

Psychopathological and sociodemographic analysis of hospitalized patients for suicide attempt in a Chilean public hospital: An analytical cross-sectional study

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Introduction: Suicide is global public health issue. In the region, analysis of psychopathological and socio demographic aspects of suicidal attempt (SA) are just a few. **Method:** cross-sectional study aimed to psychopathologically and sociodemographically analyze adults hospitalized due to SA in a public Hospital in Chile. The participants were socio demographically and clinically featured, evaluating neuropsychiatric syndromes, personality disorders and levels of hopelessness, impulsiveness, intentionality, lethality and aggressiveness of the SA. Nonparametric statistics was applied. **Results:** 45 participants were included, with an average of 39 years old. Most of them lived in urban areas, they belonged to a low socio economic level, were single and had a stressful life event and SA record. The most frequent SA method was the ingestion of medication. The most frequent diagnosis were disorders caused by alcohol consumption and borderline personality. In half of cases hopelessness was mild or nonexistent. Lethality was positively and significantly correlated with suicidal ideation, as well as impulsiveness and aggressiveness. SA family background and psychic trauma were significantly higher in women and chronic pain in men. Severe cases depicted high levels of hopelessness, intentionality and lethality, while impulsiveness was significantly lower in non severe cases. In this group, the most frequent diagnosis was depressive episode. **Conclusions:** The analyzed sample depicted psychopathological and sociodemographic characteristics. SA lethality and intentionality must be systematically evaluated. Severe SA cases showed differential psychopathological characteristics .

Key words: suicide, psychopathology, adult, hospitalization

INTRODUCTION

Suicide has increased during the last 50 years, thus becoming a global public health problem⁽¹⁾. According to data provided by the World Health Organization (WHO), deaths caused by this problem could reach 15 million

during 2020, thus becoming the second cause of death among the population between 15 to 29 years old⁽²⁾. In Valparaíso Region, Chile, the records of the Health Department, Viña del Mar- Quillota showed 437 cases of suicidal attempts (SA) at the hospitals of the Department⁽³⁾. This figure was doubled in 2015,

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reaching 969 cases⁽⁴⁾. This figure matches the national statistics.

Suicidality is a problem starting from ideation, communications and behavior associated to SA, to completed suicide. This conceptual differentiation is important when reviewing the frequency of these situations. For instance, for every completed suicide, at least, 20 people have a SA⁽²⁾. This phenomenon varies according to sex, age groups, geographic area and socio political scenarios, thus suggesting a heterogeneous etiology with several causes⁽⁵⁾. Therefore, learning about individual and social factors is necessary in global understanding of suicidal risks. In fact, there is evidence of certain risk factors for suicidal behavior, such as psychopathological characteristics, stressful life events and sociodemographic determinants⁽⁶⁾. Even though, historically, literature has linked SA severity to parameters, such as psychiatric disorders, family or individual SA background and/or access to lethal methods, highly diverse sociodemographic factors according to the sample studied, it is equally important, such as the presence of support networks, chronic pathologies, age, labor position and economic level⁽⁷⁾. Same situation with psychopathological characteristics that are not usually evaluated at Emergency Rooms, as these do not have specialists, such as hopelessness⁽⁸⁻¹⁰⁾ and impulsiveness⁽¹¹⁾. All these factors are quite useful when evaluating suicidal risk on patients go to Emergency Rooms, i.e. a critical spot to identify and intervene suicidality in high risk patients. in fact, it has been proved that a high amount of people who died because of a suicide have been assisted at Emergency Rooms, prior to death⁽¹²⁾. In a cohort study followed up for five years to a group of 302 SA hospitalized patients with high medical severity, it was estimated that 37% of them tried, at least, another SA and 6.7% died because of a suicide⁽¹³⁾. This also confirms that people who have a highly severe SA may have some specific characteristics. Notwithstanding, the profile of patients who required assistance, due to SA has been poorly described at a regional level and even at a national level. Such information would allow better prevention and management^(12,14). Therefore, the objective of this investigation is to psychopathologically

and sociodemographically characterize patients who were assisted because of SA at a hospital in Viña del Mar, Chile, identifying the most severe cases and analyzing correlations among the various parameters on this nature.

