**Disclosure of Interest:** None Declared

## EPV1318

### Assessing Quality of Life After Return to Work Among Victims of Work-Related Hand Injuries

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**Introduction:** Work-related hand injuries (WRHI) can have profound impacts on an individual's physical capabilities, and these injuries often carry long-term consequences that extend beyond physical impairment. Upon returning to work, victims may face challenges in performing occupational tasks and daily activities.
**Objectives:** This study aims to assess the quality of life in workers who have suffered WRHI after returning to their professional activities.
**Methods:** We conducted a cross-sectional study among victims of WRHI in the private sector after returning to work, from January 2021 to December 2022. Sociodemographic and professional data were collected along with characteristics of the WRHI. Quality of life was assessed using the Short Form-12 (SF-12) score, which evaluates both physical and mental health components (PCS-12 and MCS-12). The Quick Disabilities of the Arm, Shoulder, and Hand (Quick DASH) score was used to measure the functional disability of the hand. Job satisfaction and pain level were auto-evaluated with a scale of 0 to 10.
**Results:** We included 126 workers, 88.1% of whom were male, with a mean age of 41.3 ± 10.6 years. Tobacco and alcohol use were reported by 42.9% and 9.5% of participants, respectively, while caffeine consumption was noted in 57.9%. The most represented sectors were metallurgy (22.2%) and the chemical industry (16.7%). The median job satisfaction after the accident was 6 (IQR [5; 8]). In 61.9% of cases, the dominant hand was affected. Both rehabilitation sessions and surgical treatment were required for 69% of participants. The median pain level was 5 (IQR [4; 7]), and 47.6% of participants reported sleep disorders following the accident.
The median Quick DASH score was 34.1 (IQR [13.1; 50.6]), and the median Quick DASH work module score was 43.8 (IQR [25; 68.8]). The mean PCS-12 score was 39.5 ± 7.6, while the mean MCS-12 score was 46.8 ± 11.4. The PCS-12 score was significantly associated with caffeine consumption (p = 0.03), alcohol consumption (p = 0.03), rehabilitation sessions (p = 0.029), and sleep disorders (p < 0.001). It was also significantly correlated with pain level (p = 0.005; r = -0.247), Quick DASH score (p < 0.001; r = -0.4), and the Quick DASH work module (p < 0.001; r = -0.44).
The MCS-12 score was significantly associated with job satisfaction (p = 0.008; r = 0.237), Quick DASH score (p = 0.003; r = -0.265), the Quick DASH work module (p = 0.012; r = -0.23), and sleep disorders (p = 0.012).

**Conclusions:** Work-related injuries, particularly hand injuries, pose significant challenges to both the professional and personal lives of those affected. Addressing these challenges is crucial to ensuring a successful return to work and social reintegration.

**Disclosure of Interest:** None Declared

## EPV1319

### Cognition in Treatment Resistant versus Non-Treatment Resistant Schizophrenia

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**Introduction:** Despite antipsychotic treatment, around one-third of individuals of schizophrenia remain unresponsive.
**Objectives:** Comparing cognitive impairments in TRS versus non-TRS patients.
**Methods:** 50 adult patients with schizophrenia(DSM-5) were recruited in this cross-sectional cohort study, categorised into TRS (14) (treatment-resistant schizophrenia) and NTRS (36) (non-treatment-resistant schizophrenia) by modified Kane criteria. Positive and Negative Syndrome Scale (PANSS) and Montreal Cognitive Assessment Scale (MoCA) were used.
**Results:**

| Table 1 | TRS | NTRS | Overall |
|---|---|---|---|
| Male(%) | 42.8 | 63.8 | 58 |
| Female(%) | 57.1 | 36.1 | 42 |
| AGE (years) | 41.7 ± 13.1 | 41.4±12.3 | 41.5±12.4 |
| DURATION OF ILLNESS(years) | 17.2±10.8 | 6.3±6.8 | 9.4±9.4 |

| Table 2 | TRS | NTRS | Independent sample students' T test pvalue |
|---|---|---|---|
| MoCA | 19.2±6 | 27.8±5.4 | <0.01 |
| TOTAL PANSS | 106.3±22.4 | 57.4±21. | <0.01 |
| POSITIVE PANSS | 22.1±7.3 | 13.8±6.4 | <0.01 |
| NEGATIVE PANSS | 26.8±5.7 | 14.1±5.1 | <0.01 |
| Generalised PANSS | 57.3±13.2 | 29.4±11.4 | <0.01 |
| COMPOSITE SCORE | -4.71±7.6 | -0.2±5.6 | 0.02 |

