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doi: 10.1192/j.eurpsy.2023.577

Introduction: Schizophrenia is a severe and disabling psychiatric disorder probably based on complex pathophysiological mechanisms of reduced inhibition, impaired connectivity and reduced plasticity in neural networks. Beside clinical symptomatology, a core feature of schizophrenia is a global cognitive and social disability, which strongly affect patients' lives and their quality of life. The cognitive impairment involves memory, attention, executive functions, language, facial emotion recognition and theory of mind abilities. Cognitive remediation strategies, in addition to pharmacological and psychological treatments, has received increasing attention in recent years, as well as the use of non-invasive brain stimulation techniques such as TMS, which have demonstrated promising therapeutic potential.
Objectives: The present study aimed to evaluate the efficacy of TMS to induce improvements in cognitive functioning in schizophrenia. It also aimed to test the effects of a combined approach to rehabilitation, using both TMS and cognitive remediation strategies.
Methods: 16 patients were submitted to effective or sham iTBS over the left dorsolateral prefrontal cortex during 3 consecutive weeks. In half of patients the neuromodulation was combined with daily cognitive remediation training (Cogpack software), administered immediately after the application of TMS. Clinical, cognitive and social functioning were tested at baseline and at different timepoints after conclusion of the rehabilitation protocol (immediately after the 3 weeks protocol, and after 1, 3 and 6 months).
Results: The preliminary results indicate that the proposed TMS protocol induced significant improvements in global cognition. In addition, patients submitted to TMS, even without combined cognitive rehabilitation training, showed major benefits after 1 month from brain stimulation.
Conclusions: These preliminary data suggest that TMS can induce long-lasting plastic changes in the prefrontal cortex of schizophrenic patients, improving their cognitive perfomances. TMS could be therefore considered in the treatment of schizophrenia to reduce cognitive impairments.

Disclosure of Interest: None Declared

EPP0253

Suicide following treatment with electroconvulsive therapy: A nationwide study of risk factors among 11,780 patients

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doi: 10.1192/j.eurpsy.2023.578

Introduction: Despite the well-established anti-suicidal effect of electroconvulsive therapy (ECT), patients receiving ECT remain at high risk of dying from suicide.
Objectives: In the present study, we aimed to quantify this risk and identify risk factors for suicide among patients receiving ECT.
Methods: We used nationwide Danish registers to identify all patients that initiated ECT between 2006 and 2016. These patients were matched on sex and age to 10 reference individuals from the general Danish population. First, we compared 2-year suicide risk between patients initiating ECT and the matched reference individuals. Second, we investigated if any patient characteristics were associated with suicide following ECT via Cox proportional-hazards regression.
Results: A total of 11,780 patients receiving ECT and 117,800 reference individuals were included in the analyses. Among the patients receiving ECT, 161 (1.4%) died from suicide within two years. Compared to the reference individuals, patients receiving ECT had a substantially elevated suicide rate (Hazard rate ratio (HRR)=44.5, 95%CI=31.1-63.6). Among those receiving ECT, we identified the following risk factors for suicide: Male sex (HRR=2.3, 95%CI=1.7-3.1), age 60-70 years (HRR=1.6, 95%CI=1.0-2.6), Medium-term higher education (HRR=1.5, 95%CI=1.0-2.2); Long-term higher education (HRR=1.9, 95%CI=1.1-3.1), history of substance use disorder (HRR=2.0, 95%CI=1.4-2.8) and history of intentional self-harm/suicide attempt (HRR=4.0, 95%CI=2.8-5.8).
Conclusions: Among patients receiving ECT, those who are male, aged 60-70 years, have mediumterm to long-term higher education, or have a history of substance use disorder or intentional self-harm/suicide attempt, are at particularly elevated risk of suicide. These findings may guide initiatives to reduce the risk of suicide.

Disclosure of Interest: None Declared

Schizophrenia and other psychotic disorders 02

EPP0254

Impact of insight quality on treatment adherence in schizophrenia

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doi: 10.1192/j.eurpsy.2023.579

Introduction: Schizophrenia is a chronic, frequent, and disabling psychiatric condition. The prognosis is more severe in the absence of treatment.
Objectives: The aims of our study were to evaluate the quality of treatment adherence and the quality of insight of patients with schizophrenia and to assess the implication of these factors as predictors of poor adherence.
Methods: We conducted a cross-sectional and analytical study. We recruited 150 patients with schizophrenia treated at Razi Hospital of Manouba, divided into 113 patients with good adherence compared to 37 patients with poor adherence. We used the Medical Adherence Report Scale (MARS) to assess the quality of therapeutic adherence and the Birchwood Insight Scale for Insight Assessment.
Results: Poor treatment adherence in patients with schizophrenia was significantly associated with poor insight (p=0.001). Good adherence was associated with positive perception of treatment effectiveness (p<0.001). The predictive factor for poor adherence to therapy in multivariate analysis, after adjusting for the confounding variables was the negative perception of side effects (p=0.02).

The predictive factor for good adherence was the presence of insight into the need for treatment (p=0.002).
Conclusions: To prevent poor treatment adherence, a systematic screening for predictive factors and adequate management of schizophrenia would be imperative.

