NR4. Transcultural psychiatry/primary care

Chairmen: M Lipsedge, J Cervilla

PSYCHIATRIC MORBIDITY IN PRIMARY HEALTH CARE. PREVALENE, HIDDEN PSYCHIATRIC MORBIDITY AND TREATMENT. A SCANDINAVIAN MULTICENTRE INVESTIGATION

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The study includes 1,281 patients consecutively consulting their general practitioner at four Scandinavian centres (Turku (Finland), Orup and Nacka (Sweden), and Aarhus (Denmark)). Initially a questionnaire including the SCL-25 (Symptom Check List) was applied and a subsample of the high scoring patients and a random sample of the low scoring patients were interviewed by the PSE (Present State Examination).

Firstly, the internal validity of the SCL-25 was tested by means of Rasch latent structure analysis, secondly the external validity of the screening instrument was tested by ROC analyses. Based on this a short 8-item version, i.e. the SCL-8D was developed.

The prevalence of mental illness in all centres combined was 26%, varying from 14% in Nacka to 36% in Turku. Compared to a diagnostic interview (PSE) the GPs detected 44% of the psychiatric cases, but their performances varied considerably between the centres, from 33% in Orup to 60% in Aarhus. The severity and the diagnostic category did not influence the GPs' ability to detect mental illness. Only 1/4 of the patients with a mental illness consulted their GP due to their mental illness, and only 4% did not present physical symptoms.

The GPs treated the patients themselves and only a most limited part were referred to psychiatrists or psychologists.

Conclusion: Mental Illnesses are most prevalent in primary care, and the patients usually present physical symptoms. Mental illnesses are frequently not recognised by the GPs, and if so most of the patients are treated in primary care. This points to the GPs' important role in mental health care.

SOVIET MENTALITY AND PSYCHIATRIC DIAGNOSIS: SOME SEMANTIC AND SEMIOTIC ASPECTS

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A huge amount of misdiagnoses (in 1988 about 2 million persons were taken from "register" in former USSR) raises curiosity, concerning the diagnostic criteria used (broad Schizophrenia concept), but in the political misusings (psychiatric expertises directed by KGB, for example) axiological differences, up to antipodal of such human values, as spirituality, conscience, activity, self-esteem, moral philosophy, God — the Higher Power, and also medical ethics, are evident, comparing Western and Soviet societies, the latter being represented by diagnosing psychiatrists. A method of semantic analysis of KGB interrogators' motivation for dissidents' psychiatric examination, and forensic psychiatry statements (evidences), written by leading Soviet psychiatrists, also in comparison with the same axiological concepts, as they appear in literature and philosophy of Lithuanian emigrants to USA, Australia and France of the same time, is being used.

Analysis suggests, that the differences in identifying psychic illness, appearing between Western and Soviet (also post-soviet) psychiatric practises, are determined not only by different diagnostic criteria, but also axiological difference of concepts of human values.

CROSS-CULTURAL STUDY OF PSYCHOLOGICAL DISTRESS AMONG ETHIOPIAN AND RUSSIAN IMMIGRANTS TO ISRAEL

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During the last decade waves of mass immigration brought to the country about 700000 Jews from the former USSR and more than 50000 Jews from Ethiopia. Differences between these two immigrant populations include their history, cultural background, norms and traditions, educational level, professional composition, and socioeconomic status. Goals of the current study were: 1) to assess the psychological distress level of Ethiopian and Russian immigrants; 2) to study the influence of gender and age on distress level and symptoms; and 3) to assess psychological symptoms and distress level over time since immigration. The study was designed as an community survey. Psychological distress in those two immigration groups was measured by Talbieh Brief Distress Inventory (TBDI) and compared between Ethiopians (N = 110) and Russians (N = 165). These samples were matched by sex, age and time since immigration. The reliability of the TBDI dimensions (Cronbach's alpha) ranged of 0.75 to 0.94 for Russian and of 0.41 to 0.83 for Ethiopian respondents. A significant difference between the two groups was found in levels of psychological distress, with lower distress level for Ethiopian than for Russian immigrants. Ethiopians were characterized by a higher level of paranoid ideation symptoms, while Russians exhibited significant higher degree of hostility and anxiety. Younger Ethiopians (under 31) were more sensitive and paranoid, but less anxious than younger Russians, whereas elder Ethiopians (31 and over) were less obsessive, hostile, sensitive, and anxious compared to elder Russians. Hostility, sensitivity and depression were higher in Russians with the duration of residence longer than 48 months. The results suggest that differences in psychological distress and its specific expressions are determined by the cultural differences between the two immigrant samples.

