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Psychiatric comorbidity and socio-demographic profile of adults with attention deficit hyperactivity disorder

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Background and aims: This study aims to characterize the adults with ADHD in comparison to control individuals without a psychiatric diagnosis, in terms of symptoms of inattention, impulsivity and hyperactivity, presence of psychiatric comorbidity and socio-demographic profile.

Method: Thirty-six individuals who were diagnosed with ADHD according to DSM-IV diagnostic criteria at the ADHD clinic for adults of the Marmara University Hospital, were included in the study. The control group consisted of 40 age and sex matched volunteers.

The socio-demographic characterization was done using a semi-structured interview. To evaluate the presence of psychiatric comorbidity, structured clinical interviews (SCID-I and II) were conducted by two general psychiatrists experienced in ADHD and trained in SCID administration. All groups were given SCL-90-R for general psychopathology assessment, Wender-Utah rating scale for childhood ADHD symptoms, and Beck DI for current depression rating.

Results: The results of the study indicate that the adults with ADHD had poorer anger control ($X2=8.904$, $p<.05$). ADHD patients, in contrast to the control group, were more likely to have greater number of psychiatric diagnoses. (Wilks' Lambda= .597, $p<.001$; SCL90, $F(71,1)=29.258$, p,.001 ; SCID I: $F(69,1)=27.373$, $p<.001$; SCID 2; $F(69,1=37.803$, $p<.001$; BDI $F(70,1)=19.698$, $p<.001$) The greater the number of comorbidities were more severe ADHD symptoms (SCID I: $r=.621$, $p<.001$).

Conclusion: The greater likelihood and the number of a psychiatric comorbidity are associated with more severe ADHD symptoms in ADHD patients. Functional impairment and treatment needs also increase as the number of comorbidities.

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Medical criteria of disability in psychiatric practice

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One takes clinical and psychopathologic symptoms, which cause 'circulus vitiosus' as a criteria of disability. On one hand it is a provocative factor, and on the other it is a consequence of worsening of the psychological condition, which leads to the breach in the society order in one or another area. It is important to determine the medical constituents which limit the vital functions and lead to development of social insufficiency and psychic disorders of patients.

In order to determine the medical criteria which lead to limitations in vital functions and social insufficiency we have examined 460 patients. We found out that the patients having positive syndromes which lead to limitations in vital functions have depression embarrassment, hallucinations, paranoid depression prevail. The negative include asthenic change, reduction of energy potential reduction and regress of a personality. The differentiative diagnostics of clinical and psychopathologic symptoms is not effective under conditions of psychiatric hospital. We found out that the hyperdiagnostics of the criticism level as ''absent'' and self-appraisal as 'reduced' is not proven and needs to be proved experimentally. In its turn, the diagnostics of level of self-appraisal as 'reduced' and development of 'passive' and 'supportive' rehabilitation measures may lead to destruction of the rehabilitation potential of a personality and forms the basis behavior. The examination of the suicidal tendencies should be based on obligatory use of screening methods.

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"Ego-dystonic" delusions in psychotic patients

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This paper aims to report a possible warning sign for dangerous behavior in delusional psychotic patients. We demonstrate an association between aggressive or auto-aggressive ideation and ''ego-dystonic'' grandiose delusions, where the patient believes to possess unique qualities but finds them unbearable.

The study is based on the sample of 7 interviews with 5 psychotic in-patients at the Kfar Shaul Mental Health Center, Jerusalem, Israel. All patients experienced an acute psychotic episode, and committed acts of aggression or suicidality. The research method is narrative analysis of semi-structured interviews.

Patients report ideas of grandiose self-identification with deities, Biblical figures or celebrities, yet report their reluctance to be in these high positions due to feelings of unworthiness, withdrawal, and social isolation. Resulting frustration arguably leads to aggressive and suicidal ideation or actions.

Contrary to the established view, grandiose delusions are not free of association with (auto-)aggression. The patient's ego-dystonic attitude towards his/her delusional identity may serve as the warning sign for dangerous behavior and, as such, should be searched for and recognized by the mental health professionals.

Poster Session 2: EPIDEMIOLOGY

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Smoking and mental disorders: associations derived from longitudinal data over 20 years

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Background: To examine the associations between tobacco use and a broad spectrum of mental disorders using longitudinal population based data over 20 years.

Methods: The data were derived from the Zurich Study – a longitudinal community study which started in 1979 with a stratified sample of 591 participants aged 20/21 years. Follow-up interviews were conducted at age 23, 28, 30, 35 and 41. Statistical analysis relies on logistic regression and longitudinal data analysis. The analyses focussed on smokers (having ever regularly smoked) and on strong smokers (having ever smoked more than 22 cigarettes per day).

Results: In general, a lifetime diagnosis of mental disorders yields a heightened risk for smoking (OR ~ 4) and being a strong smoker (OR ~ 6) up to age of 40. The risk is particularly high in substance use, but also in dysthymia and bipolar diagnoses (OR > 15). At the other end of the scale are obsessive-compulsive disorder and bulimia with ORs almost similar to the general population. Simple phobia,

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agoraphobia, panic disorder and neurasthenia do not differ in terms of ever smoking, however their ORs are astonishingly high in strong smokers.

