

of the problem in many European countries and directly created a network of researchers and suicide research centres. The knowledge of risk groups was also increased. In some countries, in the context of the study, suicide prevention programmes for the whole country or specific groups were introduced, or suicide was acknowledged by the governments as a major health problem. Due to the benefits of these fall downs, the study is now expanding in more countries (Eastern and Southern countries as well as in some countries in other parts of the world).

S10-5

SUICIDE PREVENTION — AN ISSUE FOR THE WORLD BANK

R. Jenkins. *WHO Collaborating Centre, Institute of Psychiatry, London, UK*

This talk will present the burden of suicide in different regions of the World, the methodological problems of national suicide data collection, and the contribution of epidemiological suicide research to national policies for suicide prevention.

S10-6

IDENTIFYING AND TREATING DEPRESSION IN OLDER ADULTS: A KEY ISSUE IN SUICIDE PREVENTION

D. De Leo*, P. Scocco. *WHO Collaborating Centre for Suicide Prevention, Dept. Neurological and Psychiatric Sciences, University of Padua, Italy*

Data deriving from the WHO/EURO Multicentre Study on Parasuicide, for the period 1989–1993, indicate that depressive disorders are the most frequent diagnoses in non-fatal suicidal behaviour. In the elderly in particular, they represent the large majority of psychiatric diagnoses (those routinely performed). The study shows how their percentage rises through age-groups, whilst diagnoses such as personality disorders are most relevant in younger subjects and very infrequent in old age. Considering that the suicide/attempted suicide ratio in the European study in the elderly is 1:2 (almost 1:1 in men), correct identification and proper treatment of depressive disorders appears to be at the forefront of any preventive strategy in this age group. Better education of general practitioners in this field also appears to be an absolute priority.

SEC11. Antecedents and early course of functional psychoses

Chairs: H Häfner (D), AH Mann (UK)

SEC11-1

EARLY ANTECEDENTS OF FUNCTIONAL PSYCHOSES

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Developmental precursors of schizophrenia suggest models of causes, mechanisms and preventive strategies. Specificity to sub-groups of patients, or to schizophrenia itself amongst the psychoses is fundamental to such models. Developmental precursors of a

range of adult psychiatric were studied in two longitudinal samples: the British 1946 (n = 5362), and the North Finland 1966 (n = 12058) birth cohorts. Motor and speech milestones, were later in children (n = 30 & 89, respectively) who developed DSM-III-R schizophrenia as adults. In the former, IQ at 8, 11 and 15 years was lower in these children by some 33% of a standard deviation. In the British cohort, these findings were also evident in 195 cases of childhood affective disturbance; most effects were more modest than in schizophrenia but the pattern was similar. The effects for IQ occurred across the whole population, the lower the IQ, the higher the subsequent risk of both disorders. In the Finnish cohort, motor effects were also seen in other DSM-III-R psychoses, neither were they confined to sub-groups. These overt effects are crude manifestations of underlying neural mechanisms which may differ in different disorders. Unknown factors, and/or gender, may determine outcome. Low specificity is an advantage for prevention strategies.

SEC11-2

THE EARLY COURSE OF SCHIZOPHRENIA FROM ONSET UNTIL FIRST ADMISSION

H. Häfner, K. Maurer*. *Central Institute of Mental Health, Mannheim, Germany*

Within the Mannheim ABC (age, beginning, course) study we analysed the development of schizophrenia in 232 first-episode cases with a broad schizophrenia diagnosis from onset until first hospital admission. Dates of onset and pattern of course (once, recurrent, continuous) have been assessed for 66 non-specific, negative and positive symptoms by our standardised interview IRAOS.

In 3/4 of our sample schizophrenia began with a prodromal phase, lasting on average 5 years, but only in 7% it began directly with the manifestation of psychotic symptoms. 57% of the sample reported social disabilities during the early course, starting on average about 1 to 3 years before the first psychotic symptom, and 2 to 4 years prior to the first hospitalisation. The earliest positive symptoms were delusions of reference (52%), delusions of persecution (41%), and further delusions (39%). But among the 10 earliest symptoms, no positive symptom was identified. We found that schizophrenia most often begins with non-specific symptoms like tension (19%), depression (19%), anxiety (18%) and the negative symptom of impaired thinking/concentration (16%). Therefore, on average, the development of schizophrenia follows a characteristic sequence of depressive, dysphoric, and negative symptoms, and social disabilities, before the psychotic stage is reached.

Our study demonstrates a long, mostly untreated phase of early schizophrenia. As we know, that the duration of the untreated period is a predictor of an unfavorable course, early identification and early treatment is of increasing importance for schizophrenia research and clinical practice. As schizophrenia can be diagnosed only after the emergence of psychotic symptoms, early treatment has to avoid false positives, and therefore must be syndrome-related, e.g. specific for negative and depressive symptoms. Additionally, the early use of psychosocial techniques for the management of social disabilities and role deficits also is indicated.