim was to examine the equivalence of face-to-face and online methodologies, controlling for temporal change in the variable under investigation over one week and order of administration. Results demonstrate equivalence across face-to-face and online format of the EDE. These findings suggest that data obtained using EDE online can be interpreted in comparison with normative data obtained in the face-to-face Interview and that corrections trough transformations are not necessary.

Disclosure of Interest: None Declared

EPV0902

Psychiatric role in physician-assisted death requests – a study protocol for a literature review

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Introduction: The prospect of a medium-term approval of physician-assisted death in Portugal raises relevant ethical and deontological issues that need to be addressed, namely the framework of psychiatric assessments in this process. Such assessments are undermined by the lack of scientific precision in the methods used to determine decision-making capacity, making it possible for the final decision to be affected by psychiatrists' personal beliefs. As such, outlining scientific evidence and legislation pieces defining the psychiatrists' role and scope is of utmost importance to frame this debate.
Objectives: To synthetize the accumulated evidence worldwide regarding the psychiatrists' involvement in the global process of physician-assisted death requests by reviewing scientific literature, published protocols, official reports and international promulgated or amended legislation related to hasten death practices.
Methods: *PubMed*, *Scopus*, *Web of Science*, *PsycInfo* and *Google Scholar* electronic bibliographic databases will be searched for eligible articles, as well as grey literature, using the following search terms: Psychiatry AND (Euthanasia OR (Suicide AND Assisted)). Official governments' and countries health authorities' websites will also be searched for relevant reports and legislation documents, as well as right-to-die organizations and akin associations. No language, date of publication, or geographical restrictions will be applied. The full text of potentially relevant results will be retrieved from the different sources for review after screening titles and abstracts. This two-stage process will be conducted independently by two researchers. Outcomes of interest will be the descriptions of psychiatric role in the process of physician-assisted death requests, assessment methods, and measurement techniques used.
Results: Given the fact that physician-assisted death is legalized only in a few jurisdictions, we believe the number of eligible results will be limited. Data will be extracted and a descriptive summary of the evidence will be provided. We anticipate finding a significant variability, but also to identify points of consensus. The findings will be published in a peer-review indexed journal and presented at national and international conferences.
Conclusions: To our knowledge, this is the first review of both, scientific published literature, and international legislation on the role of psychiatrists in physician-assisted death requests. We hope to provide an international overview to frame the public debate by pinpointing the most consensual assessment methodology, allowing to design an optimized assessment protocol before the implementation of the law in Portugal.

Disclosure of Interest: None Declared

Schizophrenia and other psychotic disorders

EPV0903

Folie a deux / induced delusional disorder – case report and literature review

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Introduction: *Folie a deux*, also known as shared psychotic disorder or induced delusional disorder, is a rare mental disorder that was first described in France in the late 19th century and was referred to delusions shared between two individuals in close relationship. The concept has evolved and according to ICD-10 the following criteria for the diagnosis is phenomenology-based-only.
Objectives: To describe a clinical case and review the existing evidence on *folie a deux*.
Methods: Clinical case and non-systematic review of the literature, from the last 15 years, on folie a deux. For this research, the keywords "*folie a deux*", "shared psychotic disorder" and "induced delusional disorder" were used in the MEDLINE/PubMed database.
Results: The clinical case presented refers to a 56-year-old female patient with no known psychiatric history. The patient stated that 5 years ago when his mother died, neighbors began to persecute her and her sister. She was medicated with a second-generation antipsychotic without total remission of symptoms. Generally, in *folie a deux* there is a close and prolonged relationship between the

inducer and the receptor, as described in this case. We considered that the sister is the active subject. The delusion is persecutory, the most common in this disorder. The patient kept her job until she was hospitalized and as described in the literature patients with folie a deux maintain their functionality, which is responsible for the underdiagnosis of this disorder. The fact that the current evidence is based on case reports reflects the underdiagnosis and rarity of this disorder.

