Special attention should be given to the parent–infant relationship, as mood episodes may impair bonding and parenting confidence; supportive interventions can promote recovery and healthier developmental outcomes.
Overall, integrated postpartum care combining pharmacotherapy with psychosocial and family-based strategies can reduce relapse risk, improve maternal functioning, and support safe, meaningful early motherhood for women living with bipolar disorder.

Disclosure of Interest: None Declared

WS022

Psychiatrist treatment choices in schizophrenia according to clinical vignettes

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Abstract: Based on the 2023 Ambassador study on schizophrenia, conducted among 454 psychiatrists and trainees from 35 European countries using six clinical vignettes (cases A–F), we aimed to explore therapeutic approaches across different phases and clinical situations, while assessing adherence to guidelines.
Our findings showed moderate to high agreement among European psychiatrists on pharmacological treatment for first-episode psychosis, cognitive and negative symptoms, prodromal symptoms, and pregnancy, with only moderate adherence to guidelines. Treatment preferences were similar for antipsychotic-induced metabolic side effects and treatment resistance, but guideline adherence in these areas was partial. Non-pharmacological interventions—such as psychotherapy, recovery-oriented care, cognitive remediation, and physical exercise—were generally underused, with exceptions for psychoeducation, lifestyle recommendations, and cognitive behavioral therapy in the prodromal phase.
These results highlight a gap between research evidence, guidelines, and real-world practice. Clinicians' expertise and experience are key to shaping future guidelines in form of clinical consensus, particularly where practice diverges from recommendations.

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WS023

Evidence-based treatment for treatment resistant schizophrenia

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Abstract: Treatment-resistant schizophrenia (TRS) is a common clinical problem, up to 30% of patients show little or no response to treatment. The most comprehensive definition of TRS was coined by the Treatment Response and Resistance in Psychosis (TRRIP) working group. First step in the management of TRS is to rule out pseudoresistance, i.e., failure to respond from different reasons (non-adherence, poor metabolizers, incorrect diagnosis, comorbidity, insufficient dosage or duration of trial, masking side effects). There is a general agreement among various treatment guidelines, the drug of choice for TRS is clozapine. Recent meta-analyses, systematic reviews, and individual meta-analyses cast doubts on clozapine superiority, suggesting that other antipsychotics (e.g., olanzapine, clozapine) may as effective as clozapine. However, it should be noted that in many RCTs clozapine was underdosed; numerous studies where clozapine arm was not blinded were excluded from analyses, severely resistant patients were not included, and finally, clozapine was significantly superior to comparator drugs when disregarding RCTs sponsored by the manufacturer of the comparator. Patients who do not respond or do not tolerate clozapine ("ultra-resistant schizophrenia") may benefit from clozapine augmentation. Data indicate that clozapine can be effectively combined with ECT, mirtazapine, or memantine for overall symptoms, with ECT for positive symptoms, memantine, duloxetine, or mirtazapine for negative symptoms. Real-world data from Finnish and Swedish national registers showed that the dose of an augmenting agent is important (standard doses of SSRIs and SNRIs, medium doses of aripiprazole). Non-pharmacological therapeutic options for TRS, in monotherapy or as clozapine augmentation, include neurostimulatory methods (ECT, rTMS, tDCS), psychotherapy for specific symptoms (CBT), physical activity for negative symptoms, or more experimental (DBS, virtual reality).

Disclosure of Interest: None Declared

WS024

Coercion and force in psychiatry: when young doctors become forced to use force

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Abstract: As a young doctor, it is challenging to decide when coercion or forceful measures are necessary, as well as when the use of force follows the principle of "less harm". This is because there are a wide spectrum of opinions, criteria,ethical questions, moral values, and laws which one must consider, and which can be difficult to understand and balance without a great amount of prior experience.
Every medicine has primary effects and side effects, and every intervention has potentially positive benefits and negative implications. As psychiatric doctors we have the obligation to not do harm, a moral duty to help others, and a lawful compulsion to use the minimum harmful measure when needed. The decision to use coercion is complicated to navigate as a young doctor in training with potentially limited experience in making such morally and legally complex decisions. We are forced to make fast decisions when an acute situation arises, where we must grapple with many considerations, including: external input and pressure, internal ethical questions about what is right and wrong, utilitarian questions about what is the best and least harmful measure to take to help our patients, unintended consequences of our decisions for the patients recovery and wellbeing and the safety of ourselves and colleagues, and the possible lawful implications of the actions and measures taken.

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