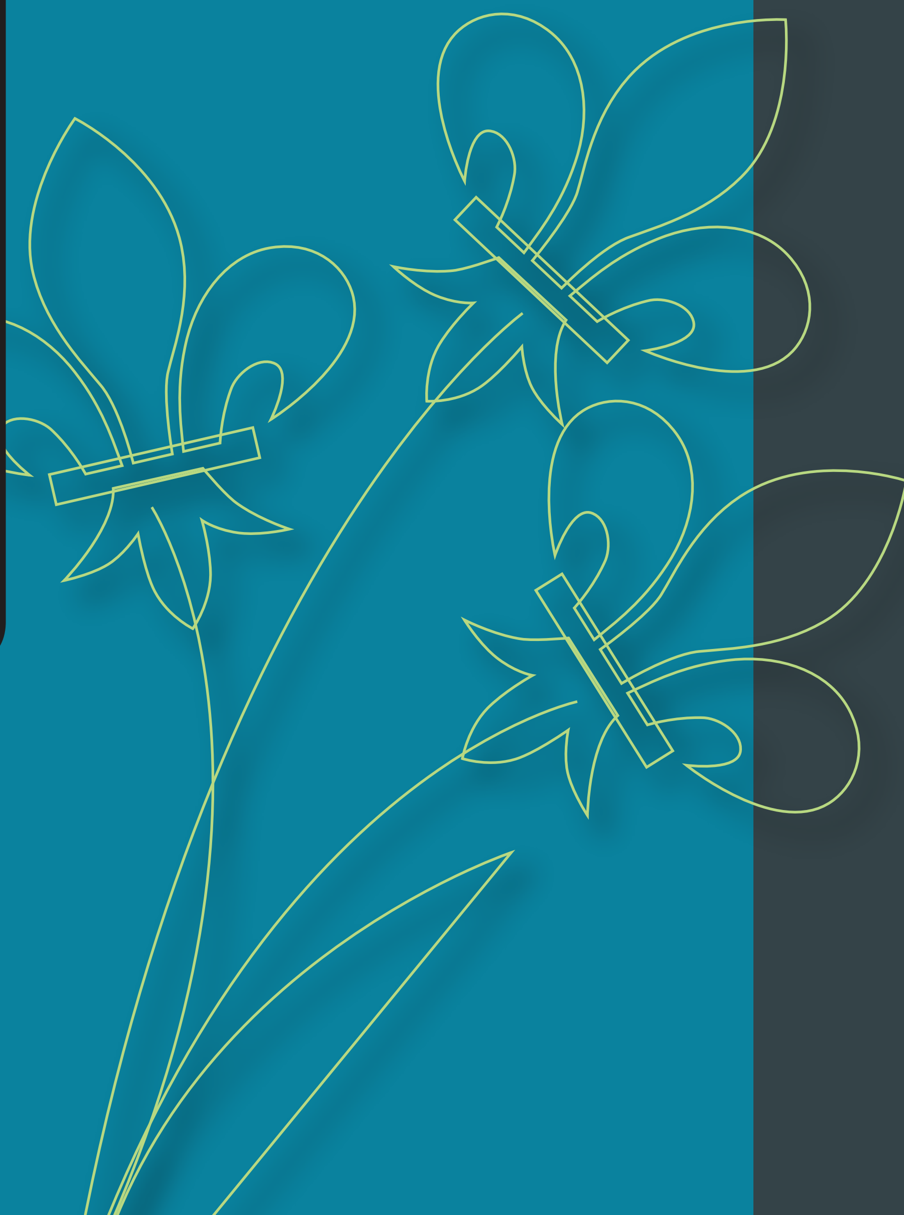
PRIDE AND PROMISE : TOWARD A NEW PSYCHIATRY

American Psychiatric Association + COURSE BROCHURE

# SYLLABUS

## AND PROCEEDINGS BOOK

To The **2010** Annual Meeting



*what's inside*

- Advances in Series
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163rd ANNUAL MEETING • NEW ORLEANS, LA • MAY 22-26, 2010

# SYLLABUS
# AND
# SCIENTIFIC PROCEEDINGS

## IN SUMMARY FORM

## THE ONE HUNDRED AND SIXTY THIRD ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

New Orleans, LA
May 22-26, 2010

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AMERICAN PSYCHIATRIC ASSOCIATION
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May 2010

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## FOREWORD

This book incorporates all abstracts of the Scientific Proceedings in Summary Form as have been published in previous years as well as information for Continuing Medical Education (CME) purposes. Readers should note that most abstracts in this syllabus include educational objectives, a list of references, and a summary of each individual paper or session. We wish to express our appreciation to all of the authors and other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to Scientific Program Office staff and the APA Meetings Department.

Julio Licinio, M.D., -*Chairperson*
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## FULL TEXTS

As an added convenience to users of this book, we have included mailing addresses of authors. Persons desiring full texts should correspond directly with the authors. Copies of papers are not available at the meeting.

**EMBARGO:** News reports or summaries of APA 2010 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

The information provided and views expressed by the presenters in this Syllabus are not necessarily those of the American Psychiatric Association, nor does the American Psychiatric Association warrant the accuracy of any information reported.

## AMERICAN PSYCHIATRIC ASSOCIATION
## CONTINUING MEDICAL EDUCATION REQUIREMENT

**APA Continuing Medical Education Requirement**

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted to have participation in Continuing Medical Education activities be a condition of membership. The CME requirement aims at promoting the highest quality of psychiatric care through encouraging continuing professional growth of the individual psychiatrist.

**Beginning January 1, 2010** The Board of Trustees has approved a revision of the Continuing Medical Education requirement for members of the American Psychiatric Association. Beginning January 1, 2010, completing an APA Certificate of CME Compliance is an option for members and not a member requirement. To receive a three-year certificate, members in compliance with APA will complete a total of 150 hours of CME activities within a three-year period. At least 90 hours must be in Category 1. The remaining 60 hours may be in either Category 1 or Category 2, encompassing all other activities such as medical teaching, research, reading of professional literature, self-study projects, and consultation. For further questions or information, contact educme@psych.org

**Obtaining an APA Three-Year Continuing Medical Education Certificate**

APA CME certificates are issued to members upon receipt of a complete report of your CME activities. You can submit a completed APA report form (available on the www.psych.org website, on the Lifelong Learning & CME page within the Education and Career Development menu)) and also through utilizing the CME recorder within the APA CME website - or by using one of the following alternate reporting methods:

> **Submit:**
> *A copy of your current Physician's Recognition Award (PRA) from the American Medical Association,*
> or
> *A copy of your current re-registration of medical licensure* from states which have CME requirements that are equal to or greater than those of the APA
> or
> *A copy of your current CME certificate from the state medical society* which have CME requirements that are equal to or greater than those of the APA

**Reciprocity with AMA**

By completing the APA's CME membership requirement and qualifying for the APA CME certificate, members may also qualify for the standard Physician's Recognition Award (PRA) of the American Medical Association (AMA). APA provides documentation of reciprocity, which can be forwarded (with a fee) to the AMA.

**Reciprocity with Canadian Psychiatric Association/Royal College of Physicians and Surgeons**

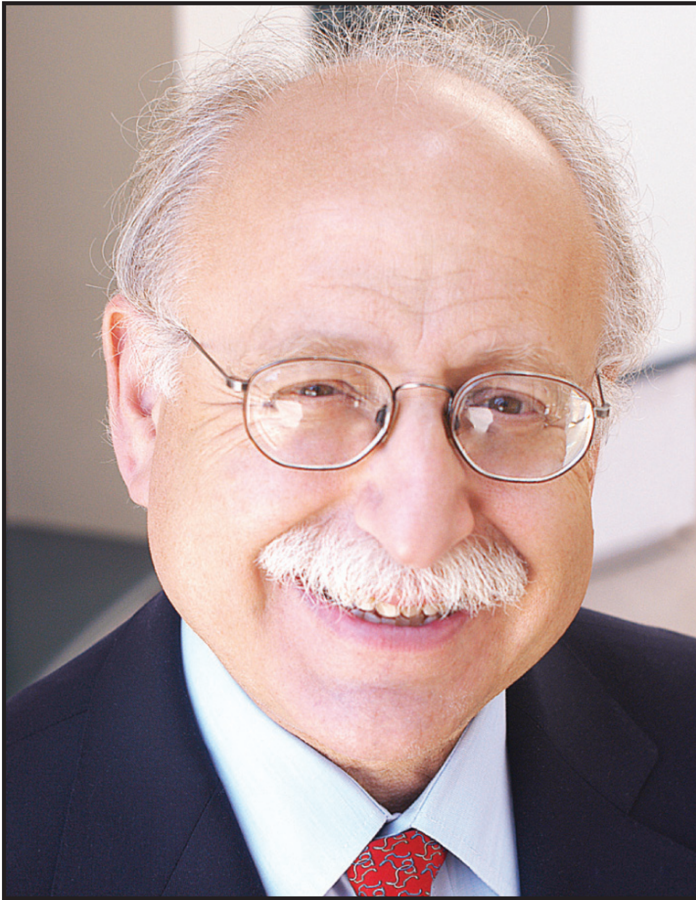
APA sponsored and jointly–sponsored CME activities qualify as accredited group learning activities as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.

By completing APA's CME membership requirement and qualifying for the APA CME certificate, Canadian members may also receive credit towards completion of the requirements of the Royal College of Physicians and Surgeons as administered by the Canadian Psychiatric Association.

The APA maintains a record of member CME compliance and reporting. However, the APA does not keep detailed or cumulative records for members; members are responsible for maintaining their own records. Members may maintain and track their CME activities on the APA web site, www.archive.psych.org/cme, through the CME recorder.

2010 Annual Meeting • New Orleans, LA

# Pride and Promise Toward a New Psychiatry



## Alan F. Schatzberg, M.D.
## President, APA

Welcome to the 163rd Annual Meeting of the American Psychiatric Association in New Orleans, a unique American city and world-class conference location noted for its rich cultural diversity, arts and entertainment, and outstanding restaurants. I think you'll find the program stronger than ever this year, reflecting a combination of new science and clinical advances. "Pride and Promise: Toward a New Psychiatry" is my theme for the meeting. To implement this theme, we called on our academic leaders to develop a comprehensive and balanced program, inviting the best psychiatristscientists from around the world to present their work in special lectures, scientific symposia, workshops and other interactive sessions. Senior scholars such as Daniel Weinberger, M.D., Florian Holsboer, M.D., Ph.D., Eve Johnstone, M.D., Mario Maj, M.D., Ph.D., Raquel Gur, M.D., Ph.D., and Francene Benes, MD, PhD, will address us on their exciting work in depression and schizophrenia. We will also have some of the top young M.D./Ph.D.s from around the country—such as Karl Deisseroth, Kerry Ressler, Vikaas Sohol, Amit Etkin, and others—show us where the field is heading. We are delighted to be partnering once again with the National Institute on Drug Abuse (NIDA) to show how cutting-edge science on substance use disorders is informing clinical practice. Lectures by its director, Nora Volkow, M.D., and A. Thomas McLellan, Ph.D., deputy director of the White House Office of National Drug Control Policy, are headlining the NIDA track. FocusLive, the Advances In series (in partnership with the American Psychiatric Publishing Inc.), Advances in Medicine, and Advances in Research (the latter chaired by former NIMH director and APA president Herbert Pardes, M.D.), all return by popular demand. Attendees also have the opportunity to be in the vanguard regarding DSM-5. A special track of DSM-5 sessions will provide insight into the evolving manual and will solicit attendees' opinions on a number of key issues. Look for symbols throughout the Program Book to help you find sessions in a variety of topical tracks that may relate to your research interests and clinical practice as well as subspecialty tracks published in the Days-At-a-Glance brochure. We hope these tools will make it easier for you to navigate the meeting and we would appreciate your feedback on this innovation. My thanks go to co-chairs, Julio Licinio, M.D., and Donald Hilty, M.D., and members of the Scientific Program Committee, and to the APA staff members who have all worked so diligently to ensure the breadth and quality of the 2010 Annual Meeting program.

Sincerely,

Alan F. Schatzberg, M.D.

**MONDAY, MAY 24, 2010**
**9:00 AM-10:30 AM**

ADVANCES IN MEDICINE 01
## DELIRIUM: NEUROBIOLOGY, PREVENTION AND TREATMENT APPROACHES

*Jose R. Maldonado, M.D., 401 Quarry Road, Room 2317, Stanford, CA 94305*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the pathophysiology of delirium; 2) Understand the research-based, effective treatment options for delirium, including the use of atypical antipsychotic and other novel agents; and 3) Learn research proven preventing techniques.

**SUMMARY:**
Psychiatrists are asked to render opinions and help in the management and treatment of a number of conditions whose etiology may be primarily neurological, but its manifestations clearly psychiatric. Delirium or encephalopathy is one of these- and the most common psychiatric disorder occurring in the medically ill patient. It is also not uncommon in the general psychiatric population, particularly the elderly. Delirium is a transient, sometimes reversible organic mental syndrome caused by dysfunction in cerebral metabolism, characterized by an acute or subacute onset. Features of delirium include disturbance of consciousness, change in cognition, perceptual disturbances, global cognitive impairment, attentional abnormalities, increased or decreased psychomotor activity, and sleep-wake cycle disruption. Medication use, intoxication and withdrawal states, and underlying medical and neurological problems are common causes of delirium. This presentation will explore the pathophysiology of delirium, address preventable causes, review diagnosis, and explore evidence-based prevention and treatment techniques.

**REFERENCES:**
1. Maldonado JR. Delirium in the Acute Care Setting: Characteristics, Diagnosis & Treatment. Critical Care Clinics, 24:657-722, 2008.
2. Maldonado JR. Pathoetiological Model of Delirium: A Comprehensive Understanding of the Neurobiology of Delirium and an Evidence-Based Approach to Prevention and Treatment. Critical Care Clinics, 24:789-856, 2008.

**11:00 AM-12:30 PM**

ADVANCES IN MEDICINE 02
## TOP 10 MEDICAL ARTICLES OF 2009: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW

*Monique Yohanan, M.D., 1100 Park Place Suite 300, San Mateo, CA 94403*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to 1) recognize the publications in the Internal Medicine literature from the past year which are most likely to impact clinical practice; 2) identify advances in Internal Medicine which have important overlap with Psychiatry, and enhance the care of patients with comorbid medical and psychiatric diagnoses; and 3) provide a critical appraisal of the evidence base and methodology of selected publications.

**SUMMARY:**
This session will provide a review of the key medical literature and guidelines in Internal Medicine published in 2009. Areas covered will include those representing important findings likely to impact clinical medical practice, with a special focus on topics common to patients with comorbid psychiatric and medical illness. Additionally, a critical appraisal of the evidence presented in these publications will be offered.

**REFERENCES:**
1. Straus S, I-Hong Hsu S, Ball C et al. Evidence-Based Acute Medicine. Oxford Medical Knowledge, 2002.
2. Nay R, Fetherstonhaugh D. Evidence-based practice: limitations and successful implementation. Ann N Y Acad Sci.

2007 Oct;1114:456-63.

**TUESDAY, MAY 25, 2010**
**9:00 AM-10:30AM**

ADVANCES IN MEDICINE 03
**MOVEMENT DISORDERS IN PSYCHIATRIC PATIENTS**

*Laura Marsh, M.D., Mental Health Care Line, MEDVAMC, 2002 Holcombe Blvd, Houston, TX 77030*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize the common clinical presentations and major clinical features of movement disorders in psychiatric practice; 2) List the subytpes and differential diagnosis of drug-induced movement disorders; 3) Identify the distinguishing features of psychogenic movement disorders; and 4) Recognize the distinguishing motor features of Parkinson's disease and related disorders and how these overlap with psychiatric pathology.

**SUMMARY:**
Movement disorders are another area of clinical concern that falls in the ever increasing interface between psychiatry and neurology. The high prevalence of affected patients underscores the importance of interdisciplinary care. The careful appraisal and appreciation of movement abnormalities and movement disorders in psychiatric patients is as an important component of general psychiatric practice as is the psychiatric assessment of movement disorder patients seen by neurologists. Accordingly, recognition and treatment of movement disorders in psychiatric patients and of psychiatric disturbances in patients with movement disorders requires knowledge of the distinctive motor, cognitive, mood, and behavioral aspects of the various movement disorders and how these clinical phenomena overlap. Using video media, this presentation will illustrate the clinical features of movement disorders of varying etiologies. Case histories will be used to describe the psychiatric presentation and treatment of the three most common subgroups of movement disorders that occur in psychiatric practice:
1) Medication-induced movement abnormalities. These include parkinsonism, tardive syndromes, dystonia, and akathisia. These iatrogenic movements are frequently unrecognized despite causing significant patient distress.
2) Psychogenic movement disorders. About 5% of new patients in movement disorder centers are diagnosed with psychogenic disorders, yet often they do not receive appropriate psychiatric care. Awareness of the clinical features that distinguish psychogenic from primary and drug-induced movement abnormalities will facilitate collaborations between psychiatrists and neurologists in the management of these challenging syndromes.
3) Primary movement disorders, defined as diseases of the central nervous system that primarily involve abnormalities of the basal ganglia, cerebellum, or both. Psychiatric disturbances figure prominently in these conditions, which include Parkinson's disease and related disorders, Tourette's syndrome, primary dystonias, Huntington's disease and other hyperkinetic disorders, and the spinocerebellar ataxias. In many patients, psychiatric disturbances begin in a prodromal phase, before the movement disorder is diagnosed. Once the movement disorder is evident, mood and behavioral abnormalities can be the greatest determinants of quality of life, as seen in Parkinson's disease and Huntington's disease. Over the course of these disease

**REFERENCES:**
1. Marsh L., Margolis R.L. Neuropsychiatric aspects of movement disorders. In Comprehensive Textbook of Psychiatry, 9th Edition, Volume 1. Sadock BJ, Sadock VA, Ruiz P (eds.). Wolters Kluwer/Lippincott Williams and Wilkins. Philadelphia, 2009. 481-503.
2. Kane JM, Fleischhacker WW, Hansen L, Perlis R, Pikalov A 3rd, Assunção-Talbott S.Akathisia: an updated review focusing on second-generation antipsychotics.J Clin Psychiatry. 2009 May;70(5):627-43.

**11:00 AM-12:30 PM**

ADVANCES IN MEDICINE 04

**AGING AND DEMENTIA: AN UPDATE ON NEUROSCIENCE AND BRAIN IMAGING**

*Chairperson.: Anne L Foundas, M.D., 935 Calhoun Street, New Orleans, LA 70118*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the neural substrates of memory and dementia subtypes; 2) Identify the construct of mild cognitive impairment including subtypes; and 3) Recognize how brain imaging can enhance early diagnosis and intervention.

**SUMMARY:**

Cognition plays a vital role in healthy aging, independent living, and quality of life. Age-related declines in cognitive abilities, such as speech and language, memory, reasoning, decision making, and problem solving are common in later life. Age-related changes in long term memory (LTM) are well documented. Volumetric change in specific brain regions, like the hippocampus, medial temporal lobe, and prefrontal cortex correlates with impaired performance on episodic memory and executive control tasks. There is recent evidence that the integrity of white matter pathways is associated with healthy aging, and increased white matter hyperintensities (WMH) are associated with reduced LTM performance in normal aging. There is also considerable individual variation in brain structure and function. In neurodegenerative disorders like Alzheimer's disease there are clear links between memory function and neuropathological changes in core memory structures. For example, atrophy of the hippocampus is associated with increased neurofibrillary tangles in the entorhinal cortex. Reduced hippocampal volume in mild cognitive impairment (MCI) predicts conversion to Alzheimer's disease and volume reductions have been found in healthy aging. This session is designed to educate clinicians, researchers, and students about recent advances in neuroimaging approaches to healthy aging, MCI, and neurodegeneration.

**REFERENCES:**

1. Dash, P.D. & Villemarette-Pittman, N.R. (2005). Alzheimer's Disease. St. Paul, Minnesota: Americal Academy of Neurology Press.
2. Mendoza, John & Foundas, Anne L. (2008). Clinical Neuroanatomy: A Neurobehavioral Approach. Springer Science and Business, Incorporated, New York.

**1:30 PM- 3:00 PM**

ADVANCES IN MEDICINE 05

**MEDICAL MYSTERIES AND PRACTICAL MEDICAL PSYCHIATRIC UPDATES: IS IT MEDICAL, PSYCHIATRIC, OR A LITTLE OF BOTH?**

*Chairperson: Robert M. McCarron, D.O., 1408 Carob Place, Davis, CA 95616*
*Lawson Wulsin, M.D., Jaesu Han, M.D., David Hsu, M.D., Sarah Rivelli, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should able to 1) Better understand the interplay between general medical conditions and abnormal or maladaptive behavior; 2) Discuss both common and less common psychiatric presentations of frequently encountered general medical conditions; and 3) Review "up to date" and evidence based practice patterns for medical / psychiatric conditions

**SUMMARY:**

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. The workshop faculty practice both internal medicine and psychiatry and will collaborate with the audience to review several case based "medical mysteries". A relevant and concise update on several "Med Psych" topics will be discussed.

**WEDNESDAY, MAY 26, 2010**

**11:00 AM-12:30 PM**

ADVANCES IN MEDICINE 06

## AN UPDATE ON GASTROENTEROLOGY AND HEPATOLOGY

*Chairperson:Nathaniel S. Winstead, M.D., M.P.H.CA4 - Gastro 1514 Jefferson Highway, New Orleans, LA 70121*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify recent developments in gastroenterology and hematology as they relate to the field of psychiatry; 2) Recognize gastrointestinal bleeding risk in patients on antidepressants; 3) Gain a better understanding of the treatment of depression and interferon treatment; 4) Demonstrate knowledge of mental health, substance abuse, and end-stage liver disease; and 5) Recognize psychiatric issues in inflammatory bowel disease, and irritable bowel syndrome (IBS).

### SUMMARY:

In this session we will review recent developments in the fields of Gastroenterology and Hepatology as they relate to Mental Health. There have been several interesting developments in this body of literature over the last few years. Topics to be discussed include:

- SSRI drugs and gastrointestinal bleeding risk. We will discuss bleeding risk in general to give mental health practitioners a clearer understanding of when these drugs should be used with caution.
- Safe and effective treatment of depression in Hepatitis C, and non-alcohol substance abuse in Hepatitis C and its influence on disease progression.
- Mental health, depression, fatigue, and well-being in patients with inflammatory bowel disease, including new data implicating depression as a causative factor in disease flareups.
- Depression, anxiety and inflamatory cytokines in inflamatory bowel disease.

### REFERENCES:

1. Hanson KA, Loftus EV, Harmsen WS, et al. Clinical features and outcome of patients with inflammatory bowel disease who use narcotics: a case-control study. Inflamm. Bowel Dis. 2009;15(5):772-777.
2. Minderhoud IM, Samsom M, Oldenburg B. Crohn's disease, fatigue, and infliximab: is there a role for cytokines in the pathogenesis of fatigue? World J. Gastroenterol. 2007;13(14):2089-2093.
3. Hézode C, Roudot-Thoraval F, Nguyen S, et al. Daily cannabis smoking as a risk factor for progression of fibrosis in chronic hepatitis C. Hepatology. 2005;42(1):63-71.
4. Hézode C, Zafrani ES, Roudot-Thoraval F, et al. Daily cannabis use: a novel risk factor of steatosis severity in patients with chronic hepatitis C. Gastroenterology. 2008;134(2):432-439.
5. Graff LA, Walker JR, Bernstein CN. Depression and anxiety in inflammatory bowel disease: a review of comorbidity and management. Inflamm. Bowel Dis. 2009;15(7):1105-1118.
6. Schmidt F, Janssen G, Martin G, et al. Factors influencing long-term changes in mental health after interferon-alpha treatment of chronic hepatitis C. Aliment. Pharmacol. Ther. 2009;30(10):1049-1059.
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9. Castellvi P, Navinés R, Gutierrez F, et al. Pegylated interferon and ribavirin-induced depression in chronic hepatitis C: role of personality. J Clin Psychiatry. 2009;70(6):817-828.
10. Hyphantis TN, Tomenson B, Bai M, et al. Psychological Distress, Somatization, and Defense Mechanisms Associated with Quality of Life in Inflammatory Bowel Disease Patients. Dig. Dis. Sci. 2009. Available at: http://www.ncbi.nlm.nih.gov/pubmed/19255844 [Accessed January 8, 2010].
11. Ghia J, Blennerhassett P, Deng Y, et al. Reactivation of inflammatory bowel disease in a mouse model of depression. Gastroenterology. 2009;136(7):2280-2288.e1-4.
12. Targownik LE, Bolton JM, Metge CJ, Leung S, Sareen J. Selective serotonin reuptake inhibitors are associated with a modest increase in the risk of upper gastrointestinal bleeding. Am. J. Gastroenterol. 2009;104(6):1475-1482.
13. Kraus MR, Schäfer A, Schöttker K, et al. Therapy of interferon-induced depression in chronic hepatitis C with citalopram: a randomised, double-blind, placebo-controlled study. Gut. 2008;57(4):531-536.

**WEDNESDAY, MAY 26, 2010**
**10:30 AM-12:30 PM**

ADVANCES IN RESEARCH 1
## ADVANCES IN RESEARCH

*Herbert Pardes, M.D., 177 Fort Washington Ave Rm 142, New York, NY 10032-3733*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) The current major directions in treatment of child psychiatric disorders; 2) An understanding of current psychopharmacological treatment of schizophrenia; and 3) An understanding of the current thinking regarding genetic and environmental effects on the development of anxiety disorders.

**SUMMARY:**

This panel of outstanding academic and clinical psychiatric researchers will give state-of-the-art presentations regarding some of the major psychiatric disorders. These include disorders of children as well as schizophrenia disorders, anxiety disorders and affective disorders. The intention is to provide for the current modern clinician the best thinking regarding the approach to and understanding of major psychiatric issues. Not only will there be a focus on clinical aspects but also on some of the translational research and the actual and potential uses of using research advances for the approach to these psychiatric disorders.

No. 1-A
### UPDATE ON CLINICAL RESEARCH IN SCHIZOPHRENIA

*Stephen Marder, M.D.*

**SUMMARY:**

This update will focus on selected findings from clinical research that have immediate implications for the treatment and management of individuals with schizophrenia. Whereas in the past, the main objective of treatment was on the reduction of psychotic symptoms, there has been a shift toward improving community functioning and the quality of life. Recent findings from large studies of antipsychotic medication demonstrate the serious limitations of antipsychotic medications for improving functioning. However, there is emerging evidence that different forms of psychosocial treatments – when combined with antipsychotics can improve functional outcomes. Research that will be reviewed will include the following areas: (1) studies in first episode psychosis indicating that this population has a considerable vulnerability to the metabolic side effects of antipsychotic drugs; (2) large epidemiological studies on the effects of antipsychotics on mortality; (3) recent findings from studies of novel pharmacological agents that target impaired neurocognition and negative symptoms; (4) studies that evaluated the effectiveness of cognitive behavioral treatment for psychosis, cognitive remediation for impairments in basic cognition; and specialized training for impairments in social cognition. These findings will be linked to revisions in the 2009 recommendations from the Schizophrenia Patient Outcomes Research Team (PORT).

No. 1-B
### THE SEARCH FOR BRAIN-BASED BIOMARKERS OF CHILDHOOD PSYCHIATRIC DISORDERS

*Bradley Peterson, M.D.,*

**SUMMARY:**

The use of brain imaging to identify biomarkers that will aid in the diagnosis and treatment has been the hope for childhood psychiatric disorders for decades. The initial belief of many investigators, that the use of conventional volumetric measures of a single brain region would suffice to aid in clinical diagnosis and management, was rather naïve, because nearly all brain regions are anatomically and functionally heterogeneous, and the likelihood that all or

most of those heterogeneous subregions would be involved in the disease process is low, thereby diluting the diagnostic effects on overall regional volumes. Recent advances in image processing techniques now permit the construction of maps of local volume at each point across the entire brain or brain subregions, permitting a much finer-grained, higher resolution representation of diagnostic effects that more adequately represent the spatially distributed, circuit-based disturbances that are thought to produce developmentally based psychiatric disturbances. These finer-grained maps across the brain are providing evidence for the presence of patterns of anatomical and functional disturbance that are specific for particular disorders and that may soon be sufficiently sensitive to aid in clinical diagnosis and management. Specific examples of promising biomarkers for conditions affecting children and adolescents include those identified in Major Depression, Tourette syndrome, Attention-Deficit/Hyperactivity Disorder, Schizophrenia, and premature birth. These biomarkers may be of help in preventing illness in high risk populations, in predicting the course of future illness, and in subtyping disorders to improve and personalize treatment.

No. 1-C

**FEAR AND ANXIETY: NEUROCIRCUITRY AND GENETICS**

*Kerry Ressler, M.D., Ph.D.*

**SUMMARY:**

This presentation will review some of the most exciting recent findings in the field of Anxiety Research. Anxiety, particularly fear-related disorders, such as Posttraumatic stress disorder, Panic Disorder, and Phobia, are particularly amenable to translational research due to the presence of clear animal models such as Pavlovian Fear Conditioning, and the detailed understanding of the neural circuitry underlying the pathways of fear. This discussion will overview genetics findings, including gene x environment interactions, that appear to be involved in enhancing risk for anxiety in adults. Further, we will explore some of the recent findings in neuroimaging data that point to convergence between the human studies of anxiety and the role of similar brain regions in animal models of fear and anxiety. We will conclude with areas of intersection between the genetics and neuroimaging results. The overall goal of this talk is to present the Practicing Psychiatrist as well as the Psychiatric Researcher betters tools for understanding the potential mechanisms of Anxiety Disorders and how our treatment approaches overlap with these mechanisms.

No. 1-D

**RESEARCH ADVANCES AND THE TREATMENT OF MOOD DISORDERS**

*Jerrold Rosenbaum, M.D.*

**SUMMARY:**

As the tools for studying how the brain gives rise to mind and how a dysregulated brain gives rise to psychopathology expand dramatically, the field of psychiatry is poised for new understandings that might underpin advances in therapeutics for mood disorders. Finding new targets, new mechanisms, and developing new modes for screening new therapeutics promise that we may yet move forward from the era of me-too drugs and advances by formulation rather than innovation. It is relevant for clinicians to understand these directions that are opening new vistas in psychotherapy, psychopharmacology, and neurotherapeutics. Nonetheless, in 2010, the therapeutic armamentarium looks very similar to that in place over preceding decades. We may be more gifted at deploying it, and while this is no small benefit to patients, the promise of neuroscience for therapeutic lies mainly in the future. We have gotten very good however at studying our treatments and knowing about efficacy, adverse effects, response, and relapse. Innovation continues to come in off-label deployment of drugs for new uses and creative combinations. This presentation will review recent research advances that are relevant to clinicians treating depression and bipolar illness.

**MONDAY, MAY 24, 2010**
**9:00 AM-10:30 AM**

ADVANCES IN SERIES 02
**ADVANCES IN PSYCHOSOMATIC MEDICINE**

*Chairperson: James L. Levenson, M.D., Box 980268, Richmond, VA 23298-0268*

**EDUCATIONAL OBJECTIVES:**
At the completion of this session participants will be able to demonstrate knowledge of: 1) Psychiatric issues in the care of obstetric and gynecologic patients; 2) Psychiatric issues in pain management; 3) Diagnosis and treatment of psychosis, mania, and catatonia in the medically ill; 4) Legal issues at the interface of psychiatry and medicine; and 5) Psychopharmacology in the medically ill.

**SUMMARY:**
This symposium is devoted to topics of relevance to all psychiatrists, though they will be of special interest to those whose practice includes seeing patients in general medical inpatient or outpatient settings, especially consultation-liaison psychiatrists. Advances in Psychosomatic Medicine will include up-to-date presentations by experts on psychiatric issues in obstetrics and gynecology; psychiatric issues in pain management; psychosis, mania, and catatonia in the medically ill; legal issues at the interface of psychiatry and medicine; and psychopharmacology in the medically ill. Psychosomatic Medicine is the newest psychiatric subspecialty formally approved by the American Board of Medical Specialties. There are now 1036 psychiatrists in the United States certified in Psychosomatic Medicine by the American Board of Psychiatry and Neurology. Psychosomatic Medicine practitioners are those who have particular expertise in the diagnosis and treatment of psychiatric disorders and psychological difficulties in complex medically ill patients. Clinically, Psychosomatic Medicine focuses on three general groups of patients: those with comorbid psychiatric and general medical illnesses complicating each other's management, those with somatoform and functional disorders, and those with psychiatric disorders that are the direct consequence of a primary medical condition or its treatment. Clinical advances in Psychosomatic Medicine are also presented annually at the meetings of the Academy of Psychosomatic Medicine (next meeting is November 11-14, 2009 in Las Vegas; see http://www.apm.org/ann-mtg/2009).

No. 2-A
**PSYCHIATRIC ISSUES IN THE CARE OF OBSTETRIC AND GYNECOLOGIC PATIENTS**
*Donna Stewart, M.D.*

**SUMMARY:**
Understanding women's mental health is incomplete without considering the social context of their lives and reproductive factors across the lifespan. This presentation will discuss a variety of topics relevant to reproductive psychiatry from a biological, psychological and social perspective: gender identity, fertility, contraception, sterilization, hysterectomy, abortion, chronic pelvic pain, endometriosis, vulvodynia, premenstrual mood disorder, psychiatric disorders in pregnancy and postpartum, perimenopause and urinary incontinence. The presentation and management of anxiety disorders, obsessive-compulsive disorders, depressive disorders, psychosis, substance abuse, personality disorders and situational anxiety and ambivalence in pregnancy will be discussed. Issues unique to pregnancy such as denial of pregnancy, pseudocyesis, hyperemesis and custody issues will be included. Postpartum issues such as perinatal death, baby blues, postpartum depression and postpartum psychosis will be presented. The most recent recommendations on psychotropic drug use and ECT in pregnancy and lactation will be provided. Despite the intense emotional aspects of the work of obstetricians and gynecologists, most have little training, or time, for psychological/ psychiatric disorders. Knowledge of psychosomatic aspects of obstetrics and gynecology is essential for clinicians and their patients for optimal care and research.

No. 2-B
**LEGAL ISSUES AT THE INTERFACE OF PSYCHIATRY AND MEDICINE**

*Rebecca Brendel, M.D., J.D.*

**SUMMARY:**
Legal issues often arise in the practice of psychosomatic medicine. Specific topics of consultation involving legal and quasi-legal topics include decisional capacity, treatment refusal, and informed consent. In addition, the sensitive nature of information obtained in psychiatric consultation may raise questions about confidentiality and patient privilege. Finally, as the practice of medicine becomes increasingly complex in terms of regulation and administration, competing values and concepts have emerged. Examples of this type of legal topic include cases in which there is known harm or a risk of harm to a third party and concerns regarding malpractice liability. This lecture will focus on legal topics commonly encountered

by the consultation-liaison psychiatrist. Specifically, participants will appreciate the rules of confidentiality applicable to psychiatric consultation and treatment and also the limitations on confidentiality. These limitations include mandated reporting, duties to third parties, and disclosure of information under the health insurance portability and accountability act of 1996 (HIPAA). Attendees will also develop an understanding of the legal and clinical concepts applicable to treatment decisions. Topics related to treatment decisions will include a discussion of informed consent, decisional capacity, treatment refusal, surrogate decision-making, and advanced directives. Presentation of these topics will integrate legal and clinical principles in presenting a practical approach to frequently encountered medico-legal issues in psychosomatic medicine. Finally, participants will appreciate key elements of malpractice theory and liability.

No. 2-C

**PSYCHIATRIC ISSUES IN PAIN MANAGEMENT**

*Michael Clark, M.D., M.P.H.*

**SUMMARY:**

This lecture reviews various aspects of the interface of psychiatry and chronic pain. While chronic pain is a common problem requiring specialized assessment and evaluation, these disorders share many features with psychiatric conditions...chronic, disabling, associated with high rates of comorbidity, and refractoriness to treatment. Definitions of chronic pain and specific examples such a neuropathic pain syndromes, migraine and other headaches, low back pain, complex regional pain syndrome, and orofacial pain will be discussed and contrasted with acute pain conditions. Major psychiatric comorbidities of chronic pain, including somatization, substance use, depression, anxiety, and other emotional states are reviewed with special attention to rehabilitative treatments that include pharmacotherapy, psychological therapies, physical therapies, and interdisciplinary programs. Successful treatment requires a comprehensive but individualized formulation that supports the design of a rational rehabilitation approach to restoring the patient to higher levels of function and subsequent improvements in quality of life.

No. 2-D

**PSYCHOPHARMACOLOGY IN THE MEDICALLY ILL**

*James Levenson, M.D.*

**SUMMARY:**

Psychiatric medications are often prescribed for the medically ill. Approximately 10% of medical-surgical inpatients and 5-12% of general practice outpatients are prescribed psychotropic medication. Nearly three fourths of patients seen in psychiatric consultation receive psychotropic medication most often for depression, anxiety, delirium, dementia with behavioral disturbances, and substance abuse and withdrawal Yet many psychiatrists feel ill-equipped to prescribe for such patients out of concerns for safety, drug-disease, and drug-drug interactions. In fact, the vast majority of clinical trials of psychiatric drugs on which governmental regulatory approval is based exclude medically ill individuals. Fortunately, there is a growing evidence base concerning the prescription, safety, and efficacy of psychopharmacologic treatment for a broad range of psychiatric problems in medically ill patients. . This lecture will summarize clinically relevant information regarding psychopharmacology in the medically ill, including pharmacokinetic and pharmacodynamic principles, alternative (nonoral) routes of administration, drug-drug interactions, and organ-system disease-specific issues.

No. 2-E

**PSYCHOSIS, MANIA, AND CATATONIA IN THE MEDICALLY ILL**

*Oliver Freudenreich, M.D.*

**SUMMARY:**

Secondary psychosis, mania, and catatonia can occur in a wide range of medical diseases and toxic states. Prompt recognition of these neuropsychiatric complications allows for specific syndromal treatments that can lead to a complete resolution of the psychiatric symptoms even if the underlying illness cannot be cured. If the neuropsychiatric symptoms are not recognized or poorly treated, substantial morbidity or even death can result. This presentation will focus on the recognition, causes and treatment of secondary psychosis, mania, and catatonia in medically hospitalized patients. Particular emphasis will be placed on medical etiologies and work-up. Treatment considerations will include a discussion of iatrogenic morbidity and mortality that can complicate the treatment of secondary psychosis, mania, and catatonia.

**REFERENCES:**

1. Levenson, J.L. (Ed), American Psychiatric Publishing Textbook of Psychosomatic Medicine, American Psychiatric

Publishing, Inc., Washington, D.C., 2005.
2. Levenson, J.L. (Ed), Essentials of Psychosomatic Medicine, American Psychiatric Publishing, Inc., Washington, D.C., 2007.
3. Ferrando S.J., Levenson J.L., Owen J.A. (Eds), Manual of Psychopharmacology in the Medically Ill, American Psychiatric Publishing, Inc., Washington, D.C., In Press
4. Levenson, J.L., Gitlin, D.F., Crone, C.C.: Psychosomatic Medicine. Psychiatric Clinics of North America, 30:593-863, 2007. Discussant: Michael Clark, M.D., M.P.H., Oliver Freudenreich, M.D., Rebecca Brendel, M.D., J.D., James Levenson, M.D., Donna Stewart, M.D.,

**9:00 AM-12:00 PM**

ADVANCES IN SERIES 01

## ADVANCES IN CORRECTIONAL PSYCHIATRY: FROM PROVISION OF CARE TO MALPRACTICE PREVENTION

*Chairperson: Charles Scott, M.D., 2230 Stockton Blvd, 2nd Floor, Sacramento, CA 95817*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize special needs of juvenile offenders; 2) Identify unique treatment considerations for inmates in super max or death row facilities; 3) Identify key principles in managing disruptive or aggressive inmates; 4) Recognize the importance of quality assurance programs and documentation and 5) Understand the standard of care required to prevent malpractice lawsuits and claims of constitutional rights violations.

### SUMMARY:

At midyear 2007, more than 2.3 million persons were incarcerated in the nation's prison and jails and (Minton and Sabol 2009). Correctional facilities have become the new mental health treatment centers for individuals with mental disorders. As increasing numbers of individuals with mental disorders are living behind bars, many mental health professionals are discovering that their new workplace is located inside a jail or prison. Despite the obvious need for psychiatrists trained to provide care to those who are incarcerated, very few general psychiatry residency programs provide specialized education in correctional mental health. This session, Advances in Correctional Psychiatry, draws from the American Psychiatric Publishing Handbook of Correctional Mental Health to provide updated reviews in areas essential for psychiatrists practicing in a correctional environment. The areas that will be reviewed include the management of juveniles in a correctional setting, state-of-the-art correctional mental health screens and assessment of malingering, importance of quality assurance programs and documentation, key principles in managing the disruptive or aggressive inmate, unique treatment considerations for inmates in supermax or death row facilities, and important legal concepts to understand in order to meet standard of care to prevent malpractice lawsuits and claims of constitutional rights violations.

No. 1-A

## JUVENILE OFFENDERS AND CORRECTIONAL MENTAL HEALTH

*Christopher Thompson, M.D.*

### SUMMARY:

This presentation provides an overview of juvenile arrest and violence epidemiology and trends regarding juvenile crime. Risk factors for those youth who become persistent offenders will be highlighted. Comparisons with the juvenile versus the adult legal process will be noted. The prevalence of mental disorders in the juvenile justice system will be summarized with special emphasis on screening and assessment instruments. Interventions with suicidal youth will be noted as well as the provision of informed consent for pharmacotherapy. Special attention will be given to the management of juveniles who are placed in adult correctional facilities. The use of evidence-based therapies in this population will be reviewed to include cognitive-behavioral therapy, cognitive-behavioral intervention for trauma in schools, anger management training, motivational interviewing, and the "girls… moving on" program. Community programs, alternative placements, and diversion programs will be presented in addition to a review of community-based programs such as multisystemic therapy, multidimensional treatment foster care, and functional family therapy.

No. 1-B

## CONDUCTING MENTAL HEALTH ASSESSMENTS IN CORRECTIONAL SETTINGS

*Humberto Temporini, M.D.*

### SUMMARY:

This presentation will review the prevalence of psychiatric disorder in correctional settings to include psychotic disorders, mood disorders, anxiety disorders, substance use disorders and personality disorders. Particular attention will be given to the use of mental health screens to include the Correctional Mental Health Screen (CHMS)

and the Brief Jail Mental Health Screen (BJMHS). The identification of suicide risk factors unique for inmates will be emphasized. Strategies to assess malingering will be discussed. Stages of inmate evaluation will be reviewed to include medication review at booking, intake mental health screens, comprehensive mental health evaluations, and postclassification referral. The emerging use of telepsychiatry in correctional settings will be discussed. The professional roles and responsibilities of various disciplines in the provision of mental health care to inmates will also be reviewed.

No. 1-C

**CONTINUOUS QUALITY IMPROVEMENT AND DOCUMENTATION**

*Amanda Ruiz, M.D.*

**SUMMARY:**

Given that medical and mental health care within a correctional setting are hold to a community standard, quality medical documentation and a sound continuous quality improvement committee (CQI) are important cornerstones of a strong correctional health care system. This presentation reviews the role of CQI in a correctional setting and provides practical guidelines for documentation useful in the provision of care to inmates. Important terminology and definitions related to the CQI process will be reviewed. The utilization of standard peer review of multisource feedback (MSF) in the CQI process will be presented. The importance of correctional mental health care documentation will be noted with practical guidelines for documentation in this setting provided.

No. 1-D

**MANAGING THE DISRUPTIVE OR AGGRESSIVE INMATE**

*Robert L. Trestman, M.D.*

**SUMMARY:**

The disruptive/aggressive inmate presents unique management challenges within jail and prison environments. Maintaining facility safety and order, and reducing the likelihood of maladaptive inmate behaviors require collaborative management strategies. This presentation explores various categories of disruptive inmate behaviors and details tools and strategies for joint management among disciplines to target a range of inmate misconduct. Particular emphasis is given to self-injurious behaviors with the importance of understanding an inmate's intent and motivation for self-injury highlighted. Inmate hunger strikes, violent behavior, inmate-on-inmate sexual behavior, and exhibitionism are reviewed. The treatment and management of self-injurious behaviors, aggressive acts, and inappropriate sexual behaviors are summarized.

No. 1-E

**SUPERMAX UNITS AND DEATH ROW**

*James Knoll, M.D.*

**SUMMARY:**

This presentation presents an overview of supermax confinement; the inherent difficulties faced by inmates housed in these settings; and the potentially deleterious psychological effects of prolonged isolation, especially for offenders with mental illness. Important case law related to supermax facilities will be discussed. Common barriers to rendering adequate mental health treatment in administrative segregation are summarized. In addition, guidelines for the effective screening, monitoring, and treatment of segregated inmates are provided to assist the psychiatrist in meeting both the community standards of care and constitutional requirements for care to inmates. Psychiatric and legal aspects unique to death row inmates will be highlighted.

No. 1-F

**LEGAL ISSUES REGARDING THE PROVISION OF CARE IN A CORRECTIONAL SETTING**

*Charles Scott, M.D.*

**SUMMARY:**

For nearly two centuries in the United States, inmates' legal rights were significantly limited during their incarceration, with the government rarely interfering with a penal institution's management on behalf of the inmate. During the turbulent time of the 1960s, courts more closely scrutinized inmates' rights and in 1964, the U.S. Supreme Court ruled that state prison inmates have a right to sue in federal court to address their grievances. Psychiatrists who work in a correctional setting should be familiar with common legal mechanisms used by inmates to address concerns regarding the care they are provided. This presentation will review inmate tort claims alleging medical negligence, claims alleging a violation of an inmate's constitutional rights, involuntary treatment and transfers of inmates, and prison litigation reform.

**REFERENCES:**

1. Scott CL: Handbook of Correctional Mental Health, Second

Edition. Arlington, VA: American Psychiatric Publishing, 2009
2. Minton TD, Sabol WJ: Jail inmates at midyear 2008-statistical tables. Bureau of Justice Statistics. NCH 225709, March 2009
Discussant: Robert L. Trestman, M.D., Charles Scott, M.D., Humberto Temporini, M.D., Amanda Ruiz, M.D., James Knoll, M.D.,

**2:00 PM- 5:00 PM**

ADVANCES IN SERIES 03
**ADVANCES IN FORENSIC PSYCHIATRY**

*Chairperson: Robert I. Simon, M.D., 8008 Horse Shoe Lane, Potomac, MD 20854-3831*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of new developments in forensic psychiatry and 2) Understand these new developments with a focus on suicide risk assessment, civil competency, the internet, malingering children and adolescents.

**SUMMARY:**
Forensic psychiatry is a dynamic sub-specialty of psychiatry. Constantly changing issues in law and psychiatry drive new developments. Forensic psychiatrists apply clinical and scientific expertise to legal issues in civil, criminal, correctional and legislative matters. The presenters will discuss cutting edge forensic issues relating to suicide risk assessment, civil competency, the internet and the treatment of adolescents.

No. 3-A
**QUALITY ASSURANCE REVIEW OF SUICIDE RISK ASSESSMENTS: REALITY AND REMEDY**

*Robert Simon, M.D.*

**SUMMARY:**
Suicide risk assessment is a core competency. The joint commission requires psychiatric facilities to use established tools to assess patients at risk for suicide. Assessment criteria established for quality assurance review can provide the basis for monitoring the adequacy of suicide risk assessment. Unless there is a continuing review and oversight process for compliance with standard risk assessment measures, competent assessment of suicidal patients, with appropriate documentation, will continue to be sporadic, idiosyncratic and inadequate. Patient suicides account for the highest percentage of malpractice claims filed against psychiatrists and the highest percentage of settlements.

No. 3-B
**CUTTING-EDGE ISSUES IN THE EVALUATION OF MALINGERING**

*H. LeBourgeois III, M.D.*

**SUMMARY:**
The assessment of malingering presents a significant challenge for mental-health clinicians. The traditional clinician-patient relationship is based on the assumption that a patient is invested in accurately reporting symptoms so that correct diagnoses and effective treatment can be provided; in contrast, individuals who malinger during clinical or forensic evaluations engage in purposeful deception of clinicians to achieve an identifiable external incentive. Clinicians who are abreast of cutting-edge issues in the evaluation of malingering and equipped with guidelines for assessment of malingering will better approach these assessments with confidence and the assurance that they have undertaken a reasonable methodology when coming to conclusions about the presence or absence of malingering. In this presentation, we will review cutting edge issues in the evaluation of malingering to include: 1) recent, large-scale data on base rates of malingering to help inform the likelihood of malingering in various evaluation settings, 2) recent data on the impact of financial incentive as relates to the probability of malingering, 3) forensic assessment instruments (FAIs) to improve validity and reliability of conclusions regarding malingered mental illness, 4) technological advances in obtaining, reviewing, and incorporating collateral information into malingering assessments (e.g., internet searches, video), 5) a recently-developed mnemonic that aids in the process of seeking clarification from evaluees safely and productively, and 6) a guide available by internet purchase that instructs employees how to successfully malinger to achieve sick leave, as those who engage in malingering assessments should be aware not only of cutting-edge issues in assessment, but also cutting-edge issues in simulation. We will end with a brief review of guidelines for malingering assessment as provided in Simon and Gold's upcoming Textbook of Forensic Psychiatry, 2nd edition.

No. 3-C
**THINKING ABOUT DELINQUENCY**

*Peter Ash, M.D.*

**SUMMARY:**
When the juvenile crime rate, and especially the juvenile homicide rate, peaked in 1993, many states toughened their laws on juvenile crime under the "adult crime, adult time" mantra and began moving more adolescent offenders to adult courts where they received adult sentences. With the marked fall in juvenile crime rates over the past 15 years, and with advancing research on juvenile delinquency, there has been a rethinking of this approach. When the U.S. Supreme Court considered the constitutionality of the death penalty for juveniles in 2005, the APA signed on to an amicus brief arguing for its elimination, the position later adopted by the court in its decision eliminating the death penalty for minors. In the summer of 2009, in another amicus brief to the court, the APA supported the elimination of life without parole sentences for minors convicted of a crime less than murder. We will know of the court's decision in those cases by the time of this presentation. The presentation will focus on the evolving conceptualization of adolescent culpability and the recent research relevant to the rationales for punishing adolescent delinquents. This research has several foci: adolescent decision-making, explored at both the psychological and neurophysiological level; the effects on adolescent recidivism of punishing adolescents as adults; the developmental progression of delinquent behavior; and the effectiveness of rehabilitation efforts. Finally, the presentation will address the implications of these findings for a psychiatrist called upon to assess an adolescent who is facing criminal charges.

No. 3-D
**FORENSIC PSYCHIATRY AND THE INTERNET**

*Patricia Recupero, J.D., M.D.*

**SUMMARY:**
The internet and related technology are continually gaining importance in the practice of forensic psychiatry. In both criminal and civil cases, the internet may yield helpful information in the form of digital evidence that supports, refutes, or elaborates upon the psychiatrist's initial impressions. Digital evidence may be helpful to assess the credibility of an evaluee's self-report, and electronic data can be useful when conducting risk assessments. Problematic internet use may arise in employment or family law proceedings, as when an individual neglects personal and professional responsibilities in order to spend more time online. Courts or attorneys may ask forensic psychiatrists to assess whether the person's problematic internet use is a manifestation of a mental illness and/or disability and to what extent it impacts the person's level of functioning. Anonymity, disinhibition, and transference related to internet use often play a role in numerous crimes and related behavior, including cyber-harassment (such as cyber bullying or cyber stalking), threats of violence, and sex crimes (such as child pornography and seeking victims for sexual assault). It may be helpful for psychiatrists to explain these phenomena in relation to human behavior on the internet in order to situate a defendant's behavior in the appropriate context. The internet also contains a vast abundance of medical information that can have implications for malpractice, malingering, and factitious disorders. As forensic psychiatrists encounter more cases in which the internet plays a prominent role, understanding the ways that people use the internet and how the internet relates to human psychology and the law will be crucial to assisting the courts in these types of cases.

No. 3-E
**FORENSIC CIVIL COMPETENCY ISSUES**

*Alan Abrams, M.D., J.D.*

**SUMMARY:**
Forensic civil competency issues in many areas have been stable or fossilized for the past hundred years. There are two areas of present uncertainty and change related to civil competencies – 1) competency to "stand trial" for civil commitment proceedings; and 2) competency to make medical decisions for the non-objecting patient who agrees to medical treatment but who also presents with cognitive and psychiatric deficits. A 2009 California appellate case, in re Moore decided that respondents in sexually violent predator (SVP) civil commitment proceedings have the right to be competent to stand trial prior to being committed under the SVP law. This is a significant departure from rulings in other jurisdictions regarding competency to stand trial in civil commitment proceedings. 2010 is the twenty year anniversary of the Supreme Court's decision in Zinermon v. Burch. The narrow focus of that decision has left the approach to assenting patients with questionable decisional competency in doubt. Developments and uncertainties in these two areas, and practice approaches will be discussed.

**REFERENCES:**
1. Meyer DJ, Simon RI, Shuman DW: Psychiatric Malpractice and the Standard of Care in Simon, RI, Gold LH (eds.) The American Psychiatric Publishing Textbook of Forensic Psychiatry. Second Edition. American Psychiatric Publishing, Inc, Arlington, VA 2010
2. Abrams AA: Civil Competency in Simon, RI, Gold LH

(eds.) The American Psychiatric Publishing Textbook of Forensic Psychiatry. Second Edition. American Psychiatric Publishing, Inc,, Arlington, VA, 2010
3. Recupero PR: Forensic Psychiatry and the Internet in Simon, RI, Gold LH (eds.) The American Psychiatric Publishing Textbook of Forensic Psychiatry. Second Edition. American Psychiatric Publishing, Inc,, Arlington, VA 2010
4. LeBourgeois III, HW: Malingering in Simon, RI, Gold LH (eds.) The American Psychiatric Publishing Textbook of Forensic Psychiatry. Second Edition. American Psychiatric Publishing, Inc,, Arlington, VA 2010

**TUESDAY, MAY 25, 2010**
**9:00 AM-12:00 PM**

ADVANCES IN SERIES 06
**ADVANCES IN THE USE OF ANTIPSYCHOTIC MEDICATIONS**

*Chairperson: Anthony J Rothschild, M.D., 361 Plantation Street, Worcester, MA 01605*
*Co-Chairperson: Kristina Deligiannidis, M.D.,*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to understand: 1) The use of antipsychotic medications in patients with schizophrenia and schizoaffective disorder; 2) The use of antipsychotic medications in patients with personality disorders; 3) The use of antipsychotic medications in patients with mood and anxiety disorders; and 4) The use of antipsychotic medications in patients with medical illnesses.

**SUMMARY:**
This Advanced Session is based, and all the speakers are authors from, the recently published Evidence Based Guide To Antipsychotic Medications (Rothschild AJ (ed.), American Psychiatric Press, 2010). Each speaker will review both FDA-approved and off-label uses of the antipsychotic medications (both First Generation and Second Generation) and the evidence base that supports (or does not support) their use. Each of the speakers has taken a large amount of medical literature and synthesized it into a comprehensive, yet understandable, form for the practicing clinician. This Advances In session will focus on the use of antipsychotic medications in schizophrenia, schizoaffective disorder, personality disorders, mood and anxiety disorders, and in the medically ill. Antipsychotic medications revolutionized the practice of psychiatry after the discovery of chlorpromazine in 1952. Patients who would have otherwise been chronically psychotic and institutionalized began to receive treatment that alleviated many of their symptoms and permitted treatment as an outpatient. In the ensuing years, more than 20 antipsychotic compounds were identified that had similar pharmacologic properties as chlorpromazine; namely, dopamine antagonism. This first wave of antipsychotic medications are referred to as conventional antipsychotic medications, “typical” antipsychotics or first generation antipsychotics (FGA). A second revolution occurred with the introduction of the first “atypical” or second generation antipsychotic (SGA), clozapine, in the United States in 1990. This led to the second-wave of antipsychotic medication development. Although most of the antipsychotic medications were initially approved by regulatory bodies for the treatment of schizophrenia, over the years they have received additional regulatory approval for use in bipolar disorder and as adjunctive therapy for unipolar treatment-resistant depression. In addition, the use of antipsychotic medication by clinicians for non-FDA approved illnesses, so-called “off-label” use, has been growing.

No. 6-A
**USE OF ANTIPSYCHOTIC MEDICATIONS IN SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER**

*Jayendra Patel, M.D.*

**SUMMARY:**
Schizophrenia is a devastating chronic mental illness that requires life long treatment with antipsychotics and other medications. This lecture will focus on advances made in the use of antipsychotic medications in the treatment of schizophrenia and schizoaffective disorders. Specifically, we will discuss acute as well as long-term management of schizophrenia during the first break and in chronic, treatment refractory patients. Though significantly efficacious, the burden of side effects from these medications has become a major obstacle in achieving favorable and enduring outcomes. Thus, management of these side effects is critically important in ensuring compliance. Clinically, how do first generation antipsychotics and second-generation antipsychotics compare against each other? Do long-acting antipsychotics have a place in modern psychopharmacology? Answers to these important questions will be discussed.

No. 6-B
**ANTIPSYCHOTIC MEDICATION USE IN PERSONALITY DISORDERS**

*Kenneth R. Silk, M.D.*

**SUMMARY:**
The role of antipsychotic medications in patients with personality disorders has been studied for more than 3 decades. In personality disordered patients, these medications are used for a wide array of symptoms in addition to their use in psychotic and psychotic-like states. There is evidence for the use of antipsychotic medications primarily in schizoptypal (STPD) as well as borderline (BPD) personality disorder. In these disorders, antipsychotics (both typicals and atypicals) are most often used in doses lower than those used in psychotic states. In STPD, there is evidence for their use for ideas of reference, paranoia, and general anxiety. In BPD, there is evidence for their use for impulsivity, aggression and hostility especially when accompanied by paranoia, anxiety, paranoia, transient psychotic states, and derealization. In both STPD and BPD, the evidence for effectiveness of these medications for depressive symptoms is contradictory. In general, side effects and adverse effects of these medications are no different in personality disordered patients. In addition to more specific information about the use of these medications in patients with personality disorders, this presentation will also review the concept of psychosis and how that manifests itself in patients with personality disorders.

