

induced skin damage is the means used to satisfy a conscious or unconscious desire to assume the sick role, particularly in those with an underlying psychiatric diagnosis or external stress. DA should be distinguished from malingering, in which skin damage may be inflicted for the purpose of secondary gain.

**Objectives:** Review what dermatitis artefacta and factitious disorders in general consist of and the challenges they present.

**Methods:** Presentation of a patient's case and review of existing literature, in regards to factitious dermatitis and factitious disorders.

**Results:** In general, in regards to factitious disorders in literature, the majority of patients were female with mean age at presentation at thirty. A healthcare or laboratory profession was reported most frequently, as well as a current or past diagnosis of depression was described more frequently than personality disorder in cases reporting psychiatric comorbidity, and more patients elected to self-induce illness or injury than simulate or falsely report it. Patients were most likely to present with endocrinological, cardiological and dermatological problems. In our patient's case, common factors described previously are dermatological lesions, comorbid psychiatric disorder and the beginning of the disorder at an earlier age.

Specifically, when it comes to DA, the hallmarks of diagnosis include self-inflicted lesions in accessible areas of the face and extremities that do not correlate with organic disease patterns. Importantly, patients are unable to take ownership of the cutaneous signs.

Management in these cases is challenging, and different modalities may be employed, including topical therapies, oral medications, and cognitive behavioural therapy; adopting a multidisciplinary team approach has been shown to be beneficial in allowing patients to come to terms with their illness in an open, non judgmental environment.

**Conclusions:** DA is a rare cutaneous condition that must be considered when the clinical presentation is atypical and investigations do not yield an alternate diagnosis. Few are referred to psychiatric services and even fewer accept care. They have a protracted course, complicated by repeated hospitalizations, ultimately leading to their premature deaths. Clear guidelines on the management of these patients need to be set to protect both patients and providers in light of the ethical and legal considerations.

**Disclosure of Interest:** None Declared

## EPV1174

### Exploring Exercise Intervention as a Therapeutic Catalyst within the Mental Health and Addiction Program in Nova Scotia: A Proof-of-Concept Study

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**Introduction:** Many mental health conditions, including anxiety, mood disorders, and depression, can be effectively treated at a relatively low cost. Exercise interventions can be a therapeutic strategy, but even though exercise has consistently been shown to improve physical health, cognitive function, and psychological

well-being, as well as reduce depression and anxiety symptoms, this intervention is often neglected in mental health care services.

**Objectives:** The study aims to assess the feasibility of incorporating an Exercise Intervention Program (EIP) as a therapeutic pathway within the Mental Health and Addictions Program (MHAP) in Nova Scotia, as well as to evaluate the effectiveness of the program on mental health outcomes and incremental costs, and the patient acceptability and satisfaction with the program.

**Methods:** This proof-of-concept study has a pragmatic, prospective, controlled observational design with an embedded one-phase qualitative component. Patients with a primary diagnosis of depression or anxiety attending the Rapid Assessment and Stabilization Program (RASP, Halifax, Nova Scotia, Canada) will be offered to receive 60-minute exercise sessions three times per week, per 12 weeks. Patients with similar mental health conditions that have opted to wait for Cognitive Behavioral Therapy (CBT) with the community provider and declined from the EIP will be part of the control group. A certified recreational therapist will conduct the EIP. Participants of both groups (EIP and control condition) will be assessed at baseline and then weekly for four weeks, six weeks and then at 12 weeks post-enrollment. Primary outcomes include differences in the mean change in functional (well-being, resilience, and recovery) and symptom variables (depression, anxiety, and suicidal risk), which will be assessed through online validated scales/questionnaires. Service variables (patient acceptance and satisfaction) and health care utilization (crisis calls, emergency department visits, hospital admissions and readmissions, length of stay for each admission) will comprise the secondary outcomes.

**Results:** The results of the study will provide information about the effectiveness of EIP in the treatment of anxiety and depression compared to those only wait-listed to receive CBT or counselling from a CMHA provider. The study will also inform about the acceptability and satisfaction of the EIP, as well as the incremental cost-effectiveness of the intervention compared to the control condition.

**Conclusions:** This proof-of-concept study will demonstrate the effectiveness of EIP as an adjunctive or alternative therapeutic option for the treatment of anxiety and depression in patients seeking mental health support from the MHAP in Nova Scotia.

**Disclosure of Interest:** None Declared

## EPV1175

### Negative factors of personality hardiness that effect on ability to control situation and cope with the stress

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**Introduction:** Personality hardiness expresses the characteristics that help to overcome stress and achieve well-being.

**Objectives:** This study focused on the Hardiness as the important personality trait, which allow coping with stress and the relationship of empathy, emotional sensitivity and the personality hardiness.

**Methods:** 88 healthy volunteers, students aged 17 to 26 years (mean age = 19, SD = 1,69), participated in this study. We used Cloninger's Temperament and Character Inventory (TCI), the Maddi Hardiness Survey (adapted by Leontyev), Buss Perry Aggression Questionnaire (BPAQ), the Barratt impulsiveness scale (BIS-11), Maslach Burnout Inventory (MBI), the Questionnaire Measure of Emotional Empathy (QMEE).

