culture, loss of transcultural elements, more social and especially more economical control by the insurance systems and governmental institutions.

Apart from these more global points of criticism there are some critical groups of diagnoses or single diagnoses like depressive disorders, eating disorders or some personality disorders, which are to be discussed critically, at some points in comparison to DSM-IV.

DEVELOPMENTAL ASPECTS IN THE CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS

M. Rutter. *Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, United Kingdom*

Both DSM-IV and ICD-10 have included a somewhat greater developmental perspective than their predecessors, although several unresolved issues remain. Where there is demonstrated continuity between psychiatric conditions in childhood and in adult life, the same diagnostic code is used. This applies to a substantial range of conditions, but queries remain. New categories have been provided for a few disorders that are particularly important in early childhood (eg. attachment disorders) but this constitutes an age group for which the classification remains suboptimal. The same applies to disorders associated with severe mental retardation, apart from the progress in the field of pervasive developmental disorders and of specific disorders of psychological functions (such as language). The paper considers some of the key tasks remaining with respect to developmental issues in relation to the classification of psychiatric disorders.

S24. Recognition and treatment of depressive disorders in primary care

Chairmen: Y Lecrubier, M Ackenheil

THE UTILITY OF MEASURING PLASMA LEVELS OF ANTIDEPRESSANTS IN THE TREATMENT OF AFFECTIVE DISORDERS

M. Ackenheil, H.-J. Kuss. *Department of Neurochemistry, Psychiatric Clinic of the University of Munich*

Steady state plasma levels (Css) are determined by different factors such as genetic variations in the P450 enzyme activity, gender, body habitus, smoking, food intake etc. The genotyping of eg. cytochrome CIP2D6 is associated with low or high metabolism. An additional phenotyping, e.g. dextromorphane challenge, includes additional factors.

Both, genotyping and phenotyping cannot totally predict Css plasma levels. The complexity of the interaction of the P450 and isoenzymes is not sufficiently clarified. Therefore, the measurement of plasma levels of antidepressants is necessary in therapeutic studies.

The rate of metabolism of the different antidepressants, which can vary depending on the substance and the individuum, is of therapeutic significance, because the pharmacological effects of metabolites are different as regards norepinephrine reuptake inhibitors. Furthermore, there are competitive interactions with co-medication.

With regard to the therapeutic effect, monitoring of plasma levels prevents non-compliance and side effects due to too high Css.

PSYCHIATRIC CLASSIFICATIONS AND DIAGNOSTIC INSTRUMENTS IN PRIMARY CARE SETTINGS

Patrice Boyer, E. Weiller. *INSERM, CMME, 100 rue de la Santé, 75014, Paris, France; INSERM U 302, Paris, France*

More patients with mental disorders are cared for in the primary care sector than in the mental health sector. However primary care physicians in office settings fail to diagnose and treat 50% to 75% of patients suffering of common mental illnesses. In order to facilitate the rapid and accurate diagnosis of psychiatric disorders seen by general practitioners several standardized procedures (brief diagnostic interviews) have been developed during the last years. The structures of these different instruments (MINI, Prime-MD, SDDS) are quite comparable and consist in a self administered screen questionnaire (26 items for Prime-MD, 16 items for SDDS), followed by physician administered diagnostic modules. All of these modules are ICD-10, DSM IIR or IV based. Main disorders explored are the following: Mood Disorders, Anxiety Disorders, Somatoform Disorders, Alcoholism, Eating Disorders. Mean duration of administration of these instruments is approximately 10 mn; a longitudinal tracking form is added for some of them. Validation studies and practical use of these interviews will be discussed.

THE COPRESCRIPTION OF PSYCHOTROPIC AND SOMATIC DRUGS WITH ANTIDEPRESSANTS

J. Gibert Rahola. *Dept of Neuroscience, University of Cadiz, Spain*

The coprescription of psychotropic and somatic drugs with antidepressants usually leads to clinical interactions. These interactions may account at either pharmacodynamic or pharmacokinetic levels. Pharmacodynamic interactions (the actions of the drug at the target, i.e. receptors) are possible when two or more drugs act in the same way or when two or more drugs act in different ways. The most important pharmacodynamic interactions reported with the different antidepressants are:

TCA's anticholinergics, antagonism of antihypertensive effects of guanetidine-like and clonidine-like agents, potentiation of catecholamines, MAO inhibitors, sympathomimetics, antiarrythmics and β-blockers.

MAO inhibitors: catecholamines and sympathomimetic amines, TCA's SSRI's reserpine, L-DOPA and meperidine.

SSRI: MAOI's, lithium, and L-tryptophan.

The pharmacokinetic interactions (the handling by the body and distribution to the target site: drug absorption, drug distribution and drug elimination) are more frequent and the most important are those that involve drug metabolism via the inhibition of different families of cytochrome P-450. The drugs interacting with antidepressants at drug metabolism level are amphetamines, antiarrythmics (type IC), astemizole, other antidepressants, β-blockers, benzodiazepines, carbamazepine, cimetidine, ciproheptadine, codeine, dextromethorphan, digoxin, nifedipine, pentazozine, prociclidine, phenobarbital, phenytoin, sodium valproate, terfenadine, theophyline, tolbutamide, verapamil, and warfarin.

Theoretical interactions do not mean clinical relevance but the practitioner should have special warnings with anticoagulants, antiarrythmics, antiepileptics, β-blockers, new antihistaminics, opiates, oral hypoglycemic drugs and psychotropic drugs.

THE IDENTIFICATION OF PSYCHIATRIC DISORDERS IN PRIMARY CARE

Y. Lecrubier, P. Boyer, J.P. Lépine, E. Weiller. *U 302, La Salpétrière*

The usual rate reported for depression in primary care is very high in western countries (10–20%). Similar figures were found in develop-

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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

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