METHODS

Sample

An analytic cross-sectional study was made aimed to psychopathological and sociodemographically characterize SA patients hospitalized at the Psychiatry Department of Hospital Dr. Gustavo Fricke, in Viña del Mar, Chile. The sample was made with all the patients who required assistance between December, 2017 and February, 2018 at the Adults Emergency Room, who had an SA diagnosis, according to Silverman et al⁽¹⁵⁾ definition¹⁸ years old or older with a stable medical condition. Patients with altered consciousness were excluded. Two psychiatrists for adults and one female psychologist evaluated each patient during three days. Instruments applied are described in Table 1.

Test IPDE-SQ was not applied in cases where some psychotic disorder or a medically caused cognitive impairment is searched (MINI). In this case, the MoCA was applied in order to make the diagnosis more accurate. Participants who got high levels of SIS and BLS were categorized as “severe cases”.

Statistical Analysis

For descriptive analysis medians, inter quartile ranges (RIQ) and proportions were used. In the inferential analysis the Wilcoxon-Mann-Whitney test was used to compare medians and the Fisher's exact test was used to compare proportions. A correlation matrix of quantitative variables was made by using the Spearman's correlation test. A significance level of 5% was used. Data were analyzed with the statistics software named Stata 16 (StataCorp, Texas, USA). The report of this study is adjusted to the STROBE guidelines for observational studies⁽³⁰⁾.

Bioethical aspects

All participants followed an informed consent protocol. The study was evaluated and approved

Table 1. Description of instruments

Questionnaire of Socio Demographic/Clinic Background Questionnaire made by the authors, aimed to gather socio demographic background (age, sex, nationality, place of residence, marital status, family group, occupation, educational level, socioeconomic level, aboriginal people, belonging to a church, presence of family and/or socio labour stress) and clinical (presence of chronic and/or terminal diseases, painful syndromes and/or disability, individual and SA family background, background of pshyche trauma and SA method). The questionnaire was managed in the context of a semi-structured psychiatric interview.

Beck's Suicide Intent Scale, SIS⁽¹⁶⁾. Heteroapplied scale, widely used in the evaluation of suicidal risk. SIS values severity or intensity how someone tried to commit suicide and survived. It has 20 items aimed to quantify verbal/non verbal behavior of the attempter during the most recent SA. Every item is scored in a Scale of 0 to 2 with a total score of 0 to 30. The first part (items 1-8) evaluates the objective circumstances of the SA, including items related with the preparation and execution of the attempt. The second part (items 9-15) evaluates lethality perception of the method the attempter has, expectations about the possibility of rescue and intervention. The third part (items 16-20) evaluates subjective circumstances. This Scale generates three categories, according to severity: mild (0-7 points), moderate (8-13 points) and high (14 or more points). The SIS is a widely used tool in the evaluation of suicidal risk.

Beck's Lethality Scale, BLS⁽¹⁷⁾. Heteroapplied scale measuring lethality of a SA on people que have had a recent one. The score of medical damage goes from 0 (fully conscious and alerta) to 10 (death). The total score, from 0 to 10, is based on the physical examination of the patient and its degree of compromise at the time of admission to the Medical Service. This Scale estimates three levels of lethality: low (0-1 points), moderate (2-3 points) and high (4-10 points).

Buss-Perry Aggression Questionnaire, BPAQ⁽¹⁸⁾. It is an updated review of the Buss-Durkee Hostility Questionnaire, where the motor, cognitive and affective motros of the aggressiveness construct are included, considered as the reference standard for its measurement. The questionnaire consists of 29 self-managed items, valued, as per 5-point scale. The BPAQ includes four subscales: "physical aggression", "verbal aggression", "rage" and "hostility". The score of each scale is the summation of the items, while the total score of aggression is the summation of these Scales. The instrument has validated versions in Spanish stating if its internal consistency is correct^(19,20).

Barratt's Impulsivity Scale, BIS-11⁽²¹⁾. It is a self-applied questionnaire with 30 questions evaluating impulsiveness when acting and thinking. Every answer alludes to the frequency: "rarely or never", "occasionally", "often", "always or nearly always". The score is made by using the Likert Scale going from 0 to 4. This Scale is made up of three independent factors: cognitive impulsiveness, motor impulsiveness and absence of planning. However, it is summarized in one single total score obtained by summing the individual items. This Scale generates three levels of impulsiveness: none (0-51 points), normal (52-71 points) and high (72 or more). The BIS-11 is validated in Spanish⁽²²⁾.

