für 3 Minuten während Ruheatmung aufgezeichnet. Dann wurden die Patienten/Probanden aufgefordert, einmal tief durchzuatmen; anschliessend wurde für weitere 3 Minuten gemessen.

Ergebnisse: In beiden behandelten Patientengruppen verlief der Abfall des LDF-Signals in ähnlicher Zeit wie bei den Kontrollen. Der Mittelwert der "Flux-Halbwertszeit" des Abfalls war in der Kontrollgruppe unwesentlich kürzer als der Wiederanstieg ($\Delta t_{50\%\ down}$: 3.1 s; $\Delta t_{50\%\ up}$: 4.5 s). Bei den mit Amitriptylin behandelten Patienten war allerdings der Wiederanstieg im Vergleich zu den mit Fluoxetin behandelten Patienten, bzw. zu den Kontrollen signifikant ($p = 0.0007$) verzögert (AMI: $\Delta t_{50\%\ up}$: 12–52 s; FLU: $\Delta t_{50\%\ up}$-: 2–8 s; KON: $\Delta t_{50\%\ up}$: 2–6 s). Mittels einer Diskriminanz-Analyse konnten alle (100%) mit Amitriptylin behandelten Patienten als solche erkannt werden.

Schlussfolgerungen: Der verzögerte Wiederanstieg des LDF, d.h. die prolongierte Redilation, könnte auf (anticholinerge?) Nebenwirkungen von Amitriptylin zurückzuführen sein. Mit unserer Methode können wir nicht unterscheiden, ob es sich dabei um zentrale oder um periphere Effekte handelt. Da es jedoch nach Literaturangaben in der Fingerkuppe keine cholinerge Gefässinnervation gibt, dürften die gezeigten Effekt am ehesten auf zentralnervösen Mechanismen beruhen.

CLINICAL CLASSIFICATIONS OF ANXIETY AND DEPRESSION

J.A. Mullaney. *St. Itas Hospital, Eastern Health Board, Dublin, Ireland*

Objective: To challenge the null hypothesis that the two clinical syndromes of anxiety and depression merge insensibly into each other.

Method: A random hospital population of patient, day and outpatient, (N = 180), with affective disorders (anxiety and depression) were dictomised on the basis of the universal Bipalor Factor derived from Principal Component Analysis. Pure measures of clinical state i.e. anxiety and depression were examined for invariance across the putative diagnostic boundary.

Result: Anxiety was found to be invariant across this 'diagnostic' boundary. In contrast (unlike any other puratative boundaries e.g. age, social class etc) depression was not so.

Conclusions: All affective patients whether depressed or not are anxious. The quality of depression is not coextensive in anxious and depressed patients. A patient either has or has not got depression. A patient with depression is likely to have anxiety in addition. Both categorical and dimensional models fit the data. This result has important implications for classification and psychopharmacological research.

SUICIDE AND DELIBERATE SELF HARM IN MALTA

P. Muscat, J. Cassar, J.C. Scicluna, J.R. Saliba. *Department of Psychiatry, Medical School, G'Mangia, Malta*

The University & Health Departments of Psychiatry entered into a collaborative study to identify:

– The trends for 77 completed suicides over a five period (1990–1994) through a retrospective analysis of data obtained from the Health Department Information Unit.

– The trends for 94 accidental/undetermined deaths (some possibly suicides) through a retrospective analysis of data obtained from the Health Department Information Unit.

– The trends for 962 attempted suicide/deliberate self harm cases presented to Casualty SLH over the period Jan 1990–June 1994 through a retrospective analysis data obtained from the Casualty Registers.

– Seasonal variation — by studying the trends over a 4-year period (Summer 1990–Spring 1994) of a total number of 890 cases that presented with attempted suicides to Casualty.

– A prospective analysis of attempted suicide cases over a one-year research period (July 1993–June 1994). During this period 276 cases were admitted to Casualty with attempted suicide. A total sample of 170 that were eventually referred for psychiatric consultation were analysed in detail to identify trends. This was based on a structured interview which formed part of the initial psychiatric assessment.

The instrument itself provides further information as to the physical intervention, immediate follow-up after 6 weeks from discharge from hospital and whether the patient kept follow-up appointment.

The scope of this exercise was to build a clear profile of the persons attempting suicide in Malta.

It is the aim of the research that the structured interview, which is a comprehensive one, would be modified and eventually developed into a standard tool for assessment and information collection in suicide attempts/deliberate self harm.

