

W07. Workshop: DO BRAIN IMAGING AND NEUROPHYSIOLOGY DIFFERENTIATE BORDERLINE DISORDER AND DEPRESSION?

W07

Do brain imaging and neurophysiology differentiate borderline personality disorder and depression?

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The workshop will give an overview of distinct neurophysiological and brain imaging studies with patients suffering from Borderline personality disorder and from depressive affective disorder. The contribution of Jose Manuel De la Fuente will report findings of sleep EEG recordings of patients with Borderline personality disorder (BPD), Major Depression (MD), Recurrent Brief Depression (RBD), and of controls. It was detected that BPD patients expressed less slow wave sleep than MD and RBD patients without BPD. Oliver Pogarell performed a radioligand brain imaging study that revealed an increase of the availability of the specific serotonin transporter (SERT) in the hypothalamus and brain stem of BPD patients which is in contrast to the findings of a SERT decrease in patients with depression. Christine Norra recorded event-related auditory evoked potentials (AEP) obtained through the application of various loudness stimuli. The strong loudness dependency of AEP in patients with BPD correlated with aspects of impulsiveness which may point to a serotonin disturbance in this disorder. Thomas Zetzsche and his colleagues performed a quantitative volumetric magnetic resonance imaging (MRI) analysis of temporolimbic regions in patients with BPD and MD. They found a significant increase of amygdala volume both in BPD patients with comorbid MD and in MD patients without BPD. Comparison of abnormal neurobiological findings between BPD and MD could provide a better insight into potential differences but also into similarities of the pathophysiology of these important psychiatric disorders.

CS04. Core Symposium: CHANGING PATTERNS OF SUICIDE IN EUROPE

CS04.01

Changing patterns of suicide attempts in Europe

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Similar to the different suicide rates in Europe (also in EU countries) also the European suicide attempt rates in various areas are quite different. The results of the WHO Multicentre Study on Suicidal behaviour show a ratio between the catchment area with the highest suicide

rates (Tallin) and the catchment area with the lowest rates with 1: for males and 1: for females. Over the period covered by the study the rates changed, however the rank order between the various catchment areas remained stable, thus showing that the differences can not only be caused due to different assessment procedures. In all catchment areas the suicide attempters belonged more often to the lower social classes, were more often unemployed and showed in general more detrimental social factors. Repetition of suicide attempts were often made in a relatively short period after the first suicide attempt. One reason for this can be that the time lag before the uptake of the first psychotherapeutic treatment (appointment) for many cases was very long, more than 20% of the patients had the first psychotherapeutic treatment only after six months. Also the stability of the therapeutic contacts was not very consistent after the suicide attempt: many patients had contacts with more than five care providers. This pattern changed only a little during the period under investigation.

CS04.02

Changing suicide rates in western and central Europe

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Although suicide is a very complex, multicausal behaviour, Hungarian and international results show that untreated or unsuccessfully treated major depressive episode is the leading cause of suicide, particularly in the presence of other suicide risk factors. However, large-scale, long-term clinical follow-up studies clearly demonstrate that appropriate acute and prophylactic pharmacotherapy of major mood disorders substantially reduces the suicide mortality even in this high-risk population.

Between 1980 and 2003, in Western and Central Europe, out of the 13 countries with high baseline suicide rates (20 or more) in 1980/1981, 10 countries (Denmark, Hungary, Austria, Switzerland, Estonia, Slovenia, Latvia, Finland, Czech Republic and Belgium) showed decrease (in average: 26.9%, range: 6-57%), and 3 countries (Lithuania, Russian Federation Ukraine) showed increase (in average: 15.7%, range: 10-25%). Out of the 16 countries with low baseline suicide rates (less than 20) 9 countries (Sweden, Germany, U.K., Norway, Greece, Slovakia, Netherlands, France and Italy) showed decrease (in average 15.2%, range: 7-31%), and 7 countries (Ireland, Spain, Romania, Poland, Portugal, Iceland and Bulgaria) showed increase (in average 49.1%, range: 3-102%). In the vast majority of the countries, unemployment, alcohol consumption, GDP, and divorce rate did not correlate with changing suicide rates and the only and mostly consistent (negative) correlation has been found between increase in antidepressant-prescription (9-fold increase in Hungary) and declining suicide rates (38% decrease in Hungary. Political / economic changes after 1990 does not seem to have a fundamental role in changing suicide rates in Western and Central Europe.

CS04.03

Suicides in the countries of the former Soviet Union

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Using WHO "Health for all" database we looked at suicide rates in 15 former USSR republics up to latest data. Since A.Värnik and D.Wasserman in the end of 90s have described an effect of anti-alcohol campaign during "perestroika", in the period from 1991-1992 to 1995-1996 there was a sharp rise in suicide rates in the majority of