Beck's Hopelessness Scale, BHS⁽²³⁾. It is a self-applied Scale with 20 items containing true and false statements, designed to evaluate positive and negative believes about the future and about himself/herself during the last week. These 20 items are scored as “0” or “1”, depending if the answer is false or true. The total score goes from 0 to 20. This Scale generates four categories, according to the level of hopelessness: none (0-3 points), mild (4-8 points), moderate (9-14 points) and high (15-20). The version of the validated instrument in Spanish for patients with suicidal risk was used⁽²⁴⁾.

Montreal Cognitive Assessment, MoCA⁽²⁵⁾. This instrument evaluates the executive and visuospatial function, identification, memory, attention, language, abstraction, memories and orientation. Validation in Spanish made in Chile provides a score <21 it has the highest performance for mild cognitive deterioration (sensitivity, 75% and specificity, 82%)⁽²⁶⁾.

MINI International Neuropsychiatric Interview, MINI⁽²⁷⁾. It is a brief structured interview for neuropsychiatric diseases used for diagnosis standardization. It is divided into modules identified by letters corresponding to a diagnosis category. At the beginning of each diagnosis module there are screening questions for the main pathology criteria. All questions must be classified as “Yes” or “No”. Criteria must not be qualified as positive when symptoms may be caused by consumption of substances or by any other basic medical cause. Therefore, the clinical criterion to execute the interview must be prevalent, in order to qualify the questions.

International Personality Disorder Evaluation Screening Questionnaire, IPDE-SQ⁽²⁸⁾. This is a self applied questionnaire aimed to identify those traits and relevant behavior for evaluating criteria of personality disorders, according to the classification system of the Diagnosis and Statistics Manual of Mental Disorders, 4th version (DSM-IV). These aspects must be present in adult people and must be steady for the last five years. It has 77 items with answers classified as true or false. The true answers are scored with “1” and false ones with “0”. There are items not applicable for some people and are scored as “Non applicable”. If the person scores more than three points for one type of personality disorder, it is necessary to apply the full semi-structured interview. Results are categorized in 10 personality disorders exposed in the DSM-IV. The interview must not be applied in patients with severe agitation, psychosis, intellectual disability or cognitive impairment. The instrument has a validated version in Spanish⁽²⁹⁾.

by the Bioethics Committee of the Faculty of Medicine, Universidad de Valparaíso, Chile (Assessment Act #40/2017).

RESULTS

Total sample

The sample was made with 45 participants. Average age was 39 years old (RIQ 29-52). 64.4% were women (n=29), almost all of them were Chilean (97.7%) and lived in urban areas (95.5%). 40% (n=18) was single; 20% (n=9) married; widows (widowers) and cohabitants 11.1% (n=5) at each stage. The most frequent

type of family was nuclear family (33.3%; n=15), highlighting later un 26.6% (n=12) who lived as house guest and 13.3% (n=6) who lived alone. Nearly half (46.6%) had high school studies, while 31.1% (n=14) had only basic studies; a minority (11.1%; n=5) had higher education. Regarding occupation, a third was employed (n=15), a third unemployed (n=15), 7 had a retirement pension, 5 were housewives and 3 students. Nearly half of the sample was in the second quintile of income (48.8%; n=22), i.e. they had a monthly income of USD86 to 145 USD. The majority did not identify any aboriginal people (95.5%; n=43) or with any

religious belief (53.3%; n=24), but the church or main belief was the catholic (33.3%; n=15). Almost all the sample had some stressful life events (n=44), being the most frequent those associated to couples conflicts (60%; n=27).

Methods of suicidal attempt had ingestion of medication (66.6%; n=30), hanging (13.3%; n=6), ingestion of other substances (8.8%; n=4), stab wounds (6.6%; n=3), drowning (2.2%; n=1) and fall from height (2.2%; n=1). 55.5% (n=25) had some background of psychic trauma and 68.8% (n=31) already had a SA.

