new independent states. Two main clusters can be distinguished: 1) countries with prevailing ethno-cultural factor (Azerbaijan, Georgia, Armenia, Tajikistan, Turkmenistan, Uzbekistan, partly Republic of Moldova) - general rise was not so marked or did not happen, highest rates were registered in Soviet times and even painful period of transition did not cause higher suicidal activity; 2) countries with prevailing economic factor (Baltic countries, Belarus, Russian Federation, Ukraine, Kazakhstan and Kyrgyzstan) - on the contrary, lowest rates were registered in the Soviet times and maximums were achieved after USSR split. These are mostly industrial countries and dramatic rise in suicides may be attributed to severe economic problems and ''shock therapy''. Since 1994-1996 and especially after 2001 in these countries a gradual lowering of suicide rates started, which may be attributed to overcoming main economic difficulties. However in the Russian Federation there was a sharp rise in 1999, shortly after default in summer of 1998. Emerging of new independent states on the world map made it possible to see the interplay of economical, social, political and ethno-cultural factors in provoking (or protecting) populations from suicidal behavior in the transition periods.

CS04.04

Changes in male suicidality in a changing Europe

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In Europes countries of heavy societal transition, especially male patterns of suicide reflect seismographically the stress load in a country, induced by societal and individual transition.

Suicidality is hereby embedded in stress related morbidity and mortality, mediated by risk taking behaviour and lifestyles, cardiovascular and cerebrovascular morbidity and mortality as well as addictive behaviour and violence.

Male suicide rates are highest in societies where a stressful transition even afflict gender roles that untill recently had been traditional. They seem even connected to males shortcomings in their ability to cope with changes regarding their societal status, dignity, self estimation social significance and sense of existential cohesion.

Most male suicides are commited without help seeking and contact with medical or other support systems.

Thus, problems are aggravated by males traditional inability to seek help and be compliant - combined with the incapacity of mental health support structures to provide services that not only are accessible but also acceptable for men.

In addition to this, there are problems of diagnosing males typical ''atypical'' symptoms of depression and suicidality by traditional depression assessment criteria, leading to both underdiagnosis of male depressive states as well as a consequent male oversuicidality.

CS04.05

Diminishing alcohol consumption is the most effective suicide preventive program in modern history for males

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Between 1984-88 in USSR male suicide rates decreased by 40% and female by 18%, as compared with 22 European countries where the decrease was 3% and 7% respectively. Decreases in suicide rates occurred in all republics and for both sexes, but most in the republics where alcohol consumption was high and for men aged 25-54 years. Analyses of the impact of restrictive anti-alcohol policy during perestroika on suicide rates showed that alcohol has a considerable explanatory value for falling suicide rates during this period. The estimated attributable fraction of alcohol in the whole USSR in this period was approximately 50% for male, and 27% for female suicides.

The natural experiment that took place in all 15 republics of the former USSR during perestroika (''restructuring", 1985-90) appears to have been one of the most effective programmes for suicide prevention in modern history.

The results of a case-control study psychological autopsy study performed with relatives of people who committed suicide and with controls confirmed our previous results on the aggregate level and showed that alcohol abuse and dependence (AAD) was diagnosed in 68% of male and 29% of female suicides.

35-59-year old males who committed suicide had the highest risk of alcohol dependence. Among suicide cases only 29% had received life-time diagnoses of alcohol abuse and dependence.

AAD is markedly underdiagnosed by general practitioners and clinicians. In suicide prevention it is important to screen for AAD among patients in both general practices and in psychiatric out- and in patient clinics.

S22. Symposium: NATURE AND NARRATIVES OF IMPULSE CONTROL

S22.01

The phenomenology of impulse control disorders

C. Mundt. *Psychiatric Clinic, University of Heidelberg, Heidelberg, Germany*

Firstly the descriptive phenomenology of impulse control disorders will briefly be delineated with its focus on the heterogeneity with regard to etiology and psychotherapeutic access.

Secondly the functional findings will be reported which suggest very different categorisations and different psychotherapeutic techniques with the domains of dysfunctions characteristic for addiction, OCD, and impulse control disorder sensu strictu.

The nosological and functional heterogeneity becomes a special difficulty for forensic assessment since psychopathological context, functional underpinnings and societal attitude are very different across the category of impulse control disorders. Categorical and dimensional concepts are intermingled.

Thirdly special aspects of the phenomenological approach will be given eventually with a concluding consideration of what we can make clinically of this heterogenic cluster of disorders and what needs to be clarified by future research.