No. 6-C

**AN EVIDENCE BASED APPROACH TO THE USE OF ANTIPSYCHOTIC MEDICATIONS IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS**

*Kristina Deligiannidis, M.D.*

**SUMMARY:**
An increasing number of investigations have evaluated the efficacy of antipsychotic medication augmentation or monotherapy strategies for the treatment of mood and anxiety disorders. This presentation provides an overview of the latest research supporting the use of antipsychotic medications in the treatment of bipolar disorder, psychotic depression, treatment resistant depression (TRD), non-psychotic depression, obsessive compulsive disorder (OCD), generalized anxiety disorder (GAD) and post-traumatic stress disorder (PTSD). The evidence for both FDA-approved and off-label treatment strategies are reviewed. The majority of typical and atypical antipsychotic medications have efficacy, either as monotherapy or in combination with lithium or valproate, in the treatment of bipolar manic or mixed episodes. Fewer antipsychotic medications however, either as monotherapy or in combination with other agents, are approved for the treatment of bipolar depression. Regarding unipolar depressive disorders, the most effective pharmacotherapy of psychotic depression (major depression with psychotic features), is the combination of an antipsychotic with an antidepressant. Nonetheless, there are no medications, including the antipsychotics, which have an FDA indication for the treatment of psychotic depression. The use of antipsychotic augmentation of antidepressants in the acute treatment of non-psychotic depression and TRD can be effective for some patients, though the long-term efficacy, tolerability and safety of this strategy requires further investigation. Many patients suffering from anxiety disorders, despite receiving adequate treatment, fail to experience a response or full remission of symptoms. A growing literature demonstrates that antipsychotic augmentation is an effective treatment for OCD patients who have not responded to a maximally dosed serotonin reuptake inhibitor. Additionally, typical antipsychotics have been found to be as effective as benzodiazepines in the treatment of a variety of anxiety symptoms. Trifluoperazine has an FDA indication for the short-term treatment of GAD and has the strongest evidence of efficacy among antipsychotics for this disorder. While support for the use of atypical antipsychotics in the treatment of PTSD is accumulating, no antipsychotic medication has FDA approval for this indication, and further research is needed in this area.

No. 6-D

**USE OF ANTIPSYCHOTIC MEDICATIONS IN THE MEDICALLY ILL**

*David Gitlin, M.D.*

**SUMMARY:**
The use of antipsychotic medications in patients with co-occurring medical illness adds a layer of complexity to the usual decision making regarding treatment of neuropsychiatric illness and symptoms. Individuals receiving antipsychotic medication for the treatment of chronic psychotic disorders may have an acute and/or chronic medical condition, and patients with no prior history of mental illness may develop signs and symptoms of a psychotic disorder in the context of management of a medical disorder. In addition, delirium may complicate the course of an acute medical or surgical illness. Lastly, neurobehavioral aspects of dementia may markedly worsen during the course of a medical illness. All of these situations require a more nuanced approach to the use of antipsychotic medications. This presentation will focus on several common medical conditions, including cardiac disease, diabetes, and post-operative states, with a

goal of helping to guide acute treatment of psychotic and neurobehavioral symptoms.

**REFERENCES:**


1. Rothschild AJ (ed): Evidenced Base Guide To Antipsychotic Medications. Washington: American Psychiatric Press, 2010.
2. Putnam K, Silk KR: Emotion Dysregulation and the Development of Borderline Personality Disorder. Devel Psychopath 17:899-925, 2005.
3. Patel JK, Pinals DA, Breier A (2008): Schizophrenia and other psychosis, in Psychiatry, third edition, Tasman A, Kay J, Leiberman J, First MB, & Maj M (eds), John Wiley and Sons, Chichester, UK, Chapter 70, Volume 1, pp 1201-1282.
4. Rothschild AJ (ed): Clinical Manual For The Diagnosis And Treatment of Psychotic Depression. Washington: American Psychiatric Press, 2009.


**9:00 AM-12:00 PM**

ADVANCES IN SERIES 05

**FAMILY ASSESSMENT AND INTERVENTION FOR PSYCHIATRISTS**

*Chairperson: Gabor I Keitner, M.D., Rhode Island Hospital/Warren Alpert Medical School of Brown University 593 Eddy Street, Providence, RI 02903*

**EDUCATIONAL OBJECTIVES:**

At the completion of this session participants will be able to demonstrate knowledge of : a comprehensive approach to the assessment and treatment of families; how to systematically assess a wide range of family functions; and the stages and steps of a systematic short term treatment approach.

**SUMMARY:**

This course will outline the McMaster model of family functioning and the problem centered systems therapy of the family (PCSTF). The McMaster model provides a conceptual framework for assessing a wide range of family functions including; communications, problem solving, affective involvement, affective responsiveness, roles, and behavior control. Structured assessment instruments to measure these family dimensions from the family's perspective, (the family assessment device –fad, available in 24 different languages) and an interviewer's perspective, (the McMaster structured interview of family functioning - McSiff) have been developed and will be reviewed. The PCSTF is a short term, time limited family intervention that consists of defined stages of treatment (assessment, contracting, treatment, closure) and is outlined in a treatment manual. The PCSTF has been found to be useful in the management of patients with mood disorders in randomized clinical trials. The course will consist of a review of the family dimensions, the assessment process and principles of connecting and intervening with families. Excerpts from a DVD of a family assessment and stages of treatment will be shown.

No. 5-A

**A COMPREHENSIVE APPROACH TO PATIENT CARE / THE PROBLEM CENTERED SYSTEMS THERAPY OF THE FAMILY (PCSTF)**

*Gabor Keitner, M.D.*

**SUMMARY:**

First Presentation: Comprehensive patient care requires a biopsychosocial approach. This presentation will outline the value of including the family in the assessment and treatment of a wide range of presenting problems. An overview of the McMaster Model will be presented including the range of family functions assessed, instruments (from the family's as well as an independent observers perspective) to help with the assessment process and a treatment model (the Problem Centered Systems Therapy) that helps the family to address identified problems. An emphasis will be on integrating family treatment with pharmacotherapy and individual therapy as indicated. Second Presentation: This presentation will review in depth the stages of the PCSTF including, assessment, contracting, treatment and closure. The role of the therapist is to provide a safe environment in which problems can be identified, options for dealing with the problems outlined, steps to change the problems negotiated and the family's follow through evaluated. Excerpts from a DVD showing stages of treatment will be used to demonstrate how to deal with a family's success in making changes and what to do when a family is not able to follow through on mutually agreed upon goals. Issue relating to resistance, unrealistic expectations and commitment to change will be discussed.

No. 5-B

**THE ASSESSMENT OF FAMILIES**

*Alison Heru, M.D.*

**SUMMARY:**

This presentation will review in depth the assessment of the six dimensions of family functioning outlined by the Mc Master Model including; communications, problem solving, affective responsiveness, affective involvement, roles and behavior control. A comprehensive assessment is central to developing a formulation to guide treatment.

A thorough assessment is not infrequently the treatment. Excerpts from a DVD of a family assessment will be used to demonstrate the process. Key issues relating to ways of engaging the family, keeping them focused on the assessment and ways of dealing with resistance and disruptions will be discussed.

**REFERENCES:**

1. Keitner GI, Heru AM, Glick ID: Clinical Manual of Couples and Family Therapy.American Psychiatric Publishing Inc. 2009.
2. Heru AM, Drury LM: Working with Families of Psychiatric Inpatients:A Guide for Clinicians.The Johns Hopkins University Press, 2007
3. Ryan CE, Epstein NB, Keitner GI, Miller IW, Bishop DS: Evaluating and Treating Families:The McMaster Approach. Routledge, 2005.
4. Glick ID, Berman EM, Clarkin JF, Rait DS: Marital and Family Therapy. American Psychiatric Press 2000.

**2:00 PM- 5:00 PM**

ADVANCES IN SERIES 08
**ADVANCES IN PERSONALITY DISORDERS**

*Chairperson: John M Oldham, M.D., M.S.2801 Gessner Drive, Houston, TX 77080*
*Co-Chairperson: Andrew E Skodol, M.D.,*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to demonstrate knowledge of new developments in research, treatment, and new directions relating to personality disorders (PDs).

**SUMMARY:**
Interest in the PDs continues to grow. The Task Force for DSM 5.0 has recognized the importance of personality traits as the "building blocks" of behavior, of key importance in understanding the "person behind the illness" in patients with psychiatric disorders. This session will include updated information derived from the recently published volume, The American Psychiatric Publishing Essentials of Personality Disorders, as well as selected other areas of focus. Emerging strategies to reconceptualize the PDs in preparation for DSM 5.0 will be presented from the APA Workgroup, and a current literature review carried out for the Workgroup on borderline PD will be presented. Up-to-date data on the genetics of the PDs will be presented, as well as new neuroimaging findings linked to cognitive tasks in patients with borderline PD. There will also be presentations focusing on treatment of patients with obsessive-compulsive PD and with antisocial PD.

No. 8-A
**PERSONALITY DISORDERS IN DSM-V: EMERGING PERSPECTIVES**

*Andrew Skodol, M.D.*

**SUMMARY:**
A personality domain in DSM-V is intended to describe the personality characteristics of all patients, whether they have a personality disorder or not. The full proposed assessment of the personality domain consists of four parts: 1) an overall rating of personality functioning ranging from normal to severely impaired; 2) descriptions of major personality (disorder) types; 3) personality trait assessment, on which the types are based, but which can also be used to describe major personality characteristics of all patients; 4) and generic criteria for personality disorder consisting of impairment of sense of self or identity and ineffective interpersonal functioning. The assessment "telescopes" the clinician's attention from a global rating of the overall severity of impairment in personality functioning through increasing degrees of detail and specificity in describing personality psychopathology that can be pursued depending on constraints of time and information and on expertise. The levels of personality functioning and the generic criteria for personality disorder are based on disturbances in self and interpersonal functioning. Disturbances in thinking about the self are reflected in the dimensions of identity-integration, integrity of self-concept, and self-directedness. Interpersonal disturbances consist of impairments in empathy, intimacy and cooperation, and complexity and integration of representations of others. An example of personality traits under consideration is "emotional lability," defined as having unstable emotional experiences and mood changes; having emotions that are easily aroused, intense, and/or out of proportion to events and circumstances. Personality types consist of combinations of core personality pathology and personality traits. Levels of personality functioning, personality traits, and the degree of correspondence between a patient's personality (disorder) and a type will all be rated dimensionally.

No. 8-B
**A CURRENT REVIEW OF THE LITERATURE ON BORDERLINE PERSONALITY DISORDER**

*John Oldham, M.D., M.S*

**SUMMARY:**
The Workgroup on Personality and Personality Disorders of the American Psychiatric Association Task Force on DSM 5.0 has conducted literature reviews on all of the 10 DSM-IV-TR personality disorders. The literature on borderline personality disorder (BPD) is extensive, and the review was undertaken by several members of the Workgroup, with the help of several advisors and collaborators. The review was subdivided into 6 domains: 1) clinical description and construct validity, 2) epidemiology, 3) premorbid background, 4) family studies, 5) neurobiology and laboratory studies, and 6) longitudinal course. Overall, there is a reasonable body of evidence that BPD as defined in DSM-IV-TR represents a cohesive class that should be represented as a specific PD type in DSM-V, in spite of internal heterogeneity and criteria that represent a hybrid of environment-reactive symptoms and dimensional traits. Population prevalence of BPD from pooled data is estimated to be slightly greater than 1%. History of parental neglect or inconstancy is common, and considerable though not invariable early life experience of abuse. Studies suggest substantial heritability of BPD, and the genetic and neurobiological contributors to BPD appear prominent in the serotonin system. Imaging data suggest decreased volume in limbic and anterior cingulated regions, presumably correlated with difficulties with impulse control and emotion regulation. Longitudinally, significant remission rates have been observed, suggesting that BPD is less "enduring" then previously believed. In this presentation, these areas will be reviewed in greater detail.

No. 8-C
**BEHAVIORAL GENETICS OF DSM-IV PERSONALITY DISORDER**

*Ted Reichborn-Kjennerud, M.D.*

**SUMMARY:**
The structure of the genetic and environmental risk factors for DSM-IV Personality Disorders (PDs) disorders is poorly understood, and it is not clear how these risk factors contribute to the pattern of comorbidity between the PDs and between PDs and Axis I disorders. Results from an ongoing population-based twin study on the relationship between DSM-IV Axis I and Axis II disorders will be presented. Method: Axis I and Axis II disorders were assessed in 2801 Norwegian twins using structured interviews. Twin models were fitted to the data using the software package Mx. Dimensional representations of the PDs were used for analyses. Results: All DSM-IV PDs are modestly heritable, ranging from 20% to 41%. Although several PDs had substantial disorder specific genetic risk factors, genetic and environmental risk factors for the PDs appear to a large extent to be shared. Three common genetic and individual-specific factors were identified. The first genetic factor had high loadings on PDs from all clusters, and seemed to reflect broad PD pathology or negative emotionality. The second factor had substantial loadings on borderline and antisocial PD, and the third on avoidant and schizoid PD. Obsessive-compulsive PD had the highest disorder-specific loading. The three environmental factors identified, however, had high loadings on cluster B, A, and C respectively. Genetic risk factors for DSM-IV PDs do not reflect the cluster A, B and C typology, but rather vulnerability to broad PD pathology, impulsivity/low agreeableness and introversion. The A, B, C typology is however well reflected in the structure of the environmental risk factors, suggesting that environmental experiences may contribute to this phenotypic cluster structure.

No. 8-D
**NEUROIMAGING SOCIAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER**

*Brooks King-Casas, M.D.*

**SUMMARY:**
Impairments in interpersonal functioning are core features of a variety of personality disorders, and Cluster B disorders in particular. Advances in experimental and neuroimaging methodologies have enabled the measurement of localized neural activity during active interactions of trust, cooperation and aggression. However, despite these advances neural correlates of social abnormalities in these pathologies have only recently become a focus of attention. In this talk, we review recent work utilizing these methods to investigate healthy and pathological social behavior, with special emphasis on borderline personality disorder.

No. 8-E
**PSYCHODYNAMIC PSYCHIATRY OF OBSESSIVE-COMPULSIVE PERSONALITY DISORDER**

*Glen Gabbard, M.D.,*

**SUMMARY:**
Psychodynamic psychiatry of obsessive-compulsive personality disorder is developing a solid empirical base that demonstrates it is an efficacious treatment for the condition. The randomized controlled trials will be

reviewed, and the disorder will be differentiated from obsessive-compulsive disorder. The core components of obsessive-compulsive personality disorder such as perfectionism, the need to control, the fear of aggression and sexuality, and the need to be morally superior will be broken down into themes that must be addressed in the course of the therapy. Specific techniques will be suggested, and the typical transference-countertransference dimensions of the treatment will be explored. Strategies for managing the transference will be illustrated, along with clinical examples.

No. 8-F

**MENTALIZATION AND MENTALIZATION BASED TREATMENT FOR ANTISOCIAL PERSONALITY DISORDER**

*Anthony Bateman, M.D.*

**SUMMARY:**

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful based on intentional mental states. There are four main dimensions to mentalizing – self and other, cognitive and affective, external and internal, and automatic and controlled mentalizing. Individuals with antisocial (ASPD) show problems with mentalizing in all dimensions but particularly in self and other and cognitive-affective dimensions. Antisocial characteristics stabilize mentalizing by rigidifying relationships within fixed ways of functioning. Loss of flexibility makes the person vulnerable to sudden collapse when their schematic representation of a relationship is challenged. This exposes feelings of humiliation, which can only be avoided by violence and control of the other person. The common path to violence is via a momentary inhibition of the capacity for mentalization. In this talk an outline will be given of the current understanding of mentalizing and its relation to antisocial characteristics and violence and how this has led to modifications to mentalization based treatment (MBT), originally developed for borderline personality disorder, to target the specific difficulties of people with ASPD. Treatment combines group and individual therapy. The focus is on helping patients maintain mentalizing about their own mental states when their personal integrity is challenged. A patient with ASPD does not have mental pain associated with another's state of mind; thus, to generate conflict in ASPD by thinking about the victim will typically be ineffective in inducing behavior change. Some cohort data will be presented of a pilot study of MBT for patients with ASPD.

**REFERENCES:**

1. Gabbard GO: Psychoanalysis and Psychodynamic Psychotherapy. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., 2009.
2. King-Casas B, Sharp C, Lomax-Bream L, Lohrenz T, Fonagy P, Montague PR: The rupture and repair of cooperation in borderline personality disorder. Science 321:806-810. Commentary: Meyer-Lindenberg, A "Trust me on this". Science 321:778-780, 2008.
3. Kendler KS, Aggen SH, Czajkowski N, Roysamb E, Tambs K, Torgersen S, Neale MC, Reichborn-Kjennerud T: The Structure of Genetic and Environmental Risk Factors for DSM-IV Personality Disorders A Multivariate Twin Study. Archives of General Psychiatry 65, 1438-1446, 2008.
4. Skodol AE, Bender DS, Oldham JM: Future Directions: Toward DSM-V. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., 2009.

**2:00 PM-5:00 PM**

ADVANCES IN SERIES 07

**ADVANCES IN SUBSTANCE ABUSE TREATMENT**

*Chairperson: Marc Galanter, M.D., 550 First Avenue, Room NBV20N28, New York, NY 10016*
*Co-Chairperson: Herbert D. Kleber, M.D.,*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to; 1) Demonstrate knowledge of the psychology and physiology underlying five emerging areas of addiction pathology; 2) Be familiar with innovative techniques for management of these problem areas and 3) Be able to apply the material presented to a broad array of substance use disorders.

**SUMMARY:**

Progress in the addiction field has been achieved on many fronts in recent years, and some specific problem areas illustrate how these advances can be implemented. In this symposium, five areas of particular interest will be reviewed by experts on those respective issues, illustrating the variety of techniques now available: Buprenorphine has come to be widely accepted among psychiatrists who work with opioid-dependent patients, and all clinicians, whether certified for use of this medication or not, should be aware of recent findings on both detoxification and maintenance. Perinatal patients and their progeny may suffer from the complex consequences of excessive use of

alcohol and other drugs; the complexity of physiologic and social issues involved reflect how new research can be applied. Marijuana is the illicit drug most widely used in the united states; there are pharmacologic approaches to treatment of its abuse, as well as psychotherapeutic models of treatment, that illustrate how emerging research interfaces with conventional approaches to rehabilitation. Anabolic-androgenic steroids interact with multiple metabolic systems, although their use and abuse, particularly by young men, continues unabated. Ill consequences and clinical approaches to AAS abuse can serve as a model for research on innovative approaches to addiction. At present, patients dually diagnosed for substance abuse and mental illness constitute a large portion of those hospitalized in general psychiatry units and those appearing in office practice. The complex interaction between substance dependence and general psychiatric illness needs to be understood in framing effective treatment.

No. 7-A

**THE USE OF BUPRENORPHINE IN THE TREATMENT OF OPIOID DEPENDENCE**

*John Renner, M.D.*

**SUMMARY:**

The introduction of buprenorphine has been a highly significant advance in the opioid treatment field because of the both efficacy of the medication itself and, equally important, the success of an office-based treatment model that has revolutionized the management of opioid dependence in the U.S. For forty years, clinic-based methadone maintenance has been the standard pharmacotherapy for opioid dependence. Despite obvious clinical efficacy, methadone and the highly regulated methadone clinic system have never attracted more than 15% of the opioid addicted population and opiate agonist therapy gained only moderate support from the public and within the medical community. In 2002, the FDA approved the partial opioid agonist buprenorphine for the treatment of opioid dependence and initiated a new era in addiction treatment in the U.S. This talk will review the unique pharmacology and clinical efficacy of buprenorphine, along with the significant regulatory changes that permitted its use in office-based settings. Data on the number of patients treated and the characteristics of this patient group will give the participant an appreciation for the clinical and public health importance of this new treatment and the implications for future medical practice and physician training.

No. 7-B

**THE TREATMENT OF PERINATAL ADDICTION**

*Hendree Jones, M.D.*

**SUMMARY:**

The presentation will highlight common questions that arise when treating opioid dependence during the perinatal period. The most current research evidence based upon the final results from the maternal opioid treatment: human experimental research (mother) project will be summarized to aid clinical decision making. The mother project is a double-blind, double-dummy, flexible-dosing, parallel-group clinical trial examining the comparative safety and efficacy of methadone and buprenorphine for the treatment of opioid dependence in pregnant women and their neonates. The questions discussed will include those questions related to maintenance medication selection, induction, and stabilization during pregnancy as well as issues important in the post-partum period. These post-partum issues include opioid agonist medication management related to pain management during and after delivery, breast-feeding, and health and medical management of the neonate. The treatment of co-morbid psychiatric disorders in the opioid dependent pregnant and post-partum patient will be reviewed.

No. 7-C

**TREATMENT OF MARIJUANA ABUSE AND DEPENDENCE**

*Mark Gold, M.D.*

**SUMMARY:**

Marijuana (MJ) is the most used illicit drug in the U.S. and the 2nd most commonly smoked drug. MJ is smoked by students espousing a healthy lifestyle as vegetarian non-smokers. Studies report that lifetime use of MJ increases in adolescence, from about 7% of 13-year-olds to more than 40% of 17-year-olds. In 2007, among past month MJ users 35.3 % used the drug on 20 or more days. Regular or daily MJ smoking and self-reported "MJ addiction" is increasing. Almost 17% of past-year MJ users met criteria for dependence or abuse, and among the 3.1 million people receiving treatment for alcohol or drugs in the past year, an estimated 852,000 people received treatment for MJ abuse and dependence according to SAMHSA. About 4% of new cannabis users become dependent in the first 2 years of use; and increasingly MJ smoking is the gateway drug rather than tobacco use. Effects of D9-THC in humans include short-term memory disruption, cognitive impairment,

learning problems, time distortion, acquired drive for MJ, inattention, enhanced body awareness and an increased risk of schizophrenia. MJ, like other drugs of abuses, produces addiction through positive reinforcement, sensitization of incentive salience, and by induction of new brain processes. An estimated 20% of individuals who smoke several times will meet DSM-IV criteria for dependence. Withdrawal has been described and commonly observed in dependent patients. Treatment has included detoxification and abstinence with CBT and self-help groups with urine testing to confirm outcome. Dronabinol is the most promising maintenance treatment studied to date. Relapse prevention trials have included the promising combination of lofexidine and marinol. Our group has reported second-hand neurobiological effects as a result of exposure to tobacco, opium, and is studying cannabis.

No. 7-D
**TREATMENT OF THE DUALLY DIAGNOSED**

*Richard Ries, M.D.*

**SUMMARY:**
This presentation will update the clinician on screening, diagnostic, interventional and treatment strategies for persons with the most common types of co-occurring mental and addictions disorders (COD). First a brief review of COD typologies will be presented then interview, diagnostic, and treatment issues constructed for those kinds of patients most often encountered in psychiatrists practices. Key issues will be strategies for screening, testing and interviewing patients with psychiatric disorders about the types and degree of use of substances which may be problematic for them. Once identified, then models of engagement and integrated treatment which the busy clinician may utilize will be offered by utilizing a patient with Bipolar disorder complicated with alcohol dependence and cocaine abuse, as a model. These interventional approaches will include both behavioral and medication based strategies.

No. 7-E
**TREATMENT OF ANABOLIC-ANDROGENIC STEROID ABUSE**

*Harrison Pope, M.D.*

**SUMMARY:**
Historically, anabolic-androgenic steroid (AAS) users have rarely sought substance-abuse treatment, but demographic trends may soon change this picture. Specifically, illicit AAS use did not become widespread until the 1980s, and therefore the first large wave of illicit AAS users – men who initiated AAS use as youths in the 1980s – is only now approaching middle age. Members of this group who have developed AAS dependence (a syndrome affecting about 30% of AAS users) are entering the age of risk for cardiac and psychoneuroendocrine complications that may bring them to clinical attention. Although knowledge remains limited, recent findings have identified several aspects of the AAS dependence syndrome that will require multiple treatment strategies. First, body image disorders such as "muscle dysmorphia" are clearly associated with AAS use; these syndromes may respond to cognitive behavioral therapy and to selective serotonin reuptake inhibitors in the same manner as other forms of body dysmorphic disorder. Second, chronic suppression of the hypothalamic-pituitary-testicular axis by exogenous AAS may necessitate endocrine treatments, such as human chorionic gonadotropin or clomiphene, to restore testicular functioning and prevent prolonged hypogonadism. In addition, recent laboratory studies have shown that pharmacologically induced hypogonadism will precipitate severe depression in a subgroup of men; similar idiosyncratic major depressive episodes may occur in withdrawing AAS users, requiring antidepressant treatment and occasionally, hospitalization. Third, lessons may be drawn from the close overlap between AAS dependence and opioid dependence, documented both in humans and in animal models. For example, hamsters will self-administer testosterone, even to the point of death, and this testosterone addiction can be prevented or treated with opioid antagonists. By inference, treatments effective for human opioid dependence might also benefit AAS dependence.

**REFERENCES:**
1) McCance-Katz, EF. Office-based buprenorphine treatment for opioid-dependent patients. Har Rev Psychiatry 2004; 12:321-338
2) Jones HE, Martin PR, Heil SH, Kaltenbach K, Selby P, Coyle MG, Stine SM, O'Grady KE, Arria AM, Fischer G. Treatment of opioid-dependent pregnant women: clinical and research issues. J Subst Abuse Treat. 2008 Oct;35(3):245-59.
3) Gold MS, Roytberg A, Frost-Pineda K, Jacobs WS, Teitelbaum SA. (2006). Marijuana. In Gabbard GO (Ed.). Treatment of Psychiatric Disorders. 4th Edition. Arlington VA. American Psychiatric Publishing.
4) Pope HG Jr., Brower KJ. Treatment of Anabolic-Androgenic Steroid Abuse. In Galanter M and Kleber HD, Eds. American Psychiatric Publishing Textbook of Substance abuse Treatment, 4th Ed. Washington DC: American Psychiatric Publishing, 2008, pp 237-245.

**MONDAY, MAY 24, 2010**

**9:00 AM - 10:30 AM**

CASE CONFERENCE 01
**PTSD AND THE AMERICAN SOLDIER TODAY**
*Moderator: Elspeth C Ritchie, M.D., M.P.H., 5109 Leesburg Pike Skyline 6, Room 671, Falls Church, VA 22041-3258;*
*Presenter: Robert Ursano, M.D.*

**EDUCATIONAL OBJECTIVE:**
At the conclusion of this session, the participant should be able to: 1) Understand the pathophysiology of delirium and discuss research-based, effective treatment options for delirium, including the use of atypical antipsychotic and other novel agents; 2) Understand the incidence, epidemiology and clinical features of the most common neuropsychiatric disorders masquerading as psychiatric illness; and 3) Understand the research-based, effective treatment options for these conditions.

**TUESDAY, MAY 25, 2010**

**9:00 AM - 10:30AM**

CASE CONFERENCE 02
**DEATH OF A PHYSICIAN BY SUICIDE**
*Moderator: Michael F Myers, M.D., 450 Clarkson Avenue, Brooklyn, NY 11203*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Put a human face to suicide; 2) Identify principles in treating the suicidal physician; and 3) Recognize the centrality of postvention examination in advancing our knowledge of suicide and promoting resolution in the treating psychiatrist.

**REFERENCES:**
1. Gitlin MJ: A psychiatrist's reaction to a patient's suicide. Am J Psychiatry 1999;156:1630-1634.
2. Hendin H, Pollinger Haas A, Maltsberger JT et al: Problems in psychotherapy with suicidal patients. Am J Psychiatry 2006;163:67-72.
3. Myers MF: When Physicians Die By Suicide: Reflections of Those They Leave Behind. Videotape. 1999.
4. Myers MF, Fine C. Touched By Suicide: Hope and Healing After Loss. Gotham/Penguin, NY, 2006.

**11:00 AM - 12:30 PM**

CASE CONFERENCE 03
**HELPING PARENTS OF A FIRST EPISODE PSYCHOTIC PATIENT**
*Moderator: S. Charles Schulz, M.D., 2450 Riverside Avenue F282/2A West, Minneapolis, MN 55454;*
*Presenters: Richelle Moen, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the completion of the session, participants will be able to: 1) Recognize the major issues facing a family with a first episode psychosis young person; and 2) Enumerate the differences in the approach to a family with a first episode psychosis person and a family with a person who has been ill for many years.

**REFERENCES:**
1. Hogarty GN, Anderson CM, Reiss DJ, Kornblith SJ, Greenwald DP, Javna CD, Madonia MJ. (1986). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. I. One-year effects of a controlled study on relapse and expressed emotion. Arch Gen Psychiatry, 43, 633-42.
2. Falloon IR, Boyd JL, McGill CW, Razani J, Moss HB, Gilderman AM. (1982). Family management in the prevention of exacerbations of schizophrenia: a controlled study. N Engl J Med., 306, 1437-40.
3. Collins A.A. (2002). Family Intervention in the Early Stages of Schizophrenia. (Zipursky RB, Schulz SC, Eds.) Washington DC: American Psychiatric Publishing, Inc.
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**WEDNESDAY, MAY 26, 2010**

**9:00 AM - 10:30 PM**

CASE CONFERENCE 04
**THE SELF-DEFEATING PATIENT**
*Moderator: Glen O Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 77030-1316;*
*Presenters: Glen Gabbard, M.D., Funmilayo Rachal, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Inform participants of the link between self-defeating and treatment-defeating behavior; 2) To educate participants about helpful psychotherapeutic strategies to deal with patients who do not comply with the psychotherapeutic treatment plan; and 3) To illuminate common countertransference patterns that may interfere with the treatment of self-defeating patients.

**REFERENCES:**
1. Gabbard GO: Long-Term Psychodynamic Psychotherapy: a Basic Text: 2nd Edition. Arlington, VA: American Psychiatric Publishing, 2010.
2. Gabbard GO: On gratitude and gratification. Journal of the American Psychoanalytic Association 48: 697-716, 2000
3. Cooper AM: The narcissistic-masochistic character. Psychiatric Annals 39: 904-912, 2009
4. Cooper AM: Psychotherapeutic approaches to masochism. Journal of Psychotherapy Research and Practice 2:51-63, 1993.

**MONDAY, MAY 24, 2010**

**9:00 AM-10:30 AM**

FOCUS LIVE! 01

**PSYCHOTHERAPY**

*Chairperson: Priyanthy Weekasekera, M.D. , M.Ed., Department of Psychiatry and Behavioral Neurosciences, McMaster University, Hamilton ON, Canada*

*Moderators: Deborah J. Hales MD, Director APA Division of Education*

*Mark Hyman Rapaport MD, Chairman, Department of Psychiatry, Cedars-Sinai Medical Center*

**EDUCATIONAL OBJECTIVES**

As a result of participation in this interactive FOCUS Live workshop, participants will review multiple choice questions, self-assess their knowledge of psychotherapeutic treatments and gain increased understanding of the efficacy and the application of these treatments in clinical practice.

**SUMMARY:**

In FOCUS Live! sessions, expert clinicians lead lively multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing and emerging knowledge on a topic important to practicing psychiatrists. In addition to the key psychotherapies in the field—psychodynamic psychotherapy, cognitive behavior therapy and interpersonal therapy—additional evidence-based psychotherapies have emerged that have significance for patients with psychiatric disorders. This illustrates the need for the practicing psychiatrist to maintain a strong connection with the empirical literature, in order for clinical practice to follow an evidence based approach. The clinical practice of established psychotherapies has evolved with more integrated approaches being observed. This interactive presentation provides multiple choice questions about current approaches in psychotherapy and provides information about taking an evidence-based approach to the practice of psychotherapy.

**REFERENCE:**

1. Weerasekera P. Psychotherapy update for the practicing psychiatrist: promoting evidence-based practice. FOCUS 2010;1:3-18.

**11:00 AM–12:30 PM**

FOCUS LIVE! 02

**GENETICS AND GENOMICS**

*Chairpersons: Michele Pato M.D., Carlos Pato, M.D. Professors, Associate Chair and Chair, Department of Psychiatry and the Behavioral Sciences, Keck School of Medicine, University of Southern California*

*Moderators: Deborah J. Hales MD, Director APA Division of Education; Mark Hyman Rapaport MD, Chairman, Department of Psychiatry, Cedars-Sinai Medical Center*

Special interactive multiple choice Q&A session using an Audience Response System

**EDUCATIONAL OBJECTIVES**

At the conclusion of the session, participants will be able to gain an increased understanding of psychiatric genetics as it applies to psychiatric disorders.

**SUMMARY:**

This FOCUS LIVE session will present multiple choice questions and discussion to familiarize the psychiatrist with concepts in psychiatric genetics and what is currently known. Advances in genetics present an opportunity

to identify genes that confer risk or that are involved in treatment response for psychiatric disorders. Psychiatric disorders are complex genetic disorders which do not have a clear pattern of inheritance where there is likely involvement of multiple genes, each with an effect. Research has advanced our understanding of genetics and specific disorders: depression, bipolar disorder, schizophrenia, OCD, and autism . This FOCUS LIVE session emphasizes the implications of this science for psychiatry.

In FOCUS LIVE sessions expert clinicians lead lively multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing knowledge and new developments on a topic important to psychiatrists.

**REFERENCES:**

1. Pato M, Pato C. Genetics and Genomics: FOCUS Winter 2010 8(2) in progress

2. Burmeister M. Genetics of psychiatric disorders: a primer: FOCUS 2006.4: 317-326

**2:00 PM-5:00 PM**

FOCUS LIVE! 03

**DISORDERS OF SEX AND SLEEP**

*Chair: Stephen B. Levine, Clinical Professor of Psychiatry, Case Western Reserve University School of Medicine, Cleveland OH*

*Presenter:Karl Doghramji, M.D., Professor of Psychiatry and Human Behavior, Thomas Jefferson University, Philadelphia PA*

*Moderators:Deborah J. Hales MD, Director APA Division of Education Mark Hyman Rapaport MD, Chairman, Department of Psychiatry, Cedars-Sinai Medical Center*

Special interactive multiple choice Q&A session using an Audience Response System

**EDUCATIONAL OBJECTIVES:**

As a result of participation in this interactive FOCUS Live workshop, participants will review multiple choice questions, and self-assess their knowledge of sexual disorders and sleep disorders. Participants will answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from more study.

**SUMMARY:**

In FOCUS LIVE sessions expert clinicians lead multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing knowledge and new developments on a topic important to psychiatrists. Stephen B. Levine will cover topics related to sexual disorders such as sexual history-taking; the interplay of biology, psychology, interpersonal relationships, and concepts of normality and culture in generating sexual problems; and how psychiatrists may intervene in the treatment of sexual dysfunctions. Karl Dogramji will present material related to insomnia and other sleep disorders and their treatment. A variety of cognitive/ behavioral and pharmacological management techniques are available to treat sleep disorders that can coexist with a variety of medical and psychiatric disorders.

**REFERENCES:**

1. Doghramji K, Grewal R, Markov D. Evaluation and management of insomnia in the psychiatric setting. FOCUS Fall 2009 7(4) 441-454

2. Levine SB. A Reintroduction to clinical sexuality. Focus Fall 2005; 3: 526 - 531.

# FORUMS

## MONDAY, MAY 24, 2010
## 11:00 AM-12:30PM

FORUM 01
### CHOPIN AT 200: HIS MIND AND HIS MUSIC

*Chairperson: Richard Kogan, M.D., 333 West End Avenue, New York, NY 10023, Presenters: Richard Kogan, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize the psychological factors that influenced Chopin's artistic development; 2) Appreciate the challenges of retrospective/posthumous psychiatric diagnosis; and 3) Understand some fundamental concepts about creativity.

**SUMMARY:**
The great Polish composer Frederic Chopin (1810-1849) spent his entire adult life in exile from his beloved homeland and he was plagued by chronic respiratory illness that killed him at age 39. Chopin experienced a variety of psychiatric symptoms including panic attacks, phobias, mood swings, and hallucinations, but he possessed a remarkable resilience that allowed him to convert adversity into musical masterpieces. Psychiatrist and concert pianist Dr. Richard Kogan will explore the relationship between Chopin's psyche and his creative output. The discussion will be illuminated by performances of some of the composer's most glorious music, including his mazurkas, polonaises, preludes, and ballades.

**REFERENCES:**
1. Eisler, Benita, Chopin's Funeral
2. Siepmann, Jeremy Chopin
3. Szulc, Tad, Chopin in Paris

FORUM 02
### *DSM-5*: PROGRESS IN RESEARCH AND DEVELOPMENT

*Chairperson: David J Kupfer, M.D., Dept of Psychiatry University of Pittsburgh School of Medicine Western Psychiatric Institute and Clinic 3811 O'Hara Street, Suite 279, Pittsburgh, PA 15213,*
*Presenters: Darrel A. Regier, M.D., Lawson R. Wulsin, M.D., David Kupfer, M.D., Jack Burke, M.D., M.P.H., Geoffrey Reed, Ph.D., Jane Paulsen, Ph.D*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to briefly describe the research planning process that initiated DSM-V development; identify the primary tasks DSM-V Work Groups are currently undertaking; explain how ICD-11 development is progressing; and recognize major cross-cutting issues under discussion by the three featured study group chairs.

**SUMMARY:**
The American Psychiatric Institute for Research and Education (APIRE), in partnership with the National Institutes of Health and the World Health Organization, recently completed the 5-year international series of 13 diagnostic conferences that comprised on of the primary development phases for *DSM-5*. Dr. David Kupfer, *DSM-5* Chair, and Dr. Darrel Regier, *DSM-5* Vice-Chair, will provide a brief update on *DSM-5* progress to date. Dr. Geoffrey Reed from the World Health Organization (WHO) will discuss international aspects of *DSM-5* planning, namely, the recent efforts by the WHO in developing the ICD-11. The second half of the forum will feature presenters from three *DSM-5* Study Groups, formed to address cross-cutting issues pertinent to all diagnostic work groups. Dr. Jane Paulsen will discuss the role of functional impairment, disability, and activity limitations in determining diagnostic threshold, and how *DSM-5* can potentially improve on current problems with these areas. Dr. Jack Burke will speak on instrument and assessment issues in *DSM-5* revisions, particularly those related to integrating dimensional aspects of diagnosis with the current categorical system. Finally, Dr. Lawson Wulsin will discuss recommendations for development of *DSM-5* Primary Care.

**REFERENCES:**
1. Kupfer DJ, First MB, Regier DA (eds). A Research Agenda for the DSM-V. Washington, DC: American Psychiatric Association, 2002.
2. Regier DA, Narrow WE, Kuhl EA, Kupfer DJ. The Conceptual Development of DSM-5. Americal Journal of Psychiatry 2009; 166(6):645-650.

## TUESDAY, MAY 25, 2010
## 9:00 AM-10:30AM

FORUM 03
### IS A GAME CHANGING PSYCHOTROPIC TOO MUCH TO EXPECT?

*Chairperson: Phi Ninan, M.D., 500 Arcola Rd., Collegeville, PA 19426, Presenters: Philip Ninan, M.D., Amir Kalali, M.D., Jeffrey Lieberman, M.D., Stephen Stahl, M.D., Ph.D.*
**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Examine the process of new drug discovery and development; 2) Review novel mechanisms of pipeline psychotropic drugs; and 3) Explore the role of regulatory agencies in drug registration.

**SUMMARY:**

The mid-twentieth century saw revolutionary advances in psychotropic medications through serendipitous discovery. They fundamentally altered the treatment of psychiatric disorders, influenced diagnostic nomenclature and advanced research in the neurosciences. A period of consolidation followed, with subsequent advances in psychotropics being largely evolutionary. The past two decades have witnessed an explosion of knowledge in the neurosciences - from molecular to complex genetics, brain development to circuitry mediation of symptoms, and understanding obligatory behaviors to top-down executive control. So what hurdles prevent their translation into truly novel psychotropic agents with impact? Current drug discovery focuses on 'hits' on identifiable targets, their optimization, preclinical testing for safety and efficacy in animal models prior to clinical trials for a specific diagnosis or behaviors. Such an approach underemphasizes systems biology - the evolutionary uniqueness of the human brain with its multiple overlapping redundant and compensatory systems, the contextual nature of behavior and executive top-down capability. There is limited knowledge of the mechanisms of mental derivatives from brain function, as well as disease pathophysiology and etiology. Such ignorance precludes a shift from symptomatic treatments to disease modification, and from small molecules to biopharmaceutical psychotropics and vaccines. There is a detachment of settings for clinical trials from treatment seeking patients to volunteer subjects, and an increasing placebo response. Methodological challenges make CNS drug development one of the most risky therapeutic areas. Regulatory hurdles have expanded for demonstrating efficacy with a renewed emphasis on safety. Key boards of health differ in their opinions, provide contradictory guidelines, complicating global development programs for novel treatments. Economic factors driven by generic psychotropic medications threaten the high gains required by capital markets to invest in the high risk enterprise of psychotropic development. Market forces are thus shifting resources to therapeutic areas where laboratory models are better predictors of clinical efficacy. These challenges can only be addressed by a radical rethinking of strategy for developing new psychotropic agents. The dialogue must include government agencies including regulatory bodies, leaders in the pharmaceutical industry, academicians and experienced clinicians as well as advocacy organizations that vocally demand better treatments.

**REFERENCES:**

1. Insel TR. Disruptive insights in psychiatry: transforming a clinical discipline. J Clin Inv 2009; 119(4):700-705
2. Markou A, Chiamulera C, Geyer MA, Tricklebank M, Steckler T. Removing obstacles in neuroscience drug discovery: the future path for animal models. Neuropsychophamacology 2009;34:74-89

**3:30 PM - 5:30 PM**

FORUM 04

**GLOBAL DISASTERS FORUM: LESSONS LEARNED FROM CHILE, HAITI & NEW ORLEANS**

*Chairperson: Eliot Sorel, M.D. 2301 E St NW Ste A1011, Washington, D.C., 20037. Karen DeSalvo M.D, 121 Rio Vista Avenue, Jefferson, LA, 70121.*
*Presentors: General Russel L. Honoré (Ret.), Jean Luc Poncelet, M.D., Ben Sppringate, M.D.*

**SUMMARY:**

Major disasters, human-made, (chemical accidents, wars, armed conflicts, ethnic cleansing) and natural (earthquakes, tsunamis, hurricanes, droughts), have resulted in enormous traumas, deaths and destruction throughout the world, over the centuries. In the Region of the Americas, approximately, 130 natural disasters occur annually. Most recently, in January 2010, it is estimated that more than two hundred thousand people died in Haiti following the earthquake that month and hundreds of thousands were injured, and/or left homeless. The impact of the Chile earthquake of February 2010, 8.8 on the Richter scale, and its consequences are currently being assessed and responded to. Although of a lesser magnitude, hurricane Katrina devastated New Orleans and the surrounding region, a few years ago. *The Global Disasters Forum* at the annual APA meeting in New Orleans, an APA, WPA, PAHO/WHO collaborative, addresses the multidimensional aspects of disasters' response including: preparedness & mitigation; logistics/coordination, search and recovery; complex emergencies responses; systemic integration of surgical/medical, mental health, public health interventions; the continued assistance toward infrastructure revival, recovery and resumed societal functioning across systems. Field presentations with a focus on Chile, Haiti & New Orleans illustrate the challenges and opportunities for systemic responses and effective models of primary care, mental health & public health integration. *The Forum* will provide a robust dialogue between and among the audience and the panelists following the panelists' stimulus presentations.

**REFERENCES:**

1. Health in the Americas 2007, Regional Volume, Coping with Disasters, PAHO.
2. Inter-Agency Standing Committee (IASC), 2007, Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Geneva: IASC

**SATURDAY, MAY 22, 2010**

**6:00 PM-8:00 PM**

Industry Supported Symposium 1

*Supported by Dainippon Sumitomo Pharma America (DSPA)*

## NEW DEVELOPMENTS IN SCHIZOPHRENIA RESEARCH AND PRACTICE: FROM THE PIPELINE TO THE CLINIC

*Chairperson: Prakash S. Masand, M.D., Duke University Medical Center NC-CTN 2218 Elder Street, 2B Suite 202Durham, NC 27705, Durham, NC 27705*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe the challenges of CNS drug development, understand the time, cost and risk of bringing new neuropharmacologic agents to market, explain the process to translate a genetic association study into a clinically useful test, describe the clinical risks and benefits of switching antipsychotic medications, apply evidence-based strategies to adjusting therapeutic regimens and discuss strategies to increase patient adherence to clinical recommendations to treat psychosis.

**SUMMARY:**

While the exact etiology of schizophrenia is still elusive, schizophrenia appears to reflect a convergence of pathologic processes, one or more genetic factors that alter the neurotransmitter mechanisms regulating the activity of cortical neurons, and nongenetic factors. Today, neuroscience is flourishing with discoveries and advances in all areas of brain function, particularly in the diagnostic and molecular aspects. The translation of this evidence into clinically viable treatments has been at times disappointing; hampered by multiple limitations. The effectiveness of antipsychotics in treating the symptoms of schizophrenia has also furthered our understanding regarding the underlying neurobiological aspects of the disorder. The discovery and development of the second-generation atypical antipsychotics has challenged the simplicity of the dopamine hypothesis and broadened understanding of the pathophysiological basis of schizophrenia. Because no one medicine or class of medications has been shown to work for all people with schizophrenia, patients and their doctors often try multiple treatment options before a successful response is achieved. Many face obstacles in achieving positive outcomes due to challenges including differential efficacy, side effects and lack of psychosocial and vocational support. Patients with schizophrenia will routinely stop their antipsychotic medications. In fact, nonadherence rates after relapse range from 50% to 80%. Effectively treating and managing schizophrenia remains an important area of educational need especially as the understanding of this complex and devastating disorder continues to evolve leading to additional therapeutic options and refinements in evidence-based medical management practices. This presentation will address four distinct topics of unmet need in schizophrenia care with a focus on practical evidence-based strategies in therapy and the evidence underpinning those recommendations.

No. 1-A

### OBSTACLES AND OPPORTUNITIES IN NEW CNS DRUG DEVELOPMENT

*Kenneth Kaitin, Ph.D., 75 Kneeland St., Suite 1100, Boston, MA 02111*

**SUMMARY:**

New drug development is a time-consuming, risky, and expensive process. Neuropharmacologic drug development represents an area of extreme challenge for research-based pharmaceutical and biopharmaceutical companies. Recent analyses by the Tufts Center for the Study of Drug Development at Tufts University, an academic research group exploring the economic, political, scientific, and legal factors that influence pharmaceutical and biopharmaceutical innovation, have shown that timelines for CNS product development are among the longest of any therapeutic area – an average of 8.8 years from the initiation of clinical testing to the date of regulatory approval by the Food and Drug Administration – and the likelihood of failure during the clinical development process, whether for safety, efficacy, or market-related reasons, is among the greatest – clinical success rates are 8% on average. Not surprisingly, with long development times and high failure rates, CNS drugs are some of the most expensive medicines to develop. Despite these challenges, many drug companies are

focusing on CNS product development, with about 17% of the world's pharmaceutical R&D activity in the CNS area. The primary drivers of this focus are the substantial size of the market for CNS products, rapid growth in that market, and enormous unmet medical need. This presentation will examine the challenges of bringing new neuropharmacologics, in particular antipsychotic drugs, to market.

No. 1-B

**DO PHARMACOGENETICS HAVE A ROLE IN TREATING SCHIZOPHRENIA?**

*Roy H. Perlis, M.D., M.S.C., 50 Staniford Street, 5th Floor, Boston, MA 02114*

**SUMMARY:**

The emerging evidence base of genomewide association studies examining psychotropic treatment response has led to a resurgence of efforts to introduce pharmacogenetic testing in psychiatric clinical practice. Whether to identify patients most likely to benefit from a given treatment, or most likely to be harmed by it, these tests offer the possibility of achieving true personalization of treatment in psychotic disorders. On the other hand, the clinical application of such diagnostic tests is not without risk. As in any genetic association study, the risk for type I error remains very high, and the need for replication acute. In addition, even where convincing evidence of association can be demonstrated, a finding may have statistical significance but lack clinical significance, such as when a predictor identifies individuals with worse outcomes *regardless* of treatment type. This presentation will summarize recent findings from large-scale studies of treatment response in schizophrenia and other psychotic disorders. It will then explore additional steps necessary to translate these findings into clinically-useful diagnostic tools, so that participants are better able to determine when such tools are likely to emerge, and how to evaluate them.

No.1-C

**SWITCHING ANTIPSYCHOTIC THERAPY: LESSONS FOR THE CLINICIAN**

*Prakash Masand, M.D., Duke University Medical Center NC-CTN 2218 Elder Street, 2B Suite 202, Durham, NC 27705*

**SUMMARY:**

Frequent switching of antipsychotic medications is widespread in schizophrenia care. Although more effective therapies than ever before are available for schizophrenia, not all patients respond similarly to the existing medications. There are various reasons for switching including a partial or complete lack of efficacy and nonadherence with medication. Adverse side effects that vary widely by individual agents also remain a concern. Antipsychotics are associated with a wide range of adverse effects including activation and akathisia, extrapyramidal symptoms, sedation, and metabolic and endocrine abnormalities. In some cases an adverse effect will necessitate a switch to a different medication. Subjective experience with medication treatments may also affect illness outcomes among populations with schizophrenia. In addition to frequent switching from one drug to another, many patients remain on multiple antipsychotics. Studies carried out under conditions of routine clinical care have indicated that over time, patients may be on multiple medications through the course of initiating and ceasing therapies. How much of this is rational polypharmacy and how much is due to concern on the part of the clinician of a worsening of symptoms following cessation of the initial treatment remains a topic of debate. Patients switched from conventional drugs to oral atypical antipsychotic drugs have been shown to benefit from significant improvements in clinical response and tolerability. Careful selection of drug therapy, with emphasis on a drug's efficacy and tolerability is necessary in successful medication switches. This presentation will highlight the factors that prompt switching a patient's antipsychotic therapy and address practical strategies in making evidence-based changes in drug regimens. The available evidence for the clinical risks and benefits of switching antipsychotics will be explored in terms of 3 key factors—efficacy, tolerability, and adherence. On the basis of available clinical data, several strategies for switching antipsychotic therapies including tapering and cross-over strategies will also be discussed.

No.1-D

**INNOVATIVE STRATEGIES TO IMPROVE ADHERENCE IN SCHIZOPHRENIA**

*Mehul Mankad, M.D., 44110 Ashburn Shopping Plazam*

*Suite 251, Ashburn, VA 20147*

**SUMMARY:**
As noted in the CATIE trial, discontinuation of antipsychotic medication for patients with schizophrenia is more common than previously believed. Strategies to improve adherence should impact symptoms of illness, quality of life, rehospitalization rate, and lifespan. These strategies can be divided into three groups: psychotherapy to improve adherence, assisted treatment, and novel pharmacotherapy. Psychotherapy to improve adherence to schizophrenia treatment includes Compliance Psychotherapy, Motivational Interviewing, and Cognitive Behavioral Therapy with a focus on medication adherence. Each of these models is supported by empirical validation in improved medication adherence and enhanced patient outcomes. Assisted treatment of patients with schizophrenia can take many forms, ranging from supportive methods to involuntary systems of care. Supportive uses of technology, such as telepsychiatry, SMS text messaging, and virtual reality simulators can be targeted to increase patient involvement in their treatment regimen. Assertive Community Treatment allows participants with a variety of adherence problems to access care in nontraditional settings. Psychiatric Advanced Directives empower patients to take an active role in their treatment plan while also providing guidance when adherence to that plan fails. Outpatient commitment, often combined with involuntary treatment, can represent the least restrictive alternative prior to involuntary inpatient hospitalization. Finally, the mode of delivery of antipsychotic medication may impact adherence in the appropriate patient. Although depot preparations of first-generation antipsychotic medications have been a mainstay of treatment for patients with schizophrenia who have problems with adherence, the availability of second generation depot preparations has been limited until recent years. The focus on increased patient adherence maintains the goal of decreasing illness burden in the outpatient setting. As the needs of individuals differ, the range of strategies designed to improve adherence must be synthesized into an optimal treatment plan that will benefit the unique requirements of each patient.

**REFERENCES:**

1. Kaitin KI. Obstacles and Opportunities in New Drug Development. Clinical Pharmacology & Therapeutics. 2008;83:210-212.
2. Bakker PR, van Harten PN, van Os J. Antipsychotic-induced tardive dyskinesia and polymorphic variations in COMT, DRD2, CYP1A2 and MnSOD genes: a meta-analysis of pharmacogenetic interactions. Mol Psychiatry. 2008;13(5):544-56.
3. Masand PS. A review of pharmacologic strategies for switching to atypical antipsychotics. Prim Care Companion J Clin Psychiatry. 2005;7(3):121-129.
4. Masand PS, Roca M, Turner M, Kane JM. Partial adherence to antipsychotic medication impacts the course of illness in patients with schizophrenia: a review. Prim Care Companion J Clin Psych. 2009;11(4):147-154.

**MONDAY, MAY 24, 2010**

**7:00 P.M.-9:00 P.M.**

**INDUSTRY SUPPORTED SYMPOSIUM 2**
**NOVEL APPROACHES TO ASSESSING AND TREATING DEPRESSION IN THE MEDICALLY-ILL**

***Supported by Lilly USA***

*Bradley Gaynes, M.D., UNC, School of Medicine, Rm 10306, 1st Floor Neurosciences Hospital, Campus Box 7160, Chapel Hill, NC 27599*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to identify evidence-based strategies for diagnosing depression in medically ill populations, recognize the emerging evidence supporting the role of cytokines and the inflammatory response in the development of depressive illness and distinguish between clinical trial evidence of pharmacologic and nonpharmacologic treatment for depression in the medically ill population, including patients who are defined as treatment-resistant.

**SUMMARY:**
Half of patients with major depressive disorder (MDD) have a coexisting medical illness. Comorbidities are associated with poorer clinical outcomes, including a slower response to treatment, a greater chance of treatment resistance, and a higher risk of relapse following successful treatment. Recent research has improved our understanding of how

best to diagnose and manage depressed, medically ill patients. A key first step is the successful identification of depressive illness in the medically ill patient. Dr. Gregory E. Simon will review evidence-based strategies to identify MDD and monitor treatment response in this challenging population, with a focus on particularly relevant medical illnesses such as diabetes. Emerging evidence supports the role of cytokines and the inflammatory response in the development of depressive illness. Dr. Janet M. Witte will review the results of these and other pathophysiologic mechanisms to provide an up-to-date understanding of the biologic underpinnings of the MDD/medical illness comorbidity. Consideration of risk factors for poor outcomes can guide MDD treatment in the medically ill. Dr. Bradley N. Gaynes will review available clinical trial evidence and address how best to manage depression in this population, including considerations of both newer pharmacotherapies and nonpharmacologic treatments. Finally, given the greater risk of a failure to remit in this group, strategies to address treatment-resistant depression (TRD) are crucial. Dr. Maurizio Fava will review recommendations to address patients with TRD, including findings from the STAR*D study and the use of newer pharmacotherapies.

No.2-A

**ASSESSING MOOD AND SOMATIC SYMPTOMS IN THE MEDICALLY ILL DEPRESSED PATIENT**

*Gregory Simon M.D., 1730 Minor Street, Suite 1600, Seattle, WA 98101*

**SUMMARY:**

The prevalence of depressive illness is significantly greater in people with chronic medical conditions and is associated with numerous adverse effects, including poorer medical prognosis, more severe pain and somatic symptoms, increased disability, and increased mortality. Several misconceptions have hampered recognition and effective treatment—namely, that depression is an inevitable consequence of chronic illness; that depressive symptoms in medically ill patients often reflect medical "mimics" of depression; that standard depression diagnostic criteria or symptom measures are not valid or accurate in people with chronic medical illness; and that disability and functional impairment are determined by severity of medical illness rather than by depression. These misconceptions often reflect traditional prejudices regarding psychiatric illness, and are not supported by empirical evidence. Misdiagnosis of medical illness as depression is much less common than the converse. Even in patients with serious chronic medical conditions, physical symptoms attributed to medical illness are often more closely tied to depression. Standard diagnostic criteria and measures for depression appear just as valid in medically ill patients as in the general adult population. Somatic symptoms that are typically considered indicators of depression (ie, fatigue, changes in weight or appetite, or psychomotor changes) should not be discounted in people with chronic medical illness. Improvement in depression leads to corresponding improvements in disability and daily functioning, even when medical illness does not improve. Data from several large observational studies of depression in chronic medical illness will be presented.

No.2-B

**PATHOPHYSIOLOGY OF SOMATIC SYMPTOMS AND MAJOR DEPRESSIVE DISORDER IN MEDICALLY ILL POPULATIONS**

*Janet Witte M.D., 7 Whitman Street, Somerville, MA 02144*

**SUMMARY:**

Emerging evidence supports the role of cytokines and the inflammatory response in the development of major depressive disorder (MDD). Studies in animals have demonstrated that acute activation of proinflammatory cytokine signaling in the brain is associated with withdrawal from their physical and social environment, including decreased motor activity, social withdrawal, reduced food and water intake, increased slow-wave sleep, and altered cognition—deficits similar to depressive symptoms. In humans, both medical illness and medical treatments support a role for cytokine-mediated inflammation in the etiology of depression. MDD is more prevalent in patients afflicted with conditions leading to chronic inflammation (cardiovascular diseases, cancers, type 2 diabetes, and rheumatoid arthritis) than in the general population. With respect to therapeutic intervention, MDD develops in roughly one-third of patients treated with the recombinant human cytokines IL-2 and interferon alpha. Possible mechanisms for this association include the role of inflammatory proteins in

the degradation of the serotonin precursor, tryptophan, and cytokine-induced alterations of the HPA axis. A growing understanding of the role of inflammation has major implications for the treatment of major depression: biomarkers of inflammation may become intermediate measures of response to the treatment of depression. Drugs targeting inflammatory mediators may open the way to new pathways to treat depressive symptoms. By reviewing the putative pathophysiologic mechanisms of cytokine-induced depression, this presentation will provide an up-to-date understanding of the biologic underpinnings of MDD/medical illness comorbidity.

