

17 to 50,7 for the siblings. Unlike parents, siblings generally attended a limited number of sessions.

Image:

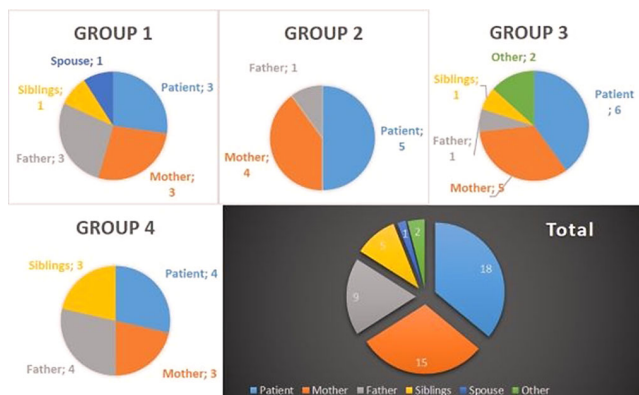
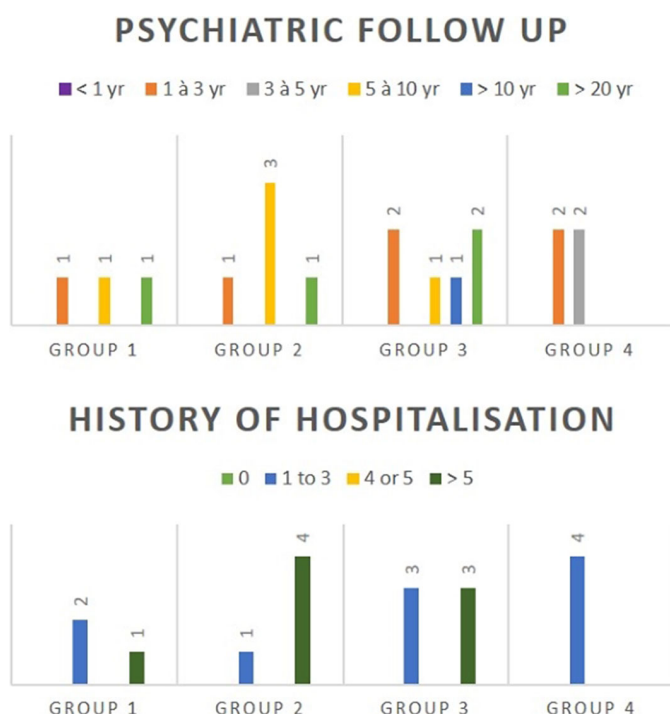


Image 2:

	PATIENTS			MOTHER		FATHER		SIBLINGS		SPOUSE	
	Patient	Age	sex	PRESENT	Age	PRESENT	Age	Age	Sex	Age	Sex
GROUP 1	1	27,5	M	Yes	56,4	Yes	56,5			50,2	F
	2	31,3	F	Yes	58,6	Yes	50,7				
	3	40,8	F	Yes	70,5	Yes	73,6	43,2	SISTER		
GROUP 2	4	28,7	M	Yes	61,8						
	5	30,2	M	Yes	61,3	Yes	63,8				
	6	33,2	F	Yes	59,1						
	7	31,6	F	Yes	59,1						
	8	53,1	F	Yes	80,4						
GROUP 3	9	35,7	M	Yes	63,6						
	10	20,1	M	Yes	79,4						
	11	47,5	F	Yes	80,9						
	12	57,5	M	Yes	79,3			50,7	SISTER		
	13	27,0	M	aunt	47,9	uncle	52,3				
GROUP 4	14	35,4	M	Yes	61,5	Yes	59,4				
	15	20,9	M	Yes	57,3	Yes	58,6				
	16	26,7	F	Yes	55,3	Yes	58,7	20,8	BROTHER		
	17	21,5	M			Yes	54,3	24,3	SISTER		
	18	20,4	F	Yes	51,1	Yes	50,8	17,2	SISTER		

Image 3:



