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

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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

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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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