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

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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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