interventions of cognitive rehabilitation and deciding how to evaluate them. Further research is required to strengthen this evidence.

Disclosure of Interest: None Declared

O0112

""Why shouldn't I expect things from life?" – what people with lived experience from psychosis highlight as important to their personally defined long-term recovery process"

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Introduction: Many people with lived experience from psychosis recover and thrive, contrary to the common stigmatizing belief that they will be chronic "patients". But there are several ways to understand recovery, one is as a subjective process best explored through qualitative interviews with people who have recovered from psychosis. However, there is a need for more qualitative interview studies exploring what has been important for long-term subjective recovery for people with lived experience from psychosis outside of treatment. Exploring themes that are novel than previous research will have important clinical implications.
Objectives: This study aims to qualitatively explore what people with lived experience from psychosis believe has been the most important to attain and sustain their long-term personally defined recovery.
Methods: Qualitative interviews with 20 individuals participating in two follow-up-studies (TOP and TIPS-study) 10 and years 20 years after first treatment for a psychotic disorder (schizophrenia- or bipolar spectrum), respectively. All participants were in either clinical recovery (symptom remission and adequate functioning) or personal recovery (self-rated questionnaire) or both. Interviews were analyzed with thematic analysis in group meetings between the PhD-candidate, the main supervisor, a professor emerita in qualitative method and a co-researcher with lived experience from bipolar disorder.
Results: Participants defined recovery differently, but: "understanding myself", "stable symptoms" and "finding the life that is right for you" were of the most common definitions. Tentatively, five main themes appear to be the most salient contributions to recovery: 1. Balance stress management with taking risks and following personal goals. 2. Accepting experience/"owning your story" in order to strategically disclose and manage stigma. 3. Taking agency over own recovery and mastery of everyday life. 4. Social support is crucial, but should change over time depending on need. 5. Feeling a sense of belonging to society does not need to entail "normality".
Conclusions: Recovery was defined differently by each participant, but common themes across participants highlight that appropriate risk-taking, accepting your experience/owning your story, sense of agency, social support and inclusion are important to long-term recovery in psychosis.

Disclosure of Interest: None Declared

O0113

Accelerated repetitive transcranial magnetic stimulation (ATMS) vs standard repetitive transcranial magnetic stimulation (RTMS) in the treatment of major depressive episodes. preliminary data of a randomized, single-blind, controlled trial

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Introduction: Major Depressive Disorder is a frequent and disabling condition. More than 20% of patients do not respond to pharmacotherapy alone, so there is the need to find alternative strategies in order to potentiate the drugs. Therapeutic alternatives include repetitive Transcranial Magnetic Stimulation (rTMS), which has shown an antidepressant effect in the last decades.
Objectives: Comparison of the efficacy of accelerated repetitive Transcranial Magnetic Stimulation (aTMS) treatment (4 sessions/day for 5 days) with the standard rTMS protocol treatment (1 session/day for 4 weeks), using the FDA-approved parameters.
Methods: 33 patients affected by Major Depressive Episodes treated with either Fluvoxamine or Venlafaxine were enrolled. Patients were randomly assigned to the two protocol groups: standard rTMS protocol (15 patients) and aTMS protocol (18 patients). In the standard protocol, patients received 1 rTMS session/day for 4 weeks, while in the aTMS protocol they received 4 rTMS sessions/day for 5 days. Symptomatological improvement was evaluated through MADRS, BDI-II and SSI rating scales administered on day: 0, 1, 2, 3, 4, 5, 14, 21, 28, 56. The study is single-blind, since the clinical rater was unaware of the treatment protocol group. Response and remission rates were calculated, defined respectively as a reduction ≥50% in the MADRS score and a MADRS score <10.
Results: The analysis was carried out on 32 patients (18 in the aTMS group and 14 in the rTMS group). ANOVA for repeated measures shows a statistically significant difference in the MADRS scores on day 5 (p=0.001) and on day 56 (p=0.037). Regarding the BDI-II evaluation, the differences were not fully statistically significant on day 5 and not significant on day 56. No statistically significant differences between the two protocols were observed in the SSI assessment. The aTMS and rTMS response rates were respectively 84.6% vs 45.5% on day 28 (p=0.043) and 92.3% vs 45.5% on day 56 (p=0.012). The aTMS and rTMS group remission rates were respectively 76.9% vs 18.2% on day 28 (p=0.004) and 69.2% vs 36.4% on day 56 (p=0.107). Concerning side effects, no statistically significant differences were observed between the two groups.
Conclusions: Treatment with aTMS seems faster and more effective than treatment with standard rTMS in improving the clinical condition in patients with Major Depressive Episodes, allowing to treat patients in just 5 days instead of 4-6 weeks, without impacting on side effects and tolerability.

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