S22.02

Loss of impulse control in psychotic disorders

M.L. Figueira. *Department of Psychiatry, St[a] Maria Hospital, Faculty of Medicine of Lisbon, Lisbon, Portugal*

In this presentation we will explore the different psychopathologic presentations and meanings of impulsive behaviour in psychotic patients. A first distinction will be made in schizophrenic patients

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between impulsive acts (previously conceptualized as impulsions), whose paroxysmal, automatic psychomotoric and internally generated nature could be close to catatatonic behaviour or immediate reflexive actions, and from other type of aggressive impulsivity, secondary to delusions or hallucinations with a strong self- implication. Quite a different phenomenon is observed in Bipolar patients (phase dependent) in which goal-directed impulsivity can assume two expressions: a ''pure'' appetitive impulsivity form connected with euphoric or dysphoric mood and a desinhibited impulsivity one close to a more labile mood. The later expressive behaviour is distinct from reckless and desinihibited impulsivity common to ADHD and hypertimic bipolar patients.

In schizophrenic psychotic patients, impulsive acts can be understood as psychopathological expressions of a morbid process at the same level of other psychotic symptoms. On contrary, in mood psychotic disorders the main emphasis is both on the role of self awareness and control, as well as on the understating of several types of impulsivity in a continuum between normal primary emotions and excessive emotional experiences and drives.

S22.03

Loss of control in personality disorders

M. Roca. *Palma de Mallorca, Spain*

Abstract not available at the time of printing.

S22.04

Pathological gambling: Addiction or impulse control disorder

M. Musalek. *Anton Proksch Institute, Vienna, Austria*

In ICD-10 we find pathological gambling in the rest-category ''Habit and Impulse Disorders'' together with pathological fire setting (pyromania), pathological stealing (kleptomania), trichotillomania and other habit and impulse disorders. In DSM-IV the same disorders have to be attributed to the rest-category named ''Impulse control Disorders''. In ICD-10 as well as in DSM-IV the diagnosis impulse (control) disorders should be used for kinds of persistently repeated maladaptive behaviour that are not secondary to a recognized psychiatric syndrome, and in which it appears that there is repeated failure to resist impulses to carry out the behaviour and the patients report a prodromal period of tension with a feeling of release at the time of the act. Without any doubt, pathological gambling cannot be reduced to mere maladaptive behaviour. As we know from clinical praxis, patients suffering from pathological gambling show a much more complex psychopathology. Beside the signs of a strong desire or sense of compulsion to gamble and an impaired capacity to control gambling in terms of its onset, termination, or levels of gambling (which may seem similar to symptoms of impulse control disorders) all other signs of a dependence syndrome (e.g. evidence of tolerance with a need for significantly increased frequency of gambling, preoccupation with gambling, persistent gambling despite clear evidence of harmful consequences, physical withdrawal states) can be observed in patients suffering from pathological gambling. Concluding we may say that pathological gambling is a much more complex disorder than impulse control disorders. Beside phenomenological analyses also comorbidity studies indicate similarities of pathological gambling to substance-related addictions. Therefore we propose for DSM-V that pathological gambling should not longer be part of the rest-category ''impulse control disorders'' but should be attributed as gambling addiction (or gambling dependence syndrome) together with other substance-related and non-substance related addictions (e.g. internet addiction, buying addiction, working addiction) to a new group of dependence disorders.

S23. Symposium: NEW ADVANCES IN MENTAL ILLNESS SUBSTANCE MISUSE (Organised by AEP section on Alcoholism and Drug Addiction)

S23.01

Comorbidity across the life span

I.B. Crome. *Academic Psychiatry Unit, Keele University Medical School, Stoke on Trent, United Kingdom*

Over the last decade there has been an increasing awareness of comorbidity in the adult population. It is also increasingly recognised that substance misuse is increasing in young people and the older population is increasing. Prevalence estimates and clinical experience point to more younger and older addicts attending clinical services. Substance problems are associated with psychological and physical comorbidities and social difficulties across the lifespan. This leads to poorer outcome. Inadequate assessment of substance problems, prescription and over the counter medication, including interactions and compliance, in younger and older age groups leads to ineffective management. The key principles which inform the implementation of effective pharmacological and psychological treatment interventions for nicotine, alcohol and illicit drugs treatment options in adults is well established. Outcome studies in the adult population suggest patient benefit. Although limited, studies of substance misuse treatment interventions that have been carried out in younger and older age groups demonstrate improvement. Although outcome studies that have been undertaken in comorbid groups do not yet point to a particular type of intervention or service model, administration of effective interventions for substance misuse may lead to improvements, which has policy ramifications. Most of the scientific research has been carried out is in the United States which has a very different health care system and there is need for a focus on neurobiological and social research in particularly vulnerable populations.

S23.02

Policy and dual diagnosis

A. Baldacchino. *Stratheden Hospital, Bycooper, Fife, Scotland, United Kingdom*

Despite legislation to harmonise mental health practice and convergence in systems of training there remains an extraordinary diversity in mental health practice in Europe. Approaches to tackling substance misuse and attitudes towards substance misuse and mental illness also show definite international differences.

Whilst mental health services are organised and financed in very different ways there are nevertheless a number of common trends and issues. The most obvious trend has been the run-down of psychiatric beds, giving rise to the problem of providing alternative services. Throughout Europe people are striving, with mixed success, to establish new community-orientated services, providing reasonable levels of clinical care, some continuity and co-ordination, and appropriate accommodation and day-time activities.

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