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Structured assessment of acute suicide risk: An emotion focused approach

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Suicide risk assessment remains a challenging task for all clinicians. Despite the vast literature on suicide, there is no consensus on how to best conduct a comprehensive suicide risk assessment. In clinical practice, various methods of assessment are employed. Some studies suggest that structured suicide assessments are less likely to miss important risk factors. Although a structured professional judgment methodology (S-RAMM) for suicide risk assessment has been recently developed, it has not received wide acceptance in clinical practice, partly because it is time consuming and it focuses mostly on chronic, non-affective, suicide risk factors. Furthermore, there is evidence that commonly assessed risk factors such as suicidal ideation and plan are not good predictors of acute suicide risk. The objective of this paper is to introduce an evidence-based, time sensitive, structured approach for the assessment of acute suicide risk that can be easily incorporated into a psychiatric interview. In this approach, in addition to assessing risk and protective factors, the clinician systematically assesses the individual's emotional reaction to distressing events. Five affective domains that are associated with suicide are examined including: humiliation/shame, anger, guilt, depression, and emotional detachment. Specific guidelines and questions are provided to ensure a structured and systematic evaluation. Case studies will be used to illustrate the application of this model in diverse clinical settings.

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Psychotic symptoms and cognitive impairment with herpes encephalitis

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Herpes encephalitis with psychiatric symptoms and cognitive impairment are reported previously. We report a case of herpes encephalitis who had delirium, psychosis and depressive disorder respectively during the acute encephalitis and post encephalitic term.

A 27 years old man, who was hospitalized by microbiology clinic, diagnosed with herpes encephalitis by PCR. The MRI study showed high-signal areas in bilateral temporal lobes. He had delirium symptoms during acute encephalitis so a low-dosage of Haloperidole was added to herpes treatment. Delirium symtoms recovered in a few days. 2 months after discharge he admitted to psychiatry outpatient clinic with the complaints of irritability and hipomnesia. In psychiatric examination; delusions, hallucinations, aggression, disorganized behavior were found, postencephalitic lesions in bilateral temporal lobes and abscess formation in left hippocampus secondary to encephalitis determined by repeated MRI. At the neurupsychiatric evaluation; deficits in verbal-episodic memory, visuoperceptual functions and disorientation were present. Olanzapine was started and titrated up to 20 mg/day. His psychotic symptoms recovered but few mounts later depressive symptoms especially feelings of insufficiency occurred. Olanzapine was gradually decreased; simultaneously Sertralin was started and titrated up to 150 mg/day. The following MRI studies showed a recovery in the counts and sizes of abscess formations. At the end of one year depressive symptoms and cognitive impairment continued with a partial recovery.

The pathologic changes and alterations including bilateral temporal lobes and hippocampus may be responsible for the occurrence and variety of symptoms in this case so it highlights the relationship between psychiatric disorders and different brain regions.

P0280

30-year prospective longitudinal study of ADHD

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Background and Aims: Knowledge of the long-term course of childhood Attention Deficit Hyperactivity Disorder (ADHD) is limited by the lack of longitudinal studies that extend beyond age 25. Information about the later adult status of children with ADHD, one of the most common disorders of childhood, is important since the disorder is widely reported to persist through adulthood. Findings from this prospective 30 year longitudinal study also address the claim that bipolar disorder masquerades as ADHD.

Methods: We report on the psychiatric status of 90 males at mean age 41, diagnosed with ADHD at ages 6-12 (Mean, 8), and 102 non-ADHD males matched for age and SES in childhood, interviewed blindly by trained clinicians.

Results: As expected, ADHD at follow-up was significantly elevated in probands (13% vs.1% in comparisons, $p<.001$). When the number of ADHD criteria is reduced, as recommended for ADHD in adults, rates rise to 36% and 12%, respectively ($p<.001$). Other disorders significantly more prevalent in probands were: antisocial personality disorder (APD) (10% vs. 0%, $p<.001$), drug (non-alcohol) disorders (17% vs 7%, $p<.03$), and nicotine dependence (29% vs 9%, $p<.001$)). Childhood ADHD was not associated with elevated rates of mood or anxiety disorders in adulthood.

Conclusions: The extended clinical course of ADHD appears diagnostically specific, consisting of ADHD, APD and drug (non-alcohol) use disorders. Findings are not consistent with expectations that ADHD persists through adulthood in the majority, or that bipolar disorder was misdiagnosed as ADHD in childhood. Findings pertaining to other functional domains also will be presented.

P0281

Continuation of ADHD from childhood into adulthood

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Attention deficit/hyperactivity disorder (ADHD) is a worldwide and highly prevalent disorder neurobiological disorder which affects affect 5–10% of children. Controlled prospective follow-up studies on ADHD have demonstrated persistence of symptoms into adolescence in 60-85% of individuals diagnosed in childhood (Weiss et al., 1971; Hechtman, Weiss, 1983; Barkley, 1990; Hechtman, 1985,1989,1992, 2000). Hechtman and Weiss were among the first to conduct controlled, prospective follow-up studies of children with ADHD into adulthood (Weiss et al, 1978; Hechtman et al, 1986).

Author has reviewed these most important studies for the establishment of the entity ADHD in adults.

ADHD in adulthood is a prevalent condition which is highly comorbid and causes significant social, occupational and/or emotional functional impairment.