(IL)-6 followed by tumor necrosis factor (TNF)-a, Apolipoprotein E e4 allele-carriers, C-reactive protein contributed most to suicidal ideation. Although EOD is a strong determinant of suicidal ideation, other non-psychiatric factors, i.e., serum inflammation biomarkers, APOE e4 allele, and multimorbidity, should be taken into account when evaluating a suicidal ideation phenotype in older age.

Disclosure: No significant relationships.
Keywords: epigenetics; older age; Late-life depression; suicidal behaviour

S0060

E-Mental Health in Older Age

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E-Mental Health in older age Ulrich Hegerl, Caroline Oehler Department of Psychiatry, Psychosomatics, and Psychotherapy, Goethe Universität Frankfurt/M, Germany European Alliance against Depression e.V. (www.EAAD.net) The implementation and uptake of digital tools for self management or psychotherapy for people suffering from depression or other mental disorders has gained momentum during the Covid-19 pandemia. While studies using waiting list or treatment as usual control groups are of limited value, meta-analyses of RCTs with face-to-face psychotherapy as control condition have found a comparable antidepressant effect, especially when the interventions were provided together with professional guidance. The iFightDepression-tool offered by the European Alliance against Depression (EAAD) is available in 10 different languages and is broadly used in several European countries. Data will be presented concerning the attitude of older people concerning iCBT and also concerning effects of age, guidance, and gender on both adherence to the iFightDepression-tool and antidepressant effects.

Disclosure: No significant relationships.
Keywords: e-mental health; depression; self-management; CBT

S0061

Suicide and Ageism

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Suicide in old age is frequently considered the result of a rational decision. Accumulation of physical illnesses, frailty, dependence on others, loss of partner and loneliness are often seen as reasons that might justify suicidal acts. Depression is an important risk factor for suicidal behaviour even at very advanced age. However, ageistic views tend to consider depression as a normal feature of the aging process; it is possible that its presence can be overestimated or perhaps generalized more than necessary by making it the scapegoat of any situation related to suicide. In fact, adopting an attitude that involves excessive simplification of problems, where everything is attributable to 'depression', can induce a rigid prescriptive approach, often limited to the indication of an antidepressant drug. In this way, the appreciation of the multifactorial nature of an individual's crisis becomes too narrow and the chances of counteracting the complexities of a dangerous suicide progression too modest. From a prospect of suicide prevention, approaching a patient carefully and prudently is always to be preferred to the disposition that considers life events as inevitable as well as all reactions related to them, including the most extreme, such as suicide. This attitude can lead to a poor involvement of the treating physicians, who might become too acceptant of the 'unavoidability' of the unfavourable progression of their patient. Such a passive approach may especially characterise the relationship with patients of very advanced age, where stressors of physical and non-physical nature easily aggregate, multiplying their impacting power.

Disclosure: No significant relationships.
Keywords: Suicide; prevention; ageism; old age

Forward and Backward Translation in Psychiatry: Lessons Learned

S0062

Network Analyses: Understanding the Pathways of Functional Improvement in Schizophrenia

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Improving real-life functioning is the main goal of the most advanced integrated treatment programs in people with schizophrenia. The Italian Network for Research on Psychoses used network analysis in a four-year follow-up study to test whether the pattern of relationships among illness-related variables, personal resources and context-related factors differed between patients who were classified as recovered at follow-up versus those who did not recover. In a large sample (N=618) of clinically-stable, community-dwelling subjects with schizophrenia, the study demonstrated a considerable stability of the network structure. Functional capacity and everyday life skills had a high betweenness and closeness in the network at both baseline and follow-up, while psychopathological variables remained more peripheral. The network structure and connectivity of non-recovered patients were similar to those observed in the whole sample, but very different from those in recovered subjects, in which we found few connections only. These data strongly suggest that tightly coupled symptoms/dysfunctions tend to maintain each other's activation, contributing to poor outcome in subjects with schizophrenia. The data suggest that early and integrated treatment plans, targeting variables with high centrality, might prevent the emergence of self-reinforcing networks of symptoms and dysfunctions in people with schizophrenia.