controlled trials: in others, the rationale for combination can be unclear, and treatment associated with potential hazards.

Methods: Structured review of the relevant findings of naturalistic studies of antidepressant prescribing in primary and secondary care; appraisal of randomised controlled trials of combining antidepressants with benzodiazepines, lithium, anticonvulsants, atypical antipsychotic drugs and other compounds.

Results: Naturalistic (typically retrospective) studies indicate that antidepressants are frequently prescribed in combination with other psychotropic drugs. Meta-analyses and/or randomised controlled trials support the common clinical practice of attempting to enhance efficacy through combining lithium, and some benzodiazepines or atypical antipsychotics, with antidepressant drugs: the evidence is less strong for approaches that attempt to enhance tolerability through combination treatment. However, it is uncertain how much of clinical practice is determined by awareness of this evidence base, or is influenced by other factors.

Conclusion: There is a need for prospective naturalistic studies of the reasons for use of concomitant psychotropic medication during antidepressant treatment.

S-14-04

Is there a psychopharmacological rationale for polypharmacy?

W. Müller. *Frankfurt, Germany*

Monday, April 4, 2005

YP-S-01. Symposium: New challenges for young psychiatrists in europe

Chairperson(s): I.T. Calliess (Hannover, Germany), Kai Treichel (Germany)
08.30 - 10.00, Holiday Inn - Room 4

Sunday, April 3, 2005

SS-04. Section symposium: Recent development in psychotherapy - from schools to evidence based approaches

Chairperson(s): G. Gotestam (Norway), Fritz Hohagen (Lübeck, Germany)
14.15 - 15.45, Holiday Inn - Room 3

SS-04-01

Why do we need disorder-specific psychotherapy?

F. Hohagen. *Clinic for Psychiatry Medical University of Lübeck, Lübeck, Germany*

During the last decades training in and the clinical practice of psychotherapy have been dominated by psychotherapy schools. At present, psychodynamic psychotherapy/psychoanalysis and cognitive behavioral psychotherapy are the most common methods. However, there is increasing critical discussion of whether a school-oriented approach to psychotherapy is justified or whether it should be replaced by a disorder-oriented approach. Although school-oriented psychotherapy is based on a plausible theoretical background, this does not necessarily mean that the therapy of respective mental disorders is clinically beneficial. For example, the "Critical Incident Stress Debriefing Therapy" according to Mitchell is based on a plausible theory, but evaluation studies have shown that this method of therapy did not prevent patients from developing posttraumatic stress disorder (PTSD) one year after the trauma but that PTSD symptoms actually increased. Furthermore, psychotherapists trained only in the methods of one school of psychotherapy tend to employ only those techniques learned during their training, not taking into consideration disorder-oriented therapy interventions. Additionally, although most schools of psychotherapy claim to be able to treat every mental disorder with one methodological approach, very often they do not meet the specific demands of the respective mental disorder and show a certain resistance to integrating other psychotherapy methods into the treatment plan. In recent years, an increasing number of disorder-oriented psychotherapies have been developed and evaluated. These focus on the special symptomatology of a mental disorder, taking into consideration both the patient's needs and the special demands of the respective mental disorder. Examples include dialectic behavioral therapy for borderline-personality disorders according to Linehan, cognitive-behavioral analysis system of psychotherapy (CBASP) according to McCullough for the treatment of chronic depression, and interpersonal psychotherapy according to Klerman and Weitzman for the treatment of acute depression. Changing from school- to disorder-oriented psychotherapy has consequences for psychotherapy training, which should include basic psychotherapy training. Furthermore, the costs for psychotherapy methods should be reimbursed only if a sufficient number of evaluation studies have shown their clinical efficiency in controlled trials for certain indications. In the future, the practice of psychotherapy will have to become much more specialized than it is today in most countries.

SS-04-02

Why do we need school-specific psychotherapies?

M. Linden, C. Müller. *Charite Berlin Rehab. Centre Seehof, Teltow/Berlin, Germany*

Psychotherapy is what psychotherapists do with their patients. Evaluation of psychotherapist behaviour and competency has to differentiate between therapist-patient relationship, gen-eral techniques, illness specific techniques, session strategy, therapy strategy, and treatment heuristics. Skills on these different levels of psychotherapeutic behaviour can be described, monitored, learned and evaluated. In respect to therapist training, competency in general techniques is most important to guarantee that a therapist can cope with different patients and problems. For behaviour therapy, the authors have developed the therapist competency checklist, an instrument which allows to qualify therapist expertise in general behaviour therapy tech-niques. Items are e. g. home work assignment, eliciting of automatic thoughts, or role play. It is evident, that such techniques need a theoretical framework in order to understand how they work, when they should be used in the treatment of an individual patient, or how to evaluate their effects. Techniques and background theory are what is traditionally called a "psychotherapy school". Psychotherapist do what they have learned and what they know how to do. They need prac-tice in administering techniques and they need theoretical knowledge in order to guide their interventions. The question is, how many sets

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of techniques are needed and must be learned in order to be able to treat different illnesses and patient problems. This question must be answered under consideration of the fact, that no psychotherapist has ever been long enough in training in order to see only one patient of all types, which he may see when being in clinical practice. Our view is that it is preferable to give a therapist a profound expertise in one set of general techniques and theories than to provide him or her with a superficial glimpse of diverse approaches. This means to give psychotherapists a basic training in one school. Apart from training issues, this also allows to ask for differential indications of alterna-tive treatment approaches. Therapists and patients should be appreciate that also in psycho-therapy there is more than one treatment approach and option.

