revealing the need to assess them properly. Although EA are increasingly speaking out on their own MHP in public, research-informed approaches for practitioners are still lacking.
Objectives: We aim to perform an overview of the MPH among EA, emphasizing the potential risk factors and interventions.
Methods: We conduct a non-systematic review of the recent evidence on the topic using PubMed/Medline database.
Results: Although EA have comparable prevalence rates of MHP to the general population, they are exposed to various sports-related stressors. Studies reveal that 50% of EA face MHP during their career, with onset peak around 19 years. Therefore, there is a need for early detection and intervention. Burnout, alcohol abuse, anxiety, depression, insomnia and eating disorders are some MHP reported. Their management should address psychosocial and environmental aspects. Psychoeducation and psychotherapy are considered the first line treatment. Moreover, EA may encounter barriers to seeking mental healthcare. Therefore, it is important to promote positive attitudes about MHP, create an environment that supports mental well-being, resilience, psychological flexibility, self-compassion and coping skills. Screening tools may facilitate the process, so there is a need for validated athlete-specific questionnaires for MHP screening and measuring.
Conclusions: Mental health is an integral dimension of EA well-being and performance and should be assessed. Specific programs to support EA mental health are recommended and research targeting common MHP for athletes are needed to better understand how to minimize their distress.

Disclosure: No significant relationships.
Keywords: Mental Health Problems; sports activities; mental health promotion; elite athletes

Schizophrenia and other Psychotic Disorders 08 / Sleep Disorders

EPP0732

Interrelations between insomnia, dreaming, and schizotypy in the general population: A network model

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Introduction: Insomnia and Nightmare disorder are the two most common comorbid sleep disturbances in psychotic conditions. However, insomnia and psychotic symptoms are umbrella terms that hide the heterogeneity of these concepts. Several studies have found that worsening sleep quality is associated with the strengthening of psychotic symptoms. Until now, there was less interest in the relationship between the specific insomnia symptoms (trouble with falling asleep, fragmented sleep, early awakenings, daytime consequences) and the specific dimensions of schizotypy (disorganization, unusual perceptual experiences, anhedonia, and impulsive nonconformity).
Objectives: The study aimed to depict the network structure of insomnia, dreaming features (dream recall/bad dream/nightmare frequency), and schizotypy dimensions.
Methods: Exploratory network analysis was conducted on cross-sectional data of the general population (N=1419, 77 % female). We modeled the interrelations between insomnia symptoms (Athens Insomnia Scale), dreaming features (the frequency of dream recall/bad dreams/nightmares), and the dimensions of schizotypy (OLIFE-S).
Results: show a highly connected network with strong stability. The nodes of schizotypy, insomnia, and dream feature perfectly correspond to their own clusters, but the nodes were also densely connected between the three clusters. Disorganization, frequent awakenings, and nightmares are the most central nodes of the clusters. The node of frequent nightmares seems to be the bridge symptom in this network which connects unusual experiences dimension and frequent awakenings.
Conclusions: These results suggest that specific dimensions of schizotypy and specific sleep complaints are differently connected. However further research is needed to investigate the finer details of these heterogenic phenomena.

Disclosure: No significant relationships.
Keywords: dreaming; network model; schizotypy; Insomnia

EPP0733

Clozapine-Treatment-Resistant Schizophrenia Successfully Managed with Brexpiprazole Combination Therapy: Two Case Reports

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Introduction: Clozapine has proven to have a unique efficacy on treatment-resistant schizophrenia (TRS). Nevertheless, studies show that 47%-63% of clozapine-treated patients may fail to respond after around 12-years of treatment (CRS). Several augmentation strategies have been proven to be effective in CRS.
Objectives: Hereby, we present two clinical cases of CRS successfully managed with brexpiprazole augmentation.
Methods: A 48-year-old man without comorbid substance use, treated with clozapine-brexpiprazole augmentation, and a 20-year-old man with comorbid substance use, treated with clozapine-brexpiprazole combination and subsequently with twice-injection aripiprazole (TIA). They were administered with the following assessments at t0, t1-3 (first month), t4-8 (monthly until 6-month follow-up): CGI, BPRS, PANSS, CDSS, Craving VAS, BARS, BIS-11, HRS-A, MADRS, YMRS, AIMS.
Results: At 1-month follow-up, both patients showed a considerable improvement (respectively 75% and 55.9% reduction of PANSS total score). At 6-month follow-up, reached only with the first patient, we noticed a further improvement (an overall 37.5% reduction of PANSS total score from the baseline).
Conclusions: The present work is the first report describing combination treatment strategies with clozapine and brexpiprazole which appear to give promising results.