Two years later, venlafaxine was gradually discontinued without relapse.
Conclusions: Despite various hypotheses—such as latent bipolarity—there is no scientific consensus on the etiology of antidepressant discontinuation mania. Misdiagnosis as primary bipolar disorder may lead to unnecessary long-term mood stabilizer use, highlighting the need for clinical awareness. Our case, featuring mania without prior mood disorder, differs from most reports and may aid in elucidating both antidepressant neurobiology and bipolar pathophysiology.

Disclosure of Interest: None Declared

EPV205

Blunted Loss Reactivity in Subclinical Bipolarity During Risky Choice

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Introduction: Risk-taking is shown to be common in bipolar disorder (BD). We hypothesized that the alignment (or misalignment) between expected and immediate affective responses can shape risky choice. We examined the expectation–experience gap in subclinical bipolar disorder (SBD) as a putative mechanism relevant to risky decision-making.
Objectives: To quantify and compare the difference between expected and immediate affect (negative and positive) across monetary loss and win outcomes in SBD versus a control group, and to assess whether group differences emerge—especially for loss-related responses.
Methods: Fifty-five adults (SBD = 27, control group = 28, age range= 18-45) completed a coin-toss gambling task arranged as eight rounds of five tosses each (40 total). Outcomes were pre-generated so that each participant completed two low-loss, two high-loss, two low-win, and two high-win rounds. On each round, participants provided expected affect ratings before the five-toss sequence and immediate affect ratings after the sequence (both negative and positive; 5-point Likert scale). SBD status was defined using Bipolar Prodrome Scale (BPS) cut-offs (Frequency ≥18 or Severity ≥40; Turkish validation by Aydemir et al., 2018). We targeted a subclinical sample to probe early mechanisms and minimize confounds from medication use and illness chronicity. For analysis, per-round difference scores were computed as expected minus immediate for each valence and averaged within loss/win categories. Between-group comparisons used two-tailed independent-samples tests with $\alpha = .05$ and Cohen's d as the effect-size index.
Results: We compared the expected–immediate difference scores between groups. For loss rounds, the difference in negative affect (expected minus immediate) was larger in the control group than in the SBD group ($t = 2.96$, $p = .005$, Cohen's $d = 0.80$). For positive affect, the expected–immediate difference showed no between-group differences.
Conclusions: Findings are consistent with blunted loss reactivity in SBD as a potential pathway influencing risky decision-making. Design features (round-level ratings, fixed outcomes) and sample size maybe limiting generalizability. Results should be replicated with larger cohorts to clarify when the expected–immediate gap impacts behavior and how it can inform interventions targeting emotional awareness and emotion regulation during decision-making.

Disclosure of Interest: None Declared

EPV207

Implementing a Homogeneous Psychotherapy Group for Bipolar Disorder: Outcomes and Case Study

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Introduction: Bipolar affective disorder (BAD) is a chronic mental illness characterized by mood instability, impaired insight, and high suicide risk. While pharmacotherapy remains essential, patients often face ongoing psychosocial challenges and stigma. Group psychotherapy offers a supportive setting to reduce isolation and foster coping, but BAD patients are often considered difficult group members due to impulsivity and mood fluctuations. This work presents clinical experience and a case report illustrating therapeutic outcomes .
Objectives: To evaluate the feasibility, challenges, and benefits of implementing a homogeneous group psychotherapy format for patients with BAD and to illustrate therapeutic group dynamics through a clinical case.
Methods: Since October 2018, a BAD-specific psychotherapy group met weekly to complement pharmacotherapy. Sessions focused on psychoeducation about bipolar disorder, treatment adherence, suicide risk monitoring, and group cohesion development. Attendance, drop-out rates, group interactions, and setting adaptations in pandemic circumstances (outdoor and online formats) were monitored.
Case Presentation: A 35-year-old married man, father of two, working in entertainment, participated regularly. Despite economic stability, he struggled with life dissatisfaction, traumatic childhood experiences, marital communication problems, and gambling addiction. The group provided a safe space to share intimate issues, normalize symptoms, and receive peer support. Acceptance empowered him to articulate needs and seek specialized gambling addiction treatment. He described the group as a "good mother" and found participation transformative, viewing bipolar disorder as ultimately contributing to his personal growth.
Results: The group faced high drop-out and slower cohesion due to poor insight and behavioral challenges. Nevertheless, core members sustained attendance, fostering mutual support, reducing stigma, and enhancing psychosocial functioning. Group therapy was notably more effective during depressive phases and helped prevent suicidal impulses.
Conclusions: A homogeneous group psychotherapy setting for patients with bipolar affective disorder offers a unique, non-judgmental microcosm that facilitates self-reflection, emotional support, and psychoeducation. It reduces stigma and promotes personal development while serving as a bridge to supplementary

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treatments such as specialized addiction therapy. The presented case illustrates the transformative potential of group therapy, demonstrating how consistent participation can empower patients to articulate their needs, seek additional treatment, and experience meaningful personal growth.

