ing countries. Operational well accepted definitions of depression are now available and epidemiological studies showed that only cardiac surgery was more disabling than depression. In addition, a high treatment and health care consumption is found in depressed patients as well as a high suicidal rate (18–25% lifetime) and an increased mortality for the associated physical conditions. Effective treatments of depressive states do exist.

It is therefore paradoxical that most studies showed low detection rates of depressed patients by their GP, from 50% down to 14% in the study of Moffic and Paykel. We studied the factors influencing the identification by their GP of depressed patients in a sample of 2096 patients included in the PPGHC World Health Organisation study.

GPs identified 2% depressed and 12% anxious patients while the CIDI, based on ICD-10 criteria, identified 8.7% Depressive episode and 6% Anxiety disorders. 5.7% of additional patients were reaching criteria for both disorders. 61% of depressed were identified as psychological cases, 17% as depressed, 28% as mixed anxiety depression states. However the latest were treated with anxiolytics.

The factors helping for identification were the symptomatic severity, the importance of social disability, the presence of a stressing event "explaining" depression. Some factors obscured the picture: the absence of spontaneous psychological complaints by the patient is a major factor, the existence of a physical diagnosis, belonging to the 18–24 years age class, the absence of "good reasons" to be depressed.

If a diagnosis of depression is suspected then a good knowledge of diagnostic criteria may improve diagnosis, however many factors inducing a low identification appear to obscure the picture before the existence of a possible depressive state is suspected.

PSYCHOTROPIC DRUG PRESCRIPTION IN PRIMARY CARE

M. Linden, Y. Lecrubier, C. Bellantuono, O. Benkert, S. Kisley, G. Simon. *Department of Psychiatry, Free University of Berlin, Eschenallee 3, D 14050 Berlin, Germany*

Psychiatric disorders are common in patients of general practitioners. Psychotropic drugs are one important mode of treatment and are prescribed frequently. The available drugs all have more than one efficacy dimension and can therefore be used in different disorders. On the other hand, there are always several treatment options in one particular illness. This leaves some freedom to therapists to tailor their own treatment strategy under the influence of personal experiences, patient preferences, or characteristics of the health care system. As a result, it has repeatedly been shown, that there are large differences in prescription rates between different physicians but also between different regions. It is therefore highly interesting to study international prescription modes, in order to learn more bout the scope and determinants of psychotropic drug prescription especially in the primary care field.

In an international study of WHO in 12 centers around the world type and frequency of mental disorders in primary care patients were assessed by standardized interviews. Additionally general practitioners were asked about their drug treatment of those patients, which they had recognized as suffering from psychological disorders.

Results show that general practitioners prescribe the whole spectrum of psychotropic drugs with a share of about 20% each for anxiolytics, hypnotics and antidepressants. 11.5% of all practice attenders or 51.7% of the recognised cases get at least one prescription from the general practitioner because of a psychological problem. Prescription is depending on the prominence of psychological features in the presenting complaints and the severity of the disorder. Diagnostic classes have a moderate influence on prescription. Finally prescriptions are also depending on social variables as age or gender and the center or country.

S25. Gender differences in mental health

Chairmen: M Kastrup, K Mann

SEX DIFFERENCES IN SCHIZOPHRENIA

H. Häfner. *Central Institute of Mental Health, J 5, D-68159 Mannheim (Germany)*

Sex differences in schizophrenia have been described at various levels, with respect to genetic load, brain development, pre- and perinatal brain damage, endocrine factors, age and type of onset, symptomatology, course and outcome as well as therapy responsiveness. With the exception of a 3 to 4 years higher age of onset in women the results were not conclusive, but indicated a poorer tendency for men. To ensure valid results, male-female comparisons must be conducted based on epidemiological samples with the same stages of illness by taking age into account.

In the ABC schizophrenia study a representative sample of 232 first-episode cases were assessed. For women, showing the 3 to 4 years higher mean age at onset, a second peak of onsets in the age group 45 to 50 years emerged. After animal experiments and a controlled clinical study the finding was explained by a protective effect of estrogen persisting until menopause. Late-onset schizophrenias, developed after menopause, were more frequent and more severe among women. Due to lacking protection by estrogen men fell ill more frequently and more severely at young age and less frequently and more mildly later in life. The social standing of women — employment and marriage — at onset was more favourable than that of men, resulting in a more favourable early social course. With increasing length of illness the differences disappeared.

The disease variables, type of onset and core symptoms, in the prodromal phase and first psychotic episode did not differ between the sexes. The illness behaviour of young men was characterized by a highly significant excess of socially negative behaviour with an unfavourable impact on early course. Women and older men showed a better social adjustment. No evidence emerged for natural subtypes of schizophrenia at the epidemiological level, even if genetic and morphological findings were considered.

The symptomatology and course of schizophrenia can obviously not be explained by the biological disease process alone. They seem to be governed by a complex pattern of interaction between biological disease variables, age- and sex-related determinants of cognitive and social development and endocrine and behavioural factors.

AN EPIDEMIOLOGICAL PERSPECTIVE ON GENDER AND MENTAL HEALTH

M. Kastrup. *Psychiatric Dept., Hvidovre Hospital, Broendbyoestervej 160, DK-2650, Hvidovre, Denmark*

Summary: Population surveys have shown that women are more likely to complain of psychological problems and to seek help to alleviate these conditions. Women show in most surveys a higher psychiatric morbidity than men and the female excess is related to a preponderance of women with anxiety and depressive disorders, but also phobias and symptoms pertaining to somatic areas, while men tend to have personality disorders and problems of abuse and anti-social conduct.

Particular attention is paid to gender aspects related to schizophrenia and depression in terms of manifestations, treatment and outcome.

