

changed the risk setting. The aim of this study was to estimate the cases of suicide of schizophrenics between 1990/2000 in the Psychiatric Service of Varese.

**Method:** a retrospective analysis about patients with schizophrenia spectrum disorders dead from suicide was carried out. Sociodemographic information (sex, age, school level, marital status, employment situation) and some aspects of illness (family history of affective disorders, illness duration, previous admissions and self-injuries, psychopathological condition) were evaluated.

**Results:** schizophrenic patients dead from suicide in contact with the service were 18 (M/F 12/6); that is approximately 2 suicides/year (1.7 events/100.000 inhabitants, 5.3 events/100 treated patients). Data confirm this high risk profile: young men, who commits suicide in the year after the last discharge and in any case in the first 10 years of illness, suffers from a paranoid form, has poor compliance, family history of psychiatric pathology, and previous suicide attempts.

**Conclusions:** findings emphasise the importance of monitoring trends in schizophrenic mortality from suicide for corrective strategies. Several prevention measures must be made to improve compliance and prevent loss of contact.

### P18.05

12-month prevalence of panic disorder in the Swedish general population

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**Objective:** The present study examined the prevalence of panic disorder with or without agoraphobia according to DSM-IV criteria in the Swedish general population.

**Method:** Data were obtained by means of a postal survey administrated to 1000 randomly selected adults. The panic disorder module of the World Health Organization's Composite International Diagnostic Interview (CIDI) was included in the survey.

**Results:** 12-month prevalence was estimated at 2.2% (CI 95% 1.02–3.38%). There was a significant sex difference, with a greater prevalence for women (5.6%) compared to men (1.0%).

**Conclusion:** The Swedish panic disorder prevalence is relatively consistent with findings in most other parts of the western world.

### P18.06

Suicide risk in relation to socioeconomic, demographic, psychiatric and familial factors

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**Objective:** To address suicide risk in relation to the joint impact of factors regarding family structure, socioeconomics, demographics, mental illness and family history as well as gender differences in risk factors.

**Method:** Data was based on 4 Danish longitudinal registers. Subjects were all 21,169 suicides in 1981–1997 and 423,128 controls matched for age, gender and calendar time using a nested case-control design. The effect of risk factors was estimated through conditional logistic regression, gender interaction was examined using the likelihood ratio test, the population attributable risk was calculated.

**Results:** A previous psychiatric disorder leading to hospitalisation was the most important risk factor and associated with the highest attributable risk for suicide. Cohabitation, being single, unemployment, low income, retirement, disability, sickness

absence from job and a family history of suicide and/or psychiatric disorders were also significant risk factors for suicide. Moreover, significant gender differences were found in risk factors for suicide. A psychiatric disorder increased suicide risk more while having a young child reduced suicide risk more in females than in males. Unemployment and low income had stronger impacts on the risk of suicide for males. Suicide risk was increased for females but reduced for males living in urban areas. A family history of suicide increased suicide risk more in females than in males.

**Conclusions:** Suicide risk is strongly associated with mental illness, unemployment, low income, marital status, and family history of suicide. The effect of most risk factors on suicide differs between the two genders.

### P18.07

Psychiatric epidemiology and genetics

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Epidemiology studies prevalence and incidence of mental disorder and tries to connect mental illness to age, sex and social conditions. Modern epidemiology has gone from a descriptive to an analytical phase. A worrisome observation is that disorders such as alcohol and substance abuse, common depression and suicide, antisocial behaviour and bulimia have increased during the last decades, particularly in the young age group. These epidemiological changes cannot be ascribed to heredity since the gene pool does not change in such a short time span.

Genetic research, family studies, twin and adoption studies have established that Alzheimer's disease, manic depressive disorder and schizophrenia have a major genetic component. However, obviously genes also play a role in anxiety states, common depression and even posttraumatic stress disorder. Molecular biological research has shown that schizophrenia is linked to chromosome 6 and other chromosomes. Genes linked to these chromosomes provide an increased risk of schizophrenia, but cannot in themselves create illness. To complicate the matter, in several studies one has reported that schizophrenia and manic depressive illness are linked to the same chromosome.

During the last thirty years psychiatric epidemiology and genetics have prospered. In order to advance psychiatric theory we need, however, to combine the empirical facts from modern epidemiology and genetics.

### P18.08

Occupational and industrial differences in anxiety and depression

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**Objectives:** Study the relationship between level of anxiety and depression, measured by HADS (Hospital Anxiety and Depression scale), and occupation and industry (recorded according to Standard Classification of Occupations and Standard Industrial Classification). Various demographic and job characteristics will be adjusted for. Possible explanations to the findings will be discussed.

**Method:** The sample consists of the 17,384 participants of The Hordaland Health Study 1997–99 (HUSK) born 1953–57 and 1950–51 who had valid HADS scores on both anxiety and depression, and had given information on industry, occupation or both. Occupation and industry was registered and classified manually. Self-administered questionnaires includes information on level of anxiety and depression measured by HADS, demographic characteristics and various job characteristics.