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

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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

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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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contents of the specialist training meet the demands of the work once specialist degree is obtained. The trainees need more skills for work in private sector and administration.

S7-4

RESIDENCY TRAINING OF PSYCHIATRISTS IN FRENCH SPEAKING COUNTRIES

J.M. Cloos. *European Forum of Psychiatric Trainees, Belgium*

Background: Training of psychiatrists remains quite heterogenous in European countries. The requirements and the regulations of postgraduate psychiatry training in some French speaking countries are reviewed and compared.

Methods: The author was interested to compare residency training in Belgium and Switzerland. Comparisons include length and content of theoretical courses, training, supervision, log book, examinations, publications, as well as research. Special emphasis is given to the problem of including psychotherapy during the training period. As a basis of comparison, the "charter on training of medical specialists in the EU - requirements for the specialty psychiatry (UEMS, 1995)" has been used.

Results: The UEMS criteria are globally being met, even though differences exist in the mandatory character of these requirements. Switzerland recently updated its postgraduate education in psychiatry, including e.g., compulsory psychotherapy and examinations within the training. Belgium keeps a rather flexible training model, allowing the trainee a residency fitting better to her/his personal expectancies. Although recommended, a training in psychotherapy is not compulsory at this moment.

Conclusion: Training models in psychiatry remain rather disparate and evoluate rapidly over time. Compromises have to be made to ensure on the one hand minimal standards of training and on the other hand enough flexibility to allow a personalised program in the broad field of psychiatric and psychotherapeutical orientations.

S7-5

STRIVING FOR THE HARMONIZATION OF TRAINING IN EUROPE: THE WORK OF THE EUROPEAN BOARD OF PSYCHIATRY

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The European Board of Psychiatry main objective is the harmonisation of psychiatric training within the European Union.

To achieve this end, the Board has carded out several surveys to obtain information on psychiatric training and psychiatric practice in Europe. Obviously, there are similarities and as well as dissimilarities. On the basis of this information several reports containing recommendations aiming at the harmonisation of the training in Europe have been issued.

However, issuing reports surely is not sufficient to achieve harmonisation; other strategies may be in order, such as facilitating trainees exchange between countries; promoting the international exchange of information, as well as personal contacts, between trainers and between trainees; setting up the practice of international visiting of training centres; and the use of an European Trainees Logbook.

DEB8. Mental health care under pressure

Chair: N Sartorius (CH)

S9. Multiple perspectives on neurasthenia and chronic fatigue syndrome

Chairs: V Starcevic (YU), N Sartorius (CH)

S9-1

NEURASTHENIA AND CHRONIC FATIGUE SYNDROME: CROSS-CULTURAL AND CONCEPTUAL ISSUES

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Similarities have been observed between neurasthenia (NS) - which is listed in the International Classification of Diseases (ICD), but not in the American psychiatric classifications - and chronic fatigue syndrome (CFS) - prevalent not only in the United States, but also in Great Britain, Canada, and some other Western nations. On the other hand, there are also differences between the clinical presentation of NS and CFS in different countries: instead of debilitating fatigue, pain and dizziness are hallmarks of NS in China, whereas in Yugoslavia, it is irritability. This suggests that in different cultures there may be different "idioms of distress" for the same psychopathological condition if it is assumed that NS and CFS are, indeed, the same illness - for which, however, there is no sufficient evidence. The question arises, then, as to whether there is some underlying and "pathognomonic" feature, shared by both NS and CFS. If not, use of the same diagnostic label, whether it is NS or CFS, may pertain to disorders that are essentially different, with and without regard to the cultural context.

Another important issue pertains to the relationship between NS/CFS, depression and anxiety disorders. The substantial overlap between these illnesses raises questions about diagnostic and conceptual validity of NS/CFS. The ICD-10 deals with this problem by proposing a controversial diagnostic "primacy" of depression and specific anxiety disorders over NS.

Unfortunately, there has been very little dialogue between researchers of NS and CFS, and as a result, these issues remain unresolved. Future research should therefore attempt to answer the following questions: 1) Is there only one syndrome of NS/CFS, diagnosable world-wide, with certain key characteristics, or are there different subtypes of NS/CFS, with features that are confined to specific social settings? 2) Can there be a cross-cultural agreement on what are the "core" characteristics of NS/CFS, which would improve international communication between clinicians and researchers, and reduce heterogeneity of the concept? 3) How should the overlap/comorbidity between NS/CFS, depression and anxiety be better conceptualized?

S9-2

EPIDEMIOLOGY OF NEURASTHENIA

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Like depressive syndromes neurasthenic syndromes comprise a wide spectrum of manifestations. They may take episodic, recurrent

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