MoCA Scores (Table 2) are significantly lower in the TRS group, implying NTRS has a moderate cognitive decline, and TRS has severe cognitive decline. Total PANSS, Positive, Negative,and Generalised PANSS are significantly lower in the TRS group indicating severe symptoms than NTRS.Classifying based onTotal PANSS Score, the TRS has severely ill, while the NTRS has borderline

mentally ill patients. The composite score indicates that the TRS group tends to have more negative symptoms. Computing the data's variances and independent sample Welch's t-test (Image 3) for data with unequal variances and independent sample student's test (Images 1, 2) for data with equal variances were performed. Age does not significantly affect TRS(Table 1). Duration of illness is significantly higher in the TRS group. MoCA domains (i.e., executive function, visuospatial, orientation, and attention) except memory and language have significantly lower scores in the TRS group. Positive symptoms (conceptual disorganisation, excitement, grandiosity, suspicion, and hostility) except delusion and hallucinatory behaviour were significantly higher in the TRS group. Negative symptoms (emotional withdrawal, poor rapport, passive/apathetic social withdrawal, difficulty in abstract thinking, lack of spontaneity and flow of conversation, stereotype thinking) except blunted effect were significantly higher in the TRS group. Generalised symptoms (somatic concern, anxiety, guilt feelings, mannerism and posture, depression, motor retardation, uncooperativeness, unusual thought content, social disorientation, poor attention, lack of judgement, disturbance of volition, poor impulse control, preoccupation, and active social avoidance) except tension were significantly higher in the TRS group.

**Image:**

## Independent Samples T-Test

Independent Samples T-Test

|  |  | Statistic | df | p |
| --- | --- | --- | --- | --- |
| Age | Student's t | -0.0751 | 48.0 | 0.940 |
| Duration of illness | Student's t | -4.2746 | 48.0 | <.001 |
| executive function domain | Student's t | 4.4947 | 48.0 | <.001 |
| Visuospatial domain | Student's t | 3.1370 | 48.0 | 0.003 |
| Orientation domain | Student's t | 2.8948 | 48.0 | 0.006 |
| Language domain | Student's t | 1.5489 | 48.0 | 0.128 |
| P2: Conceptual disorganization | Student's t | -3.2697 | 48.0 | 0.002 |
| P3: Hallucinatory behavior | Student's t | -1.4251 | 48.0 | 0.161 |
| P6: Suspiciousness/persecution | Student's t | -2.2800 | 48.0 | 0.027 |
| P7: Hostility | Student's t | -3.0416 | 48.0 | 0.004 |
| N1: Blunted affect | Student's t | -1.2411 | 48.0 | 0.221 |
| N2: Emotional withdrawal | Student's t | -3.3814 | 48.0 | 0.001 |
| N3: Poor rapport | Student's t | -6.8527 | 48.0 | <.001 |
| N4: Passive/apathetic social withdrawal | Student's t | -6.1280 | 48.0 | <.001 |
| N5: difficulty in abstract thinking | Student's t | -3.0803 | 48.0 | 0.003 |
| N7: Stereotype thinking | Student's t | -4.3449 | 48.0 | <.001 |
| G1: Somatic concern | Student's t | -2.3602 | 48.0 | 0.022 |
| G2: Anxiety | Student's t | -3.1125 | 48.0 | 0.003 |
| G3: Guilt feelings | Student's t | -2.7835 | 48.0 | 0.008 |
| G4: Tension | Student's t | -0.9162 | 48.0 | 0.364 |
| G5: Mannerisms and posturing | Student's t | -3.7032 | 48.0 | <.001 |
| G6: Depression | Student's t | -3.6616 | 48.0 | <.001 |
| G7: Motor retardation | Student's t | -2.9291 | 48.0 | 0.005 |
| G8: Uncooperativeness | Student's t | -3.5697 | 48.0 | <.001 |
| G9: Unusual thought content | Student's t | -4.7306 | 48.0 | <.001 |
| G12: Lack of judgment or insight | Student's t | -5.6360 | 48.0 | <.001 |
| G13: Disturbance of volition | Student's t | -4.2718 | 48.0 | <.001 |
| G14: Poor impulse control | Student's t | -5.0190 | 48.0 | <.001 |
| G15: Preoccupation | Student's t | -4.5274 | 48.0 | <.001 |