No.2-C

**MANAGING DEPRESSION IN THE MEDICALLY ILL: AN UP-TO-DATE EVIDENCE-BASED GUIDE**

*Bradley Gaynes M.D., UNC, School of Medicine, Rm 10306, 1st Floor Neurosciences Hospital, Campus Box 7160, Chapel Hill, NC 27599*

**SUMMARY:**

Depressed patients with comorbid medical disorders have increased morbidity and greater functional impairment; additionally, medical comorbidities are a risk factor for treatment resistance in major depressive disorder (MDD). When treating MDD, knowledge of comorbidities may be used to guide initial treatment decisions. The current evidence will be reviewed regarding the impact of specific medical illnesses, including cardiac disease, stroke, HIV/AIDS, and diabetes, on depression outcomes with attention to associated changes in efficacy. Emerging data are beginning to address whether medical comorbidities can contribute to the selection of intervention for the treatment of depression. Accordingly, the evidence for both pharmacologic and nonpharmacologic treatments in this at-risk population will be reviewed, with a focus on the role of medical and psychiatric collaborative care. This discussion will include available evidence that directly compares the effectiveness of specific treatments. The available evidence addressing the role of newer treatments, both pharmacologic and nonpharmacologic, in patients with MDD and comorbid medical disease will be presented.

No.2-D

**MANAGEMENT OF TREATMENT-RESISTANT PATIENTS WITH SOMATIC SYMPTOMS AND MEDICAL ILLNESS**

*Maurizio Fava, M.D., Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*

**SUMMARY:**

Treatment resistance in depression is quite common in "real world" clinical practice and tends to be associated with a greater degree of medical comorbidity, as suggested by findings from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. In addition, a pilot study on the prevalence of somatic symptoms in patients with treatment-resistant depression (TRD) showed that 95% of patients with TRD reported at least 1 somatic symptom. The pilot study also found that high levels of somatic symptoms noted during the screening visit predicted poorer response to treatment with the tricyclic antidepressant nortriptyline. These studies, therefore, suggest the need to use even more aggressive treatment strategies in the presence of treatment resistance associated with medical comorbidities and/or somatic symptoms. On the other hand, it is unclear what should be the appropriate next-step treatment approach for these patients. Many clinicians favor treatments that match side effects with symptom profiles, but the empirical evidence in support of this approach is lacking. This presentation will review the results of the studies on the most common augmentation and combination strategies in resistant depression and will discuss their clinical implications.

**REFERENCES:**

1. Dantzer R, O'Connor JC, Freund GG, Johnson RW, Kelley KW. From inflammation to sickness and depression: when the immune system subjugates the brain. Nat Rev Neurosci. 2008;9:46-57.
2. Krebs EE, Gaynes BN, Gartlehner G, et al. Treating the physical symptoms of depression with second-generation antidepressants: a systematic review and meta-analysis. Psychosomatics. 2008;49:191-198.
3. Scott KM, Von Korff M, Alonso J, et al. Mental–physical comorbidity and its relationship with disability: results from the World Mental Health Surveys. Psychol Med. 2009;39:33-43.
4. Thase ME, Friedman ES, Biggs MM, et al. Cognitive therapy versus medication in augmentation and switch strategies as second-step treatments: a STAR*D report. Am J Psychiatry. 2007;164:739-752.

## LECTURES

### SATURDAY, MAY 22, 9:00 AM-10:30AM

LECTURE 1-
### TRANSLATIONAL RESEARCH IN SCHIZOPHRENIA: CHALLENGES AND PROMISES

*Raquel E. Gur, M.D., Ph.D., 3400 Spruce, Philadelphia, PA 19104*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify current methods applied in translational research in schizophrenia; 2) Appreciate major challenges in advancing the field; and 3) Recognize the clinical implications of the research effort.

**SUMMARY:**
With DSM V efforts well underway, scrutinizing progress in understanding the phenomenology of schizophrenia, the field is witnessing converging advances in methods that may elucidate the neurobiology of schizophrenia. Harnessing technological advances in genomics and neuroimaging to make them relevant for meeting clinical challenges in treatment of patients requires bi-directional interactions of interdisciplinary teams. Cognitive deficits and negative symptoms have profound impact on the ability of individuals with schizophrenia to attain higher levels of functioning. This presentation will illustrate how progress in understanding these major deficits can be achieved through the application of methods that transverse the pre-clinical to the clinical arena. In the cognitive domain, the application of computerized testing indicates that deficits are present already in those at risk before meeting current diagnostic criteria. Similarly, impaired emotion processing is also evident. The availability of efficient neuroscience-based computerized measures enables large-scale genetic studies that can help in translating neural models into clinical practice. These measures come from neuroimaging research that probes the underlying brain systems. Therefore, their application in large samples can generate links between behavioral deficits and putative brain systems affected by schizophrenia. Furthermore, since these measures can be obtained from individuals at risk and family members, they can shed light on genetic mechanisms. The presentation will highlight how behavioral and neurobiological approaches converge to reveal abnormalities that may underlie the behavioral manifestations of schizophrenia. Pharmacological and behavioral remediation efforts could combine to develop a more comprehensive and neuroscience based approach towards the treatment of schizophrenia.

### 11:00 AM-12:30PM

LECTURE 2-
### THE FUTURE OF DEPRESSION RESEARCH

*Florian Holsboer, M.D., Kraepelinstr 2/10, Muchen, D-80804 Germany*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify potential biomarkers that can be used in the diagnostic algorithms for major depression; 2) Recognize the major developments in the genetics of mood disorders, including next generation sequencing, epigenetics, gene x environment interactions and validation through animal models; and 3) Identify current strategies for personalized medicine in major depression using multi-modal phenotyping.

**SUMMARY:**
Severe depression affects 10-15 percent of all individuals during their lifetime, can result in suicide and increases risk for other health problems including cardiovascular disease, diabetes or dementias. Its contribution to the global burden of disease has been recognized and has stimulated huge research efforts on causality and treatment. Basic and clinical neuroscience enabled us to compile a vast amount of exciting evidence that genetic, cellular and neural network perturbations cause depression. However, the progress in drug treatment is only incremental, as we still employ pharmacologies that are based upon enhancement of monoaminergic neurotransmission, a principle not fundamentally different from a serendipitous discovery in the 1950ies. The heritability of depression and the fact that antidepressants work in most patients had been viewed as portal for studies of causality, but failed to deliver so far. Genetic studies, based on the hypothesis that multiple common genetic variants with small effects lead to a common disease phenotype were of limited success because technologies used were unable to detect rare and spontaneous mutations as well as some other abnormalities. Genetics will remain the key driving force in depression research, but several realignments will be needed: (1) Recruitment of cohorts will require integration of objectifiable biomarkers into diagnostic algorithms and diagnoses must come from the laboratory not from the conference room; (2) Genetics will move away from assembling huge cohorts where single nucleotide polymorphisms are interrogated with DNA-chips. Instead, next-generation sequencing (NGS) will be employed where DNA is fragmented and clonally amplified in one reaction. Genetic depression research will also benefit from studies of gene-gene as well as gene-environment interactions;

(3) The latter area will clearly involve epigenetics, such as DNA-methylation patterns that change as consequence of experience-related events. Understanding epigenetic regulation will become the prime future challenge in depression research. Proteomics have become a daunting task as there are over a million of proteins that continuously change their quantitative composition and will become the most important source for biomarkers.

**SUNDAY, MAY 23, 2:00 PM- 3:30PM**

LECTURE 3-
**PATIENT VIOLENCE AGAINST MENTAL HEALTH CLINICIANS: SAFETY ASSESSMENT AND PREVENTION**

*Robert I Simon, M.D., 8008 Horse Shoe Lane, Potomac, MD 20854-3831; Kenneth Tardiff, M.D., M.P.H., 525 E. 68th St., New York, NY 10065*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: At the conclusion of this session, the participant should be able to: 1) recognize that every professional healthcare provider is a potential target or risk of violence by patients, 2) clinically assess the factors associated with an increased potential of violence by a specific patient, 3) come to a decision as the level of imminent risk of physical violence by a specific patient and 4) identify and implement clinical and environmental measures to prevent physical violence by a patient.

**SUMMARY:**
The clinician has a responsibility to assessment, treat and prevent physical violence by patients and toward himself or herself as well as toward other persons in society. Every health care professional is a potential target of rare but the ever present risk of patient violence. Safety measures against patient violence are an integral part of clinical practice. Denial is a major impediment to successful safety management. It is necessary to acknowledge and confront threats of potential patient violence. The prodrome of violence-aggression rarely occurs suddenly and unexpectedly. Threat management techniques will be discussed. The clinician must evaluate the patient and make a decision about the risk that a specific patient poses to the clinician in terms of imminent physical violence, namely in the coming days or week or so. He or she should interview the patient and use multiple sources of information in the determination of the potential for violence. There should be analysis of violent ideation in terms of degree of formulation and intent by the patient in carrying out violence. Other areas that must be assessed include a history of physical violence including past targets, degree of severity of injury and the specific patterns of escalation and circumstances surrounding the violence. There should be evaluation of alcohol and drug abuse, psychosis and other psychopathology, presence of organic disorders of the brain and a history of non-compliance with treatment. If the clinician decides that the patient poses a significant imminent risk of violence, a specific, detailed plan of protecting possible targets of that violence, including the clinician, must be developed and implemented. Further discussion of such plans will be part of this session.

**MONDAY, MAY 24, 9:00 AM-10:30 AM**

LECTURE 4-
**WHY I TEACH**

*Glen O. Gabbard, M.D., 6655 Travis St., Suite 500, Houston, TX 77030-1316*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the role that internalization plays in psychiatric education; 2) Recognize current thinking regarding the reciprocal relationship between altruism and self-interest as it relates to educators; and 3) Explicate motives for devoting oneself to education.

**SUMMARY:**
In an era of tightening budgets in academic psychiatry, there are growing demands on faculty to increase revenues from clinical work and grant support in order to cover their salaries. Education is increasingly marginalized as an academic activity because funding sources that cover teaching are increasingly rare. Educators in psychiatry are often hard-pressed to find time to teach, and yet many continue to regard classroom teaching, mentoring, and supervising as high priorities. What drives us to teach? In this highly personalized account, I contemplate my own motives for devoting much of my professional life to education. Our motives transcend the Hippocratic Oath. Passing on what we have learned to those who are learning involves something fundamental in the fabric of who we are as human beings. An exploration of these motives leads us to a contemplation of thorny existential issues. In this lecture I will touch on the importance of being remembered, of remembering, and of internalization in shaping our professional and personal identities. I will also examine the concept of altruism as it applies to teaching and the unique combination of self-interest and devotion to others that is inherent in those who devote themselves

to training others to be psychiatrists. This exploration leads to a consideration of both neural networks and psychoanalytic notions of internal representation.

**REFERENCES:**

*1. Gabbard GO: How not to teach psychotherapy. Academic Psychiatry 29: 332-338, 2005 2) Shapiro Y, Gabbard GO: A re-consideration of altruism from an evolutionary and psychodynamic perspective. Ethics and Behavior 4: 23-42, 1994*

LECTURE 5-
## THE PERPLEXITIES & PROVOCATIONS OF EATING DISORDERS

*Katherine A Halmi, M.D., 21 Bloomingdale Road, White Plains, NY 10605*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the model of allostasis for eating disorders. 2) Identify three major provocations in treating eating disorders; and 3) Recognize the similar characteristics of addictions and eating disorders.

**SUMMARY:**

Out of control eating behavior occurs when homeostasis, a self-regulating process for multisystem coordination in response to a challenge, fails. An activation of brain and hormonal stress responses results in a dysregulation f reward circuits defined as an allostatic state. When the allostatic maladaptation diminishes, deterioration occurs with eventual death in the case of anorexia nervosa. Reinforcing neurobiological mechanisms in eating disorders involve the neurotransmitter systems including dopamine, serotonin, opioid peptides, GABA and glutamate. There is evidence of a genetic vulnerability for developing eating disorders, which may be an intrinsic specific brain neurocircuitry that interacts with environmental life events and stresses.
The treatment of eating disorders can be frustrating, especially for anorexia nervosa, due to a persistent resistance to treatment. The best prevention of chronicity for eating disorders is an early diagnosis with effective treatment before the legal age of 18. These adolescents respond best to a cognitive behavioral family based therapy.

**REFERENCES:**

*1. Halmi, KA. "Perplexities and Provocations of Eating Disorders". J Child Psychol. and Psychiat. 50:1-2, 2009, pp 163-169*

**11:00 AM-12:30PM**

LECTURE 6-
## OPTOGENETICS - DEVELOPMENT AND APPLICATION

*Karl Deisseroth, M.D., 318 Campus Drive West, Stanford, CA 94305*

**EDUCATIONAL OBJECTIVES**

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of opto-genetics; 2) Demonstrate knowledge of gamma oscillating; and 3) Demonstrate knowledge of rewards.

**SUMMARY:**

In 1979, Francis Crick delineated the major challenges facing neuroscience and called for a technology by which all neurons of just one type could be controlled, "leaving the others more or less unaltered". We have sought to meet this challenge by developing and applying optogenetics, a technology based on single component opsin-based regulators of transmembrane ion conductance and signaling; in this approach, opsin genes are delivered by genetically or topologically-targeted vectors, and light is delivered to the freely moving mammal by portable solid-state optical devices. In previous work (refs 1-9) we have developed and engineered a panel of optogenetic genes and related optical devices, with which cells can be turned on or off with millisecond precision and in different patterns within freely moving mammals, and we have applied this technology to probe the dynamics of cells and circuits relevant to schizophrenia, narcolepsy, Parkinson's disease, depression, and addiction. More recently (refs 10-12), we have shown that application of molecular engineering and trafficking principles can further expand the optogenetic repertoire along several long-sought dimensions. For example, we have shown that membrane trafficking strategies now permit 1) optical regulation at the far red/infrared border; 2) increased potency of optical inhibition without increased light power requirement (chloride-mediated photocurrents beyond the nanoampere level that maintain the light sensitivity and behaviorally-significant reversible, step-like stable kinetics of earlier tools); and 3) generalizable strategies for targeting cells based not on genetic identity, but on morphology and tissue topology, to allow versatile targeting when promoters are not available. Together these results illustrate use of molecular and cellular principles to enable versatile, fast optogenetic technologies suitable for the study of circuit dynamics, mammalian behavior, and neuropsychiatric disease.

**REFERENCES:**

*1.Z hang F., et al. (2007). Nature 446, 633-9.*

*2. Boyden E.S., et al. (2005). Nature Neuroscience 8, 1263-1268.*

LECTURE 7-

**NEUROIMAGING CLUE TO THE CAUSES OF BIPOLAR DISORDER: WHERE WE ARE AND WHERE WE'RE GOING**

*Stephen M Strakowski, M.D., 260 Stetson, Suite 3200, Cincinnati, OH 45267-0559*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify functional brain abnormalities associated with bipolar disorder; 2) Recognize how magnetic resonance spectroscopy is used to study bipolar disorder; 3) Recognize the role neuroimaging can play in defining the causes of bipolar disorder.

**SUMMARY:**

Bipolar disorder is a common, serious psychiatric condition affecting up to 4% of the population. Despite being widely recognized, the specific underlying neuropathophysiology of this illness remains incompletely described. During the last 10-15 years, advances in magnetic resonance imaging (MRI) and spectroscopy (MRS) have permitted sophisticated, in vivo examination of the human brain, in general, and individuals affected by bipolar disorder specifically. As these data have accumulated, a model of bipolar disorder is emerging that involves overactivation and modulatory dysfunction of the anterior limbic network. The anterior limbic network is comprised of iterative prefrontal-striatal-pallidal-thalamic iterative circuits that modulate deeper brain structures involved in the expression of emotion. In particular, loss of ventral prefrontal control over extended amygdala seems to contribute to mood episodes. MRS research suggests that prefrontal hypermetabolism in bipolar disorder may underlie this loss of prefrontal control, as expressed in excessive glutamate neurotransmission within these iterative circuits. As neuroimaging continues to refine this functional and chemical neuroanatomic model of bipolar disorder, we may be able to identify new targets for treatment development, as well as treatment response markers and predictors. Additionally, as this model evolves, we may be able to identify specific indicators of illness progression, even before the onset of the first manic episode that could provide targets for preventing the onset of bipolar disorder. Coupled with advances in genetic research, neuroimaging may revolutionize our understanding and treatment of this common psychiatric condition, ultimately benefiting outcomes of our patients.

**REFERENCES:**

*1. Strakowski et al. The functional neuroanatomy of bipolar disorder: a review of neuroimaging findings. Molec Psychiatry 2005; 10:105-116*

*2. Stork & Renshaw. Mitochondrial dysfunction in bipolar disorder: evidence from magnetic resonance spectroscopy research. Molec Psychiatry 2005; 10:900-919.*

**1:30 P.M.- 3:30 P.M.**

LECTURE 8-

**THE AUDACITY PRINCIPLE IN SCIENCE?**

*Solomon H. Snyder, M.D., Department of Neuroscience Johns Hopkins Medical School 725 N Wolfe St., Baltimore, MD 21205*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the history of psychotropic drug development; 2) Understand actions of major psychoactive drugs; and 3) Identify brain mechanisms underlying the influence of psychotropic agents.

**SUMMARY:**

The last half of the 20th century witnessed the emergence of psychopharmacology and the birth of molecular neuroscience. The principal antipsychotic, antidepressant and anti-anxiety agents reflected serendipitous discoveries. Only after these drugs were widely used clinically did researchers uncover their molecular mechanisms of action. These actions generally involve the major biogenic amine and amino acid neurotransmitters. Research over the past few decades has greatly expanded the number of neurotransmitters with potential for influencing emotional behavior. Almost 50 neuropeptides have been characterized. Gases such as nitric oxide influence myriad events in the brain and periphery. Nitric oxide has been joined by carbon monoxide as a neuromodulator. More recently, hydrogen sulfide has been recognized as a major regulator of blood vessels and potential central transmitter. D-amino acids such as D-serine and D-aspartate are of importance. All of these offer new targets for drug development and potential as mediators of normal and abnormal mentation.

**REFERENCES:**

*1. Snyder SH, The Audacity Principle in Science. Proc. Amer. Philosoph.Soc. 149: 141-158, June 2005.*

LECTURE 9-

**YOUR BIPOLAR DAD IS A BAD REASON TO BECOME A PSYCHIATRIST: ADVOCACY ADVENTURES OF A BEWILDERED BOY WHO GREW UP TO BECOME NAMI'S MEDICAL DIRECTOR**

*Kenneth S. Duckworth, M.D., 44 Arborough Rd., Roslindale, MA 02131-1602*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify key historical mental health advocacy victories; 2) Recognize progress historically made in achieving parity and treatment reforms; and 3) Possess a clear view of the important role advocacy will play in the future role of psychiatry.

**SUMMARY:**
Advocacy can take many forms. On the personal and system change level; there are many ways to work for more effective care and culture with and for consumers and family members. This lecture will review lessons from key mental health advocacy victories and defeats as seen through the eyes of one public sector psychiatrist. Cases will include reduction of the use of restraints, mental health insurance parity, “Grading the States” on mental health care systems, the New York adult home scandal and lawsuit, and preventing early death. The audience will be invited to discuss where psychiatry has grown and where it needs to go to change the world.

**3:30 PM- 5:00PM**

LECTURE 10-
**THE SIMPLE TRUTH ABOUT THE GENETIC COMPLEXITY OF SCHIZOPHRENIA**

*Daniel Weinberger, M.D., National Institute of Mental Health, Genes, Cognition and Psychosis Program, 10 Center Dr., Bethesda, MD 20892*

**EDUDATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Analyze current issues related to understanding genetic risk for schizophrenia; 2) Review approaches to characterizing intermediate phenotypes related to genetic risk for schizophrenia; and 3) Describe how specific genes, such as AKT1 and KCNH2 impact on brain functions related to risk for schizophrenia.

**SUMMARY:**
Over the past eight years, genes putatively related to the etiology of schizophrenia and related conditions have been identified. There is considerable controversy about whether any of the genetic evidence so far is valid. This controversy resides largely in questions about the strength of statistical evidence, though it is generally agreed that the end game in gene identification of complex disorders such as mental illnesses cannot be based on statistics. The end game is a biological one, based on demonstrating that variation in a candidate gene impacts on the biology of the gene so that it biases towards expression of the biology of the illness. With this in mind, a number of candidate genes have been studied at the level of gene expression, cell models, neural systems functions and cognitive parameters. These studies have identified a number of heuristically valuable biological associations. Ultimately, the genes tell us what schizophrenia is at a basic cellular level. This talk will address the biological clues that have emerged so far about the genetic origins of schizophrenia and some of the likely explanations for the current controversies. The findings that will be reviewed converge on the conclusion that there are many genetic and molecular pathways to schizophrenia and related phenotypes, that Interactions of variations within genes, between genes, and with the environment confound simple models of genetic association in psychiatry but show biologically lawful effects on brain-related intermediate phenotypes. Thus, simple models of genetic association do not work, and solutions will require new approaches and new thinking.

**REFERENCES:**
1. *Huffaker SJ, Chen J, Nicodemus KK, et al: A primate-specific, brain isoform of KCNH2 affects cortical physiology, cognition, neuronal repolarization and risk of schizophrenia. Nature Medicine 15: 509-518, 2009.*
2. *Tan HY, Nicodemus KK, Chen Q, et al: Genetic variation in AKT1 is linked to dopamine-associated prefrontal cortical structure and function in humans. J Clin Investigation 18:2200-2208, 2008.*
3. *Nicodemus KK, Marenco S, Batten AJ, et al: Serious obstetric complications interact with hypoxia regulated vascular expression genes to influence schizophrenia risk. Mol Psychiatry 13:873-877, 2008.*

LECTURE 11-
**SOLOMON CARTER FULLER: WHAT WOULD HE SAY ABOUT RACIAL POLITICS IN AMERICAN PSYCHIATRY TODAY?**

*Donna M. Norris, M.D., 1 Washington St., Ste 211, Wellesley, MA 02481-1706*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session the participant should be able to: 1) Exhibit knowledge regarding the contributions of Dr. Solomon Carter Fuller to American psychiatry; 2) Identify the significance of African- American psychiatrists leaders to American psychiatry viewed from the context of American history; and 3) Recognize Dr. Fuller’s experiences as an African American psychiatrist in the early 20$^{th}$ century compared with the views and experiences of

African-American psychiatrists in the latter 20th and early 21st centuries in this country.

**SUMMARY:**
Dr. Solomon Carter Fuller, the grandson of an American slave born and raised in Liberia, moved to this country in 1889. He went on to achieve a distinguished career in medicine and medical research and is considered the first African-American psychiatrist in the United States. This lecture will present data from Dr. Fuller's life which offers insights into his views of racial politics in medicine in his day. In addition, the presentation will highlight information from interviews with selected African-American psychiatrists who are leaders in American psychiatry, some of whom have served in elected offices at the American Psychiatric Association and allied health organizations. Dr. Fuller's observations, views and experiences in the early 20th century will be compared with the views of these African-American psychiatrists from the latter 20th and early 21st century. Their perspectives on the influence of race and politics in organized psychiatry in America today and their impact on health care for African American and other under-represented minority patient groups will be discussed.

**REFERENCES:**
1. *Willie CV, Kramer B, Brown B. Racism and Mental Health. University of Pittsburgh Press 1973*

**TUESDAY, MAY 25, 9:00 AM-10:30AM**

LECTURE 12-
**ADDICTION: CONFLICT BETWEEN BRAIN CIRCUITS**

*Nora D. Volkow, M.D., 6001 Executive Blvd., Room 5274, MSC 9581, Bethesda, MD 20892*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize the complex biological and environmental factors that underlie vulnerability to drug abuse and addiction; 2) Identify the changes in the brain dopaminergic system that distinguish drug use or drug intoxication from addiction; and 3) Understand the complexity of the interactions between the multiple brain circuits involved in addiction and their implications for addiction treatment.

**SUMMARY:**
Addiction is a disorder that involves complex interactions between genes, development and the social environment. Studies employing neuroimaging technology paired with behavioral measurement have led to extraordinary progress in elucidating many of the neurochemical and functional changes that occur in the brains of addicted subject. Although large and rapid increases in dopamine have been linked with the rewarding properties of drugs, the addicted state, in striking contrast, is marked by significant decreases in brain dopamine function. Such decreases are associated with dysfunction of prefrontal regions including orbitofrontal cortex, cingulate gyrus and dorsolateral prefrontal cortex. In addiction, disturbances in salience attribution result in enhanced value given to drugs and drug-related stimuli at the expense of other reinforcers. Dysfunction in inhibitory control systems, by decreasing the addict's ability to refrain from seeking and consuming drugs, ultimately results in the compulsive drug intake that characterizes the disease. Discovery of such disruptions in the fine balance that normally exists between brain circuits underling reward, motivation, memory and cognitive control have important implications for designing multi-pronged therapies for treating addictive disorders.

**REFERENCES:**
1. *Volkow ND, Fowler JS, Wang G-J, Baler R, Telang F. Imaging dopamine's role in drug abuse and addiction. Neuropharmacology 2009; 56 Suppl 1: 3-8.*

LECTURE 13-
**FROM CIRCUITS TO CELLS TO MOLECULAR REGULATION: IDENTIFYING NOVEL TARGETS FOR THE TREATMENT OF PSYCHOTIC DISORDERS**

*Francine M Benes, M.D., 115 Mill St., Belmont, MA 02478-1041*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify corticolimbic circuitry that is involved in the pathophysiology of schizophrenia and bipolar disorder; 2) Characterize the subtypes of GABA cells dysfunctional in psychotic disorders and understand how complex circuits may be miswired; and 3) Explore how functional differentiation of post mitotic GABA cells in adult hippocampus may be influenced by the regulation of cell cycle and genomic integrity.

**SUMMARY:**
In the last 25 years, significant strides have been made in defining the pathophysiology of schizophrenia and bipolar disorder in terms of brain regions, circuits and specific subtypes of neurons. It is now broadly believed that these two disorders may be caused by subtle abnormalities in the "wiring" of the corticolimbic system, particularly in

GABAergic interneurons that provide critical inhibitory modulation. With increasingly sophisticated forms of technology now available for postmortem studies of the human brain, a steady increase in the numbers and scale of such studies is occurring. For example, by using a combination of laser microdissection and microarray-based gene expression profiling, it is now possible to reproducibly identify abnormalities in microscopic and molecular markers in key brain regions where GABAergic interneurons are the exclusive neuronal cell type. The results of many blind, quantitative studies of postmortem tissue have demonstrated that many of the abnormalities are found within two particular sites within the anterior cingulate cortex and hippocampus. Both of these latter regions receive rich innervations from the basolateral amygdala, suggesting that all three regions may comprise a key circuit involved in the pathophysiology of schizophrenia and bipolar disorder. Based on these findings, a rodent model for postmortem abnormalities in these disorders has been developed and is proving to be an invaluable tool for testing important hypotheses regarding the cellular and molecular mechanism related to the integration of the glutamate and GABA systems within this circuitry. A wealth of evidence now indicates that GABAergic neurons, inhibitory interneurons that play a key role in modulating the activity of projection neurons in complex circuits, are probably dysfunctional in schizophrenia and bipolar disorder. One of the most replicated findings in postmortem studies of schizophrenia and bipolar disorder is a reduced expression of messenger RNA for the GAD67 gene (GAD1), a key marker for GABA cell differentiation. The molecular regulation of GAD67 expression involves a complex network of genes that influence the growth, differentiation and genomic integrity of these neurons. Although this finding is present in both schizophrenia and bipolar disorder, the underlying molecular changes associated with decreased GAD67 expression are fundamentally different. This has lead to the hypothesis that in these two disorders, a common cell phenotype may belie the presence of specific endophenotypes. Current research using postmortem tissue and a specific rodent model developed from postmortem findings is focusing on identifying the basic cellular and molecular mechanisms that regulate the functional differentiation and genomic integrity of GABAergic interneurons and the integration of their activity within complex local circuits within the hippocampus. This strategy will eventually lead to the development of innovative and specific strategies for treating unique neural circuitry abnormalities found in schizophrenia and bipolar disorder.

**REFERENCES:**

*1. Benes FM, Lim B, Matzilevich D, Walsh JP, Subburaju S, Minns M (2007) Regulation of the GABA cell phenotype in hippocampus of schizophrenics and bipolars. Proc Natl Acad Sci U S A 104:10164-10169.*

*2. Benes FM, Lim B, Matzilevich D, Subburaju S, Walsh JP (2008) Circuitry-based gene expression profiles in GABA cells of the trisynaptic pathway in schizophrenics versus bipolars. Proc Natl Acad Sci USA 105:20935-20940.*

**11:00 AM-12:30PM**

LECTURE 14-
**CO-MORBIDITY OF PSYCHIATRIC DISORDERS**

*Ronald C Kessler, Ph.D., Department of Health Care Policy, Harvard Medical School, 180 Longwood Avenue, Boston, MA 02115*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize commonly occurring patterns of co-morbidity between psychiatric and physical disorders; 2) Identify commonly occurring patterns of co-morbidity among mental disorders; and 3) Identify promising intervention opportunities aimed at onset, persistence, and severity of secondary co-morbid disorders through targeted treatment of primary psychiatric disorders.

**SUMMARY:**

Co-morbidity is a common feature of psychiatric disorders, both with physical disorders and among themselves. An understanding of mental-physical comorbidity has important implications for understanding the societal costs of psychiatric disorders and the cost-effectiveness of treatment. An understanding of mental-mental comorbidity has important implications for understanding developmental psychopathology and the cost-benefit of early treatment. Recent epidemiological research on both kinds of comorbidity is reviewed in this presentation. Regarding mental-physical comorbidity, results are reviewed from the WHO World Mental Health (WMH) Survey Initiative documenting two types of influences of mental disorders on chronic physical disorders. First, a number of temporally primary mental disorders have been shown to be powerful risk factors for the subsequent onset of certain chronic physical disorders. Second, co-occurring mental disorders have been shown to be related to persistence and severity of a number of chronic physical disorders. Research on the extent to which expanded treatment of mental disorders would reduce the prevalence, persistence, or severity of these physical disorders is only in its infancy, but represents an important emerging area of inquiry. Regarding mental-mental comorbidity, results are reviewed from recent developmental epidemiological

studies, most importantly the recently completed National Comorbidity Survey Replication Adolescent Supplement (NCS-A). These studies attempt to trace out the temporal sequencing and unfolding of co-morbidity in an effort to improve understanding of the dynamics underlying the cumulative progression of complex co-morbid disorders. The results of these studies show that fear-circuitry, distress, and impulse-control disorders have separate but inter-related processes of temporal unfolding that suggest heretofore unexploited opportunities for early intervention that might prove effective in secondary prevention.

**REFERENCES:**

*1. Von Korff MR, Scott KM, Gureje O 2009 Global Perspectives on Mental-Physical Comorbidity in the WHO World Mental Health Surveys. NY: Cambridge University Press.*

LECTURE 15-

## HIGHLIGHTS AND LESSONS FROM 40 YEARS IN PSYCHIATRY

*Eve C Johnstone, M.D., 20 Park Crescent, London, W1B 1AL United Kingdom*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the biological basis and pathophysiology of psychiatric disorders; 2) Learn how the history of research using CT scans and known causes of dementia relates to recent findings in schizophrenia research; and 3) Recognize how this new research crosses diagnostic boundaries and challenges accepted norms and has provided findings of value to many psychiatrists.

**SUMMARY:**

I have spent the last 41 ½ years working as a psychiatrist and I have enjoyed it enormously. When I began the scientific basis of psychiatry was very far from strong although there had been some very major pharmacological advances in the last 15 or so years. I entered research practice 37 years ago because I felt that although I enjoyed psychiatry I could not continue in a subject where treatments were of such limited value unless I tried to do something about it. I thought that it was in terms of treatment that advances would come and, of course, they haven't really. The thing that has changed and in a way that I never all those years ago anticipated is that we understand the biological basis and pathophysiology of at least some psychiatric disorders at least to a reasonable degree. This has been a major highlight. I developed an interest in neuroimaging very early because I was fortunate enough to work with the prototype CT (EMI) scanner in 1974. In investigating just why the memories of some people with schizophrenia were so impaired and assessing them from the point of view of known causes of dementia we used CT scans and were dramatically surprised by the results. This was a highlight indeed and an interest which has lasted and developed right up to the present as I shall show in my latest results. I was by then working for the Medical Research Council at their clinical research centre in London. My main field of interest was in the exploration of the biological basis of schizophrenia but we did do some treatment trials and we did randomised controlled studies of antipsychotics, of ECT and of antidepressants and benzodiazepines in the treatment of depression and anxiety. We also did large scale treatment and follow up studies of a variety of aspects of schizophrenia. The results of all of these were highlights but not always in quite the way that we expected. I then came back to Scotland, my native land, to try to establish research there. Circumstances were very different and the population is small but it has great strengths and those strengths have allowed us to do work which crosses diagnostic boundaries which challenges accepted ideas and which we believe has provided findings of value not just in Scotland and the UK or Europe but we hope on an international basis.

**1:30 PM- 3:00PM**

LECTURE 16-

## NEW DIRECTIONS IN DRUG POLICY: PRESIDENT OBAMA'S NATIONAL DEMAND REDUCTION PRIORITIES

*Andrew T McClellan, Ph.D., 750 17th Street, NW, Washington, DC 20503*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session the participant should be able to: 1) Identify the characteristics of a national network of "Prevention Prepared Communities"; 2) Identify how mainstream healthcare can be used to screen and intervene with emerging substance use disorders; 3) Recognize the role of government in assisting with the expansion of addiction treatment and incorporating it into mainstream healthcare; 4) Identify ways to create safe, effective management of drug related offenders in community settings; and 5) Understand the role of a performance oriented information system.

**SUMMARY:**

Substance abuse takes a terrible toll on the public health, public safety and financial resources of the United States. In 1986 Congress created the White House Office of National Drug Control Policy (ONDCP) and charged it with coordinating federal efforts to reduce drug use and drug-

related problems facing the country. This Administration has accepted the reality that attempts to stop drug production and importation, should be matched by equal efforts to reduce control what Secretary of State Clinton aptly called "…America's insatiable demand for drugs." Recent scientific discoveries in the areas of prevention, brief intervention and treatment have paved the way for a more balanced drug control strategy, characterized by greater emphasis upon research-derived "demand reduction" efforts in the areas of prevention, intervention, treatment and recovery. This presentation will describe five national priorities within the new *US Drug Control Strategy* where scientific discovery, problem severity and practicality have converged to create opportunities for impact. The presentation will introduce each of these areas, discussing background and rationale, and describing the types of projects and policies proposed in each area.

LECTURE 17-
## TOWARD A NEW PSYCHIATRY: VALUING THE POSITIVE EMOTIONS

*George E. Vaillant, M.D., 1249 Boylston St., 3rd Floor, Boston, MA 02215*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize why positive emotions are important to psychiatrists and why psychiatry has been resistant to them; 2) Identify the benefits of positive emotions and how they involve the parasympathetic nervous system and lower blood pressure, BMR and cortisol and elevate the bonding hormone oxytocin; and 3) Recognize that greater attention to positive emotions reflects the direction of dynamic psychotherapy of the future.

**SUMMARY:**
Emotion has often been an unwelcome guest at the academic table; for emotion, especially positive emotion, threatens to muddy Enlightenment science. In part, this is the explanation why spirituality, perhaps better understood as the positive emotions – like hope, love, joy, compassion, forgiveness, trust, gratitude and awe -is an historical blind spot for both psychiatry and psychology. Unlike the so-called negative emotions of anger, lust, grief and fear, positive emotions free the self from the self. Unlike negative emotions, positive emotions are future oriented, prosocial and rarely "all about me". Many of these emotions, although tangibly demonstrable in fMRI and, of course, given pride of place in all the great world religions, are ignored by experimental and clinical psychology. This lecture is focused to examine why the positive emotions are important and why psychiatry has been so afraid of them. From a clinical standpoint to ignore the positive emotions is a mistake because focus only upon negative emotions evokes in our patients the fight or flight sympathetic system and elevates cortisol and blood pressure. In contrast, the positive emotions—think of the physiology of cuddling—involve the parasympathetic nervous system and lower blood pressure, BMR and cortisol, even as they elevate the bonding hormone oxytocin. For example, joy is not easy to talk about; for joy can feel too intense, too private for others to bear. The Victorians, before Freud, felt that way about sexual excitement. When Icarus rose up, as larks do, flying triumphantly, flying joyfully towards the sun, did not his cautious father, Dedalus, warn him that the sun would melt his wings. And so our last view of Icarus is always one of his falling, chastened, to his death. How puritanical, how sad. What a waste of joy. After all the sun is 93 million miles away, and air grows cooler as we ascend. Flying high does not melt waxwings. It makes them stronger. Of all the major emotions, joy is the only one that even Freud ignored. In contrast, Teilhard de Chardin, the very model of a Jesuit Darwinian, considered "joy" the most infallible sign of the presence of God. It is so much easier to talk of cognitive happiness than of emotional joy. Our joy often seems too over the top; and yet, paradoxically, joy also feels like the most intimate connection. So why are we all so wary of talk about joy? And yet, paradoxically, why is joy so easy to sing about? I will argue that greater attention to positive emotions reflects the direction of dynamic psychotherapy of the future. Patients need to be "held" and "seen" in order to bear the positive emotions of joy, forgiveness and love, as much as they need to be supported in bearing resentment, rage and grief.

**REFERENCES:**
*1. Vaillant GE (2008): Spiritual Evolution: How We Are Wired For Faith, Hope And Love. New York: Doubleday Broadway. Paperback*

LECTURE 18-
## PREVENTION INITIATIVES IN SCHIZOPHRENIA

*Thomas H. McGlashan M.D., 301 Cedar St., New Haven, CT 06519*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the two types of prevention it is now possible to achieve with patients suffering with psychosis; 2) Recognize why moving backward in developmental time with psychotic disorders toward prevention is becoming a guiding force in psychiatry; and 3) Analyze

the reorientation of psychiatrist perspective relating to psychosis and what direction current trends will be taking them in treating these patients in the future.

**SUMMARY:**

The irreversibility and chronicity of psychosis, even with current treatments, demands that strategies of prevention be designed and tested. This presentation will outline the two types of prevention now possible to achieve with psychosis. The first identifies and treats persons as soon as possible in their first break and the second tries to identify and track persons who have never been psychotic but who are at very high risk of developing first psychosis in the near future. Moving backward in developmental time with psychotic disorders toward prevention is the guiding idea (1-3). It promises to transform our work from that of alienists caring for the chronically ill to that of clinicians treating risk and protecting health. It is a new and sometimes uncomfortable reorientation of our perspective, but it is the future.

**REFERENCES:**

*1. McGlashan TH, Johannessen JA: Early detection and intervention with schizophrenia: Rationale. Schizophrenia Bulletin, 22(2): 201-222, 1996.*

*2. McGlashan TH, Hoffman RE: Schizophrenia as a disorder of developmentally reduced synaptic connectivity. Archives of General Psychiatry, 57: 637-648, 2000.*

*3. Melle I, Larsen TK, Haahr U, Friis S, Johannessen JO, Opjordsmoen S, Rund BR, Simonsen E, Vaglum P, McGlashan, T. H. Prevention of negative symptom psychopathologies in first-episode schizophrenia: Two-year effects of reducing the duration of untreated psychosis. Archives of General Psychiatry. 65(6):634-640, 2008.*

**4:30 PM- 5:30PM**

LECTURE 19-

**DEPRESSION AND SUICIDAL BEHAVIOR IN LATINO POPULATIONS**

*Maria A. Oquendo, M.D., 1051 Riverside Dr., New York, NY 10032*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify risk factors for suicidal behaviors in Latino populations; 2) Recognize risk factors for depression in Latino populations; and 3) Identify population trends in Latino groups.

**SUMMARY:**

Latino populations are growing faster than other US populations and are estimated to constitute about 25% of the US population by 2050. Major Depression, a leading cause of disability world wide affects Latinos to varying degrees depending on the subgroup. Similarly, the risk for suicidal behavior per case of depression varies among Latinos by subgroup as well, with Cuban Americans showing rates of suicide per case of depression similar to those of non-Latino whites, while Mexican Americans appear relatively protected. Differences in rates of suicide attempt vary as well. Epidemiologic data, clinical data, risk factors and protective factors will be discussed. Issues of access to care, cultural constructs and other determinants appear to relate to the variations in these psychiatric manifestations.

**REFERENCE:**

1. Oquendo, MA; Lizardi, D; Greenwald, S; Weissman, MM; Mann, JJ. Rates of Lifetime Suicide Attempt and Rates of Lifetime Major Depression in Different Ethnic Groups in the United States. Acta Psychiatrica Scandinavica. 2004; 110(6):446-51

**WEDNESDAY, MAY 26, 9:00 AM-10:30AM**

LECTURE 20-

**SO YOU WANT TO BE A PHYSICIAN EXECUTIVE**

*Arthur L Lazarus, M.D., M.B.A., 9 Carriage Path, Chadds Ford, PA 19317*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the career options available for physicians interested in careers in medical management; 2) Analyze the pros and cons of leaving practice for administration; and 3) Recognize the skills required to become an effective organizational leader.

**SUMMARY:**

Increasingly, psychiatrists are assuming executive roles in health systems as the complexity of care delivery increases. The physician executive's position may be viewed as the hub around which the many spokes of the healthcare system turn. The physician executive is responsible for integrating the needs of the patients and the physicians in the community into the vision, mission and goals of the health system. The critical skills required of psychiatrists to function at the executive level include a broad knowledge of primary care practice, strong leadership abilities, technical expertise, and management know-how. Leadership skills are the key factor in determining the success or failure of an organization. Technical skills require

an understanding of information systems and conflict resolution. Managing change has become a significant core competency for physician executives; change will be universally resisted unless physician executives can obtain the buy-in of colleagues and administrators. In addition to the skills required to become a successful physician executive, this lecture will review controversial topics such as combining practice with administration, and walking the fine line between being a patient advocate and corporate representative. A discussion of the rewards and challenges of management will ensue, with a focus on whether management is a good fit for you. The reasons why physicians fail as administrators, and why their employment may be terminated, will be discussed, along with various job-loss prevention and post-survival strategies. The value of business school and investing in "soft skills" will be assessed. The lecture will contain a liberal sprinkling of personal anecdotes, and it is hoped that the information presented will help attendees decide whether a full-time career in administration is feasible, and how they can avoid making critical errors in the clinical-administrative interface while pursuing their interest in this career pathway.

**REFERENCES:**

1. *Lazarus A: Professional and career issues in administrative medicine. Journal of Healthcare Leadership, 1(1):1-5, 2009. Open access article available at:* http://www.dovepress.com/articles.php?article_id=3681.

2. *Lazarus A: The physician executive as a guiding force in health care. Physician Executive Journal, 29(3):37-39, 2003.*

**11:00 AM-12:30PM**

LECTURE 21-

**SEEK AND TREAT FOR OPTIMAL PREVENTION OF HIV/AIDS: STOP HIV/AIDS**

*Julio Montaner, M.D., Room 667, 1081 Burrard St., Vancouver, British Columbia, V6Z 1Y6 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Gain a comprehensive understanding of the overall impact of antiretroviral therapy on HIV related morbidity/mortality; 2) Characterize current gaps in the therapeutic success of antiretroviral therapy; 3) Highlight the role of combination prevention approaches to decrease morbidity, mortality and HIV transmission; and 4) Review preliminary data regarding the impact of expansion of HAART in hard-to-reach populations in British Columbia.

**SUMMARY:**

While an outright cure or a preventive vaccine for HIV/AIDS remain elusive, remarkable advances in HIV treatment have been achieved over the past two decades. Most significant among these advances is the development of highly active antiretroviral therapy (HAART). HAART can fully suppress HIV replication and therefore render the number of viral copies present in a patient's blood undetectable, as measured by commercially available plasma viral load assays. Since 1996, the use of HAART dramatically reduced HIV/AIDS related morbidity and mortality. More recently, we have provided evidence that the viral load suppression achieved by HAART has a substantial impact on the transmission of HIV. Specifically, in August 2006, we published a viewpoint article in The Lancet that outlined the expansion of HAART coverage to all those in medical need as a key strategy to dramatically reduce HIV transmission to those at risk (Montaner et al, The Lancet, 2006). We further proposed that HAART expansion in addition to preventing AIDS morbidity and mortality, would become cost-averting as it would virtually eliminate vertical transmission of HIV, and dramatically reduce HIV transmission by all routes (Lima et al, JID, 2008). More recently, we published the first study demonstrating the role of HAART in the prevention of HIV transmission in injection drug users in the Downtown Eastside of Vancouver (Wood et al, British Medical Journal, 2009). "Treatment as Prevention" has now gained the support of the international community, including investigators based at the World Health Organization (WHO) (Granich et al, The Lancet, 2009). The expansion of HAART currently underway in British Columbia, Canada, aims to increase coverage among clinically eligible HIV-positive individuals on treatment, monitoring the impact of such expansion on HIV incidence, as well as AIDS morbidity and mortality over several years. Our mathematical models suggest that this will generate a substantial decline in AIDS related morbidity and mortality and also a decrease in HIV incidence. We have entitled this initiative Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS). This work is supported in part by the Provincial Government, and an Avant Garde Award to Dr J Montaner, from the National Institute for Drug Abuse at the NIH.

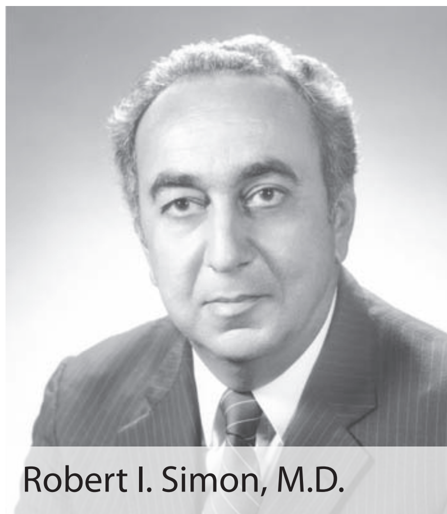
# PROFILE PHOTOS

Raquel E. Gur, M.D., Ph.D.

Kenneth Tardiff, M.D., M.P.H.

Florian Holsboer, M.D.

Glen O. Gabbard, M.D.


Robert I. Simon, M.D.

Katherine A. Halmi, M.D.

Karl Deisseroth, M.D., Ph.D.

Kenneth S. Duckworth, M.D.

Stephen M. Strakowski, M.D.

Donna M. Norris, M.D.

Solomon H. Snyder, M.D.

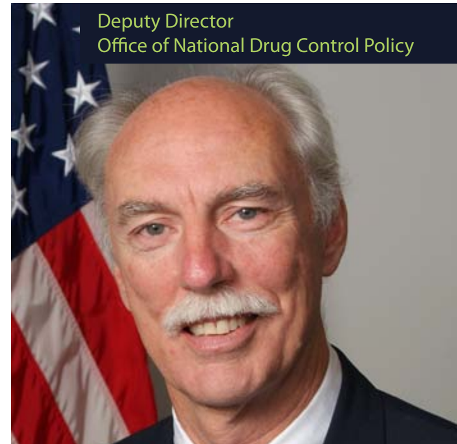
Daniel R. Weinberger, M.D.

# PROFILE PHOTOS

Nora Volkow, M.D.

Eve Johnstone, C.B.E., M.D.

Francine Benes, M.D., Ph.D.

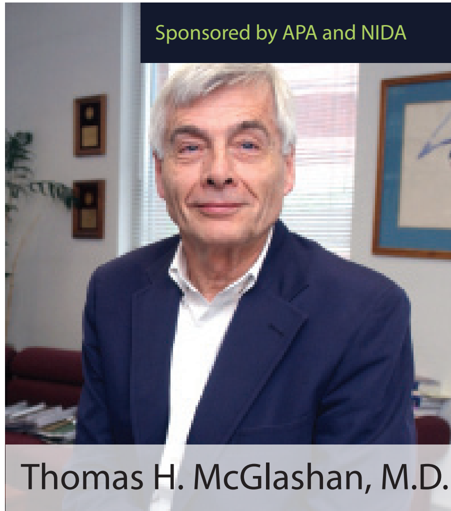




A. Thomas McLellan, Ph.D.

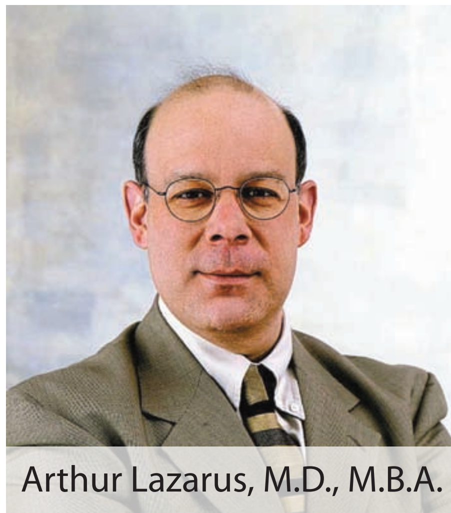
Ronald C. Kessler, Ph.D.

George Vaillant, M.D.

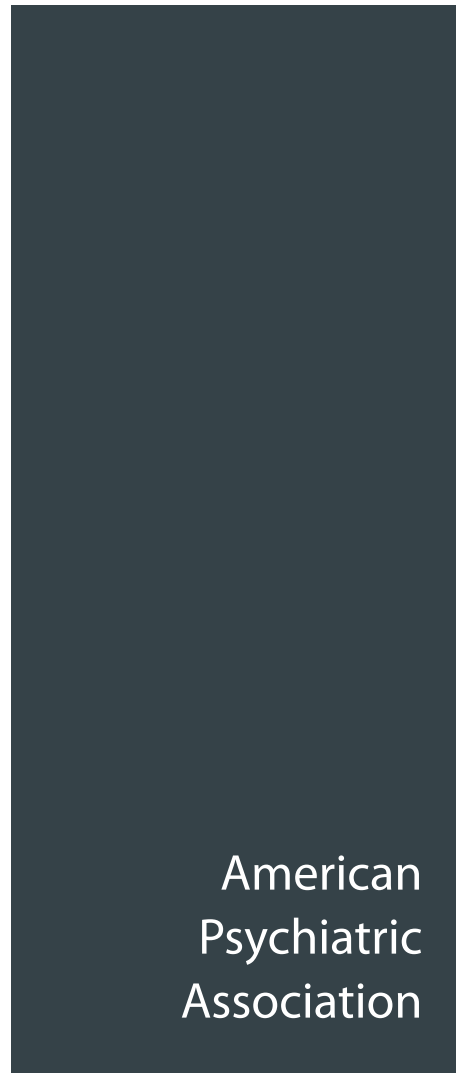


Thomas H. McGlashan, M.D.

Julio Montaner, M.D.


Arthur Lazarus, M.D., M.B.A.

Maria A. Oquendo, M.D.



**SATURDAY, MAY 22, 2010**
**2:00 PM- 5:00PM**

## PRESIDENTIAL SYMPOSIUMS 1
## THE EMERGING NEUROBIOLOGY OF ANTIDEPRESSANT TREATMENT RESPONSE

*Chairperson: Katharina Domschke, M.D., M.A., Albert-Schweitzer-Strasse 11, Muenster, D-48149 Germany*
*Co-Chairperson: Yvette Sheline, M.D., Washington University Medical School, 4940 Children's Pl Ste 8134, St. Louis, MO 63110*

### EDUCATIONAL OBJECTIVES:
At the conclusion of this presentation, the participant should be able to: 1) Increase knowledge about key circuits involved in depression; 2) Provide a basis for understanding the application of pharmacogenetics and MRI to guide treatment of depression; and 3) Provide a rationale for placement of electrodes in DBS.

### OVERALL SUMMARY:
Antidepressant pharmacologic treatment is effective, however, up to 60% of the patients do not respond to first-line treatment. Thus, one of the greatest challenges in the field is to delineate predictors of antidepressant treatment response. The proposed symposium attempts to provide a framework for integrating and discussing recent knowledge on cellular (genetic) and circuit (neuroimaging) functions relevant for the prediction of individual differences in antidepressant treatment response and thereby possibly the development of a more personalized treatment approach in the future. Pharmacogenetic findings point to a significant influence of genetic variants predominantly of the serotonergic and noradrenergic as well as the NPY and endocannabinoid systems on antidepressant treatment response differentially for clinical subtypes of depression. It has been shown that genetic variants predicting treatment resistance in depression might confer this risk via distorted emotional processing of depression-related stimuli in the limbic-frontal circuit. Neuroimaging predictors of antidepressant treatment response comprise brain structural neuroanatomy as well as altered emotional processing in amygdala and orbitofrontal and prefrontal cortex regions. Recently, the "default mode network" model and self-referential processes have been proposed to be involved in the pathophysiology of depression and also possibly antidepressant treatment response. Finally, novel network-based neuromodulatory interventions to different brain targets in very treatment resistant depression seem to have some efficacy, lending a different angle on the neurobiology of depression with regards to integrating network aspects. Target specific effects and putative predictors to such interventions might lead to adapted conceptualizations of major depression and treatment options. Background: The recently discovered default mode network (DMN) is a group of areas in the human brain characterized, collectively, by functions of a self-referential nature. In normal individuals activity in the DMN is reduced during non-self-referential goal directed tasks, in keeping with the folk-psychological notion of losing one's self in one's work. Imaging and anatomical studies in major depression have found alterations in both the structure and function in some regions that belong to the DMN suggesting a basis for the disordered self-referential thought of depression. Methods: Here we sought to examine DMN functionality as a network in patients with major depression, asking whether the ability to regulate its activity and, hence, its role in self-referential processing was impaired. To do so we asked patients and controls to examine passively negative pictures as well as actively re-appraise them. Results: In widely distributed elements of the DMN--ventromedial prefrontal cortex (BA 10), anterior cingulated (BA 24/32), lateral parietal cortex (BA 39) and lateral temporal cortex (BA 21)-- depressed, but not control subjects, exhibited a failure to reduce activity while both looking at negative pictures and reappraising them. Further, looking at negative pictures elicited a significantly greater increase in activity in other DMN regions (amygdala, parahippocampus and hippocampus) in depressed than in control subjects. Conclusions: These data suggest depression is characterized by both stimulus-induced heightened activity as well as a failure to normally down-regulate activity broadly within the DMN. These findings provide a brain network framework within which to consider the pathophysiology of depression.

PS1 -1
## CONNECTIVITY OF THE SUBGENUAL CORTEX AND HPA AXIS IN DEPRESSION

*Alan Schatzberg, M.D., 401 Quarry Road, Stanford, CA 94305-5717*

### SUMMARY:
Background: Our group has reported, using a resting-state fMRI approach, that subgenual cingulate connectivity, within a posterior cingulate-hippocampal-medial prefrontal network, is increased in a mixed group of delusional and nondelusional depressives compared to healthy controls. The subgenual region has been thought to participate in a circuit that involves anterior and posterior cingulate and prefrontal cortex as well as the hypothalamus. Methods: Herein, we report on the relationship of resting-state functional connectivity in the subgenual region to activity of the hypothalamic-pituitary-adrenal (HPA) axis in 60

patients with major depression (30 delusional and 30 non-delusional) as well as 30 healthy controls. Patients were assessed for serum cortisol and ACTH activity on an hourly basis beginning at 6 p.m. and ending at 9 a.m. in a G-CRC setting. MRI's were obtained after completing blood collections. Results: Data are presented on the relationship of mean cortisol levels from 6 p.m. to 1 a.m. and from 1 a.m. to 9 a.m. with connectivity profiles of the subgenual region. We also present data on the relationship between hippocampal connectivity and the HPA axis. Implications of these data for understanding a key circuit involved in the pathogenesis of depression are discussed.
Conclusions: Resting-state fMRI can identify abnormalities in brain connectivity in depression and relationships with elevated HPA axis activity.

PS1 -2

**PREDICTION OF ANTIDEPRESSANT TREATMENT RESPONSE: A PHARMACO- AND IMAGING GENETIC CONTRIBUTION**

*Katharina Domschke, M.D., M.A., Albert-Schweitzer-Strasse 11, Muenster, Germany D-48149*

**SUMMARY:**
Background: In major depression, an increasing number of pharmacogenetic studies have examined association of antidepressant treatment response with variation in candidate genes. Given only few consistently reproducible findings, we attempted to further refine investigation of the clinical phenotype of depression in pharmacogenetic studies with particular attention to gender, melancholic and anxious depression as well as the intermediate phenotype of emotional processing. Methods: In a sample of 256 Caucasian patients with Major Depression, candidate gene variants of the serotonergic, noradrenergic, NPY and endocannabinoid systems were investigated for their impact on antidepressant treatment response. A subsample of 35 patients was additionally scanned by means of fMRI at 3 T under visual presentation of emotional faces using an imaging genetics approach. Results: The MAO-A VNTR and the COMT val158met variants were found to influence antidepressant treatment response specifically in female patients. The 5-HT1A -1019 C/G polymorphism was associated with treatment response in patients with melancholic, but not atypical depression. 5-HTTLPR, CNR1 rs1049353 and NPY rs16147 were observed to significantly impair treatment response particularly in anxious depression via altered brain activity in amygdala, prefrontal and striatal regions during processing of depression-related emotional stimuli. Conclusions: The present results suggest a significant impact of 5-HTT, 5-HT1A, MAO-A, COMT, CNR1 and NPY gene variants on antidepressant treatment response with differential effects regarding gender and clinical subtypes of melancholic and anxious depression, potentially mediated via distorted emotional processing in the limbic-frontal circuit. These findings point towards a network model of cellular (genetic) and circuit (brain network) factors contributing to antidepressant treatment success.

