Are these gender differences real or artefactual and a consequence of the socio-cultural construction of gender roles?

It is suggested that beyond biological predispositions, women's health is in double jeopardy by gender role related risks, which affect morbidity both directly through immunology systems and indirectly through health perceptions. These factors has big consequences for treatment strategies now and in the future.

S5-2

WITH BATED BREATH: COGNITIVE AND EMOTIVE ASPECTS OF BREATHING IN PATIENTS WITH MODERATE ASTHMA

Gretty M. Mirdal. *Institute of Clinical Psychology, University of Copenhagen, Copenhagen, Denmark*

The psychological literature on asthma has principally focused on the possible psychological **causes** of asthma; very little attention has been paid to the emotional and cognitive **effects** of having or having had breathing difficulties. The present study has focused on understanding the psychological difficulties of asthma patients as the consequents rather than the antecedents of the disease.

With **asthma patients as co-researchers and psychotherapy as a method of data collection** that allows for the investigation of complex psychosomatic interactions, this study has focused on the relationship between **psychological hyperreactivity** and **bronchial hyperreactivity** in 10 women patients with moderate asthma. The results demonstrate an interaction between attention, mood, concentration, memory, and breathing. The paper discusses these findings and their therapeutic implications.

S5-3a

POSTPARTUM PSYCHOSES: CLINICAL DIAGNOSES AND RELATIVE RISK OF ADMISSION

I.M. Terp[1]*, P.B. Mortensen[2]. [1]*Department of Psychiatry, KAS Glostrup, Nordre Ringvej DK-2600 Glostrup;* [2]*Institute for Basic Psychiatric Research, Department of Psychiatric Demography, Psychiatric Hospital in Aarhus, DK-8240, Risskov;* [3]*Centre for Research in Health and Social Statistics, Sejrøgade 11, DK-2100 Copenhagen Ø, Denmark*

Previous studies have suggested that the risk for psychosis, especially affective psychosis, is highly increased during the first 30 day's after delivery. The aim of our study was to replicate these findings. Linking The Danish Medical Birth Register and The Danish Psychiatric Central Register from January 1st 1973 to December 31st 1993 has revealed 1253 admissions diagnosed as psychosis within 91 days after delivery. The admission rate after delivery was compared to the admission rate among non-puerperal women in the general, Danish female population. The relative risk of all admissions was only slightly increased, RR = 1.09 (CI, 1.03–1.16). The admission rate concerning first admissions was highly increased, RR = 3.21 (CI, 2.96–3.49) whereas the admission rate concerning readmissions was reduced, RR = 0.66 (CI, 0.61–0.72.

S5-3b

POSTPARTUM PSYCHOSES: PROGNOSIS AND RISK FACTORS FOR READMISSION

I.M. Terp[1]*, G. Engholm[3], H. Møller[3], P.B. Mortensen[2]. [1]*Department of Psychiatry, KAS Glostrup, Nordre Ringvej DK-2600 Glostrup;* [2]*Institute for Basic Psychiatric Research, Department of Psychiatric Demography, Psychiatric Hospital in Aarhus, DK-8240, Risskov;* [3]*Centre for Research in Health and Social Statistics, Sejrøgade 11, DK-2100 Copenhagen Ø, Denmark*

Linking the Danish Medical Birth Register and the Danish Psychiatric Central Register revealed 1173 women admitted between 1973 and 1993 to a psychiatric hospital diagnosed a psychosis within 91 days after delivery. The relative risk of rehospitalisation was estimated with Cox proportional hazard regression models. A diagnosis of schizophrenia, RR = 2.4 (1.9–3.1) and a history of prior psychiatric admission among non-schizophrenic women, RR = 1.8 (1.5–2.1) predicted an increased risk of rehospitalisation compared to the rate of rehospitalisation among non-schizophrenic women with no prior psychiatric history. Unmarried women had an increased risk of readmission, only preterm delivery was associated with a reduced risk of readmission.

Stress factors as preterm delivery predicts the best prognosis after puerperal psychosis. The majority of psychotic relapses are related to the psychopathology of the patient, a history of psychiatric admission and to family relations.

S5-4

SUFFERING OF THE BODY AND MIND: PREDICTORS FOR PSYCHOSOMATIC PROBLEMS IN FEMALE REFUGEES

L.T. Arcel. *Institute of Clinical Psychology, University of Copenhagen, Denmark International Rehabilitation Council for Torture Victims, (IRCT) Copenhagen, Denmark*

In a sample of 120 Bosnian female refugees, tests were carried out regarding the level of various health problems and a number of factors which, according to the suggested model, influence the level of adjustment. Each subject was asked to state whether a given symptom had been present before the war. This provided us with information about the level of problem before the experienced traumatic events. The most frequent somatic and psychological symptoms are reported. Many of the somatic symptoms indicate a high level of physiological arousal indicative of PTSD reactions, anxiety, and depressive states. Correlation between health problems before and after the war is higher than 0.40, and implies the importance of previous health status, primarily for somatic problems. The general level of health problems is significantly increased in comparison to the period prior to the war. There is a high correlation between somatic and psychological symptoms. After trauma, body and mind suffer simultaneously. Important predictors found were the extent of experienced traumatic events, losses of relatives, age and level of health problems before the war.

S5-5

WOMEN'S MENTAL HEALTH IN UKRAINE

V. Bitenskaya. *Odessa Psychiatrical Association; Youth and Family Social & Psychological Support Agency (NGO), Ukraine*

Now we have in Ukraine the significant growth of women's mental disorders and psychological problems in different ages. The most prevalent are depression, agoraphobia and social phobia, addictive disorders, suicidal behavioral, drug abuse and alcoholism. Very serious problems are frequent events of women's abuse and domestic violence.

