

Introduction: Persistent depressive episodes and subsyndromic depressive symptoms frequently characterize mood alterations in bipolar disorder (BD) and negatively influence quality of life and suicide risk. BD patients with predominant depressive episodes generally show significantly higher treatment resistance rates. Although not specifically approved in Italy for bipolar depression, recently published observational data suggest that the cariprazine add-on may be a potential effective short-term treatment for resistant bipolar depression. Nevertheless data on long-term cariprazine treatment are lacking.

Objectives: This study evaluated the efficacy and safety of long-term cariprazine augmentation in patients suffering from treatment-resistant bipolar depression.

Methods: 30 resistant bipolar depressed patients, whose resistance was defined according to The CINP Guidelines on the Definition and Evidence-Based Interventions for Treatment-Resistant Bipolar Disorder, were treated with cariprazine 1,5 -3 mg flexible dose for 4 weeks, added to previous mood stabilizing and/or antidepressant treatment. Psychopathology at time 0 and at 4, 8, 12, 16, 20, 24 weeks of treatment was evaluated using the Hamilton Depression Rating Scale (HDRS), the Hamilton Anxiety Rating Scale (HARS), the Young Mania Rating Scale (YMRS) and the Bipolar Depression Rating Scale (BDRS); safety and tolerability was measured by the UKU Side Effect Rating Scale. The drop-out rate was assessed throughout the study duration.

Results: Cariprazine add-on was effective in the study sample but only during the first 4 weeks of treatment. Improvement in depression scores started from the first week, reaching about 40% mean HDRS score reduction at T4; a moderate ulterior decrease (-15%) was reached at T24 but was accompanied by a significant drop-out rate; anxiety symptoms improved (mean HARS score reduction 37% at T4) mainly during the first 4 weeks. The treatment was generally well tolerated. From week 4 to 24 we observed a near 70% drop-out rate (18 total drop-outs) with maximum drop-outs between weeks 4-8 (n=7) and 18-24 (n=7). Discontinuation causes were inefficacy (5/18); clinical worsening (10/18); side effects (3/18); hypomanic shift (2/18).

Conclusions: Despite the relatively small population examined and the observational design, our results suggest that cariprazine may represent an effective and safe short-term enhancement strategy in resistant bipolar depression. Long-term treatment, in this sample, did not lead to significant improvements and was burdened by a high drop-out rate, mainly due to inefficacy/clinical worsening. Further studies on larger samples are needed to confirm these preliminary findings, both in short-term and in longer observations.

Disclosure of Interest: None Declared

O0086

Mitochondrial respiratory capacity in patients with acute episodes of bipolar disorder compared with clinical remission

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Introduction: Bipolar disorder (BD) is a chronic and recurrent disease characterized by acute mood episodes alternated with periods of euthymia. The available literature postulates that a biphasic dysregulation of mitochondrial bioenergetics might be observed in BD.

Objectives: We aimed to explore differences in *in vivo* mitochondrial respiration (1) intra-individually: longitudinally within patients during an acute mood episode of BD and after clinical remission, and (2) inter-individually: between patients with BD on depressive or manic episodes and healthy controls (HC).

Methods: Patients admitted to our acute psychiatric ward with a manic episode or bipolar depression were recruited. Different mitochondrial oxygen consumption rates (OCRs) were assessed during the acute episode (T0) and after clinical remission (T1) in one million of peripheral blood mononuclear cells (PBMC): Routine, Leak, ETC and Rox. They were measured as picomoles of oxygen per million cells (pmol O₂/million). This experiment was also conducted in HC. High-resolution respirometry was performed at 37°C by polarographic oxygen sensors in a two-chamber Oxygraph-2k system. Manic and depressive symptoms were assessed using standardized psychometric scales. Oxygen consumption capacity was compared (1) intra-individually, during acute episodes and after clinical remission, and (2) inter-individually, during acute manic and depressive episodes, and in HC. Statistical analyses were performed with SPSS, GraphPad and R Statistics.

Results: 20 patients with BD (15 manic, 5 depressed) and 10 HC were included. A significant increase in the maximal oxygen consumption capacity (ETC) was observed in clinical remission (27.4 ± 17.4) compared to the acute episodes (21.1 ± 11.7, p = 0.001), which remained significant after subtracting Rox from the other rates (p = 0.001). At T1, patients admitted with a manic episode tended to show higher mean ETC (31.2 ± 18.7) compared with T0 (24.1 ± 12.0, p = 0.074); the tendency persisted after Rox subtraction (p = 0.076). Patients admitted with a depressive episode also showed higher ETC means in T1 (16.3 ± 3.8) compared to T0 (12.1 ± 3.4), but there were not significant differences (p = 0.231). When HC, manic and depressive patients at T0 were compared between them, significant differences were observed in ETC (H = 8.5; p = 0.014) and Rox (H = 13.8; p = 0.001). After Rox deduction, differences in ETC remained (H = 11.7; p = 0.003). Individuals with bipolar depression showed lower ETC rates (12.1 ± 3.4) than those with a manic episode (24.1 ± 12.0; t = -3.5, p = 0.003), which was also found after Rox deduction (p = 0.001).

