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Supplementary Material

Article Title: Relationship Between Sporadic Behavioral Variant Frontotemporal Dementia and Primary Psychiatric Disorders: A Study in Families

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Disclaimer

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Appendix 1. Questionnaire QFTD-NL 1.0

Instruction manual QFTD-NL 1.0

Questionnaire QFTD-NL 1.0 – Drawn up December 2012, supplemented January 2015, translated in English October 2019

- Interviewer should at least have a Bachelor's degree in Medicine or a related field
- Interviewer received a short practical instruction of carrying out questionnaire QFTD-NL 1.0 by a psychiatrist
- Interviewer has read the general instruction manual of the *M.I.N.I. Plus International Neuropsychiatric Interview Dutch version 5.0.0. (2000)* including questionnaires for the following disorders: depression, bipolar disorder, psychotic disorders, ADHD, alcohol, drug and substance use
- Questionnaire QFTD-NL 1.0 can be carried out real-life or by phone. In case of a cognitive stable participant questions can be asked to the participant directly. In case of a cognitive unhealthy participant questions should be asked to a relative who knows the medical and family history of the participant. Answers to the questions should be written down by the interviewer on a form.
- Part C should not be filled out in the case a participant scores negative on part B; or in the case of a cognitive healthy subject also positive on part A.
- In the case part C is filled out, a family tree should always be drawn or be described for all questioned disorders

Screening questionnaire healthy control subject PART A

Code number _____

Name participant: _____ 0 Male 0 Female

Date of birth ____/____/____ Date of interview ____/____/____

Name researcher: _____

1. Have you ever been treated by a psychologist or psychiatrist, and if so, why?

2. Have you ever visited your general practitioner with complaints of mental illness, and if so, why?

3. Are you or were you addicted to a substance use or action. And if so, did you or your environment experience a negative influence of this use/action? Please explain.

4. Have you ever been treated by a neurologist, and if so, why?

5. Does your environment notice that your behavior changed recently? If so, please explain

6. Mapping subjective complaints

- Do you experience memory complaints? yes/no
- If so, which complaints do you experience?

- Is your memory deteriorated compared to the past? yes/no
- If so, how do you notice it?

- Is your memory worse than your peers? yes/no
- Do you worry about your memory? yes/no

7. Do you know all your (biological) first-degree family members? If not, please specify.

8. Is a close family member possibly diagnosed with frontotemporal dementia? If so, how are you related to him/her?

QUESTIONNAIRE bvFTD (QFTD-NL 1.0) PART B

(to be filled out by researcher)

Code number _____

Name participant: _____ ☐ Male ☐ Female

Date of birth ____/____/____ Date of interview ____/____/____

Name researcher: _____

1. Participant agreed to use encoded data, obtained by this questionnaire, for scientific research

☐ Yes ☐ No

2. To which patient group does the participant belong?

☐ 1. Behavioral variant Frontotemporal Dementia

☐ 2. Alzheimer's disease

☐ 3. Healthy control subjects

☐ 4. Bipolar disorder

3. Participant meets inclusion criteria for respective patient group as can be read in the article of Icho et al. (2019)

☐ Yes ☐ No

4. Participant does not meet one or more of the exclusion criteria for respective patient group as can be read in the article of Icho et al. (2019)

☐ Yes ☐ No

5. Questionnaire was answered by (a well-known of) the participant, depending on the patient group

☐ Yes ☐ No

QUESTIONNAIRE bvFTD (QFTD-NL 1.0) PART C

(to be filled out by researcher)

Code number _____
Name participant: _____ 0 Male 0 Female
Date of birth ____/____/____ Date of interview ____/____/____
Name researcher: _____

5. What is your cultural origin?

- ☐ 1. The Netherlands
☐ 2. Surinam or the Nederland's Antilles
☐ 3. Turkey
☐ 4. Morocco
☐ 5. Asia
☐ 6. Other: _____

6. What is your current marital status?

- ☐ 1. Married or cohabitants
☐ 2. Living apart together
☐ 3. Single
☐ 4. Divorced
☐ 5. Widow(er)

7. What is your highest completed education?

- ☐ 1. Less than primary school
☐ 2. Primary school completed
☐ 3. Primary school and further education less than 2 years
☐ 4. Less than general secondary education (MAVO), for example LTS, LEAO, LHNO
☐ 5. General secondary education, for example MULO/MAVO/MEAO
☐ 6. Higher secondary education, for example HAVO/VWO/HEAO/HBS/HBO
☐ 7. University degree

8. Do you smoke?

☐ Yes ☐ No ☐ Ceased

☐ Cigarettes ☐ Cigars ☐ Pipe

If yes/ceased: amount _____ /day, during _____ years = _____ packyears

9. Do you drink alcohol?

If yes/ceased: amount units/week, during years

(for example. benzodiazepines of barbiturates)

11. Have you ever used cannabis (marihuana or hasj)?

12. Have you ever used other recreational drugs?

Note: Multiple answer possibilities

0 1. Stimulants (for example Amphetamines, Ritalin®)

0 2. Opiates (for example Heroine, codeine, methadon)

0 3. Cocaine

0 4. Hallucinogens (for example LSD, mescaline, mushrooms)

0 5. Other (i.e.)