Causes of bad effect on women's mental health are: the chronic economical and social crisis, violence of human rights, absence of confidence in the future, the loss of significance and sense of life. This situation is intensified by obsolescence of the Governmental Mental Health Services, a fear of psychiatrists and psychologists,

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undeveloped system of Psychological Services, the low activity of the women's social organization of Ukraine.

In 1992 in Odessa (Ukraine) the Youth and Family Social and Psychological Support Agency (the first Community Mental Health Services in Ukraine) works with technical, educational and informational support from Canadian-Ukrainian Program "Partners to Partners in Health". We (psychiatrists, psychologists, social workers and volunteers) are realizing the programs of psychological, psychotherapy and social help and support for women, children and family (confidential, anonymous, free of charge). Now our model of new Community Mental Health Services is being inculcated in different cities of Ukraine.

The improvement of the mental health of women and family in Ukraine is also connected with development Community Mental Health Services Services of Ukraine.

TC6. ICD-10 advanced training seminar I

Chairs: A Bertelsen (DK), J van Drimmelen (WHO, CH)

S7. Central problems in specialist training in Europe

Chairs: R Vermeiren (B), R Kaltiala-Heino (FIN)

S7-1

HARMONISATION OF PSYCHIATRIC TRAINING IN GREECE BEFORE THE DAWN OF THE NEW MILLENNIUM

K. Kollias*, G.N. Christodoulou. *Department of Psychiatry, University of Athens, Eginition Hospital, 74 Vas. Sophias Av., 11528 Athens, Greece*

The Greek Presidential Order of 1994, concerning the time of training in Medical Specialities and particularly in Psychiatry, gives a schedule of the training program which should be followed. This schedule does not contain details of how practical problems, such as the rotation or the provision of theoretical courses in each training centre, would be solved. The Hellenic Association of Psychiatric Trainees (H.A.P.T.), whose primary goal is the elaboration and promotion of propositions that will improve the psychiatric training in our country in a harmonious way, has offered its opinions on such matters from time to time. Those proposals, which were presented at congresses in which members of the H.A.P.T. participated (e.g. 11th Conference of the South East European Society for Neurology and Psychiatry (Sept. 1996), 2nd Panhellenic Congress on the New Structures of Mental Health Care in the N.H.S. (May 1997), Conference on Thoughts about Education in Psychiatry (Oct. 1997), will be summarised. The advantages and disadvantages of the initiatives proposed, as well as the problems faced towards the goal of harmonising psychiatric training with the requirements of the European Board of Psychiatry, will be dealt with.

S7-2

CURRENT ISSUES IN PSYCHIATRIC TRAINING IN THE UK

P.L. Cornwall. *University Department of Psychiatry, Royal Victoria Infirmary, Newcastle upon Tyne, NE1 4LP, UK*

Postgraduate medical training in the UK has undergone significant changes in the past 5 years following the publication of the Calman Report. One of the aims was to shorten specialist training by combining the two higher training grades into one. The Royal College of Psychiatrists, with the support of trainees, attempted to avoid radical changes to the structure of training as the existing arrangements were felt to be more appropriate and successful. However, this has resulted in a number of new problems. In particular, general professional training in psychiatry (the first part of postgraduate training) is now longer than in other disciplines (3–4 years as opposed to 2–3 years), while higher specialist training is shorter. The implications of these changes will be discussed.

The availability of training in psychotherapy remains a problem. Most training schemes are able to offer basic training in dynamic therapy, but very few are able to offer more than token training in cognitive-behavioural and other psychotherapies. Supervision is another important question. The evidence is that 25–30% of trainees do not receive the required one hour per week face-to-face supervision with their trainer. Trainers and trainees alike express uncertainty over the nature and purpose of supervision and are often dissatisfied with the process.

A number of developments have occurred recently to deal with these issues. One of the most significant is the introduction of a Personal Training File (or Trainee's Log Book) for all pre-MRCPsych trainees. The log book is trainee-owned, and consists of a record of training experiences rather than a list of cases seen. It will not be employed as a tool of assessment of the trainee, but will be used to set objectives for training and to promote supervision.

S7-3

PSYCHIATRIC SPECIALIST TRAINING — REAL OR FORMAL COMPETENCE AHEAD?

Riittakerttu Kaltiala-Heino. *University of Tampere, Tampere School of Public Health and Tampere University Hospital, Department of Psychiatry, Finland*

In Finland, psychiatry is the second most popular speciality in medicine as measured by number of active trainees. The training itself is under active development. The Finnish Psychiatric Association has published its new proposal for the psychiatric curriculum in accordance with the European recommendations in 1996. The trainees have participated by evaluating the proposal and giving suggestions. The trainees' section has also surveyed the trainees' opinions and experiences of their training in psychiatry. Based on the proposal, discussion between trainers, trainees and training institution and the survey to trainees, I shall discuss some topics I find central problems in the psychiatric curriculum in Finland. To my mind, the trial to improve quality of specialist training is too much focused on controlling trainees, and this exclusively in form of demanding them to evidence they have attended specified courses and departments. Too little attention is paid to seeing that education is of high quality and that the training institutions guarantee access to rotation that is demanded. The specialist training should become more co-operation between trainees and trainers, instead of hierarchical positions and control. Another problem is that even if training institutions are state supported for their educational tasks, many trainees face demands to spend less time in education. From survey to trainees a concern arises whether the

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