Instruments: Standardized instruments were used, such as the State Trait Anxiety Inventory (STAI), Beck's Depression Inventory (BDI) and Coping Strategies Scale Modified (CSS-M).
Procedure: First, the study was disclosed, the participants were informed and signed informed consent. They were asked to complete an instrument on teeth grinding/clenching habits and if it was fulfilled, it was included in the study and the psychological evaluation instruments were administered.
Data analysis: An analysis was made using descriptive statistics.
Results: The STAI results showed a high Anxiety-State in all the participants and the Anxiety-Trait had a prevalence of 92.3%. Regarding the levels of depression, it was evidenced that 7.7% presented moderate depression and 31.6% showed mild symptoms. The most used coping strategies were problem solving (87.2%), positive reappraisal (74.4%) and religious support (71.8%), while the least used were seeking professional help (92.3%), waiting (76.9%), aggressive reaction (74.4%) and expression of coping difficulty (71.8%).
Conclusions: University students must cope with an academic load that exceeds their capacity to face academic challenges (Wikes et al., 2019). This demand causes significant discomfort that increases emotions with a high negative charge and favors the appearance or intensification of mental health problems, such as chronic stress, anxiety, depression, nervousness and behavioral disorders.

Disclosure of Interest: None Declared

EPV0077

Managing a functional disorder with vertigo or dizziness in a primary care setting: Clinical case

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doi: 10.1192/j.eurpsy.2023.1435

Introduction: A heterogeneity in prevalence rates of functional and/or dissociative disorders is evidenced in primary care settings. At least one medically unexplained symptom is diagnosed in 40–49% of all primary care patients and 91% of all patients with a functional diagnosis are managed exclusively by general practitioners (GP) and nonpsychiatric specialists. It is therefore important that GPs identify these disorders so that individualized, multimodal treatment, with psychiatric collaboration, can be initiated promptly.
Objectives: Our objective is to demonstrate the role of consultation-liaison (CL) psychiatrists in the management of patients with a functional diagnosis in primary care, as well as the potential impact of non-collaboration between GPs and psychiatrists.
Methods: Case report of Mrs. P., a 32-year-old patient, married for one year. Following a burnout that occurred two years ago, associated with anxiety-depressive symptoms, she developed gradually persistent dizziness, with balance disorders and asthenia. Mrs. P. consulted a psychiatrist for these symptoms and was treated first with an SSRI and then with an SNRI, which increased her symptoms of dizziness and vertigo. She stopped the psychiatric treatment, being disappointed by the proposed care, and asked her GP for help. No pathology was revealed by the neurological and ENT assessment requested by her GP. He referred her for a second opinion at the university center for general medicine.
Results: After an initial GP assessment, a CL-psychiatric evaluation was performed (a first joint GP-psychiatrist session, 3 psychiatric sessions, and a feedback joint GP-psychiatrist session), during which a feeling of loss of control was noted in a patient with obsessive personality traits and controlling tendencies. A bidirectional relationship between anxieties, underlying uncontrolled internal conflicts, and dizziness was demonstrated. A dynamic work around the underlying conflicts according to the bio-psycho-social model allowed to identify the presence of a dissociative neurological symptom disorder, with vertigo or dizziness (6B60.2) of which the patient could become aware. This brief CL-psychiatric and psychotherapeutic intervention, proposed and accompanied by the GP, made it possible to explore and elaborate on the patient's modes of functioning in her relationship to her body, to herself, and to others. At the same time, vestibular rehabilitation was performed by a ENT, with a favorable clinical and postural evolution. Thanks to this multidisciplinary treatment led by the GP, Ms P. was able to resume her professional and social activities after 3 months.
Conclusions: GPs have a central role in the detection of dissociative neurological symptom disorder, with vertigo or dizziness, and in the rapid organization of an adapted care network. Collaboration with CL-psychiatrist can offer optimal management of such disorders in primary care settings.

Disclosure of Interest: None Declared

EPV0078

Gluten and anxiety: a difficult balance in people with celiac disease

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doi: 10.1192/j.eurpsy.2023.1436

Introduction: Celiac disease (CD), triggered by gluten ingestion, occurs in people genetically predisposed to develop this chronic autoimmune condition. The triggering environmental factor, gluten, is known as a protein present in wheat, rye and barley. In recent decades, specialists have found more knowledge about the disease mechanisms, how it develops and other disturbances which accompany it. The CD was considered a pediatric main gastrointestinal disorder, associated with symptoms of abdominal pain, diarrhea, constipation and bloating, and characterized by damage to the villi of the small intestine. People with CD may experience anemia, fatigue, osteopenia or osteoporosis, bone fracture, neurological and psychiatric problems beside anxiety as depression, ataxia, neuropathy. However, the results of several studies conducted on the fact that people with CD have an increased level of anxiety are mixed.
Objectives: The present work is highlighting the importance of observing the anxiety levels in people diagnosed with CD beside the suitable interventions in reducing it.
Methods: For our study scientific databases were screened using certain keywords and combinations of it as: "celiac disease",

