possible. To what extent can psychiatric training by rotation or exchange be developed beyond the current limited movement of a small number of trainees for some of their training?

### PSYCHIATRIC EDUCATION IN EUROPE. INTRODUCTION

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The teachings of Hippocrates and the "holistic" approach of the ancient Greek physicians and philosophers have been infiltrated through the Centuries in the French and German "schools" which were dominant in the 19th Century. A productive osmosis between these two schools was later extended to include the factual and experimental "Anglosaxon" approach.

Yet, European Psychiatry, is by no means homogeneous and the differences in psychiatric tradition in the various European countries are reflected in psychiatric education and practice.

Following the establishment of the European Community (Treaty of Rome, 1958) mutual recognition of basic and specialist medical qualifications has occurred (Directive 93/16/EEC/1993). This called for "harmonization" of psychiatric training among the European Union countries (and also the EFTA countries). For this purpose the European Board of Psychiatry was established in October 1992 as a working Committee of the Psychiatry Section of the UEMS. The purpose of this symposium is to present some of the surveys carried out by the Board and some of its basic recommendations.

### PRESENT STATE OF POSTGRADUATE PSYCHIATRIC EDUCATION IN EU COUNTRIES

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*Aim:* To obtain a description of National Guidelines on Psychiatric Training in the countries of the European Union.

*Method:* Delegates of the "Union Européenne des Médecins Spécialistes" UEMS Section of Psychiatry representing 18 European countries were asked to fill in questionnaire on Psychiatric Training, according to the information contained in the National Training Guidelines of their country.

*Results:* Fifteen valid questionnaires were analysed. Results will be described under three headings: administrative and training requirements for entering psychiatric training, the content of the National Training Programmes and quality assurance.

*Conclusion:* Results are discussed in relation to the difficulties of harmonizing psychiatric training in EU. The main obstacles are the differences in the process of selection of trainees, the requirements to enter psychiatric training, the duration of training. The con-tents of the programmes are not sufficiently specified in some countries and this makes difficult any comparisons.

### TRAINING IN PSYCHIATRY IN EUROPE — RECOMMENDATIONS OF THE EUROPEAN BOARD OF PSYCHIATRY

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At present, the concept of psychiatry and psychiatric training in Europe is changing. Due to highly different standards of specialty training in psychiatry in the respective European countries, there is a great need to harmonize psychiatric training requirements in Europe. This should contribute to the goal of achieving comparable and high standards of psychiatric training and patient care in all of Europe. The European Board of Psychiatry has formulated requirements for the specialty of psychiatry. These include rules about recognition of teachers and training institutions, quality assurance, as well as selection procedures for and access to the training itself. Training duration should be five years. Theoretical training should include a structured training over four years, on average for four hours per week. All relevant aspects concerning diagnosis and therapy of psychiatric disorders should be taught. Psychotherapy training should be compulsory with one theoretical course per week (120 hours in total). Psychotherapeutic theory should include at least psychodynamic and cognitive-behavioral approaches. Personal therapeutic experience is highly recommended but not mandatory. A minimum of 100 hours of psychotherapy supervision should offer the trainee experience in different therapeutic approaches. Practical training must include alongside the normal clinical work, daily clinical supervision of minimum one hour per week (at least 40 hours/year).

The different activities of the trainee should be recorded in a log-book. Rotation in training should be compulsory including training in in-patient and out-patient settings.

The main objective of these requirements is to offer a multidimensional approach to diagnosis and therapy of psychiatric disorders based on biological psychiatry, psychotherapy and social psychiatry.

## S90. Biomed II project: outcome of depression in Europe

*Chairmen:* G Wilkinson, O Dalgard

### THE OUTCOME OF DEPRESSION IN EUROPE: THE EFFECT OF PERSON CENTRED PREVENTION IN URBAN AND RURAL SETTINGS

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This study has two objectives: to provide reliable and valid data on the prevalence, risk factors and outcome of depressive illness in rural and urban settings within the European community based on an epidemiological sampling frame; and to assess the impact of a person-centred preventive approach on the outcome of depression and on service utilisation and costs.

Six centres across the EU with expertise in mental health epidemiology and interventions are participating in this study. Suitable urban and rural areas have been identified in each centre. The sampling frame is adults aged 18–64, identified via primary care data bases or electoral registers. A two stage screening procedure has been adopted. Potential cases of depressive illness and depressive adjustment disorder are identified using the Beck Depression Inventory. Then detailed interviews are undertaken by mental health trained researchers. They use PSE10/SCAN to assign caseness against DSMIV and ICD10 criteria; they also assess co-morbidity, disability, genetic/familial susceptibility, psychosocial stressors, personality traits and cognitive factors; and assess provision, expectations and utilisation of local health care services. A randomised controlled trial of person-centred prevention is then undertaken for respondents identified as cases of depression/depressive adjustment disorder. This has three arms. 1: Individual intervention: a community mental health facilitator (MHF) provides individual training in cognitive problem solving approaches. 2: Group intervention: as above, but group rather than individual training in problem solving approaches. 3: A control group with no intervention from the research project. Subjects will be followed-up at

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6 and 12 months to assess outcome for subjects and health care utilization.