PSYCHIATRIC DISORDERS AMONG MIGRANTS: CORRELATION BETWEEN PSYCHOPATHOLOGY AND PSYCHOPHARMACOLOGY

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There has been much debate on the prevalence of mental disorders among migrants, with certain studies finding an increased rate among certain subgroups (Cochrane & Bal 1987, Charalabaki et al. 1995), others finding no increase (Häfner 1980). This lead to further debate on the problems of describing psychopathology among patients of different cultural backgrounds with its possible consequence of misdiagnoses (Westermeyer 1987). Furthermore. the course of illness among migrants with schizophrenia has been described as poorer (Birchwood et al. 1992), implying that more special attention is needed in this area. Treatment factors can affect the course of illness, and differences in the treatment of mentally ill migrants have been

https://doi.org/10.1016/0924-9338(96)88798-0 Published online by Cambridge University Press

described: migrants were prescribed anxiolytic drugs more frequently while being less likely to be referred to psychotherapy (Charalabaki et al. 1995) and received neuroleptics more often (Lloyd & Moodley 1992).

We examined all charts of migrants admitted to the psychiatric clinic during 1993 and 1994 with respect to sociodemographic factors, diagnosis, and treatment factors. 263 admissions of migrants were recorded, which make up about 8% of all admissions. 58% were male, 42% female. The place of origin was Turkey in 19% of the cases, ex-Yugoslavia in 14%, 19% came from other West European countries, 16% from Eastern Europe, 14% from the Near East, 6% from the Far East, 5% from Africa and 6% from Latin- and North America. In 42% of the cases the diagnosis was a schizophrenic disorder, while only 11% received the diagnosis of a depressive disorder, 4% a bipolar disorder and 6% a diagnosis of a stress or adjustment disorder with depressed mood. The mental status on clinically relevant psychopathology showed that 32% of all admissions had psychotic symptoms, 29% had depressive symptoms, and 19% had psychotic and depressive symptoms.

With respect to psychopharmacological treatment, 49% received high-potency neuroleptics, while only 13% received antidepressants. While only 15% of the cases with psychotic symptoms did not receive high-potency neuroleptics, 77% of those with depressive symptoms did not receive antidepressants. Anxiolytics were used in 25% of the cases, mostly in combination with high-potency neuroleptics. Low-potency neuroleptics were prescribed in 49%' of the cases, also mostly together with high-potency neuroleptics.

There seems to be a tendency to diagnose a schizophrenic disorder when psychotic symptoms are present, while a depressive disorder seems to be underdiagnosed when correlated with the psychopathology. Correspondingly, the use of high-potency neuroleptics correlate with the presence of psychotic symptoms, while depressive symptoms seldomly lead to antidepressant use. As migrants are becoming more common in Europe, this study points to the necessity of becoming more familiar with transcultural aspects of psychopathology and optimizing the psychopharmacological treatment, especially antidepressant treatment.

WHY DO DOCTORS PRESCRIBE PSYCHOACTIVE DRUGS IN PRIMARY CARE? RESULTS OF AN INTERNATIONAL STUDY

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Objective - To determine the factors associated with the use of psychoactive drugs by general practitioners.

Design - A multicentre cross-sectional design using a two-stage stratified sampling strategy.

