S16-4

PSYCHOPHARMACOEPIDEMIOLOGY IN ICELAND: THE SHIFT OF PRESCRIPTIONS TOWARD ANTIDEPRESSANTS

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Introduction: The registered total sales of psychopharmaca has waxed and waned during the last quarter of a century with peaks in 1975 and 1997. The sale of antidepressants has been greater in Iceland than in any other of the Nordic countries. The purpose of the presentation is to show the increase in the use of antidepressants and how these have to some extent replaced anxiolytics.

Material: Official sale figures in Iceland for the period 1975–1997 and prescriptions to outpatients in Reykjavik during one month in 1984, 1989, and 1993.

Results: The aggregate sales of antidepressants and anxiolytics was similar in 1975 and 1997, 62 and 68 Daily Defined Doses (DDD)/1000 inhabitants, respectively. In 1975 antidepressants accounted for only 13%, while in 1997 they accounted for 65% or 45 DDD/1000 which is a threefold increase from 1993. The combined one-month prescription prevalence for these two groups of drugs was similar in 1984 and 1993. In the latter year the prevalence of antidepressant prescriptions was almost double that in the former, while the prevalence of anxiolytic prescriptions had decreased correspondingly.

Discussion: The sale of antidepressants has reached the prevalence of depressive disorders, but the sale of anxiolytics has decreased. The difference in the age distribution of patients receiving prescriptions for antidepressants and that of patients with depressive disorders calls for further studies.

S16-5

WHO IS TREATED, NON TREATED AND/OR OVER TREATED IN PRIMARY CARE?

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Two epidemiological studies conducted in primary care explored the recognition of and treatment offered to depressed patients. The first (1991, 1992) was organised in the Paris region as part of the PPGHC WHO study and recruited 2096 consecutive patients among whom 405 were selected for a second stage large interview and followed up for 1 year. The second referred to as DEPMG (1996–1997) included 2415 consecutive patients presenting to a random sample of GPs over 5 different French regions. Among those all patients with at least some depressive complaints and a subsample of non-psychiatric patients were fully described, the follow up was 6 months. In both studies, information was obtained from the GP (diagnosis, severity and treatment), from the patient (self-assessment, severity, disability, personality questionnaires, and treatment consumed, economic evaluation) and from a specialised interviewer (diagnostic structured interview: CIDI or MINI, severity, disability). Results were strikingly similar in the two samples. Major depression (MDD) prevalence was present in more than 10% of consecutive patients. Minor depression was less frequent (3%) as well as dysthymia (2%). Recurrent brief depression (RBD) was highly disabling even when the condition was "pure".

In both studies, GPs recognised about 60% of MDD patients as having a psychiatric problem, in the first study conducted in 1992, only 15% were identified as depressed, in the second study (1996–1997) this proportion increased to 30% for "depression" plus 10% for "depressive symptoms". Dysthymics and RBD were recognised as frequently as MDD (20 and 25%). On the contrary, only 5% of patients with minor depression were considered depressive. Prescriptions are much lower than recognition but show parallel figures. Among the 15%, recognised as depressed in the PPGHC study 43% had an antidepressant. In the DEPMG study, when the GP thought the patient depressed, anxious or had no diagnosis, the prescription rates were 34, 16 and 8%. Interestingly, if the MINI was used, MDD prescription was 20%, minor depression 17% and non depressed 4%. The new trends for recognition and prescription will be discussed as well as the **low proportion** of non depressed treated still ending with **large numbers** of prescription out of the depressive spectrum.

S17. Modern concepts of sleep disorders

Chairs: E Rüther (D), N Stanley (UK)

No abstracts received.

SEC18. Changing concepts in psychiatry

Chairs: N Retterstøl (N), E Lungershausen (D)

SEC18-1

REACTIVE PSYCHOSES — A VALID DIAGNOSTIC CATEGORY AFTER ALL

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The ICD-9 category of reactive psychoses (298) has been deleted in ICD-10, and DSM-IV also has deleted "reactive" as a descriptive term in the classification of psychoses. Scandinavian psychiatry has regretted these changes since the validity and reliability of reactive psychoses are quite good.

Face validity from around the world is well documented. There are many clinical descriptions of psychoses that start in close temporal connection with a well-defined psychosocial stressors.

Descriptive validity is shown by the fact that the well-defined psychosocial stressor, the close temporal relationship, and the psychological meaning of the psychotic reaction distinguish reactive psychoses from schizophrenic, paranoid, and affective psychoses.

Procedural validity issupported by the fact hat interrater reliability of reactive psychoses is just as high as that reached for schizophrenia and affective psychoses. A "reactivity of psychoses rating form" has been developed, and the form has shown good psychometric properties.

The predictive validity of reactive psychoses is shown by the of good outcome, the short duration, and the limited need of treatment with neuroleptic drugs. Follow-up studies show that a small proportion of reactive psychoses develop into other functional psychoses.

As to construct validity, Danish and Norwegian studies have demonstrated family aggregation of reactive psychoses, but twin studies have been to few and with small samples.

Further work on construct validity is obviously needed.

In sum, the validity and reliability demonstrated on reactive psychoses did not warrant the deletion of this diagnostic category from the current psychiatric classifications.

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