Conclusions: The risk of being (or having been) a smoker differs distinctly by mental disorder. This is most apparent in mood disorders. Moreover, in another group of disorders the amount of smoking interplays in a particular way. It seems unlikely that the causal linkage follows a consistent pattern.

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Medical morbidity in psychiatric (de-)institutionalized patients

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Introduction: The physical comorbidity of chronic psychiatric patients is affected not only by their psychiatric condition and treatment but also by the different access they have to health care facilities.

Aim: To record the medical morbidity of patients of the Psychiatric Hospital of Petra, Olympus, during its deinstitutionalization project.

Methods: The physical diseases of 196 chronic psychiatric patients (71.4% men), who were treated in long-stay wards or in community-based psychiatric facilities, were recorded during the autumn of 2003.

Results: Circulatory and neurological diseases were the most prevalent between psychiatric patients, both affecting 62 (31.6%) patients. Hypertenstion, coronary heart disease, stroke and dementia were quite frequent, approximately as much as in the general population. Epilepsy and hypotension were markedly frequent, possibly due to association with their psychiatric condition and its treatment. It is remarkable that anemia was the most frequent physical problem (25.5%), while 13.3% of the patients had a history of bone fractures. 14.8% of the patients had gastrointestinal problems (mostly ulcers), 15.3% had endocrinological (mainly diabetes) and 8.7% respiratory conditions. Finally, incontinence, prostate hyperplasia and other urological diagnoses were found in 10.7% of the patients.

Conclusions: The (de)institutionalized psychiatric population seems to suffer by medical problems that are associated a) generally with their age and gender and b) specifically with their psychiatric condition and the side-effects of the corresponding medication. It is hoped and expected that the deinstitutionalization will help improve the treatment of the former without at least hindering the handling of the latter.

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Lifetime risk and age-of-onset of mental disorders in the Belgian general population

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Aims: To estimate lifetime risk and ages of onset of mental disorders in the adult general population of Belgium.

Method and materials: For the World Mental Health Surveys of the World Health Organization, a representative random sample of non-institutionalized inhabitants from Belgium aged 18 or older (n=2419) were interviewed. The interview took place by means of the CIDI 3.0. Lifetime prevalence, projected lifetime risk, and age of onset were assessed.

Results: Compared to lifetime prevalence rates, projected lifetime risk remains fairly stable for anxiety disorders, but is increased for mood and alcohol disorders: The lifetime risk for any mental disorder was 37.1%: 22.8% for mood disorders, 15.7% for anxiety disorders, and 10.8% for alcohol disorders. Prevalence estimates of mood and alcohol disorders were significantly higher in the cohorts between 18 and 34 years. Age of onset-distribution are presented for mood, alcohol and anxiety disorders.

Discussion: This is the first study that assessed projected lifetime risks and ages of onset in the Belgian general population. A significant difference is noted between lifetime prevalence rates and projected lifetime risk. Median age of onset varies from disorder to disorder and younger cohorts had higher likelihood for developing mental disorders.

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Migration and mental disorders in an outpatient setting

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Background and aims: As a putative risk for mental disorders, particularly for schizophrenia, migration has reached an increasing interest. There are some evidences of high incidence rates of psychotic disorders in migrant populations. Most of the studies focus on inpatient, first-admissions samples. The aim of this study is to compare the rates of treatment for mental disorders between native-born and migrant patients in an outpatient setting.

Methods: A retrospective analysis of all patients (n= 3619) attended throughout the latest 3 years at an outpatient resource involving and area of 92234 inhabitants was carried out. Demographic variables (age, sex, country of birth) and clinical data (diagnosis at first contact and at follow-up, DSM-IV criteria) were collected. Patients were divided in two groups: natives (n=3486) and immigrants (n=133). Comparisons between both groups for the rates of any mental disorder and for syndromic diagnoses were performed.

Results: Compared to native patients, immigrant patients showed higher rates of psychotic disorders (15.2% vs 4.2%, $p<0.001$, chi square; OR=3.6, 95% CI=2.1-6). As a striking finding, all of the ''not specified'' diagnostic categories (psychotic disorder NOS, bipolar disorder NOS, depressive disorder NOS, anxiety disorder NOS) were significantly more prevalent in the migrant group.

Conclusions: Among the patients referred to an outpatient mental health resource, a higher prevalence of psychotic disorders in migrants compared to native patients was found. The higher rates of not specified diagnoses in immigrant patients underlines the hazard of misunderstanding their symptoms and, therefore, to overestimate the prevalence of severe disorders in this group.

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Transgenerational transmission of agressive behaviour

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Objective: The objective of the present paper was to assess associations between parental agressive behaviour and agressive behaviour in adolescents, as well as to define the possible correlation between the parental agression and the psychopathology presented by the adolescents.

Methods: We surveyed 100 adolescents in the age from 14 years to 16 years and their parents. Adolescents and their parents fullfilled set of self-rating scales. Adolescents completed the Overt agression

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