Setting - Primary care facilities in 15 different countries.

Subjects - 1763 consecutive GP attenders aged between 16 and 65 years of age.

Main outcome measures - Antidepressant, anxiolytic, hypnotic and overall psychotropic drug prescription

Results - Diagnosis was only one determinant in the prescription of psychotropic medication. Although antidepressants tended to be used for depressive disorders, and anxiolytics for patients with anxiety, the differential diagnosis was otherwise not an important factor in prescribing behaviour. Older age and female sex were independently associated with prescription. Several other factors emerged when individual classes of medication were considered; these included the loss of a spouse and the absence of physical ill health in the case of antidepressants, and unemployment in the case of anxiolytics. The style of health service delivery was strongly associated with the pattern of psychoactive drug use. Antidepressants and anxiolytics were prescribed between two and three times more frequently in client centred clinics following a 'personal physician model' as opposed to non client centred settings where care was less personalised (odds ratios of 3.4 and 1.9 respectively). The reverse was true of hypnotics (odds ratio of 0.4)

Conclusions - Social factors are at least as important as clinical features in the prescription and choice of psychotropic medication even allowing for potential confounding factors. The appropriateness of some of these prescriptions may be questionable given the lack of association between their use and symptom severity. The growing cost of such medication suggests the importance of education and training to ensure that medication is appropriately targeted.

DIAGNOSIS AND TREATMENT OF PSYCHIATRIC DISORDERS IN PRIMARY HEALTH CARE

The ICD-10-PHC (Primary Health Care) Multicenter Field Trial in German Speaking Countries. *Silke Kleinschmidt, Angela Schürmann, Heidi Müssigbrodt, Horst Dilling*

Participants of the ICD-10-PHC Field Trial of the World Health Organisation in German speaking countries were asked to assess the new classification and to give information about their daily work. Although the data is biased by a certain selection of participants (e.g. interest in training sessions) the 93 general practitioners (37% female, 63% male) in 8 field trial centers showed a wide range in terms of age distribution, work experience and interest in psychological problems. The majority of participants thought that psychiatric diagnosis is of high importance in general practice (94%) but they felt quite insecure about their diagnostic abilities concerning psychiatric disorders (low degree of security 39.8%, moderate 52.7%). Only 14% of the GP's had any experience with the ICD-10 classification system. They achieved an interraterreliabilty of 0.8 (kappa) using the ICD-10-PHC for the diagnostic assessment of patients in video training sessions. The percentage of own patients suffering from psychiatric disorders was assessed as high (< 10%: 11%, < 20%: 27%, < 30% 23.7%, > 30%: 27%). The percentage of patients with e.g. depressions was even higher (> 30%: 37.6%). This could lead to the conclusion, that GP's are able to identifie specific syndroms but do not identifie them as psychiatric disorders. Another explanation would be that there is a high comorbidity of psychological problems in primary care. These and other data about e.g. rate of drug prescriptions, referrals to psychiatrists and social institutions will be shown.

DO GENERAL PRACTITIONERS DISCRIMINATE AGAINST PATIENTS WITH SCHIZOPHRENIA?

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Objective - To examine general practitioners' attitudes to patients with schizophrenia.

Method - A random sample of primary care physicians were alternately sent a case vignette of a patient with or without schizophrenia, in an otherwise identical clinical abstract, and asked to indicate their level of agreement with fifteen statements based on it. The median score on each statement was compared between the two groups of doctors with the two-tailed Wilcoxon Rank Sum test.

Results - Doctors responding to the vignette of the patient with schizophrenia were significantly less willing to have the patient on their practice list ($p = 0.0002$), more likely to refer them to a specialist ($p < 0.0001$) and more likely to think that they would be violent ($p = 0.002$); whereas there was no difference in the perception of how much time the patients would take up ($p = 0.4$).

https://doi.org/10.1016/0924-9338(96)88798-0 Published online by Cambridge University Press