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

M. Gómez-Beneyto. *Facultad de Medicina, Unidad Docente de Psiquiatría, Valencia, Spain*

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

V. Starcevic[1,2]. *Institute of Mental Health, Belgrade;* [2] *University of Belgrade School of Medicine, Belgrade, Yugoslavia*

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

J. Angst. *Zurich University Psychiatric Hospital, Zurich, Switzerland*

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

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or chronic course and manifestations vary in length from hours to years. Recurrent brief neurasthenia (of a few days' duration) and extended neurasthenia of two weeks' or more duration were operationally described and have also been called prolonged fatigue Both represent shorter manifestations than the three months required by ICD-10 (WHO 1993).

In the WHO general health care study 8.7% of patients were found to be suffering from neurasthenia and 8.7% from depressive episodes, which represented the two most common psychological disorders. Most studies also reported that 70% or more of the cases of neurasthenia were associated with psychological disorders.

In the Zurich cohort study of a community sample, which assessed morbidity through five interviews (each covering one year) from the ages of 20 to 35, we found a longitudinal prevalence rate of 4.3% for ICD-10 neurasthenia and 6.3% for extended (prolonged) neurasthenia. Recurrent brief neurasthenia was observed in a further 11.4%, The prevalence in females was three to five times higher than in males.

Most neurasthenic syndromes were found to lead to subjective work and social impairment and to be associated with a positive family history of the syndrome. The validity of several neurasthenic subgroups can also be demonstrated by the degree of suffering/distress, treatment seeking, prescribed medication and diminished quality of life. Longitudinally ICD-10 neurasthenia was associated in 78% of the cases with major depressive episodes (especially with atypical major depression), with anxiety disorders in 70% and with substance abuse in 12% of the cases.

The data support a descriptive approach for the definition of the spectrum of neurasthenia from brief through extended to more chronic forms and suggest that they should be analysed in their complex association with all subgroups of psychological disorders.

S9-3

DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF CHRONIC FATIGUE SYNDROME

Simon Wessely. *Academic Dept of Psychological Medicine King's College School of Medicine & Institute of Psychiatry, Denmark Hill, London, SE5 9RS, UK*

In this paper I shall review the recent epidemiological studies on the prevalence of chronic fatigue syndrome (CFS) in the general population and primary care, concluding that it is by no means uncommon, and is also a common cause of personal morbidity. However, patients who present to doctors with the label of CFS are less common, and also frequently present management problems. I shall consider the current diagnostic criteria, when and how to make the diagnosis of CFS, and what to do next. I will review the limited number of investigations necessary, and then conclude with a discussion of practical treatment strategies and the evidence to support them.

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S9-4

CHRONIC FATIGUE SYNDROME, SEROTONIN AND DEPRESSION: HOW STRONG THE LINK?

A.J. Cleare. *Kings College School of Medicine and Dentistry, and the Institute of Psychiatry, London, UK*

There is a high degree of co-morbidity between chronic fatigue syndrome (CFS) and major depression (MD). Indeed, several symptoms in the diagnostic criteria for the two conditions overlap. However, there is now emerging data to suggest a neurobiological distinction between CFS and MD. First, the consensus of studies using neuropharmacological challenge tests reveal reduced central serotonergic function in MD, consistent with the serotonin hypothesis of MD. In contrast, studies in CFS show the opposite effect, with enhanced responses to serotonergic challenge, suggesting enhanced central serotonergic function. Second, MD has long been known to be associated with hypercortisolaemia and a range of abnormalities related to hypothalamo-pituitary-adrenal (HPA) axis overdrive. Emerging evidence in CFS points to a reduction in HPA axis output, with low circulating cortisol levels, and abnormal responses to dynamic testing of the HPA axis components. There is now much evidence of an inverse link between cortisol levels and serotonergic function; whether serotonergic abnormalities cause the HPA axis changes or vice versa is not yet known. However, since low cortisol levels lead to fatigue and other symptoms in Addisons disease, we tested the hypothesis that low cortisol levels in CFS were related to some symptomatology by giving low-dose cortisol replacement with 5 mg or 10 mg of hydrocortisone in a randomised double blind placebo controlled crossover. Both doses of cortisol led to significant improvements in fatigue and disability, suggesting that low cortisol levels may be a significant factor in maintaining symptoms in CFS.

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S9-5

A COGNITIVE BEHAVIOUR FORMULATION AND TREATMENT OF CHRONIC FATIGUE SYNDROME

M. Sharpe. *University of Edinburgh, UK*

A variety of treatments have been tried for chronic fatigue syndrome. The only one to be shown to be efficacious in replicated randomised controlled trials is rehabilitative cognitive behaviour therapy (CBT).

The cognitive behavioural model emphasis the interaction of patient beliefs, emotional arousal and physiological disturbance within an interpersonal context. Particular importance is paid upon the belief that activity will be harmful and on the behavioural change of stabilising and increasing activity.

To date there have been three randomised controled trials of CBT published and one of a behavioural (exercise) programme.

The first of these by Lloyd et al. used a brief CBT and did not find this to be superior to good medical care. The next study by our own group used an intensive sixteen session cognitive behaviour therapy with a strong emphasis on rehabilitation and found a clinically and statistically significantly greater improvement in the functioning of patients who had received this treatment from that obtained by routine medical care. It is of considerable interest that the patient improvement was gradual and persisted after therapy had been completed. These results were substantially replicated in a further trial by Deale et al. which compared a similar form of cognitive behaviour therapy with time matched relaxation.

More recently Fulcher et al. have shown that graded aerobic exercise (accompanied by a considerable explanation and support) is also superior to simple flexibility exercises.