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

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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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