properties. Further comparison of instruments revealed that the concept of negative symptoms has changed. Older scales show greater inconsistencies regarding item content and factor structure. They also tend to rate performance deficits rather than negative symptoms as such. Newer scales were developed following a National Institute of Mental Health consensus meeting. They include items on pleasure, affiliation, interest, and motivation, and show a two factor model of negative symptoms with an expression and an experience factor.
Conclusion: The attempts have increased to not only assess expression, but also the internal experience of negative symptoms. Remaining challenges are that the available instruments do not differentiate between primary and secondary symptoms even though this distinction does have therapeutic implications. Moreover, some instruments are relatively long, which may limit their clinical practicability. Finally, more research is needed to build upon and further develop psychometrically sound self-report tools that can serve to improve the understanding of the internal experience of negative symptoms.
Policy of full disclosure: None.

P-02-005
The acceptance and action scale for delusions: development and preliminary results

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Objective: Our aims were: (a) to develop a new measure to assess both experiential acceptance of delusions and action towards valued living directions (in spite of delusional thoughts); and (b) to validate this measure in a clinical population with a diagnosis of a psychotic-spectrum disorder.
Methods: The sample comprised 44 participants (91 % male, 89 % single, 66 % living with parents, 39 % unemployed) with a non-affective psychotic disorder (75 % schizophrenia), between 20 and 49 years old (M = 34.27). The participants had on average 9.89 years of education and 2.35 hospitalizations. 54.5 % reported delusions (past week). Participants were assessed with: Acceptance and Action Scale for Delusions (AAS-D); Satisfaction with Life Scale. 19 participants filled the Paranoia Checklist.
Results: The items of the AAS-D were generated by the authors in order to measure the concepts of acceptance and action with commitment to valued living directions as defined by the acceptance and commitment therapy model (Hayes et al. 2006). A beta version was tested in a sample of 50 students who evaluated language clarity. The final version comprised 20 items: the participant was asked to rate each item on a 0 ("disagree") to 3 ("totally agree") scale. Two subscales were proposed: acceptance (11 items) and action (9 items). Considering sample size, acceptable internal consistency was found for both subscales (.56 and .82) and total (.78). Significant correlations were found with paranoid ideation (distress and total -.54; and distress and action -.52; distress and acceptance −.50; conviction and acceptance −.51) and satisfaction with life (.45 with total; and .53 with action subscale). Both subscales were correlated (.57).
Conclusion: This is an on-going study therefore the results are preliminary and in need of further replication with a larger sample and with more sophisticated statistical analysis (e.g., confirmatory factor analysis). Nevertheless, preliminary results indicate the reliability and validity of the AAS-D.
Policy of full disclosure: None.

P-02-006
The Bern Psychopathology Scale: comparison of symptom dimensions in patients with schizophrenia and major depressive disorder

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Objective: In order to assess clinical symptoms of psychoses and categorize specific subgroups based on a system-oriented approach the Bern Psychopathology Scale (BPS) was established. Our study focused on three specific symptom domains (language, affectivity and motor behavior) comparing patients with affective and non-affective endogenous psychoses.
Methods: 146 patients with schizophrenia spectrum disorders (77 men, 69 women) and 58 patients with major depressive disorder (MDD) were investigated. Inclusion criteria were MDD or psychotic episode due to schizophrenia, schizoaffective disorder or schizophreniform disorder. We assessed global scores for each of the symptom dimensions language (GSL), affectivity (GSA) and motor behavior (GSM) as indicated by the BPS. Ratings were done on a seven-point Likert scale (−3 to −1: Inhibition, 0: Normal, +1 to +3: Disinhibition). Additionally, patients with distinct inhibition or disinhibition behavior (less than −2 or more than +2) were categorized as patients with extreme scores. Statistics included Chi-squared-tests and ANOVAs.
Results: The majority of patients endorsed normal or slightly abnormal ratings (−1, 0, +1), irrespective of the diagnostic entity. In MDD, more pronounced negative ratings of affect were seen, indicating a stronger tendency to inhibition. Yet, comparison of GSL- and GSM-severity yielded no differences between SZ and MDD. Further analyses showed an increased endorsement frequency of extreme scores in the motor and language dimension in patients with SZ, whereas in the GSA almost half of the MDD patients presented extreme ratings. Extreme ratings in all dimensions occurred only in schizophrenia.
Conclusion: Patients with schizophrenia spectrum disorders and MDD share many psychopathological features as assessed by the BPS, supporting a dimensional approach to psychopathology in endogenous psychoses. However, the groups differ in the severity of affect ratings as well as in the distribution of language, affectivity and motor ratings with more variance among the group of non-affective psychoses.
Policy of full disclosure: None.

