

facets of the gender differences are discussed and the latest trends in morbidity patterns elucidated.

SEX DIFFERENCES IN ALCOHOLISM

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Female alcoholics differ from their male counterparts in various ways. Identical doses of ethanol per body weight produce higher blood ethanol concentrations. Brain shrinkage and cognitive performance are comparable between both sexes, despite significantly shorter ethanol expositions in the females (Acker 1986; Jacobson 1986; Mann et al., 1992 and 1995).

The hypotheses of our current study were: female alcoholics exhibit a higher degree of comorbidity, more psychiatric symptoms (i.e. anxiety, depressiveness, general complaints), and poorer treatment outcome than males.

We investigated a hospital based sample of alcoholics (57 females and 62 males) who participated in a six-week inpatient treatment programme followed by one year of weekly outpatient group sessions. The Composite International Diagnostic Interview (CIDI), self-rating questionnaires (BDI, SDAQ, FPI) and the Institute's Clinical Interview were administered.

Female and male patients did not differ with respect to age, education, severity of dependence (SADQ) and alcohol intake in the year prior to admission. Females had a shorter duration of dependence and a shorter history of somatic and social complaints. In spite of shorter periods of heavy drinking, more females exhibited signs of CNS impairment. Women showed a higher 6-month-prevalence of comorbid psychiatric disorders (55% vs 29%), they were more likely to suffer from anxiety or affective or additional addictive disorders. They reported more body complaints as well as higher impulsiveness (FPI). Depressiveness (BDI) tended to be higher. Adverse social consequences of alcoholism was higher in men, however. Six months after inpatient treatment more women had relapsed. At a global level comorbidity was not related to treatment outcome.

SOCIOCULTURAL FACTORS AND GENDER DIFFERENCES ON MENTAL HEALTH

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Epidemiological research carried out in the past 20 years has shown unequivocally the existence of marked gender differences on mental health. These differences, however, do not only apply to the general morbidity figures of psychiatric illness and to diagnostic differences in morbidity, but also to the way in which socio-demographic factors are associated to these differences. Thus, for example factors such as marital status, the presence of young children in the home, employment and educational status, which appear to impose specific social roles in either sex, are held responsible for the ways in which men and women manifest their psychological distress and for the strategies they adopt to satisfy their need for psychiatric care.

The specific object of this presentation will be to outline, using data from recent epidemiological studies: i) the presence of gender differences in mental illness at the syndromic and diagnostic level and the way in which these differences may be, at least partially, conditioned by the methodological characteristics of the studies; and, ii) the ways in which socio-cultural factor appear to be associated to sex differences on psychiatric morbidity and on the utilisation of mental health resources. The ultimate aim is to identify risk factors on which the development of preventive action programmes can be based.

S26. Defeat depression: a European perspective

Chairmen: D Baldwin, B Deakin

THE DEFEAT DEPRESSION CAMPAIGN: INTERIM RESULTS AND FUTURE DIRECTIONS

David S. Baldwin.

The United Kingdom Defeat Depression Campaign was launched in January 1992. Organised by The Royal College of Psychiatrists, in association with The Royal College of General Practitioners, the Campaign is a five-year initiative which aims both to increase the knowledge of health care professionals in the recognition and treatment of depressive illness and to enhance public awareness of the nature, course and treatment of depressive disorders.

This presentation outlines the reasons for launching the Defeat Depression Campaign and describes its principal messages and objectives in professional training and public education. A discussion of the activities of the campaign will be followed by a description of the findings of recent investigations of its effectiveness. The presentation will conclude with some thought relating to future initiatives in defeating depression.

DEPRES (DEPRESSION PATIENT RESEARCH IN EUROPEAN SOCIETY): THE PATIENTS' PERSPECTIVE OF DEPRESSION

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DEPRES is a survey of depression in the community conducted in two phases across six countries: Belgium, France, Germany, Netherlands, Spain and the UK. DEPRES 1 assessed the 6-month prevalence of depression in 78,463 subjects using the depression section of the MINI (Mini-International Neuropsychiatric Interview); the proportion of depressed subjects who consult a physician and whether they are prescribed drug therapy; and the impairment associated with depression.

In DEPRES 2, interviews were conducted with 1884 depressed patients, identified by the MINI, who had consulted a healthcare professional about their symptoms during the previous 6 months. The 6-month prevalence of major depression was 6.9% (females 8.7%; males 5.0%). Only 57% of depressed subjects had consulted a medical specialist; 31% were prescribed drug therapy, antidepressant drugs accounting for 25% of medication. Most healthcare visits were made by subjects with major depression (4.4 over 6 months vs 1.5 for subjects without depression). Consistent with other epidemiological surveys, the DEPRES study shows that depression is prevalent in the community and affects twice as many females as males. More than 40% of sufferers fail to seek medical advice and the impairment associated with depression, as measured by the days of work lost, increases with the severity of the symptoms. The results suggest the need for educational programmes directed at subjects in the community as well as physicians, to encourage effective prevention and treatment of depressive illness.