**Image 2:**

Group Descriptives

| | Group | N | Mean | Median | SD | SE |
| --- | --- | --- | --- | --- | --- | --- |
| Age | NTRS | 36 | 41.42 | 40.00 | 12.271 | 2.062 |
| | TRS | 14 | 41.71 | 39.50 | 13.15 | 3.514 |
| Duration of illness | NTRS | 36 | 6.38 | 5.00 | 6.803 | 1.134 |
| | TRS | 14 | 17.29 | 15.00 | 10.84 | 2.898 |
| executive function domain | NTRS | 36 | 3.25 | 3.50 | 0.841 | 0.140 |
| | TRS | 14 | 1.86 | 2.00 | 1.29 | 0.345 |
| Visuospatial domain | NTRS | 36 | 2.36 | 2.00 | 1.150 | 0.192 |
| | TRS | 14 | 1.21 | 1.00 | 1.19 | 0.318 |
| Orientation domain | NTRS | 36 | 4.89 | 6.00 | 1.737 | 0.289 |
| | TRS | 14 | 3.21 | 3.00 | 2.08 | 0.556 |
| Language domain | NTRS | 36 | 4.19 | 4.00 | 0.920 | 0.153 |
| | TRS | 14 | 3.71 | 3.50 | 1.14 | 0.304 |
| P2: Conceptual disorganization | NTRS | 36 | 2.06 | 2.00 | 1.351 | 0.225 |
| | TRS | 14 | 3.43 | 3.00 | 1.28 | 0.343 |
| P3: Hallucinatory behavior | NTRS | 36 | 1.89 | 1.00 | 1.348 | 0.225 |
| | TRS | 14 | 2.57 | 2.00 | 1.91 | 0.510 |
| P6: Suspiciousness/persecution | NTRS | 36 | 2.28 | 2.00 | 1.446 | 0.241 |
| | TRS | 14 | 3.36 | 3.50 | 1.65 | 0.440 |
| P7: Hostility | NTRS | 36 | 2.56 | 3.00 | 1.297 | 0.216 |
| | TRS | 14 | 3.86 | 4.00 | 1.51 | 0.404 |
| N1: Blunted affect | NTRS | 36 | 2.39 | 2.00 | 1.225 | 0.204 |
| | TRS | 14 | 2.93 | 2.50 | 1.73 | 0.462 |
| N2: Emotional withdrawal | NTRS | 36 | 2.17 | 2.00 | 1.276 | 0.213 |
| | TRS | 14 | 3.64 | 4.00 | 1.65 | 0.440 |
| N3: Poor rapport | NTRS | 36 | 1.53 | 1.00 | 0.971 | 0.162 |
| | TRS | 14 | 4.00 | 4.00 | 1.52 | 0.406 |
| N4: Passive/apathetic social withdrawal | NTRS | 36 | 2.31 | 2.00 | 1.411 | 0.235 |
| | TRS | 14 | 5.07 | 6.00 | 1.49 | 0.399 |
| N5: difficulty in abstract thinking | NTRS | 36 | 2.25 | 2.00 | 1.610 | 0.268 |
| | TRS | 14 | 3.93 | 4.00 | 2.02 | 0.539 |
| N7: Stereotype thinking | NTRS | 36 | 1.92 | 1.50 | 1.156 | 0.193 |
| | TRS | 14 | 3.57 | 4.00 | 1.34 | 0.359 |
| G1: Somatic concern | NTRS | 36 | 1.75 | 1.00 | 1.402 | 0.234 |
| | TRS | 14 | 2.86 | 3.00 | 1.70 | 0.455 |
| G2: Anxiety | NTRS | 36 | 1.92 | 1.00 | 1.273 | 0.212 |
| | TRS | 14 | 3.29 | 3.00 | 1.68 | 0.450 |
| G3: Guilt feelings | NTRS | 36 | 1.83 | 1.00 | 1.298 | 0.216 |
| | TRS | 14 | 3.00 | 3.00 | 1.41 | 0.378 |
| G4: Tension | NTRS | 36 | 2.17 | 2.00 | 1.404 | 0.234 |
| | TRS | 14 | 2.57 | 3.00 | 1.40 | 0.374 |
| G5: Mannerisms and posturing | NTRS | 36 | 2.03 | 2.00 | 1.230 | 0.205 |
| | TRS | 14 | 3.50 | 3.50 | 1.34 | 0.359 |
| G6: Depression | NTRS | 36 | 2.25 | 2.00 | 1.402 | 0.234 |
| | TRS | 14 | 3.93 | 4.00 | 1.59 | 0.425 |
| G7: Motor retardation | NTRS | 36 | 2.14 | 1.00 | 1.496 | 0.249 |
| | TRS | 14 | 3.57 | 3.50 | 1.70 | 0.453 |
| G8: Uncooperativeness | NTRS | 36 | 1.67 | 1.00 | 1.095 | 0.182 |
| | TRS | 14 | 3.07 | 3.00 | 1.59 | 0.425 |
| G9: Unusual thought content | NTRS | 36 | 1.78 | 1.00 | 1.124 | 0.187 |
| | TRS | 14 | 3.71 | 4.00 | 1.68 | 0.450 |
| G12: Lack of judgment or insight | NTRS | 36 | 1.72 | 1.00 | 1.085 | 0.181 |
| | TRS | 14 | 3.93 | 4.00 | 1.59 | 0.425 |
| G13: Disturbance of volition | NTRS | 36 | 2.08 | 1.00 | 1.381 | 0.230 |
| | TRS | 14 | 4.14 | 4.50 | 1.88 | 0.501 |
| G14: Poor impulse control | NTRS | 36 | 1.64 | 1.00 | 1.099 | 0.183 |
| | TRS | 14 | 3.57 | 4.00 | 1.50 | 0.402 |
| G15: Preoccupation | NTRS | 36 | 1.81 | 1.00 | 1.261 | 0.210 |
| | TRS | 14 | 3.86 | 4.50 | 1.83 | 0.490 |