”gluten”, ”gastrointestinal disorder”, ”treatment”, ”neurological problems”, ”anxiety”. Inclusion criteria were studies that (1) investigated anxiety levels in CD people, (2) reported gender results, (3) were written in English, and (4) were published within the last 20 years.
Results: In some cases, as main intervention in CD, gluten removal from the people's diet usually reported improvements of the present symptoms. In addition, data from literature are describing a higher level of anxiety in females compared to males diagnosed with CD. This can be a consequence of females concerns about how they can manage the CD issues and, especially, what this is bringing in their lifestyle. On the opposite, there are reports which showed that demographic parameters (gender, age, education) are not associated with CD presence.
Conclusions: The balance between CD and anxiety needs to be more investigated in order to identify and fully understand what is the background mechanism and how this can be regulated through specific interventions.

Disclosure of Interest: M. Robea Grant / Research support from: , Platformă multidisciplinară de cercetare-dezvoltare medicală în regiunea N-E,,, acronim: CENEMED, cod mySMIS: 127606, proiect cofinanțat prin Programul Operațional Competitivitate, Axa Prioritară: Cercetare, Dezvoltare tehnologică și Inovare (CDI)., A. Ciobica: None Declared, C. Stanciu: None Declared, A. Trifan: None Declared

EPV0079

Conversive and Factitious disorders: Differential diagnosis based on a case report

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doi: 10.1192/j.eurpsy.2023.1437

Introduction: Conversive disorder is characterised by the presence of one or more involuntary neurological symptoms that are not due to a clear medical pathology. On the other hand, consciously simulated illnesses fall into two diagnostic categories: factitious disorders and malingering, which are differentiated by both the motivation for the behaviour and the awareness of that motivation. Factitious disorder behaviours are motivated by an unconscious need to assume the sick role, whereas malingering behaviours are consciously driven to achieve external secondary gains.
Objectives: Study of the differences between conversion disorder and factitious disorder and their repercussions from a case of difficult diagnosis.
Methods: Bibliographic review of scientific literature based on a relevant clinical case.
Results: We present the case of a 14-year-old male patient. Adoptive parents. Studying in high school. Social difficulties since childhood. He comes to the emergency department on several occasions referring stereotyped movements and motor tics in the four extremities with left cervical lateralization. Increase of these symptoms in the last month, so it was decided to admit him to the pediatric hospital. After observation and study of the patient's movements with normal complementary tests he should return home. The following day he returned to the emergency department after an episode of dizziness, mutism and emotional block. It was decided to admit him to Psychiatry for behavioral observation and differential diagnosis.
Conclusions: In the assessment of patients it is essential to make an appropriate diagnosis taking into account the patient's symptomatology and the patient's background and life context. Conversion disorder is the unintentional production of neurological symptom, whereas malingering and factitious disorder represent the voluntary production of symptoms with internal or external incentives. They have a close history and this has been frequently confounded. Practitioners are often confronted to medically unexplained symptoms; they represent almost 30% of neurologist's consultation. The first challenge is to detect them, and recent studies have confirmed the importance of “positive” clinical bedside signs based on incoherence and discordance. Multidisciplinary therapy is recommended with behavioral cognitive therapy, antidepressant to treat frequent comorbid anxiety or depression, and physiotherapy. Factitious disorder and malingering should be clearly delineated from conversion disorder. Factitious disorder should be considered as a mental illness and more research on its physiopathology and treatment is needed, when malingering is a non-medical condition encountered in medico-legal cases.

Disclosure of Interest: None Declared

EPV0080

Stigma of mental illness in the gypsy ethnic group

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doi: 10.1192/j.eurpsy.2023.1438

Introduction: The Roma population constitutes the largest ethnic minority in Spain (more than 2% of the population), with our country having the third largest total population of Roma in the world. The concept of health and disease varies with the sociocultural context. It is important to know the cultural characteristics to exercise good clinical practice. The stigma surrounding mental illness is widely known, and is even stronger in the Roma community, leading to marginalization and shame.
Objectives: We present a case of a gypsy woman misdiagnosed from the age of 8 with hebephrenic schizophrenia.
Methods: Patient frequents the emergency department with symptoms of predominantly anxiety, including episodes of psychomotor agitation, self-harm, verbalization of visual hallucinations of a mystical-religious nature. In treatment with antipsychotics since diagnosis, with no therapeutic adherence. It is observed during all the episodes how the anxiolytic treatment, even, sometimes, the verbal restraint, make the symptoms subside. Psychotic symptoms over the years are ruled out.
Results: Due to the diagnosis, this patient has been relegated from the gypsy community, she has not married or had children (an important milestone in gypsy culture), this has generated an exponential increase in anxiety symptoms and home problems.