Daraus resultieren bestimmte Dilemmata und Han dlungsaporien, die vom forensisch tätigen Psychiater als handelndem Subjekt gelöst werden müssen. Eine ethische Fundierung der Position des forensischen Psychiaters tut daher not. An einem historischen Beispiel aus der NS-Zeit wird die Bedeutung der weltanschlichen Einstellung für die Haltung zu forensisch-psychiatrischen Problemen herausgearbeitet. Die ethischen Probleme in der forensischen Psychiatrie lassen sich nicht stringent lösen. Aber eine Betrachtung — wie dargestellt — unter den Gesichtspunkten Subjektivität versus Objektivität trägt erheblich zur Trausparenz in verantwortlichen Entscheidungen bei.

DYSTHYMIC DISORDERS AND FRONTOTEMPORAL DEMENTIA

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Ten right handed patients (F/M = 9/1) became dysthymic in their fifties (m = 49.8 + 7.6 yr). All initially met the DSM III-R criteria for mood disorders. They were all treated with the standard drugs or ECT. Although initially responsive all the patients relapsed and their dysthymic disorders became less typical in presentation. At a mean age of 63.6 + 2.9 yrs a particular dementia of fronto temporal type became evident. Five new patients who had also received treatment for dysthymia were later added to the group. However the age of onset of their mood disorders and of the FTD were more variable.

In the group as a whole, the diagnosis of FTD relied on clinical and neuropsychological signs of frontal lobe dysfunction. The main symptoms were apathy and a lack of spontaneity as a result of which the patients were no longer able to live alone. Other symptoms were only observed in some cases: stereotyped behaviours, eating or drinking disorders, gait instability, extrapyramidal signs, etc.

On HMPAO-SPECT: all the patients had clear hypoperfusion of the frontal and temporal lobes, but only some of them showed a cortical atrophy on XCT.

None of the patients had a family history of dysthymia but 2 patients were siblings (i.e. brothers).

Although our patients probably don't form an aetiologically homogeneous group, they share common characteristics which are very similar to those which differentiates FTD from Alzheimer's Disease.

As all the patients first manifested dysthymia then FTD, we propose the existence of 2 mechanisms:

(1) some of these FTD appeared to be of the primary type which means that the pathological alterations involved the frontal cortex.

(2) in others the lesion of the fronto-temporal lobes may represent a dysfunctional (secondary) phenomenon due to a deafferentation (or diaschisis) mechanism originating from:

– a pathological lesion involving subcortical or basal areas.

– a "biochemical lesion", in dysthymia of the essential type.

Since a reversible frontal hypometabolism is found in essential dysthymia, we suggest that with time, and for as yet unknown reasons, the frontal hypoperfusion in our patients lost its reversibility and, as a result, a particular type of dementia became manifest. This diaschisis protractiva may lead in some cases to a disuse atrophy and the evolution of some dysthymic states towards dementia corresponding to the old concept of "démence vésanique".

PSYCHIATRIC MORBIDITY AND ITS RELATION TO LESION LOCATION FOLLOWING STROKE

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Introduction: Knowledge of discrete organic cerebral lesions resulting in clearly definable psychiatric disorders may provide an understanding of the underlying pathophysiological basis of these disorders. Both stroke and affective illnesses are common, but how often they co-exist remains unclear, with reported rates of depression following stroke ranging from 14–60%. Equally unclear is the relationship between lesion location and psychiatric illness following stroke, and recent studies have disputed earlier findings of an association between left anterior cerebral lesions and major depression.

Methods: Six months after their presentation to a city hospital with an acute stroke, 145 patients were assessed using a Standardised Semistructured Psychiatric Interview (SADS). Based on CT scan findings, the relationship between lesion location and psychiatric disorder was investigated in 55 of these patients (CT sample).

Results: 26% of all patients met DSM-IV criteria for an anxiety or depressive disorder. Depression was the most common diagnosis (20%). Pathological emotionalism was diagnosed in 18% of patients, particularly those who were depressed ($p < 0.0001$). Depression was also associated with a younger age group ($p = 0.03$) and greater physical disability ($p = 0.001$). In the CT sample, depression was significantly associated with larger lesions involving the right cerebral hemisphere ($p = 0.01$).

Conclusion: This finding supports seminal work by Lishman [1] and Flor-Henry [2] advocating an association between right hemispheric pathology and affective disorders. Factors which may complicate the assessment of depression in these patients and ICD-10 guidelines regarding right hemispheric organic affective disorder are discussed.

[1] Lishman, W. (1968) Brain damage in relation to psychiatric disability after head injury. Br. J. Psychiatry 114, 373–410.
[2] Flor-Henry, P. (1969) Psychosis and temporal lobe epilepsy: a controlled investigation. Epilepsia 10, 363–395.

EPIDEMIOLOGY OF MENTAL DISEASES AND THE PSYCHIATRIC REFORM IN GREECE: INDICATORS OF CHANGE

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A comparative analysis is made in order to outline the changes over the last thirteen years in the mental health care delivery system due to implementation of the Regulation (E.E.C.) 815/84 programme B initiated in 1984 and compare its organization patterns and characteristics between the years 1981/82, 1993 and 1995, focusing on basic elements of the transformation of the custodial towards community care.

Parallel to the changes in the mental health care delivery system, the patterns of discharge from mental hospitals are presented.

