5) Positive relations between 5-HIAA, MHPG, and AQ-RSV revealed significant relationships between self-rated aggression and monoaminergic turnover. 
6) Gender distinctly modified the linkage between aggressive symptoms and central monoaminergic turnover in PDD.

Self-report

Astheno-emotional disorder after aneurysmal subarachnoid hemorrhage. Classification, outcome, and relation to anxiety and depressive disorders

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Psychiatric symptoms such as fatigue, concentration and memory difficulties, anxiety, and depressive symptoms are frequently reported after aneurysmal subarachnoid hemorrhage (aSAH) and in various other neurological diseases. These symptoms may indicate the presence of organic psychiatric disorders (OPDs), such as the Astheno-Emotional (AE-) disorder, of anxiety or depressive disorders, or both, but psychiatric classification and differentiation between such disorders have seldom been used in follow-up studies of neurological disease.

The aim is to study the AE-disorder described in Lindqvist & Malmgren’s (LM) diagnostic system for organic psychiatry in terms of outcome, reliability, validity and relation to anxiety and depressive disorders, and to compare the coverage for OPDs between the LM, ICD-10 and DSM-IV systems in a prospective study after aSAH.

Two cohorts of patients admitted due to aSAH were assessed by repeated clinical interviews during the first year after surgery (n = 119). Psychiatric disorders were diagnosed according to the LM, ICD-10 and DSM-IV systems. The reliability of the AE-disorder was evaluated by joint interviews (n = 33) and the validity by assessments of symptomatology (Comprehensive Psychopathological Rating Scale), clinical course, predictors (age, bleeding severity and hypertension), and social outcome (Glasgow Outcome Scale, GOS).

The frequencies of AE-disorder at 3, 6 and 12 months were 60%, 49% and 38%, respectively. The agreement for AE-disorder was 85%, the kappa coefficient 0.65 and the systematic disagreement was negligible. The most frequent AE-disorder symptoms were mental fatigability and concentration and memory difficulties. Persistent AE-disorder was significantly associated with hypertension before the bleeding, and with impaired social function after the bleeding (“moderate disability” on GOS). The AE-disorder showed a significantly higher coverage than corresponding ICD-10 and DSM-IV diagnoses, but the coverage for other OPDs did not differ between the systems. An association between persisting AE-disorder and development of anxiety or depressive disorders (19% of all patients) was found with a relative risk of 3.5 (95% confidence interval 1.05–11.7).

To conclude, AE-disorder, the most common psychiatric disorder after aSAH, can be diagnosed with high reliability, impairs social outcome, has a higher coverage than corresponding ICD-10 and DSM-IV diagnoses, and is most likely a vulnerability factor for development of anxiety and depressive disorders.

Self-report

Causes of death and risk factors for suicide in patients with affective disorder

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Ph.D. dissertation, National Centre of Register-based Research, University of Aarhus, Aarhus, Denmark, 2003.

Patients with affective disorders have high mortality rates, especially from suicide. Generally, studies have been based on populations too small to give precise estimates of mortality from specific natural causes. Only a few case control studies on suicide risk in affective disorder have been conducted. The aim of the study was to compare the cause specific mortality with that of the general population, to compare the cause specific mortality of the different subgroups of affective disorder, to study changes in mortality during the period 1973 to 1993 and to identify risk factors for suicide in this high-risk group. All patients admitted for the first time during the period 1973–93 because of affective disorders were included. We used data from The Danish Psychiatric Central Register. The cause-specific mortality rates were calculated and Poisson regression was used to identify risk factors of suicide. Furthermore, all patients with affective disorder, ICD-10 codes F30–39, who during the period 1 January 1994 to 31 December 1995 committed suicide either during psychiatric inpatient treatment or less than 1 year after a discharge, were included (135 case-control pairs). Data was analysed using conditional logistic regression.

We found that patients admitted because of affective disorder, especially those with a short duration of illness, have an elevated mortality especially from suicide. The risk of suicide was highest immediately after admission and discharge. Increased risk of suicide was also
associated with a history of multiple admissions and male gender. A prior suicide attempt and loss of job during the year before the last admission was associated with a higher risk of suicide. A lower risk of suicide risk was associated with clinical improvement during inpatient treatment.

Our conclusions are: patients hospitalized because of an affective disorder are a relevant target group for preventive measures. Factors associated with suicide risk in inpatients and recently discharged patients are mainly associated with the affective disorder and different from risk factors in the general population.

Self-report

Affective disorder and neurological diseases

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Doctoral dissertation, Faculty of Health Sciences, University of Copenhagen, Psychiatric Clinic, Rigshospitalet, Copenhagen, Denmark, 2003.

The purpose of this Ph.D. thesis was to study the temporal relationship between affective disorders and neurological diseases. The study was carried out during my appointment at the Psychiatric Clinic, Rigshospitalet, Copenhagen.

The study was based on data from the Danish Hospital Discharge Register (Landspatientregisteret) and the Danish Psychiatric Central Register. A study base was formed consisting of all hospitalized patients for the period 1977–97, given diagnoses of Parkinson's disease, dementia, multiple sclerosis, epilepsy, cerebral haemorrhage, cerebral thrombosis, osteoarthritis and diabetes mellitus, and registered in the Danish Hospital Discharge Register. Patients admitted to hospital in the period 1970–97, who were given a diagnosis of affective disorder, dementia, schizophrenia, alcoholism, alcohol abuse or drug abuse were registered in the Danish Psychiatric Central Register. All of these patients were searched for in the Causes of Death Register for establishment of the time of death, if this had occurred. Survival analyses were used: Poisson regression with competing risks models and Cox regression.

Patients with some neurological diseases have an increased risk of being admitted with a diagnosis of depression or mania compared with control groups. In patients with Parkinson's disease and dementia, this increased risk remains elevated throughout the observation period. In patients with multiple sclerosis, it was found that there was a decreased risk of developing affective disorder compared to the control groups. Patients with Parkinson's disease and dementia have an increased probability of developing an affective disorder compared with control groups, but also compared with patients suffering from other neurological diseases. In the studies of cohorts with patients with affective disorders, the risk of developing neurological diseases was found to be elevated compared to the control groups. For some patient groups, there seem to exist a relationship between the neurological diseases and affective disorders, which may imply a neurobiological mechanism between the two.

Future studies will hopefully clarify these relationships.

Self-report