EV1257

Suicide attempters: Clinical characteristics and management

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Background Suicide attempts, defined as self-inflicted, potentially injurious behaviors with a nonfatal outcome, and with evidence of intent to die are extremely prevalent. Literature suggests that suicide is more common among males, while attempted suicide is more frequent among females. Depression, mental disorders, substance use disorders and history of suicidal behavior are important risk factors for suicide: the risk of suicide attempt is 3 to 12 times higher in psychiatric patients than in the general population.
Aim The aim of our study was to compare severity of depressive symptoms in a sample of suicide attempters with a diagnosis of bipolar and related disorders or depressive disorders and in a sample of sex- and diagnosis-matched patients who do not commit a suicide attempt. The severity of attempted suicide and the suicidal risk in the hospital will be assessed as well.
Material and methods We collected a sample of inpatients who committed a suicide attempt during 2015. For each attempter, we selected another sex- and diagnosis-matched patient with no history of attempted suicide. Socio-demographic and clinical characteristics of the sample were gathered. Assessment included: Montgomery-Asberg Depression Rating Scale (MADRS) for severity of depressive symptoms in both groups, Suicide Intent Scale (SIS) for the severity of attempted suicide and the suicidal risk with a nurse assessment for suicide.
Results Data collecting is still ongoing. We expected to find more severe symptoms in patients who attempted suicide. Clinical implication will be discussed.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Who is a survivor of suicide loss? A systematic review

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Introduction Death by suicide stuns with soul-crushing surprise, leaving family and friends not only grieving the unexpected death, but confused and lost by this haunting loss. The underlying structure of grief for survivors of suicide loss appears complicated.
Aims The purpose of this study consists in reviewing literature data about survivors of suicide, especially exploring the few informations emerged by researches on the role of psychiatrist as "survivor".
Methods A PubMed search was conducted using combinations of the following keywords: survivors suicide or bereavement suicide or suicide psychiatrists and randomized.
The search was conducted through September 10, 2015, and no conference proceedings were included.
Results Bereavement following suicide is complicated by the psychological impact of the act on those close to the victim. It is further complicated by the societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue and ultimately society affixes blame for the loss on the survivors. This individual or societal stigma introduces a unique stress on the bereavement process that in some cases requires clinical intervention.
Conclusions Suicide bereavement seems to be different from natural loss. Clinicians may react to a patient's suicide both on a personal and professional level, with emotions such as loss of self-esteem or blame. This grief somehow nullifies the core of a helping relationship and may imply a more conservative management of future patients or even avoiding to accept suicidal patients for treatment. Support interventions have been proposed.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Who gains from suicide risk assessment: Health inspectorate and health insurances, or also psychiatrist and patient?

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Introduction The number of suicides rises in the Netherlands. In 2008, 1435 suicides were recorded; in 2012: 1753 (CBS). Adequate risk assessment with suicidal behaviour (SRA) is essential for prevention. The Health Inspectorate and Insurances seek to have a stronger grip on the way suicide risk is assessed and insist on using questionnaires. This runs counter to the multidisciplinary guidelines in the Netherlands for diagnosis and treatment of suicidal behaviour, which state that "questionnaires or observation instruments cannot replace clinical diagnostic examination."
Objective Do questionnaires rather than 'care as usual' (CAU) in SRA lead to different treatment policies?
Aim To determine whether the use of questionnaires rather than CAU in SRA leads to different treatment policies.
Methods Patients who were seen by staff at the department of Psychiatry at the ETS Hospital, either for in-house consultation or at the MPU, in connection with attempted suicide, auto-intoxication, or psychological distress with suicidal statements. Patients were examined by conducting a questionnaire, resulting in treatment policy (admission, discharge with an appointment with patient's own practitioner, discharge with referral to a practitioner, discharge without aftercare). Then, the same patient was again examined by another colleague in a free interview (CAU). The colleague was not informed about the outcome of the first assessment. Again, treatment policy was determined as a result. The two outcomes were then compared.
Results Data collection still continues.
Conclusions There are signs that there are no differences in the determined treatment policies following SRA based on the use of questionnaires or CAU.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Suicide: A major public health problem

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