Introduction Burn out mainly occurs among healthcare employees. This professional category is exposed to a large load of emotional disturbance.
Objectives The aim of this work was to study the levels of burnout syndrome in caregivers who were victims to occupational accident.
Methods This cross-sectional study was conducted during 2014-2015 in the occupational medicine department. The target population consisted of the healthcare employees who reported their exposure to occupational accident. A semi-structured self-reported questionnaire including the Maslach questionnaire was used to collect information. Data were analyzed using SPSS-20.
Results One hundred and sixty health professionals returned the questionnaire (58% women, mean age 31.9 years old). Occupational accidents occurred mostly in the morning (62.5%). Among the healthcare providers, 112 health professionals (70%) had had sharp injuries. Burn out was found among 23.1% of the studied population. It was defined by its three domains: a high emotional exhaustion (46.9%), high depersonalization with low personal accomplishment (36.3%) and high depersonalization without low personal accomplishment (34.4%). Professionals with less years in the function ($P = 0.031$) and technicians ($P = 0.028$) were more affected by Burnout. A significant relationship was found between traumatic accidents ($P = 0.012$), needle stick injuries ($P = 0.009$) and burnout.
Conclusion The prevalence of burnout is high among health professionals which can increase the risk of occupational accidents and its subsequent risks. It seems that holding workshops and increasing healthcare givers' awareness and skills to face these risks can be effective in mitigating them.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.02.253

EW0640

Cognitive dysfunction in depression. Is it well detected?

M. Serra-Blasco[1,*], E. Aguilar[2], M. Vicent[3], G. Navarra[1], M.J. Portella[3], I. Figuereo[2], S. Crivillés[2], E. Martínez-Amorós[2], G. Lahera[4], J.A. Monreal[2], N. Cardoner[2]
[1] *Institut de Recerca Parc Taulí-I3PT, psychiatry, Sabadell, Spain*
[2] *Hospital universitari Parc Taulí, psychiatry, Sabadell, Spain*
[3] *Institut d'investigació biomèdica Sant Pau IIB-Sant Pau, psychiatry, Barcelona, Spain*
[4] *Príncipe de Asturias university hospital, psychiatry, Madrid, Spain*
[*] *Corresponding author.*

Introduction Major depression cognitive impairments lasts in remission periods, have an impact on treatment outcome and hamper psychosocial functioning. Thus, its accurate detection and specific treatment has become a crucial step.
Objectives In order to assess objective cognitive functioning (OCF), a neuropsychological battery was administered. For subjective cognitive functioning (SCF), cognitive perception was evaluated by clinicians and patients.
Aims To determine the concordance between OCF and SCF.
Methods One hundred and two patients were grouped according to Hamilton Depressive Rating Scale (HDRS−17): 18 remitters (RE < 7), 40 partly remitters (PR, 7–18) and 44 acutely depressed (AD > 18). OCF was computed combining T-scores of digit symbol substitution test (WAIS-IV) with two RAVLT subtests (learning and memory). SCF was assessed with a CGI adaptation for cognitive disturbances severity.
Results The OFC was 41.21(8.49) for all patients and 45.54(6.8), 41.93(6.8) and 38.7 (9.7) for RE, PR, and AD, respectively. Psychiatrist and patients' SCF had a poor agreement (α=0.518), with Cronbach's alpha for RE, PR and AD of −0.607, 0.518 and 0.404. Concordance between OCF and SCF was calculated for all patients (psychiatrist, $r = -0.317$, $P = 0.002$; patient, $r = -0.310$, $P = 0.002$), for RE ($r = -0.535$, $P = 0.022$; $r = 0.395$, $P = 0.105$) for PR ($r = -0.013$, $P = 0.94$; $r = -0.328$, $P = 0.045$) and for AD ($r = -0.252$, $P = 0.122$; $r = -0.333$, $P = 0.033$). Patients rated their SFC as more impaired than did clinicians.
Conclusions Concordance between clinicians and patients regarding SCF is very poor, worsening in AD group and being null in remission. This study also points out that CF is best detected by patients in acute episodes and by psychiatrists when patients are in clinical remission.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.02.254

EW0641

Predictors of functioning in major depression

M. Serra-Blasco[1,*], E. Aguilar[2], M. Vicent[3], G. Navarra[1], M.J. Portella[3], A. Sánchez[2], L. Ros[2], S. Acebillo[2], G. Lahera[4], D. Palao[2], N. Cardoner[2]
[1] *Institut de Recerca Parc Taulí-I3PT, psychiatry, Sabadell, Spain*
[2] *Hospital Universitari Parc Taulí, psychiatry, Sabadell, Spain*
[3] *Institut d'investigació biomèdica Sant Pau IIB-Sant Pau, psychiatry, Barcelona, Spain*
[4] *Príncipe de Asturias university hospital, psychiatry, Madrid, Spain*
[*] *Corresponding author.*

Introduction Life functioning difficulties are a relevant but undervalued consequence of major depression. Mood symptoms and cognitive deficits have a significant, and somehow independent, impact on them. Therefore, cognitive difficulties should be considered a potential target to improve patients' functioning.
Aims To examine the degree in which objective and subjective cognition explain functional outcome.
Objectives To assess objective cognitive function (CF) with a neuropsychological battery and to measure subjective CF using measures of cognitive perception.
Methods Ninety-nine patients with depression were assessed by age, sex and level of schooling. Depressive symptoms severity was measured by Hamilton Depression Rating Scale (HDRS-17). Objective CF consisted in the following cognitive domains: memory, attention, executive functioning and processing speed. Subjective CF was assessed with Perceived Deficit Questionnaire-Depression (PDQ-D). Functioning Assessment Short Test (FAST) was used to evaluate life functioning, excluding the cognitive domain. All the listed measures were included in a multiple regression analysis with FAST scores as dependent variable.
Results The regression model was significant ($F_{1,98} = 67.484$, $P < 0.001$) with an R of 0.825. The variables showing statistical power included (from higher to lower β-coefficient) HDRS-17 ($\beta = 0.545$, $t = 8.453$, $P < 0.001$), PDQ-D ($\beta = 0.383$, $t = 6.047$, $P < 0.001$) and DSST ($\beta = -0.123$, $t = -1.998$, $P = 0.049$).
Conclusions The severity of depressive symptoms is the variable that best explains life functioning. Surprisingly, the second factor hindering it is the patients' perception of their cognition. Current findings highlight the importance of correcting cognitive bias in order to improve functionality. However, results have to be taken cautiously as mood symptoms could partly explain the bias.
Disclosure of interest The authors have not supplied their declaration of competing interest.

http://dx.doi.org/10.1016/j.eurpsy.2017.02.255

EW0642

Phenomenology of religious obsessive – compulsive disorder

E. Soliman[1,2,*], W. Abohendy[1,2,3], A. Fayed[4]
[1] *Faculty of medicine, Zagazig university, Zagazig, Egypt*