Results of instruments applied to the whole sample, the correlation matrix among the score obtained and the comparison, as per sex are summarized in the following tables.**Table 2**

IPDE-SQ was not applied in one participant who was diagnosed with psychotic disorder and in six participants with medically caused cognitive impairment. In the last six cases MoCA test was applied. 5/6 participants had results compatible with mild cognitive impairment.**(Table 3 - Table 4)**

Severe cases

The most severe cases, determined as per intentionality and lethality, had 11 participants; average age was 41 years old (RIQ 31-68), 54.5% (n=6) were women and 45.4% (n=5) had a SA background. In 72.7% (n=8) of cases the method was ingestion of medication. 81.8% (n=9) did not have current employment. Two of them were students, while 90.9% (n=10) did not have a couple. The most frequent psychiatric diagnosis was major depressive episodes (54.5%; n=6), followed by alcohol consumption disorders (36.3%; n=4) and mild cognitive impairment (36.3%; n=4). Table 4 depicts a comparative analysis, according to SA severity. **(Table 5)**

DISCUSSION

The study was made with participants who had an average age of 39 years old, 64% were women, who mostly lived in urban areas and belonged to a low socio economic level. Almost all the participants had a stressful event. Half of them had a background of psychic trauma and 68.8% had of SA.

It has been observed that in developed/

developing countries being females is a risk factor for SA⁽³¹⁾. In turn, background of family SA and psychic trauma were significantly higher in women ($p=0.004$), suicide risk factors consistently informed by literature. Likewise, sex distribution could have been correlated with the most used SA method was ingestion of medication (66.6%). This was the most used means among women⁽³²⁾.

on the other hand, more than half of the sample did not have a couple during the SA. This is a controversial aspect in literature. Some statistic models that control due to confusion factors have proved that marital status did not significantly influence on SA⁽³³⁾, while other reported that having a relationship is a protecting factor for suicide, as it provides a safety/support network. However, widowhood and recently having broken in a relationship did increase SA likelihood (vital stressors) and not necessarily the fact of being single, as proved by a prospective study recruiting 47,604 participants⁽³⁴⁾. Our results also proved that almost all participants had, at least, one stressful life event, being the most frequent that of interpersonal conflicts, mostly couples conflicts, observed in nearly 60% of the patients. This could be associated to the high frequency of personality disorders, as further described, which hinder a good relationship with others.

From a socio economic point of view, a third of the sample had basic studies. 46.6% had high school studies. Half of them belonged to the second quintile of income, i.e., that of lowest income. in fact, only a third had a stable employment. All this causes a higher level of adversity-stress and few life options, which increases likelihood to commit SA as a way to solve the conflict. in this sense, according to districts, a study led by Näher et al⁽³⁵⁾ analyzed the sociodemographic data of 149.033 suicides in Germany. Regarding suicide rates, an increase of 1.2% was found per each 1% of jobless increase and a decrease of 0.39% per each 1% of increase on income, which proves the relevance of the socio economic conditions as determinants for suicide.

All participants of this study had, at least, a psychiatric diagnosis, being the most frequent that of personality disorder, mostly borderline type, with around 50%, followed

Table 2. Results of SIS, BLS, BPAQ, BIS-11, BHS, MINI and IPDE-SQ of the whole sample.

Instrument	Median (RIQ) or Proportion (absolute number)	
SIS	15 (10-19)	Mild 15.5% (n=7)
		Moderate 31.1% (n=14)
		Severe 53.3% (n=24)
BLS	2 (2-5)	Mild 22.2% (n=10)
		Moderate 33.3% (n=15)
		Severe 44.4% (n=20)
BPAQ		76 (68-85)
BIS-11	60 (44-68)	None 37.7% (n=17)
		Normal 40% (n=18)
		High 22.2% (n=10)
BHS	9 (5-14)	None 4.4% (n=2)
		Mild 44.4% (n=20)
		Moderate 28.8% (n=13)
		Severe 22.2% (n=10)
MINI	Suicidality	86.6% (n=39)
	Alcohol Consumption Disorder	33.3% (n=15)
	Major Depressive Episode	28.8% (n=13)
	Substances Consumption Disorder (not alcohol)	24.4% (n=11)
	Medical Cognitive Impairment	13.33% (n=6)
	Nervous Bulimia	4.4% (n=4)
	Bipolar Affective Disorder Type II	2.2% (n=1)
	Psychotic Disorders	2.2% (n=1)
	Post Traumatic Stress Disorders	2.2% (n=1)
	Panic Disorder	2.2% (n=1)
IPDE-SQ	Limit	44.7% (n=17)
	None	42.1% (n=16)
	Antisocial	7.8% (n=3)
	Narcissist	2.6% (n=1)
	Avoider	2.6% (n=1)

Table 3. Matrix of Correlation between Total Score of SIS, BLS, BPAQ, BIS-11 and BHS.