**Results:** The cluster analysis was used to identify groups of hardy personalities. We demonstrated a negative relationship between hardiness and depression and burnout. It revealed significant differences between these groups by the following traits: Attention (BIS-11), Self-Control (BIS-11), Cognitive Complexity (BIS-11), Hostility (BPAQ), Exploratory activity (NS1 TCI), Shyness of strangers (HA3 TCI), Resourcefulness (S3 TCI). Regression analysis was used to identify Hardiness factors and to build the following regression models. For the first group the models describe 100% of dispersion (R-square=1,000, Durbin-Watson statistic = 1,419) and are:

$Control = -16,998 - 2,922 * C2 + 3,549 * C5 + 3,264 * CI + 0,723 * ST2 + 0,747 * S4 - 0,306 * SC + 0,166 * RD3 - 0,020 * C - 0,003 * NS2$ , where C2 – scale Empathy (TCI), C5 – scale Principles (TCI), CI – cognitive instability, ST2 – Transpersonal identification scale (TCI), S4 – Self-acceptance (TCI), SC – Self-Control (BIS-11), RD3 – Social attachment (TCI), C – Cooperativeness (TCI), NS2 – Impulsive decision making (TCI).

The *Hardiness* model described 50% (R-square=0,456) of dispersion:  $Hardiness = 63,527 - 4,080 * C2$ , where C2 –Empathy scale (TCI) ( $p=0,003$ ).

The regression models of the second group explain 50% of group dispersion (R-square=0,512) and are Independent variables significance  $p < 0,05$ :

$Challenge = 12,484 + 0,389 * SC + 0,197 * EE - 0,702 * RD1 - 0,206 * A$ , where SC- Self-Control scale (BIS-11), EE – Emotional Empathy (Personality test of Emotional Empathy), RD1 – Sentimentality scale (TCI), A – Anger (BPAQ).

The *Hardiness* model describes 35% of dispersion (R-square=0,364, Durbin-Watson statistic = 2,066):

$Hardiness = 100,352 + 0,941 * SC - 0,527 * H$ , where SC – Self-Control scale (BIS-11) ( $p=0,009$ ), H – Hostility scale (BPAQ) ( $p=0,021$ ).

**Conclusions:** Thus, the attention and self-control problems, hostility, cognitive complexity and shyness have a negative impact on hardiness. Our results suggest that the excessive use of empathy leads to decrease of ability to control situation and cope with the stress.

**Disclosure of Interest:** None Declared

## EPV1176

### Somatic disorders in patients followed for a psychiatric disorder at the Ar Razi hospital in Morocco

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**Introduction:** Somatic disorders in patients suffering from psychiatric disorders have become an important issue in the overall care of these patients

Comorbidity studies show that 30 to 60% of patients consulted or hospitalized in psychiatry present an associated organic pathology. However, the detection of somatic conditions in psychiatric patients remains too late and this exposes them to sometimes lethal somatic complications

**Objectives:** To evaluate the prevalence of somatic disorders in patients followed for a psychiatric disorder at Ar Razi hospital in Salé – Morocco, and to determine the associated factors

**Methods:** We carried out a cross-sectional study with 80 patients followed for a psychiatric disorder at Ar Razi hospital in Salé presenting clinical signs in favor of an organic pathology and transferred for specialized advice to the medical-surgical services, in the period from September 1st, 2022 until August 31st, 2023.

**Results:** Most of our patients were male (65%) with ages ranging from 18 to 65 years. Addictive behaviors were found in more than half of our patients.

The most frequent reasons for requests for advice from medical-surgical services was the suspicion of an organic cause of psychiatric symptoms in 25% of cases or the presence of an organic warning sign in 30% of cases.

The comorbidity of somatic illness and psychiatric disorder was noted in 35% of cases.

Somatic comorbidities were essentially: infections and cardiovascular diseases.

Side effects of psychotropic drugs were predominantly neurological in 40 % of cases

**Conclusions:** Somatic comorbidities in patients hospitalized or in consultation in psychiatric hospitals are very common, often unrecognized, hence the need for early screening in order to improve care.

**Disclosure of Interest:** None Declared

## EPV1178

### Introduction of Hungarian Association of Psychiatric Trainees - EPA - Hungarian NPA Joint Symposium

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**Introduction:** The purpose of my presentation is to introduce the Hungarian Association of Psychiatric Trainees (HAPT), - our NAT - to you, which includes residents and young specialists within five years of training.

**Objectives:** Currently we have 108 members, from 15 cities and villages throughout Hungary, and one person is working in Denmark. The vast majority (58 %) of the members are from Budapest, our capital city. There are 14 members, who are young specialists, the others are doing residency training. We have 21 members who are working in child and adolescent psychiatry.

HAPT has been existed since 2013, so in the previous years, our founder members have reached the point when they no longer meet the criteria of being 'psychiatric trainee' or 'young specialists', however every year we encourage the new residents to join us.