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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