

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

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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 about 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

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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

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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