some conflicting discussions in the literature about how to distinguish this disorder from other childhood psychiatric disorders and how to treat it.
Objectives: The aim of this study was to determine the phenomenological and neuropsychological differences between children and adolescents with a diagnosis of BPD (Pediatric Bipolar Disorder), DMDD (Disruptive Mood Dysregulation Disorder), and children and adolescents who are genetically at high risk for Bipolar Disorder (BD), and healthy controls (HCs) who do not have any psychiatric diagnosis, to investigate endophenotypes that may be predictive for BD.
Methods: Our study sample consists of four groups, the BPD group (n=30), the Risk group (n=25), the DMDD group (n=36), and the Healthy Control group (n=29). All participants were evaluated by the "Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children—Now and Lifetime Pattern (K-SADS-PL)". "Young Mania Rating Scale/Parent Form (YMRS-ABF), Conner's Parent Rating Scale (CPRS-48), Child and Adolescent Behavior Rating Scale (CBCL)" scales were filled by parents, and "Child Depression Inventory (CDI), Youth Self-Report Form for 11-18 Years Olds (YSR)" scales were filled by children and adolescents. Neurocognitive test battery was applied to each participant: Continuous Performance Test (CPT), Wisconsin Card Sorting Test (WCST), Stroop Color and Word Test (SCWT), Trait Making Test A and B sections (TMT-A/B), California Verbal Learning Test-Child version (CVLT-C).
Results: While it was determined that the cases in the BPD and DMDD groups performed significantly worse in CPT, SCWT, CVLT-C, TMT A/B tests compared to healthy controls, it was found that the subjects in the Risk group performed worse at the CPT test than healthy controls. In addition, the cases in the BPD, Risk and DMDD groups reported more clinical and behavioral problems than the healthy controls.
Conclusions: There is a significant deterioration in the areas of continuous attention, processing speed, cognitive flexibility, response prevention, verbal memory and working memory in the BPD and DMDD groups, and in the continuous attention area in the Risk group compared to healthy controls. Prospective follow-up and imaging studies using larger samples and a larger neurocognitive test battery in the future will better reveal the neuropsychological characteristics of the BPD, Risk and DMDD groups.

Disclosure of Interest: None Declared

O0084

Internalized Stigma in Patients with Bipolar Disorder: A Cross-sectional Study on Its Associations with Sociodemographic, Marital and Clinical Characteristics

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Introduction: Bipolar disorder (BD) is a chronic and complex affective disorder among top diseases that cause disability worldwide. Internalized stigmatization is a process including the awareness of negative stereotypes adopted by the society, participation in and internalization of these judgements, associated with impaired social functionality. Studies examining internalized stigma and related factors in BD is limited.
Objectives: In this study, it is aimed to investigate the associations between internalized stigmatization and clinical characteristics, as well as sociodemographic and marital features of patients with BD.
Methods: This observational and cross-sectional study was conducted at a specialized affective disorders clinic in a university hospital between November 2020 and March 2021. During routine follow-up, each consecutive patient with BD was invited and a total of 118 were included in the study. Information about sociodemographic, marital and clinical characteristics of patients was collected through a prepared data form and follow-up documents. Internalized Stigma of Mental Illness Scale (ISMIS) was administered to assess internalized stigma. Statistical analysis of data was conducted by SPSS version 25 and a statistical significance level of $p<0.05$ was determined.
Results: Mean ISMIS total score of the sample was 56.50 ±13.65. Multiple linear regression was used to test the predictors of higher ISMIS scores. Being currently unemployed (p=0.012, B=0.208), shorter BD duration (p<0.001, B=0.302) and presence of inter-episode residual symptoms (p=0.004, B=0.248) predicted higher ISMIS total. Younger age (p=0.002, B=0.264), being female (p=0.007, B=0.226) and absence of mania dominance (p=0.019, B=0.190) predicted higher alienation scores. Presence of inter-episode residual symptoms predicted both stereotype endorsement (p<0.001, B=0.320) and perceived discrimination (p<0.001, B=0.358). Younger age (p=0.001, B=0.281) and total number of depressive episodes (p=0.015, B=0.212) also predicted perceived discrimination. Shorter BD duration and absence of seasonality predicted higher ISMIS social withdrawal, while history of hospitalization predicted higher ISMIS stigma resistance.
Conclusions: Our study demonstrated similar mean ISMIS total scores to the findings previously reported in Türkiye, while roughly lower than results in the international literature. Considering that internalized stigmatization was increased in earlier stages of BD and in younger patients, as well as in patients with inter-episode residual symptoms, it might be important to implement psychosocial interventions for internalized stigmatization and appropriate psychoeducation programs in the earlier periods of BD. Therefore a multidimensional and holistic approach towards internalized stigmatization may positively contribute to the functionality of patients with BD.

