system functions, such as learning and memory, but also mood regulation. Despite this, there is only anecdotal evidence on the potencial role of the ECS in the pathophysiology of BD.
Objectives: This study aims to retrospectively assess clinical and sociodemographic variables of patients whose manic episode is temporally associated with the suspension of cannabis use, compared with the rest of a sample of manic patients admitted to an acude psychiatry ward. The objective of the study is to investigate the presence of a specific group of BD patients, with potential clinical and therapeutic implications.
Methods: We retrospectively analysed all admitted patients to the acute psychiatry unit at Hospital Clinic of Barcelona from 2015 to 2019 and hospitalized for a manic episode. Patients with core manic symptoms started after cannabis withdrawal were included in the study. Cannabis Withdrawal Induced Mania (CWIM) group (n=20) was compared with the rest of bipolar manic patients in our sample according to several clinical and sociodemographic variables. Univariate and multivariate logistic regression models were performed.
Results: between 2015 and 2019, 315 patients were admitted to the acute psychiatry unit with diagnosis of manic episode. In 282 of the cases, the history of cannabis use was documented. 20 of them meet criteria for CWIM. CWIM group patients were significantly more frequently men (p=0.015) and younger (p<0.001), were not married or in a relationship (p = 0.018) and less frequently had somatic illnesses (p=0.41). Patients with CWIM debuted with a first manic episode and had their first psychiatry admission at a significantly younger age (p=0.008 and p=0.004, respectively). Previous treatment with antipsychotic medication was significantly less frequent in the CWIM group (p=0.022). According to follow-up, there were no significant differences in relapse after three years (p=0.936).
Conclusions: This study found a new clinical profile of patients, who are more suggestive to have a manic episode in context of cannabis withdrawal.

Disclosure of Interest: None Declared

EPV0229

Emotion dysregulation in bipolar disorder according to predominant polarity

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Introduction: Emotion dysregulation (ED) is a core feature of bipolar disorder (BD), impacting patients' ability to manage intense emotional responses and maintain mood stability. Predominant polarity (PP) is a clinical specifier in BD with important implications for prognosis, treatment planning, and outcomes. PP categorizes patients based on the mood episode type they experience most frequently: depressive PP (DPP), manic PP (MPP), or undetermined PP (UPP) when no episode type prevails. Given that PP reflects the types of symptoms most commonly experienced by patients, and that ED is closely linked to mood symptoms in BD, it remains unclear whether ED differs across PP subgroups.
Objectives: We aimed to compare overall levels of ED and specific emotion regulation (ER) domains across patients with BD and DPP, MPP, and UPP.
Methods: We analyzed data from patients with BD enrolled in the Bipolar Exposome-Gene Interaction Naturalistic (BEGIN) study. ED and ER strategy alterations were assessed using the Difficulties in Emotion Regulation Scale (DERS-28) and its subscales: Lack of Control, Non-Acceptance, Interference, Inattention, and Confusion. PP was defined based on the Barcelona proposal. Due to non-normal DERS score distributions (Shapiro-Wilk $p < 0.05$), the Kruskal-Wallis test was applied to compare DERS total and subscale scores across PP groups, followed by Dunn's test with Bonferroni correction for pairwise comparisons.
Results: The sample included 64 patients with BD (mean age=51 ±12.5; 46.9% female). Of these, 17 had DPP, 7 had MPP, and 40 had UPP. Significant differences across PP groups were observed in overall ED (p=0.04), with the UPP group showing higher total DERS scores than the MPP group (Z=2.55, p=0.03). In the Lack of Control subscale, both the DPP and UPP groups scored higher than the MPP group (Z=2.43, p=0.04 and Z=3.14, p=0.01, respectively). No other significant differences were found.
Conclusions: These findings indicate that ED varies across PP groups, emphasizing the potential advantages of tailored interventions within a precision psychiatry framework. Personalized approaches to managing ED may improve long-term outcomes and decrease the risk of recurrence across mood states in BD.