Recommendations are made that:

– Such data should be stored in a database for future systematic analysis and research on the subject.

– Specialized services should be set up for those in crisis.

INTRODUCING OPERATIONAL DIAGNOSTIC SYSTEMS INTO GENERAL HEALTH CARE — RESULTS OF THE ICD-10 PRIMARY HEALTH CARE (PHC) STUDY IN GERMAN-SPEAKING COUNTRIES

H. Müssigbrodt, S. Kleinschmidt, A. Schürmann, H.J. Freyberger, H. Dilling. *Department of Psychiatry, Lübeck Medical University, Ratzeburger Allee 160, 23538 Lübeck, Germany*

Epidemiological data show that about 30% of patients attending general health care facilities in Germany suffer from psychological disorders. If those remain undetected or without adequate treatment, they may represent an important cost factor to the health system. To improve the standard of diagnosis and treatment of mentally ill patients in general health care, the World Health Organization (WHO) developed a primary health care version of ICD-10 chapter V for mental and behavioural disorders. The concept of the ICD-10 PHC version is to offer a brief classification scheme linked with management guidelines to general practitioners. The preliminary version was reviewed by our working group for use in German-speaking countries. In addition to the acceptance of the concept the feasibility, suitability, ease of the diagnostic process and interrater-reliability in use of the ICD-10 PHC were assessed in a worldwide WHO field trial. In German-speaking countries 8 centres took part in a standardized programme of training sessions with participation of 107 general practitioners. The analysis of data shows a comparatively high acceptance of the new system and a sufficient interrater-reliability (kappa 72.4–96.1) for the different diagnostic categories. However, as general practitioners in Germany are obliged to classify psychiatric diagnoses on a four-figure level, the ICD-10 PHC version seems to be too much reduced in various aspects compared to the original classification. Therefore diagnostic criteria and treatment guidelines have to be described in more detail for use in German-speaking countries.

PHYSICIANS LIVING WITH DEPRESSION

Michael F. Myers. *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada*

Because depression in doctors is not always recognized by physicians themselves and is not always carefully treated, the Committee on

https://doi.org/10.1016/0924-9338(96)89116-4 Published online by Cambridge University Press

Physician Health, Illness, and Impairment of the American Psychiatric Association has produced this videotape. In two fifteen minute interviews, an emergency physician and a pediatrician describe the stresses in their lives, their symptoms, the process of reaching out for help, how their psychiatrists responded to them, how they responded to treatment, and the reactions of their families and medical colleagues to their illness. Both physicians, who have completely recovered, discuss their fears of recurrence and the stigma associated with psychiatric illness in doctors.

HOW DO GP REGISTRARS LEARN ABOUT DEPRESSION?

A. Nagy, M. Slater[1], M. Orrell[2]. *Department of Psychiatry, Charing Cross & Westminster Medical School, London W6 8RP, UK;* [1] *Watford General Hospital;* [2] *University College Medical School*

Depression is very common in primary care so it is essential that the subject is adequately covered during GP training. The Defeat Depression Campaign was launched to raise awareness and to improve recognition and management of depression. GPs were a key target audience. Post graduate education is at its most intensive during the Registrar training years, and many of the issues in improving recognition of depression are educational so Campaign literature was specifically prepared for trainees; "Recognition and management of depression in primary care" and "Counselling depression in primary care". Only 40% of GP Registrars work in a senior house officer capacity in psychiatry so many may have to gain their knowledge about depression from vocational training schemes. The study was carried out in 1995, in the fourth year of the Campaign. Questionnaires were distributed (to a random sample of training schemes throughout the UK) by the Vocational Training Scheme Tutors who had agreed to participate. Preliminary findings: a 63% response rate was achieved from GP Registrars, of whom 51% had heard of the Campaign. The most important source of information about depression was undergraduate teaching. Of those who had heard about it very few cited it as an important source of information and only 29% of them regarded it as having improved their ability to manage depression. A need for more training about how to manage depression was clearly expressed by the majority (75%)- despite relatively high levels of confidence in their ability to manage the condition (55%)- but the campaign does not appear to have met this need as well it had been hoped. The Campaign may have to be more vigorously targeted at this audience if it is to achieve its aims although if their levels of confidence are justified they may prove to be too sophisticated for it. Our findings suggest that they will be receptive to more training.

