

Factor analyses of large datasets have established two dimensions of negative symptoms: expressive deficits and a motivation. This distinction is of relevance as the dimensions differ in their cognitive and clinical correlates (e.g. with regard to functional outcome). Using functional MRI, we examined the neural correlates of the two negative symptom dimensions with brain activation during social-emotional evaluation. Patients with schizophrenia ( $n=38$ ) and healthy controls ( $n=20$ ) performed the Wall of Faces task during fMRI, which measures emotional ambiguity in a social context by presenting an array of faces with varying degrees of consistency in emotional expressions. More specifically, appraisal of facial expressions under uncertainty. We found severity of expressive deficits to be negatively correlated with activation in thalamic, prefrontal, precentral, parietal and temporal brain areas during emotional ambiguity (appraisal of facial expressions in an equivocal versus an unequivocal condition). No association was found for a motivation with these neural correlates, in contrast to a previous fMRI study in which we found a motivation to be associated with neural correlates of executive (planning) performance. We also evaluated the effects of medication and neurostimulation (rTMS treatment over the lateral prefrontal cortex) on activation during the social-emotional ambiguity task. The medication comparison concerned an RCT of aripiprazole versus risperidone. Compared to risperidone, aripiprazole showed differential involvement of frontotemporal and frontostriatal circuits in social-emotional ambiguity. We conclude that deconstruction of negative symptoms into more homogeneous components and investigating underlying neurocognitive mechanisms can potentially shed more light on their nature and may ultimately yield clues for targeted treatment.

*Disclosure of interest* AA received speaker fees from Lundbeck.

<http://dx.doi.org/10.1016/j.eurpsy.2017.01.183>

## Symposium: Clinical Management and Treatment of Suicidal Patients

### S110

#### Clinical Use of Biomarkers in Suicidal Behaviors

P. Courtet

*CHU Lapeyronie, Emergencic Psychiatry, Montpellier, France*

The epidemiology, risk factors, and biological basis of suicidal behaviors have been the object of an ever-increasing research in the last three decades. During this period, researchers all over the world have identified potential biomarkers of risk and developed several theories about the mechanisms leading to suicidal behavior. However, the lack of common terminology, instruments, and cooperation has been a major deterrent. Today, the community has established the bases for this collaboration and evidence coming from neuroscientific studies can already be applied to the field of suicidology. We present here a potential semiology based on current evidence coming from biological, clinical, and neuroimaging studies.

*Disclosure of interest* The author declares that he has no competing interest.

<http://dx.doi.org/10.1016/j.eurpsy.2017.01.184>

### S111

#### The Patient is Suicidal: What Should I Do as a Clinician?

V. Carli

*Karolinska Institutet, National Centre for Suicide Research and Prevention of Mental Ill-Health NASP, Stockholm, Sweden*

Suicidal behaviour is the most common psychiatric emergency. A large proportion of suicidal behaviour can be prevented, particularly in cases associated with mental disorders. Early recognition of suicidality and reliable evaluation of suicide risk are crucial for the clinical prevention of suicide. Evaluation of suicidal risk involves assessment of suicidal intent, previous suicide attempts, underlying psychiatric disorders, the patients' personality, the social network, and suicide in the family or among acquaintances as well as other well-known risk factors. Suicide risk assessment should take place on several levels and relate to the patient, the family and social network but also to the availability of treatment, rehabilitation and prevention resources in the community. As suicide risk fluctuates within a short period of time, it is important to repeat the suicide risk assessment over time in an emphatic and not mechanistic way. The suicidal person may mislead both family members and hospital staff, giving a false sense of independence and of being able to manage without the help of others. Although extreme ambivalence to living or dying is often strongly expressed by the suicidal individual, it is not seldom missed by others. If observed in the diagnostic and treatment process, dialogue and reflection on such ambivalence can be used to motivate the patient for treatment and to prevent suicide. If ambivalence and suicidal communications go undiscovered, the treatment process and the life of the patient can be endangered. Today, several measurement tools of suicide risk exist, including psychometric and biological measurements. Some of these tools have been extensively studied and measures of their sensitivity and specificity have been estimated. This allows for the formulation of an approximate probability that a suicidal event might happen in the future. However, the low precision of the predictions make these tools insufficient from the clinical perspective and they contribute very little information that is not already gained in a standard clinical interview. Psychiatrists and other mental health professionals have always longed for reliable and precise tools to predict suicidal behavior, which could support their clinical practice, allow them to concentrate resources on patients that really need them, and backup their clinical judgement, in case of eventual legal problems. In order to be useful, however, the approximate probability that a suicidal event might happen in the future is not sufficient to significantly change clinical routines and practices. These should rely on the available evidence base and always consider the safety of the patient as paramount.

*Disclosure of interest* The author declares that he has no competing interest.

<http://dx.doi.org/10.1016/j.eurpsy.2017.01.185>

### S112

#### Diagnosing and treating suicidal adolescents

J. Balazs<sup>1,2</sup>

<sup>1</sup> *Eotvos Lorand University- Institute of Psychology- Budapest-Hungary, Department of Developmental and Clinical Child Psychology, Budapest, Hungary*

<sup>2</sup> *Vadaskert Child Psychiatry Hospital and Outpatient Clinic, Budapest, Hungary*

Suicide is the second leading cause of death in Europe among 15–29 year olds. Adolescence is a sensitive period during development with several age specific factors, which can increase suicidal risk.