	SIS	BLS	BPAQ	BIS-11	BHS
SIS	1				
BLS	0.391 *(0.007)	1 -			
BPAQ	0.003 (0.980)	-0.187 (0.217)	1 -		
BIS-11	-0.234 (0.121)	-0.150 (0.322)	0.310 *(0.03)	1 -	
BHS	0.281 (0.061)	0.022 (0.884)	0.015 (0.920)	0.037 (0.805)	1 -

Results in Coefficient of Correlation (p value obtained by means of Spearman's Correlation Test).

*Statistically significant associations

by alcohol consumption disorder (33,3%), major depressive episode (28,8%) and disorder caused by consumption of other substances (24,4%). It would have been possible to find a higher frequency of other diagnosis that have been associated to suicidality, such as bipolar disorders or schizophrenia, but we think this was limited by the small size of the sample.

SA severity assessment may be made in accordance with intentionality levels (SIS) and medical lethality (BLS). In our study severe levels of intentionality and lethality were observed in 53.3% and 44.4% of the sample, respectively. This explains that the hospital under study is a referral center for more severe SA cases simultaneously, both intentionality as medical lethality were significantly correlated ($p=0.007$), which reasserts the relevance of assessing both aspects during SA management. In this sense, a recent prospective study including 479 patients from a psychiatric emergency unit who required assistance due to self injuring events, compared predictive accuracy of suicide one year after the clinical interview and the SIS, and no differences were found⁽³⁶⁾. However, this results must be carefully assessed, as suicide cases included were few.

No high levels of impulsiveness in this sample were highlighted, as around 80% had

null or normal levels. This proves that, even if suicidal behavior has been associated to impulsiveness, this dimension is still a source of discussion⁽³⁷⁾. In fact, some authors have described a paradox relationship between impulsiveness and lethality: the least impulsive SA have turned out to be more lethal⁽³⁸⁾. This is a controversial phenomenon, as it is also possible to say that SA lethality is associated to lower impulsiveness, i.e., longer reflection around suicide. Even though our results support this inverted relationship, as the correlation coefficient between BIS-11 and BLS was negative, the correlation was not statistically significant. A statistically significant positive correlation was found ($p=0.03$) between impulsiveness and aggressiveness. That is theoretically expectable. Aggressiveness had a median of 76, with no significant differences neither for sex nor for SA severity.

Impulsiveness, as well as hopelessness is a dynamic concept which could be a state or as a trait, being the latter with higher predictive value and is associated to suicidal behavior⁽³⁹⁾. Some hypothesis have proved that constructs, such as hopelessness, frustrated belonging (i.e., the perception of lack of reciprocal relationships of care and unfulfilled desire of "belonging") and perception of being a burden (i.e., to feel he/she

Table 4. Comparative analysis as per sex.

		Men (n=16)	Women (n=29)	Value p
Age (years)		35 (26.5-57)	45 (32-52)	0.6
Individual SA background		68.7% (n=11)	68.9% (n=20)	1
Family SA background		0% (n=0)	24.1% (n=7)	*0.04
Medical Disease	Chronic	37.5% (n=6)	20.68% (n=6)	0.29
	Terminal	0% (n=0)	3.44% (n=1)	1
	Chronic pain	18.75% (n=3)	0% (n=0)	*0.03
	Disability	6.25% (n=1)	6.89% (n=2)	1
Stressful Event	Family conflict	25% (n=4)	37.93% (n=11)	0.5
	Couple conflict	62.5% (n=10)	58.62% (n=17)	1
	Labour conflict	6.25% (n=1)	3.44% (n=1)	1
	Economic Conflict	37.5% (n=6)	13.79% (n=4)	0.13
	Mourning	6.25% (n=1)	17.24% (n=5)	0.39
	Domestic Violence	0% (n=0)	13.79% (n=4)	0.28
Psychic Trauma Background		25% (n=4)	72.41% (n=21)	*0.004
SIS		17 (13.5-22)	12 (9-17)	0.08
BLS		2 (0-5.5)	3 (2-4)	0.34
BPAQ		79 (70.5-80.5)	76 (67-81)	0.34
BIS-11		54.5 (42.5-72)	60 (44-67)	0.75
BHS		8 (5-14)	9 (7-15)	0.34

Results in medians (RIQ) or proportions (absolute number) p value p based on Fisher's exact Test or Wilcoxon-Mann-Whitney's Test. * Statistically significant differences.

