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

V. Mitikhin[*], D. Oshevsky and L. Alieva

Mental Health Research Centre, Moscow, Russian Federation
*Corresponding author.
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≤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

J. Bar Yosef[1][*] and L. Lipskaya-Velikovsky[2]

[1]Occupational Therapy, Clalit, Afula and [2]The school of occupational therapy, Hebrew University of Jerusalem, Jerusalem, Israel
*Corresponding author.
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