Disclosure of Interest: None Declared

EPV0230

Profiles of affective temperaments can support differentiation of bipolar I disorder, bipolar II disorder, and major depressive disorder

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Introduction: Differentiating bipolar I, bipolar II, and major depressive disorders is essential; therefore, the relationship between affective temperaments and mood disorder diagnoses has garnered considerable attention.
Objectives: The current study aimed to explore the representative types of Temperament Evaluation of Memphis, Pisa, Paris, and San Diego-Autoquestionnaire (TEMPS-A) profiles observed in the actual clinical setting using a data-driven approach and verify the relationship between TEMPS-A profiles and the proportions of three mood disorders (bipolar I, bipolar II, and major depressive disorders). Through this research, we intend to enhance the utility and applicability of affective temperament assessment based on the TEMPS-A when differentiating among mood disorders in clinical practice.

Methods: Psychiatric outpatients diagnosed with bipolar I, bipolar II, or major depressive disorder and aged ≥18 years were analyzed. Latent profile analysis was conducted using TEMPS-A scores, and each patient was classified into a subgroup according to their TEMPS-A scores. After that, multinomial logistic regression was conducted to verify the relationship between TEMPS-A profiles and mood disorder diagnoses.
Results: The findings indicate that seven types of TEMPS-A profiles are the most appropriate (Table 1). The depressive profile did not significantly increase the likelihood of being diagnosed with both bipolar II disorder and bipolar I disorder. The cyclothymic profile and anxious, cyclothymic and depressive profiles significantly increased the likelihood of the diagnosis of bipolar II disorder but did not significantly increase the likelihood of the diagnosis of bipolar I disorder. Furthermore, the cyclothymic and hyperthymic profile; cyclothymic, depressive and irritable profile; and anxious, cyclothymic, hyperthymic and irritable profiles significantly augmented the likelihood of being diagnosed with both bipolar II disorder and bipolar I disorder (Tables 2 and 3).

Image 1:

Table 1

Model fit indices for the five-, six-, seven-, eight-, and nine-latent profiles model comprising five affective temperament dimensions

# of latent profiles	Log-likelihood	AIC	BIC	SABIC	BLR test *p*-value	Entropy
5	-7245.672	14579.344	14779.780	14640.070	.01	.703
6	-7226.333	14552.666	14780.434	14621.673	.01	.707
7[a]	**-7204.074**	**14520.148**	**14775.248**	**14597.436**	**.01**	**.716**
8	-7200.862	14525.725	14808.157	14611.294	.43	.705
9	-7200.243	14536.485	14846.250	14630.335	.92	.684

Notes. AIC = Akaike Information Criterion; BIC = Bayesian Information Criterion; SABIC = Sample-Size Adjusted Bayesian Information Criterion; BLR = Bootstrapped Likelihood Ratio
[a] The number of profiles and model fit indices for the favored model are in **bold**.

Image 2:

Table 2

Means and standard deviations of five affective temperament dimensions in the total sample and each subgroup

Affective temperament dimensions	Total (*N* = 703) *M* (*SD*)	Profile 1 (*n* = 99) *M* (*SD*)	Profile 2 (*n* = 69) *M* (*SD*)	Profile 3 (*n* = 100) *M* (*SD*)	Profile 4 (*n* = 137) *M* (*SD*)	Profile 5 (*n* = 108) *M* (*SD*)	Profile 6 (*n* = 100) *M* (*SD*)	Profile (*n* = 90 *M* (*SD*
Anxious[a]	1.58 (1.15)	1.04 (1.06)	1.61 (1.13)	1.37 (1.08)	**2.01** (1.08)	1.31 (1.13)	1.69 (1.15)	**1.93** (1.08
Cyclothymic[b]	7.58 (3.31)	2.54 (1.80)	3.75 (1.73)	**8.78** (1.90)	**9.25** (1.81)	**8.14** (2.56)	**9.41** (2.09)	**9.51** (2.33
Depressive[c]	4.30 (2.43)	1.28 (1.20)	**6.45** (1.17)	2.43 (1.16)	**6.09** (1.18)	3.06 (1.82)	**6.48** (1.40)	4.40 (2.07
Hyperthymic[d]	2.83 (2.21)	1.96 (1.58)	1.04 (1.39)	1.48 (1.09)	2.05 (1.41)	**5.64** (1.13)	1.87 (1.43)	**5.54** (1.38
Irritable[e]	2.34 (2.09)	0.75 (1.08)	1.62 (1.24)	1.37 (1.09)	1.28 (1.07)	1.47 (1.12)	**4.83** (1.07)	**5.61** (1.22

