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Abstracts for oral sessions

Sunday, 18 March 2007
CS01. Core Symposium: EUROPEAN CONTRIBUTION TO THE CLASSIFICATION OF MENTAL DISORDERS

CS01.01

Towards ICD-11 and DSM-V: Some current problems of diagnosis in psychiatry

M. Maj. *Department of Psychiatry, University of Naples, Naples, Italy*

Current operational systems have made psychiatric diagnosis more precise and reliable. They have also contributed, however, to the emergence of several problems which are currently being addressed in empirical studies (1). The first problem is that of the threshold for the diagnosis of mental disorder. At present, this threshold is based on the presence of a given number of symptoms (often fixed arbitrarily) and a significant degree of personal suffering or impairment of social functioning (both left to the subjective evaluation of the individual clinician). However, for some mental disorders, the existence is well documented of cases which are ''sub-threshold'' concerning the number of symptoms, but fulfil completely the criterion of impairment of social functioning. On the other hand, for other mental disorders, the criterion of impairment of social functioning appears to be not relevant. A second problem concerns the frequent concomitance of two or more psychiatric diagnoses (so-called ''psychiatric comorbidity''). The emergence of this phenomenon is in part an artefact of some characteristics of current classification systems, such as the proliferation of diagnostic categories, the reduced number of hierarchical rules, a certain tendency to psychopathological oversimplification. The use of multiple psychiatric diagnoses in the same patient may prevent a holistic approach to the individual case and encourage an unwarranted use of polypharmacy.

Reference

1 Maj M. 'Psychiatric comorbidity': An artefact of current diagnostic systems? (Editorial). Br J Psychiatry 2005;186:182–4.

CS01.02

Prospects for the classification of mental disorders of the elderly

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The diagnostic categories of mental disorder in DSM-IV and ICD-10 are very powerful in determining how patients are treated, how services are planned, resourced and monitored, and how progress through research is made. It is unfortunate therefore that all of these categories are problematic when applied to elderly patients. Areas of difficulty include: ageist criteria that ignore important changes in social role and functioning with age; co-morbid physical illness and disability (e.g. anxiety, depression); frequent co-morbidity between mental disorders (e.g. anxiety and depression, 'mixed dementia', dementia and delirium, dementia and depression); categories vs. dimensions - the issue of clinically significant and treatment-responsive episodes of mental illness that do not meet diagnostic criteria (e.g. mild depression, sub-syndromal delirium); the possible aetiological role of cerebrovascular disease in late-onset disorders (e.g. depression, schizophrenia, dementia); the diagnostic status of 'new' conditions (e.g. Lewy body dementia, fronto-temporal dementia, mild cognitive impairment); and the definition of dementia as a progressive and irreversible disorder in the new era of symptomatic treatments. This presentation will review these issues, and will discuss the extent to which the available evidence can support the move to a more aetiologically-based classification of mental disorders in old age.

CS01.03

Prospects for the classification of mental disorders of children and adolescents

M.H. Schmidt. *Department of Child and Adolescent Psychiatry, Central Institute of Mental Health, Mannheim, Germany*

During the last decades progress in classification of child and adolescent psychiatric disorder has mainly been reached considering the course of mental illness. On the other hand etiological approaches recurring on biological markers are fairly immature. Therefore the question of allowing combined diagnoses as already discussed on occasion of the AEP/WPA meetings in Vienna and Cairo is of continuous relevance. Suggestions are to be made for affective disorders of children, eating disorders of adolescents, multiple pervasive developmental disorder, the subtypes of conduct disorder and possible subtypes of enuresis. Following DSM phonological disorder should replace articulation disorder. Finally the idea of introducing categories of interaction disorder as proposed for DSM V has to be addressed.

CS01.04

Prospects for the classification of mental disorders in women

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Many mental disorders show marked gender differences as regards prevalence, symptomatology, risk factors or course. Other disorders

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do per definition only occur in women – e.g. PMDD – or are markedly influenced by female specific factors such as hormonal changes over the life cycle or reproductive processes.

Current classification systems have tried to take into account these gender aspects, but some problems will certainly have to be discussed again with the next revisions of the ICD and DSM.