is a negative burden for others, and everything is better dying), interact and contribute to suicidal thoughts, that along with the capacity to carry out a lethal SA, are the key factors for suicide, as defined by the interpersonal theory of suicide⁽⁸⁾. Therefore, it would be quite relevant to explore the three dimensions during suicidality assessment. Likewise, the cognitive theory of the suicide states that hopelessness is a significant precondition for suicidal ideation in depressive patients. Notwithstanding, a cohort study questioned this statement, as this reasserted that severity of depressive symptoms would predict suicidal ideation, more precisely hopelessness⁽⁹⁾ which must be assessed in context and perspective, as hopelessness has proved to be a construct consistently associated to suicidality. In our study, nearly half of the sample had mild levels of hopelessness or no clinic significance. Hopelessness measured

by the BHS is rather a status phenomenon, by contrast, in the sample the most prevalent was a determined personality structure that would not necessarily reflect a level of constant hopelessness, i.e. as a trait. In the group of severe cases, the most frequent diagnosis was that of major depressive episodes, reaching 54.5%; likewise, levels of hopelessness in severe cases were higher, with an average of 14 (RIQ 4-16), versus an average of 8 (RIQ 5-13) for non severe cases, but this difference did not reach statistical significance. The median of impulsiveness was 44 (RIQ 36-62), significantly lower than with non severe cases, where a median of 63,5 was found (RIQ 45-74). This is a contradiction with the frequent diagnosis of unipolar depression in severe cases, where high levels high of hopelessness and low levels of impulsiveness are confirmed, contrary to what was observed with predominant borderline

Table 5. Comparative analysis according to severity

		Non severe (n=34)	Severe (n=11)	Value p
Age (years)		38 (27-51)	41 (31-68)	0.25
Individual SA background		73.5% (n=25)	54.5% (n=6)	0.27
Family SA background		14.7% (n=5)	18.1% (n=2)	1
Medical Disease	Chronic	23.5% (n=8)	36.3% (n=4)	1
	Terminal	2.9% (n=1)	0% (n=0)	1
	Chronic pain	5.8% (n=2)	9% (n=1)	1
	Disability	5.8% (n=2)	9% (n=1)	1
Stressful Event	Family conflict	35.2% (n=12)	27.2% (=3)	0.72
	Couple conflict	61.7% (n=21)	54.5% (n=6)	0.73
	Labour conflict	2.9% (n=1)	9% (n=1)	0.43
	Economic Conflict	17.6% (n=6)	36.3% (n=4)	0.22
	Mourning	8.8% (n=3)	27.2% (n=3)	0.14
	Domestic Violence	8.8% (n=3)	9% (n=1)	1
Psychic Trauma Background		64.7% (n=22)	27.2% (n=3)	*0.04
SIS		12 (8-16)	21 (19-25)	*<0.001
BLS		2 (1-4)	6 (4-9)	*<0.001
BPAQ		76.5 (68-86)	76 (67-85)	0.93
BIS-11		63.5 (45-74)	44 (36-62)	*0.04
BHS		8 (5-13)	14 (4-16)	0.38

Results in medians (RIQ) or proportions (absolute number). p value based on Fisher's exact Test or Wilcoxon-Mann-Whitney's Test. *Statistically significant differences

personality in the other cases. At the same time, among the most severe cases it was observed that 36.3% had a mild cognitive impairment, which is associated to a lower availability of cognitive and affective resources to solve vital psychic conflicts. A controversial finding was that the rate of psychic trauma background was significantly higher among non severe cases, in so far as the investigations have documented psychic trauma as a high risk factor for SA⁽⁴⁰⁾. We think this was because of the low amount of severe cases analyzed.

Results presented must be carefully assessed, as the sample size was reduced parametric inferential statistics was applied. This method only allows to draw conclusions with respect to the sample, but not to extrapolate results to the population it came from; in this way, it was not possible to make theoretically expectable correlations. Along with this, dimensional/

category diagnosis was made by using validated tests, but these are neither comprehensive nor complex diagnosis which may be obtained in a clinic and longitudinal context.

A comprehensive characterization and an analysis of psychopathological and sociodemographic variables was made by means of validated and widely used assessment instruments in the investigation, highlighting differences as per sex and severity. This allowed to learn about a biodemographic/ clinic profile of patients who had an SA in the region, characteristics which have been poorly described locally, which represent population groups in a particular socio geographic context. These findings are relevant, as they reveal a profile of severe patients who should be searched and managed in the various spaces of outpatient assistance at intersectorial level.

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