More specifically in this report the following are presented:

- the changes in public mental hospital beds and personnel.
- the changes in mental hospital utilization and patterns of discharge.
- the development of extramural community based psychiatric facilities.
- the changes in the available psychosocial rehabilitation places of any kind.

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Finally there will be a comparison of the number of long-stay mental patients for possible deinstitutionalization between 1982 and 1995.

DEPRESSIVE SYMPTOMS IN PEOPLE WITH A LEARNING DISABILITY

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Depression is a significant cause of morbidity in the learning disabled (LD) population. Standardised diagnostic criteria such as ICD 10 and DSM IV rely on adequate verbal communication skills. These skills may be limited in the LD population potentially limiting the reliability of such criteria. As a consequence it is likely that cases of depression will be missed. This study attempted to identify symptoms that might help differentiate depressed from non-depressed people within this population.

A check list of 32 symptoms was completed with 86 patients and their carers, looking at changes of at least 2 weeks duration within the preceding 12 months. A second, independent, assessor later used case notes and interviews to make a diagnosis. Differences in symptom presentation between the depressed and non-depressed group, across the spectrum of learning disability, was then analysed using chi squared tests with Yate's correction.

36 patients were found to be depressed. Symptoms of depressed affect and sleep disturbance were significantly different between the depressed and non-depressed group, throughout the spectrum of LD. Other "classical" symptoms of depression were found to be significantly different in the mild/moderate LD population, but not at the severe/profound level. Here, symptoms such as screaming, aggression and self injurious behaviour were significantly different between the depressed and non-depressed group.

We found that standardised diagnostic criteria can successfully be used to recognise depression in the mild and moderately LD population. However, as verbal communication skills worsen in the severe and profound groups, such instruments become less useful. Here it would seem that "behavioural" equivalents should have more emphasis placed on them to ensure depression is not missed.

THE PRIORITY TRENDS OF REFORMATION OF PSYCHIATRIC AID IN ESTONIA

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When evaluating the development of psychiatric aid in Estonia it is necessary to take into consideration:

1) what system of organization Estonia has just left;

2) what socio-economic and socio-psychological state of affairs Estonia is situated now;

3) the socio-psychological factors affecting spread and structure of psychic disorders.

The main changes reforming Estonian psychiatric aid are following:

Organizational measures

- decentralization and despecialization of psychiatric aid, the enlargement of the share of general practitioners and family doctors when dealing with persons with psychic disorders;
- the preferential development of the out-patient forms of psychiatric aid;
- development of programmes of rehabilitation;
- determination of the principles of optimal loading and paying of the staff and the structure of establishments.

Raising the standard of education of the staff

- schooling in psychiatry of hospital nurses and caring personnel;
- schooling in psychiatry of general practitioners and family doctors;
- more thoroughful treatment than up to now of dealing with non-biological methods of diagnostics, and treatment and rehabilitation in schooling of psychiatrists.

Changing of orientation of psychiatric aid

- maximum taking into account of the free will of a person in rendering psychiatric help to him/her;
- enlarging of empathy of the republic in their attitude in regard to the persons with psychiatric disorders;
- enlarging of social and legal safety of a patient.

EMIL KRAEPELIN'S ACTIVITIES IN TARTU (DORPAT)

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In 1996 140 years (15.02.1856) will pass from Emil Kraepelin's birth and 70 years (07.10.1926) from his death. His working period in Tartu (1886–1891) was essential because of experimental psychological and psychopharmacological investigations carried out here.

Eight doctor's dissertations were finished under E. Kraepelin's instruction in Tartu, seven of them were works in experimental psychology. Probably H. Dehio's ("Über Einflüsse des Coffeins und Thees auf die Dauer einfacher psychischen Vorgänge." 1887.) and A.Oehrn's ("Experimentelle Studien zur Individualpsychologie." 1889.) doctor's dissertations having been accomplished under the instruction of E. Kraepelin are the first experimental-psychological dissertations at all.

He has presented the results of his research in experimental psychology and psychopharmacology mainly collected in Tartu in his monograph "Ueber die Beeinflussung einfacher psychischen Vorgänge durch einige Arzneimittel". Jena, 1892, 260.

INFLUENCE OF EXAMINATIONS IN SLEEP QUALITY OF THE STUDENTS IN MEDICINE IN VALLADOLID EVALUATED BY PSQI

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Moans about sleep problems are very frequent and its prevalence in the population is referred between 15% and 30%, even more the incidence of insomnio reaches the 35% of the patients in Psychiatry consulting. In spite of this, only a few scales had been specifically designed to measure sleep quality.

The Pittsburgh Sleep Quality Index (PSQI) developed by BUISSE et al. at Pittsburgh's University is a self-applied questionary which has 19 questions about sleep problems during the last month. From the analysis we obtain seven scores referring to seven subscales about sleep quality: subjective quality, sleep latency, lasting, efficiency, sleep disorders, using of hipnotic drugs and disturbance in the daily activity. Adding these partial scores we obtain a total score.

The spanish version of PSQI was applied to a group of 120 student in Medicine in Valladolid, in two different moments, attending to the presence or absence of examinations. So it was applied for first time in February and for second time in March. Obtained results show that, during exams, students have less sleep latency and also less total time of sleeping, with an early wake up time, being significative the differences in all cases. There were no significative differences in the rest of scores in the PSQI.

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