**Conclusions:** This descriptive study reflects the work carried out with 18 patients and their relatives in an MFT group providing psychoeducation to patients suffering from schizophrenia and their caregivers. 50 persons benefited from psychoeducation in 2 years. We learned from these results to improve the constitution of our groups and the benefits of our psychoeducation program. We were careful to include families with siblings as we know they are affected by the mental illness in the family and are often left aside of all care/support proposals. We questioned ourselves on the advantages of homogeneous or heterogeneous groups, considering age, history of follow up. How could it impact affiliation to the group or differentiation movements? How useful or harmful it is for sharing experiences between the families. A proper study would be necessary to answer these questions.

**Disclosure of Interest:** None Declared

### Classification of mental disorders

#### EPP0099

### Traumatic Brain Injury and Conversion Disorder in a Veteran's Atypical Presentation

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**Introduction:** Traumatic brain injury (TBI) induces cognitive and behavioral changes due to environmental impacts on brain tissue.

**Objectives:** Highlighting the atypical TBI presentation challenging conventional diagnostics and obscured by conversion disorders.

**Methods:** A 36-year-old male veteran, injured by a sniper rifle in 2011, presented with right ear tinnitus and monthly, unresponsive right hemcranial headaches. Seizures occurred every two weeks with no reported loss of consciousness or sensation. The gunshot wound to the neck in 2011 prompted emergency intervention, with entry and exit wounds located in the posterior lateral neck. Post-injury symptoms comprised hearing loss, tinnitus, restricted neck movement, and weakness in the right arm. Seizures persisted, accompanied by numbness and neck movement. Management included physical therapy, hyperbaric oxygen therapy (improving weakness but not tinnitus), and administration of piracetam (2400 mg/day), sertraline (100 mg/day), and ginkgo biloba (2400 mg/day). Psychiatric consultation suggested a diagnosis of "conversion disorder."

**Results:** Neuropsychological Evaluation: Raven Standard Progressive Matrices Test showed borderline impairment. Psychiatric Evaluation noted monotonous mimics, occasional depersonalization, reduced emotional involvement, and slowed psychomotor activity. Elevated trait anxiety was observed per the State-Trait Anxiety Inventory. Neurological Examination identified left arm weakness and impaired resting balance. Imaging Findings: F18-FDG PET/CT Scan at 1 year post-GSW showed hypermetabolism in the right frontal lobe, and at 3.5 years post-GSW demonstrated decreased glucose metabolism in the bilateral cerebellar cortex, temporal lobe, and bilateral parietal lobe.

**Conclusions:** A high-kinetic-energy bullet passed through the right lateral base of the neck without causing apparent brain damage.

Proposed is the generation of upward pressure waves in neck tissues through the transmission of kinetic energy, compressing and displacing soft tissues toward the skull. Gunshot injuries create cavities, forming high-pressure waves capable of damaging distant brain regions, leading to TBI such as crush injury, edema, and myelin and axonal damage (Courtney & Courtney, 2007). Microscopic brain damage, undetectable by current imaging, may only surface during autopsy (Yilmaz & Pekdemir, 2007). Rat studies after primary blast injuries reveal brain alterations, highlighting that high-pressure pulses can cause neuronal damage, potentially yielding related symptoms (Cernak et al., 2001). The patient's atypical symptoms, combined with the initial conversion disorder hypothesis, underscore the need for a diagnostic paradigm shift to differentiate traumatic brain injury from other potential misnomers.

**Disclosure of Interest:** None Declared

## Rehabilitation and psychoeducation

### EPP0100

#### Self-stigma and its reduction in patients with bipolar affective disorder

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**Introduction:** The phenomenon of self-stigma in patients with bipolar affective disorder (BD) has been studied much less than in other mental disorders (Favre, Richard-Lepourie, 2023). However, self-stigma has equally negative psychosocial consequences for them (Shargh et al, 2015). Therefore, identifying the clinical and psychological characteristics of self-stigma in BD patients, especially in the initial stages of the disease, and developing on this basis new directions for their psychosocial rehabilitation to reduce self-stigma is relevant.