Disclosure of Interest: A. Rami Shareolder of: no, Grant / Research support from: no, Consultant of: no, Employee of: no, Paid Instructor of: no, Speakers bureau of: no, E. Sana Shareolder of: no, Grant / Research support from: no, Consultant of: no, Employee of: no, Paid Instructor of: no, Speakers bureau of: no, C. Mejda Shareolder of: no, Grant / Research support from: no, Consultant of: no, Employee of: no, Paid Instructor of: no, Speakers bureau of: no, D. Rahma Shareolder of: no, Grant / Research support from: no, Consultant of: no, Employee of: no, Paid Instructor of: no, Speakers bureau of: no

EPP0256

Attributional styles and other cognitive biases in patients with delusional disorder: A systematic review

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doi: 10.1192/j.eurpsy.2023.580

Introduction: The accurate examination of attributional patterns and cognitive biases in delusional patients is relevant to explain the externalizing tendency in paranoid schizophrenia patients. In subjects with delusional disorder (DD), attributional styles and other cognitive bias have been poorly investigated.
Objectives: Our main goal was to review the tendency to use external-internal attributions for negative events and the presence/absence of other cognitive biases in patients suffering from DD.
Methods: A systematic review was conducted in PubMed and ClinicalTrials.gov databases/registers up to September 2022 according to the PRISMA Guidelines. The following key-words were searched in the title and abstracts: (attributions OR attributional OR "cognitive" OR "cognition" OR "social cognition") AND ("delusional disorder"). Additionally, references of included studies were manually examined to identify further studies.
Results: A total of 144 records were identified (Pubmed, n=125; ClinicalTrials.gov, n=16; other sources, n=13), five studies met our inclusion criteria, reporting attributional styles (n=5) and other cognitive biases (n=2) in DD. (A)Attributional style in DD. Mainly excessive external attributions implying the ascribing of negative experiences to another person's behavior or action. Other authors describe attributions of negative events to internal causes (n=2). (B) Cognitive biases: Jumping to conclusions bias or judgments made on inadequate evidence have been described in DD (n=2).
Conclusions: Findings in attributional patterns in DD are mixed. Several authors report external and stable attributions in DD, whereas others described internal attributes for negative events, suggesting that depressive vs. "pure" paranoid core dimensions may appear in DD.

Disclosure of Interest: None Declared

EPP0257

Antidepressant use and psychosis hospitalization in persons with schizophrenia

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doi: 10.1192/j.eurpsy.2023.581

Introduction: Antidepressants are often used by persons with schizophrenia. These medications are used for a variety of symptoms, such as negative or depressive ones. Effectiveness of antidepressant use in persons with schizophrenia has rarely been studied in the real-world setting.
Objectives: The aim of this study was to investigate the risk of hospitalization due to psychosis related to antidepressant use in persons with schizophrenia.
Methods: This cohort study utilized data combined from Finnish nationwide registers. The study cohort included all 61 889 persons treated in inpatient care due to schizophrenia (defined as International Classification of Diseases, ICD, version 10 codes F20-F25 during 1972–2014 in Finland). National Prescription register data was utilized to obtain drug purchase data, and modelled into drug use periods with PRE2DUP (From Prescriptions to Drug Use Periods) method, developed by our research group. The follow-up covered the years from 1996 to 2017. Antidepressants (Anatomic Therapeutic Chemical classification system, ATC code N06A) were categorized by mechanism of action (non-selective monoamine reuptake inhibitors, TCAs, ATC-codes N06AA, selective serotonin reuptake inhibitors, SSRIs, N06AB and serotonin-norepinephrine reuptake inhibitors, SNRIs, including venlafaxine, milnacipran and duloxetine), and also on drug-substance level. Main outcome was hospitalization due to psychosis (ICD-10 diagnoses F20-F29) as the main diagnosis. We used within-individual design to compare the risk of outcome between the time periods of antidepressant use and non-use within the same person to minimize selection bias. Stratified Cox regression analyses were utilized to calculate adjusted hazard ratios (aHR) with 95% confidence intervals (CIs). These analyses were then adjusted for sequential order of treatments, time since cohort entry, use of antipsychotics, mood stabilizers, benzodiazepines, and Z-drugs.
Results: The mean age of the study cohort was 46.2 (SD 16.0) years at cohort entry, and 50.3% of were males. Altogether 49.3% (N=30 508) of the study cohort used antidepressants during the follow-up (median 14.8 years, IQR 7.5-22.0), with citalopram and mirtazapine being the most commonly used antidepressants. The risk of psychosis hospitalization was lower during antidepressant use as compared to non-use (aHR 0.93, 95% CI 0.92-0.95). Use of SSRIs was associated with similar risk (aHR 0.91, 95% CI 0.89-0.93), followed by SNRIs (aHR 0.92, 95% CI 0.88-0.97) and TCAs (aHR 0.93, 95% CI 0.89-0.98). Considering individual drug substances, lowest risk were obserwed with use of sertraline (aHR 0.87, 95% CI 0.83-0.91), fluoxetine (aHR 0.88, 95% CI 0.83-0.91) and citalopram (aHR 0.92, 95% CI 0.90-0.95).