increasingly recognised that sedation is not a prerequisite for acute symptom control. Moreover, excessive sedation or 'over-sedation' can interfere with the physician's ability to evaluate the patient and establish an effective therapeutic alliance with them, thus potentially influencing future compliance and treatment outcomes. Over-sedation is also strongly disliked by patients. Thus, achieving control of agitation via rapid calming rather than sedation is becoming an important therapeutic goal. Sedative agents, such as lorazepam, have traditionally been used for the management of acute agitation. However, problems with over-sedation have led to the increased use of intramuscular (IM) antipsychotics – which are easy to administer and provide rapid symptom relief of acute agitation – as a first-line approach in the acute setting. The recent availability of atypical antipsychotics as IM formulations represents a significant step towards meeting the goal of efficacy without over-sedation. Aripiprazole, olanzapine and ziprasidone have demonstrated efficacy in the management of acutely agitated patients with schizophrenia. Indeed, IM aripiprazole has been shown to be equally effective as IM haloperidol with a lower risk of extrapyramidal symptoms. Importantly, calming of acutely agitated patients without excessive sedation is emerging as a significant clinical advantage of IM atypicals over older treatments such as typical antipsychotics or benzodiazepines. Thus, physicians should consider the specific, sedation-independent calming effects of atypicals.

Core Symposium: Combined psychopharmacotherapy and psychotherapy

CS02.01

Combination of antidepressants and cognitive behaviour therapy

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The investigation of the comparative efficacy of the combination of pharmacotherapy and psychotherapy versus either modality alone has to consider several methodological issues. Neglect of these methodological aspects can lead to severe pitfalls. Also, the interpretation of the results of such studies should be performed very carefully, considering several aspects. Among others, the following questions have to be addressed:

- Was the study performed in a more psychopharmacology-oriented or more psychotherapeutically-oriented institution?
- Were the patients acutely or chronically ill?
- Were the patients already refractory to pharmacotherapy or psychotherapy prior to inclusion in the study?
- Was the pharmacotherapy performed according to the state of the art?
- Was the psychotherapy performed according to the state of the art?
- Was the pharmacotherapy administered under double-blind conditions, using a placebo control or another kind of control?
- Was the psychotherapy administered in the context of a pseudo placebo control group?
- Was the sample size adequate for a confirmative trial?

Generally it has to be taken into consideration that it is much more difficult to prove efficacy of a combination therapy versus an active mono-therapy then to prove efficacy of a mono-therapy or combination therapy versus placebo. Overall, there seems to be evidence for superior efficacy of the combination of antidepressants with cognitive behaviour therapy, especially in certain subgroups of patients.

CS02.02

Psychological treatments combined with drug therapy in bipolar disorder

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There is now a large body of controlled trial research into the efficacy of psychological treatments in unipolar affective disorder, indicating their place in acute treatment and in prevention of relapse and recurrence. In bipolar disorder the evidence is still less strong, but studies are rapidly accumulating. Psychological treatments have been almost always combined with medication. The psychological approaches have included psychoeducation, cognitive therapy (CBT), interpersonal and social rhythm therapy (IPSRT), family therapy. Some approaches have used mixtures of elements, particularly psychoeducation with family or cognitive therapy. Benefits found have included symptom improvement, improvement in social function, relapse prevention and improved adherence to drug regimes. However findings have not been entirely consistent, so that definitive recommendations are still premature. Effects may be weaker than in unipolar disorder. In contrast to unipolar disorder, where the strongest body of empirical evidence favours cognitive therapy for symptom remission and relapse prevention, in bipolar disorder psychoeducationally-based approaches may emerge to be of greater benefit.

CS02.03

The relevance of psychoeducation in the treatment of schizophrenia

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Background and Aims: Due to the multifactorial origin of Schizophrenia, a multidimensional therapeutic approach has become state of the art in our days (APA 2004; DGPPN 2006). Whereas the efficacy of pharmacotherapy has been proven in a great number of studies (Möller 2005), data concerning the efficacy of psychotherapeutic and psychosocial measures are mixed up to now.

Methods: There are many studies about psychoeducation, cognitive behavioural therapy, cognitive remediation, social skills training and other psychotherapeutic interventions, but we don't know exactly if these measures are successful on their own or only in combination with other therapeutic measures. The newest findings in the literature will be screened concerning their efficacy.

Results: Significant results have meanwhile been found concerning the rehospitalisation-rate during the first and the second year after discharge (Pekkala 2004; Pitschel-Walz et al 2006). For the time frame of 5-8 years after discharge in a pooled data analysis, a rehospitalisation rate of 54% among the intervention group and 80% among the controll group ($p < .05$) could be found in the tree long term follow-up studies of Tarrier et al (1994), Hornung et al (1999) and Bäuml et al (2007).

Conclusions: Psychoeducation has proven as most effective, if relatives were included into the intervention (Pitschel-Walz, Bäuml et al 2001). The newest data concerning psychosocial interventions in general and concerning psychoeducation in particular will be

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