As regards gender differences in prevalence and symptomatology questions of gender bias in diagnostic instruments and diagnostic criteria will have to be readdressed. New findings from unselected epidemiological samples, which were analysed by gender will have to be taken into account as well as new findings from research into gender specific personality traits, which can influence the symptomatology of mental disorders. Decisions will have to be taken whether to revise existing diagnostic criteria and provide alternative diagnostic thresholds for men and women or even develop alternative criteria sets in certain disorders, or rather to enhance the gender neutrality of criteria.

A further question to be addressed will be that of gender specific diagnoses versus diagnostic specifiers – e.g. regarding peripartum disorders. In the whole discussion the general aim of identifying ''true'' entities with a common aetiology should always be kept in mind – i.e. we should be able to identify specific diagnostic entities with descriptive, construct and predictive validity quite independently of the influences of gender.

CS01.05

Should long-term outcome play a role in classification? considerations from european primary care research on affective disorders

J. Ormel. *Department of Psychiatry, University Medical Center, Groningen, The Netherlands*

Although the notion of a nosological category suggests that disorders within the same category have roughly similar etiology and natural history, reality in psychiatry is rather different. Not only between diagnostic categories but also within most diagnostic categories enormous variation in long-term outcome has been observed. This issue is of utmost importance for general practitioners and nurse practitioners given their position in the health care system as primary care provider and referral agent to specialty mental health care. My presentation will address the question what role long-term outcome should play in the classification of mental disorders, especially in the context of primary care and the stepped care model of collaborative care. To this end I will use longitudinal data of mostly depression collected in European general population and primary care studies.

CS01.06

Prospects for the classification of mental disorders for use in primary and general health care

C. Dowrick. *School of Population, Community and Behavioural Sciences, University of Liverpool, Liverpool, United Kingdom*

Existing classification systems fail to capture the complexity of mental disorders as manifest in primary and general health care settings. They do not adequately address the problems of co-morbidity, sub-threshold disorders, cross-cultural applications or social dimensions, or acknowledge the difference between severity and impairment.

An effective classification system for primary and general health care needs to pay attention to four key elements: diagnosis, severity, chronicity and disability.

- Categorical diagnoses should be more stringent and precise, so that they become rarer but more significant events in primary and general health care.
- Measurement of severity can be achieved by combining categorical and dimensional approaches.
- Disability is important in its own right, as many people with current sub-threshold disorders have significant levels of impairment.

We also need to consider classification of social problems, to enable dialogue with social care.

This approach is likely to reduce unnecessary medicalisation, and enable better focus on those most in need of care. The addition of measures of severity, chronicity and impairment will encourage better targeting of interventions.

For successful adoption within primary and general health care, a classification system needs to be simple, grounded in research and reality, adaptable for specific populations and countries, useful as a teaching tool and accessible for routine data collection. CD10-PHC and WONCA's International Classification in Primary Care provide good models to build upon.

These issues are currently being considered by the WONCA Working Party on Mental Health and the APIRE Primary Care Conference Expert Group.

S01. Symposium: BURNOUT AND WORK-RELATED MENTAL HEALTH PROBLEMS AMONGST MEDICAL DOCTORS (Organised by the AEP Section on Epidemiology and Social Psychiatry)

S01.01

Individual and contextual predictors of burnout among mid-career Norwegian doctors: A ten-year follow-up nationwide study

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Background and Aims: Burnout among physicians account for an increase in long-time sick leave. Prevention of this burnout necessitates identification of predictors related to the individual and to the job.

Method: Prospective mailed survey of a nationwide cohort of all the physicians that graduated in Norway 1993/94 (N=631). Approached in their graduating semester (T1), at the end of internship (T2), four years later during postgraduate training (T3) and in established jobs in their 10th postgraduate year (T4). 262 (42%) responded at all four occasions. Personality was assessed at T1 and T2; contextual variables were assessed at T2, T3 and T4. The burnout dimension of emotional exhaustion was measured at T4.

Results: Both individual factors (age, gender, personality), stress (perceived medical school stress at T1, emotional pressure at T3, work-home interface stress at T3) and contextual factors (working hours) were examined as contributors to the variance in burnout. There were no gender differences in burnout and no differences between house officers and other physicians. Further results will be presented at the conference.

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