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.

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Symposium: Clinical Management and Treatment of Suicidal Patients

S110

Clinical Use of Biomarkers in Suicidal Behaviors

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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.

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S111

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

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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.

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S112

Diagnosing and treating suicidal adolescents

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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.

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As it is in all cases, the first step of the diagnostic procedure of suicidal adolescents is creating an appropriate environment for the evaluation and rapport building.
More than 90% of suicidal adolescents has ongoing and usually untreated psychiatric disorder/s and about three-quarters of them has at least one subthreshold diagnosis. Potential common risk factors of adolescence suicide include both internalizing and externalizing disorders, such as major depressive episode, substance use and conduct disorder. The comorbidity of psychiatric disorders–both subthreshold and threshold - has been associated with increased risk for suicide. The careful assessment of subthreshold and full psychiatric disorders of suicidal adolescent is important in suicide prevention and the treatment of suicidal adolescents. The diagnostic procedure includes both clinical assessment and using validated (semi) structured diagnostic interviews. Rating scales can provide information on the severity of the patient's symptoms. Next to the assessment of the symptoms it is important to take the history and to get know about adolescents' possible life events. Clinicians should carefully screen potential suicidal behavior itself, which includes both clinical assessment and validated interviews and tests.Complex treatment of suicidal adolescents can include, if it is necessary hospitalization due to the management of acute suicide risk and the appropriate treatment of subthreshold and threshold psychiatric disorders with the consideration of possible life events.
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S113

When your patient dies by suicide; aftermath and implications

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Over fifty percent of psychiatrists will have at least one patient die by suicide while in treatment and some will have more than one patient suicide during the course of their career. The impact of patient suicide on the personal and professional lives of those psychiatrists can be profound. Personally, many suffer a grief reaction than can progress to depression in some cases. Almost all experience a sense of shock upon first learning of the event. Feelings of guilt are also common. Professionally, many fear disapproval from peers and may never again treat a suicidal patient. Some psychiatrists leave the field completely or go into administration so that they never have to treat patients again.
Surveys of training programs have found that most provide training in the assessment of suicide risk and in the management of the suicidal patient but there is minimal training in how to deal with the aftermath of a patient suicide. There is a need to teach and to help practicing psychiatrists, at whatever stage in their career, cope with the stress that occurs when one of their patients dies by suicide during the course of therapy. Important issues are how and when to contact family members and other survivors, whether or not to attend a funeral or memorial service and what and what not to do regarding discussing the case with others. The risk of litigation also is influenced by how psychiatrists behave after patient suicide occurs. The case of Ernest Hemingway is used as an example to illustrate some of these concepts.
Disclosure of interest The author declares that he has no competing interest.

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Symposium: E-Mental Health in Psychiatry–Future Perspectives of an Emerging Field

S114

From Telepsychiatry to eMental Health–Experiences and Prospects in Europe

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What started with telepsychiatry (videoconference) has been turned into e-Mental Health (eMH) due to rapid development of IT technology, decreased prices and increased user experiences. Access to mental health care is one of the identified problems within EU mental health services. Increased migration into and within EU cause the increased demands for clinicians with selected skills. Telepsychiatry is the oldest and most common eMH application. The first international telepsychiatry collaboration established between Sweden and Denmark back in 2006 was a success. This model might be used as collaboration prototype while speaking about current refugee crisis in Europe and treatment of mentally ill migrants. The experiences from this pioneer international transcultural telepsychiatry service in combination with various eMH applications may be used as an inspiration for conducting of larger international eMH service capable to provide mental health care toward diversity of patient populations underserved on their mother tongue within EU.
eMH applications could improve quality of care and access to mental health care in rural, remote and under-served as well as in metropolitan areas all around EU.
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S115

E-Mental health for mental disorders–focus on psychotic disorders and PTSD

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Introduction E- mental health technologies have developed rapidly over the past years and may support finding solutions to challenges like scarce resources or the treatment gap in psychiatry.
Objectives Provision of guidance on eMental health technologies in the treatment of post traumatic stress disorder and psychotic disorders.
Methods Two evidence- and consensus-based EPA Guidance papers on eMental health technologies for the treatment of posttraumatic stress disorder and psychotic disorders were developed.
Conclusions The evidence on the efficacy of e-mental health interventions for the treatment of PTSD and psychotic disorders is promising. However, more research is needed in the field.
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