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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doi: 10.1192/j.eurpsy.2024.324

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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doi: 10.1192/j.eurpsy.2024.325

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 ($5.26<F<10.6$, $p<.01$, $0.3<<0.4$) while participation frequency differs by employment status ($t(485) = -2.84$, $p<0.05$, Cohen's $d=0.25$). No differences were found

between groups in symptoms' severity. Regression analysis indicates that cognition, functional capacity and employment status explain in a significant way integrated index of objective participation (χ^2 =47.52, p<0.001). For the subjective dimension, the logistic regression was not found statistically significant (χ^2 =20.99, p=0.51).
Conclusions: Limitations in diversity, enjoyment and satisfaction with participation, were demonstrated to be a transdiagnostic feature in SMI. Objective participation dimensions can be explained with demographic, personal and illness related factors, while modeling of subjective dimensions should be further investigated.

Disclosure of Interest: None Declared

Comorbidity/Dual Pathologies

EPP0103

Transcranial Magnetic Stimulation and Dual Pathology: An Integrative Protocol

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doi: 10.1192/j.eurpsy.2024.326

Introduction: Dual pathology, characterized by the simultaneous presence of substance use disorders and psychiatric disorders, is a topic of growing interest in the scientific community. In particular, obsessive-compulsive disorder (OCD) is a common comorbid psychiatric condition in patients with substance use disorders.
Objectives: To evaluate the efficacy of rTMS on comorbid disorder symptoms by applying specific protocols for OCD and substance use disorder in a clinical case of dual pathology.
Methods: Case Description: A 36-year-old male diagnosed with OCD and habitual cocaine use (an average of 6 times per month). Previous unsuccessful attempts to quit substance use. Undergoing psychotherapy and psychopharmacological treatment for OCD since the age of 22 with no significant clinical improvement.
Methodology: The severity of OCD was quantified before and after the intervention using the Yale-Brown Obsessive Compulsive Scale (YBOCS). To assess addictive behavior, the Maudsley Addiction Profile (MAP) was used. During the intervention period, the occurrence of substance use was recorded based on the patient's and family members' reports. The intervention involved the administration of an rTMS protocol tailored to the specific case, consisting of the simultaneous application, using a double-cone coil, of rTMS at 20Hz over the right dorsomedial prefrontal cortex (DMPFC) at an intensity of 100% of the resting motor threshold (RMT) to treat OCD symptoms, followed by intermittent theta burst stimulation (TBS) over the left DMPFC at an intensity of 120% of the RMT to address substance addiction. The patient received a total of 30 sessions at a rate of one session per day, five days a week, for six weeks.
Results: Results: The results showed an improvement in the total score on the YBOCS scale, decreasing from a value of 26 in the pre-intervention assessment to 16 in the post-intervention assessment, representing a reduction of more than 35% from pre- to post-intervention, meeting response criteria. Thus, there was a decrease in both obsessive and compulsive symptoms, with reduced associated distress and increased control. Additionally, throughout the intervention, there was a gradual decrease in substance use, decreasing from an average of 6 monthly instances before treatment initiation to a total of 1 in the month the treatment ended.
Conclusions: Conclusions: This unique case study represents a therapeutic window for the treatment of patients with comorbid disorders, demonstrating promising preliminary benefits of the combined rTMS intervention for both conditions, especially in the field of addictions.
Keywords: rTMS, neuromodulation, obsessive-compulsive disorder, addictions

Disclosure of Interest: None Declared

EPP0104

A Challenging Conundrum; Learning Disability, Schizophrenia and Autism - a Case Report

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doi: 10.1192/j.eurpsy.2024.327

Introduction: Psychiatric disorders are common in patients with learning disabilities. There are also patients with the triad of autism, schizophrenia and learning disability. Patients with this background can be admitted to general hospitals for psychiatric or non-psychiatric reasons.
We are presenting a case who had a very complicated clinical course and her discharge planning was challenging.
Objectives: The objective of this work was to show the challenges in the investigation, medical management, and discharge planning of the patients with concomitant learning disability, schizophrenia and autism.
Methods: We scrutinized the patient's casenotes, including blood results and all relevant imaging. We paid a particular attention to all the entries from the psychiatry team, general medical doctors, oncologists, learning disability team and discharge planners.
Results: The lady had a protracted 4-month inpatient admission throughout which she was physically and verbally aggressive to hospital staff. She was deemed to lack capacity for hospital admission and treated in her best interests under Mental Capacity Act (MCA), frequently requiring sedation with Haloperidol and Lorazepam. Following consultation with the local Psychiatrist her medications were altered to: Risperidone 2 mg BD, Diazepam 5 mg OM, 5 mg afternoon and 10 mg evening, Procyclidine 5 mg BD, Chlorpromazine 25 mg BD, Promethazine 25 mg OD PRN, and Midazolam 10 mg buccal PRN.
A change in her clinical condition was noted by the Psychiatry team; increased agitation, confusion and dysarthria. A repeat blood test was advised, due to patient refusal this took weeks to achieve despite the use of buccal Midazolam following Anaesthesiologist advice. Although blood tests were not significantly deranged, she was treated for presumed urinary tract infection with a course of antibiotics. A urine sample was unobtainable.
She reported right breast pain and underwent a mammogram. This showed a hypoechoic lesion 8x7x9 mm. Following consultation with a Breast Surgeon and Oncologist, Letrozole was replaced with