PS1 -3

**THE ROLE OF THE DEFAULT MODE NETWORK (DMN) IN UNDERSTANDING EMOTIONAL CIRCUITRY IN MDD PRE- AND POST- ANTIDEPRESSANT TREATMENT**

*Yvette Sheline, M.D., 4940 Children's Pl Ste 8134, St Louis, MO 63110*

**SUMMARY:**
Background: The recently discovered default mode network (DMN) is a group of areas in the human brain characterized, collectively, by functions of a self-referential nature. In normal individuals activity in the DMN is reduced during non-self-referential goal directed tasks, in keeping with the folk-psychological notion of losing one's self in one's work. Imaging and anatomical studies in major depression have found alterations in both the structure and function in some regions that belong to the DMN suggesting a basis for the disordered self-referential thought of depression. Methods: Here we sought to examine DMN functionality as a network in patients with major depression, asking whether the ability to regulate its activity and, hence, its role in self-referential processing was impaired. To do so we asked patients and controls to examine passively negative pictures as well as actively re-appraise them. Results: In widely distributed elements of the DMN--ventromedial prefrontal cortex (BA 10), anterior cingulate (BA 24/32), lateral parietal cortex (BA 39) and lateral temporal cortex (BA 21)-- depressed, but not control subjects, exhibited a failure to reduce activity while both looking at negative pictures and reappraising them. Further, looking at negative pictures elicited a significantly greater increase in activity in other DMN regions (amygdala, parahippocampus and hippocampus) in depressed than in control subjects. Conclusions: These data suggest depression is characterized by both stimulus-induced heightened activity as well as a failure to normally down-regulate activity broadly within the DMN. These findings provide a brain network framework within which to consider the pathophysiology of depression.

PS1 -4

**RESETTING CHEMICAL DYSBALANCE TO MODULATING NETWORKS: LESSONS ON THE**

**NEUROBIOLOGY OF TREATMENT RESISTANT DEPRESSION FROM DEEP BRAIN STIMULATION**

*Thomas Schlaepfer, M.D., Sigmund Freud Strasse 25, Bonn, Germany*

**SUMMARY:**
Background: Deep brain stimulation (DBS) is a procedure that referring to stereotactic placement of electrodes in a given brain region with electrodes connected to a neurostimulator implanted under the skin of the chest. It is a FDA approved method for control of severe forms of tremor in Parkinson's disease, essential tremor and primary dystonia. Recently, it has been proposed as a treatment in treatment resistant major depression. It might be, that more focused, targeted treatment approaches modulating well defined targets within affective networks will prove a more effective approach to help treatment-resistant patients. Methods: We assessed antidepressant effects of bilateral DBS to the nucleus accumbens in fourteen patients suffering from treatment resistant depression not responding to pharmacotherapy, psychotherapy, and ECT. The mean (+/-SD) length of the current episode was 10.5 (+/- 7.4) years, the number of past treatment courses was 20.8 (+/- 8.4), the mean Hamilton Depression Rating Scale (HDRS) was 32.9 (+/- 5.1). Results: Twelve months after initiation of DBS treatment 7 patients reached the response criterion (Responders, HDRS = 15.4 (+/- 2.8). The number of hedonic activities increased significantly in the responders only. Interestingly, ratings of anxiety measured with the Hamilton Anxiety Scale were reduced in both responders and non-responders, but more pronounced in the responders. Conclusions: We demonstrate antidepressant and anti-anhedonic effects of DBS to NA in patients suffering from extremely TRD. In contrast to other DBS depression studies, there was a specific anti-anxiety effect. The presentation will discuss relevance of these results and others from DBS studies for the understanding of TRD.

**MONDAY, MAY 24, 2010**
**9:00 A.M.- 12:00 P.M.**

**PRESIDENTIAL SYMPOSIUM 2**
**COMPARATIVE EFFECTIVENESS OF PSYCHOTROPIC DRUGS: WHAT CAN WE LEARN FROM PRACTICAL CLINICAL TRIALS?**

*Chairperson: Jeffrey Lieberman, M.D., New York State Psychiatric Institute, 1051 Riverside Dr., Unit 4, New York, NY 10032-1007*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) The manner in which practical clinical trials can inform treatment choices and evaluate specific comparative effectiveness data in the studies presented by the speakers; and. 2) The substantive differences between traditional industry sponsored randomized controlled trials comparing marketed treatments and practical clinical trials which are designed to investigate questions relevant to clinicians and policy makers.

**OVERALL SUMMARY:**
This symposium will address the question of how practical clinical trials can provide data on the comparative effectiveness of approved treatments for major mental disorders that can help in treatment selection. Currently, there is a lack of such information which leaves clinicians unable to make rational evidence based treatment decisions and know how one treatment compares with another. The majority of research that is done comparing marketed treatments is sponsored by the pharmaceutical industry, usually in the context of traditional randomized controlled trial designs. Practical clinical trials address real world questions relevant to clinicians and policy makers that are applicable to treatment in standard clinical settings. The US overnment has prioritized the funding of comparative effectiveness research to provide clinicians and policy makers with this vital information. This symposium brings together the leading researchers in the US and the UK who have conducted comparative effectiveness research in recent times. Each will present on the studies of treatments for the disorder in which they specialize. The discussant will be the official who heads the FDA division responsible for psychotropic drugs.

PS2 -1
**BIPOLAR AFFECTIVE DISORDER: LITHIUM ANTICONVULSANT COMPARATIVE EVALUATION (BALANCE): AN INTERNATIONAL OPEN-LABEL RANDOMIZED CLINICAL TRIAL**

*John Geddes, M.D., University of Oxford Warneford Hospital, Oxford, United Kingdom OX37JX*

**SUMMARY:**
BALANCE (Bipolar Affective Disorder: Lithium Anticonvulsant Comparative Evaluation) was an international (UK, France, Italy, USA) open-label randomized clinical trial comparing combination lithium plus valproate with lithium and valproate monotherapy in the long-term treatment of bipolar disorder. Patients were recruited into the main phase of BALANCE between 2002 and December 2006: 459 participants entered the active run-in phase of whom 330 were randomized. Follow-up was concluded

in July 2008. The hazard ratio for time to new intervention for mood episode was 0.59 (95% confidence interval 0.42 to 0.83, p=0.002) for combination therapy compared to valproate semisodium, 0.82 (95% confidence interval 0.58 to 1.17, p=0.27) for combination therapy compared to lithium and 0.71 for lithium compared with valproate semisodium (95% CI 0.51 to 1.00, p=0.05). There were two key methodological aspects of BALANCE which had a major effect on the feasibility and success of the trial but must be considered in interpreting the results: 1. ACTIVE RUN-IN: aim was to reduce post randomization withdrawal by selecting out patients who could not tolerate, or adhere to, the trial treatments or protocol in the short-term. The run-in successfully reduced dropout. 2. OPEN DESIGN: BALANCE was unblinded for pragmatic reasons to promote recruitment. BALANCE included strategies to reduce the risk of consequent performance and ascertainment biases.

PS2 -2

**EFFECTIVENESS OF TREATMENT STRATEGIES FOR DEPRESSION**

*Madhukar Trivedi, M.D., 5323 Harry Hines Blvd, Dallas, TX 75390*

**SUMMARY:**

Significant advances in the development of antidepressant treatments have provided treatments that are safer to use with relatively few side effects. While these advances are important, deciding what treatment to use with which patient has remained a process of trial and error. Remission rates are low with first step antidepressant treatments. In efficacy trials involving symptomatic volunteers (as opposed to self-declared patients) with uncomplicated, non-chronic depression, only 30-35% of the subjects achieve remission. In representative real world patients, remission rates are even lower. Patients also leave treatment at high rates prior to achieving remission. In the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, 33% of qualified patients achieved remission during the first step treatment, despite the use of Measurement Based Care. As a result treatment of depression entails a sequenced treatment approach for non-remitters to first step treatments leading to either a switch to another antidepressant or an augmentation of the first treatment with another agent. Remission rates with four treatment steps were approximately 65%. There remains significant interest in developing more aggressive and personalized augmentation and combination treatment approaches for this difficult to treat patient population. Finally, an examination of clinical and biological predictors within the context of a sequential as well as a long-term treatment trial would allow us to answer questions such as: 1) Which of the many first-line antidepressant treatments should be chosen as the initial treatment? 2) What duration of treatment is needed (i.e., should a patient continue a treatment after achieving remission and for how long)? 3) Should a patient receive an anti-depressant alone or in combination with another medication directed at metabolic dysfunction? 4) Which particular set of biosignatures are best suited to guide treatment?

PS2 -3

**LITHIUM MODERATE DOSE STUDY (LITMUS): A PRACTICAL CLINICAL TRIAL FOR BIPOLAR DISORDER**

*Andrew A. Nierenberg, M.D., 50 Staniford St., Ste 580, Boston, MA 02114*

**SUMMARY:**

Recent data indicate that lithium use for bipolar disorder has declined over the last decade and been replaced with medications that may or may not result in better outcomes. This presentation describes LiTMUS, a multisite, prospective, randomized clinical trial of outpatients with bipolar disorder. LiTMUS seeks to address whether initiating therapy at lower doses of lithium as part of optimized treatment improves outcomes and decreases the need for other medication changes. LiTMUS randomized 283 adults with bipolar disorder (Type I or II) across 6 study sites. The *Co*-primary outcomes are overall illness severity on clinical global improvement scale for bipolar disorder and a novel measure, necessary clinical adjustments over 6 months of treatment. This metric provides a composite that reflects both clinical response and tolerability. As of November 5, 2009, 67% have completed the 6 month study with a drop out rate of about 13%. While criteria were for mild overall severity of illness, 90% were in episode at the time of entry and 85% had moderate or greater severity. About 40% had made prior suicide attempts and were hospitalized. LiTMUS includes several methodological innovations that facilitated recruitment and retention and could inform future effectiveness trials in psychiatry.

PS2 -4

**PRACTICAL CLINICAL TRIALS IN SCHIZOPHRENIA**

*T. Scott Stroups, M.D., 1051 Riverside Drive, Unit 100, New York, NY 10032*

**SUMMARY:**

The National Institute of Mental Health originally established the research organization known as the Schizophre-

nia Trials Network (STN) to conduct the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project. Since the completion of CATIE, the STN has continued to collaborate with many investigators to conduct a series of studies meant to inform clinicians, patients, and policy makers about interventions of public health significance. The STN recently completed a study that addressed the impact of switching medications in two situations—from multiple antipsychotics to a single antipsychotic or from an older long-acting antipsychotic (fluphenazine or haloperidol) to long-acting injectable risperidone microspheres. In October 2009 the STN completed enrollment in a study evaluating the effectiveness of two strategies commonly used to address metabolic problems associated with antipsychotic drugs (introduce a weight management program alone or change antipsychotic medications along with the weight management program). Also ongoing on the STN is a placebo-controlled trial of examining the use of metformin as a treatment to address antipsychotic-induced weight gain and metabolic problems. Dr. Stroup will discuss the ongoing work of the STN, including the daunting challenges of obtaining funding, maintaining a network of sites able to conduct large-scale trials, and recruiting study participants.

PS2 -5

**PRACTICAL CLINICAL TRIALS IN CHILD AND ADOLESCENT PSYCHIATRY**

*John Walkup, M.D., New York Presbyterian, Room F-1109, 525 E. 68th St., New York, NY 10065*

**SUMMARY:**

Objective: To review the use of practical clinical trial networks in the evaluation of psychotropic medications in children and adolescents and discuss the potential of such networks for furthering clinical and healthcare policy. Method: Literature search of pubmed and WebofScience. Search terms included practical clinical trials, pragmatic clinical trials, and clinical trial networks.
Results: The use of practical clinical trials is in its infancy in child and adolescent psychiatry. To date the efficacy of psychotropic medications has been established for most childhood psychiatric disorders. However, effectiveness data that would guide clinical and healthcare policy makers is very limited. Although the potential value of practical clinical trials to establishing optimum clinical care is known, there is lack of support from the federal government and industry to the implement such trials in child and adolescent psychiatry.
This presentation will review the existing literature, and discuss the strengths of practical clinical trials and barriers to their implementation. Conclusions: Although data from practical clinical trials is necessary to inform clinical and health care policy, barriers to the funding and implementation of such studies are hindering what we know about the effectiveness of psychotropic medication in children.

PS2 -6

**THE FDA'S PERSPECTIVE ON COMPARATIVE EFFICACY AND SAFETY**

*Jing Zhang, M.D., 10903 New Hampshire Ave., Silver Spring, MD 20993*

**SUMMARY:**

This presentation will give an overview of how the Division of Psychiatry Products (DPP) thinks about comparative efficacy and safety data and how such data may influence regulatory decisions. Comparative data are of much interest to clinicians and patients, however, the evidence for making claims based on comparative findings has to meet certain minimum standards. Examples will be provided of situations in which FDA has used comparative safety and efficacy data in making risk benefit decisions. Principles and approaches for developing comparative claims will be summarized.

**MONDAY, MAY 24, 2010**
**2:00 PM- 5:00PM**

**PRESIDENTIAL SYMPOSIUM 3**
**CAN BASIC AND TRANSLATIONAL NEUROSCIENCE IMPROVE TREATMENT IN PSYCHIATRY?**

*Chairperson: Alan F Schatzberg, M.D., 401 Quarry Road, Stanford, CA 94305-5717*
*Co-Chairperson: Karl Deisseroth, M.D., 318 Campus Dr. W., Stanford, CT 94305*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Apply optogenetics to the understanding of brain circuitry; 2) Understand the use of f-MRI to assess emotional processing; and 3) Understand studying genetics to assess risk for developing depression.

**OVERALL SUMMARY:**

In recent years advances in basic and translational research are opening potential new avenues for developing new psychosocial and somatic treatments or improving efficacy with current regimes. This symposium will highlight recent basic and translational research conducted by MD/PhD psychiatrists. Optogenetics has allowed millisecond-precision bidirectional control of defined cell types

in freely behaving mammals. Chr2 was the first microbial opsin brought to neurobiology, where we initially found that chr2-expressing neurons can fire blue light-triggered action potentials with millisecond precision, without addition of chemical cofactors; this approach has since proven versatile across a variety of preparations. We next found that neurons targeted to express the light-activated chloride pump halorhodopsin from natronomonas pharaonis (nphr) can be inhibited from firing action potentials when exposed to yellow light in intact tissue and behaving animals; because of the excitation wavelength difference, the two optical gates can be simultaneously used in the same cells even in vivo. We then employed genomic strategies to discover and adapt for neuroscience a cation channel (vchr1) with action spectrum significantly redshifted relative to chr2, to allow tests of the combinatorial interaction of cell types in circuit computation or behavior. Along the way we have developed genetic targeting tools for versatile use of microbial opsins including cell type-specific promoter fragments, transgenic animals, and aav-based cre-loxp reagents, as well as developed fiberoptic approaches to allow specific cell types, even deep within the brain, to be controlled in freely behaving mammals. We are currently probing and quantifying measures of circuit performance during optogenetic control of defined neural elements to address longstanding questions about neural dynamics. For example, we have used this approach for depth targeting of 1) hypocretin/orexin cells in the lateral hypothalamus 2) subthalamic nucleus region circuit elements in animal models of parkinsons disease, and 3) neuronal subtypes relevant to neural reward, brain oscillations, and schizophrenia. In this work we have for the first time been able to establish causal relationships between frequency-dependent activity of genetically defined neurons important in neuropsychiatric disease, and complex orchestrated mammalian behaviors.

PS3 -1

**TRANSLATIONAL STUDIES IN GENETICS: GENETIC TOOLS IN ANIMAL MODELS TO UNDERSTAND HERITABLE RISK FACTORS IN DEPRESSION AND POSTTRAUMATIC STRESS DISORDER**

*Kerry Ressler, M.D., Ph.D., 954 Gatewood Dr., Atlanta, GA 30329*

**SUMMARY:**

This presentation will examine recent data describing genetic risk factors for psychopathology and genetic approaches (transgenic, inducible, and viral vector) to understand the role of these gene pathways in neural systems. Exposure to stressful events during development has consistently been shown to produce ong-lasting alterations in the hypothalamic-pituitary-adrenal (hpa) axis, which may increase vulnerability to disease, including ptsd and depression. Recently reported genetic association studies indicate that these effects may be mediated, in part, by gene x environment (gxe) interactions involving polymorphisms within at least two hpa-related genes, crhr1 and fkbp5. Data suggest that these genes regulate hpa axis function in conjunction with exposure to child maltreatment or abuse. In addition, a large and growing body of preclinical

research suggests that increased activity of the amygdala-hpa axis induced by experimental manipulation of the amygdala mimics several of the physiological and behavioral symptoms of stress-related psychiatric illness in humans. Notably, interactions between the developing amygdala and hpa axis underlie critical periods for emotional learning which are modulated by developmental support and maternal care. These translational findings lead to a testable hypothesis: high levels of early life trauma lead to disease through the developmental interaction of genetic variants within neural circuits that regulate emotion, together mediating risk and resilience in adults. Additionally, new studies examining genetic manipulation of amygdala function in animal models of fear, anxiety, and depression will be described.

PS3 -2

**EMOTION REGULATION: TOWARDS A NEUROBIOLOGICAL UNDERSTANDING OF PSYCHOTHERAPY**

*Amit Etkin, M.D., Ph.D., 401 Quarry Road, Stanford, CA 94305*

**SUMMARY:**

Psychotherapy is a cornerstone of treatment for many psychopathologies. Despite this, we lack a biological perspective on how psychotherapy works. An understanding of the mechanisms of action of psychotherapy will aid in the design of novel therapies and in the application of current therapies, provide an objective evidence base that will inform and test psychological theories, and open up new avenues for combining psychotherapy with other interventions. One way to understand how psychotherapy works is through its alteration of dysfunctional patterns emotional processing. In this talk, I will therefore present our understanding of the neural circuitry underlying emotion regulation. My particular focus will be on “implicit emotion regulation” – the process by which individuals regulate emotion from moment-to-moment

spontaneously and without deliberate effort, which guides and supports healthy adaptation. I will describe the role of

medial prefrontal-limbic circuitry in this process and how abnormalities in these regions characterize a range of affective disorders, as well as link this circuitry to the prediction of treatment outcome. These data will provide neuroscientific grounding for clinical experience, which suggests that dysregulated emotional states often arise out of deficits in implicit emotion regulation, and that correction of these deficits is important for successful psychotherapy.

PS3 -3
**OPTOGENETICS: DEVELOPMENT AND APPLICATION**

*Karl Deisseroth, M.D., 318 Campus Drive West, Stanford, CA 94305*

**SUMMARY:**
Optogenetics has allowed millisecond-precision bidirectional control of defined cell types in freely behaving mammals. Chr2 was the first microbial opsin brought to neurobiology, where we initially found that chr2-expressing neurons can fire blue light-triggered action potentials with millisecond precision, without addition of chemical cofactors; this approach has since proven versatile across a variety of preparations. We next found that neurons targeted to express the light-activated chloride pump halorhodopsin from natronomonas pharaonis (nphr) can be inhibited from firing action potentials when exposed to yellow light in intact tissue and behaving animals; because of the excitation wavelength difference, the two optical gates can be simultaneously used in the same cells even in vivo. We then employed genomic strategies to discover and adapt for neuroscience a cation channel (vchr1) with action spectrum significantly redshifted relative to chr2, to allow tests of the combinatorial interaction of cell types in circuit computation or behavior. Along the way we have developed genetic targeting tools for versatile use of microbial opsins including cell type-specific promoter fragments, transgenic animals, and aav-based cre-loxp reagents, as well as developed fiberoptic approaches to allow specific cell types, even deep within the brain, to be controlled in freely behaving mammals. We are currently probing and quantifying measures of circuit performance during optogenetic control of defined neural elements to address longstanding questions about neural dynamics. For example, we have used this approach for depth targeting of 1) hypocretin/orexin cells in the lateral hypothalamus 2) subthalamic nucleus region circuit elements in animal models of parkinsons disease, and 3) neuronal subtypes relevant to neural reward, brain oscillations, and schizophrenia. In this work we have for the first time been able to establish causal relationships between frequency-dependent activity of genetically defined neurons important in neuropsychiatric disease, and complex orchestrated mammalian behaviors.

PS3 -4
**USING OPTOGENETIC TOOLS AND INFORMATION THEORY TO ELUCIDATE PREFRONTAL MICROCIRCUIT DYSFUNCTION IN SCHIZOPHRENIA**

*Vikaas Sohal, M.D., 401 Quarry Rd, Stanford, CA 94305*

**SUMMARY:**
Dysfunction of the dorsolateral prefrontal cortex (dlpfc) is a hallmark of schizophrenia. Within the dlpfc, numerous post-mortem studies have found abnormal signaling through a subpopulation of gabaergic interneurons defined by expression of the calcium-binding protein parvalbumin. Parvalbumin interneurons are hypothesized to generate gamma (30-80 hz) oscillations, which are thought to play important roles in cognition, and are disrupted in schizophrenia. We have used novel optogenetic technologies to selectively control parvalbumin interneurons, and information theory to measure the function of prefrontal microcircuits, in order to test the hypothesis that by generating gamma oscillations, parvalbumin interneurons improve information processing in the dlpfc. We found that inhibiting parvalbumin interneurons suppresses gamma oscillations in vivo, whereas driving these interneurons is sufficient to generate emergent gamma rhythms. Moreover, gamma-frequency modulation of input in turn enhances signal transmission in prefrontal microcircuits by reducing noise and amplifying signals. These results illustrate a general method for functionally dissecting neural circuits using a combination of optogenetic technology to control specific circuit elements, and information theory to quantifying circuit output. This approach may be useful to identifying how particular elements contribute to circuit dysfunction in neuropsychiatric disease, and conversely, how targeting specific circuit elements may restore normal function.

**TUESDAY, MAY 25, 2010**
**9:00 AM-12:00PM**

**PRESIDENTIAL SYMPOSIUM 4**
**RECENT ADVANCES IN PSYCHIATRIC GENETICS: FROM FUNDAMENTAL DISCOVERY TO CLINICAL IMPLICATION**

*Chairperson: Alan F Schatzberg, M.D., 401 Quarry Road, Stanford, CA 94305-5717*
*Co-Chairperson: Solomon H. Snyder, M.D. Johns Hopkins Medical School, Dept of Neuroscience, 725 N. Wolfe St., Baltimore, MD 21205*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify new findings in psychiatric genetics; 2) Recognize the opportunities and limitations of whole genome scanning; 3) Identify new advances on the genetic basis of major psychiatric disorders; and 4) Address issues of minority inclusion in psychiatry and psychiatric research.

**OVERALL SUMMARY:**

In 2010 it is universally accepted that psychiatric disorders are disorders of gene – environment interactions. However, the exact genes and environmental factors involved in specific disorders remain elusive. Genes that affect brain functions of relevance to psychiatry are pleiotropic and redundant. These two concepts are of great importance and explain why it has been so challenging to identify factors that are specific to diagnostic entities. The genes of relevance to brain development and function are pleiotropic: they affect several brain circuits and will consequently be relevant to more than one disorder. Genetic variants of relevance to schizophrenia for example can also be found in autism, bipolar disorder or depression. Redundancy indicates that each function or brain circuit of relevance to psychiatry is regulated by multiple genes; therefore, it will be highly unlikely that all patients with a specific disorder will share a single genetic substrate, as the function of interest, be it mood, affect, or cognition, is regulated my multiple genes. As a result of redundancy, patients with myriad genetic variations can present with the same syndrome, such as depression. How can we approach and understand something that is simultaneously so simple and so complex? In this symposium, renowned experts will provide an overview of the status of psychiatric genetics in 2010 (Douglas F. Levinson), and then we will cover the most recent advances on the genetics of a variety of major psychiatric disorders across the life span, such as autism (Daniel Geschwind), Alzheimer's disease (Allen D. Roses), bipolar disorder (Pamela Sklar), schizophrenia (Patrick F Sullivan) and depression (Julio Licinio). Throughout the entire symposium the presentations will emphasize the translational and clinical implications of recent advances in contemporary psychiatric genetics.

PS4 -1

**OPPORTUNITIES AND PITFALLS IN PSYCHIATRIC GENETICS IN 2010: CLINICAL IMPLICATIONS**

*Douglas Levinson, M.D., 701A Welch Rd Ste 3325, Palo Alto, CA 94304*

**SUMMARY:**

During the past two years, the first replicable findings have emerged from the modern era of psychiatric genetic research. Examples are genomic copy number variations (CNVs -- deletions and/or duplications of stretches of DNA) that greatly increase one's risk of schizophrenia and/or autism, and common single nucleotide polymorphisms (SNPs) associated with a small increase in risk of schizophrenia. These findings (and others in autism and bipolar disorder) represent the first successes after twenty years of research using genome-wide strategies, an effort which has also required learning how to assemble the very large clinical samples needed for these studies. The pace of discovery could accelerate rapidly with the application (just starting) of new whole-genome sequencing technologies to psychiatric disorders. The critical opportunities will arrive when further study of genetic findings shed light, for the first time, on the underlying susceptibility mechanisms. This could lead to new strategies for treatment, or for prevention, depending on the mechanisms. Our ways of thinking about these disorders will also change. We search the genome with no preconceptions, and we need an open mind to understand the results. For example, popular causative metaphors for schizophrenia invoke "chemical imbalance" and "excess dopamine." But initial findings point in other directions. We will need to find out why the same CNV regions are associated with both schizophrenia and autism; one CNV implicates a single gene: neurexin-1, involved in control of neuronal development; and the robust common-SNP association to schizophrenia spans the Major Histocompatibility Complex region, the location of the HLA antigens which are associated with autoimmune diseases. This raises the possibility of immunological or even infectious mechanisms, although no specific HLA link has been identified yet, and there are other types of genes in the region. It will be a major challenge to help patients, clinicians and society to deal with genetic information. Issues of discrimination will arise despite laws against it. Explanations of biological susceptibility can reduce stigma but also increase it by emphasizing a sense of difference. Genetic tests pose major issues. Currently, autism-related CNVs can be tested as part of a work-up, and the VCFS syndrome (associated with several psychiatric disorders) has long-term medical implications. But so far, the strongly-associated CNVs increase risk of several different "phenotypes", and thus are generally less useful for planning than a good clinical evaluation. Common SNPs are usually too weakly predictive in individual cases to be good genetic tests. But we can expect premature commercialization and resulting confusion. In the long run, genetic testing could provide a foundation for more objective diagnosis and treatment planning of some disorders.

PS4-2
**THE GENETICS OF AUTISM**

*Daniel Geschwind, M.D., David Geffen School of Medicine, University of California, Los Angeles, 695 Charles E. Young Dr. So., Los Angeles, CA 90095-1761*

**SUMMARY:**
Autism is a broad and highly variable neuro-developmental syndrome that is defined by problems in language, social cognition and repetitive, stereotyped behaviors. Autism is highly heritable, yet identifying causal genes has been challenging, which is largely due to autism's extensive clinical and genetic heterogeneity. Many genes have been identified, but none account for more than 1% of ASD, which has led us to conceive of autism more as "the autisms" than as a singular entity. Thus, one over-arching theme that is emerging from these genetic studies is that autism is not one disorder, but a group of disorders that relates to disruption of specific brain circuits, especially involving the frontal lobes and other interconnected regions. We have used the term developmental disconnection to emphasize this notion that the final common pathway in the autisms is in the disruption of the development and function of specific brain circuitry. We have begun to bridge the gap between genes and brain by studying the expression of autism candidate genes in developing human and rodent brain. This has revealed that some autism susceptibility genes, including CNTNAP2, are remarkably restricted to frontotemporal-subcortical circuits, providing us with the first tangible link between genetic susceptibility and specific brain circuits involved in autism. Via study of CNTNAP2, we have also shown a genetic link between language function in autism and specific language impairment and identified changes in brain connectivity related. Understanding how the specificity of ASD symptomotology arises from disruption of these circuits and distinguishes it from other neuropsychiatric disorders and intellectual disability remains a crucial challenge.

PS4 -3
**A TOMM-40 VARIABLE LENGTH POLYT REPEAT POLYMORPHISM, INHERITED THROUGH EVOLUTION, DETERMINES THE AGE OF ONSET DISTRIBUTION OF LATE ONSET ALZHEIMER'S DISEASE**

*Allen Roses, M.D., One Science Drive, Suite 342, Box 90344, Durham, NC 27708*

**SUMMARY:**
We sequenced the linkage disequilibrium region containing TOMM-40 and APOE in multiple AD patients, and analyzed with phylogenetic mapping technologies. We found a variable polyT polymorphism [rs10524523] inherited on each allele, inherited over evolutionary time. Larger variants were associated with earlier age of onset of AD. APOE4 was virtually always on the small strand as a long variant and APOE3 containing strands could be inherited either with a long or short variant.

PS4 -4
**NEW DIRECTIONS IN THE GENETICS OF BIPOLAR DISORDER**

*Pamela Sklar, M.D., Ph.D., 185 Cambridge Street, Boston, MA 02114*

**SUMMARY:**
Bipolar disorder (BD) is a severe mood disorder affecting greater than 1% of the population. Classical bipolar disorder is characterized by recurrent manic episodes that often alternate with depression. With onset in late adolescence or early adulthood BD results in a chronic illness with moderate to severe impairment. Numerous epidemiological studies have identified a strong heritable component with family, twin and adoption studies consistently finding markedly elevated relative risks in first-degree relatives and monozygotic *Co*-twins. Over the last 5 years, genetic studies have sought to look at single nucleotide polymorphisms (SNPs) across the genome simultaneously for evidence of association using high-throughput genomic technologies. The current high-density genotyping products are best tailored to the study of common genetic variation and rare structural variation. For BD they have successfully identified specific loci – genes, and in some cases individual variants – strongly and consistently associated with BD. For example, these studies have discovered that genetic variants in ankyrin 3 (*ANK3*), which was not at all a prior candidate, increase BD risk. Surprisingly, the literature already supports a biological connection since ANK3 is critical for the proper insertion of sodium channels, a known target of the mood stabilizing agent lamotrigine, into the axon initial segment. A critical need for psychiatric genetics continues to be the identification of consistently observed association of particular loci with BD. To this end, the Psychiatric Genome-wide Association Study Consortium (PGC) was established in 2007 and has conducted meta-analyses of autism, attention-deficit hyperactivity disorder, bipolar disorder, major depressive disorder and schizophrenia. The BD group has recently completed a large-scale analysis of 16,731 individuals that identified additional genes and gene classes associated with BD. With what is proving to be a highly complex genetic landscape, existing

approaches that model genetic changes in multiple, and complex ways will be needed. Our traditional, somewhat simplistic views of molecular etiology need revision. In the future, research must bring to bare new technologies to develop an understanding of human genetic risk variants on brain function. Powerful tools such as single neuron imaging to probe synapse structure and function, model systems such as *Drosophila*, *C. Elegans* and Zebrafish, and investigations of neural networks computationally and biologically already exist to probe neural circuitry. The fast evolving field of stem cell technology – in particular the use of induced pleuripotent stem (iPS) cells created from individual patients – may be able to help us define a variety of molecular signatures and recapitulate aspects of the developmental abnormalities that lead to mental illness. While ambitious, the goal should be to make genetics and neuroscience relevant to the clinical practice of psychiatry.

PS4 -5
**PROGRESS IN SCHIZOPHRENIA GENETICS**

*Patrick Sullivan, M.D., University of North Carolina Chapel Hill, Department of Genetics, 4030 Bondurant Hall, CB# 7000, Chapel Hill, NC 27599*

**SUMMARY:**
The past two years have seen a set of remarkable changes in psychiatric genetics, and nowhere more so than for the genetics of schizophrenia. The sample sizes under analyses are now very large (>20,000 cases plus controls) and genomic technologies have are sufficiently mature to begin to answer the fundamental questions about the genetic architecture of schizophrenia that have tantalized generations of psychiatrists. This talk will update participants regarding: (a) the case for studying the genetics of schizophrenia, (b) the basic study designs and technologies, (c) summary of large-scale "mega-analyses" conducted by the Psychiatric GWAS Consortium, (d) the role of copy number variation, and (e) description of the next-generation studies currently in progress.

PS4 -6
**GENOMICS OF ETHNIC MINORITY GROUPS: PHARMACOGENOMICS OF DEPRESSION IN MEXICAN-AMERICANS**

*Julio Licinio, M.D., Bldg 131 Garron Road, Canberra, Australia ACT 2601*

**SUMMARY:**
We have resequenced eight key candidate genes in a Mexican-American population from Los Angeles that represents recent immigrants from all Mexican states (264 controls and 272 major depressive disorder patients). Those genes were brain-derived neurotrophic factor (BDNF), ATP-binding cassette subfamily B member 1 (ABCB1), the noradrenaline, dopamine, and serotonin transporters (SLC6A2, SLC6A3 and SLC6A4), cyclic AMP-responsive element binding protein 1 (CREB1), corticotropin-releasing hormone receptor 1 (CRHR1) and neurotrophic tyrosine kinase type 2 receptor (NTRK2). We found associations with depression and antidepressant treatment response. However, the most important finding was that over 50%
of the genetic variation observed was new and not present in databases. These results highlight the importance of direct re-sequencing of key candidate genes in ethnic minority groups in order to discover novel genetic variants that cannot be simply inferred from existing databases.

**REFERENCES:**
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Gordon-Smith K, Green EK, Grozeva D, Gurling HM, Hamshere ML, Heutink P, Holmans PA, Hoogendijk WJ, Hottenga JJ, Jones L, Jones IR, Kirov G, Lin D, McGuffin P, Moskvina V, Nolen WA, Perlis RH, Posthuma D, Scolnick EM, Smit AB, Smit JH, Smoller JW, St Clair D, van Dyck R, Verhage M, Willemsen G, Young AH, Zandbelt T, Boomsma DI, Craddock N, O'Donovan MC, Owen MJ, Penninx BW, Purcell S, Sklar P, Sullivan PF. Meta-analysis of genome-wide association data of bipolar disorder and major depressive disorder. Mol Psychiatry 2010 Mar 30. [Epub ahead of print].

**PRESIDENTIAL SYMPOSIUM 5**
**HEALTH REFORM AND PSYCHIATRY**

*Chairperson: Steven S Sharfstein, M.D., 6501 North Charles Street, Baltimore, MD 21204*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the impact of health reform on access, cost, and quality of psychiatric treatment; 2) Recognize the economic incentives that would encourage or discourage participation by psychiatrists in either public or private health insurance; and 3) Appreciate how reform would impact academic departments of psychiatry with a focus on both their teaching and research functions.

**OVERALL SUMMARY:**

The nation's economy is struggling, its health system is

broken, and the mental health system is "in shambles." A major overhaul of the health system is one of the Obama Administration's top objectives. This will be a huge undertaking that will primarily focus on the high cost of care, the lack of access to insurance coverage for millions of Americans, and the shortfalls in quality of care that many Americans experience. This symposium will assess the impact of these reforms on access to inpatient and outpatient psychiatric care, the public mental health system, academic psychiatry, and the role of managed behavioral health care. Each presentation will focus on the issues of cost, access, and quality. The experience of patients and families, providers, payers, and reviewers in the next period of time will be described. The strengths and shortfalls in the current reform proposal will be elucidated, including questions of adequate supply of specialty and subspecialty psychiatrists, and a future reform that will improve opportunities for effective
treatment will be described.

PS5 -1

**WHAT WILL BE THE ROLE OF THE PUBLIC SECTOR FOLLOWING HEALTH REFORM?**

*Howard Goldman, M.D., Ph.D., University of Maryland School of Medicine, Baltimore, MD 21201*

**SUMMARY:**
As the number of uninsured and under-insured Americans dwindles, what will be the role of the traditional public mental health system? This system historically met the demand for services from individuals who were uninsured and under-insured. After health reform will there still be a population of individuals who cannot be treated in the expanded private sector, such as forensic patients or those needing long-term care?Will there be a special role for a public mental health system to oversee services and perform quality assessments? Will the public system offer a range of non-traditional, non-medical evidence-based services, such as assertive community treatment and supported employment, which are unlikely to be covered (in full) by insurance benefits? How will a public mental health system coordinate services provided by other human services sectors, such as housing, employment and vocational rehabilitation, education and criminal justice? This presentation reviews current thinking about the role of the public mental health system.

PS5 -2

**THE IMPACT OF HEALTH REFORM ON INPATIENT AND OUTPATIENT PSYCHIATRIC PRACTICE**

*Steven Sharfstein, M.D., 6501 North Charles Street, Baltimore, MD 21204*

**SUMMARY:**
How will health reform impact inpatient and outpatient psychiatric treatment, especially the tasks expected of psychiatrists in these settings? Today, trends in treatment include the dramatically shortened length of stay in acute hospital care; high volumes of admissions, discharges, and readmissions; an emphasis on medical management and prescription writing in the outpatient setting; and a de-emphasis in the use of psychotherapy, especially conducted by psychiatrists. These trends are highly influenced by the economic incentives in both public and private insurance programs. The key questions that need to be answered include: What will be the new fee structure under health reform? What will the fees be for psychotherapy in contrast to "medical management"? How will parity coverage influence the question of fees? What will be the hassle factor as a result of external utilization review? Will there be an emphasis on demonstrating positive outcomes and an implementation of evidence-based approaches? If the fee structure is lowand there are multiple hassles in getting paid, this will encourage the exodus of psychiatrists from participating in insurance and escalate the numbers of private practicing psychiatrists who "opt out" and manage their caseload based on out-of-pocket fees. The payment and hassle structures are greatly simplified in the single-payer Canadian health care system, and the great majority of Canadian psychiatrists participate. The American approach of encouraging a robust marketplace in private insurance creates costly overhead as well as multiple points of hassle for the practicing psychiatrist in private practice. The author will discuss these problems and gaps in the current health reform and its impact on psychiatry.

PS5 -3

**HEALTH CARE REFORM: AN ACADEMIC EXERCISE?**

*Anthony Lehman, M.D., 110 S. Paca Street, Room, PP-4N140, Baltimore, MD 21201*

**SUMMARY:**
The national debate on health care reform has remained largely silent with regard to its implications for academic medicine. However, health care reform will likely exert wide ranging impacts on the three missions of academic psychiatry, clinical care, teaching and research. Since the clinical services provided by academic departments are embedded within their larger health care communities, the impacts of health care reform and its associated revised incentive structures for care delivery will have substantial

impacts on our clinical services. Access, parity, reimbursement structures will all have their marks. Teaching missions will be swayed by a changing emphasis on primary care and alterations in reimbursement structures that will modify the appeal of various specialties for medical students. Psychiatry training programs may be able to take advantage of a new emphasis on coordinated care models. To the extent that research infrastructures depend upon the fiscal vitality of clinical services, they too will be affected by health care reform. Health care reform offers significant opportunities for new directions in teaching and research mission.

PS5 -4

**THE ROLE OF MANAGED CARE IN HEALTH CARE REFORM**

*Henry Harbin, M.D., 2002 Sulgrave Avenue, Baltimore, MD 21209*

**SUMMARY:**
The U.S. is moving to make substantial changes in the way health care is both financed and delivered. These changes are being driven by the need to offer health insurance to all Americans and to find ways to reduce costs while improving outcomes. The exact nature of how these reform efforts will be expressed in legislation will likely be decided by the end of 2009, but the broad outlines of many of the major policy objectives are in most of the draft bills currently being debated in Congress and the nation. This presentation will focus on what type of managed care interventions will be used in the broader health care benefit structure as well as how the management of Mental Health and Substance Use Disorder (MH/SUD) benefits will change, if at all.. When the final health care bill is passed (assuming it will be), it will be possible to measure what types of managed care techniques will be allowed for both private and public insurance options. It is possible that a final bill will provide some type of national regulation that will set different standards for appropriate cost containment mechanisms, e.g., provider access standards, use of comparative effectiveness research, national quality standards. Clearly, the management of the MH/SUD benefits will be determined, in part, by these broader legislative guidelines for all health management activities. However, we do know that one of the most important determinants of how the MH/SUD benefits will be managed is the recently passed Mental Health Parity Bill (Oct 2009). This historic legislation provides a legal requirement for "parity" between MH/SUD benefits and medical surgical benefits. The law itself has a number of broad guidelines, and many of the details are going to be clarified in regulations that are due to for publication by October 2009. Even if this deadline isn't met, it is assumed the regulations will be out in late 2009 or early in 2010.

PS5 -5

**THE IMPACT OF HEALTH REFORM ON PSYCHOTHERAPY BY PSYCHIATRISTS**

*Eric Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962*

**SUMMARY:**
Health reform arrives in the midst of a two-decade transformation of funding and practice patterns in American medicine and psychiatry. In terms of its impact on the practice of psychotherapy by psychiatrists, health reform comes at a moment of great irony. There is growing evidence that [1] therapy of various types, including but not limited to CBT and psychodynamic therapy, is efficacious for a range of single, non-comorbid mood, psychotic spectrum, anxiety, and personality disorders, and for complex comorbid disorders, [2] therapy is associated with brain change, and [3] therapy responders can be differentiated from non- responders by imaging studies. Since psychiatrists are physicians, therapy provided by psychiatrists offers the maximum opportunity for integration of mind and body and the optimal integration of medication with psychotherapy, maximizing adherence to regimens that are often difficult for patients to accept and tolerate. Yet, at the same time evidence is growing that therapy is efficacious, there is also evidence that the skilled provision of therapy to patients is dwindling as part of the identity, skill set and training of psychiatrists. The decline in the provision of psychotherapy by psychiatrists is a loss that has major implications for the
field of psychiatry. It forces us to wonder if we are the best we can be. Shall psychiatry become relegated to prescribing the same 50 or so medications to patients with all disorders? And what if, in the name of cost savings, other disciplines become prescribers of these medications? Beyond the impact on psychiatry, though, the loss of psychotherapy as part of the identity, skill set and training of psychiatrists is a loss for our patients. Shall we ignore evidence that combined medication and therapy or sometimes therapy alone are the best treatment for some disorders, particularly when early abuse, neglect or deprivation is present, or for those with complex comorbid disorders? This presentation will review the impact health reform is likely to have on recent trends in the practice of psychotherapy by psychiatrists.

**REFERENCES:**

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2.Sharfstein SS, Stoline AM, Goldman HH: Psychiatric care and health insurance reform. Am J Psychiatry, 150(1):7-18, January 1993.

**SUNDAY, MAY 23, 11:00 AM - 12:30PM**

## SCIENTIFIC AND CLINICAL REPORTS SESSION 01 – ADDICTION PSYCHIATRY

No.1

### MEDIATION AS TREATMENT MODALITY IN ACTIVE DUTY SERVICE MEMBERS PARTICIPATING IN RESIDENTIAL SUBSTANCE ABUSE REHABILITATION

*Amy Canuso, D.O., 2390 Greenbriar Dr. Unit C, Chula Vista, CA 91915*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identify meditation as a possible treatment modality for active duty members with substance disorders.

**SUMMARY:**

Objective: To evaluate the usefulness of meditation on state of change for attitudes toward drinking in an active duty population who are in residential treatment for alcohol and substance abuse. Method: IRB permission was gained to do anonymous survey using the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) in active duty service members who were enrolled in a mindfulness based meditation education class. This class was an 4 class group meeting once a week for 90 minutes which involved teaching mindfulness based mediation practice. The class provided educational materials on medication and an audio CD to facilitate practice though the week. Practice logs and journals were kept by participants. Twenty service members were surveyed at the beginning of the 30 day residential program and at the end of the program. The meditation group was a voluntary class that was in addition to the treatment curriculum of the substance abuse rehab program. Results: Significant improvement were made in recognition (17.1 to 32.3), ambivalence ( 8.4 to 12.7) and taking steps towards change in drinking behaviors (16.6 to 36.9), as assessed by the SOCRATES. Student T test showed results to be statistically significant for all subscales ($p < 0.001$). Conclusions: Using mindfulness breath centered mediation may be a helpful treatment modality for service members who wish to recover from substance dependence and or abuse. Randomized studies will be necessary to determine if the benefits described above are exclusively due to the effects of participation in meditation class.

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2. Harv Rev Psychiatry. 2009;17(4):254-67. The emerging role of meditation in addressing psychiatric illness, with a focus on substance use disorders. Dakwar E, Levin FR.

No. 2

### "FULL BLOWN" TRAMADOL DEPENDENCE: CASE REPORT AND REVIEW OF LITERATURE

*Durga Bestha, M.B.B.S, 9222 Burt Street 118, Omaha, NE 68114*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be familiar with: 1) Multi-modal mechanism of action of Tramadol 2) Addiction potential, withdrawal symptoms and their management and maintenance treatment strategies for tramadol dependence.

**SUMMARY:**

A 23 year old male with no substance abuse history was started on tramadol for persistent pain following knee surgery. From the initial 4-8,50mg tramadol tablets everyday, he was soon taking 30-40 tablets a day. When he tried to stop he would experience severe anxiety, palpitations, cramps and intense craving.In a period of 18 months he had 30 ER and 20 clinic visits to obtain tramadol.He underwent inpatient medical detoxification and started outpatient drug-rehab but relapsed. Finally he admitted himself to the residential rehabilitation program and mentioned that tramadol gave him a "high" and was wonderful for pain. Tramadol is a centrally acting analgesic and its main actions are:1)Agonist at opiate-mu receptor. Its o-desmethylated(M1)metabolite is more potent in this regard. This underlies tramadol's addictive potential.2) Reuptake inhibitor of both norepinephrine and serotonin. This multi-modal action makes tramadol an effective analgesic for both moderate to severe musculoskeletal and neuropathic pain. Tramadol was initially introduced as having less side effects and addictive potential than opiates. Over the years, there have been several case reports of tramadol dependence. Apart from psychosocial and occupational impairment accidental overdose can occur. This can precipitate seizures, respiratory depression, serotenergic syndrome with concurrent antidepressant use and liver toxicity with formulations containing tramadol and acetaminophen. Based on such adverse event reporting, FDA directed the manufacturing company to

caution physicians and patients about the risk of physical and psychological dependence. Withdrawal symptoms with tramadol are similar to opiate withdrawal and include nausea, vomiting, diarrhea, cramps and sweating. These can be managed using clonidine, loperamide, anti-spasmodics and NSAIDS. Based on extent of drug usage and comorbid pain, tramadol or a narcotic analgesic taper can be used. There are case reports of maintenance treatment with methadone and suboxone for tramadol dependence. In addition to the pharmacological measures motivational enhancement techniques, psychosocial interventions are essential in order to help gain insight and prevent relapse. Conclusion: Tramadol is not a controlled substance; hence educating the patient and family about addictive potential, monitoring prescription use and screening for and treating comorbid psychiatric/substance misuse disorders cacan prevent development of tramadol dependence.

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1. Raffa,R.B: Basic pharmacology relevant to drug abuse assessment: tramadol as example;
Journal of Clinical Pharmacy and Therapeutics (2008) 33, 101–108

2. Schug SA: The role of tramadol in current treatment strategies for musculoskeletal pain, Therapeutics and Clinical Risk Management 2007; 3(5): 717–723

No. 3

**AN UPDATE ON TESTING FOR DRUGS OF ABUSE: SCIENTIFIC BACKGROUND AND PRACTICAL CLINICAL CONCERNS.**

*Dwight Smith, M.D., Boston Medical Center Dowling 7 850 Harrison Avenue, Boston, MA 02118*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe common methods of testing for drugs of abuse and identify the strengths and weaknesses of each. 2) List several substances which have been associated with false positives or negatives on drug screening tests.

**SUMMARY:**

Introduction: Testing for drugs of abuse is a common and accepted practice in psychiatry. It is a recommended component of treatment for those with substance use disorders, and, given the high co-morbidity between several psychiatric conditions and substance abuse, routine screening tests for drugs of abuse are suggested in several published guidelines. Despite the ubiquity of testing for drugs of abuse there is often little discussion regarding either the basic laboratory science which makes testing possible or the statistical methods behind test interpretation. The central concepts involved in testing for drugs of abuse provide a rich opportunity for instruction in multiple areas of interest to psychiatrists which extend far beyond substance use disorders and include pharmacodynamics and pharmacokinetics, immunochemistry, sensitivity and specificity, and Baye's theorem, among others. In addition, there are several issues which frequently arise in clinical practice involving testing for drugs of abuse, such as the possibilities of false positive or false negative results, as well as the use of adulterants or other ways of defeating drug testing. Given the significance drug testing results often have in making clinical decisions, these issues also merit an informed and comprehensive discussion. Methods: A PubMed search was performed from 1/1/1980 to 9/1/09 for literature regarding drug screening and testing. Further reports were identified through references cited in the PubMed search described above. Articles were then reviewed for relevancy and utility. Common substances identified with false positive results were noted, as well as conditions which would lead to a false negative test. Frequent methods of thwarting drug testing were also identified. Conclusions: The topic of testing for drugs of abuse offers a wealth of opportunities for instruction in both basic and clinical sciences which is all too frequently overlooked. In addition, practical clinical considerations involving drug of abuse testing are common. Clinicians should be aware of common substances which are associated with false positives on drug testing, as well as frequently employed methods and substances to defeat drug testing. They should also know the limitations of drug testing and recognize the importance of these limitations in clinical practice.

**REFERENCES:**

1. Moeller KE, Lee KC, Kissack JC. Urine drug screening: practical guide for clinicians. Mayo Clin Proc. 2008 Jan;83(1):66-76.

2. Jaffee WB, Trucco E, Teter C, Levy S, Weiss RD. Focus on alcohol & drug abuse: ensuring validity in urine drug testing. Psychiatr Serv. 2008 Feb;59(2):140-2.

**SUNDAY, MAY 23, 1:30 PM - 3:00PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 02- MOOD DISORDERS**

No. 4

**SIGNIFICANT BIPOLAR RISK FACTORS IN**

**PATIENTS PRESENTING A CURRENT MAJOR DEPRESSIVE EPISODE**

*Charles Bowden, M.D., University of Texas Health Science Center, San Antonio, TX 78229-3900*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize risk factors for bipolar disorder.

**SUMMARY:**

Objective: The objective of this study was to evaluate the characteristics of patients presenting with a current major depressive episode (MDE) who were assigned a diagnosis of bipolar disorder (BD) using different diagnostic algorithms, and thus to determine the most explicative bipolar risk factors in these patients. Methods: An international cross-sectional epidemiological study was carried out in eighteen countries in Europe, Asia and North Africa. These data come from an analysis of patients recruited between April 2008 and May 2009. Community- and hospital- based psychiatrists included consecutively in a patient registry all adult patients consulting with a diagnosis of MDE (DSM-IV criteria). At this consultation, participating psychiatrists completed a questionnaire on patients' clinical features which enabled a diagnosis of BD to be assigned using three different algorithms (DSM-IV-TR, modified DSM-IV(m-DSM-IV) and Bipolarity Specifier). Results: A total of 5635 MDE patients were included. Overall 1645 (39%) received a clinician's diagnosis of BD, 16% fulfilled DSM-IV-TR criteria for BD, 31% fulfilled m-DSM IV criteria and 47% fulfilled the Bipolarity Specifier criteria. Using these different algorithms, several variables could be identified as risk factors for bipolar disorders. The variables most strongly associated with a diagnosis of BD according to DSM-IV, m-DSM-IV and the Bipolarity Specifier compared to patients with unipolar depression were a family history of mania (Odds Ratio(OR): 2.2; 2.4; 3.8 respectively), at least two mood episodes in the past (OR: 2.6; 2.9; 2.1 respectively), the occurrence of first psychiatric symptoms before the age of 30 years (OR: 1.5; 1.4; 1.7 respectively), a switch to mania/hypomania (OR: 0.6; 4.9; 9.5 respectively) and mixed states during current depressive symptoms (OR: 1.4; 1.4; 2.2 respectively). A history of suicide attempts appeared to be significantly associated with a diagnosis of BD according to m-DSM-IV (OR: 1.2) and the Bipolarity Specifier(OR: 1.2). Conclusions: The description of patients diagnosed with BD according to different algorithms identified a number of shared risk factors for BD. Systematic screening for such risk factors may contribute to improved diagnosis.
This study was funded by sanofi-aventis.

No. 5

**THE PREVALENCE AND CLINICAL CONSEQUENCES OF CONCURRENT HYPERTENSION IN PATIENTS WITH BIPOLAR DISORDER**

*Dale D'Mello, M.D., Department of Psychiatry, Michigan State University, St Lawrence/Sparrow Hospital, 1210 W Saginaw Lansing, MI 48915, Lansing, MI 48917*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Appreciate the high prevalence of concurrent cardiometabolic disorders in patients withbipolar disorder. 2) Understand how concurrent hypertension may modify the expression and outcome of bipolar disorder.

**SUMMARY:**

Patients with bipolar disorder suffer a disproportionate burden of cardiometabolic disorders. The athogenesis and clinical consequences of these comorbid medical conditions on the expression and course of bipolar disorder have not been satisfactorily elucidated. Objective: The purpose of the present study was to determine the prevalence and examine the clinical correlates of cardiometabolic disorders in patients hospitalized with bipolar disorder. Methods: All patients who were hospitalized on an inpatient psychiatry unit in id-Michigan for the treatment of bipolar manic and mixed states during calendar years 2002-2006 were invited to participate in the study. Following stabilization, the patients completed a brief inventory which included demographic, disease and treatment variables. The DSM-IV-TR psychiatric diagnoses and Young Mania Rating Scale ratings were completed by a psychiatrist. Results: A total of 99 patients were included in the study. Forty-five percent were hypertensive. As expected, the patients with hypertension were older; mean age 44 (SD=11) vs 37 (SD=12) years. They were more obese; mean BMI 33 (SD=9) vs 28 (SD=8). The patients with hypertension had an earlier mean age of onset of bipolar disorder: 24 (SD=9) vs 29 (SD=12) years; F=4.0, df=1, p=0.05. They achieved higher mean mania ratings than the others; 40 (SD=8) vs 35 (SD=8), F=4.55, df= 1, p=0.04. Discussion: As expected the prevalence of hypertension was higher in this cohort than in the general population. An earlier age of onset of bipolar disorder was predictive of the future development of hypertension. The presence of concurrent hypertension was associated with more severe

mania ratings, and longer hospital stays. Is it conceivable that the prevention of hypertension may modify the expression and outcome of treatment in patients with bipolar disorder?

No.6

**ASSOCIATION OF MEDICATION ADHERENCE WITH THERAPEUTIC ALLIANCE IN INDIVIDUALS WITH BIPOLAR DISORDER**

*Louisa Sylvia, Ph.D., 50 Staniford Street, Boston, MA 02114*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand aspects of patient-clinician alliance that may affect medication adherence in individuals with bipolar disorder.

**SUMMARY:**

Objective: Despite low medication adherence rates for bipolar disorder and the impact of adherence on outcomes, little is known about the association of adherence with specific aspects of the therapeutic alliance. Our aim is to understand aspects that may affect medication adherence among patients with bipolar disorder.

Methods: We examined data from 3,640 patients with a DSM-IV diagnosis for bipolar disorder I, II or NOS, cyclothymia, or schizoaffective disorder bipolar type who participated in the multicenter Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Logistic regression models were utilized to investigate the association between self-reported medication adherence and participants' perceptions of their relationship with their provider and quality of psychiatric care, as assessed by the Helping Alliance

Questionnaire at baseline and Care Satisfaction Questionnaire over the study duration. Results: Factors endorsed by participants, such as degree of collaboration, empathy, compassion and accessibility, were significantly associated with treatment adherence (uncorrected $p<0.05$). Conversely, some factors, such as patients' perceptions of their providers' experience as well as of their degree of discussing medication risks and benefits, were not significantly associated with adherence. Conclusions: Patients' perception of a collaborative therapeutic alliance and an efficient, yet respectful, treatment environment were positively associated with medication adherence, with some notable exceptions. This study informs strategies which may positively impact medication adherence.

**REFERENCES:**

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Lebowitz B, Rudorfer M, Frank E, Nierenberg AA, Fava M, Bowden C, Ketter T, Marangell L,
Calabrese J, Kupfer D, Rosenbaum JF: Rationale, design, and methods of the systematic
treatment enhancement program for bipolar disorder (step-bd). Biol Psychiatry 2003;53:1028-1042.
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**SCIENTIFIC AND CLINICAL REPORT SESSION 03- PSYCHPHARMACOLOGY**

No. 7

**CARCINOGENESIS OF PSYCHOPHARMACOLOGICAL TREATMENTS PRESCRIBED IN GENERAL PSYCHIATRY: A SYSTEMATIC REVIEW**

*Juan Galvez, M.D., 800 Washington Street, Boston, MA 02111*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, participants should be able to: 1) Recognize the importance of evaluating benefits/risks of prescribing psychotropic medications based on the carcinogenesis results described in preclinical and epidemiological studies; and 2) They should realize this is an area highly neglected from research, poorly understood, with potentials hazards for patients exposed chronically to some classes of drugs.

**SUMMARY:**

Introduction: The risk for carcinogenesis of psychotropic drugs in the market has been fairly understudied. Preclinical and epidemiological studies looking at these risk factors in specific clinical populations with major mental disorders are scarce. Most research includes small sample sizes, potential for confounding bias and methodological limitations. Objective: Sistematic Review on the available data regarding preclinical and epidemiological studies looking at the carcinogenesis of psychotropic medications used in psychiatry. Methods: We search the published scientific literature from 1965-2009 regarding preclinical and epidemiological studies on carcinogenesis for antidepressants, antipsychotics, benzodiazepines, psychostimulants, and mood stabilizers. Results: Two-thirds of psychotropic medications available in the market have

some availability of data regarding carcinogenesis (Table 1). Amphetamines seem to produce a significant risk of hematologic and renal malignancies associated with frequency and dose-response. Methylphenidate exposure appears not to produce a long-term risk in children and adults with ADHD(Table 2). Most studies regarding antidepressants, antipsychotics and benzodiazepines report limited evidence against their long-term use (Table 3). Mood stabilizers such as lithium and valproate may have antineoplastic and chemopreventive properties inherent to their intracellular mechanisms of action (Table 4). Carbamazepine, newer antiepileptics and anti-dementia medications have not been adequately studied to date in terms of carcinogenesis (Table 5). Conclusions: There is a strong need for clinical trials including risk of carcinogenesis as their main outcome when evaluating psychotropic treatments used in psychiatry. In the meantime issues regarding carcinogenesis in clinical practice should rely mostly on results and findings from preclinical studies of experimental models in animals and humans.

**REFERENCES:**

1. Brambilla, G., Martelli, A., 2009. Update on genotoxicity and carcinogenicity testing of 472 marketed pharmaceuticals. Mutation Research-Reviews in Mutation Research 681, 209-229.
2. Brambilla G., Mattioli F., Martelli A. Genotoxic and carcinogenic effects of antipsychotics and antidepressants. Toxicology 261 (2009) 77–88.

