

EPP1026

External and Internal Shame in people with migraines

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Introduction: Migraine often leads to reduction of social power and prestige of the patients, hence leading further emotions of shame.**Objectives:** Exploring the role of external and internal shame in people with migraines.**Methods:** The sample consisted of 180 people, more specifically 140 people from the general population and 40 people who have been diagnosed with migraine and receiving treatment for migraine, who completed the following questionnaires voluntarily and anonymously: a) Migraine Experience Questionnaire and Headache Impact Test-6 (HIT-6), b) the Other As Shamer scale (OAS) c) the Experience of Shame Scale (ESS), and socio-demographic and self-reported questionnaire.**Results:** Patients scored higher level external Shame (OAS) rates (31.28 ± 6.98) than people from the general population who scored lower external Shame (OAS) rates (16.89 ± 10.00) with a statistically significant difference between them ($p = 0.000$). Also, patients scored lower-level internal shame (ESS) rates (45.58 ± 6.91) than people from the general population who scored higher internal shame (ESS) rates (53.36 ± 15.62) with a statistically significant difference between them ($p = 0.003$).**Conclusions:** Patients with symptoms of migraine show statistically higher level of external shame and lower level of internal shame and further study is considered necessary.**Disclosure of Interest:** None Declared

EPP1027

Where art thou? Reflecting on auditory hallucinosis

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Introduction: Hallucinosis has evolved out of classification systems but what about patients who present with exclusive or almost exclusive hallucinations? Auditory hallucinations are especially likely to swiftly be considered due to psychiatric illness.

An elderly patient with chronic auditory hallucinations without other significant psychopathology nor other symptoms prompted reflection and literature review.

Objectives: To review differential diagnosis of auditory hallucinosis.**Methods:** Pubmed search for terms: auditory and hallucinosis.**Results:** Hallucinations should be evaluated according to: type, onset and evolution, association with physical and /or neurological

symptoms, association with other hallucinations and/or other psychopathology, characteristics.

Auditory hallucinations may present along a continuum from tinnitus, simple, verbal, musical.

The Pubmed search retrieved articles pertaining to auditory hallucinations associated with:

1. Sensory deprivation; 2. Hearing loss, auditory Charles Bonnet syndrome; 3. Dementia, neurodegenerative disorders; 4. Brainstem lesions; 5. Other central nervous lesions: thalamus, temporal, other; 6. Epilepsy; 7. Tic disorders; 8. Alcohol use disorders; 9. Borderline personality disorder; 10. Others.

Conclusions: Patients presenting with auditory hallucinosis should be carefully evaluated to exclude non-psychiatric disorders.

In some patients, such as the one who prompted the review, an identifiable cause may not yet be found.

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EPP1028

Diagnostic stability of 346 patients with borderline personality disorder based on retrospective clinical records

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Introduction: State-of-the-art research highlights that borderline personality disorder have high rates of comorbid Axis I disorders, which imply uncertainty in establishing an accurate diagnosis and can be some of the most challenging patients for clinicians and researchers.**Objectives:** This study seeks to observe the diagnostic stability in borderline personality disorder patients, in order to increase empirical knowledge through a retrospective look at the historical line of diagnoses.**Methods:** A twenty-year retrospective study at a psychiatric hospital, searching at the electronic clinical records for all patients with borderline personality disorder diagnosis, under the code 301.83 from World Health Organization's International Classification of Diseases, 9th Revision (WHO ICD9). A 346 patients' sample was identified aged between 18 and 83 years ($M_{age}=44.14$ years, $SD=11.18$; predominantly female 73.70%; $M_{schooling}=9.31$ years; $M_{admissions}=4.72$ times, $SD=9.21$; 2nd-5th comorbid diagnosis, a 75.72% sample with three diagnosis); excluding organic cerebral syndrome and no comorbidity besides drug abuse, or no comorbidity at all.**Results:** As a general observation, the following diagnoses are indicated: 44.09% major depressive disorder, 33.16% affective disorder, 13.05% schizophrenia, and 9.70% mania. As a spectrums