P-02-007
Can basic symptoms be reliably assessed in a self-rating questionnaire?

C. Michel (KJP Bern, Forschung, Bern, Switzerland; B. G. Schimmelmann, F. Schultze-Lutter)

Objective: Assessments of risk criteria for psychosis generally require intensive training and several hours of clinician's time. Thus screening instruments, in particular for ultra-high risk criteria, were developed as a first selection step. Yet, so far no screening for basic symptom (BS) criteria was proposed, although their subjective nature might make them a good target for self-assessments.
Methods: We therefore explored the concurrent and convergent validity of the 'Frankfurt Complaint Questionnaire' (FCQ) as a screening for BS criteria assessed in a clinical interview (=gold standard) with the 'Schizophrenia Proneness Instruments' (SPI-A/SPI-CY). The sample consisted of 81 patients of an early detection of psychosis service.

Results: Compared to the gold standard of interview assessment, the concurrent and convergent validity of the questionnaire was poor. Only two perception-related FCQ-items reached a sufficient level of agreement beyond chance. For all other 69 FCQ-items, the level of agreement with their clinician-assessed counterpart was only slight and, therefore, insufficient. Moreover, an only insufficient level of agreement between assessment modes was found for the BS criteria 'cognitive perceptive basic symptoms' (kappa = 0.228) and 'cognitive disturbances' (kappa = 0.130). With regard to the concurrent validity, diagnostic accuracy measures for the total FCQ as well as for the subset of criteria-relevant BS were also unsatisfactory.
Conclusion: These results indicate a poor criterion validity of self-rated BS compared to their assessment of a clinical interview. Results suggest that FCQ should not be used in its present form as a screening instrument for BS criteria and that the convergent validity—and thereby the specific item wording—should be carefully assessed beyond face validity in potential future developments of screenings.
Policy of full disclosure: None.

P-02-008
Movement disorders in psychiatry: novel instrumental devices

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Objective: Motor symptoms are expected to become more prominent in diagnosis and prognosis of mental disorders alongside mental and cognitive symptoms, because motor symptoms are presumed phenotypes of neurodevelopmental vulnerability. Several studies have reported that subtle motor symptoms are accurate predictors for conversion to psychosis in Ultra High Risk individuals. Moreover, the assessment of motor symptoms has become easier and more objective thanks to the development of sensitive and reliable devices. Examples of devices and tools that have been developed to measure movement disorders and motor symptoms are; a pressure sensitive spatula and button for lingual and body dyskinesia, a motion capture set-up for bradykinesia, a depth-camera for orofacial dyskinesia, and an app for motor abnormalities and neurological soft-signs (NSS).
Methods: An overview is provided of several devices and tools for assessing movement disorders and motor symptoms, including the results of studies in which these devices were investigated.
Results: Studies have shown that the variability of force exerted on a pressure sensitive button or spatula, respectively with finger or tongue, is a sensitive (sensitivity 82 % and specificity 75 %) and reliable measure for dyskinesia (ICC = 0.85, $p < 0.01$). Valid and reliable (ICC = 0.90, $p < 0.01$, N = 25) assessment of bradykinesia was achieved with a wearable motion capture set-up (XSENS technology®), measurements with the device were strongly associated with scores on the Unified Parkinson Disease Rating Scale ($r^2 = 0.55$, $p < 0.01$, N = 64). Furthermore, details are provided on promising devices/tools for assessing orofacial dyskinesia using a depth-camera (Kinect, Microsoft) and an app for NSS.
Conclusion: There are several devices capable of valid and reliable measurement of motor symptoms. The diagnostic value of motor symptoms in mental disorders and the relation to prognosis and treatment will be discussed.
Policy of full disclosure: None.