No. 8

**CLOZAPINE TREATMENT CAUSES OXIDATION OF PROTEINS INVOLVED IN ENERGY METABOLISM IN LYMPHOBLASTOID CELLS: POSSIBLE MECHANISM FOR METABOLIC ALTERATION**

*Muhammad Baig, M.D., M.S., 5624 Poppy Seed Run, San Antonio, TX 78229*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identify irreversibly oxidized proteins by clozapine treatment, possibly the mechanism by which atypical antipsychotics induce increased risk of metabolic syndrome.

**SUMMARY:**

Background: There is increasing concern about the serious metabolic side effects and neurotoxicity caused by atypical antipsychotics. We have previously shown, using a novel proteomic approach, that clozapine treatment in SKNSH cells induces oxidation of proteins involved in energy metabolism, leading us to hypothesize that protein oxidation could be a mechanism by which atypical antipsychotics increase risk for metabolic alterations. In this study, the same proteomic approach was used to identify specific proteins oxidized after clozapine treatment in lymphoblastoid cell lines of schizophrenia patients and normal controls. Methods: Cells were treated with 0 & 20 μM clozapine for 24 hrs and protein extracts were labeled with 6-iodoacetamide fluorescein (6-IAF). The incorporation of 6-IAF to cysteine residues is an indicator of protein oxidation. Labeled proteins were exposed to 2D-electrophoresis, and differential protein labeling was assessed. Results: Increased oxidation after clozapine treatment was observed in ten protein spots ($p<0.05$). Seven different proteins in 10 spots were identified by HPLC-ESI-MS/MS as enolase, triesophosphate isomerase, glyceraldehyde-3-phosphate dehydrogenase (GAPD), Rho GDP dissociation inhibitor, Cofilin, UMP-CMP kinase and translation elongation factor. Discussion: Several of these proteins play important roles in energy metabolism and mitochondrial function. These results further support the hypothesis that oxidative stress may be a mechanism by which antipsychotics increase risk for metabolic syndrome and diabetes.

**REFERENCES:**

1. Walss-Bass C, Weintraub ST, Hatch J, Mintz J, Chaudhuri AR. Clozapine causes oxidation of proteins involved in energy metabolism: a possible mechanism for antipsychotic-induced metabolic alterations. Int J Neuropsychopharmacol 2008;11:1097-104.
2. Kaneto H, Katakami N, Kawamori D, et al. Involvement of oxidative stress in the pathogenesis of diabetes. Antioxid Redox Signal 2007;9:355-66.

No. 9

**META-ANALYSIS OF PLACEBO RESPONSE IN ANTIPSYCHOTIC TRIALS**

*Ofer Agid, M.D., 250 College ST, Toronto, Ontario M5T 1R8 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to learn more about placebo response in antipsychotic trials and their implications in clinical trial design.

**SUMMARY:**

Objective: Large placebo response in antipsychotic trials

presents a major challenge for psychopharmacologic drug development. The objective of this analysis was to identify predictors of placebo response in antipsychotic trials. Method: We searched the MEDLINE database for RCTs published in 1966 to 2008, supplemented by other electronic databases and hand search. Data were extracted from published (English) RCTs of antipsychotic treatment in schizophrenia and schizoaffective disorder (SAD). In this analysis, placebo response in short-term treatment (2 to 12 weeks) was defined as mean change from baseline in BPRS total score (derived from PANSS in 11 studies). The systematic review used a weighted mean and 95% confidence interval (CI) based on a random effects model. A meta-regression analysis was performed to identify influential moderators of placebo response. Patient-level analysis was conducted to identify additional predictors, based on data from 1 long-term trial and 2 identically-designed, short-term trials in the ziprasidone clinical trial database. Results: A total of 1246 placebo-treated patients from 41 RCTs had valid BPRS total scores with a median placebo group size of 20. Demographics included: weighted mean age 38, duration of illness 16 years, and 77% male (median). The weighted mean baseline, endpoint, and reduction in BPRS were, respectively, 48.58, 46.10, and -2.59 (95% CI -4.08, -1.09). The average effect size was 0.27 (-0.44, -0.11) and heterogeneous across studies (p<0.001). Meta-regression analysis showed that greater placebo response was associated with shorter trials (p<0.001), community hospital (or mixed) treatment settings (p=0.02), more recently published studies (1990-2009) (p<0.01), and higher baseline severity score (p<0.01). Analysis of patient-level PANSS total score, however, showed no improvement over a 1-year period in the higher baseline PANSS subgroup using GMM. Analysis of the placebo arms in the 2 short-term ziprasidone trials showed placebo responses in SAD bipolar patients were significantly lower than schizophrenia patients. Conclusions: Our findings suggest that treatment settings, trial duration, schizoaffective bipolar diagnosis, and baseline level of symptom severity might influence the magnitude of placebo response.

Supported by funding from Pfizer, Inc.

**REFERENCES:**

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2. Kemp AS. et al. Schizophrenia Bulletin 2008.

**SUNDAY, MAY 23, 3:30 PM - 5:00PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION**

**04- CHILD AND ADOLESCENT PSYCHIATRY**

No. 10

**SCHOOL-BASED INTERVENTION FOR K – SECOND GRADERS PRESENTING WITH DISRUPTIVE BEHAVIOR**

*Jacob Venter, M.D., 570 W. Brown Rd, Mesa, AZ 85201*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the Dinosaur School Small Group intervention; and 2) Identify children who may benefit from this intervention and recognize the potential results from this intervention.

**SUMMARY:**

Objective: The aim of the study is to assess changes in pro- and antisocial behaviors in response to an intensive, school-based early intervention for students with classroom disruptive behaviors. Method: Teachers/parents referred kindergarten through second graders due to difficult to manage, disruptive classroom behavior. Students who met criteria for an Attention Deficit/Hyperactivity Disorder, Pervasive Developmental Disorder or Mood Disorder in association with significant disruptive behavior were included. Prior to and at completion of the intervention, teachers scored participants' behavior using the School Social Behavior Scales (2nd Ed). The intervention duration was one school year and consisted of the Dina Dinosaur Child Training Programs (Small Group Therapy) component of The Incredible Years. Data were analyzed using paired t-tests to examine the differences in mean scores before versus after the intervention. Results: Eighty eight participants (male = 71), aged five to eight years, completed the study. Scores on all the pro-social scales (Social Competence scale, Peer Relationship, Self-management/Compliance and Academic Behavior subscales) improved significantly (p<.001). Scores on all the antisocial scales decreased significantly with scores on the Antisocial Behavior Scale and the Defiant/Disruptive subscale decreasing to a more significant degree (p<.001) than the Hostile/Irritable and Antisocial/Aggressive subscales (p<.01). Conclusions: The small group module of The Incredible Years program proved effective in reducing disruptive behavior and increasing pro-social behavior in kids K to 2nd grade. Although all measured behaviors improved, those assessed by two of the Antisocial Behavior subscales seems to either benefit less robustly, or possibly need longer intervention to respond. Benefits due to the intervention support its implementation for disruptive

behavior in schools.

No. 11

**CLINICAL PREDICTORS OF CARDIOMETABOLIC RISK IN CHILDREN TREATED WITH ANTIPSYCHOTIC MEDICATIONS**

*John Newcomer, M.D., 660 S. Euclid Ave, St. Louis, MO 63110*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand the effect of antipsychotic treatment on changes in adiposity and insulin sensitivity.

**SUMMARY:**

Introduction: Youth receiving antipsychotic medications are at risk for adverse changes in adiposity and insulin sensitivity, [1] key predictors of long-term cardiometabolic risk. Rates of metabolic screening and monitoring for patients treated with antipsychotics remain low overall, with children having the lowest rates of monitoring compared to other age groups. [2] The aims of this analysis, conducted in a dataset of children undergoing antipsychotic treatment, were to characterize the relationship between 1) commonly-used surrogate measures of adiposity such as body mass index percentile (BMI%ile) versus gold-standard measures of adiposity measured by dual energy X-ray absorptiometry (DEXA) and magnetic resonance imaging (MRI) and 2) clinically available laboratory measures such as fasting plasma insulin versus gold-standard measure of whole body insulin sensitivity derived from hyperinsulinemic-euglycemic clamps.

Methods: Antipsychotic-naïve participants ages 6-18 are assessed before and after 3 months of antipsychotic therapy using gold standard and clinical measures of adiposity and insulin sensitivity. Gold-standard measures include DEXA total and % total fat, abdominal MRI (visceral and subcutaneous fat), and hyperinsulinemic-euglycemic glucose clamps with stable isotope tracing. Clinical measures include anthropomorphic assessment (height, weight, BMI%ile and waist circumference), fasting lipids, glucose, HgbA1c and insulin. For this analysis (N=86) scatterplots were constructed and correlations run comparing clinical versus laboratory measures of adiposity and insulin sensitivity, examining both baseline and
change values. Results: Significant correlations were observed between most clinical and surrogate measures of adiposity with somewhat stronger relationships observed at baseline compared to during treatment-induced change. Several laboratory measures (e.g., fasting plasma, triglycerides and insulin) were significantly correlated with insulin sensitivity at baseline but not during change. Overall however, clinical measures explained only limited proportions of the variance in gold standard measures of both adiposity and insulin sensitivity. Conclusions: Efforts to understand the effect of treatment on changes in adiposity and
insulin sensitivity require the use of direct, sensitive measures of cardiometabolic risk rather than clinical surrogate measures.

**REFERENCES:**

1. Correll, C.U., et al., Cardiometabolic risk of second-generation anti

No. 12

**PREVALENCE OF MENTAL ILLNESS AND SUBSTANCE ABUSE AMONG CHILD AND ADOLESCENT SUICIDE VICTIMS**

*Yilmaz Yildirim, M.D., Child & Adolescent Psychiatry, Department of Psychiatric Medicine Brody School of Medicine, Greenville, NC 27834*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participants will be able to: 1)Analyze the risk of mental illnesses and substance abuse for child and adolescent suicide. 2) Recognize the importance of diagnosing and treating mental illnesses, especially depression, and substance abuse among youth. 3) Identify main methods of suicide in both North Carolina and National level.

**SUMMARY:**

Objective: The objective of this study is to explore how mental illness (MI) and substance abuse (SA) vary and covary among children and adolescents who commit suicide. Suicide is the third leading cause of mortality for children under 18 after unintentional injury and homicide. (1)There is a significant relationship between MI and suicide; and depression has been the main predictor of suicidal ideation.(2) SA increases the risk of suicide as well, especially when it co-occurs with mood and disruptive behavior disorders. This study examines the prevalence and relationships of MI and SA histories among child and adolescent suicide victims, and their relationship to suicide methods used in North Carolina. Method: Medical investigation records of 234 suicide victims, between 6 to 17 years old, were obtained from the NC Coroners Office for the years 1999-2008. National

rates were obtained from the CDC. Descriptive statistics and logistic regression analyses were performed using SPSS 16.0. Results: Of 234 victims, 120(51.3%) had a history of MI and/or SA, 10 victims (4.3 %) had comorbid of MI and SA, 95(40.6%) had only MI history and 15(6.4%) had only SA history. 27(11.5%) were intoxicated and 17(7.3%) victims were positive only for alcohol at the time of suicide. Depression (DEP) was the leading MI among victims with 68(29%) cases followed by disruptive behavior disorder (DBD) with 25(10.6%) victims. There were gender and racial differences in DEP history. It was 44% more prevalent for females than males (p=0.01) and 43% more for Caucasians (CA) than African-Americans (AA) (p=0.04). The DEP history rate was 11% higher for AA females than AA males (p=0.01). There were no gender differences among CAs. Of victims with only SA history (n=15), 13 (86.7%) were CA and 14 (93.3%) were male. In NC, firearms (FAs) were the leading method of suicide, followed by hanging (HNG) and overdose (OD). Males are 1.8 times more likely to use FAs. Among DEP, FAs were the most common method (50%) followed by HNG (35.3%) and OD (12%). Among DBD, HNG was the most common method (62.5%) followed by FA (25%) and OD (8.3%). There were higher rates of suicides with FAs and lower rates of HNG in NC than in US. Conclusion: Diagnosis of MI and SA, especially DEP, is present in more than 50% of child/adolescent suicides, an important risk factor for suicide in child and adolescent populations for all races and both genders.

**REFERENCES:**

1. www.cdc.gov/injury/wisqars (Accessed November 14, 2009)
2. Cash S. J and Bridge J. A.; Epidemiology of youth suicide and suicidal behavior; Curr Opn Pediatr; 21; 613 – 619.

## SCIENTIFIC AND CLINICAL REPORT SESSION 05- PSYCHOSOMATIC MEDICINE AND HEALTH SERVICES

No. 13

### PSYCHIATRIC VITAL SIGNS

*Mark Zimmerman, M.D., 235 Plain Street, Suite 501, Providence, RI 02905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation the participant should be able to describe the concept of psychiatric vital signs and how their measurement could enhance the adoption of measurement-based care in clinical practice.

**SUMMARY:**

Background: Medical vital signs are measures of basic physiological functions that are routinely determined in medical settings. Vital signs are often a primary outcome measure, and also often adjunctive measurements. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services project we examined the frequency of depression and anxiety in a diagnostically heterogeneous group of psychiatric outpatients to determine the appropriateness of considering their measurement as psychiatric vital signs.
Methods: Three thousand psychiatric outpatients were interviewed with the Structured Clinical Interview for DSM-IV (SCID) supplemented with items from the Schedule for Affective Disorders and Schizophrenia (SADS). We determined the frequency of depression and anxiety evaluated according to the SADS items.
Results: In the entire sample of 3,000 patients 79.3% (n=2,378) reported clinically significant depression of at least mild severity, 64.4% (n=1,932) reported anxiety of at least mild severity, and 87.4% (n=2,621) reported either anxiety or depression. In all 10 diagnostic categories examined, the majority of patients had clinically significant anxiety or depression of at least mild severity. At the disorder level, for 28 of the 29 specific disorders studied, the majority of patients with that disorder as the principal diagnosis reported clinically significant depression or anxiety. Conclusions: The vast majority of a diagnostically heterogeneous group of psychiatric outpatients had clinically significant anxiety or depression upon presentation for treatment. These findings support the routine assessment of anxiety and depression in clinical practice because almost all patients will have these problems as part of their initial presentation. Even for those patients without depression or anxiety, the case could be made that the measurement of depression and anxiety is relevant and analogous to measuring certain physiological statistics in medical practice such as blood pressure and body temperature regardless of the reason for the visit.

**REFERENCES:**

1. Trivedi M, Rush A, Wisniewski S, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D implications for clinical practice. Am J Psychiatry 2006;163:28-40.
2. Zimmerman M, McGlinchey JB. Why don't psychiatrists use scales to measure outcome when treating depressed patients? J Clin Psychiatry 2008;69:1916-1919.

No. 14

## CHARACTERISTICS OF DELIRIUM IN THE SEVERELY MEDICALLY ILL CANCER POPULATION

*Soenke Boettger, M.D., 641 Lexington Ave, New York, NY 10022*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify features of delirium in the severely medically ill cancer population and be able to recognize that the severity of delirium does not necessarily have to correspond with the severity of medical illness, but rather the disturbance of consciousness, disorientation and attentional deficits may indicate the level of severity of illness.

### SUMMARY:

Objectives: To examine characteristics of delirium in the severely medically ill on the basis of the Karnofsky scale of performance status (KPS) and Memorial Delirium Assessment Scale (MDAS). Methods: We analyzed our delirium database in respect to delirium in the severely medically ill (KPS<30). All subjects in the database were recruited from all psychiatric referrals at MSKCC. Measures used were the Karnofsky Performance Status Scale (KPS), Memorial Delirium Assessment Scale (MDAS) at baseline (T1), 2-3 days (T2) and 4-7 days (T3). Results: We retrieved 111 subjects from our delirium database. Out of this sample 67 patients qualified as severely medically ill (KPS<30). KPS scores were 19.7 and 30.7 respectively. There were no significant differences in respect to age, history of dementia and MDAS scores at baseline. Within the symptoms of delirium we were able to find increased severity of disturbance of consciousness, disorientation and inability to maintain and shift attention. Etiologically an increased prevalence of hypoxia and infection in KPS<30 was found. On the other side corticosteroids administration was more often associated with a KPS>30. There were no significant differences in respect to opiate administration, dehydration and CNS disease including brain metastasis. Significance of Results: Delirium in the severely medically ill cancer population may be characterized by an increased disturbance of consciousness, disorientation and inability to maintain and shift attention. Etiologies associated with delirium in severe medical illness were with hypoxia and infection.

### REFERENCES:

1. Lawlor, P. G., Gagnon, B., Mancini, I. L., Pereira, J. L., Hanson, J., Suarez-Almazor, M. E., and Bruera, E. D. Occurrence, Causes, and Outcome of Delirium in Patients With Advanced Cancer: a Prospective Study. Arch.Intern.Med. 27-3-2000;160(6):786-94.

2. Breitbart, W. and Strout, D. Delirium in the Terminally Ill. Clin.Geriatr.Med. 2000;16(2):357-72.

No. 15

## PILOT OF MEASUREMENT-BASED CARE FOR DEPRESSION IN AN HIV OUTPATIENT CLINIC

*Julie Adams, M.D., 1022 Starlight Drive, Durham, NC 27707*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of co-occurring HIV-infection and depressive disorders as well as the clinical implications of co-morbidity; 2) Describe the service model of measurement-based for depression; and 3) Apply measurement-based care in the safe and effective treatment of HIV-infected individuals with depression.

### SUMMARY:

Depression occurs up to twice as frequently in HIV-infected individuals as in those not infected. It can lead to decreased adherence to antiretroviral therapy (ART), greater viral loads, lower CD4 counts, faster HIV disease progression, and increased mortality. Treatment with selective serotonin reuptake inhibitors (SSRIs) increases adherence to ART, increases CD4 counts, and decreases viral loads. Successful treatment requires access to
knowledgeable providers, often hampered by lack of insurance or paucity of mental health specialists. Measurement-based care (MBC) is a health service model that trains non-physician, depression care managers to detect likely depression in patients, utilize a decision-support tool to recommend treatment to prescribers, and monitor response prospectively while making treatment adjustments as outlined by the decision-support tool, all under the supervision of a psychiatrist. The authors conducted a single-condition, 12-week, prospective pilot study of MBVC for depression in a university-based infectious diseases clinic. A decision support tool was developed with specific attention paid to potential drug interactions between ART and antidepressant medication (AD). A licensed clinical social worker functioned as the depression care manager. Participants were enrolled if they scored 10 or greater on the Patient Health Questionnaire-9 item (PHQ-9) and diagnosis of depression was confirmed by a psychiatrist. The depression care manager met with participants at baseline and monthly for three months to

measure depression symptom severity and review ART use. The care manager then applied this information to the decision support tool and conveyed recommendations to participants' prescribers. Of 183 patients screened between May and August 2008, 53 (29%) scored 10 or higher on the PHQ-9 indicating likely major depression. Fifteen patients were excluded as they were already in depression care and fifteen were screened on a day when the care manager was not available to consent them. A total of 13 were enrolled for the three-month intervention. Participants were mostly men (69%), single (62%), employed (54%), and had attained at least a high school education (77%). All participants had a concurrent anxiety disorder and three had a substance use disorder. PHQ-9 scores dropped from a mean of 17 (n=13) to 11 (n=9) with three remissions (PHQ of 5 or less) by study end.

**REFERENCES:**

1. Ciesla, J.A. and J.E. Roberts, Meta-analysis of the relationship between HIV infection and risk for depressive disorders. Am J Psychiatry, 2001. 158(5): p. 725-30.
2. Gaynes, B.N., et al., Primary versus specialty care outcomes for depressed outpatients managed with measurement-based care: results from STAR*D. J Gen Intern Med, 2008. 23(5): p. 551-60.

**MONDAY, MAY 24, 9:00 AM - 10:30AM**

## SCIENTIFIC AND CLINICAL REPORT SESSION 06 –PSYCHOTHERAPY AND DEPRESSION

No. 16

### SUDDEN GAINS IN SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPY IN DEPRESSION: A REPLICATION AND EXTENSION

*Dahlia Mukherjee, M.A., 3720 Walnut Street, Philadelphia, PA 19104*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Define what sudden gains are and describe the methods researchers have used to uncover them; 2) Describe how sudden gains might differentially relate to outcome in psychodynamic therapy compared to treatment with either antidepressant medication or pill-placebo; and 3) State how psychodynamic interventions might be related to the occurrence of sudden gains in supportive-expressive therapy.

**SUMMARY:**

Objective: To test (a) whether the use of psychodynamic interventions predicts sudden gains (large symptom improvement in an inter-session interval) in supportive-expressive psychodynamic therapy (SET) and (b) whether sudden gains are more predictive of outcome in SET than in clinical management with antidepressant medication (MED+CM) or pill-placebo (PBO+CM). Design: Correlational Setting: University of Pennsylvania School of Medicine Patients: 156 patients with MDD enrolled in a NIMH-sponsored randomized controlled trial of SET vs. MED+CM vs. PBO+CM. Main Outcome Measure: Beck Depression Inventory. Results: Among SET patients exhibiting sudden gains, sessions that preceded a sudden gain did not display any difference in the levels of psychodynamic interventions compared to sessions from those same patients that did not precede a sudden gain. Sessions from SET patients with sudden gains did display greater levels of psychodynamic interventions when compared to sessions from SET patients never experiencing sudden gains. Sudden gains were observed in SET, MED+CM, and PBO+CM patients, but were most associated with outcome for patients in SET. Conclusion: Sudden gains seem to be a viable predictor of outcome specific to SET, and occurred in SET patients who received higher levels of psychodynamic interventions at every session. Written with support from National Institute of Mental Health grant R01 MH 061410 (Jacques P. Barber, PI). The sertraline and the placebo pills were provided by a grant from Pfizer Corp. Neither sponsors had any role in the study besides funding the study (NIMH) or supplying the sertraline and placebo pills (Pfizer).

No. 17

### SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY VS. PHARMACOTHERAPY VS. PILL PLACEBO FOR MAJOR DEPRESSIVE DISORDER IN AN URBAN, DISADVANTAGED SAMPLE

*Jacques Barber, Ph.D., 3535 Market Street Room 683, Philadelphia, PA 19104*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe how this sample differed from many other samples in randomized controlled in terms of gender, race, and income; 2) Describe the relative efficacy of psychodynamic therapy, antidepressant medication, and pill-placebo for an urban, disadvantaged sample, based on the results of this trial; and 3) Modify or begin to think about ways to modify the treatments they offer to their

urban, disadvantaged patients.

**SUMMARY:**
Objectives: To determine that supportive-expressive psychotherapy (SET) and pharmacotherapy for MDD are more efficacious than placebo (PBO). Design: NIMH–sponsored randomized controlled trial. Setting: University of Pennsylvania School of Medicine. Patients recruited mostly from the community Patients: 156 patients with MDD and a 17-item Hamilton-Rating Scale of Depression (HRSD) =14 for two consecutive weeks. This underserved urban sample consisted of 41% males, 52% minority, and 76% under $30,000 of annual income. Interventions: Patients were randomized to 16 weeks of serotonin reuptake inhibitor (sertraline, MED) + clinical management (CM) vs. SET vs. PBO+CM. MED+CM patients who failed to respond by week 8 (maximal 200mg of sertraline) were switched to venlafaxine (maximal dose of 375 mg). Non-responding PBO+CM patients were switched to another PBO. Main Outcome Measure:HRSD. Results: Patients significantly improved on HRSD over time ($F(1,133)=159.19$, $p<.0001$), but there were no differences between groups ($F(2,131)=0.05$, $p=0.95$). MED+CM or SET were not more effective than PBO+CM (Cohen's d=.03 (95%CI:-0.35-0.41) and .06 (95%CI:-0.33-0.45)). Similar findings were found at week 8. Conclusion: There is a need to develop and test treatments for disadvantaged depressed patients. Written with support from National Institute of Mental Health grant R01 MH 061410 (Jacques P. Barber, PI). The sertraline and the placebo pills were provided by a grant from Pfizer Corp. Neither sponsors had any role in the study besides funding the study (NIMH) or supplying the sertraline and placebo pills (Pfizer).

No. 18

**THE RELATION OF SPECIFIC, COMMON, AND UNINTENDED FACTORS TO OUTCOME IN PSYCHODYNAMIC THERAPY FOR DEPRESSION**

*Kevin McCarthy, 422 S. Carlisle Street, Philadelphia, PA., 19146*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe the types of interventions that occur in supportive-expressive psychodynamic therapy; 2) State how interventions from different theoretical orientations might relate to outcome in psychodynamic therapy, based on the results of this study; and 3) Identify at least 2 possible reasons why moderate intervention levels might predict outcome better than higher or lower levels.

**SUMMARY:**
Objectives: To test how interventions from a number of theoretical orientations relate to symptom improvement in psychodynamic therapy for MDD. Design: Correlational. Setting: University of Pennsylvania School of Medicine. Patients: 44 patients with MDD randomized to the psychotherapy arm of a randomized controlled trial comparing supportive-expressive therapy vs. sertraline/venlafaxine vs. pill placebo.
Interventions: The Multitheoretical List of Therapeutic Interventions was used to measure techniques in supportive-expressive therapy from 8 therapy systems: psychodynamic, common factors, behavioral, cognitive, dialectical-behavioral, interpersonal, person-centered, and process-experiential. Main Outcome Measure: Hamilton Rating Scale for Depression (HRSD). Hesults: Common factor, person-centered, process-experiential, and psychodynamic interventions were prominent in psychodynamic therapy. Moderate levels of psychodynamic and process-experiential interventions were related to better subsequent outcome on the HRSD than were higher or lower levels of these interventions (curvilinear relations). Common factor interventions did not predict outcome. Conclusion: Symptom improvement in psychodynamic therapy may be predicted by the moderate use of interventions from multiple theoretical orientations. Further investigations of the processes of psychodynamic therapy are encouraged.

## SCIENTIFIC AND CLINICAL REPORT SESSION 07 – BORDERLINE PERSONALITY DISORDER AND EMOTION DYSREGULATION

No. 19

**NEURAL SENSITIZATION AS A POSSIBLE MECHANISM OF EMOTIONAL REACTIVITY: A COMPARISON OF BORDERLINE AND AVOIDANT PERSONALITY DISORDER AND HEALTHY CON**

*Harold Koenigsberg, M.D., 130 West Kingsbridge Road, Bronx, NY 10468*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to identify brain regions which show increased BOLD activation to repeated vs novel presentation of aversive cues in borderline personality disorder patients in comparison

with avoidant personality disorder patinets and healthy controls.

**SUMMARY:**
Background: Intense emotional reactivity is a hallmark feature of Borderline Personality Disorder (BPD) and is associated with many of the disorder's most maladaptive features such as suicidality, intense anger, unstable relationships, and identity disturbances. Avoidant Personality Disorder (AvPD), a distinct anxiety-related personality disorder, shares with BPD an excessive reactivity to social cues, but lacks the emotional instability characteristic of BPD. The neural bases of these emotional responses are poorly understood, but a failure to habituate or a sensitization to aversive social cues have been posited as underlying mechanisms. Method: BOLD fMRI images were obtained as patients with BPD (n =17) , AvPD (n =21) and healthy volunteers (HC's) (n=19) viewed, in a counterbalanced design, novel and repeated presentations of neutral and aversive pictures depicting social interactions. Results: When viewing repeated compared to novel pictures, BPD patients showed greater activation in the right amygdala, fusiform gyrus, caudal anterior cingulate cortex (ACC), and inferior frontal gyrus, whereas HC's showed the reverse. In contrast, AvPD patients showed greater activation in the caudal ACC and decreased activation in the hippocampus when viewing novel pictures vs. repeat pictures. HC's showed the reverse. Conclusions: These data suggest that BPD patients sensitize to repeated presentations of social cues in contrast to HC's who habituate. This tendency to sensitize may account for the increased social reactivity of BPD patients in ongoing relationships. AvPD patients on the other hand, who are also sensitive to interpersonal situations but do not have emotional instability show a different neural response to repeated encounters with social cues.

No. 20

**SHORT VS. LONG TERM DIALECTICAL BEHAVIOR THERAPY FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER: PREDICTORS OF RESPONSE AND ELEMENTS OF CHOICE**

*Nader Perroud, M.D., 8 rue du 31-Décembre, Geneva, 1207 Switzerland*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Demonstrate a greater knowledge on the characteristics of intensive and standard dialectical behavior therapy (DBT); 2) Better understand the effectiveness and predictors of response for both therapies; and 3) Understand how to better target intervention's focus and duration when treating patients with borderline personality disorder (BPD).

**SUMMARY:**
Objective: Standard DBT reduces the symptoms of BPD. The effectiveness of an intensive DBT for the
treatment of BPD patients has also been shown (Perroud et al. 2009). However little is known on the specific predictors of response to the two therapies and how they differ in their outcome. We propose to address these issues in order to help the clinicians to choose between the two settings. Method: Seventy three outpatients were firstly followed for four weeks in an intensive DBT setting. They were then addressed to a standard DBT setting for a period of one year. Participants were evaluated seven times with the Beck Depression Inventory (BDI), the Beck Hopelessness Scale (BHS), and the Kentucky Inventory of Mindfulness Skills. Linear mixed models with fixed effect of time and a random effect of individual, fitted with maximum likelihood were used to analyze the effects of the two settings on outcomes and to analyze predictors of response. Results: 21 subjects dropped-out during the follow-up with the best predictor being low educational level for both settings. The two therapies were effective in reducing BDI and BHS scores ($p<0.0001$) with a greater effect-size for the intensive DBT as compared to the standard DBT. Older age was the only predictor of poor response to standard DBT, that being probably related to a longer duration of the disorder. Interestingly, standard DBT and not intensive DBT was associated with an increase in mindfulness skills with a high effect size on Observing and Accepting skills. Finally, for subjects scoring higher than 6 (N=41) on the
BPD items of the International Personality Disorder Examination Screening Questionnaire (IPDE), standard DBT was associated with a reduction in BPD scores. Conclusions: Both intensive and standard DBT dramatically reduced depression over time but with a greater effect size for the former. Intensive DBT should therefore be chosen for severely depressed patients before undergoing a standard DBT. Standard DBT was effective in reducing core symptoms of BPD probably by increasing mindfulness skills and should be proposed to subjects with high BPD profile. As low educational level predicted drop-out in both settings, education should be considered in assessment and during DBT in order to reduce drop-out rates.

Funding: Nader Perroud was founded by the University

of Geneva

**REFERENCES:**
1. Predictors of response and drop-out during intensive dialectical behavior therapy. N
Perroud, R Uher, K Dieben, R Nicastro, P Huguelet. J Pers Disorder. In Press.

No. 21

## DYSREGULATED BRAIN NETWORKS IN THE COGNITIVE CONTROL OF EMOTION IN BORDERLINE PERSONALITY DISORDER: AN FMRI STUDY

*Harold Koenigsberg, M.D., 130 West Kingsbridge Road, Bronx, NY 10468*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to identify the diffrerences in neural activation patterns in borderline patients compared to healthy volunteers as subjects employ cognitive processes to emotionally distance from aversive social cues.

**SUMMARY:**
Background: Affective instability, a core feature of borderline personality disorder (BPD), is associated with the extreme emotional reactivity, the interpersonal turmoil and the suicidal behaviors which characterize the disorder. One contributing mechanism to affective instability may be an impaired ability to appropriately engage neural networks that are customarily employed in conscious cognitive control of emotion. Method: We compared regional brain activity in 18 BPD patients and 16 healthy control subjects (HC's) as they
used a cognitive reappraisal strategy of emotional distancing to downregulate their reactions to negative social emotional pictures from the International Affective Pictures System (IAPS). fMRI images were obtained as BPD patients and HC's followed instructions to either maintain or decrease their emotional reactions to negative IAPS pictures. Results: When distancing, both groups decreased the negativity of their reactions to aversive pictures. BPD patients did not show the increased activation in the dorsal anterior cingulate (ACC) and in the intraparietal sulci (IPS) when distancing compared to maintaining that was seen in the HC's. The reverse was seen in the superior temporal sulcus region and superior frontal gyrus. Consistent with a model of impaired downregulation of emotion in BPD patients, the BPD's showed a greater distance-maintain BOLD signal in the right amygdala than the HC's. Conclusion: These findings suggest that BPD patients are less able, than healthy controls, to mobilize the ACC and IPS, regions implicated respectively in the cognitive control of emotion and the regulation of attention, when attempting cognitive control of their emotional reactions to negative pictures.

**REFERENCES:**
1. Ochsner KN, Ray RD, Cooper JC, Robertson ER, Chopra S, Gabrieli JD, et al. (2004):
For better or for worse: neural systems supporting the cognitive down- and up-regulation of
negative emotion. Neuroimage. 23:483-499.

2. Koenigsberg HW, Siever LJ, Lee H, Pizzarello S, New AS, Goodman M, Cheng H, Flory J,
Prohovnik I: Neural Correlates of Emotion Processing in Borderline Personality Disorder.
Psychiatry Research:Neuroimaging 172: 192-9, 2009

**MONDAY, MAY 24, 11:00 AM - 12:30PM**

## SCIENTIFIC AND CLINICAL REPORT SESSION 08 –BORDERLINE PERSONALITY DISORDER

No. 22

## GENDER DIFFERENCES IN THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

*Uday Patil, M.A., 5323 Harry Hines Blvd., Dallas, TX 75390*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, participants should be able to: 1) Identify prodromal features of Borderline Personality Disorder (BPD) that can occur as early as infancy; 2) Discern between female and male presentations of the disorder, and; 3) Understand that gender-based differences may attenuate throughout the development and course of BPD.

**SUMMARY:**
REVIEW: Borderline Personality Disorder (BPD), with a general prevalence of 1-2%, is a particularly debilitating disorder marked by various symptom dimensions. Since women comprise 75% of all BPD diagnoses, the literature is aimed primarily at identifying and treating female clinical presentations. Few studies account for gender-based distinctions when describing the pathology. METHODS: We surveyed parents of BPD offspring with an online, anonymous questionnaire to identify

gender-based differences in symptom dimensions throughout the development of the disorder. Two hundred items covered clinical variables from infancy through adulthood. Responses on BPD offspring (identified as such with embedded
diagnostic criteria and a professional diagnosis of BPD) were compared to those of non-BPD siblings.
RESULTS: We report on 495 BPD probands (409 females, 86 males) and 188 sibling controls (98 females, 90 males). Probands showed increased endorsement in various symptom dimensions, as far back as infancy.
Regarding individual symptom dimensions, sibling gender differences in unusual temperament and anger in childhood or adolescence were no longer evident in BPD probands. Similarly, sibling gender differences in deliberate self-harm and interpersonal features, such as separation anxiety as an infant and difficulty making friends in childhood or adolescence, were also attenuated in BPD probands. Regressions by epoch show a core of clinical features that predict BPD, in both men and women. These include: unusual oodiness/temperament and separation anxiety in infancy; emptiness, lying, difficulty making friends in childhood, and; odd thinking, deliberate self-harm, impulsivity and outbursts in adolescence. However, certain features uniquely predict an onset of BPD in females (body image dissatisfaction as early as childhood; promiscuity in adolescence) and in males (cognitive and verbal delays in infancy; victimization, poor academic performance, and alcohol abuse in childhood; destruction and alcohol abuse in adolescence). CONCLUSIONS: These data suggest overlapping, but differential, developmental trajectories to BPD across gender. Additionally, gender-based differences seen in the domains of impulsivity, interpersonal relationships, self-harm and anger attenuate throughout the development and course of BPD. Continued definition of these gender-based differences may facilitate recognition of at-risk populations. Updated data will be presented.

## REFERENCES:


1. Johnson D, Shea M, Yen S, Battle C, Zlotnick C, Sanislow C, Grilo C, Skodol A, Bender D, McGlashan T, Gunderson J, Zanarini M. Gender differences in borderline personality disorder: findings from the collaborative longitudinal personality disorders study. Comprehensive Psychiatry 2003; 44:4, 284-292
2. Zlotnick C, Rothschild L, Zimmerman M. The Role of Gender in the Clinical Presentation of Patients with Borderline Personality Disorder. Journal of Personality Disorders 2002; 16:3, 277-282


No. 23

## RECURRENT SUICIDE ATTEMPTS AND MEDICAL LETHALITY IN BORDERLINE PERSONALITY DISORDER


*Paul Soloff, M.D., Western Psychiatric Institute and Clinic3811 O'Hara St. Pittsburgh, Pa. 15213, Pittsburgh, PA 15213*


## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify clinical characteristics associated with increasing degrees of medical lethality in recurrent suicide attempts of patients with Borderline Personality Disorder.

## SUMMARY:


Objective: Recurrent suicide attempts are a diagnostic characteristic of BPD. At the time of initial assessment, patients report an average of 3 lifetime attempts, and widely varied degrees of lethality. The suicidal process may last months to years, but results in a completion rate of up to 10%. As part of a longitudinal study of suicidal behavior in BPD, we asked if medical lethality increased with recurrent attempts, and whether clinical
characteristics predict increased lethality over time. Method: 253 BPD subjects, defined by IPDE and DIB/R, were assessed for Axis I/ II diagnoses, clinical and psychosocial characteristics, suicidal behavior and childhood abuse using standard measures. Suicide attempts were rated for medical lethality on an 8 point scale, where a score of 2 or greater is medically significant. Subjects were re-assessed at 3 mos., 1 yr., and annually.Medical lethality scores were compared within subjects across attempts.Characteristics discriminating single and repeat attempters were related to measures of medical lethality. Results:195 BPD attempters had a mean(s.d.) of 4.0(3.5) attempts, with a range of 1 to 20. The maximum medical lethality scores across the first 6 attempts averaged 3.0(1.8), and increased significantly between the first and third attempts. For 91 subjects with increasing lethality, the mean maximum was 4.0(1.5), across 5.3(4.0) attempts. The time to maximum
was 465.0(414.0) wks. Maximum scores were significantly correlated with age, baseline depression, psychosocial function, and number of lifetime attempts, but not impulsivity or aggression.They were best predicted by global function and number of lifetime attempts at intake. Conclusions: Medical lethality increased significantly to the third attempt, though the time to maximum was highly variable. Depressed mood, impaired global and psychosocial function and number of lifetime attempts at intake are risk factors for increasing medical lethality over time.

**REFERENCES:**

1. Soloff PH: Risk factors for suicidal behavior in borderline personality disorder: A review and update, in Borderline Personality Disorder. Edited by Zanarini MC. Boca Raton, Fla., Taylor & Francis, 2005, pp.333-365.

No. 24

**TIME-TO-ATTAINMENT OF RECOVERY FROM BORDERLINE PERSONALITY DISORDER AND ITS STABILITY: A 10-YEAR PROSPECTIVE FOLLOW-UP STUDY**

*Mary Zanarini, Ed.D., McLean Hospital 115 Mill Street, Belmont, MA 02478*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize that recovery from BPD combining both symptomatic remission and good psychosocial functioning is more difficult to achieve than remission from BPD. 2) The participant should also be able to recognize that such a recovery once attained is relatively stable over time.

**SUMMARY:**

Objective: The first purpose of this study was to determine time-to-attainment of recovery from borderline personality disorder (BPD) and the second was to determine the stability of this important outcome. Method: 290 inpatients meeting both DIB-R and DSM-III-R criteria for BPD were assessed during their index admission using a series of semistructured interviews and self-report measures. The same instruments were readministered at five contiguous two-year time periods. Results: All told, 50% of the borderline patients studied achieved a recovery from BPD-an outcome which required being remitted from BPD and having good social and vocational functioning during the past two years. In contrast, 93% of borderline patients attained a remission of BPD lasting two years and 86% attained a sustained remission of BPD that lasted four years. In terms of stability of these outcomes, 34% of borderline patients lost their recovery from BPD. A similar 30% had a recurrence of BPD after a two-year long remission but only 15% experienced a recurrence of BPD after a sustained remission. Conclusions: Taken together, the results of this study suggest that recovery from BPD combining both symptomatic remission and good psychosocial functioning seems difficult for many borderline patients to attain. These results also suggest that such a recovery once attained is relatively stable over time.

**REFERENCES:**

1. Zanarini MC, Frankenburg FR, Hennen J, Silk KR. The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. Am J Psychiatry 2003; 160:274-283

**SCIENTIFIC AND CLINICAL REPORT SESSION 09 – CHILDHOOD ABUSE**

No. 25

**CLINICAL PHENOMENOLOGY OF CHILDHOOD ABUSE-RELATED COMPLEX PTSD PATIENTS: DIFFERENTIAL PATTERNS OF PERSONALITY DISTURBANCE**

*Ethy Dorrepaal, M.D., AJErnststraat 887, Amsterdam, NE 1081 HL*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to distinguish subtypes of Complex PTSD patients based on personality characteristics and knows about its clinical consequences

**SUMMARY:**

Purpose: To distinguish personality related subtypes of Complex Posttraumatic Stress Disorder (PTSD) in women traumatized in childhood abuse Introduction: Especially after interpersonal traumatization in childhood, PTSD symptoms - may be complicated by personality changes such as disturbed affect regulation, memory, self-image and relational problems. This syndrome has been labelled 'PTSD with associated features' in DSM-IV-TR and is known as 'complex PTSD'. The large amount of symptoms, co-morbidity and personality disturbance encompassed by complex PTSD, though, limits its descriptive and clinical usefulness. Considerable inter-individual variability exists in patterns of co morbidity and other manifestations of posttraumatic stress. Method: Seventy one women diagnosed with Complex PTSD, were analysed, using hierarchical cluster analysis on personality characteristics based on SIDP- IV. To understand the cluster solution, we performed one-way analysis of variances (ANOVAs) on each of the personality disorder scales. The same procedure was used to determine differences among clusters on related psychometric measures (PTSD , complex PTSD, dissociation, borderline, and depressive symptoms as well as trauma and parental bonding variables) to validate

and 'colour' the cluster solution. Results: The cluster analysis distinguished five subtypes: a relatively adaptive subgroup as well as two more isolated groups and two less isolated groups. The most isolated subgroups consisted of a "pure"cluster C group - characterized mainly by high avoidance - and a more hostile group - with additional paranoidy and disinhibition called alienated. The less isolated groups a difference in disinhibition was found, producing a depressive 'suffering' group and an aggressive group with high levels of DSM axis II cluster B pathology. Importance: Complex PTSD is a heterogeneous population. For clinical indication, the process of identifying relevant personality factors might be important.

No. 26

## EFFECT OF COGNITIVE BEHAVIOURAL STABILIZING GROUP TREATMENT ON BRAIN ACTIVITY IN CHILDHOOD ABUSE RELATED COMPLEX PTSD PATIENTS

*Kathleen Thomaes, M.D., GGZ Ingeest A.J.Ernststraat 887, Amsterdam, 1081HL Netherlands*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participant will be able to demonstrate knowledge of the effects of CBT stabilizing group therapy on brain activity in complex posttraumatic stress disorder (PTSD) patients.

**SUMMARY:**

Purpose: To describe effects of cognitive behavioral stabilizing group treatment on brain activity in childhood abuse related Complex PTSD patients. Introduction: Impaired memory function and related brain changes have been found in different types of PTSD. In Complex PTSD, net memory performance of negative words was impaired in Complex PTSD compared to controls, mainly due to a higher false alarm rate, and encoding of later remembered negative words was associated with an enhanced BOLD-response in the left posterior hippocampus and in the left ventral and dorsal anterior cingulate (ACC) extending to the medial prefrontal cortex of Complex PTSD patients compared to controls. In our RCT we found evidence for the effectiveness of a translated and adapted a stabilizing (fase I) treatment manual of C. Zlotnick by psycho-education and cognitive behavioral interventions. From seventy-one referred patients with Complex PTSD and severe co-morbidity (e.g. Axis II co-morbidity), 33 participated in a repeated functional MRI study, using an emotional memory task and an emotional Stroop task. They were randomly assigned to (1) the experimental group: a 20-week stabilizing group treatment based on psycho-education and cognitive behavioral therapy in addition to treatment as usual (TAU), or to (2) TAU only. Method: We will analyze task performance (memory and/or Stroop task) and BOLD responses in complex PTSD patients responding to the cognitive behavioral stabilizing group treatment condition compared to complex PTSD patients in the TAU condition. Results: Data are currently being analyzed. We expect the activity in the prefrontal cortex to spread from ventral more to lateral parts, associated with more cognitive control over complex PTSD symptoms. Importance: To understand better the process of improving by a cognitive behavioral stabilizing group treatment on the level of brain activity in childhood abuse related Complex PTSD patients.

**REFERENCES:**

1. Thomaes K, Dorrepaal E, Draijer NP, de Ruiter MB, Elzinga BM, van Balkom AJ, Smoor PL, Smit J, Veltman DJ. Increased activation of the left hippocampus region in Complex PTSD during encoding and recognition of emotional words: a pilot study. Psychiatry Res. 2009 Jan 30;171(1):44-53.
2. Thomaes, K; E.Dorrepaal, N.Draijer, M. B. de Ruiter, A. J. van Balkom, J.H. Smit, D.J. Veltman. Reduced anterior cingulate and orbitofrontal volumes in child abuse related Complex PTSD. Clin J Psychiatry, in press.

No. 27

## CHILDHOOD MALTREATMENT IN WOMEN WITH BINGE-EATING DISORDER: ASSOCIATIONS WITH PSYCHIATRIC COMORBIDITY, PSYCHOLOGICAL FUNCTIONING, AND EATING PATHO

*Daniel Becker, M.D., 1501 Trousdale Dr., Burlingame, CA 94010*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identify the correlates of childhood maltreatment-with respect to psychiatric comorbidity, psychological functioning, and eating pathology-among patients with binge-eating disorder.

**SUMMARY:**

Objective: This study examined the correlates of childhood maltreatment-with respect to psychiatric comorbidity, eating disorder pathology, and associated psychological factors-in women with binge-eating disorder (BED). Method: Subjects were a consecutive series of 137 treatment-seeking women who met DSM-IV research criteria for BED. All

were reliably assessed with semistructured interviews to evaluate DSM-IV axis I disorders and eating disorder psychopathology. Self-reported childhood maltreatment was assessed in 5 domains. Results: Emotional abuse was reported by 52% of subjects, physical abuse by 28%, sexual abuse by 31%, emotional neglect by 66%, and physical neglect by 48%. These forms of childhood maltreatment were not significantly associated with age at onset of eating or weight problems, current body mass index (BMI), or eating psychopathology-but were negatively associated with self-esteem. With respect to lifetime psychiatric disorders, the maltreatment categories were not significantly associated with most diagnoses. However, specific associations were observed for emotional abuse with dysthymic disorder, physical abuse with alcohol use disorders, and sexual abuse with posttraumatic stress disorder. Conclusions: The reported rates of childhood maltreatment in women with BED are comparable to those for clinical groups, and much higher than those for normative community samples. Although prevalent in women with BED, childhood maltreatment is not associated with the onset of weight or eating problems, or with variability in current BMI or eating psychopathology. With a few notable exceptions, childhood maltreatment is also not associated with most axis I psychiatric disorders. Several forms of childhood maltreatment are, however, associated with lower self-esteem in this patient group. These findings have implications for the psychopathological relationship between childhood maltreatment and BED, and may also have implications for assessment and treatment.

**REFERENCES:**

1. Fairburn CG, Doll HA, Welch SL, Hay PJ, Davies BA, O'Connor ME: Risk factors for
binge eating disorder. Arch Gen Psychiatry 1998; 55:425-432

**MONDAY, MAY 24, 1:30PM - 3:00PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 10 - COGNITIVE DISORDERS**

No. 28

**INCIDENCE RATES AND PROBABILITY TO DEVELOP DEMENTIA AND ALZHEIMER'S DISEASE IN A SOUTHERN EUROPEAN CITY: THE ZARADEMP PROJECT**

*Antonio Lobo, M.D., Hospital Clínico Universitario, pta. 3, Zaragoza, AL 50009 Spain*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize the incidence rate as well as the probability to develop dementia and dementia of Alzheimer's type in a rather typical Southern European city.

**SUMMARY:**

Specific purpose: To document the incident rates of overall dementia (OD) and dementia of Alzheimer's type (DAT); and the probability to develop dementia and DAT. Methodology: Data from the Zarademp Project longitudinal study are presented. A representative stratified random sample of older adults aged 55+ years (n = 4,803) was assessed in wave I, and dementia free subjects were followed up at 2.5 and at 4.5 years. A two-phase case finding process was applied in each wave. Validated instruments, including the MMSE, the
GMS-AGECAT and the History and Aetiology Schedule, were used. A panel of psychiatrists diagnosed incident cases using DSM-IV zacriteria. Age and sex specific incident rates per 1,000 persons-years (Poisson 95%CI) were calculated. To document the probability to develop dementia and DAT cumulative incidence was also calculated and Poisson regression models, adjusted by age, sex and education were used to obtain the expected incident cases. Results: Both incident rate and the probability to develop dementia increased exponentially with age and were higher in women. During 16,025 person-years of follow-up, 138 incident cases of OD and 86 of DAT were found resulting in an incidence rate of 8.6 for OD and 5.4 for DAT. From the youngest to the oldest 5-year age band, the incidence rate for OD increased from 0.0 to 54.6 and from 0.0 to 38.9 for DAT. Similarly, the adjusted probability to develop dementia increased from 0.006 to 0.41 for OD and from 0.0 to 0.24 for DAT. Importance: Data on incident dementia have implications for public health and for the prediction of service needs. At least, 106,000 new cases of OD per year may be expected in Spain. Data on the probability to develop dementia have also clinical implications. Conclusions: To our knowledge, this is the first report about the adjusted probability to develop dementia: Not taking into account the competing risk of dying, the probability for OD after the age of 85 years is 0.41 and 0.24 for DAT.

**REFERENCES:**

1. Lobo A, Saz P, Marcos, G, et al.: The ZARADEMP Project on the incidence, prevalence
and risk factors of dementia (and depression) in the elderly community: II. Methods and first

results. Eur J Psychiatry 2005; 19: 40-54.

No. 29

**ART AND DEMENTIA: PATHOLOGICAL AND CLINICAL FEATURES OF DIFFERENT SUBTYPES OF DEMENTIA, WITH A FOCUS ON THE CHANGES IN ART PRODUCTION**

*Laura Safar, M.D., M.A., BIDMC - CNU; 330 Brookline Ave - KS 2, Boston, MA 02215*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss neurological basis for the production of visual arts; 2) Explain the pathological mechanisms and clinical characteristics of different subtypes of dementia, with emphasis on the changes in art production and 3) Describe behavioral interventions for the management of patients with dementia.

**SUMMARY:**

Objectives: 1) To identify the neurological mechanisms involved in art production; 2) To explain how those mechanisms are altered in different subtypes of dementia; 3) To describe therapeutic applications of this knowledge. Method: A review of the medical literature discussing dementia and art was conducted in Pub Med. 169 articles were reviewed, and 26 of them were included in this study. An additional literature review integrated the psychological literature describing the use of art in the treatment of patients with dementia. Results: Making art involves multiple cognitive, emotional, and motor functions, and engages different brain areas. The visual association cortex may be divided into a dorsal pathway involved in seeing scenes as a whole, and a ventral one involved in object recognition and representation. The right posterior parietal lobe allows people to copy images, pull out internal imagery and represent it on paper. The dorsolateral prefrontal cortex helps with the planning and organization of the art piece. The cingulate cortex modulates drive and emotion. The motor and premotor frontal regions carry out the movements needed to create art. The language areas play a role in portraying symbolic concepts. The patterns of change in art production vary in Alzheimer's disease, Fronto-temporal dementia, Lewy body disease, and Cortico-basal degeneration, and may be explained by the neuropathology of these disorders. Visual creativity helps patients with dementia maintain communication when other cognitive functions are impaired. Art interventions can improve mood and decrease behavioral disturbances in this population.

**REFERENCES:**

1. William W. Seeley, Brandy R. Matthews, Richard K. Crawford, Maria Luisa Gorno-Tempini, Dean Foti, Ian R. Mackenzie and Bruce L. Miller
2. Unravelling Bolero: progressive aphasia, transmodal creativity and the right posterior Neocortex Brain 2008 131: 39-49

No. 30

**METACOGNITIVE CAPACITY MEDIATES OF THE IMPACT OF NEUROCOGNITIVE DEFICITS ON FUNCTION IN SCHIZOPHRENIA**

*Paul Lysaker, Ph.D., roudebush VA Med Center1481 west 10th street (116h), indianapolis, IN 46202*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to idenitfy different forms of metacognitive deficits in schizophrenia and recognize how they may mediate the impact of neurocognitive deficits upon social function.

**SUMMARY:**

Research has strongly suggested that in schizophrenia patients, deficits in neurocognition interfere with interpersonal and community function. More recently, interest has arisen in whether the relationship between neurocognition and function is mediated by other factors including social cognition. This paper reports the result of a path analysis that examined the related possibility that deficits in metacognition, or the ability to think about thinking may mediate the effects of neurocognition on social functioning. This possibility is consistent with studies confirming that many with schizophrenia experience significant difficulties thinking about thinking and that metacognition has been implicated as a potential source of dysfunction in a range of non-psychotic mental disorders. Participants were 102 adults with schizophrenia. Neurocognition was represented by a single factor score produced by a principal components analysis of a neurocognitive test battery which included assessments of verbal memory, visual memory, processing speed, premorbid intellectual function and executive function. Mastery was assessed using the Metacognitive Assessment Scale and social functioning by the Quality of Life Scale. Using structural equation modeling, specifically measured-variable path analysis, a mediational model consisting of neurocognitive capacity linked to mastery and capacity for social relationships and mastery linked with frequency of social contact and capacity for social relatedness showed acceptable fit to the observed data

after controlling for negative and cognitive symptoms. Results suggest that certain forms of metacognition may mediate the influence of neurocognition upon function in schizophrenia. This may help us better understand the course by which deficits in neurocognition come to affect function and present metacognition as a possible new target for intervention.

## SCIENTIFIC AND CLINICAL REPORT SESSION 11-DIAGNOSTIC ISSUES AND DSM-V

No. 31
### INTELLECTUAL DISABILITY IN DSM-5

*Walter Kaufmann, M.D., 716 N. Broadway, Room 137, Baltimore, MD 21205*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to identify the main issues being considered in the review of diagnostic guidelines for Intellectual Disability during the DSM-V development process.

**SUMMARY:**
The Intellectual Disability Subworkgroup of the DSM-V Neurodevelopmental Disorders Workgroup has been reviewing the diagnostic criteria for Intellectual Disability, attempting to develop a set of guidelines that takes into consideration similar efforts by the American Psychological Association and the American Association on Intellectual and Developmental Disabilities. Review of terminology has also considered other organizations' guidelines (e.g., Child Neurology Society). To date, the Subworkgroup has revised DSM-IV criteria in terms of terminology, specific criteria, age range, and level of severity. Preliminary recommendations include: (1) Replacement of the outdated term "Mental retardation" by "Intellectual Disability", for individuals older than 5 years, and Developmental Disability" for those below this age; (2) Definition of Intellectual/Developmental Disability as a deficit of 2 or more standard deviations on an individualized, standardized, culturally appropriate, and psychometrically sound test; (3) Use of IQ and Adaptive functioning as diagnostic specifiers for Intellectual Disability; (4) Consideration of age of onset for Intellectual Disability as the developmental period (birth to 18-21 years); and (5) Coding of Intellectual Disability no longer based on IQ level (usefulness of the four DSM-IV categories of severity is being examined). Other issues under evaluation include determination of specific domains of adaptive behavior to be included in the diagnostic guidelines and examination of the influence of cognitive impairment, directly or as language impairment, on diagnostic criteria for autism spectrum disorders (also to be discussed in this session). In addition to the current interaction with representatives of the APA and AAIDD, the Subworkgroup will seek feedback (through RFIs and meetings with stakeholder groups) on these changes in definition, as well as on the specific criteria to be proposed for Intellectual Disability in DSM-V.

No. 32
### ADDING DIMENSIONAL ASSESSMENTS OF PSYCHOPATHOLOGY TO PSYCHIATRIC DIAGNOSES: IMPLICATIONS FOR DSM-5

*William Narrow, M.D., M.P.H., Suite 1825, 1000 Wilson Blvd, Arlington, VA 22209*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) understand how patterns of co-occurring DSM-IV-TR categorical diagnoses differ from patterns of co-occurring dimensional symptomatology among psychiatric patients in routine psychiatric practice; and 2) appreciate the clinical utility of dimensional assessments of patient symptomatology in addition to categorical diagnostic assessments.

**SUMMARY:**
Aims: To assess the use of dimensional measures of psychopathology in documenting the clinical status of patients seen in routine psychiatric practice. Methods: Data from a study of Medicare Part D psychiatric patients were analyzed. Psychiatrists randomly selected from the AMA Masterfile provided detailed data on systematically sampled Medicare/Medicaid dual eligible patients (N= 2,941 patients, 67% response). Respondents listed all DSM-IV-TR Axis I and II disorders and rated the severity level of six symptoms on a simple dimensional scale. Results: Depending on the symptom, 94%-97% of psychiatrists provided dimensional ratings of symptom severity in addition to categorical diagnoses. The majority of patients
assessed had moderate to severe anxiety, sleep, and depressive symptoms and a substantial proportion had moderate to severe psychotic, manic and substance use symptoms. The symptom ratings crossed diagnostic boundaries and patients frequently had significant symptoms of other disorders, without the corresponding diagnosis being made. For example, 43% (SE=1.5) of schizophrenia patients had moderate to severe anxiety

symptoms, while 6% (SE=0.7) had an anxiety disorder reported; 34% (SE=1.5) had moderate to severe depressive symptoms, while 3% (0.5) had a depressive disorder reported. Conclusion: The use of dimensional symptom severity measures revealed a more complex characterization of patients' psychopathology than could be identified from categorical diagnoses alone. These findings also suggest that simple dimensional measures
of psychopathology are feasible and potentially useful in routine practice. Plans for dimensional assessments in DSM-V will be discussed.