Conclusions: In both manic and depressive episodes in BD, mitochondrial respiration might be reduced and increase after clinical remission. Further studies with larger samples will allow to confirm these results and also to identify potential mitochondrial state-dependent biomarkers.

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Comorbidity/Dual Pathologies

O0087

A qualitative exploration of the lived experience of informal caregivers of people with severe mental illness and co-existing long-term conditions.

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Introduction: People with severe mental illness (SMI), including schizophrenia and bipolar disorder, experience significant health inequalities and are more likely to develop long-term physical health conditions (LTCs), such as type 2 diabetes and cardiovascular disease. Many people with SMI rely on informal caregivers, typically friends and family, to support their health and enable them to live in the community. Informal caregivers of people with SMI experience high levels of caregiver burden, social isolation, and poor health outcomes. However, it is unclear how co-existing LTCs contribute to the caregiving experience.

Objectives: The aim of this study was to explore the lived experience of informal caregivers of people with co-existing SMI and LTCs.

Methods: We conducted a qualitative study with informal caregivers of people with co-existing SMI and LTCs in England. We recruited 12 informal caregivers and conducted five semi-structured interviews and two focus groups between December 2018 and April 2019. The interviews and focus groups were audio recorded, transcribed verbatim and thematically analysed.

Results: SMI impacts profoundly on the health and well-being of both service users and their informal caregivers. Service users were described as too unwell with their SMI to engage in self-management of their mental and physical health, with the primary responsibility for these tasks falling to informal caregivers. There were significant barriers to adequate physical healthcare for service users, therefore informal caregivers needed to advocate extensively for their loved ones to ensure access to services. Informal caregivers felt significantly under-supported and struggled with the caregiver burden associated with SMI and LTCs. This burden included the constant monitoring of risk, anxiety around the vulnerability of their loved one, repeated hospitalisations, physical health concerns, lack of respite services, lack of recognition of their role, the guilt

associated with paternalistic care, shame and stigma, and the difficulties managing the changeable nature of SMI.

Conclusions: Informal caregivers of people with SMI face an additional caregiver burden resulting from co-existing LTCs. This adds substantially to their caring role, yet they do not receive the necessary support, and therefore their own health and wellbeing are negatively impacted. Improved recognition of the role of informal caregivers and additional support, including improved provision of respite services, are needed to improve the well-being of informal caregivers.

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Personality and Personality Disorders

O0088

Physical illness and multimorbidities in patients diagnosed with personality disorder

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Introduction: People with personality disorder (PD) often experience suffering, suboptimal psychiatric treatment outcomes, and early mortality due to chronic physical illness (CPI) and multimorbidity (≥ 2 CPI) (CPM). Increasing research underscores the elevated prevalence of CPI and CPM in those with PD.

Objectives: To compare the prevalence of CPI/CPM between the general population and those with PD and to explore the relationship between CPI/CPM and various aspects of PD.

Methods: This cross-sectional study enrolled 126 PD patients (70.6% female, mean age 41.22 years) based on the ICD-10 criteria, and 126 socio-demographically matched individuals from the general population. The participants completed the following instruments: the ICD-11 Personality Disorder Severity Scale (PDS-ICD-11), the Personality Assessment Questionnaire for ICD-11 (PAQ-11), Subjective Emptiness Scale (SES), the Reflective Functioning Questionnaire-Revised-7 (RFQ-R-7), and self-reported chronic physical illnesses questionnaire.

Results: The mean number of CPI in patients with PD and matched controls was 2.69 (SD=2.371) and 1.02 (SD=1.702), respectively, and this difference was statistically significant. Patients with PD also suffered more often from CPM than none or one CPI, compared to matched controls. In the multivariate logistic regression analyses among the patients with PD, higher personality disorder severity, increased trait Negative Affectivity and poorer reflective functioning/mentalizing were predictive of having CPM. These relationships were independent of age, gender, education status, income level, length of psychiatric treatment, and smoking status. Subjective emptiness was not significantly predictive of having CPM.