SS-04-03

Individual treatment plan, disorder-oriented psychotherapy, or both?

F. Caspar. *Universität Freiburg Klinik Psychologie, Freiburg, Germany*

To provide essentially the same kind of psychotherapy for all patients is outdated: It needs to be adapted to the patients. The question is, how and according to what criteria. A differenciation according to diagnoses has become the main avenue of adapting treatment to patients. It is obvious that effect sizes can be increased when taking into account that different disorders require different treatments. Problems arise in the case of comorbidity, in the case of obvious suffering requiring treatment without fitting any ICD or DSM category, for the many diagnostic categories for which no disorder specific manual exists, and for the cases in which additional factors make the treatment of choice for a disorder less than ideal. While the experimental logic of creating and using evidence for the effectiveness of treatment seems to require a bleaching out of variation, practice with patients who do not correspond to the selection for randomized cinical trials, requires variation. A general model is presented which postulates the simultaneous, smooth integration of a variety of factors according to which it is a matter of course that treatment plans should at the same time take disorder specific techniques into account AND be individualized along a number of additional criteria.

SS-04-04

A comparison of dynamic and cognitive psychotherapy in the treatment of cluster personality disorders

M. Svartberg. *Trondheim, Norway*

Monday, April 4, 2005

SS-11. Section symposium: Psychotherapy in postpartum

Chairperson(s): Christiane Hornstein (Wiesloch, Germany), Anette Kersting (Münster, Germany)
16.15 - 17.45, Holiday Inn - Room 2

SS-11-01

Interaction focussed psychotherapy for postpartum disorders

C. Hornstein. *Center f. Psychiatry Nordbaden, Wiesloch, Germany*

Postpartum illness of the mother affects the interaction with the baby and may cause cognitive and emotional deficits in the baby, especially in case of severely and chronically ill mothers. Therefore postpartum disorders require specific psychotherapy focussing on maternal disorder and mother-infant-interaction. An integrated therapy program for women with psychotic disorders or severe depression in early motherhood was developed at the mother-baby-unit in the Psychiatric Hospital Nordbaden, Wiesloch. The standardized six-week treatment program combines a cognitive group therapy, an individual video microanalytic therapy as well as a daily support program and a psychoeducational group for fathers. The evaluation of the treatment in an naturalistic design shows significant effects on several parameters. Treatment outcome will be demonstrated in 44 mother-baby-dyades with regard to psychopathological parameters, maternal self-confidence, mother-to-child-bonding and mother-infant-interaction (microanalytic interaction scales of Laucht & Esser). The different treatment outcomes of diagnostic subgroups be discussed.

SS-11-02

Outcome of brief mother-infant psychotherapies as a function of maternal depression

C. Robert-Tissot. *Switzerland*

A research program of the Geneva Group (C. Robert-Tissot) provide data on maternal depression at pre-treatment assessment on 132 mothers consulting for a functional (sleep, feeding) or behaviour problem (excessive crying, opposition) of a child (2 to 30 months of age). The effects of maternal depression on infants behaviour and development, on mother-infant interactions and on maternal representations were examined before and after treatment, and at preadolescence, for a sub-group having participated to the different assessments and follow-up. Mother-infant brief psychotherapy (mean of 6 sessions) prove to be affective to reduce infant symptoms as well as to modify maternal feelings and self-esteem. Results are discussed in the framework of a transactional and developmental model."

SS-11-03

Psychotherapy of parents after the birth of a dead child

A. Kersting. *Münster, Germany*

Despite improved medical possibilities the number of stillborn children has not change in the past 10 years. The psychological consequences of a stillbirth for women and their families have comprehensively been examined in the past 25 years, in particular after it was revealed that normal mourning reactions after a stillbirth differed only insignificantly from those of other mourning situations. The loss of a child late in a pregnancy, while or briefly after birth can lead to over months and years of continuing psychological symptoms and can affect family relations in different ways even as far as the bonding to the following child. During the treatment of women, who have experienced the perinatal death of a child, the physicians, midwives and nurses are frequently confronted with their own helplessness. Even if the psychological consequences of stillbirths have often been described in the literature, to date there has been no standardized psychotherapeutic intervention program whose effectiveness has been empirically proven. In this context the characteristics of the psychotherapeutic treatment of parents after the birth of a dead child will be

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