CHARACTERISTICS OF ANXIETY AND DEPRESSIVE DISORDERS (DSM-IV) ASSOCIATED WITH INSOMNIA

M.M. Ohayon, M. Caulet, P. Lemoine. *Centre de Recherche Philippe Pinel de Montréal, Montréal, H1C 1H1, Canada*

There is a paucity of information regarding epidemiological comorbidity of mental disorders and sleep disorder symptomatology in the general population. The purposes of this study was to evaluate associations with anxiety and depressive pathologies within a subsample of subjects within general population complaining about their sleep.

The current study reports the findings of a large (n = 5,622) representative (80.7% of contacted stratified sample) French cohort. Telephone interviews were performed by 16 lay interviewers using the knowledge based system Eval for sleep disorders and psychiatric diagnoses. This is a previously validated computerized system designed to guide the interviewers during the interview process. A subset of 997 (17.7%) of these subjects was identified who were dissatisfied with the quality and/or quantity of sleep.

The 997 subjects were aged between 15 to 96 years old, 63% were women and 37% men. At the time of the survey, 53% (526/997) of subjects reported taking a prescribed hypnotic (19.8%), anxiolytic (37.2%), antidepressant (6.8%), or other psychotropic (2.6%) drug at least twice a week. In 79% of cases these drugs were prescribed by a general practitioner and by a psychiatrist in 6.8% of cases. In multivariate models, the conditions of: being between 15 and 44 years old, reporting disrupted sleep, having difficulties getting started in the morning ($p < 0.01$), having sleep drunkenness, daily coffee consumption, medical consultation for insomnia problems ($p < 0.05$), and the presence of insomnia problems for more than 5 years ($p < 0.01$) were positively associated to Depressive Disorder with insomnia symptoms. The report of memory difficulties ($p < 0.01$) or decreased efficiency ($p < 0.05$) and smoking daily ($p < 0.05$) were associated to the presence of insomnia related to a Depressive Disorder. Dissatisfaction with sleep duration or shorter sleep duration ($p < 0.01$) and nocturnal awakenings ($p < 0.01$) were positively associated to the presence of insomnia related to an Anxiety Disorder.

The finding that many subjects who report depressive symptomatology seek independent medical treatment for their sleep problems raises the unsettling possibility that many instances of depression go undetected in the general community or are treated without addressing their sleep component.

OVERCONSUMPTION OF ALCOHOL AND DRUGS AMONG SUICIDE ATTEMPTERS

U. Magne-Ingvar, A. Öjehagen, L. Träskman-Bendz. *Dept Psychiatry, University Hospital of Lund, Sweden*

Although alcohol dependence is a wellknown risk factor for suicidal behaviour, overconsumption of alcohol and drugs are not always investigated.

Methods: 126 patients, 74 women and 52 men, 39 ± 13 years old, who had been admitted to a psychiatric ward after a suicide attempt, were investigated concerning their social background and social support by the Interview Schedule for Social Interaction (ISSI). The patients were especially questioned about periods of overconsumption of alcohol, tranquillizers, or narcotics. Psychiatric diagnostics (DSM-III-R axis I) were performed by two psychiatrists, and among biological tests, platetMAO-activity was measured in 45% of the patients.

Results: 75 patients (60%) reported periods of overconsumption, 60 of alcohol (17 of them in combination with tranquillizers), 13 of tranquillizers only, and 2 of narcotics. Overconsumers of alcohol did not differ in sex, while 12/13 of those with psychotropic overconsumption only were women. Only 21 of the 60 alcohol overconsumers had a diagnosis of alcohol dependence, and 16 of these had concomitant diagnoses; 6 major depression, 4 adjustment disorders, 4 depression UNS, and 2 panic disorders. In comparison with those with no overconsumption, the overconsumers of alcohol were younger (36.6 ± 12 vs 42.6 ± 14 years, $p < 0.05$), less often married (33% vs 53%, $p < 0.05$), and they were less satisfied with deep emotional contacts according to ISSI. Furthermore, they more often had a father who had been treated for psychiatric disorders (49% vs 27%), and mostly alcohol dependence. Previous suicide attempts were more common among those with alcohol overconsumption (50% vs 31%), and they had lower levels of platetMAO activity ($p < 0.05$) than those who had no overconsumption.

Conclusion: Overconsumption is common among suicide attempters, and they have special clinical and social features. It is important to pay attention to previous and present overconsumption, since this is a riskful behaviour for suicide attempters.

https://doi.org/10.1016/0924-9338(96)89116-4 Published online by Cambridge University Press