**REFERENCES:**

1. Kraemer, H.C. (2008). DSM Categories and dimensions in clinical and research contexts. In Helzer, J.E., et al (Eds.). Dimensional Approaches in Diagnostic Classification: Refining the research agenda for DSM-V. (pp. 5 – 17). Arlington, VA: American Psychiatric Association.
2. Helzer, J.E., Witchen, H., Krueger, R. F. and Kraemer, H.C. (2008). Dimensional options for DSM-V: The way forward.. In Helzer, J.E., et al (Eds.). Dimensional Approaches in Diagnostic Classification: Refining the research agenda for DSM-V. (pp. 115 – 127)Arlington, VA: American Psychiatric Association.

No. 33

**NOSOLOGY FOR BEGINNERS: HISTORICAL AND CURRENT PERSPECTIVES ON THE FUNDAMENTAL ISSUES AND PROBLEMS IN THE CLASSIFICATION OF PSYCHIATRIC DISORDERS**

*Avram Mack, M.D., Georgetown University Hospital3800 Reservoir Road NW Kober Cogan 618, Washington, DC 20007*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Identify several issues that are inherent in creating psychiatric nosology; 2) Differentiate the underlying bases of recent attempts at classification; 3) describe ways in which changes in scientific understanding of illness affects classification of psychiatric disorders; and to understand the ideals of the neo-Kraepelinian movement that influenced DSMs III, IIIR, and IV.

**SUMMARY:**

Over the course of the history of medicine, some individual thinkers and medical organizations have attempted to use classification and nomenclature to make sense of the range of normal and abnormal human behavior. Today this is a fundamental task of the profession of psychiatry and the products of this endeavor have far-reaching effects, such as in clinical care, reimbursement, forensic issues, and of course research. This report reviews the history of medical and psychiatric classification in order to highlight the issues and considerations that necessarily arise in the creation or refinement of psychiatric diagnostic definitions and the systems in which they are placed. This includes basic systematic issues, such as: whether disorders are specific to the individual or are part of a regular grouping, "splitting" versus "lumping," etiological versus descriptive (or, "empirical") approaches, theory versus atheoreticity, and categorical versus dimensional approaches. In
addition, psychiatric classification and the caseness of various disorders and the establishment of operationalizable boundaries between normalcy and disease has immense effects on the epidemiology of psychiatric illness and on forensic issues and historical examples of these will be reviewed as well. The energy now being given to revising the DSM highlights the importance of past attempts to make or refine psychiatric classifications and so this report aims to review salient issues that are inherent to this work. The report will
use examples ranging from ancient Greece to Enlightenment France to post-World War II United States to highlight the many facets of psychiatric nosology. Particular attention will be given to the developments of the neo-Kraepelinian movement and the calls to move beyond the current state of classification.

**REFERENCES:**

1. Wilson M. DSM-III and the transformation of American psychiatry: a history. Am J Psychiatry. 1993 Mar;150(3):399-410.
2. First MB, Frances A. Issues for DSM-V: unintended consequences of small changes: the case of paraphilias. Am J Psychiatry. 2008 Oct;165(10):1240-1

**MONDAY, MAY 24, 3:30 PM - 5:00PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 12 – PSYCHOSOMATICS AND CARDIAC VULNERABILITY**

No. 34

**SEX DIFFERENCES IN THE SADHART-CHF TRIAL**

*Jonathan Lee, M.D., DUMC 3837, Durham, NC 27710*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should

be able to recognize differences between women and men with regard to treatment of depression in patients with congestive heart failure.

**SUMMARY:**

Objective: To determine if sex differences exist in baseline characteristics as well as in psychiatric and cardiovascular outcomes among patients who participated in the SADHART-CHF trial.
Background: Depression in heart failure (HF) patients is prevalent and associated with worse prognosis. The recently completed SADHART-CHF trial failed to show that SSRI is superior to placebo in improvement of depression and prognosis in HF patients. Characteristics of sex differences and effects on treatment response are poorly understood.
Method: Sub-analysis of the SADHART-CHF trial based on sex for depression prevalence, treatment response, and prognosis. Results: Among 469 participants, 40.5% were women. Women had higher LVEF (32% vs. 30%); less ischemic cardiomyopathy, coronary artery disease, coronary artery bypass graft surgery, arrhythmia, implantable cardioverter defibrillators, but more permanent pacemakers ($p<0.05$). A greater rate of diabetes was seen in women (56% vs. 46%, $p<0.05$). Although women reported more depressive symptoms on BDI than men (19.24±7.37 vs. 17.86±6.51, $p<0.05$), the observer-rated HDRS showed that there was no statistical significance between women and men (18.68±5.39 vs. 17.99±5.47, p=0.302). After 12 weeks of intervention, women were less likely to remit than men (44% vs. 57%, p=0.026). Neither women nor men benefited more from sertraline than placebo. During long-term follow-up, men and women had similar death rates (28.7% vs. 25.8%). The Cox proportional model demonstrated no difference in survival between men and women (RR: 0.88, 95% CI 0.618-1.260). Nevertheless, women had less cardiovascular (CV) events than men (1.27±1.67 vs. 1.75±2.5, p=0.042).
Conclusions: Women in the SADHART-CHF study had a lower rate of depression remission over 12-week intervention compared to men. However, women had a lower rate of CV events compared to men. Studies to examine sex-based mechanistic differences are needed to better understand these outcomes.

No. 35

**PSYCHOSOMATIC MEDICINE AND THE PHILOSOPHY OF LIFE**

*Michael Schwartz, M.D., 1106 Blackacre Trail, Austin, TX 78746*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize strenghts/limits of reasoning about “mind” and/or “brain;” 2) Understand that BOTH categories are a) Kantian “ideas,” and b) abstract entities; and 3) explore an overarching “idea” - “life” - that provides a robust grounding framework for science and for psychosomatic investigations.

**SUMMARY:**

We suggest for psychosomatic medicine a philosophy of life that surmounts mind-body dualism plaguing Western thought since the origins of modern science in 17th century Europe. Any present-day account of reality must draw upon everything we know about the living and non-living. Since we are living beings ourselves, we know what it means to be alive from our own 1st-hand experience. Therefore, our philosophy of life, in addition to starting with what empirical science tells us about inorganic and organic reality, must also begin from our own direct experience of life in ourselves and in others – and show how the 2 meet in living beings. Since life is ultimately 1 reality, our theory must reintegrate psyche with soma such that no component of the whole is short-changed, neither the objective nor the subjective. Here, we present the essentials of such a theory by clarifying that the defining features of living beings, from the most simple to the human being, emerge as polarities. We describe 3 such polarities: 1) Being vs. non-being: Always threatened by non-being, all organisms must constantly re-assert its being through its own activity. 2) World-relatedness vs. self-enclosure: Living beings are both enclosed with themselves, defined by the boundaries that separate them from their environment, while they ceaselessly reach out to their environment and engaging in transactions with it. 3) Dependence vs. independence: Living beings are both dependent on the material components that constitute them at any given moment and independent of any particular groupings of these components over time. This presentation goes on to discuss, through concrete examples from present-day biology and psychosomatics, importance features of the polarities of life: metabolism; organic structure; enclosure by a semi-permiable membrane; distinction between “self” and “other”; autonomy; neediness; teleology; sensitivity. Even moral needs and values already arise at the most basic levels of life, even if only human beings can recognize such values as moral requirements and develop responses to them. The notion of a philosophy of “life” expresses a new Kantian “idea”, on

a par with the 2 other such "ideas - "psyche" and "soma" - that today dominate scientific discourse. The latter, so long as they are not reified, can continue to be explored, but investigators should be mindful that domains such as "psyche" and "soma" are "abstracted from" more basic and concrete phenomenon of life.

**REFERENCES:**

1. Hans Jonas. The Phenomenon of Life. University of Chicago Press, 1966

No. 36

**BROKEN HEARTS: CARDIOVASCULAR & EMOTIONAL STRESS MEASURES IN RELOCATED KATRINA SURVIVORS**

*Phebe Tucker, M.D., WP 3440 P.O. Box 26901, Oklahoma City, OK 73190*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand: 1)Psychiatric diagnoses and symptoms of depression and PTSD associated with dual exposure to hurricane and relocation; 2)Implications of Autonomic reactivity and heart rate variability differences in survivors; 3)Survivors' differences in pro-inflammatory Interleukin-6, associated with cardiac risk; 4) How cardiovascular stress measures may relate to higher myocardial infarct rate in post-Katrina New Orleans

**SUMMARY:**

Understanding diverse affects of hurricane exposure and forced relocation on the mind and the body is important in helping survivors recover. Methods: We assessed 34 adult Katrina survivors relocated to Oklahoma and 34 matched Oklahoma controls for psychiatric diagnoses (SCID-IV) and symptoms of PTSD (CAPS-I) and depression (BDI), physiologic reactivity to trauma reminders (Biopac Systems, Inc.), pro-inflammatory Interleukin-6 (associated with cardiovascular risk), and power spectral analysis heart rate variability. Participants, assessed 20 months post-disaster, were medically healthy and free of psychiatric and cardiovascular medications. Wilcoxan 2-tailed tests, significant at $p<0.05$, compared groups. Results: PTSD occurred in 35% of survivors and 12% of controls, and survivors had higher PTSD and depression symptoms, within illness ranges. Survivors had significantly higher IL-6 than non-traumatized controls, higher IL-6 in the presence of PTSD and higher baseline heart rates and mean arterial blood pressure reactivity than controls. High lifetime trauma exposure in both groups may have attenuated some autonomic and cytokine differences, pointing to sociodemographic factors' contributions to stress. HR variability showed robust group differences. Survivors had lower normalized protective parasympathetic (HF) activity at baseline and with trauma cues, and higher baseline sympathetic (LF/HF) activity with a flattened response compared to controls. Importance: Results showing the hurricane's impact on cardiovascular stress measures associated with increased cardiac health risks are discussed, relating these findings to increased myocardial infarct rates in New Orleans after Katrina.

**REFERENCES:**

1. Cohen H, Kotler M, Matar MA, Kaplan Z, Loewenthal U, Miodownik H, Cassuto Y: Analysis of heart rate variability in posttraumatic stress disorder patients in response to a trauma-related reminder. Biol Psychiatry 1998; 44(10):1054-1059.

**SCIENTIFIC AND CLINICAL REPORT SESSION 13-ADDICTIVE BEHAVIOR**

No. 37

**DISPARITIES IN SUBSTANCE ABUSE PREVALENCE: IS IT TIME TO STRATEGIZE AND REFOCUS?**

*Deepak Prabhakar, M.D., M.P.H., 22200 Green Hill Road #106, Farmington Hills, MI 48335*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify disparities in substance abuse prevalence and access to services for adolescents. 2) Recognize the importance of identifying age and culture specific programs in order to have maximum impact on the substance related issues in adolescents.

**SUMMARY:**

Objective: Substance abuse is associated with some of the leading cause of mortality among adolescents such as unintentional injuries, homicide and suicide. It has long been considered a source of considerable morbidity and leads to major loss of productive days in an individual's life. This research reports Adolescent Substance Abuse prevalence data for the seven-county North Texas region, in an effort to describe existing disparities among adolescents as compared to adults. Methods: Data from Office of Applied Studies, National Survey on Drug Use and Health (NSDUH) for the seven-county North Texas region served by NorthSTAR for the time period 2002

to 2005 were used. Z test of significance was employed to compare adolescents with adults. Results: Among adolescents, 9.7% report past month use of illicit drugs, which is significantly higher compared to 5.5% for adults (p-value 0.003). Also among adolescents, 5.2% report use of illicit drugs other that Marijuana, this is significantly higher, compared to 2.7% for adults (p-value 0.014). Additionally, 11.9% of adolescents report use of Marijuana for past month, which is significantly higher than 7.2% of adults (p-value 0.003), and 4.2% of adolescents needed but did not receive treatment for their substance abuse needs, which is significantly higher compared to 1.7% of adults (p-value 0.002). Conclusions: There is a great disparity in substance abuse prevalence and treatment trends among adolescents when compared to adults, and we recommend use of age-appropriate and culturally congruent programs in order to deal with this problem.

**REFERENCES:**

1. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006b). National Survey on Drug Use and Health, 2002. (2006). Retrieved October 30, 2007 from http://www.oas.samhsa.gov/2k2State/html/appA.htm#taba.20
2. Texas Department of State Health Services. (2006). Comprehensive Mental Health Plan for the State of Texas. (2006). Texas Department of State Health Services: Austin, TX

No. 38

**PATHOLOGICAL GAMBLING: AN IMPULSE CONTROL DISORDER? MEASUREMENT OF IMPULSIVITY THROUGH NEUROCOGNITIVE TESTS**

*Pinhas Dannon, M.D., Beer Yaacov 1, Beer Yaacov, 70350 Israel*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand how to
diagnose and categorize Pathological Gambling.

**SUMMARY:**

Pathological Gambling (PG) is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and in the International Classification of Disease (ICD-10) as an impulse control disorder. Yet the association between impulsivity and pathological gambling remains a matter of debate. Some researchers find high levels of impulsivity within pathological gamblers while others report no difference in impulsivity of pathological gamblers versus controls, and yet others even suggest that impulsivity in PGs is lower than in controls. Various neurocognitive tests are available for the assessment of impulsivity. In order to explore the relationship between impulsivity, pathological gambling and neurocognitive tasks we conducted a pub-med, ovoid and med-line research. The neurocognitive tests we have found to be performed on pathological gamblers include the Stroop task, the Stop Signal Task (SST), the Matching Familiar Figures Task (MFFT), the Iowa Gambling Task, the Wisconsin Card Sorting Test, the Tower of London (TOL) and the Continuous Performance Test (CPT). The results of the above tests demonstrated, in various PG groups, less impulsivity in gambling behavior.

**REFERENCES:**

1. Kertzman S, Lowengrub K, Aizer A et al. Stroop performance in pathological gamblers.
Psychiatry Res 2006; 142(1):1-10.

No. 39

**QUITTING CANNABIS USE WITHOUT FORMAL TREATMENT IN ADULTS**

*David Gorelick, M.D., Ph.D., NIDA IRP, Baltimore, MD 21224*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize individuals more likely to successfully quit cannabis use without formal treatment; and 2) Identify coping strategies that help individuals quit cannabis use without formal treatment.

**SUMMARY:**

Background: Epidemiological data suggest that most adult cannabis users quit without formal treatment. Methods: We collected retrospective self-report data by computer-administered questionnaire from a convenience sample of 419 community-living adults (59.4% men, 79.0% African-American, 6.0% Hispanic) who had made at least one quit attempt without formal treatment while not in a controlled environment and had used cannabis at least weekly for 6 months beforehand. Results: Subjects were 27.5 (8.9) years old (range 15-64 years) at the start of their quit attempt and had been using cannabis for 12.8 (8.7) years. They used cannabis 27.5 (9.8) days in the prior month, averaging 9.0 (10.7) joints daily; 41.3% had little or no confidence that they would succeed. The most frequently reported reasons for quitting were to show themselves that they could quit (21.5%) and to avoid a bad example for children (19.8%). The index quit attempt

lasted 333 (979) days (median 61). The most frequently reported coping strategies were not associating with cannabis users (18.1%), family encouragement (15.3%), and prayer or other religious support (10.3%). Subjects who maintained abstinence until the time of interview (16.0%) were older and used less often prior to quitting than those who relapsed. Longer duration of quit attempt was associated with white race, Hispanic ethnicity, and smoking of joints rather than blunts. No other variables were significantly associated with success of the quit attempt. Conclusions: These findings suggest that "spontaneous" quitting (i.e., without formal treatment) of regular cannabis use by adults can be difficult, and that such quitters use coping strategies similar those quitting alcohol or tobacco use.

Acknowledgement: Supported by the Intramural Research Program, NIH, NIDA and NIDA Residential Research Support Services Contract HHSN271200599091CADB.

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**TUESDAY, MAY 25, 9:00 AM - 10:30AM**

## SCIENTIFIC AND CLINICAL REPORT SESSION 14- ANXIETY DISORDERS

No. 40

### THE LONG-TERM TREATMENT OF OBSESSIVE COMPULSIVE DISORDER

*Afia Sadiq, M.D., 914 48th Street, Brooklyn, NY 11219*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe factors that enhance the prophylactic effect of psychotropic medication in the long-term management of OCD

**SUMMARY:**

Introduction: While the utility of medication in the acute treatment of adult obsessive-compulsive disorder (OCD) has been well-established, the role of maintenance therapy has not been as well studied. The purpose of this study is to examine the efficacy of long-term treatment for, and predictors of stability in medicated patients with, adult OCD. Method; We evaluated retrospectively 103 OCD patients who responded to acute treatment in a naturalistic clinic setting. These patients were treated acutely, on an open basis, for 10-12 weeks and responded to treatment. Each patient was evaluated by Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) at baseline and after acute treatment. Response was defined as = 35% decrease in Y-BOCS score and a final score of £ 15 55 males and 48 females (age range 19-74) with OCD were studied for up to 92 months, until they had a relapse, or until they dropped out of the study well, whichever came first. Results: 38% of the patients relapsed within the study period. 62% were prescribed an SSRI, 16% were prescribed an SSRI plus a Benzodiazepine, 12% were prescribed Anafranil, and 10% were prescribed Anafranil plus a Benzodiazepine. 37% of the patients received CBT, 32% were diagnosed with a personality disorder, and 26% were being treated for OCD for the first time. The median survival time for the sample was 72 months. Gender, medication, CBT, or first episode was not related to the length of stability prior to relapse. However, patients with a personality disorder were significantly more likely to relapse (58%) than were patients without a personality disorder (29%), Chi-square = 8.02, p = .005, and they had significantly shorter periods of stability prior to a relapse (44 months) in comparison to patients without a personality disorder (80 months), p = .028. Patients who relapsed had significantly higher anxiety scores on the Y-BOCS before and after medication stabilization and showed significantly less improvement on the Y-BOCS than patients who did not relapse (p = .01 to <.001). They also had significantly higher anxiety and depression scores on the day they started prophylaxis (p <.001) than patients who did not relapse. Conclusions- The presence of personality disorders along with higher Y-BOCS, depression and, anxiety scores led to quicker relapse

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No. 41

### ACUTE TREATMENT OF PANIC DISORDER WITH CLONAZEPAM OR PAROXETINE: A RANDOMIZED NATURALISTIC OPEN STUDY

*Antonio Nardi, M.D., Ph.D., Laboratory of Panic &*

*RespirationFederal University of Rio de JaneiroR Visconde de Piraja 407/702Rio de Janeiro RJ22410-003Brazil, Rio de Janeiro, 22410003 Brazil*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Analyze the similarities and differences of an acute term treatment with clonazepam monotherapy or paroxetine monotherapy; and 2) Recognize the dose, main side effects, and response profile of each drug.

**SUMMARY:**

Objective: to describe in a prospective, randomized, rater blinded, study the therapeutic response to clonazepam (Cl) or paroxetine (Par) during an open 8-week treatment of panic disorder (PD). Methods: A total of 120 PD (DSM-IV) outpatients were treated for 8 weeks with Cl (1.0± 0.1 mg/day at Bl;1.9 ± 0.2 mg/ day) or Par (11.0± 2.6 mg/day at Bl 34.0 ± 9.8 mg/ day) and analyzed Intent To Treat, LVCF. AE and efficacy parameters (CGI- S and CGI-I, No of panic attacks (PA), and HAMA) were recorded at baseline, after 1 2, 4, 8 weeks. Results: Baseline characteristics of Cl and Par were similar. Cl had a faster response with a significant difference in weeks 1 and 2 for CGI-Improvement and for HAMA. After 2 weeks the CGI-I was for Cl 2.2 ± 1.0 and 2.7 ± 1.2 for Par (p=0.003); and the HAMA was for Cl 11.1 ± 3.4 and 12.7 ± 4.3 for Par (p=0.003). After the first-month of treatment the Cl group had a slightly greater decrease (p = 0.03) in the number of PA (5.4 ± 1.7 PA/month) than the Par group (5.3 ± 2.8 PA/month). After two month of treatment both groups showed similar efficacy in the scale scores, and in the reduction in PAs. More
patients under Par had AE (95% vs 73%, p=0.001). The most common adverse events during treatment were drowsiness/fatigue*, sexual dysfunction*, memory/ concentration difficulties, nausea/ vomiting*, appetite/ weight change*, dry mouth*, excessive sweating*, diarrhea/ constipation*, shaking/trembling*, tremor*, and weakness. (*= significantly more frequent under Par). Conclusion: Cl had a faster response than Par in PD, but after 8 weeks of treatment the two drugs gave equivalent response. Monotherapy of Cl and Par over 8-weeks resulted for the majority of patients in a clear and stable improvement of PA. The patients using Cl had significantly less side effects than the Par group. Acknowledgements: Brazilian Council for scientific and technological development (CNPq). INCT Translational Medicine (CNPq).

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No. 42

**RECURRENCE OF PANIC ATTACKS FOLLOWING MEDICATION DISCONTINUATION**

*Svetoslav Hristov, M.D., 914 48th Street, Brooklyn, NV 11210*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the probability of recurrent panic attacks upon medication discontinuation; and 2) Assess the factors associated with probability of less chance of recurrence upon medication discontinuation.

**SUMMARY:**

Introduction- Panic disorder is very disabling requiring medication and/or CBT acutely and long term. The goal of this paper is to examine in a naturalistic population length of stability for panic disorder off medication and factors that effect this stability Method- 122 patients with panic disorder seen were studied retrospectively in the present analyses evaluating the hazard of having a panic attack for four different treatment groups (i.e. antidepressant treatment (N = 35, 29%), antidepressant plus CBT (N = 38, 31%), combination medication treatment-antidepressant + benzodiazepine (N = 27, 22%), and combination medication plus CBT (N = 22, 18%) given while stable (before discontinuation. A total of 72 females (59%) and 50 males (41%) were followed until they had a panic attack (range 12 – 72 months). Results-The median length of stability without a panic attack was 36 months for the antidepressant group, 24 months for the combination medication group, 30 months for the antidepressant plus CBT group, and 36 months for the combination medication plus CBT group. Covariates studied among others were gender, severity of initial symptoms, presence or absence of agoraphobia, and level of functional impairment. Controlling for covariates, patients receiving combination medication treatment before medication discontinuation had an increased hazard of having a panic attack off medication vs. patients receiving antidepressant medication only 2.06 (CI 1.14 – 3.71). In other words, when patients with panic disorder did not receive CBT, the hazard of having a panic attack

was 105.5% higher in patients taking combination therapy compared to patients taking antidepressant medication. There were no other differences between treatment groups. Conclusion-Following discontinuation of medication from successfully treated panic disorder patients remained stable for approximately 30 months with length of prior stability and treatment with CBT leading to a better outcome off medication.

**REFERENCES:**

1. Bakker A, van Balkom AJ, Stein DJ. Evidence-based pharmacotherapy of panic disorder. Sep;8(3):473-82.

**TUESDAY, MAY 25, 11:00 AM - 12:30PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 15 - INFORMATION TECHNOLOGY**

No. 44

**PSYCKES: WEB-BASED ACCESS TO MEDICAID DATA TO SUPPORT THE IMPLEMENTATION OF BEST PRACTICES IN PHARMACOTHERAPY IN A LARGE SCALE QUALITY**

*Matthew Perkins, M.D., M.P.H., 1051 Riverside Dr, New York, NY 10032*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the different kinds of clinically relevant information that are stored in Medicaid claims data; 2) Understand how PSYCKES aggregates clinical information stored in administrative databases to support clinical decision making and quality improvement; 3) To learn about the feasibility and impact of providing near real time access to Medicaid data to clinicians and quality improvement staff.

**SUMMARY:**

Objective: The NYS Office of Mental Health (OMH) has implemented PSYCKES, a web-based platform for sharing Medicaid data in the context of a state quality improvement (QI) initiative. PSYCKES currently contains two indicator sets: psychotropic polypharmacy (PPI), and cardiometabolic (CMI). It profiles performance and provides HIPAA-compliant access to client level data. The purpose of this study was to assess the feasibility of conducting a large-scale clinic-based QI initiative supported by web-based data sharing,
and to examine the impact of project on prescribing practices. Methods: Participation in the PSYCKES-QI was offered to mental health clinics (n=302) and state-operated clinics (n=61). Participating clinics selected one of two QI projects (CMI or PPI), to use PSCYKES to identify patients meeting criteria for PPI, or CMI, and to implement a QI program. Process measures were participation rates, attendance at training, PSYCKES access and use, and use of technical assistance resources. Primary outcomes were percent of outliers identified and percent of these in which medications were changed resulting in the patient no longer meeting outlier criteria. Results: Participation of freestanding clinics was 92%. Use of technical assistance resources included: 986 participants at 21 Webinars, 129 prescribers completed a web-based CME course, 326 help desk calls, and 10 clinic consultations. Nine months in to the project, clinics selecting PPI identified 3179 positive cases and changed medication regimens for 522 (16%) so that they no longer met PPI criteria. Clinics selecting CMI identified 1217 positive cases and changed antipsychotic medications in 260 (21%) so that they no longer met CMI criteria. Clinics selecting both PPI and CMI identified 169 positive cases and changed 51(30%). Overall, 12% of clinics were able to change more than 50% of their positive cases, 15% changed between 30% and 49%, 39% changed between 10% and 29% and 31% of clinics changed less than 10% of their positive cases. Conclusions: Providing web-based access to Medicaid claims data to psychiatrists in mental health clinics as part of a quality improvement initiative can result in decreased rates of polypharmacy and decreased use of antipsychotics with moderate to high cardiometabolic risk in patients with cardiometabolic conditions.

No. 45

**INTERNATIONAL TELEPSYCHIATRY IN CROSS-CULTURAL RELATED MENTAL HEALTH CARE**

*Davor Mucic, M.D., Havneholmen 82, 5th, Copenhagen V, 1561 Denmark*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize alternatives to
interpreter provided care in cross-cultural settings. The results of the survey may contribute
to changes in policy and routines within mental health services towards cross-cultural patient
population both in Europe and worldwide.

**SUMMARY:**

Introduction: Since early nineties, Denmark faced significant

barriers in providing mental health service towards refugees and migrants on their respective mother tongue. In the country with only few clinicians of other ethnic origin than Danish, the most of the treatment of refugees and migrants is provided via interpreters. International telepsychiatry service was established between Denmark and Sweden in order to increase access to cross-cultural expertise that was more readily available in Sweden. Methodology: Over a period May 2006–October 2007, 30 patients were treated by telepsychiatry (21 men and 9 women). The total number of telepsychiatry sessions provided over the period of 1.5 years was 203 (range 1–22; average 6.8 sessions per patient). After the end of the telepsychiatry contact all patients were asked to complete a satisfaction questionnaire. Video-conferencing equipment connected the Swedish department of the Little Prince Psychiatric Centre with two hospitals, one asylum seekers' centre and one social institution, at four different places in Denmark. Results:Patients reported a high level of acceptance and satisfaction with telepsychiatry, as well as a willingness to use it again or recommend it to others. Patients expressed a wish to use telepsychiatry via their mother tongue, rather than through an interpreter in the future. Perceived advantages: direct contact via mother tongue that allowed them to express exactly what they wanted to and no need for travel in order to meet a doctor who speaks the same language. Discussion: There is no doubt that direct contact with the patient is preferable in almost all settings within mental health care. However, when the contact is interpreter-assisted or is preceded by long waiting times or the need to travel, then telepsychiatry may be the tool of choice. The restricted physical contact and non-verbal communication of telepsychiatry was compensated by communication via mother tongue between where the doctor and the patient had similar cultural and national references. Conclusion: Mentally ill asylum seekers, refugees and migrants are under-served in their mother tongue. The telepsychiatry project was the first to serve such a specific patient populations. Furthermore, it was the first international telepsychiatry collaboration established in Europe [1].The results of the survey may contribute to changes in policy and routines within cross-cultural related mental health services worldwide.

**REFERENCES:**

1. Mucic D : "International Telepsychiatry, patient acceptability study". J Telemed Telecare 2008; 14:241-243.

## SCIENTIFIC AND CLINICAL REPORT SESSION 16- SIDE EFFECTS OF PSYCHOTROPIC MEDICATION

No. 46

### RISK OF LOW BONE MINERAL DENSITY ASSOCIATED WITH PSYCHOTROPIC MEDICATIONS AND MENTAL DISORDERS: A POPULATION-BASED ANALYSIS

*James Bolton, B.S.C., M.D., PZ430-771 Bannatyne Ave, Winnipeg, R3E 3N4 Canada*

**EDUCATIONAL OBJECTIVES:**

After the presentation, the participant should be able to: 1)Understand that selective serotonin reuptake inhibitors and atypical antipsychotics are independently associated with risk of low bone mineral density; 2) Appreciate that use of lithium and tricyclic antidepressants is associated with reduced risk of osteoporosis, suggestive of a protective effect on bone structure; and 3) Recognize that certain mental disorders (dementia, schizophrenia) are risk factors for low bone mineral density.

**SUMMARY:**

Objective: Independent reports suggest that various psychotropic medications and psychiatric disorders are associated with changes in bone mineral density (BMD) and fracture risk. The objective of this study was to clarify the independent effects of a range of mental illnesses and psychotropic medications on BMD. Methods: Adult patients with baseline BMD measured by dual-energy X-ray absorptiometry (DXA) were identified in a database containing all clinical DXA test results for the Province of Manitoba, Canada. Records were linked with population-based administrative health databases to provide detailed information on sociodemographic factors, mental disorders, and prescription medication usage. Osteoporotic cases (N=7,994) were matched on age, sex, and ethnicity to three controls with normal BMD (N=23,928). Multivariable conditional logistic regression compared cases and controls on diagnosed mental illnesses (depression, schizophrenia, dementia, alcohol and drug use disorders) and use of psychotropic medications (selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], other antidepressants, lithium, other mood stabilizers, typical antipsychotics, atypical antipsychotics, and benzodiazepines). Results: SSRIs (adjusted odds ratio [AOR] = 1.29; 95% confidence interval [CI] 1.14-1.47) and atypical antipsychotics (AOR = 1.44; 95% CI 1.06-1.95) were associated with higher risk for osteoporosis. TCAs (AOR = 0.65; 95% CI 0.58-0.72) and lithium (AOR = 0.49; 95% CI 0.26-0.92) were negatively associated with osteoporosis, suggesting a

protective effect on bone structure. These drug effects were independent of the risk of low BMD observed in specific mental disorders including dementia (AOR = 1.34; 95% CI 1.04-1.71) and schizophrenia (AOR = 2.17; 95% CI 1.26-3.75). Conclusions: Some psychotropic medications are associated with a risk of low BMD, whereas others seem protective, and these effects are independent of mental illness diagnoses. Clinicians should consider these effects when prescribing in populations at risk for osteoporosis.

No. 47

## METABOLIC SYNDROME IN PSYCHIATRIC INPATIENTS: THE ROLE OF VALPROATE AND LITHIUM

*Bonnie Szarek, R.N., INSTITUTE OF LIVING 200 RETREAT AVENUEHARTFORD, CT 06106, Hartford, CT 06106*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the variables associated with MetS in psychiatric patients, including those specifically associated with VPA and Li exposure, and 2) discuss the contributions to MetS of variables other than pharmacotherapy.

### SUMMARY:

Objective: To determine the contribution of valproate (VPA) and lithium carbonate (Li) to metabolic syndrome (MetS). Methods: Subjects were all patients (18-59) discharged from the study site 4/05-6/08, treated with VPA, Li, or atypical antipsychotics (AP) who had documented MetS assessments (n=2,342). Each patient was classified as receiving (1) VPA, (2) Li, (3) AP, or (4) >1 of these. Logistic regressions examined the associations of MetS (defined by the five ATPIII criteria) with these medications and with other selected clinical variables. Results: Neither Li nor VPA was associated with an increased risk on any metabolic measure; patients on VPA were at lower risk of having =1 of the 5 MetS criteria (OR=0.60). For many of the criteria, increased risk was associated with a diagnosis of schizoaffective disorder (SA) (ORs=1.30-1.70), with race (Latino, ORs=1.31-1.47), with female gender (waist circumference, OR=3.07; blood pressure, OR=1.46; HDL, OR=1.31) and age. Patients 39-59 were more than twice as likely to have MetS (OR=2.41) and FBS (OR=2.48) and seven times more likely to have a diagnosis of hypertension (OR=7.32). Conclusions: Li and VPA have long been associated with weight gain and are commonly used, but few studies have specifically examined their association with MetS. This study found no association for either drug with any MetS measure, other than a possible protective effect of VPA. SA, but not schizophrenia, was associated with an increased risk for MetS that is not explained by pharmacotherapy, co-diagnosis, or demographic variables.

No. 48

## A NOVEL, PATIENT-RATED SCALE FOR SIDE EFFECTS: PROSPECTIVE PROOF-OF-CONCEPT STUDY

*Rajnish Mago, M.D., 833 S Chestnut St East, Suite 210 E, Philadelphia, PA 19107*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the uses and limitations of different methods of assessing patients for side effects of antidepressants; 2) Appreciate the key role of assessment of the causal relationship of the symptoms present to the medication; and 3) Recognize the potential usefulness of a self-report tool in assisting physician assessment of side effects

### SUMMARY:

Background: Methods to evaluate side effects (SEs) of medications are significantly underdeveloped compared to those for efficacy. Patient-rated inventories of symptoms identify too many symptoms, most of them not SEs. Clinician-rated scales for SEs are too time-consuming and lack standardized assessment of whether symptoms are SEs. We are developing a patient-rate scale to both identify symptoms present and to assess the likelihood that they are SEs. Methods: A symptom inventory (based on the Systematic Assessment For Treatment-Emergent Events-Specific Inquiry) and rating of severity of symptoms present were completed before starting a medication (usually an antidepressant) and two weeks later. For each symptom present, patients completed our Scale for Assessment of Side effects (SAS) causal algorithm. Patients were also asked a standard open-ended question about any SEs. A psychiatrist (blinded to patients' rating) classified the symptoms as "Possible," "Probable," or "Unlikely" SEs (based on the Adverse Drug Reaction Probability Scale and additional interview). Classification of symptoms by SAS and the psychiatrist ("gold standard") were compared. Results: A random sample of 193 symptoms from 15 patients was evaluated. The open-ended question identified only 33.3% of Possible/Probable SEs (Sensitivity), though 82.8% of symptoms identified on open-ended questioning were Possible/Probable SEs (Positive Predictive Value). Only 37.3% of symptoms

present on the inventory were Possible/Probable SEs. Also, 51% of symptoms that appeared or got worse after the medication were Unlikely SEs. SAS correctly identified 90.3% of the Possible/Probable SEs, and 97.5% of the Probable SEs (Sensitivity). SAS correctly ruled out 83.6% of Unlikely SEs (Specificity). Negative Predictive Value of SAS was 91.7%. Discussion: Open-ended questions miss the majority of symptoms that may be SEs. Symptom inventories elicit too many symptoms, most of which are not SEs. Half of the "treatment-emergent" symptoms are unlikely to be SEs. SAS ruled out very few Possible/Probable SEs, but ruled out many symptoms that are were Unlikely SEs and could make symptom assessment by the physician manageable. SAS may be a valid, standardized, and practicable scale for SEs to aid assessment of SEs in clinical practice and research.

Supported in part by a NARSAD Young Investigator Award 2008

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**TUESDAY, MAY 25, 1:30 PM - 3:00PM**

## SCIENTIFIC AND CLINICAL REPORT SESSION 17-- WEIGHT GAIN AND PSYCHIATRIC ILLNESS

No. 49

### BIOCHEMICAL RISK FACTORS FOR DEVELOPMENT OF OBESITY IN FIRST-EPISODE SCHIZOPHRENIA

*Robert Bodén, M.D., Ulleråkersv 21, Uppsala, s-750 17 Sweden*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize that weight gain
during the first five years of schizophrenic illness is substantial and that the development of
obesity can be predicted by easily obtained routine biochemistry variables.

**SUMMARY:**

Obesity is a serious health issue for many patients with schizophrenia. There is a lack of predictors for and understanding of the development of obesity in the early phase of the illness. Therefore we investigated a set of routine biochemistry variables in blood as predictors of the development of obesity and weight gain over 5 years in an observational cohort study of patients with first-episode schizophrenia (n=59). Seven patients were obese at baseline and 22 were obese at the 5-year follow-up. The mean body mass index (BMI) change over 5 years was a 4.1 kg/m2 increase (4.5 SD). Obesity was predicted by baseline hemoglobin levels (odds ratio per standard deviation [OR/SD] 3.3, 95% confidence interval [CI] 1.4 to 7.5), red blood cell count (OR/SD 2.6, 95% CI 1.2 to 5.5), hematocrit (OR/SD 2.8, 95% CI 1.3 to 5.9), ?-glutamyltransferase (OR/SD 2.8, 95% CI 1.2-6.3) and creatinine (OR/SD 3.1, 95% CI 1.2 to 8.0). After adjustment for baseline BMI, the associations were attenuated for ?-glutamyltransferase and creatinine. Low baseline BMI was associated with
a greater BMI increase. The major conclusion is that easily available routine biochemistry markers can be useful in predicting the development of obesity in first-episode schizophrenia. The mechanisms underlying the observed associations are unknown, but the predictors identified in this study could signify dehydration or insulin resistance. These observations open a new window to future research on the mechanisms underlying the development of obesity in schizophrenia.

No. 50

### RELATIONSHIP BETWEEN CHOLESTEROL LEVELS AND COGNITIVE FUNCTION IN PATIENTS WITH SCHIZOPHRENIA RANDOMIZED TO CLOZAPINE, OLANZAPINE AND HALOPERIDOL

*Menahem Krakowski, M.D., Ph.D., Nathan Kline Institute for Psychiatric Research140 Old Orangeburg Road, Orangeburg, NY 10962*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the relationship between cholesterol levels and various domains of cognition in schizophrenic patients; and 2) Understand how the relationship between cholesterol levels and cognition is modified with different antipsychotic medications

**SUMMARY:**
OBJECTIVE: A negative relationship between cholesterol levels and various cognitive measures has been reported in the literature. The goal of this study was to assess the relationship between change in serum cholesterol levels and change in cognitive performance in patients with schizophrenia randomized in a double-blind study to clozapine, olanzapine and haloperidol, and to see whether this relationship varied in each of the 3 medication groups. METHOD: 82 patients with fasting cholesterol levels as well as full cognitive assessments at baseline and endpoint were included in these analyses: 30, 30 and 22 in the clozapine, olanzapine, and haloperidol groups respectively. They were administered a battery of tests assessing psychomotor function, general executive function, visual and verbal memory, and visuospatial ability. A general cognitive index (GCI) was derived from this battery. Psychiatric symptoms and side effects were also assessed. RESULTS: The analyses indicated a significant overall association between decrease in cholesterol and worsening GCI in the total group of subjects after controlling for relevant covariates (ANCOVA F=13.3, df=1,81; p=.0005). Post-hoc analyses indicated that this relationship was statistically significant in each of the 3 medication groups, but most pronounced in the haloperidol group. In that group, LS Means indicated that a clinically significant decrease in cholesterol (2 SD units) was associated with impaired cognitive performance, especially in tests of psychomotor function, verbal memory, and attention (all p values <.01). CONCLUSIONS. Decreased serum cholesterol in schizophrenia patients is significantly associated with cognitive impairment in all patients. This association varied with treatment. This cholesterol decrease may impair cognition through reduction in cholinergic and serotonergic transmissions. These findings have important implications for future research regarding cognitive treatments for schizophrenia.

**REFERENCES:**

1. Elias PK, Elias MF, PhD, D'Agostino RB et al. Serum Cholesterol and Cognitive Performance in the Framingham Heart Study. Psychosomatic Medicine 2005; 67:24-30

No. 51

**OATMEAL VS. DONUTS: TREATING METABOLIC SYNDROME/OBESITY USING CBT/DBT IN AN INNER CITY SPMI POPULATION**

*Joanne Caring, M.D., Metropolitan Hospital Center, 1901 First Avenue, New York, NY 10029*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to learn some effective methods to foster weight loss and exercise in this population.

**SUMMARY:**
Objective: The problems of obesity, metabolic syndrome, and diabetes in the Latino and African-American S.P.M.I. population are well known, complex, and difficult to treat. The team implemented a comprehensive protocol to improve body mass index and increase exercise in this population. Methods: We initiated a Quality Improvement Study in 2005 in compliance with the N.Y.C. Department of Health and Mental Hygiene's mandate for ongoing quality assurance. This is a report on data at 36 months in a Quality Improvement Study in an inner city S.P.M.I. Continuing Day Treatment Program. All patients with a B.M.I.>30 were included in the Quality Improvement Study. In Phase I there were 33 clients and in Phase II there were 31 clients. We developed a comprehensive prospective program to promote healthy eating habits, weight loss, and increased exercise. Our interventions were based on and informed by C.B.T., D.B.T., and adherence techniques. Results: In Phase I (months 1-21) 66.6% (n=22) of clients lost weight. In Phase II (months 21-38) 67% (n=27) of clients lost weight. Due to the natural client turnover during the 38 months of the study, Phase I and II each encompassed somewhat different individual clients. For the clients who participated from 2005 to 2009 (n=16) 50% (n=8) of clients lost weight and 69% (n=11) lost weight, maintained weight, or gained 7 pounds or less. There was a five-fold increase in exercise session participation.Conclusion: Treating obesity and increasing exercise are well documented global public health issues. Few effective protocols exist for treating obesity in the S.P.M.I. population. That these clients lost weight indicates that effective interventions can produce results even in this population. These interventions may help decrease the risk and incidence of diabetes and cardiovascular disease in the S.P.M.I..

**REFERENCES:**

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**SCIENTIFIC AND CLINICAL REPORT SESSION 18-SUICIDES**

No. 52

## THE RELATIONSHIP BETWEEN ANXIETY DISORDERS AND SUICIDE ATTEMPTS: FINDINGS FROM THE NATIONAL EPIDEMIOLOGIC SURVEY ON ALCOHOL AND RELATED CONDITIONS

*James Bolton, B.S.C., M.D., PZ430-771 Bannatyne Ave, Winnipeg, R3E 3N4 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the relationship between anxiety disorders and suicide attempts; 2) Recognize that posttraumatic stress disorder and panic disorder are independently associated with increased risk of suicide attempts; and 3)Understand the importance of comorbidity in the relationship between anxiety disorders and suicide attempts.

**SUMMARY:**

Objective: Previous work has suggested that the presence of anxiety disorders is associated with suicide attempts. However, many studies have been limited by lack of accounting for other factors that could influence this relationship, notably personality disorders. The aim of the current study is to examine the relationship between anxiety disorders and suicide attempts, while accounting for important comorbidities, in a large nationally representative American sample. Methods: Data came from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Wave 2. Face-to-face interviews were conducted with 34,653 adults between 2004 and 2005 in the United States. The relationship between suicide attempts and anxiety disorders (panic disorder, agoraphobia, social phobia, specific phobia, generalized anxiety disorder, posttraumatic stress disorder [PTSD]) was explored using multivariate regression models controlling for sociodemographic factors, Axis I and Axis II disorders. Results: Among individuals reporting a lifetime history of suicide attempt, over 70% had an anxiety disorder. Even after adjusting for sociodemographic factors, Axis I disorders and Axis II disorders, the presence of an anxiety disorder was significantly associated with having made a suicide attempt (AOR=1.70, 95% CI: 1.40-2.08). Panic disorder (AOR=1.31, 95% CI: 1.06-1.61) and PTSD (AOR=1.90, 95% CI: 1.57-2.31) were independently associated with suicide attempts in multivariate models. Conclusion: Anxiety disorders, especially panic disorder and PTSD, are independently associated with suicide attempts. Clinicians need to carefully assess suicidal behavior among patients presenting with anxiety problems.

No. 53

## RELIGION, SPIRITUALITY AND RISK OF SUICIDAL IDEATION AND ATTEMPTS: AN EPIDEMIOLOGICAL PERSPECTIVE

*Daniel Rasic, B.S., M.D., 1573 Vernon St, Halifax, B3H 3M8 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize the longitudinal relationship between religion, spirituality and suicidal ideation and attempts; 2) Appreciate the role of social supports in this relationship; and 3) Recognize the limitations in measuring spirituality and religion.

**SUMMARY:**

Background: Religious worship attendance is associated with decreased rates suicide attempts in cross sectional surveys. Less is known about the relationship between spirituality and suicide attempts. There is a paucity of data examining the longitudinal relationships between religion, spirituality, suicidal ideation and attempts in epidemiologic studies. Few studies have examined the influence of social supports on these relationships. Methods: Data were drawn from waves 3 and 4 of the Baltimore Epidemiological Catchment Area survey (n=1,071). Multiple logistic regression analysis was used to determine the association between baseline religious worship attendance, self perceived spirituality and subsequent onset suicidal ideation and attempts. Regressions were adjusted to remove the effects of sociodemographic factors and social supports. Results: Those who attended religious services at least once/year were less likely to have a subsequent suicide attempts in longitudinal analysis (adjusted odds ratio=0.22, 95% confidence interval: 0.07-0.67) after adjusting for sociodemographic factors and social supports. There were no significant relationships between religious attendance and suicidal ideation or self-perceived spirituality and suicidal ideation or suicide attempts. Conclusion: These findings suggest that baseline religious attendance is a protective factor against suicide attempts. The effects of social supports do not account for this relationship.

**REFERENCES:**

1. Rasic, D., Belik, S., Elias, B., Katz, L., Enns, M., Sareen, J., Swampy Cree Suicide Prevention Team, 2009. Religion, Spirituality and Suicidal Behavior in a Large Community Sample. Journal of Affective Disorders. 114, 32-40.

No. 54

**A MULTI-SITE REVIEW OF POST-DISCHARGE SUICIDES**

*Virginia L. Susman, M.D., New York Presbyterian Hospital, Westchester Division, 21 Bloomingdale Road,, White Plains, NY 10605*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand current trends regarding post-discharge suicide rates and potential contributing demographic, diagnostic and treatment factors. Participants will be able to utilize these considerations in assessing suicide risk potential at discharge and in devising aftercare programs and individualized treatment planning for at-risk patients

**SUMMARY:**

Preventing suicide is a public health priority. In 1995, The Joint Commission (TJC) mandated reporting of sentinel events; since then inpatient suicide has been the second most frequently reported. In 2007, TJC made assessment of suicide risk National Patient Safety Goal 15. Concurrent with greater focus on preventing inpatient suicide, there is debate about whether the post-discharge suicide rate is decreasing or increasing. On one hand, advances in antidepressant safety and availability may be decreasing rates. On the other, shortened lengths of stay and discharging patients who are still symptomatic, could be "shifting" suicides to the post-discharge period. The Ivy League Consortium previously pooled data and reported on inpatient suicides and potentially lethal attempts occurring between 2002-2007 (3 suicides, 0.002% rate; 117 attempts, 0.076% rate). Our 6 facilities now report on the post-discharge suicide rate among the same cohort of 153,522 admissions. Our results likely underestimate the actual suicide rate as some deaths were reported as accidents, and there may have been additional unreported deaths. Nonetheless, the number of suicides and probable suicides in the first 30 post-discharge days was 45(0.031% rate), over fifteen times the number of inpatient suicides. The diagnoses, demographic data, and past histories of attempts and hospitalizations for the post-discharge suicides will be compared to those of the patients who made lethal and potentially lethal attempts during the index hospitalizations. Also, the hospital courses of the patients who suicided after discharge will be compared and contrasted with the hospital courses of patients who made lethal and potentially lethal attempts during admission. The differences between the populations and the magnitude of the post-discharge suicide rate will be the springboards for discussion of the implications for clinical treatment and risk assessment, discharge planning and resource allocation.

**REFERENCES:**

1. Pirkola, S, Sund R, Sailas E, Wahlbeck K Community mental health services and suicide rate in Finland: a nationwide small-area analysis. The Lancet. 2009, 147-153.
2. Tidemaim D, Langstrom N, Lichetenstein P, Runeson B Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long term follow-up. British Medical Journal 2008 1328-1334.

No. 55

**DOUBLE-BLIND, PLACEBO-CONTROLLED EFFICACY AND SAFETY STUDY OF LISDEXAMFETAMINE DIMESYLATE IN ADOLESCENTS WITH ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER**

*Ann Childress, M.D., Center for Psychiatry and Behavioral Medicine7351 Prairie Falcon Road Suite 160, Las Vegas, NV 89128*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to evaluate and discuss the efficacy of lisdexamfetamine dimesylate (LDX), in terms of decreased symptoms, clinical global response, and safety profile compared with placebo in treating adolescents with attention-deficit/hyperactivity disorder.

**SUMMARY:**

Objective: To examine the efficacy and safety of lisdexamfetamine dimesylate (LDX) vs placebo in adolescents with attention-deficit/hyperactivity disorder (ADHD). Methods: Eligible subjects (13-17 years) with at least moderately symptomatic ADHD (ADHD Rating Scale IV: Clinician Version [ADHD-RS] score >=28) were randomized to placebo or LDX (30, 50, or 70 mg/d) with forced dose-titration in a 4-week, double-blind study. Primary and secondary efficacy measures were the ADHD-RS and Clinical Global Impression-Improvement (CGI-I) scale. Safety assessments included adverse events (AEs), vital signs, laboratory findings, physical exam, and electrocardiogram (ECG). Results: Overall, 314 subjects were randomized, 309 included in efficacy analyses, and 49 withdrew (11 due to AEs). At endpoint, changes in ADHD-RS were significantly greater for each LDX dose vs placebo; least squares mean (SE) change was -12.8

(1.25), -18.3 (1.25), -21.1 (1.28), and -20.7 (1.25) for placebo, 30, 50, and 70 mg/d LDX (P<.006 for all), respectively. Significant differences in ADHD-RS scores relative to placebo were observed in each LDX group beginning at week 1 and at each week throughout the study. The percentage of subjects rated as very much or much improved at endpoint as measured by CGI-I was significantly greater for LDX (all doses) than for placebo (69.1% vs 39.5% [P<.0001], respectively). The most frequently reported LDX treatment-emergent AEs (>5%) were decreased appetite, headache, insomnia, weight decrease, and irritability. There were small mean increases in pulse and systolic and diastolic blood pressure with LDX. There were no clinically meaningful trends in ECG. Conclusions: LDX was effective vs placebo in decreasing ADHD symptoms from the first week of treatment in adolescents with ADHD. LDX demonstrated a safety profile consistent with previous LDX studies in children or adults and with studies of long-acting stimulants in adolescents.

Supported by funding from Shire Development Inc.

**REFERENCES:**

1. Biederman J, Krishnan S, Zhang Y, McGough JJ, Findling RL: Efficacy and tolerability of lisdexamfetamine dimesylate (NRP-104) in children with attention-deficit/hyperactivity disorder: a phase III, multicenter, randomized, double-blind, forced-dose, parallel-group study. Clin Ther 2007; 29:450-463

## SCIENTIFIC AND CLINICAL REPORT SESSION 19-- ATTENTION DEFICITS AND PSYCHOSTIMULANTS

No. 56

### IS DEFICIENT EMOTIONAL SELF REGULATION A COMORBID OR INTEGRAL FEATURE OF ATTENTION DEFICIT HYPERACTIVITY DISORDER IN ADULTS? A CONTROLLED STUDY

*Craig Surman, M.D., MGH Adult ADHD Research Program, Suite 2000, 185 Alewife Brook Parkway, Cambridge, MA 02138*

**EDUCATIONAL OBJECTIVES:**

Participants will be able to: 1) Describe historical conceptualizations of deficient emotional self regulation as intrinsic to ADHD; 2) Describe the prevalence of DESR in a large, well characterized sample of community adults with and without ADHD; 3) Understand evidence that DESR is associated with ADHD independent of mental health comorbidity and produces clinically significant functional impairment; and 4) Discuss clinical and nosological implications of these findings.

**SUMMARY:**

Background: Symptoms of deficient emotional self regulation (DESR) such as low frustration tolerance, temper outbursts, emotional impulsivity and mood lability have historically been associated with ADHD. In DSM criteria prior to 1968 and the Utah Criteria for ADHD, these traits were considered core elements of the diagnosis. Since 1968, DSM criteria include DESR traits as associated rather than criteria symptoms. Because there has been little systematic study of emotional self regulation in adults with ADHD, we investigated the specificity of these traits to ADHD and their functional impact in a highly characterized sample of adults with and without ADHD. Methods: Subjects were 206 adults with ADHD and 123 adults without ADHD. Deficient emotional self regulation was operationalized using items from the Barkley Current Behavior Scale. Subjects were comprehensively assessed for psychiatric comorbidity using structured diagnostic interview methodology. We administered the The Quality of Life, Enjoyment and Satisfaction Scale-Short Form (QLES-SF) to assess quality of life. Results: DESR was higher among ADHD compared with non-ADHD adults ($z = 23.25$, $p < 0.001$), and 61% of adults with ADHD had higher DESR than 95% of non-ADHD subjects. ADHD remained significantly associated with DESR independent of the correlation of current and lifetime comorbid conditions with DESR. DESR was also robustly associated with poorer quality of life in adults with ADHD as assessed by the QLES-SF. Conclusions: Our findings and prior literature suggest DESR is common in adults with ADHD. Our study further indicates that DESR is significantly associated with ADHD independent of comorbidity, and is associated with quality of life impairment. It is therefore of significant clinical importance to clarify the appropriate classification of DESR nosologically in adults with ADHD, and develop evidence-based interventions. Further understanding of the neuropsychological and neurobiologic correlates of DESR in adults with ADHD may also inform understanding of other conditions marked by emotional impulsivity.

**REFERENCES:**

1. Barkley RA: Inhibition, Sustained Attention, and Executive Functions: Constructing a Unifying Theory of ADHD. Psychological Bulletin 1997; 121:65-94

2. Reimherr FW, Marchant BK, Strong RE, Hedges

DW, Adler L, Spencer TJ, West SA, Soni P. Emotional dysregulation in adult ADHD and response to atomoxetine. Biol Psychiatry 2005; 58:125-131

3. Barkley RA, Murphy KR, Fischer M. (2008) ADHD in adults: what the science says. New York: Guilford.

No. 57

**ADJUNCTIVE ARMODAFINIL FOR MAJOR DEPRESSION ASSOCIATED WITH BIPOLAR I DISORDER: A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY**

*Joseph Calabrese, M.D., 10524 Euclid Avenue, 12th Floor, Cleveland, OH 44106*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, participants should be familiar with the effect of adjunctive armodafinil on major depressive episodes in patients with major depression associated with bipolar I disorder despite treatment with lithium, olanzapine, or valproic acid.

**SUMMARY:**

Objective: A previous study found adjunctive racemic modafinil improved depressive symptoms in patients with bipolar disorder (Frye 2007). Armodafinil is the R- and longer-lasting isomer of modafinil (Darwish 2009). This report presents a randomized, double-blind, placebo-controlled study of armodafinil for adults with major depression associated with bipolar I disorder. Methods: This 8-week, multicenter study enrolled patients experiencing a major depressive episode associated with bipolar I disorder despite treatment with lithium, olanzapine, or valproic acid. Patients were randomized to adjunctive armodafinil 150 mg or placebo daily. The primary efficacy measure was the 30-item Inventory of Depressive Symptomatology–Clinician-Rated (IDS-C30) total score. Statistical analyses were performed using ANCOVA. A pre-specified sensitivity ANOVA was used if there was a significant treatment by baseline interaction. Tolerability was also assessed. Results: 257 patients (54% female; 44±11.5 years) were randomized. Baseline mean±SD total IDS-C30 scores were similar for armodafinil, 37.4±7.4, and placebo groups, 36.3±6.7. Because of a significant treatment-by-baseline interaction ($p<0.10$), assumptions underlying ANCOVA were not met and ANOVA was considered a more appropriate analysis. Total IDS-C30 score decreased from baseline to final visit by 15.8±11.6 for the armodafinil group versus 12.8±12.5 for the placebo group (ANOVA $p=0.044$; ANCOVA $p=0.074$). Armodafinil was generally well tolerated; the most common adverse events (AEs) were headache (11% vs. 10% placebo), insomnia (10% vs. 8%) and diarrhea (10% vs. 6%). 3 patients in the armodafinil group and 6 patients in the placebo group developed mania, hypomania, or a mixed episode. Conclusion: This study suggests armodafinil may improve depressive symptoms in patients with bipolar I disorder and a major depressive episode despite treatment with a mood stabilizer compared with placebo.

**REFERENCES:**

1. Frye MA, Grunze H, Suppes T, McElroy SL, Keck PE Jr, Walden J, Leverich GS, Altshuler LL, Nakelsky S, Hwang S, Mintz J, Post RM: A placebo-controlled evaluation of adjunctive modafinil in the treatment of bipolar depression. Am J Psychiatry 2007; 164:1242-1249

2. Darwish M, Kirby M, Hellriegel ET, Yang R, Robertson P Jr: Pharmacokinetic profile of armodafinil in healthy subjects: pooled analysis of data from three randomized studies. Clin Drug Investig 2009; 29:87-100

**TUESDAY, MAY 25, 3:30 PM - 5:00PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 20 - INPATIENT PSYCHIATRY: ADMISSIONS AND READMISSIONS**

No. 58

**THE ASSOCIATION BETWEEN PRE-ADMISSION SUICIDALITY AND READMISSION IS MODIFIED BY PATIENT EXPERIENCES, FEELINGS AND CHARACTERISTICS**

*Stephen Woolley, D.Sc., M.P.H., 200 Retreat Avenue, Hartford, CT 06106*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Discuss how the association between previous suicidality and subsequent hospital readmission varies by demographics, beliefs, life experiences, physical health, and psychotropic medication therapy; and 2) List the patient characteristics associated with readmission.