**Image 3:**

## Independent Samples T-Test

Independent Samples T-Test

|  |  | Statistic | df | p |
| --- | --- | --- | --- | --- |
| Attention domain | Welch's t | 2.90 | 17.9 | 0.010 |
| Memory domain | Welch's t | 1.32 | 34.5 | 0.196 |
| P1: Delusions | Welch's t | -1.08 | 17.7 | 0.295 |
| P4: Excitement | Welch's t | -2.84 | 16.9 | 0.011 |
| P5: Grandiosity | Welch's t | -3.10 | 15.9 | 0.007 |
| N6: Lack of spontaneity and flow of conversation | Welch's t | -4.25 | 15.6 | <.001 |
| G10: Social disorientation | Welch's t | -4.45 | 16.0 | <.001 |
| G11: Poor attention | Welch's t | -5.32 | 15.7 | <.001 |
| G16: Active social avoidance | Welch's t | -5.81 | 16.1 | <.001 |

Note. $H_a \mu_{NTRS} \neq \mu_{TRS}$

Group Descriptives

| | Group | N | Mean | Median | SD | SE |
| --- | --- | --- | --- | --- | --- | --- |
| Attention domain | NTRS | 36 | 0.861 | 1.00 | 0.351 | 0.0585 |
| | TRS | 14 | 0.429 | 0.00 | 0.514 | 0.137 |
| Memory domain | NTRS | 36 | 2.528 | 3.00 | 1.612 | 0.2687 |
| | TRS | 14 | 2.000 | 2.00 | 1.109 | 0.296 |
| P1: Delusions | NTRS | 36 | 2.222 | 2.00 | 1.355 | 0.2258 |
| | TRS | 14 | 2.857 | 2.00 | 2.033 | 0.543 |
| P4: Excitement | NTRS | 36 | 1.556 | 1.00 | 1.252 | 0.2087 |
| | TRS | 14 | 3.214 | 2.50 | 2.045 | 0.547 |
| P5: Grandiosity | NTRS | 36 | 1.333 | 1.00 | 0.926 | 0.1543 |
| | TRS | 14 | 2.857 | 3.00 | 1.748 | 0.467 |
| N6: Lack of spontaneity and flow of conversation | NTRS | 36 | 1.556 | 1.00 | 0.909 | 0.1514 |
| | TRS | 14 | 3.714 | 4.00 | 1.816 | 0.485 |
| G10: Social disorientation | NTRS | 36 | 1.444 | 1.00 | 0.909 | 0.1514 |
| | TRS | 14 | 3.571 | 4.00 | 1.697 | 0.453 |
| G11: Poor attention | NTRS | 36 | 1.472 | 1.00 | 0.910 | 0.1516 |
| | TRS | 14 | 4.143 | 4.50 | 1.791 | 0.479 |
| G16: Active social avoidance | NTRS | 36 | 1.722 | 1.00 | 0.974 | 0.1624 |
| | TRS | 14 | 4.643 | 5.50 | 1.781 | 0.476 |

**Conclusions:** TRS patients show severe cognitive impairment, however it does not impact language and memory. TRS shows more symptom severity except delusion, hallucinatory behaviour, blunted effect, and tension as compared to NTRS.