13. Have you ever been exposed to chemical substances (i.e. during work/recreational)

Including: asbestos, ammoniac, petroleum, acetone, paint, chlorin, radioactive substances

If yes:	name	amount	years
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name	amount	years
------	--------	-------

name	amount	years
------	--------	-------

14. Do you experience thyroid problems?

If yes: hypothyroidism / hyperthyroidism (score out what does not apply)

Medication use: 0 Yes 0 No

If yes, name and dose

15. Are you familiar with cardiovascular disease?

Note: Multiple answers possible

1. Hypertension 0 Yes 0 No

2. Diabetes mellitus 0 Yes 0 No If yes: Type:

3. Hypercholesterolemia 0 Yes 0 No

4. Myocardial infarction 0 Yes 0 No

16. Have you ever had a head trauma in the past?

If yes: Amnesia 0 Yes 0 No 0 Don't know

Loss of consciousness 0 Yes 0 No 0 Don't know

17. Have you ever performed a sport associated with head trauma?

Note: More possible answers

☐ Yes ☐ No

☐ 1. Boxing

☐ 2. Football

☐ 3. Else (namely) _____

Couple of years _____ , frequency _____ /week

NOTE: The following questions should be answered for each family member, also in the case of no/don't know or not applicable

In the case of possible/ certainly, please explain in the family tree, please also report age of origin and duration of disease (part D)

18. How many siblings do you have (including deceased ones)?

Brothers: _____

Sisters: _____

19. How many children do you have (including deceased ones)?

Children: _____

20. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of FRONTOTEMPORAL DEMENTIA?

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of a DEPRESSION? *(no bipolar disorder, so no past history of a (hypo)mania; M.I.N.I. Plus p. 9-15)*

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of a BIPOLAR DISORDER? *(so with a past history of a (hypo)mania combined with a depression; M.I.N.I. Plus p. 17-20)*

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of PSYCHOSES? (so with a past history of episodes with delusions or hallucinations; M.I.N.I. Plus p. 41-47)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of SUICIDE and/or a SEVERE SUICIDE ATTEMPT? (medical help is needed in the last case)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of a AUTISM SPECTRUM DISORDER? (autism, Asperger syndrome, PDD-NOS)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of ADHD? (M.I.N.I. Plus p. 63-66)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of ALCOHOLISM? (M.I.N.I. Plus p. 33-36)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of DRUG OR SUBSTANCE ABUSE? (M.I.N.I. Plus p. 37-39)

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Do you have a close family member (grandparents, parents, siblings or children) with a medical history of MOVEMENT DISORDERS? (Parkinson's disease, ALS, Corticobasaal degeneration (CBD), progressive supranuclear palsy (PSP))

