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Clinic risk associated with comorbidity of (subclinical) psychosis, anxiety and depressive symptoms: A case for stratified medicine in psychiatry

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Background Meta-analyses link childhood trauma to depression, mania, anxiety, and psychosis. It is unclear, however, whether these outcomes truly represent distinct disorders following childhood trauma, or that childhood trauma is associated with admixtures of affective, psychotic, anxiety and manic psychopathology throughout life.
Aim To investigate the impact of trauma on psychopathological phenotype, functional outcome, and daily life stress reactivity.
Methods We used data from a representative general population sample (NEMESIS-2; $n = 6646$), of whom respectively 1577 and 1120 had a lifetime diagnosis of mood or anxiety disorder, as well as from a sample of patients with a diagnosis of schizophrenia (GROUP; $n = 825$). Multinomial logistic regression was used to assess whether childhood trauma was more strongly associated with isolated affective/psychotic/anxiety/manic symptoms than with their admixture. Additionally, we examined these groups in terms of social functioning, clinical severity, and quality of life. In a separate sample ($n = 621$), daily life (emotional and cortisol) stress reactivity was assessed, using ambulatory assessment.
Results In all samples, childhood trauma was considerably more strongly associated with an admixture of symptoms of depression, anxiety, psychosis, and mania, rather than with these symptoms in isolation. Individuals exposed to childhood trauma, who also had an admixture of symptoms, had a lower quality of life, more help-seeking behaviour, higher prevalence of substance use disorders, and lower social functioning, compared with individuals not exposed to trauma, without an admixture of symptoms, or neither. Furthermore, trauma-exposed individuals with an admixed psychopathological phenotype show a higher daily emotional stress reactivity.
Conclusion Childhood trauma increases the likelihood of a specific admixture of affective, anxiety and psychotic symptoms cutting across traditional diagnostic boundaries. Stratifying according to childhood trauma exposure thus identifies an admixed phenotype, possibly induced by continuous daily life stress reactivity, that has important clinical relevance. Identification of functionally meaningful aetiological subgroups may aid clinical practice.
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Suicidology in the 21st century

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Information and communication technologies for the follow-up of patients

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Clinical assessment in psychiatry is mostly based on brief, regularly scheduled face-to-face appointments. Although crucial, this approach reduces assessment to cross-sectional observations that often miss critical information about course of disease and risk assessment. Clinicians in-turn make all medical decisions based on this inevitably limited information. We discuss recent technological developments in terms of assessment and information triangulation, analysis of longitudinal data, approaches to enhance medical decision-making and improve communication between patients, caregivers and clinicians.
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A neurosciences based – semiology of suicidal behavior

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The epidemiology, risk factors and biological basis of suicidal behaviors have been the object of an ever-increasing research in the last three decades. During this period, researchers all over the world have identified potential biomarkers of risk and developed several theories about the mechanisms leading to suicidal behavior. However, the lack of common terminology, instruments and cooperation has been a major deterrent. Today, the community has established the bases for this collaboration and evidence coming from neuroscientific studies can already be applied to the field of suicidology. We present here a potential semiology based on current evidence coming from biological, clinical and neuroimaging studies. Besides suicidal ideation and warning signs, the clinical features related to suicide risk and revealed by neuroscientific studies include notably: impulsive-aggression and hopelessness as well as high web consumption, sedentary behaviors and reduced sleep time, an enhanced sensibility to social exclusion and loneliness, a decreased sensitivity to detect social support, interpersonal problems related to decision-making impairments, difficulties to regulate negative emotional states, a propensity to perceive psychic and also physical pain and to receive opiates treatments. Improving the assessment will also open new targets for suicide prevention. In the short-term, some of these targets await us: standard protocols for evaluation of risk, healthcare continuity, implication of the family/caregivers, mitigation of social or psychological pain.
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Follow-up and chain of care in the prevention of suicide recurrence

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Suicide constitutes one of the most important problems in global public health. However, assessment as well as corresponding verification of suicide risk, either in case histories or clinical reports, is handled poorly in several clinical settings. Aspects as important as the existence of a personal history of suicidal tendencies are frequently omitted, despite this being one of the risk factors that most clearly predict the possibility of a complete suicide in the future. During this presentation, I would like to refer specific interventions in at-risk populations, with special emphasis on individuals who have made previous suicide attempts. Suicidal behaviour is a very complex phenomenon, making a specific treatment for it difficult to produce. Consequently, when the most appropriate therapeutic approach for an at-risk population is raised, the following fact is mentioned: in approximately 90% of suicide cases, there is an underlying psychiatric disorder. This makes psychopharmacological treatment of the base pathology the most adequate. Still