to leave a substantial amount of residual symptomatology, which is probably the strongest predictor of relapse. Use of psychotherapeutic techniques geared to this residual phase (including well-being enhancing strategies) has yielded substantial advantages in terms of relapse rate over clinical management in controlled clinical trials. The most likely mechanism are that cognitive behavioural therapy prevents the progression of residual symptoms to prodromal symptoms of relapse and/or enhances the protective effects of psychological well-being.

PS01.02
PHARMACOLOGICAL AND NON-PHARMACOLOGICAL APPROACHES IN THE MANAGEMENT OF MILDER DEPRESSIONS

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This presentation will review studies of antidepressants, interpersonal therapy (IPT) and cognitive behavioural therapy (CBT) in milder depressive episodes and dysthymia, both regarding acute treatment and prevention of relapse and recurrence.

Regarding acute treatment, tricyclic antidepressants show a clear threshold level around Hamilton total score of 13 for benefit in depressive episodes. Evidence for SSRIs is still accumulating. Both classes of antidepressants also show efficacy in dysthymia, although evidence is less clear cut. There is consistent evidence from controlled trials of benefit from IPT and CBT in depressive episodes but little evidence regarding dysthymia. For continuation and maintenance treatment, although there is strong evidence of benefit overall from antidepressants, there have been only a small number of studies in milder depressions, acute or chronic. For IPT, evidence of prevention of further episodes is less overall, and so far based on severe episodes. For CBT there is increasing evidence of relapse prevention effects. Recent studies have focused on partial remission with residual symptoms after major depression, where there is high risk of relapse. In a large controlled trial, we found clear evidence of relapse prevention by CBT when added to moderately high dose antidepressants in residual depression.

PS01.03
PHARMACOLOGICAL AND NON-PHARMACOLOGICAL APPROACHES IN THE LONG-TERM MANAGEMENT OF BIPOLAR DISORDER

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In the last years, the maintenance treatment of bipolar disorders is characterized by an expansion of treatment alternatives to lithium and by the application of various psychotherapeutic approaches in this distinctly biological mental disorder.

Besides valproate and carbamazepine, initial data support the prophylactic efficacy of further anticonvulsants such as lamotrigine, gabapentine and topiramate, of calcium antagonists (nimodipine, verapamil) and of atypical antipsychotics (clozapine, olanzapine). But even regarding the differential use of lithium and carbamazepine, prospective data are very scarce.

In a randomized clinical trial (MAP-study) with an observation period of 2.5 years, we compared the differential efficacy of lithium versus carbamazepine in 171 bipolar patients (DSM-IV). The whole sample was subdivided into a classical subgroup (Bipolar-I patients without mood-incongruent delusions and without comorbidity; n = 67) and a non-classical subgroup including all other patients (n = 104). Classical bipolar patients had a significantly lower hospitalization rate under lithium than under carbamazepine prophylaxis. Regarding suicidal behavior, there was a trend in favor of lithium, whereas data on patients' satisfaction were significantly in favor of carbamazepine. In conclusion, lithium appears to be superior to carbamazepine in classical bipolar cases and might have additional impact on suicidality. The distinctly larger group of patients with non-classical features might profit more from carbamazepine which seems to be well accepted by the patients (Greil et al., J. Clin. Psychopharmacol 1998, 18, 455–460).

Various psychotherapeutic approaches, such as psychoeducation, family focused, cognitive-behavioral, interpersonal or social rhythm therapy, may improve the effectiveness of drug therapy by enhancing compliance, promoting the recognition of early signs of an emerging episode and by supporting the patient to cope with stressful life events. Self help groups, may assist the patient to overcome the denial of the illness.

S06. Evaluation of psychiatric training

Chairs: S.P. Tyrer (UK), J. Raboch (CZ)

S06.01
CONTINUING MEDICAL (PSYCHIATRIC) EDUCATION IN HUNGARY

I. Bitter. *Department of Psychiatry and Psychotherapy, Semmelweis University., Budapest, Hungary*

Continuing medical education (CME) was the responsibility of Postgraduate Medical School in the former communist countries including Hungary. After the major political changes of 1989/90 CME became decentralized, other medical faculties, professional societies and the industry became involved However no quality control existed until recently and some problems emerged, for example CME became target for marketing activities of some drug companies. The Hungarian Psychiatric Association (HPA) in collaboration with all five psychiatric departments and other professional bodies of the country initiated the establishment of a nationwide CME coordinating board which helps in supervising and evaluating the programs. A new regulation published January 2000 by the Ministry of Health confirms the initiative of the HPA. The following problems are still to be solved: 1. Access to CME programs is difficult in some remote areas of the country. 2. Financing of the system has to be improved, conditions for sponsorship have to be clarified. 3. The responsibilities of the Universities and of a newly established nationwide CME Board has to be defined. 4. The possibilities offered by new technologies such as videoconferences or the Internet should be better utilized in CME. The development and use of European Guidelines for CME would help in providing CME for psychiatrist in Hungary and perhaps in other countries as well.

S06.02
Evaluation of postgraduate training

I. Tuma

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