Disclosure of Interest: None Declared

EPV208

Late-Onset Manic Episode: Bipolar Disorder or Organic Secondary Mania ? A Case Report

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Introduction: Mania has traditionally been considered a primary mood disorder, most often occurring in the context of either bipolar disorder or, less commonly, unipolar mania. More recent evidence demonstrates the occurrence of episodes of secondary mania attributable to identified organic, metabolic, pharmacologic, or neurologic processes. Within neurological causes, focal brain lesions are especially prevalent in the production of manic symptoms.
Objectives: To demonstrate, using a clinical case and in the context of current literature, the difficulties encountered in differentiating between primary mania and secondary mood disorders in late-onset mania.
Methods: Clinical case report and literature review.
Results: Mr. A., a 48-year-old man with no relevant past psychiatric history or family psychiatric history, presented with his first-ever manic episode, demonstrating an elevated mood, grandiose and persecutory delusions, disinhibition (including coprolalia), and excessive spending on unrealistic business venture ideas. A psychiatric evaluation confirmed classical manic features. Due to the relatively late age of onset, he was subsequently evaluated for an organic cause to the episode. The initial CT scan was negative. The brain MRI revealed a nodular FLAIR hyperintense lesion in the periventricular white matter in the right medial frontal region with gadolinium enhancement; however, lumbar puncture was essentially normal (no oligoclonal bands noted). Autoimmune screens (e.g., anti-AQP4 and anti-MOG antibodies) were negative, examination of his systemic systems revealed no evidence of autoimmune or infectious disease, including neurological examination. Although multiple sclerosis was initially suspected, this diagnosis was excluded as there was no dissemination in time or space, CSF was normal, and the immunology was negative. However, we could not completely exclude secondary mania, stemming from an underlying organic cause.
The patient was admitted to the hospital, and his treatment regime included olanzapine. He made a good clinical progress as his mood was gradually stabilized, and delusional symptoms disappeared after three weeks of treatment. His treatment was subsequently optimized, reducing olanzapine gradually and switching to valproate sodium 1 g/day with close psychiatric monitoring.
Late-onset bipolar disorder is uncommon and generally requires exclusion of secondary diagnoses, such as multiple sclerosis, CNS infections, autoimmune encephalitis or frontotemporal dementia. Lesions leading to demyelination in the frontal lobe may disrupt fronto-limbic circuits potentially explaining the mood symptoms.

Image 1:

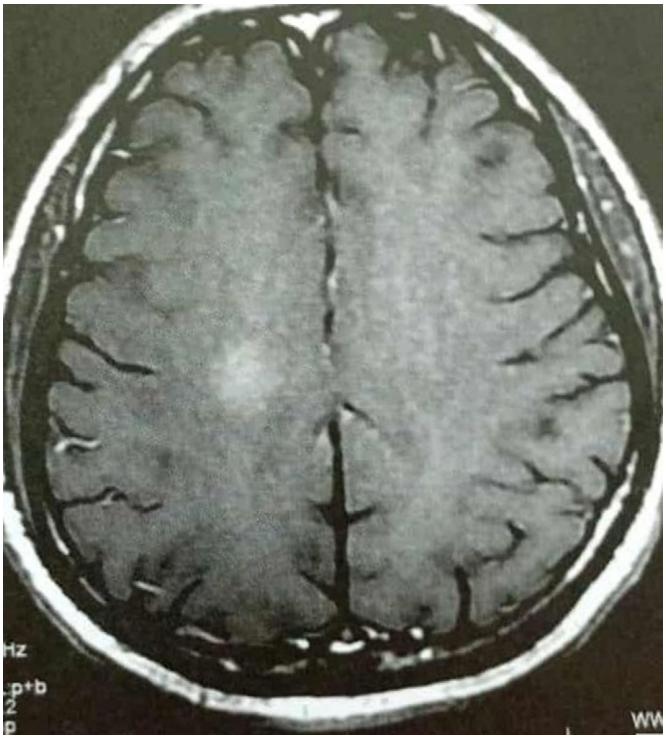
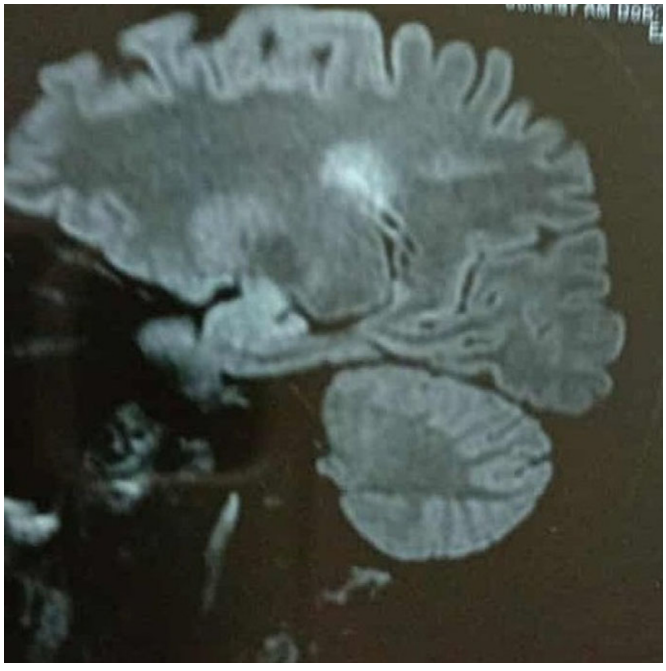


Image 2:



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