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

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