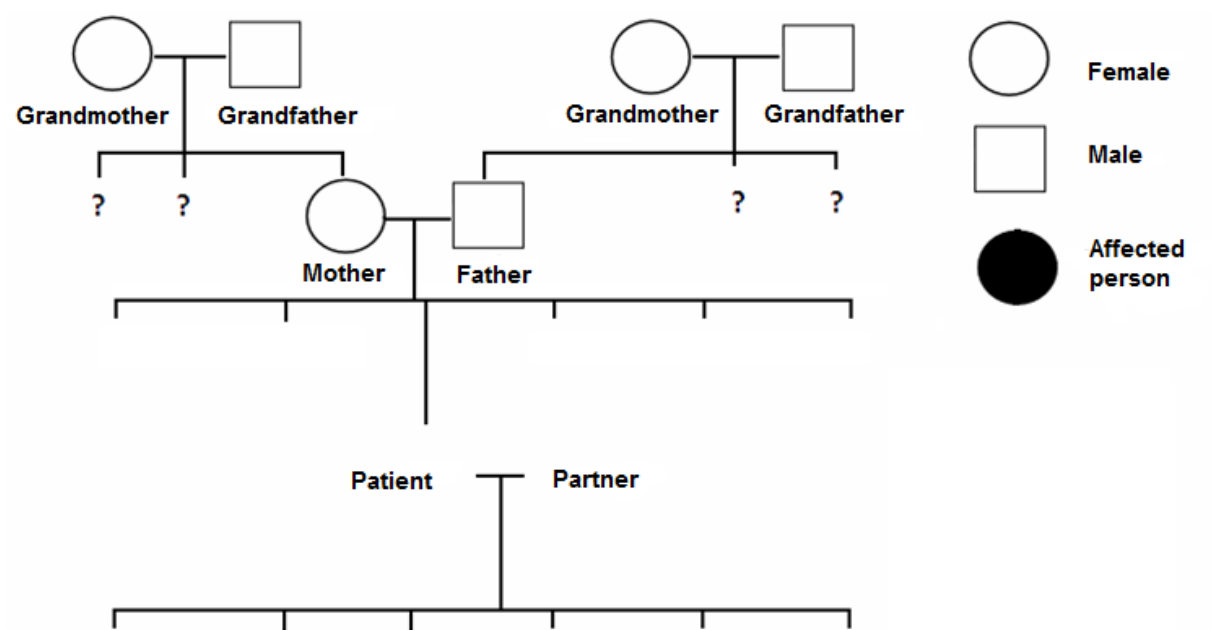
	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. (Only for patients with bvFTD) Do you have a close family member (grandparents, parents, siblings or children) with a medical history of Alzheimer's disease?

	NO	POSSIBLE	DIAGNOSED	UNKNOWN	INAPPLICABLE
a. Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Grandmother maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Grandfather maternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Grandmother paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Grandfather paternal side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for taking part

PART D: Family tree *



**(Please register siblings and/or children if present)*

NOTES:

FRONTOTEMPORAL DEMENTIA _____

DEPRESSION _____

BIPOLAR DISORDER _____

PSYCHOSES _____

SUICIDE OR SEVERE SUICIDE ATTEMPT _____

AUTISM SPECTRUM DISORDER _____

ADHD _____

ALCOHOLISM _____

DRUG OR SUBSTANCE ABUSE _____

MOVEMENT DISORDERS _____

OTHER REMARKS _____

Supplementary table 1 Prevalence of occurrence of PPD in first-degree family members of bvFTD, HC, AD and BD.

	bvFTD	HC	AD	BD
Depression	14/72	10/101	26/108	38/124
Psychosis	6/73	4/101	6/107	16/122
Bipolar disorder	2/72	3/101	4/107	33/124
Autism spectrum disorder	5/73	4/101	1/107	2/44

Supplementary table 2 Odds ratios (OR), 95% confidence interval (95%CI), Nagelkerke pseudo R square and p-values for the association between study groups compared to healthy control subjects and PPD in first-degree family members. Unadjusted models without correction for confounders and adjusted models corrected for age and education level are displayed. Significant effects are bold displayed.

	<i>Unadjusted model</i>				<i>Adjusted model</i>			
	Odds Ratio	95%CI	R²	p-value	Odds Ratio	95%CI	R²	p-value
Depression								
bvFTD	2.20	[0.92-5.27]	0.033	0.08	2.58	[1.03-6.46]	0.045	0.04
AD	2.89	[1.31-6.35]	0.059	<0.01	2.95	[1.26-6.88]	0.060	0.01
BD	4.02	[1.89-8.57]	0.101	<0.01	4.07	[1.83-9.02]	0.113	<0.01
Psychosis								
bvFTD	<u>2.17</u>	[0.59-7.99]	0.022	0.24	3.26	[0.84-12.56]	0.086	0.09
AD	<u>1.44</u>	[0.39-5.26]	0.005	0.58	1.54	[0.37-6.38]	0.010	0.55
BD	3.66	[1.18-11.33]	0.060	0.02	5.33	[1.58-17.34]	0.120	<0.01
Bipolar disorders								
bvFTD	0.93	[0.15-5.73]	<0.001	0.94	1.62	[0.26-10.20]	0.124	0.60
AD	1.27	[0.28-5.81]	0.002	0.76	1.10	[0.20-5.89]	0.013	0.92
BD	11.85	[3.51-39.96]	0.194	<0.01	13.58	[3.85-47.84]	0.200	<0.01
Autism Spectrum Disorders								
bvFTD	1.78	[0.46-6.88]	0.012	0.40	1.41	[0.34-5.90]	0.080	0.64
AD	0.23	[0.03-2.08]	0.051	0.19	0.21	[0.18-2.28]	0.084	0.20
BD	1.16	[0.20-6.55]	0.001	0.87	1.46	[0.24-9.10]	0.024	0.68