and demotivating factors influencing their participation in the study.
Methods: This study examined patients with affective disorders who refused to participate in an ongoing clinical trial (the topic of a state assignment). Semi-structured interviews with five participants (median age 31 years, all men) admitted to the clinic were recorded and transcribed verbatim. Face-to-face qualitative interviews lasted between 30 and 45 minutes and were analysed using thematic analysis.
Results: The results were summarised around key common themes characterising demotivating factors: 1. Lack of therapeutic alliance with the clinician; 2. Lack of personal meaning of the study for the patient; 3. Feeling like an object of influence rather than a subject of interaction. The motivating factor was that patients wanted the study to be responsive to their needs and interests and to have reasonable control over its progress.
Conclusions: Despite the study's small size and exploratory nature, it offers valuable insights into the factors that motivate and demotivate patients with mood disorders. Although these results may not be generalizable to other groups or women with mood disorders, they offer valuable considerations for future "motivating" interventions in this area (i.e., to address the reason for refusal). In quantitative studies of reasons for rejection, the questions included in the questionnaires are determined by the researchers themselves, and participants are not asked to choose these questions. The scientific and administrative distance of the researchers, as well as their limited understanding of the "living fabric" of the study (situational factors that demotivate the patient), can negatively influence clinical decision-making. Relying on the patient's perspective facilitates productive interactions between the physician (researcher) and the patient, motivates the patient to participate in the study, and provides more reliable answers to the research questions.

Disclosure of Interest: None Declared

EPV861

Comparing Contact Time in Traditional vs. Relational Autonomy Approaches in Mental Health Practice

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Introduction: Autonomy has long been regarded as a cornerstone of ethical mental health practice. However, the way autonomy is framed shapes the therapeutic relationship and resource allocation. While traditional autonomy emphasizes an individual's capacity for independent decision-making, relational autonomy highlights the social and interpersonal dimensions that influence choices. Understanding how these frameworks translate into practical differences in clinical encounters is crucial for both ethical deliberation and service planning.
Objectives: This study aims to compare the contact time clinicians spend with patients and families under traditional autonomy and relational autonomy approaches in mental health practice.
Methods: 51 mental health professionals participated in an online survey. Each respondent estimated average time spent per encounter with a patient and family caregiver when applying traditional autonomy and relational autonomy approaches, using the scenario of an acutely psychotic patient with schizophrenia.
Results: Under the traditional autonomy approach, clinicians reported spending an average of 10.21 minutes each with the patient and the family. Under the relational autonomy approach, these times increased to 17.86 and 15.36 minutes, respectively—an increase of approximately 7 to 8 minutes. Respondents noted that relational autonomy requires more time for empathic dialogue and collaborative explanation.
Conclusions: The choice of autonomy framework significantly affects clinical time expenditure. Relational autonomy fosters richer patient interactions but requires more resources, highlighting implications for staffing and clinical workflow in mental health services.

Disclosure of Interest: None Declared

EPV862

Lamotrigine-Induced Toxidermia

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Introduction: Lamotrigine, widely used in bipolar and depressive disorders, may rarely cause severe cutaneous adverse reactions such as DRESS syndrome. Early recognition is crucial to prevent severe complications.
Objectives: To report a case of lamotrigine-induced DRESS syndrome and emphasize the importance of early detection and careful monitoring to prevent severe complications.
Methods: Case Report: A 19-year-old female treated for recurrent depressive disorder was started on lamotrigine (50 mg/day). Six weeks later, she developed a diffuse pruritic maculopapular rash, fever (38.5°C), cervical lymphadenopathy, and fatigue.
Laboratory tests showed eosinophilia (1200/µL) and moderate hepatic cytolysis (AST 85 U/L, ALT 92 U/L).
The RegiSCAR score suggested probable DRESS. Lamotrigine was promptly discontinued, and systemic corticosteroids were introduced, leading to rapid improvement and resolution of skin lesions within 10 days.
Results: Discussion DRESS is a rare but potentially fatal drug-induced reaction, typically occurring 2–8 weeks after exposure. The risk increases with rapid dose escalation or valproate co-administration.
Management includes immediate drug withdrawal, symptomatic treatment, and systemic corticosteroids in severe cases.
Conclusions: Ce cas souligne la nécessité d'une surveillance étroite lors de l'instauration du traitement par lamotrigine.
Tout signe d'alerte cutané ou systémique doit inciter à une évaluation urgente afin de prévenir les complications graves liées au syndrome DRESS.

Disclosure of Interest: None Declared

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