Methods: 785 teen`s displaced from the zone of military operations, occupied territories were surveyed. Examinations included: K-SADS-PL, PSC-17, SCARED, CATS. 260 teen`s were examined during - 6, 400 – 6–12 months after traumatization.
Results: After 6 months of trauma, PTSD was diagnosed in 9.8%, ADHD – 10.2%, DD-22.3%, AD-30.8%, CD – 15.4%, 28.8%; examined 6 to 12 months after the injury, respectively: 21.9%, 12.6, 33.3%, 11.5%, 18.0%.
Conclusions: In war-affected children, PTSD is a risk factor for the subsequent development of comorbid depression, anxiety, conduct disorders, and ADHD. Female sex, secondary traumatization after displacement increase the risk of developing depression, signs of pervasive development and ADHD - the risk of destructive and self-injurious behavior. The prevalence of PTSD, DD, ADHD increases within 6-12 months after the trauma, the sensitivity of children with PTSD to secondary traumatic events increases.

Disclosure of Interest: None Declared

O0076

The association between glucose 6-phosphate dehydrogenase (G6PD) deficiency and attention deficit/hyperactivity disorder (ADHD)

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Introduction: Glucose-6-phosphate dehydrogenase (G6PD) deficiency is an X-linked genetic enzymopathy that impacts 4.9% of the population, with greater prevalence among Mediterranean, East Asian, and African populations. G6PD deficiency results in levels of nicotinamide-adenine dinucleotide phosphate (NADPH) and glutathione (GSH) that are insufficient for maintaining the balance of oxidation-reduction in the body. This results in elevated production of reactive oxygen species (ROS), oxidative stress on proteins and lipids, damage to DNA, and potential activation of chemokine and cytokine pathways by astrocytes and microglia. We propose that these direct and indirect effects of G6PD deficiency are associated with development of ADHD.
Objectives: This study investigated the association between G6PD deficiency and Attention Deficit/Hyperactivity Disorder (ADHD).
Methods: The study involved 7,473 G6PD-deficient patients and 29,892 matched case-controls (selected at a 1:4 ratio) from a cohort of 1,031,354 within the Leumit Health Services database. Clinical characteristics were analyzed using Fisher's Exact Tests for categorical variables and Mann-Whitney U tests for continuous variables.
Results: The average age of patients was 29.2 ± 22.3 years, with 68.7% being male. The mean follow-up duration was 14.3 ± 6.2 years. Individuals with G6PD deficiency showed a significant 16% higher risk of being diagnosed with ADHD (Odds Ratio (OR) = 1.16 [95% CI, 1.08-1.25], $p < 0.001$) on follow up. Furthermore, G6PD deficiency was associated with a 30% greater likelihood of seeking care from adult neurologists (OR = 1.30 [95% CI, 1.22-1.38], $p < 0.001$) and a 12% higher probability of consulting adult psychiatrists (OR = 1.12 [95% CI, 1.01-1.24], $p = 0.048$). The use of stimulant medications among G6PD deficient individuals was 17% higher for methylphenidate class drugs (OR = 1.17 [95% CI, 1.08, 1.27], $p < 0.001$), and use of amphetamines elevated by 16% (OR = 1.16 [95% CI, 1.03, 1.37], $p = 0.047$).
Conclusions: This study establishes a significant association between G6PD deficiency and an increased risk of ADHD diagnoses. These findings suggest potential opportunities for the development of culturally sensitive interventions.

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O0077

The bifactor model of the Hungarian self-report version of the Strengths and Weaknesses of ADHD and Normal Behaviors scale

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Introduction: Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common neuropsychiatric conditions, maintaining its presence well into adolescence and adulthood, resulting in impaired functioning. Evaluating ADHD symptoms through self-reporting plays a crucial role in assessing individuals within these age groups. The novel self-report version of the Strengths and Weaknesses of ADHD and Normal Behaviors (SWAN) scale offers a comprehensive assessment of behaviour, extending beyond just focusing on the typical signs and symptoms of ADHD, thus providing a more holistic perspective.
Objectives: Our goal was to assess the factorial validity of the Hungarian version of the SWAN self-report by comparing a two-factor model with bifactor models with a general and 1) two specific factors (inattention, hyperactivity/impulsivity), 2) three specific factors (inattention, motor hyperactivity/impulsivity, verbal hyperactivity/impulsivity) in a community sample.
Methods: Data from 717 adolescents and young adults (mean age = 20.0 years, SD = 3.10, range: 14 - 25 years, female: N = 664, 92.6%) were analysed. Participants completed an online questionnaire including the SWAN scale after giving informed consent. Confirmatory factor analyses were conducted based on the maximum likelihood estimator (ML).
Results: The bifactor model with a general and three specific factors demonstrated the best fit to our data (CFI = .933, RMSEA = .064 [90% CI: .058 – .071], SRMR = .038). While the overall composite reliability was excellent ($\omega = .91$), the reliability of the specific verbal hyperactivity/impulsivity factor fell below acceptable ($\omega_h = .40$).
Conclusions: In line with previous studies, the fit indices of the bifactor models were superior to the non-hierarchical two-factor model. Our results support the existence of a strong general factor but suggest uncertainty in the capacity of the specific factors to consistently explain the distinct variance in observed variables,