depression. Shown to improve emotional processing and engagement in therapy.

4. Enhancement of Social Skills.

Studies indicate that art therapy significantly improves social interactions, particularly in patients with learning disabilities.

Conclusion: Art therapy is a valuable adjunct that provides alternative communication channel, especially for non-verbal or emotionally withdrawn individuals.

Clinical Implications and Future Directions:

Incorporate art therapy into multidisciplinary-treatment plans for patients with learning disabilities.

Investigating neurobiological mechanisms underpinning art therapy's impact could optimise therapeutic approaches.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

When Mind and Body Speaks: Understanding Dissociative Neurological Symptom Disorder-ICD–11

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Aims: Dissociative Neurological Symptom Disorder (DNSD), also known as Conversion Disorder, is a common diagnosis among mental health patients in Pakistan. Despite its prevalence, research on DNSD, especially regarding patient experiences, is limited. Family-related stressors are significant contributing factors in its development, with familial discord playing a key role in triggering symptoms.

Methods: A 24-year-old female was referred by a neurologist after presenting to the outpatient department in a wheelchair due to a fear of falling. She reported symptoms including jerky body movements, episodes of apparent loss of consciousness, diarrhoea, weakness, visual disturbances, headaches, and palpitations, which had persisted for over two years. Despite multiple consultations, no organic cause was identified. She had been prescribed various medications with no improvement. Upon evaluation, a diagnosis of DNSD was made, compounded by significant emotional stress, particularly familial discord. A multidisciplinary approach, involving specialists in neurology, ophthalmology, ENT, and gastroenterology, helped rule out underlying physical conditions. Her pre-morbid history indicated high academic achievement but chronic familial stress.

Results: This case emphasizes the importance of recognizing psychosomatic presentations in patients with unexplained neurological and physical symptoms. Despite extensive negative investigations, the patient's psychological stressors, such as familial discord and fear of stigma, were key contributors to the onset of her symptoms. The patient's fear of walking further exacerbated her physical disability. Treatment included sertraline, mirtazapine, and short-term benzodiazepines for anxiety and depression. Psychological therapies such as Cognitive Behavioural Therapy (CBT), deep breathing, safe-place visualization, imaginal exposure, systematic desensitization, and gratitude journalling were used to address emotional issues and reduce disability. This comprehensive approach resulted in symptom resolution, and the patient was symptom-free within 18 months, now pursuing an MPhil degree.

Conclusion: This case highlights the value of a multidisciplinary approach in diagnosing and treating complex physical symptoms with unclear aetiology. Addressing underlying psychological stressors and utilizing appropriate psychosocial interventions significantly improved the patient's condition. Early identification and holistic management combining medical, psychological, and emotional support are crucial for effective treatment of DNSD.

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Sodium Amytal – No Longer Prescribed, but Still Relevant (And Dangerous!)

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Aims: Sodium amytal is a barbiturate medication, first synthesised in Germany in the 1920s to treat anxiety and sleep disorders; as well as being used as an anaesthetic. This case report discusses sodium amytal prescription and subsequent dependence in an 82-year-old female with a history of anxiety and agoraphobia. It aims to highlight historical indications, mechanism of action of and potential dangers of cessation. As such, clinical management of withdrawal is discussed including the initial use of a more commonly prescribed barbiturate in place of amobarbital; with the ultimate aim being to cease such dangerous medication and to consider safer alternatives – pharmacological and psychological.

Methods: Mrs F was referred to Older Persons Psychiatric Services in 2024. At this time, her GP reported that she was 'one of only 30 patients in the UK' to be prescribed sodium amytal, and that it was 'no longer being produced'. At the time of referral, Mrs F had just a 7-day supply of medication left.

Guidance from the local Medicines Information team had been sought prior to admission. They recommended a phenobarbital taper for seizure prophylaxis when discontinuing other barbiturates, where 100 mg amobarbital was roughly equivalent to 30 mg phenobarbital. Phenobarbital is a long-acting barbiturate which would be more commonly found in practice, given its use in management of epilepsy.

As such, an attempt was made at the safe withdrawal of sodium amytal in the inpatient setting. This was due to the significant risks associated with abrupt withdrawal, including seizure, hallucinations and cardiovascular collapse tending to occur after 16 hours of cessation with such risk remaining up until approximately 5 days.

Mrs F had run out of medication on the day that she was admitted, and given the aforementioned risks, a thorough plan was developed to ensure close monitoring. She was commenced on 1:1 special observations initially due to the risk of seizures. Her clinical observations were performed on a regular basis and a CIWA (Clinical Institute Withdrawal Assessment for Alcohol) score was also performed hourly to monitor withdrawal severity. To this end, lorazepam was prescribed at a dose of 1 mg every 6 hours, as well as an 'as required' dose of 1 mg prescribed for when CIWA score was >8.

At consultant review the following day, Mrs F was commenced on phenobarbital at a dose of 30 mg QDS + 30 mg PRN to a maximum of 150 mg/day, continuing on regular lorazepam at 1 mg QDS. Of note, this is slightly lower than the aforementioned recommendation which would equate to 162 mg/day. Subsequently, owing to increasing agitation and anxiety, Mrs F's dose was increased to 60 mg mane, 30 mg TDS plus 30 mg PRN and her dose of lorazepam