the detection of all size range and types of genetic variation including CNVs, trinucleotide repeats and translocations. All this led to an impressive change in interpreting genomic variants that need to be strictly linked to clinical information before it can be used by clinicians to improve diagnosis or care. Bioinformatic tools to annotate variants, predict their effects and select the genes and genomic regions of interest are needed to guide the clinical work followed with careful evaluation of the prioritized variants based on the clinical knowledge (https://www.cost.eu/actions/CA17130/#tabs|Name:overview).

Disclosure: No significant relationships.
Keywords: exome/genome analysis; Copy Number Variation (CNV); genetic testing; testing methods

W0018

How to do genetic counseling in psychiatry?

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Genetic counselling has been defined as the process of helping people "understand and adapt to medical, psychosocial, and familial aspects of genetic conditions." It can also help patients and families deal with stigma and understand the significance of possible genetic findings. Psychiatric genetic counselling (PGC) is an emerging field aimed to help people with a personal or family history of psychiatric illnesses such as schizophrenia, bipolar disorder, or neuropsychiatric conditions, to understand genetic etiological mechanisms as a critical component. Counselling strategies are used to identify and adapt to psychological and familial consequences of the conditions and to reduce stigma surrounding the psychiatric illness. A recent survey showed that PGC is still not routinely offered and usually only discussed at the initiative of the patient, e.g. if they ask about the possibility of "hereditary" illness, or if a caregiver during a session for another indication, identifies the family history. If a monogenetic or chromosomal cause is identified, the genetic counselling follows a more traditional path, but if, on the other hand, the cause is complex, the counselling will not be as clearcut. It will then focus on explaining risk for disease with quite uncertain riskscores as no causative genetic change is identified. Although genetic testing most often cannot be offered and individual risk scores based on genetic markers cannot be given, there is still great value for patients and their relatives in PGC. Studies have shown that the effect of PGC is an increase of empowerment and a reduction of stigma.

Disclosure: No significant relationships.
Keywords: Genetic; Counselling; schizophrénia; bipolar

Clinical/Therapeutic

Recently proposed trans-diagnostic criteria for apathy: Commonalities and differences with the avolition/apathy domain of schizophrenia

W0019

Apathy in schizophrenia: assessment in clinical settings and overlap with other dimensions of impairment

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Negative symptoms are considered a core feature of schizophrenia. They are present since the prodromal phase and tend to persist more than other psychopathological dimensions in the chronic stages. The domain of apathy has attracted research efforts for the strong association with poor functional outcome. This negative symptom domain is observed in a number of neuropsychiatric disorders and might have both overlapping and distinct pathophysiological mechanisms. In schizophrenia it can be secondary to other aspects of the disorder, such as positive symptoms and depression, to drug side effects and/or social isolation, often observed in affected subjects. When primary to schizophrenia, apathy is conceptualized in terms of a reduction of the voluntary activity due to a lack of interest and motivation for goal-directed behavior initiation and persistence. In a percentage of subjects, apathy tend to persist and do not respond to available pharmacological and psychosocial treatments. The assessment of this domain in patients with schizophrenia using internationally recognized criteria for its definition, as were recently developed in other neuropsychiatric disorders, might help disentangle the different pathophysiological mechanisms. In the presentation, studies of apathy in schizophrenia will be illustrated to highlight the relationships with cognitive dysfunction, other psychopathological dimensions and functional outcome using state of the art instruments to assess the construct in schizophrenia.

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Keywords: Avolition; negative symptoms; apathy; Primary negative symptoms

W0021

Is apathy a true trans-diagnostic construct? preliminary findings of the european study on apathy in schizophrenia

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Apathy is a quantitive reduction of goal-directed activity either in behavioural, cognitive, emotional or social dimension in comparison to the person's previous level of functioning in these areas.

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, Geneve, 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.

Disclosure: No significant relationships.
Keywords: motivation; negative symptoms; reward; apathy

W0022

Apathy in patients with schizophrenia: Treatment perspectives

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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?

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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.

Disclosure: No significant relationships.
Keywords: Suicide prevention; Elderly

W0027

Media and suicidal behaviour

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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 socalled 'Werther effect' was not only visible