**Objectives:** To identify clinical and psychological characteristics of self-stigma in BD patients, to identify targets for psychosocial rehabilitation.

**Methods:** «Questionnaire for assessing the phenomenon of self-stigmatization of mentally ill people» (Mikhailova et al., 2005), «Insight Scale for Psychosis» - ISP (Birchwood et al., 1994). We examined 17 patients (12 women and 5 men) with a diagnosis of bipolar affective disorder (F31.xxx according to ICD-10). The average age of the patients was 25.52±4.55 years. The duration of the disorder is 0.5-3 years.

**Results:** It was shown, that patients with BD had a high level of self-stigma. Indicator «General level of self-stigma» was 1.22±0.73 points, that higher its average values. The main component in the structure of self-stigmatization was an overestimation of possible limitations of one's own internal activity and self-realization (1.96 ± 0.87 and 1.62 ± 0.82 points, respectively) associated with the disease. Idealization of one's pre-illness qualities and achievements (1.62±0.82 points) and the formation of misconceptions about the loss of previous opportunities will able to lead to negative personal changes and limit the activity of patients. Correlation analysis revealed significant ( $p \leq 0.01$ ) correlations between the «Patient's ability to recognize painful phenomena as symptoms of mental

illness» scale of the ISP scale and individual parameters of the questionnaire for assessing self-stigma: «Imagination of one's own failure due to illness» -  $r = 0, 52$ ; «Fear of becoming insolvent due to illness» -  $r=0.54$ ; «Idealization of the «healthy self»,  $r=0.51$ . Thus, in BD patients, self-stigma is associated with low awareness of the disease and misconceptions about it and about themselves.

**Conclusions:** Psychoeducation programs, aimed at formation an adequate perception of mental disorder, the ability to recognize its symptoms, and destigmatization trainings to increase the social activity are needed for BD patients. Such trainings were developed during the research and are currently being tested.

**Disclosure of Interest:** None Declared

## Classification of mental disorders

### EPP0101

#### Participation limitations as a transdiagnostic feature in serious mental illness: confirmatory modeling

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**Introduction:** Participation in daily life occupations of personal and community meaning is an important component of health and recovery from mental illness. Limitations in participation were found to be a hallmark of serious mental illness (SMI). Still, previous research has mainly focused on objective dimensions of participation, largely neglecting the subjective aspects that hold particular relevance for health outcomes. Next, participation was addressed by specific diagnoses, approach which is divergent from the recovery model, a transdiagnostic approach and clinical practice. Hence, further research into participation is warranted to broaden our understanding.

**Objectives:** We investigated objective and subjective patterns of participation across a range of SMI diagnoses to delineate differences, and to identify personal and illness-related factors associated with participation dimensions.

**Methods:** A secondary analysis of cross-sectional studies (N=14). The analysis included data from 489 men (40.7%) and women (59.3%) diagnosed with one of 4 SMI conditions: psychotic, affective (AD), post-traumatic (PTSD) or personality (PD) disorders. The participants were aged 18 to 60 ( $M=34.41$ ;  $SD=10.9$ ) and were in contact with intensive mental health services. All participants completed the Adult Subjective Assessment of Participation (ASAP), which comprised participation intensity, diversity, satisfaction and enjoyment, and standard evaluations of cognitive functioning, symptom severity, and functional capacity. Z-scores were calculated for independent variables to enable comparison. Demographic and illness-related (IR) information was also collected.

**Results:** Frequency of participation was found to be significantly different between diagnostic groups, but not participation diversity, enjoyment and satisfaction. Participation diversity was altered by range of demographic variables ( $5.26 < F < 10.6$ ,  $p < .01$ ,  $0.3 < \eta^2 < 0.4$ ) while participation frequency differs by employment status ( $t(485) = -2.84$ ,  $p < 0.05$ , Cohen's  $d = 0.25$ ). No differences were found