*Results* Four distinct clusters were identified (Fig. 1): (1) a 'positive cluster', (2) a 'mild cluster', (3) a 'negative cluster', and (4) a 'mixed group'. These clusters are similar to those found by Dolffus et al.
There was a significant association between cluster and co-morbid personality disorder, $P < 0.05$. No significant association was found between clusters and other clinical variables.
*Conclusions* Among difficult-to-treat institutionalised patients four distinct subtypes of psychosis could be identified, comparable to those found in a cohort of schizophrenia patients.

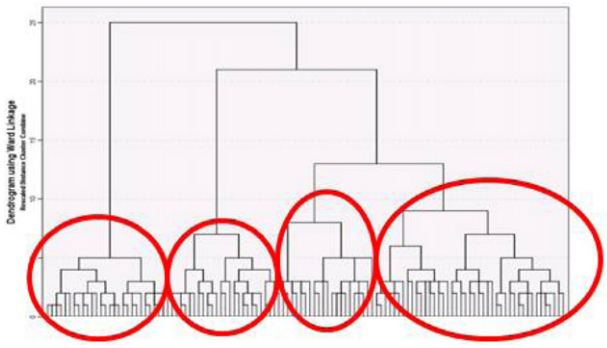

*Fig. 1* Dendrogram showing a 4 cluster solution.

*Disclosure of interest* The authors have not supplied their declaration of competing interest.
*Reference*
[1] Dolffus, et al. Identifying subtypes of schizophrenia by cluster analyses. Schizophrenia Bulletin 1996:545–55.

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**EW0086**

## Relationship of severity of ADHD symptoms with the presence of psychological trauma while controlling the effect of impulsivity in a sample of university students

E. Dalbudak [1], C. Evren [2], B. Evren [3,*], S. Ozen [1]
[1] *Private practice, Ankara, Turkey*
[2] *Bakirkoy Training and Research Hospital for Psychiatry Neurology and Neurosurgery, Research, Treatment and Training Center for Alcohol and Substance Dependence Amatem, Istanbul, Turkey*
[3] *Baltalimani State Hospital for Muskuloskeletal Disorders, Department of Psychiatry, Istanbul, Turkey*
[*] *Corresponding author.*

*Objective* The aim of the present study was to evaluate relationship of severity of ADHD symptoms with the presence of psychological trauma while controlling the effect of impulsivity in a sample of university students.
*Method* Participants included 321 volunteered university students. Participants were evaluated with the Short Form Barratt Impulsiveness Scale (BIS-11-SF), the Adult ADHD Self-Report Scale (ASRS) and the Traumatic Experiences Checklist (TEC).
*Results* Age and gender did not differed between those with the history of psychological trauma ($n = 271$, 84.4%) and those without ($n = 50$, 15.6%). BIS-11-SF and subscale scores did not differ between groups, other than motor impulsivity, which was higher among those with the history of psychological trauma. ASRS score, inattentiveness and hyperactivity/impulsivity subscale scores were higher among those with the history of psychological trauma than those without. Severity of ADHD symptoms, particularly inattentiveness score, predicted the presence of psychological trauma, together with the severity of motor and attentional impulsivities in a logistic regression model.
*Conclusion* These findings suggest that the severity of ADHD symptoms may be related with the presence of psychological trauma, while severity of motor and attentional impulsivities may have an effect on this relationship among young adults.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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**EW0087**

## Relationship of high PTSD risk with severity of ADHD symptoms while controlling the effect of impulsivity in a sample of university students

E. Dalbudak [1], C. Evren [2,*], B. Evren [3], S. Ozen [1]
[1] *Private practice, Istanbul, Turkey*
[2] *Bakirkoy Training and Research Hospital for Psychiatry, Neurology and Neurosurgery, Research, Treatment and Training Center for Alcohol and Substance Dependence Amatem, Istanbul, Turkey*
[3] *Baltalimani State Hospital for Muskuloskeletal Disorders, Department of Psychiatry, Istanbul, Turkey*
[*] *Corresponding author.*

*Objective* The aim of the present study was to evaluate relationship of high PTSD risk with severity of ADHD symptoms while controlling the effect of impulsivity in a sample of university students.
*Method* Participants included 271 volunteered university students. Participants were evaluated with the Short Form Barratt Impulsiveness Scale (BIS-11-SF), the Adult ADHD Self-Report Scale (ASRS) and PTSD Checklist Civilian version (PCL-C).
*Results* Age and gender did not differed between those with the high PTSD risk ($n = 224$, 82.7%) and those without ($n = 47$, 17.3%). BIS-11-SF and subscale scores, other than non-planning impulsivity (which showed no difference), and ASRS scores were higher among those with the high PTSD risk than those without. Severity of ADHD symptoms, particularly inattentiveness (IN) score, predicted the high risk of PTSD, together with the severity of motor impulsivity in a logistic regression model.
*Conclusion* These findings suggest that the severity of ADHD symptoms is related with the high risk of PTSD, while severity of motor impulsivity may have an effect on this relationship among young adults.
*Disclosure of interest* The authors have not supplied their declaration of competing interest.

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**EW0088**

## Dual diagnosis: On the way to an integrated treatment model?

I. Ezquiaga [1,*], Z. González Vega [2], P. Rossi [1], F. Fonseca [1], C. Tamarit [1], C. Castillo [1], I. Castro [1], M. Torrens [1]
[1] *Institut de Neuropsiquiatria i Addiccions, Parc de Salut Mar-, Psychiatry, Barcelona, Spain*
[2] *Hospital Obispo Polanco, Psychiatry, Teruel, Spain*
[*] *Corresponding author.*

*Introduction* Substance use disorders (SUD) with psychiatric comorbidity (dual diagnosis) represent a challenge for both mental health and addiction networks. Dual patients present greater disorder severity and worse prognosis than those with SUD or psychiatric disorders alone. There is a lack of consensus regarding which treatment model (sequential, parallel or integrated) is the most appropriate for them. Despite integrated treatment is seen as the model of excellence, it is a standard difficult to achieve.