**SUMMARY:**

Objective: To quantify variation in the association between suicidality and subsequent readmission due to differences in demographics, beliefs, life experiences, physical health, and psychotropic medication use. Method: Factors associated with being readmitted were assessed by telephoning 265 former adult inpatients. Relative risks (RRs) and 95%

confidence intervals (CIs) were calculated. The RR for the suicidality-readmission association was calculated after stratifying by demographics, life events, physical health, substance abuse (SAb), index psychiatric diagnosis, or psychotropic drug use. Logistic regression assessed this association after adjusting for the influences of covariates. Result: The sample was 64% female, 58% <45 years old, 73% white, and 73% had a mood disorder. 104 patients were readmitted 1–18 times within 2 years of discharge. As expected, risk of readmission was increased if patients had attempted suicide prior to index admission (RR=1.4; CI=>1.0, 2.0), but this association varied by the presence/absence of 15 factors (e.g. ~2-fold increase in relative risk for patients taking an antipsychotic (vs not), ages =45 years (vs <45), co-diagnosed with SAb (vs not), or having serious medical condition (vs not)). However the association did not vary by sex, living alone, or antidepressant use. In logistic regression, after controlling for age, anxiety and self-rated health, suicide attempts were associated with a 32% increased risk of readmission. Other pre-admission suicidal variables were also associated with elevated risk, but there was no association with attempts post-discharge. Similar results were found for 3, 6 and 12 month follow-ups. Conclusion: The expected association between suicidality and readmission varied dramatically depending on patient characteristics: e.g., the RR among patients taking an antipsychotic was more than 80% greater than the RR among those not taking an antipsychotic.

No. 59

**EFFECTIVENESS OF PEER SUPPORT IN REDUCING READMISSIONS AMONG PEOPLE WITH MULTIPLE PSYCHIATRIC HOSPITALIZATIONS**

*William Sledge, M.D., Yale-New Haven Psychiatric Hospital184 Liberty Street, Room LV113, New Haven, CT 06519*

**EDUCATIONAL OBJECTIVES:**

Participants will learn that: 1) peer mentors can feasibly be paired with psychiatric patients with a recent history of recurrent psychiatric hospitalization for post hospitalization contact; 2) the tendency for psychiatric rehospitalization can be reduced significantly when patients are paired with peer mentors, 3) patients vary considerably in how they effectively benefit from a peer mentor; and 4) psychiatric patients who are recurrently readmitted to the hospital are difficult to study

**SUMMARY:**

Background: Recurrent psychiatric hospitalization is associated with substantial costs. Furthermore,
there is not a clear model that accounts the recurrently admitted. An effective strategy to prevent or reduce avoidable recurrent psychiatric admissions remains elusive. T h e use of peers in providing mental health services is reaching a critical position with strong ideological and policy pressure to adopt programs with peer providers poised against the pressure to adopt empirically based services with proved effectiveness. This study provides evidence to address questions of feasibility and effectiveness in using peers as a means to reduce psychiatric recurrent hospitalizations. Method: Patients hospitalized 3 or more times within 18 months were randomized into treatment as usual or care enhanced by a peer recovery mentor following the index hospitalization. Patients were 18 years or older and suffered from severe mental illness. Of the 307 patients who were hospitalized over a two year period and who met the recurrent hospitalization criteria for participation in the study, 74 consented to assessments at admission to the index hospitalization and at 9 months post index hospitalization. Outcome Measures: Hospitalizations and hospitalized days at 9 months are the primary outcome measures with secondary outcome measures of symptoms and other clinical outcomes. Results: Participants assigned recovery mentors did significantly better than those without a recovery mentor on both number of admission events (.89 (+/- 1.35) vs. 1.53 (+/- 1.53), F=3.07, df=1, p<.042, one tailed) and number of hospital days (10.1 (+/- 17.31) vs. 19.1 (+/- 21.6), F=3.63, df=1, p<.03, one tailed). Psychotic patients seemed to benefit from the recovery mentors more than affectively disordered patients in terms of the primary outcomes measures. Analyses of secondary outcome variables revealed a positive association with recovery mentors on hope, reduction in substance use and other symptomatic measures. Discussion: The use of peers is a promising intervention for the mitigation of the tendency to be recurrently admitted to a psychiatric hospital for some patients. However, more research needs to be done in order to confirm this finding as the readmitted patients proved to be as difficult to engage in the research as they were in the treatment.

**REFERENCES:**

1. Davidson, L, Chinman, M, Kloos, B, Weingarten, R, Stayner, D and Tebes, J (1999). “Peer support among individuals with severe mental illness: A review of the evidence.” Clinical Psychology: Science and Practice 6: 165-187.

No. 60

**INPATIENTS WITH PSYCHOTIC VS.**

## NONPSYCHOTIC MDD: PREVALENCE AND CLINICAL CHARACTERISTICS

*John Goethe, M.D., 200 Retreat AvenueHartford, CT 06106, Hartford, CT 06106*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) discuss the diagnostic issues that distinguish MDD with vs without psychotic features; and 2) describe the variables that distinguished psychotic from nonpsychotic depressed patients in this study.

**SUMMARY:**

Objectives: To determine, among inpatients with a DSM-IV clinical diagnosis of major depressive disorder (MDD), (1) the proportion with a diagnosis of psychotic (PD) vs nonpsychotic depression (NPD), (2) the characteristics that distinguish these two groups. Methods: All patients admitted 1/2000-12/2007 with a clinical diagnosis of MDD (n=5863) were classified as either PD or NPD and compared on demographic and treatment variables as well as by length of stay (LOS) and 3-month readmission rates. Data analyses included stepwise logistic regressions. Results: 32.0% (n=1803) of the sample had PD. This group was more likely to be male (OR=1.24), Latino (OR=3.71), black (OR=2.88), and age =52 (OR=1.17), to have a co-diagnosis of PTSD (OR=1.38), drug abuse/ dependence (OR=1.32) or diabetes mellitus (OR=1.32), have LOS = 10 days (OR=2.42), and be readmitted within 3 months (OR=1.42). The PD group was less likely to have a co-diagnosis of anxiety disorder (other than PTSD) (OR=0.74), alcohol abuse/dependence (OR=0.69), or a personality disorder (OR=0.86). Readmission was associated with a diagnosis of psychosis (OR=1.51), LOS = 10 days (OR=1.42), a co-diagnosis of personality disorder (OR=1.24) and age = 52 (OR=0.78) but not with race or a substance abuse diagnosis. In a separate analysis psychosis was associated with a greater risk of readmission than age, race, co-diagnoses or LOS. Conclusion: This study, the first large investigation in more than a decade to compare psychotic and nonpsychotic depression, found between-group clinical and prognostic differences that support retention of "psychotic features" as a specifier or subtype of MDD in DSM-V.

## SCIENTIFIC AND CLINICAL REPORT SESSION 21- SCALES AND SCREENING MEASURES

No. 61

## FEASIBILITY AND EFFECTIVENESS OF USING E-MAIL TO SCREEN COLLEGE STUDENTS FOR DEPRESSION

*Irene Shyu, B.A., 50 Staniford St, Suite 401, Boston, MA 02114*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to explore the usefulness of e-mail to screen college students for depression and of online information resources to initiate help-seeking.

**SUMMARY:**

Objective: To investigate the usefulness of e-mail to screen college students for depression and of online information resources to initiate help-seeking. Methods: Undergraduate and graduate students at six participating colleges were invited to complete a depression screening survey through e-mail lists provided by student groups on campus. The e-mail described the study's purpose and the chance for participants to win a $200 gift card. The survey included questions on demographic information, treatment history, and the Patient Health Questionnaire 9-Item (PHQ-9) for depression screening. Students with a PHQ-9 score>=10 were considered screened positive for major depressive disorder (MDD). They were informed of the results and offered links to online information on depression and local treatment resources. Students who screened positive were followed-up 8 weeks later using the same survey, with added questions on their utilization and evaluation of the online information. Results: 631 students consented to take the survey. 21.7% reported history of depression; 9.4% were receiving treatment for depression, including therapy (40%), medication (30%), and both (30%). 12.9% endorsed suicidal symptoms. 82 students (14.5%) screened positive for MDD, and the prevalence is significantly greater than that reported in the national survey in the community (10.3%, p=0.002). Out of these 82 students, 46.3% completed the follow-up survey. Among them, 8 students had used the resources provided in the initial survey; depression information (n=7) and peer counseling groups on campus (n=1). Providing the resources did not increase help-seeking for depression (McNemar test, p>0.05). Conclusions: E-mail appears to be an effective and inexpensive method to screen college students for depression. The prevalence of MDD among college students was found to be high. Simply offering online information on depression and available treatment resources had limited effects on students' help-seeking behavior.

**REFERENCES:**

1. Haas A, Koestner B, Rosenberg J, Moore D, Garlow SJ, Sedway J, Nicholas L, Hendin H, Mann JJ, Nemeroff CB.: An interactive web-based method of outreach to college students at risk for suicide. J Am Coll Health 2008; 57(1): 15-22
2. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE.: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comrobidity Survey Replication. Arch Gen Psych 2005; 62: 593-60

No. 62

**THE VALUATION OF IMPAIRMENT: RELATIVE VALUES ON THE PSYCHIATRIC IMPAIRMENT RATING (PIRS) SUBSCALES**

*Gordon Davies, M.B., B.S., 33 Smith Street, Wollongong, 2500 Australia*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should have an understanding of some of the practical problems encountered in the use of the PIRS. They should also have an awareness of the developing evidence base for the use of the PIRS, of the areas in which further development is needed and some of the available techniques for further research.

**SUMMARY:**

The PIRS is now nominated as one of the measures of psychiatric impairment in the AMA Guide to the Evaluation of Permanent Impairment. While there is evidence for it to be considered a valid ordinal measure of disability the scoring system does not have interval properties. The present project examines the relationship between the various classes of impairment in each category and provides a step toward the development of revised class descriptors which have an interval property. The study asked three groups of raters (medico-legal psychiatrists who had completed the training course in the use of the PIRS, a sample of the general population and a non-acute psychiatric patient sample) to rate each of the PIRS descriptors on an analogue scale. Measures were the ordering of the descriptors and the mean values of each descriptor. All raters broadly placed the descriptors in the order of classes in the PIRS manual. However a number (including the trained psychiatrists who were using the PIRS as a rating tool) ordered some items differently. For all groups the mean values of the ratings did not fall into a linear pattern, there being a tendency to reduced intervals between the three most severe classes. Psychiatrists tended to regard the descriptors in classes four and five as more severe than the general population or psychiatric patients. The present study demonstrates a systematic bias in the descriptors used in the PIRS with a diminution of the intervals between classes at the more severe end of the continuum. This applies over all the subscales used. Furthermore some of the descriptors are inadequately defined resulting in psychiatrists trained in the use of the rating scale varying from the defined order of ratings in their ordering of the classes represented by some descriptors. If the PIRS is to occupy a central place in the evaluation of psychological impairment there is a need for further research to better define the anchor points for each class of impairment.

**REFERENCES:**

1. Davies GRW, The Psychiatric Impairment Rating Scale: Is it a valid measure? Australian Psychologist 2008;43:205-212

No. 63

**ARE SCREENING SCALES FOR BIPOLAR DISORDER GOOD ENOUGH TO BE USED IN CLINICAL PRACTICE?**

*Mark Zimmerman, M.D., 235 Plain Street, Suite 501, Providence, RI 02905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be aware of the empirical and conceptual limitations of screening scales for bipolar disorder.

**SUMMARY:**

Objective: Several research reports have suggested that bipolar disorder is underrecognized. Recommendations for improving the detection of bipolar disorder include the use of screening questionnaires. The Mood Disorders Questionnaire (MDQ) has been the most widely studied screening scale for bipolar disorder; however, the cutoff recommended to identify cases was chosen to provide the best balance between sensitivity and specificity. Derivation of a cutoff in this manner is at odds with the intended use of the scale as a screening measure. It is therefore not surprising that prior studies of the MDQ in psychiatric outpatients have found that it has inadequate sensitivity. In the present report from the MIDAS project we examined the operating characteristics of the MDQ at all cutoff scores in order to determine the cutoff point that would be appropriate for the purpose of screening. Methods: Four hundred eighty psychiatric outpatients were interviewed

with the Structured Clinical Interview for DSM-IV and completed the MDQ. Results: When MDQ caseness was based only on symptom score, without regard to level of impairment, then the cutoff score on the MDQ associated with 90% sensitivity was 5. At this cutoff, the specificity of the MDQ was 61.0% and its positive predictive value was 22.7%. When MDQ caseness required at least mild impairment, then the cutoff score associated with 90% sensitivity dropped to 1, and at this cutoff, the specificity of the scale decreased to 32.7%, and positive predictive value was only 14.3%. Conclusions: When the cutoff to identify cases on the MDQ was set to achieve a desired level of sensitivity as a screening instrument, the vast majority of cases screening positive on the scale did not have bipolar disorder. Low positive predictive value does not support the use of the MDQ, or any bipolar disorder screening scale, in clinical practice.

**REFERENCES:**

1. Hirschfeld R, Williams J, Spitzer R, et al. Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire. Am J Psychiatry 2000;157:1873-1875.
2. Zimmerman M, Galione J, Ruggero CJ, et al. Performance of the Mood Disorders Questionnaire in a psychiatric outpatient setting. Bipolar Disorders in press.

**WEDNESDAY, MAY 26, 9:00 AM - 10:30AM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 22 - GENETICS**

No. 64
**LONGER HOSPITALIZATION ASSOCIATED WITH COMBINATORIAL CYP450 DRUG METABOLISM DEFICIENCIES**

*Gualberto Ruano, M.D., Ph.D., 67 Jefferson St, Hartford, CT 06106*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of CYP450 drug metabolism deficiencies; 2) The utility of CYP450 combinatorial drug metabolism indexes in characterizing and individual's metabolic phenotype; and 3)pharmacogenetic variation relevant to utilization of psychiatric healthcare resources.

**SUMMARY:**

Objective: To examine the combinatorial impact of polymorphisms in the cytochrome P450 genes CYP2C9, CYP2C19, and CYP2D6 on length of hospitalization for patients treated for major depressive disorder (MDD). Method: We recruited 150 psychiatric in-patients referred to the Institute of Living who were treated for MDD. DNA samples were taken and genotyped to detect deficient alleles in the genes CYP2C9, CYP2C19, and CYP2D6. We analyzed length of hospitalization to test for a correlation with quantitative drug metabolism status as defined by two "CYP Indexes"; the metabolic and absolute difference from wild-type allele indexes. The metabolic index represents a series of discrete CYP450 metabolic phenotypes by scoring alleles according to their metabolic capacity as null (0), deficient (0.5), wild-type (1), rapid (1.5) and ultra-rapid (2). In the absolute difference index, wild-type alleles are scored as 0, severe mutations (null, ultra-rapid) are assigned a value of 1 and deficient and rapid alleles both receive a score of 0.5. Results: After correcting for covariates, we found that deficient CYP450 metabolizers (metabolic index of 4 or less) had longer hospitalizations than wild-type or ultra-rapid drug metabolizers (7.7 vs. 6.1 days, $p = 0.023$). Furthermore, individuals with an absolute difference index of 1.5 or less had an average length of hospitalization of 6.1 days, compared to 7.0 days for patients with an index greater than 1.5 ($p = 0.14$). Conclusions: Deficient CYP450 combinatorial genotypes are significantly associated with length of hospitalization in psychiatric patients treated for depression. The likely cause is reduced efficacy or increased side effects of medications that are metabolized by the CYP450 enzymes leading to longer hospitalizations. The results suggest that combinatorial CYP genotyping can be utilized to benchmark the innate hepatic drug metabolism reserve of the patient which is relevant to psychotropic management.

No. 65
**PSYCHIATRIC PHENOTYPE IN FRAGILE X-ASSOCIATED TREMOR/ATAXIA SYNDROME (FXTAS)**

*Andreea Seritan, M.D., 2230 Stockton Blvd., Sacramento, CA 95817*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize FXTAS; 2) Understand neuropsychiatric aspects of FXTAS; and 3) Appreciate the very high lifetime prevalence of mood and anxiety disorders in FXTAS.

**SUMMARY:**
Objective: We studied the lifetime prevalence of DSM-IV-TR psychiatric disorders in a population of adults with the fragile X premutation. Methods: Structured Clinical Interview for DSM-IV (SCID) were conducted on 85 individuals with the fragile X premutation, 47 with the fragile X-associated tremor/ataxia syndrome (FXTAS; 33 male, 14 female, mean age 66) and 38 without FXTAS (16 male, 22 female, mean age 52). Lifetime prevalence for mood and anxiety disorders among carriers with and without FXTAS was compared to available age-specific population estimates from the National Comorbidity Survey Replication (NCS-R). Results: Among subjects with FXTAS, 30 cases (65%) met lifetime DSM-IV-TR criteria for mood disorder; 24 cases (52%) met lifetime DSM-IV-TR criteria for anxiety disorder. Among the non-FXTAS subjects, there were 15 cases (42%) of lifetime mood disorder and 18 cases (47%) of lifetime anxiety disorder. When compared to age-specific NCS-R data, the lifetime prevalence of any mood disorder, major depressive disorder, any anxiety disorder, panic disorder, specific phobia, and PTSD were significantly higher in subjects with FXTAS. The lifetime rates of social phobia in individuals with the premutation without FXTAS were significantly higher than NCS-R data. Conclusion: Mood and anxiety disorders are prominent aspects of the clinical phenotype of the fragile X premutation conditions, especially in carriers with FXTAS. Clinicians encountering these patients are advised to consider FXTAS as a neuropsychiatric syndrome as well as a neurological disorder.

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No. 66

**ASSOCIATION OF SEROPOSITIVITY FOR INFLUENZA AND CORONAVIRUSES WITH HISTORY OF MOOD DISORDERS AND SUICIDE ATTEMPTS**

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*Washington, DC 20032*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate an awareness of the global disease burden due to mood disorders; 2) Recognize the fact that reports of an association between some common respiratory viruses and mood disorders date as far back as the last century; 3) Recognize the differences and similarities between sickness behavior and clinical depression; and 4). Describe the proposed pathophysiologic mechanisms through which common respiratory viruses.

**SUMMARY:**
Objective: Anecdotal reports of mood disorders sequel to common respiratory viruses have been in existence since the last century. Nevertheless a search of the literature revealed a dearth of systematic studies on the association of common respiratory viruses and mood disorders. The purpose of this study was to investigate the association between seropositivity for Coronavirus, influenza A and B viruses and the following: (a) history of mood disorders (b) having attempted suicide in the past (c) uni vs. bipolarity and (d) presence of psychotic features in mood disorders. We hypothesized that seropositivity will be associated with history of mood disorders and suicide attempts, as well as presence of psychotic features. Influenza and corona were chosen as two examples of common respiratory viruses. Method: Data for this study was derived from two preliminary studies on environmental actors and mood disorders (and suicide). A total of 257 subjects were recruited and influenza A, B and Coronavirus antibodies were measured in all 257 subjects. Of the 257 subjects, 39 were healthy normal controls. All 257 subjects underwent the Structured Clinical Interview for DSM-IV Disorders (SCID). Patients had to meet criteria for Major Depressive or Bipolar Disorders and they were excluded if they met criteria for substance dependence, cognitive disorders or primary psychotic disorders. Based on the result of serological analysis, subjects were designated as either seropositive or seronegtive. We carried out chi-square analysis to investigate the association between seropositivity for coronavirus, influenza A and B viruses and the following: a) history of mood disorders b) having attempted suicide in the past c) uni vs. bipolarity and d) presence of psychotic features in mood disorders. Results: Chi-square analysis revealed statistically significant association between seropositivity for influenza A ($p = 0.004$), influenza B ($p < 0.001$), corona virus ($p < 0.001$) and a history of mood disorders. The odds of having a history of mood disorder was increased with seropositivity for influenza A (OR = 2.90, CI 1.37 to 6.12), Influenza B (OR = 6.68, CI 2.69 to 16.57) and Corona (OR = 7.27, CI 3.49 to 15.14). However the presence of antibodies to

the viruses was not associated with the specific diagnosis of unipolar or bipolar depression. Seropositivity for influenza B was significantly associated with a history of suicide attempt (p =0.001) and the odds of having attempted

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## SCIENTIFIC AND CLINICAL REPORT SESSION 23-- ISSUES IN CHILD AND ADOLESCENT PSYCHIATRY

No. 67

### CHILDHOOD AND ADOLESCENCE PREDICTORS OF PSYCHOSIS IN GENERAL POPULATION IN THE NORTHERN FINLAND 1986 BIRTH COHORT

*Pirjo H. Maki, M.D., Ph.D., P O Box 5000, Peltolantie 5, Oulu, 90014 Finland*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand that prodromal features of psychosis are common in adolescence, especially in subjects developing psychosis.

**SUMMARY:**

Background: Prodromal symptoms are non-specific problems often preceding frank psychosis. Prospective general population based reports are lacking on specific symptoms in childhood and adolescence predicting psychosis. Objective: The aim was to describe prodromal features of first episode psychosis in general population of adolescents. Study subjects and methods: Members (N= 6,676) of the Northern Finland 1986 Birth Cohort, an unselected general population cohort, were examined in childhood and adolescence. The 8 –year field study included Rutter B2 questionnaire for teachers screening neurotic and antisocial symptoms. The 16 –year field study included a 21-item PROD-screen questionnaire screening prodromal symptoms for last six months. The Finnish Hospital Discharge Register was used to find out new cases of severe mental disorders. The follow-up of psychotic and non-psychotic disorders was from 1998 to 2005 for Rutter B2 scale analysis and from 2002 to 2005 for PROD-screen analysis. Cut-off points for PROD-screen subscales (positive and negative symptoms) were determined by Receiver Operating Characteristics (ROC) –curve analysis. Results: High scores of symptoms in Rutter B2 did not associate with later psychosis. The highest prevalence of positive symptoms in the PROD-screen were in the

group of subjects who developed psychotic disorder (77%) compared to group of subjects who developed non-psychotic disorder (36%), and to group of subjects without any disorder (28%). Respective figures for negative symptoms were 53% in the group of psychotic subjects, 11% in the group of subjects with non-psychotic disorder and 8% in the 'healthy', without psychiatric hospital treatment. Conclusions: Symptoms reported by teachers at age of 8 years did not predict later psychosis. This is understandable as Rutter Scale is not meant to assess psychotic symptoms. On the other hand both positive and negative features of psychosis were common in adolescents who later developed psychosis. Acknowledgements: This study has been funded by the Academy of Finland (JM and JV), the Signe and Ane Gyllenberg Foundation and the Sigrid Juselius Foundation, Finland.

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No. 68

**THE USE OF VIDEO FEEDBACK TO IMPROVE THE MOTHER-INFANT RELATIONSHIP IN WOMEN WITH POSTNATAL DEPRESSION**

*Anne Buist, M.D., Lance Townsend 10th Fl, Austin Health PO Box 5555, Heidelberg, Victoria, 3081 Australia*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identify mother-infant interactional difficulties in women with postnatal depression, particularly where treating the depression alone has not resolved the relationship issue and to understand some of the benefits and potential risks of video feedback in a vulnerable population.

**SUMMARY:**

Background: Postnatal depression (PND) affects up to 15% of mothers. Treating the maternal depression does not in itself improve the relationship where one of the key risks to the depression has been the mother's own attachment issues and early childhood abuse or neglect; the child can continue to activate the woman's unresolved issues, with potential for intergenerational transmission of insecure attachment, and depression. Early intervention may be preventative. Studies suggest using video feedback, may have improved outcomes in maternal sensitivity and attachment [1]. Aim: To investigate the effectiveness of a brief video feedback intervention, in an inpatient setting in improving mothering confidence and attitude to her infant (child under age of one year). The effectiveness of video feedback, in inpatient mothers diagnosed with PND (DSM IV minor or major depression occurring in the postpartum period), in improving mother-infant interaction is compared to verbal-only feedback and controls who received standard care. We also aim to evaluate mother's acceptability of video feedback. Methodology: Mothers were recruited from two inpatient PND treatment programs. After admission, those women who agreed to participate were randomly allocated to video or verbal therapy if the therapist was available, or to control if she was not. Therapy sessions lasted up to half an hour, once a week; both verbal and video were given information about attachment and watched a video on Circle of Security [2]. Changes in attitude to the infant, parenting confidence and mental health status pre and post-intervention were assessed. Results: 59 women with PND being treated as inpatients have been recruited to date; 20 to the video, 20 to the verbal group and 19 to control (standard care). Preliminary analysis from first 14 women in video and verbal groups reveal significant improvements in mental health status were observed post intervention within all groups; improvements were observed in one measure of maternal attitudes/parenting confidence and only in the video feedback group. Comparison between interventions showed no significant difference in other measures. More mothers receiving video feedback thought this intervention was useful in helping them understanding infant behaviour but there was a trend that at least initially these women lost confidence. Analysis from all three groups will be presented at the conference.

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No. 69

**MEDICAL COMORBIDITY IN BIPOLAR CHILDREN WITH RAPID CYCLES: IS IT DIFFERENT RELATIVE TO**

**NON-RAPID-CYCLING CHILDREN?**

*Ruby Castilla-Puentes, M.D., D.P.H., 530 South 2nd. St. Suite 743, Philadelphia, PA 19147*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identify the main differences in medical comorbidity between children with rapid cyclers, compared with their counterparts without rapid cycles.

**SUMMARY:**

Background: Despite the high morbidity associated with bipolar disorder (BD) in youth, most of the existing studies of course of this illness, did not include information about comparative medical comorbidity between rapid-cycling and non-rapid-cycling patients. Objective: To compare comorbidity in youths with rapid cycling bipolar with those without rapid cycles BD using information of a large US managed care database. We hypothesized that youths with multiple rapid cycles would have a higher medical and comorbidity than their counterparts without rapid cycles. Methods: Analysis was conducted on a cohort of 8,129 children and adolescents patients (=18 y.o.) with bipolar disoders (BD), from the Integrated Healthcare Information Services (IHCIS) identified from June 30, 2000 to July 1, 2003. Demographics variables, medical and psychiatric comorbidity in the year of follow-up were compared between children and adolescentes with rapid and those without rapid cycles. Results: Included were 58 patients with rapid cycles (defined as: =4 or more reports of inpatient treatment for any affective disorders per year) and 8,071 without rapid cycles. Patients with rapid cycles were more likely than those without rapid cycles to exhibited more metabolic/endocrine problems (20.8% vs. 7.8%, ?2=3.86, df=1, p= 0.049), and vascular/circulatory diseases (4.2% vs. 0.2%, ?2=24.77, df=1, $p < 0.0001$). Other medical comorbidity did not differ between the two groups. Conclusions: Bipolar children and adolescents with rapid cycles present a higher endocrine and vascular comorbidity than those without rapid cycles. Future prospective studies will help to better characterize the impact of rapid cycles in the medical comorbidity of pediatric BD that facilitate appropriate treatment strategies.

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## SCIENTIFIC AND CLINICAL REPORT SESSION 24- ANTIDEPRESSANT RESPONSE AND AUGMENTATION

No. 70

**QUETIAPINE AUGMENTATION OF ANTIDEPRESSANT TREATMENT IN ELDERLY DEPRESSED PATIENTS**

*Yoram Barak, M.D., M.H.A., 15 KKL Street, Bat-Yam, 59100 Israel*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to evaluate when quetiapine may be used to speed the onset of action and improve the quality of response to antidepressant treatment in elderly patients suffering from major depressive disorder not responding to a standard treatment course.

**SUMMARY:**

Background: Depressive symptoms are not uncommon among elderly psychiatric inpatients. In addition, these patients often present a unique treatment challenge to clinicians, since the elderly often exhibit needs quite different from those of younger patients due to substantial physical comorbidity and age-related variations in response to therapy.A recent survey of American experts on treatment of older adults selected the second generation antipsychotic quetiapine as high second line recommendation. Depressive episodes in elderly patients are often characterized by poor responses to standard antidepressants. Several reports have suggested that the atypical antipsychotic, quetiapine may have antidepressant properties. Aim: to evaluate the efficacy of quetiapine augmentation in depressed elderly patients previously unresponsive to a full course of antidepressant treatment. Methods: Elderly inpatients with depressive symptoms who were treated at our center during the period Jan 2006 to Dec 2008 were included in the study according to the following criteria: (1) 60 years and older, (2) unsuccessful treatment with at least one antidepressant during the current depressive episode, (3) severity of current episode necessitating inpatient treatment and (4) no previous exposure to quetiapine.Clinical and demographic data were extracted from computerized records and analyzed. The primary outcome measure was the change on the Clinical Global Impressions Scale for improvement (CGI-I). Results: twenty depressed elderly inpatients had received quetiapine augmentation during the study period. There were 13 female (65%) and 7 male (35%), mean age 74 years (range: 61-85), mean current

depressive episode duration 3.9 months (range: 1-12). Physical comorbidity was common in the group with the three leading co-morbid conditions being: hypertension – 10 patients, diabetes – 3 patients and dyslipidemia – 3 patients. Prior to augmentation patients had been treated with no clinically meaningful response with the following antidepressants: SSRI – 9 patients, Heterocyclics – 7 patients, SNaRI – 3 patients and Bupropion – 1 patient. Baseline mean severity of depression was 6.40 and severity after quetiapine augmentation was significantly reduced to a mean of 3.25; the change in CGI-I was 2.10 (p< 0.03). Mean quetiapine dose was 70 mg and mean duration of augmentation was 3.9 weeks. Five patients complained of somnolence. One patient discontinued psychotropics and switched to ECT.

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No. 71

## DO ADJUNCTIVE STIMULANTS DESTABILIZE MOOD IN PATIENTS WITH BIPOLAR DISORDERS? FINDINGS FROM THE STEP-BD

*Joseph Goldberg, M.D., 128 East Avenue, Norwalk, CT 06851*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe clinical characteristics associated with bipolar disorder patients who are prescribed stimulants, and data regarding the incidence of mood destabilization when stimulants are added to antimanic drugs in patients with bipolar disorder.

**SUMMARY:**

Stimulants are sometimes used in mood disorder patients for various purposes. However, their risk for possible mood destabilization in bipolar disorder patients has been understudied. This presentation will provide information on the prevalence of, and characteristics associated, with stimulant prescriptions among subjects enrolled in the NIMH Systematic Treatment Program for Bipolar Disorder (STEP-BD). From among 3,990 subjects, 59 bipolar I, II, not otherwise specified (NOS) or schizoaffective-bipolar patients were identified who newly received prescriptions for amphetamine (n=42), methylphenidate (n=12) or atomoxetine (n=1) added to an antimanic agent. Clinical characteristics were compared to those of the remaining 3931 subjects. Patients who received a stimulant were more likely to have met DSM-IV criteria for comorbid attention deficit-hyperactivity disorder (ADHD) (12% vs. 4%; p<.01), past rapid cycling (70% vs. 50%; p<.01), comorbid substance abuse (23% vs 13%; p<.05), and more lifetime depressive episodes (5.5 vs 4.8; p<.05). Stimulant recipients did not differ significantly from non-recipients in age, age at onset, history of psychosis, or history of antidepressant-associated switches to mania. The average change in manic (-0.01 points/month) and depressive (-0.06 points/month) symptoms, rated using a summed assessment of mood symptoms, was minimal over the 3 months following stimulant initiation. When data were split by a history of antidepressant-associated affective switch, no significant differences were observed in mean mania symptoms scores over the 3 months following stimulant exposure. Regression models examining changes in mania symptom severity scores over 3 months following stimulant initiation revealed no significant associations between elevation in mania symptoms and bipolar I vs. II subtype, rapid cycling, or history of substance abuse. Consistent with previously published findings on the safety of adjunctive stimulants in children and adolescents with bipolar disorder and ADHD, the present analyses do not provide evidence of adverse consequences of adding stimulants to antimanic drugs in adults with bipolar disorder, even in those who have a history of rapid cycling or treatment-emergent affective switch with antidepressants.

**REFERENCES:**

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No. 72

## DIFFERENCE BETWEEN MORNING AND EVENING TRH TESTS COULD PREDICT ANTIDEPRESSANT RESPONSE

*Fabrice Duval, M.D., Centre Hospitalier BP29, Rouffach, 68250 France*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participant should be able to understand why biomarker predictors of treatment response, such as the difference between morning and evening TSH response to TRH (DeltaDeltaTSH), would minimize trial-and-error prescribing by rationalizing the therapeutic choice-taking into account not only the

clinical features but also the "biological state" which is a major determinant in the antidepressant response.

**SUMMARY:**
Background: Although most patients recover from major depressive episodes, about 50% have inadequate response to an individual antidepressant trial. Some findings support that early improvement in the first two weeks of antidepressant treatment may predict later response and remission. This study sought to determine whether the thyroid function evaluation at baseline and after 2 weeks of antidepressant treatment could predict antidepressant response. Methods: The serum levels of thyrotropin (TSH) were measured before and after 8 AM and 11 PM TRH challenges, on the same day, in 23 medication-free DSM-IV euthyroid major depressed inpatients and 30 healthy hospitalized controls. After 2 weeks of antidepressant treatment (tianeptine, n=12; venlafaxine, n=11) the same TRH tests were repeated in all inpatients. Antidepressant response was evaluated after 6 weeks of treatment. Results: At baseline, 11 PM-DeltaTSH and DeltaDeltaTSH values (difference between 11 PM and 8 AM TSH response to TRH [DeltaTSH]) were significantly lower in patients compared to controls (p<0.003 and p<0.0007, respectively). However, DeltaDeltaTSH test status at baseline was not associated to clinical outcome. After 2 weeks of treatment, patients with reduced DeltaDeltaTSH values (n=10 [43%]) showed poor clinical outcome, while those with normal DeltaDeltaTSH values were associated to good clinical response (day 14, p<0.02; day 42, p<0.0006). Clinical efficacy and effects on thyroid function did not differ between the 2 antidepressants. Conclusion: Our data indicate that the DeltaDeltaTSH test performed after 2 weeks of antidepressant treatment could be a useful predictor of subsequent clinical outcome. In case of a lack of early improvement, a reduced DeltaDeltaTSH value may suggest a change in the therapeutic strategy (optimization, drug substitution, combination, augmentation therapy).

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## SCIENTIFIC AND CLINICAL REPORT SESSION 25- (PSYCHO)PHARMACOLOGY

No. 73

### TOLERABILITY OF HIGH-DOSE VENLAFAXINE XL IN DEPRESSED PATIENTS

*Faouzi Alam, M.D., Psy.D., 38 Heatherleigh, St Helens, WA9 5SU United Kingdom*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to determine whether or not high-dose Venlafaxine can be tolerated in depressed patients not responding to recommended doses.

**SUMMARY:**
Side effects and tolerability of high-dose Venlafaxine XL in depressed patients are rarely documented. Some studies suggested a good clinical response although at the expense of greater undesired effects and lower tolerability. The aim of this study was to assess the prevalence and severity of side effects in depressed patients who were well controlled on higher than recommended doses of Venlafaxine XL (225mg-525mg). Fifty patients, fulfilling DSM-IV criteria for major depressive disorder and who were taking high-dose Venlafaxine XL (mean dose 346mg) for at least 12 months, were recruited into an open label study. Participants completed a 19-item self-administered questionnaire to assess tolerance, side effects and severity of complaints. The most frequently reported mild complaints were sweating (60%), sexual dysfunction (56%),anxiety (50%),dry mouth (40%),constipation (38%), joint pain and tremor (24%). Of the complainants, only 6% reported having moderate to severe side effects including weight gain (2%), mood swings (2%) and sweating (2%). Three patients (6%) considered stopping the medication but decided that the benefits outweighed the discomfort of side effects.12.5% of patients developed mild hypertension after starting with Venlafaxine. There were no significant correlations between severity, number of side effects and high-dose Venlafaxine XL. On testing desmethylvenlafaxine serum levels (Venlafaxine metabolite) of all fifty recruited patients, we found no correlation between high metabolite blood levels, number or severity of side effects. This open label naturalistic study demonstrated that Venlafaxine XL is well tolerated at higher than British National Formulary recommended doses in patients suffering from depression.

**REFERENCES:**
1. S Ruiz-Doblado, T Rueda-Villar, and L Casillas-Lara: High-dose venlafaxine in delusional and severely depressed patients. J Psychopharmacol, 2009; 23(7): 859 - 860.

No. 74

**TWELVE MONTH HERBAL MEDICINE USE FOR MENTAL HEALTH FROM THE NATIONAL COMORBIDITY SURVEY: REPLICATION (NCS-R)**

*Simha Ravven, M.D., 1493 Cambridge st, Cambridge, MA 02139*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the epidemiology of herbal medicine use for mental health problems, 2) Understand the breadth and potential mechanisms of herb-drug interactions with psychotropic and non-psychotropic medications of herbs commonly used for mental health; and 3) Apply this knowledge to clinical practice.

**SUMMARY:**

Background: Though herbal medicine is widely used for problems with mental health research on the health characteristics and healthcare utilization patterns, including utilization of conventional mental health care and psychotropic medication, remains limited. Methods: Data were gathered from the National Co-morbidity Survey Replication (NCS-R), a nationally representative survey of 9,282 U.S. adults. Interviews were conducted in person from 2001 to 2003. Diagnoses of mental disorders were based on the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview (WMH-CIDI), a fully structured diagnostic interview. Results: Respondents with mental disorders were significantly more likely to have used herbal medicines for mental health problems than those who did not meet criteria for a mental disorder with OR 4.1, 95% CI 3.3-5.1 for anxiety disorders, OR 3.91, 95% CI 3.06-5.04 for mood disorders, and OR 2.49, 95% CI 1.79-3.47 for substance use disorders. Those who used herbal medicines for mental health problems were likely to utilize conventional health care as well, particularly conventional psychiatric medication. Nearly half of herb users had used conventional psychiatric medication in the preceding year. Herb use was also associated with having multiple co-morbid medical problems. Conclusions: Our study indicates that there is substantial use of herbal medicine to treat problems with mental health. We found that herbal medicine is largely used concomitantly with conventional mental health care, including prescription psychotropic medication. Herb use is also associated with having multiple chronic medical problems. There is significant potential for herb-drug interaction with both psychiatric and non-psychiatric medications given both increased medical illness of herb users and also the prevalence of coincident use of conventional medications and herbs.

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economic position and major mental disorders. Epidem Rev. 2004;26:53-62.

No. 75

**RELATIONSHIP BETWEEN SERUM VENLAFAXINE, ITS METABOLITE LEVELS (O-DESMETHYLVENLAFAXINE) AND TREATMENT RESPONSE IN PATIENTS WITH REFRACTORY DEPRESSION**

*Qaiser Javed, M.B.B.S, 5, The Cleves, Liverpool, L319PR United Kingdom*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand the correlation of O-desmethylvenlafaxine (a metabolite of Venlafaxine) with improvement in mood & a general feeling in patients taking venlafaxine for depression. This study confirms significant correlation between ODV (O-Desmethylvenlafaxine) levels, mood & a general feeling, in addition, to Venlafaxine levels which is significantly correlated to patients functioning in patients with refractory depression.

**SUMMARY:**

Objective: To evaluate the correlation of ODV with subjective improvement in patients taking venlafaxine for refractory depression. Methods: Study design was cross-sectional. The study was undertaken at the Department of Psychiatry, University Hospital of South Manchester, United Kingdom, which is a secondary referral centre. This was an independent study, which was approved by the Local Ethics Committee. Fifty patients with refractory depression who were treated with different antidepressants previously & had been on Venlafaxine for a minimum of 12 months were included in this study. Patients needed to have been on minimum of 225 mg of Venlafaxine. Global assessment functioning scale (GAFS), which determines patients best functioning & symptoms over 12 month was used. In addition, Patients were asked to fill a self rating scale of mood & general feelings since they had been on Venlafaxine compared to how they felt before starting the treatment. Patient less than 18 years of age, on dose less than 225mg & presence of other psychiatric diagnosis including alcohol dependence syndrome and substance misuse were excluded. In addition, those patients with life threatening (terminal) physical illnesses were also excluded. Results: There was a correlation between Venlafaxine dose and Venlafaxine levels ($p<0.01$) & ODV ($p<0.03$) levels. In general high Venlafaxine doses produced both high venlafaxine & ODV levels in serum. The ratio of ODV to Venlafaxine was above one although the higher the dose of Venlafaxine, the nearer was this ratio to one.84% & 78% rated themselves as very much better in mood & general feelings respectively whilst being on Venlafaxine compared to their previous treatment. 82% of patients had a level of functioning of between 70% to 100% showing mild functioning impairment (mild symptoms of depression & anxiety) to full functioning (no depression or anxiety symptoms).Our study confirmed that high levels of ODV were associated with patients reporting feeling very much better or much better. There was a significant correlation between ODV levels, mood ($p<0.04$) and general feeling ($p<0.02$). Conclusion: Our study confirmed significant correlation between ODV levels, mood & a general feeling, in addition, to Venlafaxine levels which was significantly correlated to patients functioning in patients with refractory depression.

**REFERENCES:**

1. Otto Benkert, Gerhard Gründer, Hermann Wetzel, David Hackett: A randomized, double-blind comparison of a rapidly escalating dose of venlafaxine and imipramine in inpatients with major depression and melancholia. Journal of Psychiatric Reasearch 1996; 30:441-451

**WEDNESDAY, MAY 26, 11:00 AM - 12:30PM**

**SCIENTIFIC AND CLINICAL REPORT SESSION 26- PSYCHOSIS**

No. 76

**CATATONIA: A “FROZEN CONDITION?” NEW TREATMENT OPTIONS BASED ON CASE REPORTS AND LITERATURE REVIEW**

*Cristinel Coconcea, M.D., 185 Pilgrim Road, Boston, MA 02215*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand current concept regarding pathophysiology of catatonia; 2) Identify current challenges in diagnosing and treating catatonia; and 3) Consider an evidence-based algorithm for diagnosis and treatment of catatonia

**SUMMARY:**

Recent developments in the understanding of the pathophysiology of catatonia are raising the GABAa versus GABAb hypothesis. Based on analysis of treatment-resistant and treatment responive cases of

catatonia, as well as on literature review, an evidence-based algorithm for diagnosing and treating catatonia is suggested. According to recent statistics, 5–9% of all psychiatric inpatients show some catatonic symptoms. Of these, 25–50% are associated with mood disorders, 10–15% are associated with schizophrenia, and the remainder are associated with other mental disorders. Recent developments in the treatment of catatonia are raising the GABAa vs GABAb hypothesis of catatonia. Methods: This presentation describes 7 cases of benzodiazepine-resistant catatonia responding to treatment with zolpidem and critically reviews the current literature on the treatment of catatonia, proposing an algorithm for the diagnosis and treatment of this condition. Results: All 7 patients in this report are showing similar catatonic symptoms, lack of response (or partial response) to other treatments, and same patterns of response to zolpidem, including an initial zolpidem challenge test. From the review of the literature on catatonia, there is growing evidence suggesting the role of GABAa agonists in the treatment of catatonia, as well as for the possible pro-catatonic effect of the GABAb agonists, with important potential clinical applications in the treatment of this severe condition. Conclusions: Zolpidem, a GABAa specific agonist appears to be a new and safe therapeutic approach for catatonia, potentially useful in benzodiazepine-resistant patients. More research will be needed in order to replicate and further understand the mechanism and sites of its activity. Various agents described in the literature as useful for the management of catatonia are critically reviewed in terms of mechanism of activity and strength of evidence, and an evidence-based algorithmic approach to the diagnosis and treatment of catatonia is proposed.

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No. 77

**RACIAL DIFFERENCES IN MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES**

*Karen Bullock, Ph.D., 200 Retreat Avenue, Hartford, CT 06106*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) describe the prevalence of psychotic features in Black vs White vs Latino in-patients with MDD and : 2) discuss associated variables.

**SUMMARY:**

Objective: Among patients with major depressive disorder (MDD), to identify racial difference in the assignment of a clinical diagnosis of "with psychotic features". Methods: The sample was Black, White and Latino inpatients ages 18-64 hospitalized (1/1/00-12/31/08) with MDD (n=5,327). Race was the primary predictor in a stepwise logistic regression that included gender and age. Demographic, clinical and treatment variables were examined using chi-square. Results: The sample was 64.2% White, 25% Latino and 10.8% Black, 61.3% female and had a mean age of 39.0+11.9 years. Psychotic features were present in 21.1% of Whites, 44.0% of Blacks and 50.2% Latinos (p<.001). Latinos (OR=3.79) and Blacks (OR=3.06) were much more likely than Whites to be give the specifier "with psychotic features". Whites were more likely to have a diagnosis of a personality disorder (p<.001) Among patients with psychotic MDD, Whites were least likely to receive antipsychotics (86% vs 89% of Latinos and 92% of Blacks, p=.048). Racial differences remained after controlling for gender and age. Conclusion: Further studies are needed to examine factors which contribute to racial differences in the assignment of a "with psychotic features" diagnosis.

**REFERENCES:**

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2. Minsky S, Vega W, Miskimen T, Gara M, Escobar J: Diagnostic patterns in Latino, African Americans and European American psychiatric patients. Arch Gen Psychiatry 2003; 60: 637-644.
3. Strakowski SM, Flaum M, Amador X, Bracha HS, et al.: Racial differences in the diagnosis of psychosis. Schiz Research 1996; 21: 117-124.

No. 78

**TOWARD A BETTER UNDERSTANDING OF THE INTERACTION BETWEEN RELIGIOUS DELUSIONS AND THE CLINICAL AND RELIGIOUS BACKGROUND OF PATIENTS WITH SCHIZOPHRE**

*Philippe Huguelet, M.D., Consultation Eaux-Vives, Rue du 31-Décembre 36, Geneva, 1207 Switzerland*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have: 1) Acquired a greater knowledge of how to disentangle delusion with religious content from normal faith in patients with schizophrenia; 2) Have a better understanding of how these delusions interact with patients' clinical and religious context, thus improving their ability to assess and deal with this complex phenomenon.


## SUMMARY:

Objective: Delusions with religious content have been associated with a poorer prognosis in patients with schizophrenia. Yet positive religious coping is frequent among this population. We aim to study the interaction between religious delusions and spirituality/religiousness in schizophrenia, in order to allow a better assessment and treatment of this phenomenon. Method: 236 outpatients in Geneva (Switzerland) and in Québec (Canada) were randomly selected for a quantitative and qualitative evaluation about religious coping. Patients with delusions with religious content (n=38), patients with other sorts of delusions (n= 85) and patients without persistent positive symptoms (n=113) were compared. Also, the interviews' transcripts were analyzed with a qualitative method (grounded theory) in order to get a better understanding of the intern coherence of this phenomenon. Results: Patients with delusions with religious content did not have a more severe clinical status, as compared to other deluded patients, but they were less likely to adhere to psychiatric treatment. The themes of the delusions were persecution (by malevolent spiritual entities), influence (controlled by spiritual entities) and self-significance (delusions of sin/guilt or grandiose delusions). Patients with delusions with religious content received less support from religious communities. Yet for almost half the group, religious and spirituality helped them to cope with their illness. Qualitative analyses highlighted cognitive and emotional schemes (i.e. dysfunctional beliefs) likely to interfere with life and/or treatment, thus worth taking into account. Conclusions: Patients with delusions with religious content can feature positive religious coping at the same time. They are less likely to accept treatment and benefit from the help of religious communities, despite being more religious than other patients. Clinicians should try to understand and take into account these complex interactions though a comprehensive assessment.


## REFERENCES:


1. Mohr S, Brandt PY, Gillieron C, Borras L, Huguelet P: Toward an integration of religiousness and spirituality into the psychosocial dimension of schizophrenia. Am J Psychiatry 2006;163:1952-1959


## SCIENTIFIC AND CLINICAL REPORT SESSION 27- ISSUES IN MOOD DISORDERS

No. 79

### MINOR MIXED DEPRESSION, FORMERLY MIXED AFFECTIVE STATE: A TREATABLE CONDITION IN VIOLENT COURT-ORDERED DETENTION PATIENTS WITH A PERSONALITY DISORDER


*Carel De Blécourt, M.D., Ph.D., Kienvenneweg 18, Rekken, 7157 CC Netherlands*


## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the clinical picture of minor mixed depression, formerly mixed affective state; and 2) Apply this knowledge to improve the treatment of patients with personality disorders, especially in court-ordered detention patients.


## SUMMARY:

Introduction. We were struck by the concept of minor mixed depression, formerly called mixed affective state. Method. An empirical study in different clinical settings. Results.1. In an outpatient setting(2005) about 70% of the patients referred with major depression, appeared to have mixed states using antidepressant medication. Changing the antidepressant for a mood stabilizer brought substantial relief in the majority of cases. It might be supposed here that only patients with the most intense complaints, such as racing thoughts and unprovoked outbursts of rage, had been referred. 2. In an outpatient forensic setting(2008) this clinical picture was frequently displayed, too. The patients were referred with violent offences and were diagnozed with borderline- or antisocial personality disorder and/or intermittent explosive disorder, using no antidepressants. About 70% could be treated with a mood stabilizer alone or in combination with quetiapine. 3. In a setting for court-ordered detention patients(2009) a combination of all of the above was seen in often notorious violent patients who sometimes had been prescribed SSRI's in high dosages for years. Results of tapering off the antidepressants and treatment with a mood stabilizer alone or in combination with quetiapine or periciazine, using plasma level monitoring, were dramatic, not only subjectively but also measured by the number of incidents in the ward. Discussion. In all three groups

of patients there was a positive family history for mood swings and bad temper. In the first group the mixed state was induced by antidepressants, in the second group the symptoms were genuine whereas in the third group both elements were present which caused a double worsening of the mental condition of the patients. Conclusion. Recognition of minor mixed depression, formerly called mixed affective state, can have a significant impact on treatment outcome in violent court-ordered detention patients with personality disorders.

**REFERENCES:**

1. Marneros A, Goodwin FK: Bipolar Disorders. Mixed states, rapid cycling and atypical
forms. Cambridge University Press, 2005

No. 80

**PSYCHOSOCIAL IMPAIRMENT ASSOCIATED WITH DYSTHYMIC DISORDER IN THE NESARC STUDY**

*David Hellerstein, M.D., NY State Psychiatric Institute, 1051 Riverside Drive, Unit #51, New York, NY 10032*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe the impairment of individuals with dysthymic disorder compared to individuals with acute major depression and the general population.

**SUMMARY:**

Background: Chronic depression is associated with impaired functioning. The National Epidemiologic Survey of Alcoholism and Related Conditions (NESARC) is a representative sample (N=43,093) of the United States non-institutionalized population aged 18 years and older. We hypothesized that individuals with chronic low-grade depression, dysthymic disorder (DD), would have more impaired functioning than individuals with acute major depression (MDD), or the general population. Method: Diagnoses were generated by the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (ADAUDIS-IV), administered by lay interviewers. Individuals with dysthymic disorder (DD) without current MDD constituted the DD sample (N=328). MDD with duration <=24 months, without lifetime dysthymic disorder, constituted acute depression (AD)(N=712). All other respondents were classified as general population (GP)(N=42,052). Past year functioning was assessed by Supplemental Social Security Income (SSI), employment, and Medicaid status. Past month functioning was assessed by Short-form 12-Item Health Survey, version 2, with scores for social functioning, role emotional functioning, and mental health, using odds ratios. Results: Over the past year, compared to acute depression, persons with DD were less likely to work full-time (36.2% vs. 44%; OR= 0.70, CI=.54, .92) and more often received SSI (13.9% vs. 4.5%; OR=3.4, CI=2.0,5.9) and Medicaid (20.2% vs. 13%; OR=1.7 , CI=1.1,2.6). Compared to AD, dysthymics reported accomplishing less because of emotional problems, and that emotional or physical problems interfered with social activities. Relative to the general population, respondents with DD were more likely to receive SSI (13.9% vs. 2.9%; OR=4.6, CI 3.4,6.2) and Medicaid (20.2% vs. 5.9%; OR=2.9, CI 2.0,4.1). Compared to GP, dysthymics reported accomplishing less because of emotional problems, and that emotional or physical problems interfered with social activities, and with work functioning. Conclusions: This confirms the significant psychosocial impairment associated with DD, a significant public health burden, highlighting the importance of finding effective long-term treatments.

**REFERENCES:**

1. Grant BF, Hasin DS, Stinson FS, et al. Co-occurrence of 12-month mood and anxiety disorders and personality disorders in the US: results from the national epidemiologic survey on alcohol and related conditions. J Psychiatr Res 2005;39:1-9

No. 81

**INCREASED MORTALITY AND HOSPITAL READMISSIONS IN PATIENTS DEPRESSED AT THE TIME OF DISCHARGE FROM MEDICAL WARDS**

*Antonio Campayo, M.D., Avda. San Juan Bosco, 15, Zaragoza, 50009 Spain*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participants should be able to recognize the implications of undetected depression in patients at the time of discharge from medical wards: the considerable prevalence of disorder, and the poor outcome should alert researchers, but also clinicians and administrators.

**SUMMARY:**

Objectives: A number of reports have documented the prevalence and implications of depression observed in medical wards, but a proportion of patients get better with improvement of the medical condition. To our knowledge,

this is the first study testing hypotheses about the poor outcome of medical patients depressed at the time of hospital discharge. Methods: Consecutive, adult patients admitted to Internal Medicine wards in 8 hospitals of the National Health System in Spain were examined in a two-phase case-finding procedure (1). Types I and II errors were considered in calculating sample size (N = 3,069). Standardized instruments used included the Hospital Anxiety and Depression Scale (HADS); the Standardized Polivalent Psychiatric Interview (SPPI); the Cumulative Illness Rating Scale (CIRS) for assessing severity of physical disease; and the SF-36 for assessing quality of life. ICD-10 research criteria, modified for hospital studies were used for the psychiatric diagnosis. The patients were followed up in Primary Care, six months after discharge. The statistical analysis included multiple regression techniques. Results: Mean age in this sample was 74.23 (SD=14.56) and 312 depressed patients were identified (15.96%; 95% CI 14.33-17.58), most of them previously undetected. At follow-up, 59.6% of them were still depressed or had died. Compared to non-depressed controls, and controlling for confounders, including severity of medical illness, the depressed patients had an increased risk of dying (OR=2.156; 95%CI=1.152-4.038; p=0.016). Furthermore, they had significant reduction in SF-36 scores (12.8 points less in the Mental Summary Scale and 3.6 in the Physical Summary Scale) and increased risk of hospital readmission (IR=2.952). Conclusion: Medical patients depressed at the time of hospital discharge, compared with the non-depressed, had more than twice the probability of dying in a 6-month follow-up, and three times the probability of hospital readmission.

**REFERENCES:**

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2. Spanish perspective on enlarging a small specialty: the national research network for liaison psychiatry and psychosomatics. Psychosomatics 48:46-53, 2007.

## SCIENTIFIC AND CLINICAL REPORT SESSION 28- EPIDEMIOLOGY, SLEEP, AND MEDICAL SCREENING

No. 82

### LABORATORY EVALUATION OF PSYCHIATRIC PATIENTS IN THE EMERGENCY ROOM

*Leslie Zun, M.D., M.B.A., 15th and California, Chicago, IL 60091*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to determine both the prevalence of drug and alcohol use in the emergency psychiatric population and whether this utilization leads to prolonged throughput times.

**SUMMARY:**

Objectives: The objective of this study is to determine both the prevalence of drug and alcohol use in the emergency psychiatric population and whether this utilization leads to prolonged throughput times.
Methods: This is a retrospective study that examines the charts of all psychiatric patients having drug screens and alcohol levels obtained from June 2007 to June 2008 within the emergency department of a level one adult and pediatric emergency trauma center with 60,000 annual visits. Results: Using ANOVA there was no significant difference between patients drug use prior to and after use of routine screens F = .008, p = .929, or throughput times F = .297, p = .587. There is however a significant relationship between admit diagnosis and cost of care F =7.14, p = .001, urine cannabinoid F= 1.91, p = .03, alcohol level F= 3.64, p - .01, violent
intents F= 3.29 p= .001, and disposition from ED F= 9.37, p= .001. Conclusions: There was no significant difference between admitted drug use and testing results. However, there was a significant relationship between differing types of illness and on drug use, hospitalization, throughput and cost. The usefulness of a universally given biochemical testing standard for all psychiatric patients seem less useful than determining the impact that specific diagnosis within duel diagnosis psychiatric patient population has on treatment.

**REFERENCES:**

1. Broderick, KB, Lerner, B, McCourt, JD, et. al: Emergency physician practices and requirements regarding the medical screening examination of psychiatric patients. Acad Emerg Med 2002;9:98-92.

No. 83

### STOP-BANG SLEEP APNEA SCREENING EVINCES A HIGH RISK AMONG PATIENTS ADMITTED TO PSYCHIATRIC UNITS

*Sam Al-Saadi, M.D., M.S., 401 Haddon Avenue, Camden, NJ 08103*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should

be able to identify the factors that increased the risk of obstructive sleep apnea(OSA) in patients admitted to a psychiatric ward. Participant should recognize that patients admitted to psychiatric wards are at a higher risk of OSA than the average patient in other studies. Recognize that Axis I diagnoses, psychotropic medications, and substances of abuse did not advance or reduce the risk of OSA in inpatient psychiatric admissions.

**SUMMARY:**

Introduction: Sleep disturbance is an established sign of uncontrolled mental diseases. As a consequence, it is difficult to establish if a sleep disorder is a promoter or sequela of uncontrolled mental disease. This study was conducted to assess the association of sleep apnea and mental diseases in an inpatient setting. Methods: In 2009, the STOP-BANG sleep questionnaire(SBSQ) was surveyed prospectively to a 100 of 123 patients admitted consecutively to an adult psychiatric inpatient of a crisis unit. Patients that scored 3 or more on the questionnaire were considered to be at risk for sleep apnea. Patients were compared for axis I, II, and III diagnoses, as well as demographics, comorbidities, and the SBSQ parameters. Fisher's exact test, Mann-Whitney test, and multiple Spearman regression analyses were utilized. Where appropriate, data are presented as median (mean ± SD). Results: 100 consecutive patients (55% males) were of age 35 years (38±13.7). 56 patients had been admitted involuntarily vs. 14 consensual voluntary and 30 voluntary. 53 patients scored 3 or more on SBSQ. Overall SBSQ score was 3 (3±1.7). Patients' SBSQ score did not differ between involuntary or voluntary admissions. Patients with Borderline Personality traits had significantly lower SBSQ scores compared to patients without Axis II diagnoses ($p<0.04$). SBSQ scores of patients with comorbid substance abuse did differ from patients without substance abuse. Higher risk of sleep apnea was associated with higher number of comorbidities ($p<0.0001$) and the number of none psychiatric medications ($p=0.0001$). Psychiatric medications, individually or collectively, did not correlate with higher SBSQ scores. SBSQ scores of patients with schizoaffective disorder 4 (4±1.7) were significantly higher than those of patients with bipolar disorder 2 (2±1.5) ($p=0.02$). Conclusions: Patients admitted to psychiatric inpatient units are at a high risk of having sleep apnea. The patient's risk of sleep apnea does not differ for voluntary vs. involuntary admissions. Affective disorders, psychotic disorders, comorbid substance abuse, and psychiatric medications did not change the risk of sleep apnea. Psychiatric inpatients have the highest risk of sleep apnea when there are many comorbidities.