The advances that the research seeks to make lie in clarifying the suspected differential prevalence and outcome of depressive illness in rural and urban settings and in the application of a low-cost, generalisable preventive package to improve the outcome of depressive illness, a major cause of long-term disability and loss of economic functioning.

## S91. Efficacy of psychotherapy and what causes change

*Chairmen:* D Cremniter, M Patris

### METHOLOGY AND PRACTICE OF THE PSYCHOTHERAPY MEASUREMENT EFFECTS IN NEUROTIC DISORDERS

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The main methodological problem of therapy effect evaluation is what must be measured and when to measure. The answer to the first question depends on the current knowledge of psychopathology. Paper discusses the question of measuring different dimensions having not specific value in each specific psychopathological disease as well as other concepts like wrong choosen moment in waiting for therapy on waiting list or in follow-up. In every therapy, notabely psychotherapy, the most important measurement results seem to be assessment of the changes in the main psychopathologic features. In the case of neurotic disorders, intensity of symptoms and personality desintegration are cotated, using symptom check-list and personal tests. Concerning therapeutical results collected, results are given before and after treatment. The paper presents methods of measurements as well as some data on different psychotherapeutic procedure, effects and variable causative factors.

### CRITERIA OF EFFICACY IN PSYCHOTHERAPY. APPLICATION TO PSYCHOSIS

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Since Pinel with his "moral treatment", psychotherapy has frequently been used in the treatment of psychosis. Even if efficiency is more frequently known for non psychotic patients, many researches have tried to find out criteria of efficacy for psychotherapy in psychosis. These latter are generally characterized by reduction of rehospitalizations and improvement of the patient to cope in social life, whatever the different methods studied are: familial therapy, psychoanalysis, behavioural therapy, interactive therapy, etc... which are based on different theorical approaches. Application of the criteria of efficacy to psychosis leads to take into account basic questions like (1) the introduction of psychotropic drugs in the last decades, which modifies the symptomatology, the contact with the patient and the evaluation of efficacy (2) the question of causality which modifies the conceptual approaches of clinicians and which has to be considered differently than in a classical opposition between psychodynamic, organic, or socio-familial theories.

### CAUSATIVE FACTORS IN THE PSYCHOTHERAPY OF DEPRESSION

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Knowledge of putative causative factors in psychotherapy is necessary not only for effective and economic treatment but also for evaluation studies which go beyond pre-post-comparisons. The mediation process between intervention and change in the patient should be looked at. For this purpose first pathogenetic concepts of depression are discussed, then clinical evidence for causative factors and empirical results of evaluation studies.

Pathogenetic models of depression emphasize the premorbid and intermorbid personality's structural rigidity with stringent self-standards, reward dependency and an ambalance in favour of heteronomic orientation as compared with more autonomous behaviour. This 'typus melancholicus' [1] can develop as coping mechanism to safeguard the need for dependency and acknowledgement. Interventions in the acute severe depressive state of this personality should foster relieve from the patient's 'debet-situation' or 'being for others', the ensuing ambivalence towards therapy and the feeling of emptiness which in turn agitates again the effort for pleasing others.

Fallacies of too early cognitive interventions in this stage are discussed. In the long-term course it has to be decided whether the patient should be helped to readopt patterns of over-adaptation to social expectations or whether more autonomous behaviour and conflict resistancy can be fostered without depreciation of the patient's self-image. Details of possible intervention strategies are elucidated.

[1] Tellenbach, H. (1980) Melancholy. Duquesne University Press, Pittsburgh.

### THE QUESTION OF EFFICACY IN THE HISTORY OF PSYCHOTHERAPY

Uwe Henrik Peters. *Dpt. and Clinic for Neurology and Psychiatry, University of Cologne, D-50924 Cologne, Germany*

Psychotherapy is much older than the general opinion holds it. The first treatments were already in the beginning of the 18th century, and a clear cut theory and several techniques existed as early as 1750, long before Mesmer began to work. Righ from the start is was clear that psychotherapy (which was already called psychical therapy) should be done together with pharmacotherapy, therefore the question did not arise, what would work better pharmacotherapy or psychotherapy. The influence was from philosophy of the time — as it is now — which considered the question of a comparative efficacy as useless. As long as the patient had to pay himself for any medical treatment, the question of efficacy remained undiscussed. Only when third party payment and national health plans came up and a struggle for their support began, the question of efficacy became interesting. Therefore the discussion about efficacy of psychotherapy in the historical view can be seen as being part of politics.

## S92. Pregnancy related disorders

*Chairmen:* A Coen, I Brockington

Abstracts not received.

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