P-02-009
Twin brothers with a shared delusional disorder

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Objective: To report the case of twin brothers with a shared delusional disorder (folie à deux). To list the principal psychopathological aspects of the case progression. To carry out a brief literature review on the subject.
Methods: Anamnesis of the patients and their relatives, and review of the medical file.
Results: Thirty years ago, CM, a 51-year-old male, started to present erotomanic delusions related to an ex-girlfriend and persecutory delusions related to his own family. His twin brother, PM, started to share the same delusions and together they set fire the house they were living in. This led to their first hospitalization. There was an attempt to separate the twins, but they showed a worsening in behavior. They never received a regular psychiatric treatment, but had a follow-up with a neurologist for the last 4 years regarding "memory deficit" and "spinal cord degeneration" complaints. The twins were referred to our service a year ago and treated with risperidone. CM presents a richer psychotic content (hypochondriac and grandiose delusions) and PM presents a more submissive behavior than CM, copying his brother's speech and attitude. To date, the patients did not show any improvement of their condition and CM began to use olanzapine. They refused treatment at the day hospital. Since early childhood, they are very close and rarely perform daily activities without each other.
Conclusion: We worked with the diagnostic hypothesis of schizophrenia for CM and simple schizophrenia for PM. The literature is divided regarding the treatment of this disorder, considering that the behavioral measure of separating the patients was successful in some cases and detrimental in others. The drug treatment is limited and the use of antipsychotics is still recommended.
Policy of full disclosure: None.

P-02-010
The importance of a causative underlying medical condition

E. Neroutsos (General Hospital Thriasion, Psychiatric, Magoula Elefsina, Greece; S. Foteli, A. Zachariadis, M. Fiste)

Objective: Mr. P., a 18-year-old man, was brought into the emergency psychiatric department of Thriasio Hospital by his family, after having his first episode of psychosis. We present the therapeutic procedures we followed to assist the patient.
Methods: Presentation of a clinical case, Medline research.
Results: He was admitted in the emergency department with delusion of persecution, delusion of self-accusation, olfactory hallucinations, psychomotor agitation and mood irritability. He was suspiciously looking around the examination room, appeared frightened, and was responding to internal stimuli. He received an injection of haloperidol and lorazepam. Initially confused, distracted, and agitated, he became cooperative and compliant. The patient's physical examination was unremarkable, with no evidence of focal neurological signs, movement disorder or soft neurological signs. Laboratory values such as routine blood tests (CBC), elecrtrolytes, iron studies (iron saturation, serum ferritin), serum B12, serum folate, reticulocyte count, peripheral blood smear, THS (for hypothyroidism), LFT's (liver disease), BUN and creatinine (renal disease) were within normal ranges. In addition an electroencephalogram, a brain computed tomography scan and an electrocardiograph were made, without revealing any abnormalities. His toxicology screen was negative. In the psychiatric unit, treatment with olanzapine 15 mg per day was initiated. The patient responded well to the medication, however the olfactory hallucinations were not reduced and because of them an ENT specialist examined him. He was diagnosed with a Rhinolith in his left nostril. The olfactory hallucinations were attributed to Rhinolithiasis. After the operative treatment of Rhinolithiasis the olfactory hallucinations were eliminated.