**Disclosure of Interest:** None Declared

## EPV1320

### On the Pathophysiology of Pathological Lying: A Case Report and Literature Review

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**Introduction:** Pathological lying, traditionally known as pseudologia fantastica or mythomania, is characterized by persistent or compulsive lying that often involves elaborate and fantastical narratives. Although the psychiatric community has yet to reach a consensus about its classification as a symptom or as a distinct diagnostic entity, emerging research about its pathophysiology highlights the involvement of complex interactions between neurobiological, psychological, and social factors.

**Objectives:** The aim of this study is to explore, through a clinical case of an inpatient in whom pathological lying was identified, the possible causes and underlying mechanisms of this condition.

**Methods:** A case report presentation followed by a non-systematic review of the literature available at PubMed, ScienceDirect and ResearchGate databases, using the MeSH terms "pathological lying" OR "pseudologia fantastica" OR "mythomania". From a total of 226 abstracts initially screened, we included 51 articles in the final review.

**Results:** We report the case of a 33-year-old man with a diagnosis of Charcot-Marie-Tooth disease type 2C and comorbid depressive disorder, who was admitted to the emergency department for suicidal ideation. Collateral information from family members was crucial to identify pathological lying, in this case associated with the lack of social relationships, low self-esteem, a desire for autonomy, and poor emotional and behavioral regulation. Although standard blood workup yielded unremarkable findings, imaging studies showed an old lacunar infarction localized to the right hemithalamus. While hospitalized he presented rapid clinical improvement, being discharged with outpatient follow-up. The existing body of evidence on pathological lying fails to capture specific causal factors for this phenomenon. Research into its neurobiological basis examined abnormalities in brain areas responsible for executive functioning, impulse control, and behavioral and emotional responses, such as the prefrontal cortex, the limbic and paralimbic systems, and the right hemithalamus. From a psychological perspective, the pathological liar doesn't have an external motive for lying; instead, the lie seems to be the purpose in itself, being unconsciously produced to fulfill the need for power and autonomy, to elevate one's self-esteem, or to repress reality. In addition, certain environmental factors, including childhood trauma, neglect, or abuse, also seem to play a significant role in shaping this type of behavior.

**Conclusions:** The current research on the pathophysiology of pathological lying is still limited and vague, depicting a multifactorial entity that would benefit from a multidisciplinary approach integrating Psychiatry, Neurology, and Behavioral Sciences. The

development of a more comprehensive conceptual model may help practitioners implement formal assessment and management strategies for people suffering from this condition.

**Disclosure of Interest:** None Declared

## EPV1321

### Eco-anxiety and Psychosocial Problems: A Systematic Review

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**Introduction:** Eco-anxiety, a term that encapsulates the anxiety and distress associated with climate change and environmental degradation, has emerged as a significant psychosocial issue affecting individuals across various demographics. This phenomenon is particularly pronounced among younger generations, who often experience heightened awareness of climate-related threats and their potential impacts on future well-being. The interplay between eco-anxiety and psychosocial problems is complex, involving emotional, cognitive, and social dimensions that can significantly influence mental health outcomes. Research indicates that eco-anxiety is characterized by a future-oriented worry about the potential impacts of climate change, distinguishing it from other eco-emotions such as eco-grief and eco-despair. While many individuals experience eco-anxiety in a non-clinical form, there are instances where it can escalate to pathological levels, leading to significant mental health challenges. This is particularly relevant for young people, who may face multiple life stressors, such as academic pressures and social expectations, which can exacerbate feelings of eco-anxiety and contribute to the development of mental health issues.

**Objectives:** In this study, the negative effects of climate change will be emphasized and its effects on human health and psychology will be emphasized. The main purpose of the study is to prepare the ground for future studies on eco-anxiety, which addresses the connection between climate change and psychology, and to increase social awareness.

**Methods:** The study will conduct between October 2024 and January 2025 2023 in 3 databases (PubMed, Cochrane Library, Science Direct) using the keywords "eco-anxiety" "psychosocial problems" and "mental health". These databases were preferred because they contain a significant amount of evidence-based literature in the field of biomedical sciences and psychology. Studies conducted between 2000 and 2024, whose full texts were accessed and written in Turkish and English were included in the study.

**Results:** 20 national and international research articles on the subject have been reached and the literature review continues. When the literature review is finalized, all study results will be presented together.

**Conclusions:** Conclusions: In summary, eco-anxiety represents a significant psychosocial challenge that intertwines with various mental health issues. Understanding the emotional, cognitive, and social dimensions of eco-anxiety is crucial for developing effective interventions that address the mental health impacts of climate change. By fostering emotional regulation, acknowledging the role of grief, and promoting community engagement, mental