Disclosure of Interest: None Declared

O0085

Cariprazine add-on in resistant bipolar depression. Long-term effectiveness and safety data from a multicentric real-world experience

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Introduction: Persistent depressive episodes and subsyndromic depressive symptoms frequently characterize mood alterations in bipolar disorder (BD) and negatively influence quality of life and suicide risk. BD patients with predominant depressive episodes generally show significantly higher treatment resistance rates. Although not specifically approved in Italy for bipolar depression, recently published observational data suggest that the cariprazine add-on may be a potential effective short-term treatment for resistant bipolar depression. Nevertheless data on long-term cariprazine treatment are lacking.
Objectives: This study evaluated the efficacy and safety of long-term cariprazine augmentation in patients suffering from treatment-resistant bipolar depression.
Methods: 30 resistant bipolar depressed patients, whose resistance was defined according to The CINP Guidelines on the Definition and Evidence-Based Interventions for Treatment-Resistant Bipolar Disorder, were treated with cariprazine 1,5 -3 mg flexible dose for 4 weeks, added to previous mood stabilizing and/or antidepressant treatment. Psychopathology at time 0 and at 4, 8, 12, 16, 20, 24 weeks of treatment was evaluated using the Hamilton Depression Rating Scale (HDRS), the Hamilton Anxiety Rating Scale (HARS), the Young Mania Rating Scale (YMRS) and the Bipolar Depression Rating Scale (BDRS); safety and tolerability was measured by the UKU Side Effect Rating Scale. The drop-out rate was assessed throughout the study duration.
Results: Cariprazine add-on was effective in the study sample but only during the first 4 weeks of treatment. Improvement in depression scores started from the first week, reaching about 40% mean HDRS score reduction at T4; a moderate ulterior decrease (-15%) was reached at T24 but was accompanied by a significant drop-out rate; anxiety symptoms improved (mean HARS score reduction 37% at T4) mainly during the first 4 weeks. The treatment was generally well tolerated. From week 4 to 24 we observed a near 70% drop-out rate (18 total drop-outs) with maximum drop-outs between weeks 4-8 (n=7) and 18-24 (n=7). Discontinuation causes were inefficacy (5/18); clinical worsening (10/18); side effects (3/18); hypomanic shift (2/18).
Conclusions: Despite the relatively small population examined and the observational design, our results suggest that cariprazine may represent an effective and safe short-term enhancement strategy in resistant bipolar depression. Long-term treatment, in this sample, did not lead to significant improvements and was burdened by a high drop-out rate, mainly due to inefficacy/clinical worsening. Further studies on larger samples are needed to confirm these preliminary findings, both in short-term and in longer observations.

Disclosure of Interest: None Declared

O0086

Mitochondrial respiratory capacity in patients with acute episodes of bipolar disorder compared with clinical remission

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Introduction: Bipolar disorder (BD) is a chronic and recurrent disease characterized by acute mood episodes alternated with periods of euthymia. The available literature postulates that a biphasic dysregulation of mitochondrial bioenergetics might be observed in BD.
Objectives: We aimed to explore differences in *in vivo* mitochondrial respiration (1) intra-individually: longitudinally within patients during an acute mood episode of BD and after clinical remission, and (2) inter-individually: between patients with BD on depressive or manic episodes and healthy controls (HC).
Methods: Patients admitted to our acute psychiatric ward with a manic episode or bipolar depression were recruited. Different mitochondrial oxygen consumption rates (OCRs) were assessed during the acute episode (T0) and after clinical remission (T1) in one million of peripheral blood mononuclear cells (PBMC): Routine, Leak, ETC and Rox. They were measured as picomoles of oxygen per million cells (pmol O_2/million). This experiment was also conducted in HC. High-resolution respirometry was performed at 37°C by polarographic oxygen sensors in a two-chamber Oxygraph-2k system. Manic and depressive symptoms were assessed using standardized psychometric scales. Oxygen consumption capacity was compared (1) intra-individually, during acute episodes and after clinical remission, and (2) inter-individually, during acute manic and depressive episodes, and in HC. Statistical analyses were performed with SPSS, GraphPad and R Statistics.
Results: 20 patients with BD (15 manic, 5 depressed) and 10 HC were included. A significant increase in the maximal oxygen consumption capacity (ETC) was observed in clinical remission (27.4 ± 17.4) compared to the acute episodes (21.1 ± 11.7, p = 0.001), which remained significant after subtracting Rox from the other rates (p = 0.001). At T1, patients admitted with a manic episode tended to show higher mean ETC (31.2 ± 18.7) compared with T0 (24.1 ± 12.0, p = 0.074); the tendency persisted after Rox subtraction (p = 0.076). Patients admitted with a depressive episode also showed higher ETC means in T1 (16.3 ± 3.8) compared to T0 (12.1 ± 3.4), but there were not significant differences (p = 0.231). When HC, manic and depressive patients at T0 were compared between them, significant differences were observed in ETC (H =8.5; p =0.014) and Rox (H =13.8; p = 0.001). After Rox deduction, differences in ETC remained (H =11.7; p = 0.003). Individuals with bipolar depression showed lower ETC rates (12.1 ± 3.4) than those with a manic episode (24.1 ± 12.0; t = -3.5, p = 0.003), which was also found after Rox deduction (p = 0.001).
Conclusions: In both manic and depressive episodes in BD, mitochondrial respiration might be reduced and increase after clinical remission. Further studies with larger samples will allow to confirm these results and also to identify potential mitochondrial state-dependent biomarkers.

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