Conclusions: This clinical case highlights the challenging diagnosis and difficulty in treating this condition. Patients can be diagnosed many years after the onset of symptoms, which may not resolve with treatment. Much information, as prevalence, natural history, and optimal treatment, is lacking on folie a deux, and the etiology remains unknown. As such, prospective studies should be carried out to help understand this disorder.

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EPV0904

LATE ONSET PSYCHOSIS AND VERY LATE ONSET PSYCHOSIS: WHAT ARE THE POSSIBLE ETHIOLOGIES?

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Introduction: Psychotic symptoms have long been known to show up earlier in life, typically during adolescence and early adulthood. Late Onset Psychosis (LOP), in which symptoms start between 40 and 60 years of age, and Very Late Onset Psychosis (VLOP), in which onset of symptoms happens after 60 years of age, although classically rare, have had a growing prevalence in the last decades.

Objectives: To access the definition and main etiologies of LOP and VLOP, based on the current literature.

Methods: Non-systematic review of literature using the terms "late onset psychosis" and "very late onset psychosis". Case report of a patient who was admitted and treated in our inward patient field.

Results: 51-year-old female patient. She is divorced (two previous marriages) and has two daughters (26 and 16, respectively). She was brought by police officers because of behavior problems at the shelter where she was living. She was evicted from the house she was living in because of delay in paying the rent. On observation, she verbalizes persecutory and prejudicial delusions and auditory hallucinations on the 2nd and 3rd person (commenting voices) with at least 5 years of duration. She was hospitalized for almost 3 months, with slow but progressive clinical improvement on haloperidol 7,5mg/day. At the date of discharge, she did not spontaneously verbalize her symptoms, although she did not recognize them as delusional. Recent studies have shown that the prevalence of Schizophrenia in the typical age range is 75-80%, which means that an important proportion of diagnosis is made after that age span. Primary causes of LOP and VLOP are schizophrenia (of late onset), schizophrenia-like very late onset psychosis, delusion disorder, unipolar depression with psychotic symptoms and bipolar disorder. Secondary causes should also be considered, such as delirium, dementia (Alzheimer's, Lewi bodies and vascular), and substances abuse; even more rare, other conditions should be considered, as cerebrovascular accident, encephalitis, epilepsy, and multiple sclerosis.

Conclusions: LOP and VLOP have been a growing diagnosis in the past decades. In the assessment of these patients, we must consider the importance of secondary etiologies besides the primary psychiatric ones. Primary psychosis is a diagnosis of exclusion, and the clinician must rule out secondary causes. Recent data point out these symptoms as markers for an increased risk of dementia in these patients. Further research involving individuals with LOP and VLOPs is required to increase the evidence base for treatment and improve outcomes of care.

Disclosure of Interest: None Declared

EPV0905

Prevalence and nature of childhood trauma among patients with schizophrenia and bipolar affective disorder

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Introduction: Epidemiological studies shows that exposure to early stress in the form of abuse and neglect in childhood increases the risk for later development of severe mental illneses such as schizophrenia and bipolar affective disorder.

Objectives: •Study the prevalence of childhood trauma in a sample of adult patients diagnosed with schizophrenia and bipolar disorder.
•Identify potential differences of types of childhood trauma between both groups.

Methods: This cross-sectional study was conducted on 200 patients admitted to the inpatient unit at Maamoura psychiatric hospital in Alexandria. Assessment of the history and nature of childhood trauma was done by Arabic version of childhood trauma questionnaire (CTQ).

Results: There was no statistically significant difference between the two studied groups regarding past history of childhood trauma (p=0.397). (Table 1) Regarding the nature of childhood trauma, the history of emotional abuse and physical neglect was more commonly associated with developing bipolar disorder whereas the history of physical abuse was sihnficantly more commonamong schizophrenia patients. (Table 2)

Conclusions: History of childhood trauma is common among adult patients with schizophrenia and bipolar disorder with no significant difference between both groups. Nature of trauma may be diffirent where physical abuse might be correlated with later development of schizophrenia.

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