Biological, pharmacological, psychological and sociodemographic

https://doi.org/10.1016/0924-9338(96)88499-9 Published online by Cambridge University Press

facets of the gender differences are discussed and the latest trends in morbidity patterns elucidated.

SEX DIFFERENCES IN ALCOHOLISM

Karl Mann, Klaus Ackermann, Martin Jung, Götz Mundle. *Dept. of Psychiatry, Addiction Research Center, University of Tuebingen, Osianderstrasse 22, 72076 Tuebingen, Germany*

Female alcoholics differ from their male counterparts in various ways. Identical doses of ethanol per body weight produce higher blood ethanol concentrations. Brain shrinkage and cognitive performance are comparable between both sexes, despite significantly shorter ethanol expositions in the females (Acker 1986; Jacobson 1986; Mann et al., 1992 and 1995).

The hypotheses of our current study were: female alcoholics exhibit a higher degree of comorbidity, more psychiatric symptoms (i.e. anxiety, depressiveness, general complaints), and poorer treatment outcome than males.

We investigated a hospital based sample of alcoholics (57 females and 62 males) who participated in a six-week inpatient treatment programme followed by one year of weekly outpatient group sessions. The Composite International Diagnostic Interview (CIDI), self-rating questionnaires (BDI, SDAQ, FPI) and the Institute's Clinical Interview were administered.

Female and male patients did not differ with respect to age, education, severity of dependence (SADQ) and alcohol intake in the year prior to admission. Females had a shorter duration of dependence and a shorter history of somatic and social complaints. In spite of shorter periods of heavy drinking, more females exhibited signs of CNS impairment. Women showed a higher 6-month-prevalence of comorbid psychiatric disorders (55% vs 29%), they were more likely to suffer from anxiety or affective or additional addictive disorders. They reported more body complaints as well as higher impulsiveness (FPI). Depressiveness (BDI) tended to be higher. Adverse social consequences of alcoholism was higher in men, however. Six months after inpatient treatment more women had relapsed. At a global level comorbidity was not related to treatment outcome.

SOCIOCULTURAL FACTORS AND GENDER DIFFERENCES ON MENTAL HEALTH

J.L. Vázquez-Barquero, A. de Santiago, L. Gaite, S. Herrera. *Social Psychiatry Research Unit of Cantabria, University Hospital "Marqués de Valdecilla" Av. Valdecilla s/n, 39008 Santander, Spain*

Epidemiological research carried out in the past 20 years has shown unequivocally the existence of marked gender differences on mental health. These differences, however, do not only apply to the general morbidity figures of psychiatric illness and to diagnostic differences in morbidity, but also to the way in which socio-demographic factors are associated to these differences. Thus, for example factors such as marital status, the presence of young children in the home, employment and educational status, which appear to impose specific social roles in either sex, are held responsible for the ways in which men and women manifest their psychological distress and for the strategies they adopt to satisfy their need for psychiatric care.

The specific object of this presentation will be to outline, using data from recent epidemiological studies: i) the presence of gender differences in mental illness at the syndromic and diagnostic level and the way in which these differences may be, at least partially, conditioned by the methodological characteristics of the studies; and, ii) the ways in which socio-cultural factor appear to be associated to sex differences on psychiatric morbidity and on the utilisation of mental health resources. The ultimate aim is to identify risk factors on which the development of preventive action programmes can be based.

S26. Defeat depression: a European perspective

Chairmen: D Baldwin, B Deakin

THE DEFEAT DEPRESSION CAMPAIGN: INTERIM RESULTS AND FUTURE DIRECTIONS

David S. Baldwin.

The United Kingdom Defeat Depression Campaign was launched in January 1992. Organised by The Royal College of Psychiatrists, in association with The Royal College of General Practitioners, the Campaign is a five-year initiative which aims both to increase the knowledge of health care professionals in the recognition and treatment of depressive illness and to enhance public awareness of the nature, course and treatment of depressive disorders.

This presentation outlines the reasons for launching the Defeat Depression Campaign and describes its principal messages and objectives in professional training and public education. A discussion of the activities of the campaign will be followed by a description of the findings of recent investigations of its effectiveness. The presentation will conclude with some thought relating to future initiatives in defeating depression.

DEPRES (DEPRESSION PATIENT RESEARCH IN EUROPEAN SOCIETY): THE PATIENTS' PERSPECTIVE OF DEPRESSION

A. Tylee on behalf of the DEPRES Steering Committee. *St. George's Hospital Medical School, London, UK*

DEPRES is a survey of depression in the community conducted in two phases across six countries: Belgium, France, Germany, Netherlands, Spain and the UK. DEPRES 1 assessed the 6-month prevalence of depression in 78,463 subjects using the depression section of the MINI (Mini-International Neuropsychiatric Interview); the proportion of depressed subjects who consult a physician and whether they are prescribed drug therapy; and the impairment associated with depression.

In DEPRES 2, interviews were conducted with 1884 depressed patients, identified by the MINI, who had consulted a healthcare professional about their symptoms during the previous 6 months. The 6-month prevalence of major depression was 6.9% (females 8.7%; males 5.0%). Only 57% of depressed subjects had consulted a medical specialist; 31% were prescribed drug therapy, antidepressant drugs accounting for 25 % of medication. Most healthcare visits were made by subjects with major depression (4.4 over 6 months vs 1.5 for subjects without depression). Consistent with other epidemiological surveys, the DEPRES study shows that depression is prevalent in the community and affects twice as many females as males. More than 40% of sufferers fail to seek medical advice and the impairment associated with depression, as measured by the days of work lost, increases with the severity of the symptoms. The results suggest the need for educational programmes directed at subjects in the community as well as physicians, to encourage effective prevention and treatment of depressive illness.

https://doi.org/10.1016/0924-9338(96)88499-9 Published online by Cambridge University Press