Notes. Profile 1: *Flat;* Profile 2: *Depressive;* Profile 3: *Cyclothymic*; Profile 4: *Anxious, cyclothymic and depressive;* Profile 5: *Cyclothymic and hyperthymic;* Profile 6: *Cyclothymic, depressive and irritable;* Profile 7: *Anxious, cyclothymic, hyperthymic and irritable*
[a] Score ranges from 0 to 3. Sample means of subgroups significantly higher ($p < .05$) than the total sample mean (1.58) are in **bold**.
[b] Score ranges from 0 to 12. Sample means of subgroups significantly higher ($p < .05$) than the total sample mean (7.58) are in **bold**.
[c] Score ranges from 0 to 8. Sample means of subgroups significantly higher ($p < .05$) than the total sample mean (4.30) are in **bold**.
[d] Score ranges from 0 to 8. Sample means of subgroups significantly higher ($p < .05$) than the total sample mean (2.83) are in **bold**.
[e] Score ranges from 0 to 8. Sample means of subgroups significantly higher ($p < .05$) than the total sample mean (2.34) are in **bold**.

Image 3:

Table 3

Parameter estimates for the multinomial logistic regression model with covariates

Covariates	Bipolar II Disorder vs. Major Depressive Disorder (reference)					Bipolar I Disorder vs. Major Depressive Disorder (reference)				
	B	*SE*	*p*[b]	OR	95% CI	*B*	*SE*	*p*	OR	95% CI
Sex[c]	-0.02	0.19	.806	0.98	0.68 – 1.42	-0.14	0.24	.569	0.96	0.60 – 1.53
Age	-0.01	0.01	.498	0.99	0.97 – 1.02	0.01	0.01	.312	1.01	0.97 – 1.02
Profile 2	0.59	0.40	.140	1.80	0.82 – 3.93	-0.63	0.61	.299	0.53	0.16 – 1.75
Profile 3	1.72	0.36	**<.001**	5.58	2.75 – 11.29	0.86	0.44	.051	2.35	0.10 – 5.55
Profile 4	2.03	0.35	**<.001**	7.65	3.88 – 15.07	0.74	0.44	.092	2.10	0.89 – 4.97
Profile 5	1.86	0.37	**<.001**	6.39	3.13 – 13.08	1.50	0.41	**<.001**	4.50	2.00 – 10.14
Profile 6	1.43	0.37	**<.001**	4.18	2.02 – 8.66	1.45	0.41	**<.001**	4.26	1.91 – 9.50
Profile 7	2.54	0.40	**<.001**	12.63	5.72 – 27.91	2.31	0.45	**<.001**	10.09	4.21 – 24.16

Notes. *B* = unstandardized coefficient; *SE* = standard error; OR = odd ratio; CI = confidence interval; Profile 2: *Depressive;* Profile 3: *Cyclothymic;* Profile 4: *Anxious, cyclothymic and depressive;* Profile 5: *Cyclothymic and hyperthymic;* Profile 6: *Cyclothymic, depressive and irritable;* Profile 7: *Anxious, cyclothymic, hyperthymic and irritable*
Latent profiles are dummy-coded, and profile 1 (*flat profile*) was set as the reference category.
[b] Significant findings of $p < .050$ are in **bold**.
[c] Female = 0, male = 1.

Conclusions: Our findings show that certain affective temperaments are closely correlated with one another, and cyclothymic temperament can act as a crucial risk factor for bipolarity. Moreover, our findings suggest the possibility that hyperthymic or irritable temperaments can help differentiate between bipolar I disorder and bipolar II disorder. Further studies using reliable clinical interview schedules are needed, and studies focusing on patients with other mood disorders would be helpful.

Disclosure of Interest: None Declared

EPV0231

Impact of Lumateperone compared to Quetiapine on Quality of Life of Indian patients with Bipolar II depression: A post-hoc analysis of a Phase 3 study

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