

Apathy is prevalent across many neurodegenerative, neurological, and psychiatric disorders. It represents the most common behavioural and psychological symptom in people with Alzheimer's Disease and is often observed in Parkinson's disease, vascular dementia, stroke, traumatic brain injury, amyotrophic lateral sclerosis/motor neuron disease, frontotemporal dementia, progressive supranuclear palsy, major depression, and schizophrenia. However, the definition and terminology employed to refer to apathy can vary in the context of different conditions and specialities and the diagnostic criteria have evolved. Additionally, the term apathy is employed to describe both a symptom and a syndrome. Indeed, little progress has been achieved in assessing the validity of the same construct across different disorders (eg. neurodegenerative disorders, schizophrenia or affective disorders). In 2018, a new version of the diagnostic criteria for apathy (DCA) in neuropsychiatric disorders was published. The validity of this new consensus has yet to be assessed among all relevant populations, including schizophrenia. Six European centres (Naples, Geneva, Nice, Rennes, Barcelona, Cambridge) aimed to test the prevalence of apathy, measured with the 2018 DCA, in patients diagnosed with schizophrenia. As a second aim, we focused on the relationship between DCA and other measures of apathy and negative symptoms in schizophrenia (BNSS and PANSS). In this talk, we will compare the preliminary findings of this pan-European study in schizophrenia patients with previous studies on neurodegenerative disorders.

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Keywords: motivation; negative symptoms; reward; apathy

W0022

Apathy in patients with schizophrenia: Treatment perspectives

S. Kaiser

Adult Psychiatry Division, Department Of Psychiatry, University of Geneva Hospitals, Geneva, Switzerland

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Apathy occurs in many neuropsychiatric disorders and is a central negative symptom of schizophrenia. Apathy has severe functional consequences for patients with schizophrenia and the development of evidence-based treatments is a major challenge. There is now increasing evidence that dysfunctions in reward processing underly apathy, in particular regarding reward anticipation, cost-benefit computation and reward learning. In addition, metacognitive processes such as defeatist performance beliefs modulate reward processing. Psychological interventions for negative symptoms target these processes. While the evidence for cognitive-behavioral therapy for negative symptoms remains limited, recent findings suggest that specifically targeting reward-related dysfunctions may improve efficacy of these interventions. On the neurobiological level, there is now considerable evidence that a dysregulation of the dopaminergic reward system is related to reward processing dysfunctions. Regarding pharmacological treatment approaches, psychostimulants have successfully been used for apathy in dementia to target the reward system. Pro-dopaminergic drugs to target apathy in schizophrenia seem to be safer than anticipated, but their efficacy remains to be established. At the current state of knowledge, there is no evidence-based treatment that specifically targets apathy in patients with schizophrenia today. However, there are encouraging results from research inspired by basic research in neuroscience and clinical research in patients with other neuropsychiatric disorders.

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Keywords: schizophrénia; negative symptoms; apathy; Treatment

Educational

(Assisted) suicide in the elderly

W0026

What interventions work for suicide prevention? and do they work for the elderly?

C. Van Der Feltz-Cornelis

Health Sciences, University of York, Heslington, York, United Kingdom

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Background: Suicides occur more often in the young and in the elderly. However, although several studies have been performed to evaluate the effect of suicide prevention in the young, no studies have explored this in the elderly. Somatic comorbidity is associated with elevated suicide risk, especially in case of pain, which occurs often in the elderly.

Objective: To explore if suicide prevention interventions might be applicable in the elderly and if somatic comorbidity might be relevant for their application.

Method: Evidence synthesis of controlled studies evaluating suicide prevention interventions and of collaborative care trials for depressive disorder in patients with and without somatic comorbidity.

Results: Elderly living alone and with multimorbidity are more prone to suicide risk. Hence interventions involving admission in a general hospital after a suicide attempt, short intervention and follow up might be well applicable in the elderly. In terms of outpatient interventions, and IPD analysis found that collaborative care for depressive disorder is effective in reducing suicidality, especially in the elderly. This effect is independent of somatic comorbidity.

Conclusion: There is potential to develop and evaluate suicide prevention interventions for the elderly. Such interventions should address depression, multimorbidity and social isolation and may be provided at general hospital and at outpatient level.

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Keywords: Suicide prevention; Elderly

W0027

Media and suicidal behaviour

U. Hegerl

Department Of Psychiatry, Psychosomatics, And Psychotherapy, Goethe University Frankfurt, Frankfurt a.M., Germany

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Media coverage of suicidal behaviour can induce copycat suicides. This has been clearly confirmed by analysis of suicides following the huge media coverage of the railway suicide of the German national goal keeper in 2009. A so-called 'Werther effect' was not only visible