**REFERENCES:**

1. Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology. 2008;108(5):812-21.

No. 84

## SCHIZOTYPAL PERSONALITY DISORDER IN THE UNITED STATES: PREVALENCE AND CORRELATES IN A REPRESENTATIVE GENERAL POPULATION SAMPLE

*Vanessa Lentz, M.S., B.S., PZ430-771 Bannatyne Avenue, Winnipeg, R3E 3N4 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize Schizotypal Personality Disorder (SPD) as a relatively common personality disorder in the general population; 2) Understand the substantial mental disorder comorbidity and elevated risk of suicidal behavior among individuals with SPD; and 3) Appreciate that SPD is more likely to be comorbid with certain Cluster B personality disorders than it is with the other Cluster A personality disorders.

**SUMMARY:**

Background: Schizotypal personality disorder (SPD) is a serious psychiatric disorder, characterized by a pervasive pattern of social and interpersonal deficits and marked functional impairment. However, it remains understudied among the personality disorders. Very little is known about the prevalence and psychiatric correlates of SPD in the general population. Objectives: To examine the prevalence, sociodemographic correlates, childhood adversity, mental disorder comorbidity, suicidal behavior, and quality of life associated with SPD in a representative epidemiologic sample. Method: The current study utilized data from Wave 2 of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC). The 2004-2005 Wave 2 NESARC dataset sampled the United States civilian adult population, surveying 34,653 individuals via in-person interviews. DSM-IV diagnoses were made using the Alcohol Use Disorders and Associated Disabilities Interview Schedule IV (AUDADIS-IV). Multiple logistic regression compared people with SPD to the general population across a broad range of sociodemographic characteristics, childhood adversities, comorbid psychiatric disorders, quality of life measures, and suicidal behavior. Results: The lifetime prevalence of SPD was 3.9%, with rates significantly higher in men [odds ratio (OR) = 1.29;

95% Confidence Interval (CI) = 1.12-1.49)] compared to women. SPD was strongly associated with many adverse childhood experiences and lower mental health-related quality of life. Even after adjusting for confounding factors, SPD was independently associated with major depression and several anxiety disorders, including posttraumatic stress disorder [Adjusted OR (AOR) = 1.53, 95% CI = 1.24-1.88]. Interestingly, SPD was more strongly associated with borderline (AOR = 6.96; 95% CI = 5.62-8.63) and narcissistic (AOR = 4.77; 95% CI = 3.97-5.74) personality disorders than Cluster A personality disorders. Individuals with SPD were also more likely to attempt suicide (AOR = 1.56; 95% CI = 1.20-2.04). Conclusions: This is the first epidemiological study of SPD using data from a nationally representative sample. SPD is relatively common in the general population and associated with considerable negative consequences, including suicidal behavior. The surprising association with Cluster B personality disorders requires replication in future studies, and if consistent may have potential implications for the categorization of SPD.

**REFERENCES:**

1. Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering MS: Prevalence, correlates, and disability of personality disorders in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions. J Clin Psych 2004; 65: 948-958.
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## SCIENTIFIC AND CLINICAL REPORT SESSION 29- IMPORTANT BUT INFREQUENTLY ADDRESSED TOPICS

No. 85

### OVERDIAGNOSIS OF BIPOLAR DISORDER AND DISABILITY PAYMENTS

*Mark Zimmerman, M.D., 235 Plain Street, Suite 501, Providence, RI 02905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be aware that an unconfirmed diagnosis of bipolar disorder is significantly associated with receiving disability benefits.

**SUMMARY:**

Objective: The diagnosis of bipolar disorder has received increasing attention during the past decade. Several research reports have suggested that bipolar disorder is underrecognized, and that many patients, particularly those with major depressive disorder, have, in fact, bipolar disorder. More recently, some reports have suggested that bipolar disorder is also overdiagnosed at times. There are several possible reasons for bipolar disorder overdiagnosis. In the present study we examined whether secondary gain associated with receiving disability payments might be partially responsible for bipolar disorder overdiagnosis. Method: Eighty-two psychiatric outpatients reported having been previously diagnosed with bipolar disorder which was not confirmed when interviewed with the Structured Clinical Interview for DSM-IV. The percentage of patients receiving disability payments and the duration of disability payments were compared in these 82 patients and 528 patients who were not diagnosed with bipolar disorder. Results: Compared to the patients who had never been diagnosed with bipolar disorder, the patients overdiagnosed with bipolar disorder were significantly more likely to have received disability payments at some point during the past five years, and were receiving disability payments for significantly more weeks. We conducted a regression analysis controlling for the number of lifetime diagnoses, and overdiagnosis of bipolar disorder was a significant predictor of disability status (OR=3.8, 95% CI 1.6-8.8). Conclusion: An unconfirmed diagnosis of bipolar disorder was significantly associated with receiving disability benefits.

**REFERENCES:**

1. Huxley N, Baldessarini RJ. Disability and its treatment in bipolar disorder patients. Bipolar Disord 2007;9:183-196.
2. Zimmerman M, Ruggero CJ, Chelminski I, Young D. Is bipolar disorder overdiagnosed? J Clin Psychiatry 2008;69:935-940.

No. 86

### CAN WE TALK? DO PSYCHOTHERAPISTS AND PRESCRIBING PSYCHIATRISTS COMMUNICATE WITH EACH OTHER ABOUT THEIR MUTUAL PATIENTS?

*Thomas Kalman, M.D., M.S., 11 East 87th st.apt. 1B, New York, NY 10128*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the major clinical issues related to the conduct of "split-treatment", focusing on issues of communication between psychotherapists and

psychopharmacologists; and 2) The participant will be familiar with the results of a survey of practicing psychotherapists assessing the frequency of communication with psychiatrists who prescribe for their patients.

**SUMMARY:**
BACKGROUND: In the past twenty years American psychiatrists have moved dramatically away from the provision of psychotherapy to patients. During that same time frame increasing numbers of Americans have been taking psychotropic medications. Psychotherapy is thus most frequently provided by non-MDs (often fueled by the cost-containment mechanisms of Managed Care), leading to the now established practice of "split-care" arrangements, whereby patients see two mental health professionals- one for therapy and one for medication. Although no formal guidelines exist for the provision of care under such arrangements, communication between professionals treating the same patient is a generally accepted principle necessary for optimal care. One study exists about communication between psychiatric residents and therapists in an institutional setting; however, there has been no published data documenting whether or not private practice therapists communicate with the psychiatrists who prescribe for their patients. This question is addressed by the present study. SUBJECTS AND METHODS: A nine-item anonymous survey inquiring about private practice was distributed to psychotherapists in Manhattan. Information about professional degree and discipline, duration and size of practice, and frequency of communication with professionals who prescribe for their patients was gathered. RESULTS: Fifty psychotherapists (34 holding PhD degrees and 16 with Masters degrees) returned completed surveys. The majority of respondents were Psychologists(27) and Social Workers(17), and the average time in practice was slightly over 21 years. Respondents reported on 1054 psychotherapy patients, with 417 (40%) of them concurrently taking medication. For 81 (21%) of psychotherapy patients taking medication, no communication had taken place between psychotherapist and psychopharmacologist. Quarterly communication between psychotherapist and psychopharmacologist occured for just 7 (<2%) of the 417 psychotherapy and medication patients. Additional findings will be presented. CONCLUSIONS: Communication between professionals engaged in split-care treatment, historically presumed to be a core component of optimal care, is not taking place, leaving open questions about the quality and safety of treatment delivered in this fashion, and raising questions about the need for more formalized guidelines for the conduct of split treatment.

**REFERENCES:**

1. Hansen-Grant, S. and Riba, M. (1995). Contact Between Psychotherapists and Psychiatric Residents Who Provide Medication Backup. Psychiatric Services, 46(8), 774-777.

No. 87

## THE ECONOMIC IMPACT OF MEDICATION ACCESS PROBLEMS AMONG MEDICAID PSYCHIATRIC PATIENTS IN TEN STATES

*Joyce West, Ph.D., M.P.P., APIRE 1000 Wilson Blvd, Suite 1825 Arlington, VA 22209,*
*Arlington, VA 22209*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the relationship between medication access problems and increased psychiatric emergency room visits and hospitalizations; and 2) Appreciate the extent to which medication access problems attributed to prescription drug utilization management and coverage policies may be associated with increased psychiatric emergency room visits and hospitalization costs.

**SUMMARY:**
Background: As Medicaid costs increase, states have used prescription drug (PD) utilization management to contain costs. However, some of these approaches are associated with medication discontinuations and other access problems among psychiatric patients. Study Aims: Assess whether Medicaid programs incur increased psychiatric ER and hospital costs as a result of medication access problems attributed to prescription drug coverage and management issues. Methods: 5,000 psychiatrists in ten states were randomly selected from the AMA Masterfile. 61% responded; 34% met study eligibility criteria of treating Medicaid patients, reporting clinically detailed data on 1,625 systematically-selected Medicaid patients. Propensity score multivariate models assessed the predicted probabilities and mean number of psychiatric hospital days and ER visits, controlling for confounding variables. Results: 46% of patients had at least one medication access problem the past year, including discontinuing medications or not being able to access clinically indicated refills or new prescriptions because of drug coverage or management issues. Patients with medication access problems had an 18.1% excess predicted probability of having an ER visit (100% of p values<=.05) and a 12.4% excess predicted probability of being hospitalized (100% of p values<=.05). Across the ten states, the expected number of ER visits were estimated to be between 78.2% and 147.3% higher among patients with medication access problems, controlling for clinical case mix. Among the majority of inpatients with 30 or fewer inpatient days, expected hospital days ranged from 51.0% to 143.5% higher for patients with medication access problems. Summary: Medication access problems may have significant cost-offset implications for Medicaid programs. More effective Medicaid PD management and financing practices are needed to promote medication continuity and improve outcomes of treatment for psychiatric patients.

**REFERENCES:**

1. West JC, Wilk J, Rae DS, Muszynski IS, Stipec MR, Alter CL, Sanders KE, Crystal S, Regier DA: Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings From Ten States. Psychiatric Services 60(5):601–610. 2009
2. Soumerai SB: Benefits and risks of increasing restrictions on access to costly drugs in Medicaid. Health Affairs (Millwood) 23:135-146, 2004

**SATURDAY, MAY 22, 2010**
**8:00AM-12NOON**

SM01
## MANAGING MALPRACTICE RISK FOR PSYCHIATRISTS: THE BASICS AND BEYOND

*Chairperson: Jacquline Melonas, J.D., R.N. Professional Risk Management Services, Inc., 1515 Wilson Blvd., Suite 800, Arlington, VA 22209*
*Co-Chairperson: Donna Vanderpool, J.D., M.B.A.*
*Faculty: Denita Neal, J.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to:: 1) Utilize a suicide assessment tool; 2) Document initial and on-going suicide assessment; 3) Incorporate discussion of off-label use into the informed consent process; 4) Manage medication monitoring with a formal monitoring system; 5) Minimize risks associated with disclosing confidential information; 6) Apply the termination of treatment process appropriately; and 7) Recognize professional liability risks related to technology and forensics.

**SUMMARY:**
Malpractice lawsuits are a significant concern for psychiatrists in all practice settings. Based on over 20 years managing claims and lawsuits against psychiatrists, PRMS has seen a 6-8% overall risk for a psychiatrist to be involved in a claim or lawsuit. However, news reports sensationalizing large jury verdicts may lead psychiatrists to overestimate some malpractice liability risks, while at the same time underestimating or ignoring other more common risks. From our experience, PRMS is able to share common sources of malpractice actions, including high-risk exposures, and outcomes of claims and lawsuits. This presentation will focus on identifying and discussing various risk areas and presenting proven risk management strategies to decrease risk. The goals of risk management are to increase patient safety and to decrease malpractice litigation; risk management does not support so-called "defensive medicine." On the contrary, providing clinically appropriate care and documenting it thoroughly is always the best risk management. Presenters will discuss high-risk areas, both in terms of frequency and severity, and provide guidance to help ensure that appropriate clinical care is provided to patients. Some of the information presented will be in the form of case studies. Areas that will be explored include treating suicidal patients; prescribing psychotropic medications; the importance of effective communication; confidentiality and release of patient information; proper termination of the psychiatrist-patient relationship; and the emerging risk areas of technology and forensics. There will be extensive participant interaction throughout the course by use of audience polling technology. By attending this course, participants will gain a better understanding of their true professional liability exposure and understand the value of proven risk management strategies in minimizing that liability risk.

SM 02
## EVIDENCE BASED PSYCHOTHERAPY FOR CHRONIC MAJOR DEPRESSION

*Chairperson: Eric Levander M.D., 9171 Wilshire Blvd., Suite 680, Beverly Hills, CA 90210*
*Co-Chairperson: Toshiaki A. Furukawa M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to:1) differentiate chronic depression from acute/episodic major depression; 2) understand the basic psychopathology of chronic major depression; 3) understand behavioral methods used to treatment of chronic major depression; and 4) understand the role of disciplined personal involvement rather than the traditional "neutral" therapist role for the treatment of chronic major depression

**SUMMARY:**
As recent evidence from STAR-D demonstrates, medically treating both acute and chronic depression to remission remains a difficult task for the physician. Chronic depressive illness such as dysthymic disorder or major depression with a current episode lasting longer than two years often is more treatment refractory to both medication and standard psychotherapy. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was developed specifically to treat the chronically depressed adult. Results from the largest psychotherapy and medication trial ever conducted of 681 participants demonstrated CBASP was as effective as medication alone and in combination with medication management produced significant improvements in symptom relief. Results from a second large trial of CBASP for 850 patients with chronic major depression will soon be published. Yet few clinicians are familiar with this novel psychotherapy. The principal techniques of CBASP include situation analysis (SA) in addition to two

types of disciplined personal involvement by the therapist. Situation analysis teaches chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Disciplined therapist personal involvement, a taboo from the infancy of psychotherapy, targets problematic interpersonal behaviors through the use of the Interpersonal Discrimination Exercise (IDE) and contingent personal responsivity (CPR). The IDE is a personal involvement methodology used by the CBASP therapist to heal earlier developmental trauma while CPR employs disciplined personal involvement in a contingent manner to modify pathological interpersonal behavior. With few effective evidence based psychotherapies used to treat chronic depressive illness, this course is designed to give an overview of the CBASP as well as an introduction to its major techniques.

**1:00PM-500PM**

SM03

**MANAGING MALPRACTICE RISK FOR PSYCHIATRISTS: THE BASICS AND BEYOND**

*Chairperson: Jacquline Melonas, J.D., R.N. Professional Risk Management Services, Inc., 1515 Wilson Blvd., Suite 800, Arlington, VA 22209*
*Co-Chairperson: Donna Vanderpool, J.D., M.B.A.*
*Faculty: Denita Neal, J.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to:: 1) Utilize a suicide assessment tool; 2) Document initial and on-going suicide assessment; 3) Incorporate discussion of off-label use into the informed consent process; 4) Manage medication monitoring with a formal monitoring system; 5) Minimize risks associated with disclosing confidential information; 6) Apply the termination of treatment process appropriately; and 7) Recognize professional liability risks related to technology and forensics.

**SUMMARY:**

Malpractice lawsuits are a significant concern for psychiatrists in all practice settings. Based on over 20 years managing claims and lawsuits against psychiatrists, PRMS has seen a 6-8% overall risk for a psychiatrist to be involved in a claim or lawsuit. However, news reports sensationalizing large jury verdicts may lead psychiatrists to overestimate some malpractice liability risks, while at the same time underestimating or ignoring other more common risks. From our experience, PRMS is able to share common sources of malpractice actions, including high-risk exposures, and outcomes of claims and lawsuits. This presentation will focus on identifying and discussing various risk areas and presenting proven risk management strategies to decrease risk. The goals of risk management are to increase patient safety and to decrease malpractice litigation; risk management does not support so-called "defensive medicine." On the contrary, providing clinically appropriate care and documenting it thoroughly is always the best risk management. Presenters will discuss high-risk areas, both in terms of frequency and severity, and provide guidance to help ensure that appropriate clinical care is provided to patients. Some of the information presented will be in the form of case studies. Areas that will be explored include treating suicidal patients; prescribing psychotropic medications; the importance of effective communication; confidentiality and release of patient information; proper termination of the psychiatrist-patient relationship; and the emerging risk areas of technology and forensics. There will be extensive participant interaction throughout the course by use of audience polling technology. By attending this course, participants will gain a better understanding of their true professional liability exposure and understand the value of proven risk management strategies in minimizing that liability risk.

SM04

**INFIDELITY AND MARITAL RELATIONSHIPS: DEATH KNELL OR WAKE-UP CALL?**

*Chair: Scott Haltzman M.D. 147 County Road, Barrington ,RI 02806*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify three intrapsychic and external factors that lead to affairs; 2) Gain insight into the prevelence of infidelity in American culture; 3) Have the ability to advise couples about the five steps to healing from infidelity; and 4) Know how to refer individuals or couples for support if they have suffered from infidelity

**SUMMARY:**

Infidelity rates range from 25 to 70 percent. There are many type of infidelity, and as technology expands, so does our definitions. Affairs don't rise out of a need for sex in the majority of cases, but there are emotional needs and opportunities that play a role in the emergence of an affair.

There are many moral, ethical and practical implications of infidelity, including how children fair when their parents separate because of an affair. There are several phases to the unveiling and healing of infidelity: Revelation, ending infidelity, allowing discussion/processing, acceptance of responsibility, forgiveness, and moving forward. As therapists, we must recognize that there are modalities for dealing with infidelity in psychotherapy with individuals—knowing how to counsel patients when you know they are having affair. As we know from affairs of politicians, there are other issues that arise when dealing with infidelity, issues around cultural norms, addictions and the effect on the community and family. Any treatment of infidelity must include Community, internet and bibliographic resources for the treatment of infidelity. With the current economic crisis putting external pressures on many marriages in this country and globally, it is important for psychiatrist to understand how to manage marital stress and the impact of infidelity.

**SUNDAY, MAY 23, 2010**
**9:00AM-4:00PM**

SM05:
**THE IMG INSITUTE**

Chairperson: Nyapati R. Rao, M.D., M.S. Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, MY 11554
Co-Chairperson: Deborah Hales, M.D.
Faculty: Milton Kramer, M.D., Jacob E. Sperber, M.D., Larry Faulkner, M.D., Joan Anzia, M.D., Michael Jibson, M.D., Peter Buckley, M.D., Pri Weerasekara, M.D., M.Ed., Ramotse Saunders, M.D., Mantosh Dewan, M.D., Gerald Whalen, M.D., Jeffrey Goldberg, D.O., Damir Huremovic, M.D., M.P.P.

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to; 1)Gaining self-awareness of their own ethno-cultural backgrounds and how this influences their interactions with patients/teachers/health care providers, as well asfostering cultural diversity awareness 2)Using such a knowledge as a base, instruct residents effective psychiatric interviewing strategies to help them succeed in the new clinical evaluation system introduced by the ABPN;3)Provide clarity about the American health

**SUMMARY**:
International Medical Graduates (IMGs) constitute 34% of all psychiatric trainees. Historically, IMGs have played a vital role in healthcare delivery to the poor and underserved, and many IMGs have distinguished themselves in American psychiatry. However, they are heterogeneous in their cultural, linguistic, and educational backgrounds as well as in their exposure to psychiatry in medical school. While this diversity may be an asset in a multi-cultural society like ours, it also creates hurdles to IMGs at the beginning of their careers as residents, so that IMGs may find that the American health care system is vast and complex, the educational demands in residency are overwhelming, and the sociocultural norms are hard to fathom. These challenges may manifest themselves as deficits in practice of the psychosocial aspects of psychiatry, poor performance in clinical and knowledge assessments and conflicts in doctor-patient and interdisciplinary relationships. There may be specific difficulties with language and cultural norms and values underlying these deficits, which are especially problematic in a specialty like psychiatry where facility with communication and proficiency in psychosocial areas are important prerequisites for success.
While the Residency Review Committee in Psychiatry requires instruction in cultural psychiatry, more often than not, such instruction does not address specific deficits that IMGs experience. Consequently, there is a growing recognition in the field that IMGs require a more intense and focused orientation to American medicine that addresses their specific weaknesses. It is hoped that the knowledge, skills, and cultural insights gained from this experience will form the foundation on which IMGs, with further contributions from their training activities, can build their future identity as psychiatrists. However, individual training programs may not have resources to offer such courses. Therefore, the American Psychiatric Association has taken the leadership in creating a comprehensive introduction to psychiatric residency training for IMG

**SUNDAY MAY 23, 2010**
**1:00PM-5:00PM**

SM06.
**OVERVIEW OF RECOVERY FOR PSYCHIATRISTS**

*Chairperson: Mark Ragins, M.D. 456 Elm Avenue, Long Beach, CA 90802-2426*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be

able to 1) To have a basic understanding of the proponents of the recovery movement and why it's gotten so powerful 2) To have a basic understanding of core recovery concepts and their practical application 3) To understand a 4 stage Kubler-Ross style model of recovery and how hospice can be a model for mental health recovery 4) To understand a set of recovery based goals, techniques, and treatment model transformations underlying

**SUMMARY:**

The recovery movement is gaining momentum in the public mental health system around the country. Many psychiatrists are being expected to support program transformations and make recovery based changes in our own practice. However, we often haven't been included in the orientations, trainings, planning, or implementation of the recovery model. Also, specific implications of the recovery model for psychiatrists aren't usually addressed directly. Psychiatrists can find ourselves described as resistant to recovery before we've been seriously informed and engaged. This course is designed to provide an in depth overview of the recovery model with an extra focus on specific implications for psychiatrists. Part 1 will begin with the contributors to the recovery movement (including 12 step, consumer movement, rehabilitation, "outsider staff", civil rights, and passionate professionals) and how it has grown so strong. I will describe some of the practical advantages of the recovery model (Including being a treatment culture that facilitates the integration of the evidence based practices into one seamless program, engaging people "inappropriate for treatment" or "noncompliant", creating the quality of life outcomes deinstitutionalization sought, and reducing staff burnout). I will then describe the key concepts of the recovery movement and how they apply to everyday practice (including Recovery is not the same as cure, Recovery is person centered, not illness centered, Recovery is from the crippling not the illness, Recovery is goal directed, and Recovery is strengths based building resiliency). Part 2 will describe a practical model of recovery based upon Kubler-Ross style stages emphasizing how the values of the recovery movement are important because they are the tools to facilitate people progressing through the stages of recovery and how hospice can be an inspiring, practical "person centered" system of care. I will also describe a set of recovery based transformations for the individual doctor – patient relationship emphasizing changes we can make on our own in medication visits. Part 3 will discuss Program and System based changes. I will include a recovery based service triage model (unengaged, engaged but poorly self coordinating, and self responsible) to differentiate services, including medication services. I will also describe an example of a clinic redesign that restructures services even with limited resources.

**WEDNESDAY, MAY 26, 2010**
**1:00PM-5:00PM**

SM 07

## PRACTICAL GUIDE TO THE PERFORMANCE OF THE MENTAL STATUS EXAMINATION

*Chair: Stephen Deutsch M.D.,* Ph.D., *825 Fairfax Avenue, Norflok, VA 23507*
*Faculty, Richard Fosse, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant will know: 1) The critical elements and have a strategy for performing a reliable, objective, cross-sectional, and largely observer-rated evaluation of the mental status; 2) Understand why this examination is essential to the accurate assessment of neuropsychiatric disorders; and 3) Appropriate treatment selection and monitoring course of illness.

**SUMMARY:**

The ability to perform and record the comprehensive examination of the mental status is crucial to the work of the psychiatrist. Not infrequently, however, psychiatrists at all levels of training and experience either lack confidence in their ability to perform this examination or do not have an approach to the organization and presentation of the data collected during its performance. The integration of the cross-sectionally performed mental status examination with longitudinal history is a necessary first-step in generating diagnostic "hypotheses," determining need for laboratory and imaging studies, and formulating an initial treatment plan. Serial examinations are crucial to evaluating course of illness (e.g., improvement or worsening) and response to treatment. Oftentimes, the psychiatrist's ability to examine the mental status reliably is her or his most significant contribution to patient management on general medical and surgical inpatient services. The speakers will provide an introduction and framework for conducting and presenting this essential clinical examination. The course and its content are a distillation of more than 20 years of the direct involvement in the teaching and clinicalsupervision of the performance of the mental status examination by medical students and residents in inpatient and outpatient settings by the faculty.

**SMALL INTERACTIVE SESSIONS**

**MONDAY, MAY 24, 2010, 9:00 AM-10:30AM**

SMALL INTERACTIVE SESSION 1

**DIAGNOSIS AND EVIDENCE-BASED TREATMENT OF BIPOLAR DISORDER**

*Chariperson: Terence A Ketter, M.D., 401 Quarry Rd., Room 2124, Stanford, CA 94305-5723*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session the participant should be able to: 1) Demonstrate increased knowledge of diagnosis of bipolar disorder; 2) Recognize additional information about evidence based treatment of bipolar disorder and 3) Identify additional resources for learning more about bipolar disorder, its diagnosis and treatment.

**SUMMARY:**

This session gives attendees an opportunity to discuss with Dr. Terence Ketter the contents of his book, Handbook of Diagnosis and Treatment of Bipolar Disorder. Advances in the diagnosis of Bipolar Disorders have been emerging at an accelerating pace. Unfortunately, our diagnostic system has not kept pace, as the last substantial revision was in 1994, when the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders was published. Thus, as of mid-2009, the diagnostic system was approximately 15 years old. The Handbook describes the 2008 International Society for Bipolar Diagnostic Guidelines Task Force report, which provides a much-needed update on approaches to diagnosis. The development of 9 new FDA- approved treatments since 2000 has yielded important new management options. However, efforts to summarize treatment options for clinicians, such as the 2002 revision of the American Psychiatric Association Practice Guideline for Bipolar Disorders have quickly become outdated. Clinicians and patients thus face an increasingly complex process of decision-making when selecting pharmacotherapies. At the same time, there is an increasing appreciation for the need for evidence-based, personalized care. Quantitative (numerical) as opposed to qualitative (non-numerical) approaches have the potential to yield more reproducible outcomes. The Handbook quantifies potential benefit (number needed to treat) and risk (number needed to harm) for all approved treatments for bipolar disorder, providing clinicians with information needed to balance benefits and risks in order to render individualized state-of-the-art, evidence-based care. In this small, interactive session, Dr. Ketter will discuss with attendees recent developments in diagnosis and interventions supported by controlled studies. The emphasis will be on practical clinical applications of these advances.

**REFERENCES:**

1. Ketter TA: Handbook of Diagnosis and Treatment of Bipolar Disorder. Washington, DC, American Psychiatric Publishing, Inc., 2009
2. Ghaemi SN, Bauer M, Cassidy F, Malhi GS, Mitchell P, Phelps J, Vieta E, Youngstrom E: The ISBD Diagnostic Guidelines Task Force: Diagnostic guidelines for bipolar disorder: a summary of the International Society for Bipolar Disorders Diagnostic Guidelines Task Force Report. Bipolar Disord 10: 117–128, 2008

SMALL INTERACTIVE SESSION 2

**SUCCESSFUL COGNITIVE AND EMOTIONAL AGING: HOW CAN WE GET THERE?**

*Chairperson: Dilip V. Jeste, M.D., 9500 Gilman Drive, #0664, La Jolla, CA 92093*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session the participant should be able to: 1) Recognize definitions of successful aging; 2) Identify genetic, neurobiological, and psychosocial behavioral contributors to successful cognitive and emotional aging; and 3) Demonstrate knowledge about evidence-based interventions to enhance likelihood of successful cognitive and emotional aging.

**SUMMARY:**

There have been remarkable recent advances in genetics, neuroscience, and psychological and social sciences, which have challenged long-held and largely pessimistic assumptions about aging of brain and mind. New research provides strong evidence for neuroplasticity of aging – i.e., ability of the brain to change in response to environmental and behavioral modifications. This session will describe the current understanding of aging in relation to cognitive and emotional health, describing definitions, determinants, and interventions. Historical viewpoints on how positive health is attained will be mentioned along with modern models of healthy aging from the perspectives of both scientists and older people themselves. We will review conventional topics in cognitive aging, such as memory and attention, as well as the scientific bases of less studied concepts such as wisdom, resilience, and spirituality. To discuss the putative determinants of successful aging, we will focus on the influences of genes, mental attitudes, health, and health-related behaviors on aging of brain and mind. Next, we will address the question of what people can do to increase their likelihood of successful cognitive and emotional aging. We will review the evidence base for diet and nutrition, physical exercise, brain games and cognitive interventions, as well as attitudes and behaviors on improving brain/mental health. We will conclude with suggestions for the role of psychiatrists and other clinicians

in promoting cognitive and emotional health among our patients.

**REFERENCES:**

1. Depp, C. & Jeste, D.V. Successful Cognitive and Emotional Aging. American Psychiatric Press, Inc., Washington, DC, 2009.
2. Meeks T. & Jeste, D.V. The neurobiology of wisdom. Archives of General Psychiatry, 66:355-365, 2009.

SMALL INTERACTIVE SESSION 03

## THE CRISIS OF ACCESS TO PSYCHIATRISTS IN AN ERA OF HEALTH REFORM

*Chairperson: Steven S Sharfstein, M.D., 6501 North Charles Street, Baltimore, MD 21204 U.S.A.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Identify the financial barriers that individuals with severe mental illness experience when trying to access specialty psychiatric treatment; 2)Anticipate the role of managed behavioral health care under health reform; and 3)Recognize that there are no easy solutions given the robust epidemiology and the limited number of adult and child psychiatrists in the U.S.

**SUMMARY:**

Only 20 percent of Americans in a given year experience a diagnosable mental disorder yet only 1:5 of this group have the opportunity for specialty mental health services; even fewer have the opportunity for a psychiatrist to diagnose and treat. The majority of patients who suffer symptoms of mental disorders see primary care physicians as their principle provider of care. Nearly 47 million Americans are uninsured, and another 40-50 million Americans are under-insured for treatment of mental illness. Managed behavioral health care has created the opportunity for "parity" of coverage but also barriers to comprehensive psychiatric care as they are the primary vehicle to constraining costs. Since psychiatrists are the most expensive providers of mental health care, managed care limits access to specialty psychiatrists as well as limits inpatient treatment to the shortest stay possible in a paradigm of crisis stabilization. Furthermore, fees are limited by insurance and when combined with the hassle factor under managed care, many psychiatrists have "opted out" of insurance coverage, including Medicare, and have established fee-for-service practice limited to out-of-pocket payments. It has been estimated that in many metropolitan areas, half of the psychiatrists in office practice no longer take insurance. This session will review access to specialty psychiatric treatment in an era of health reform and, with the participants' help, will brainstorm on what might be solutions so that more psychiatrists treat patients in need given cost constraints and the desire for quality care.

**REFERENCES:**

1. U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

SMALL INTERACTIVE SESSION 04

## SUICIDE AND SUICIDE RISK ASSESSMENT: PRACTICAL INFORMATION AND APPLICATION

*Chairperson: Timothy Lineberry, M.D., Mayo Clinic, 200 First Street SW, Generose 3, Rochester, MN 55905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to: 1) Participants will describe the most common conditions and periods associated with suicide; 2)Participants will be able to discuss practical issues associated with prediction of suicide; and 3)Participants will describe models of suicide risk assessment.

**SUMMARY:**

In this small interactive session, we will review some of the basics of epidemiology of suicide to include lifetime risk of suicide for specific psychiatric disorders, periods of highest risk, and the differences between suicides in the hospital versus outpatients versus the general population. We will review the challenges associated with prediction of suicide as well as reviewing different models of performing suicide risk assessment. The session will review cases and practical applications of suicide risk assessment including environmental factors, treatment issues, and documentation concerns. This session will be highly participative, and attendees are encouraged to bring case examples.

**11:00 AM-12:30PM**

SMALL INTERACTIVE SESSION 05

## ANTIPSYCHOTIC POLYPHARMACY: AN EVIDENCE-BASED PERSPECTIVE

*Chairperson: Donald C Goff, M.D., 25 Staniford Street, 2nd Fl., Boston, MA 02114 U.S.A.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant

will be able to discuss the rationale for polypharmacy; and 2) At the conclusion of this session, the participant will be able to discuss the clinical evidence for and against the use of polypharmacy in schizophrenia.

**SUMMARY:**

Antipsychotic polypharmacy has been reported at rates as high as 30% of patients with schizophrenia, despite the absence of consistent evidence to support this approach. Two rationales have been proposed to explain this practice. The first is the use of polypharmacy to reduce side effects, either by achieving therapeutic levels of D2 occupancy by combining lower doses of two drugs with dissimilar side effect profiles or by suppressing side effects with a second drug, such as the addition of aripiprazole to reduce hyperprolactinemia. The second rationale is to improve efficacy in refractory patients. Two placebo-controlled trials have reported benefit with addition of risperidone to clozapine, possibly reflecting an increase by risperidone of D2 antagonism, although several other controlled trials have been negative. The relative evidence for each approach will be reviewed.

**REFERENCES:**

1.Freudenreich O, Goff DC: Antipsychotic combination thera py in schizophrenia: A review of efficacy and risks of current-combinations. Acta Psychiatr Scand 106:323-330, 2002.

SMALL INTERACTIVE SESSION 06

## THE GRAVITY OF WEIGHT: THE IMPOSSIBLE HEAVINESS OF BEING

*Chairperson: Sylvia R Karasu, M.D., 2 E 88th St, New York, NY NY 10128-0555 U.S.A.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) to provide the participant with an overview of the complexities and multi-dimensions, including genetic, environmental, metabolic, circadian, and neuro-psychiatric factors, involved in obesity and its treatment modalities.

**SUMMARY:**

Most researchers believe obesity has reached epidemic proportions, and predictions indicate it will become significantly worse over time. There are now more overweight and obese people throughout the world than those who go hungry. Obesity has been called a genetic disorder, a metabolic disorder, a disorder due to a toxic food environment, and even a brain disease. Mental health professionals should be aware of how obesity is diagnosed, what impact it can have medically and psychologically (including issues of stigma and discrimination), difficulties involved in obesity research, and limitations, including psychological, pharmacological, and surgical approaches, to treatment.

**REFERENCES:**

1. Sylvia R. Karasu, M.D. and T. Byram Karasu, M.D. The Gravity of Weight: A Clinical Guide to Weight Loss and Maintenance. Washington, D.C., American Psychiatric Publishing, Inc., 2010

2. Thomas A. Wadden and Albert J. Stunkard (eds). Handbook of Obesity Treatment. New York: The Guilford Press. 2004 (paperback)

SMALL INTERACTIVE SESSION 07

## CHILD PSYCHOPHARMACOLOGY: SSRIS, STIMULANTS AND SAFETY ISSUES

*Chairperson: Barbara Coffey, M.D., 63 Westminster Rd., Lake Success, NY 11020*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify significant adverse effects of selective serotonin reuptake inhibitors (SSRIs) and stimulants used in children and adolescents; 2) Discuss latest findings on suicidality with SSRIs and cardiac issues with stimulants in youth and 3) Review benefit and risk profile of SSRIs and stimulants in youth.

**SUMMARY:**

Use of psychopharmacologic agents, including selective serotonin reuptake inhibitors (SSRIs) and stimulants, has risen significantly over the past decade in children and adolescents. Emerging reports of adverse effects in youth are of concern. Questions regarding safety of these medications have emerged, including suicidality with antidepressants, and cardiac issues with stimulants in youth. Safety issues in child psychopharmacology will be reviewed with a focus on SSRIs and stimulants. Guidelines for a rational, evidence-based approach to targeted psychopharmacological treatment will be discussed; comprehensive review of benefit vs. risk issues will be included.

**REFERENCES:**

1. Special section: Journal of the American Academy of Child and Adolescent Psychiatry Greenhill, L Introduction: assessment of safety in pediatric psychopharmacology, JAACAP; 42 (6); 2003; 625-626.

2. Greenhill, L. Vitiello, B. Riddle, M. et al. Review of safety assessment methods used in pediatric psychopharmacology. JAACAP; 42 (6); 2003; 627-633

3. Vitiello, B. Riddle M. Greenhill L. et al. How can we improve the assessment of safety in child and adolescent psycho-

pharmacology? JAACAP; 42 (6); 2003; 634-641.

SMALL INTERACTIVE SESSION 08

## DELIRIUM ASSESSMENT AND MANAGEMENT

*Chairperson: James R Rundell, M.D., Department of Psychiatry, Mayo Clinic, Mayo Bldg, West 11, 200 First Street SW, Rochester, MN 55905 U.S.A.*

**EDUCATIONAL OBJECTIVES:**

By the conclusion of the session, participants should be able to: 1) Demonstrate knowledge of diagnosis and etiologies of delirium; 2) Demonstrate knowledge of data on impact of delirium on mortality and morbidity; 3) Understand key elements of delirium pathophysiology; 4) Understand principles of managing and preventing delirium and 5) Review basis and relevance of "black box warnings" related to antipsychotic medications.

**SUMMARY:**

Delirium can be reliably diagnosed. It has significant morbidity, mortality and cost. Pathophysiology may be related to neurotransmission disruption, inflammation, acute stress responses or neuronal injury. It has a prevalence of 9%-22% in the general hospital and 30%-80% in the ICU. Hypokinetic delirium has a poorer prognosis than mixed or hyperkinetic delirium. Precipitating factors include toxic, metabolic, hypoxic and inflammatory etiologies. Predisposing factors include pre-existing cognitive dysfunction, age over 65, multiple medications/ medical conditions, alcohol abuse, dehydration, and malnutrition. Delirium is associated with long-term cognitive impairment. Management principles include prevention, reversal of etiology, and symptomatic management with medications and environmental manipulations. The best management strategy is prevention. Attention to six factors may significantly reduce the incidence of delirium in hospitalized patients: orientation, noise reduction, early mobilization, visual aids, hearing aids, and hydration. There are no randomized placebo-controlled drug trials to inform symptomatic treatment. Prospective studies, including a handful of comparison trials, suggest symptomatic improvement may be expected with antipsychotics and that there is no efficacy advantage among medications studied. Lorazepam may be more likely than antipsychotics to worsen confusion and cause disinhibition. Medications most frequently studied include haloperidol, quetiapine, olanzapine, and risperidone.

**REFERENCES:**

1. Fong TG, Tulebaev SR, Inouye SK: Delirium in elderly adults: diagnosis, prevention and treatment. Nature Reviews-Neurology 2009; 5:210-220

**TUESDAY, MAY 25, 2010**

**9:00 A.M.-10:30 A.M.**

SMALL INTERACTIVE SESSION 09

## NEUROPSYCHIATRIC ASSESSMENT FOR GENERAL PSYCHIATRISTS

*Chairperson: Sheldon Benjamin , M.D., 55 Lake Ave N Room S7-823, Worcester, MA 01655-0002*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Determine the most appropriate neuropsychiatric assessment techniques for the cases discussed; 2) Select the appropriate bedside mental status assessment tasks for given conditions; 3) Recognize axioms that demystify neuropsychiatric assessment.

**SUMMARY:**

Psychiatrists are frequently called upon to evaluate individuals whom they feel are atypical in some way and at higher risk of having a neurological component to their behavior. This may stem from the behavioral phenomenology; or from a history of developmental disability, learning disorder, traumatic brain injury, epilepsy, movement disorder, dementia, or other neurological disorder. Apart from referring these individuals to our neurology colleagues for consultation there are a number of diagnostic strategies that enable psychiatrists to form a hypothesis as to the etiology of a given behavior. These include the flexible application of cognitive status examination, the neurological examination, the use of neurodiagnostic assessment techniques such as neuropsychological testing, EEG, structural and functional neuroimaging, and the judicious application of laboratory testing. There is a common belief that neuropsychiatric assessment requires knowledge of long lists of arcane diagnoses. But several axioms regarding neuropsychiatric assessment can demystify the process. For developmental neurologic disorders, as in the differential diagnosis of young-adult onset psychosis, an approach using common symptoms and epidemiology can simplify the task. In other cases, recognition of common neurobehavioral patterns facilitates diagnosis. Participants in this session are encouraged to bring neuropsychiatric problems they have encountered in clinical practice. After providing a brief introduction to a set of neuropsychiatric axioms and a differential diagnostic strategy for psychotic disorders, participants will be asked to share clinical problems from their own practice. Case discussion will focus on clinical rather than research neuropsychiatric assessment strategies, emphasizing techniques available to general psychiatrists.

A neuropsychiatric approach to assessment that goes beyond DSM diagnosis can be helpful in understanding the etiology of behavioral disorders.

**REFERENCES:**

1. Benjamin S, Lauterbach M, The Brain Card, Brain Educators LLC, 2nd ed (in press) 2010.
2. Lauterbach M, Stanislawski-Zygaj, A, Benjamin S. The Differential Diagnosis of Childhood and Young Adult Disorders that Include Psychosis, Journal of Neuropsychiatry and Clinical Neuroscience, 2008 20(4) 409-418.

SMALL INTERACTIVE SESSION 10

**WHAT'S NEW IN CHILD AND ADOLESCENT PSYCHIATRY?**

*Chairperson: Mina K Dulcan, M.D., 2300 Children's Plz Ste 10, Chicago, IL 60614*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate an increased knowledge of resources to update knowledge and skills in child and adolescent psychiatry; 2) Demonstrate up-to-date knowledge on clinical questions in which the practitioner is interested; and 3) Demonstrate familiarity with the use of medication information handouts for child and adolescent psychiatry patients and their parents and teachers.

**SUMMARY:**

This session will give attendees the opportunity to discuss with Dr. Mina Dulcan the contents of two books she has edited: the new Textbook of Child and Adolescent Psychiatry and a book of medication information handouts for pediatric psychopharmacology. Dulcan's Textbook is new and offers a fresh look at child mental health. This clinically focused textbook aims to communicate the art and wisdom of child psychiatry, tied firmly to cutting-edge science and evidence-based practices. A Research Directions section in each chapter highlights what we need to know. This text is designed to be complete and efficient for the mental health professional in training or the clinician seeking an update. Of the 65 chapters in this book, only 9 chapters have the same lead author as in the book's predecessor volume. Sections of the book include chapters on developmentally focused assessment, the variety of methods and perspectives that may be considered in the clinical evaluation, disorders, and types of treatment, as well as special topics and special clinical circumstances. The Special Topics section includes 9 chapters on evidence-based practice, child abuse and neglect, HIV, bereavement, cultural issues, suicide, gender and sexual orientation issues, aggression and violence, and the fundamentals of genetics as relevant to child mental health. The 6 chapters in Special Clinical Circumstances cover psychiatric emergencies, family transitions, physically ill youth, children at risk due to ill parents, legal and ethical issues, and telepsychiatry. The sections on treatment include 7 chapters on psychopharmacology, a chapter on brain-based innovative treatments, and 10 chapters on the full range of psychosocial treatments. The final section includes 3 chapters on consultation to and collaboration with schools, primary care practitioners, and the juvenile justice system. Each chapter in the book ends with Summary Points – 5 to 10 key learning points or take home messages.

**REFERENCES:**

1. Dulcan MK (Ed): Dulcan's Textbook of Child and Adolescent Psychiatry, APPI 2010
2. Dulcan MK (Ed): Helping Parents, Youth, and Teachers Understand Medications for Behavioral and Emotional Problems: A Resource Book of Medication Information Handouts, 3rd edition, APPI 2007

SMALL INTERACTIVE SESSION 11

**REQUESTS TO EVALUATE PATIENTS' DECISIONAL CAPACITY IN THE MEDICAL SETTING: WHAT ARE THEY REALLY ASKING FOR?**

*Chairperson: Philip R Muskin, M.D., M.A., 1700 York Avenue, New York, NY 10128*

**EDUCATIONAL OBJECTIVES:**

1)Identify issues that motivate the request for a decisional capacity consultation; 2)Explore data from a prospective study on capacity; and 3)Configure strategies to uncover and respond to the "real" reason for a capacity consultation.

**SUMMARY:**

The number of requests of psychiatrists to evaluate mental capacity in general hospitals in the US and UK has increased over the past 20 years. This trend, reported primarily in psychiatric journals, is attributed to a confluence of factors: increased emphasis on patient autonomy; greater availability of life extending technology; well-publicized applicable legal decisions; legislation in the U.S. and U.K.; and the adverse impact on patient care of changes in the health care delivery system. Evaluations for mental capacity are most commonly requested to determine if patients have the legal right to reject their physician's recommendations for diagnostic procedures, treatment, post-discharge care and continued hospitalization, or to justify the assignment of a medical care proxy. This workshop will discuss the issues in the patient-physician relationship and in the healthcare system that result in requests for capacity consultations, rather than as requests for assistance in managing a difficult or uncooperative patient. We will discuss the findings from a study that examined a prospective series

of requests for psychiatric consultation to evaluate mental capacity in order to identify the circumstances that initiated them, and the interventions required to respond adequately. The hypothesis of the study was that a mental capacity evaluation, without other interventions, would be inadequate for most of these situations. The study suggests that requests for determination of mental capacity provide an fertile ground for teaching in the medical setting. How psychiatrists deal with these issues in their own setting will be a focus of the workshop.

**REFERENCES:**

1. Kornfeld DS, Muskin PR, Tahil FA: A Review of Requests for Psychiatric Evaluation of Mental Capacity in the General Hospital. Psychosomatics 2009;50:468-373.

SMALL INTERACTIVE SESSION 12-
**CAREER DEVELOPMENT FOR WOMEN PSYCHIATRY: RESIDENTS - CHALLENGES AND SOLUTIONS**

*Presenter: Carol C Nadelson, M.D., 50 Longwood Ave Ste 1114, Brookline, MA 02446 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1)Understand developmental issues and challenges of being a resident; 2) Appreciate the unique challenges for women in medicine; and 3) Obtain strategies to address these issues and challenges.

**SUMMARY:**
The speaker has a unique perspective on the subject matter of this interactive session as the first female President of the American Psychiatric Association, is a recognized leader in studying, writing and speaking on career development of women physicians, and who has personally had to deal with these issues. In addition she has mentored many trainees as future leaders in American psychiatry. She will address the developmental issues facing residents, particularly women residents in psychiatry, and the future challenges as they become early career psychiatrists. She will discuss her perspective on strategies and solutions to these issues based not only on her personal experiences, but also based on studies of development of women physicians.

SMALL INTERACTIVE SESSION 13-
**PSYCHIATRIC ISSUES IN PALLIATIVE CARE**

*Presenter: Jarrett W Richardson, M.D., Department of Psychiatry and Psychology W-11 Mayo Clinic 200 SW First St. Rochester, MN 55905, Rochester, MN 55905 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
By the end of the session, participants will: 1) Know the basic principles of palliative care; 2) Be able to recognize the most common psychiatric issues addressed in palliative care services; 3) Utilize resources that optimize knowledge of common palliative care interventions; and 4) Participants will be able to demonstrate knowledge of collaborative strategies for psychiatry with hospice and palliative care teams.

**SUMMARY:**
Palliative care is comprehensive care for patients and families dealing with incurable diseases. The focus of palliative care is on control of symptoms, management of complications, and quality of life. Palliative Care: Affirms life and regards dying as a normal process, neither hastens nor postpones death, provides relief from pain and other symptoms, integrates the psychological and spiritual aspects of patient care, offers a support system to help patients live as actively as possible until death, offers a support system to help the family cope during the patient's illness. The application of these principles to palliative care includes many areas in which psychiatrists have special skills and expertise, such as discussions about prognosis and goals of care, discussions about specific treatments and/or diagnostic interventions, advanced care planning, bereavement support, and dealing with patient and/or family emotional distress. Psychiatrist also have expertise in assessing and managing many of the major symptoms that are commonly addressed in the palliative care settings including: Pain, anxiety depression, delirium, fatigue, and insomnia. Psychiatrists are experienced in working with multidisciplinary teams in the care of patients with mental illness, and these same skills apply in collaboration with palliative care and hospice teams. Mastering the basics of palliative care with application to general medical and surgical as well as psychiatric patients enables psychiatrists to make a significant contribution beyond what non psychiatrist are able to provide.

**REFERENCES:**

1. The opportunity for psychiatry in palliative care. Irwin SA, Ferris FD. Can J Psychiatry. 2008 Nov;53(11):713-24.Review.

**11:00 AM-12:30PM**

SMALL INTERACTIVE SESSION 14-
**MEET THE EDITORS: PRINCIPLES AND PRACTICE OF CHILD AND ADOLESCENT FORENSIC MENTAL HEALTH**

*Presenter: Elissa P. Benedek, M.D., 2311 E Stadium Blvd Suite 111, Ann Arbor, MI 48104; Peter Ash, M.D., Emory University, Child and Adolescent Psychiatry, 1256 Briar Cliff Rd NE, Ste 312-5, Atlanta, GA 30306; Charles L. Scott, M.D., University of California – Davis, Dept of Psychiatry, 2230 Stockton Blvd., Sacramento, CA 95817-1353*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) To familiarize the audience with recent advances in child and adolescent forensic psychiatry; and 2) encourage audience participation in asking questions and discussing those issues.

**SUMMARY:**
Principles and Practice of Child and Adolescent Forensic Mental Health is an extensive revision of Schetky and Benedek's 2002 award-winning text Principles and Practice of Child and Adolescent Forensic Psychiatry. The editors will discuss what is new in the field of child and adolescent forensic psychiatry, both in terms of new content areas and updated information in traditional content areas. The remainder of the presentation will be an interactive forum, and the editors will answer audience questions and facilitate discussion.

**REFERENCES:**
1. Benedek, EP, Ash, P, Scott, CL (Eds.), Principles and Practice of Child and Adolescent Forensic Mental Health, Washington, DC: American Psychiatric Publishing, Inc., 2009.
2. Simon RI, Gold LH (Eds.): The American Psychiatric Publishing Textbook of Forensic Psychiatry, Washington, DC, American Psychiatric Publishing, Inc., 2004.

SMALL INTERACTIVE SESSION 15-
**ADDICTION AND THE BRAIN**

*Presenter: Nora D Volkow, M.D., 6001 Executive Blvd. Rm 5274, MSC 9581, Bethesda, MD 20892 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize what is currently known about the brain circuits involved in addition; 2) Identify the implications these findings have for successfully treating addiction and preventing relapse.

**SUMMARY:**
Addiction is a chronic, relapsing brain disease impacting numerous brain circuits and neurotransmitter systems. Studies employing neuroimaging technology paired with behavioral measurement have shown that following repeated drug exposure, disruptions can occur in the fine balance that normally exists between brain circuits underling reward, motivation, memory and cognitive control. Although large and rapid increases in dopamine have been linked with the rewarding properties of drugs, in the addicted state significant decreases in brain dopamine function can occur. Such decreases are associated with dysfunction of prefrontal regions including orbitofrontal cortex, cingulate gyrus and dorsolateral prefrontal cortex. Dysfunction in inhibitory control systems, by decreasing the addict's ability to refrain from seeking and consuming drugs, ultimately results in the compulsive drug intake that characterizes the disease.

SMALL INTERACTIVE SESSION 16-
**ETHICAL ISSUES IN PSYCHIATRY**

*Chairperson: Paul S. Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session the participant should be able to: 1) Recognize some of the major ethical issues facing psychiatrist today; 2) How to distinguish between ethical dilemmas and related legal issues; and 3) How to identify reasonable approaches to common ethical concerns.

**SUMMARY:**
Psychiatrists face a number of ethical challenges in practice, some similar to those in other medical specialties and some unique to our discipline. Among the more salient dilemmas frequently encountered in psychiatric practice are those related to: maintaining boundaries with patients (beyond merely the avoidance of sexual relationships); protecting the confidentiality of patients' communications; dealing with insurance and managed care companies in a manner supportive of patients' interests; appropriately using leverage to encourage patients to comply with treatment; getting informed consent from patients; managing relationships with pharmaceutical companies and their representatives; terminating treatment relationships with uncooperative patients; practicing forensic psychiatry; balancing the interests of patients and families; dealing with scientific advances such as the availability of genetic tests related to psychiatric disorders; and many others. This session will focus on practical ethical issues using illustrative case examples. After a brief introduction to psychiatric ethics, we will turn to actual cases drawn from Dr. Appelbaum's consultative experience and from the participants in the session, who will be encouraged to describe challenges that they have faced in their own practices. Emphasis will be placed on identifying the underlying principles that can help psychiatrists to resolve these difficult situations.

**REFERENCES:**
1. Bloch S., Green S (er.s.). Psychiatric Ethics, 4th Ed. Oxford University Press, New York, 2009.

SMALL INTERACTIVE SESSION 17-
**PSYCHIATRIC PHARMACOGENOMICS SMALL INTERACTIVE SESSION 17**

*Chairperson: David A. Mrazek, M.D., 200 First Street SW, Rochester, MN 55905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should: 1) Be familiar with the indications for pharmacogenomics testing; 2) Be familiar with the principles for interpretation of phnnacogenornic testing results; and 3) Be oriented to the cultural and ethical issues related to pharmacogenomic testing.

**SUMMARY:**
The plan for the session is to begin by providing background related to the development of phannacogenomic testing. Following this orientation, the specific genes and their variants, which are informative for medication selecting and dosing, will be reviewed. A review of both phannacokinetically relevant genes and pharmacodynamically influential genes will be included. Subsequently, the interpretations that are used to guide clinical practice will be discussed. Specific issues related to cultural and ethical issues will be summarized and a focus of discussion. Finally, a series of clinical cases that illustrate the potential benefit of phannacogenomic testing will be discussed with the group.

**REFERENCES:**
1. Kirchheiner J, Nickchen K, Bauer M, Wong ML, Licinio J, Roots r, Brockmoller J: Pharmacogenetics of antidepressants and antipsychotics: the contribution of allelic variations to the phenotype of drug response. Mol Psychiatry 9:442-73, 2004
2 Mrazek DA. Psychiatric Phannacogenomics. Oxford University Press: New York 2010 ISBN: 978-0-19-53729-4

SMALL INTERACTIVE SESSION 18-
**PSYCHIATRIC ISSUES RELATED TO RETURNING VETS FROM IRAQ AND AFGHANISTAN**

Presenter: Elspeth C Ritchie, M.D., M.P.H., 5109 Leesburg PikeSkyline 6, Room 671, Falls Church, VA 22041-3258 U.S.A.

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1)Know The Psychological Effects Of War., Including PTSD And Mild Tbi. 2)Understand The Breadth Of Programs To Mitigate The Psychological Effects; and 3) Understand How Civilian Providers Can Assist.

**SUMMARY:**
Seven Years Of War And Repeated Deployments Have Led To Both Physical And Psychological Wounds. This Abstract Will Discuss Both Old And New Challenges, Including Suicide, Post-Traumatic Stress Disorder, Traumatic Brain Injury, And Pain Management. While An Array Of Behavioral Health Services Has Long Been Available To Address The Strain On Our Soldiers And Families, These Services Are Clearly Strained. These Services Include Combat And Operational Stress Control, Routine Behavioral Health Care, And Suicide Prevention. Chaplains, Military One Source, And Army Community Service Also Offer Support. We Have Multiple Other Initiatives To Provide Outreach, Education And Training, Including "Battlemind", Combat And Operational Stress Control, Operational Stress Control And Readiness (Oscar), And Respect-Mil. The New Defense Center Of Excellence (Dcoe) Establishes Quality Standards For: Clinical Care; Education And Training; Prevention; Patient, Family And Community Outreach; And Program Excellence. The Dcoe Mission Is To Maximize Opportunities For Warriors And Families To Thrive Through A Collaborative Global Network Promoting Resilience, Recovery, And Reintegration For Ph And Tbi. There Continue To Be Major Challenges That Will Face Our Service Members, Their Families And The Nation.

**REFERENCES:**
1. Ritchie Ec, Owens M. Military Psychiatry, Psychiatric Clinics, September, 2004.
2. Ritchie Ec, Senior Editor, Combat And Operational Behavioral Health, Textbook Of Military Medicine, Borden Pavilion. Textbook Of Military Medicine. Washington, Dc: Office Of The Surgeon General, Us Department Of The Army And Borden Institute; In Press.

**WEDNESDAY, MAY 26, 2010**

**9:00 AM-10:30AM**

SMALL INTERACTIVE SESSION 19-
**ALTERNATIVE TREATMENTS IN PSYCHIATRY**

*Presenter: David Mischoulon, M.D., Ph.D., 50 Staniford St Ste 401, Boston, MA 02114 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the indications, recommended dosing, and adverse effects of the more popular and better-studied natural remedies for psychiatric disorders; and 2) Appreciate the limitations of the current efficacy and safety data regarding these drugs; and 3) Advise patients who are using or considering these remedies.

**SUMMARY:**
Mental health and primary care clinicians are seeing increasing numbers of patients who are interested in using complementary and alternative medicines. Unfortunately, medical training still largely underemphasizes this area in the training of physicians, nurses, and other allied health practitioners. This session will provide valuable and useful guidelines for clinicians who wish to learn about the proper application of these remedies. The speaker will present a short introduction and overview of the topic, followed by a more detailed discussion of some of the more popular and better studied alternative agents, such as St John's Wort

(hypericum), S-adenosyl methionine (SAMe), omega-3 fatty acids, kava, valerian, melatonin, and others. Evidence for efficacy and proposed mechanisms of action for these therapies will be reviewed, as well as safety and toxicity concerns. After the presentation there will be ample time during which participants will have the opportunity to interact with the speaker and ask questions about the topic. Participants who complete the program should emerge with greater confidence in their understanding of the state of the art of complementary and alternative medicine in psychiatry, and will be in a position to provide sound clinical advice for their patients who may be considering using these therapies.

**REFERENCES:**

1. Mischoulon D, Rosenbaum J, editors. Natural Medications for Psychiatric Disorders: Considering the Alternatives, 2nd edition. Philadelphia: Lippincott Williams & Wilkins, 2008.

SMALL INTERACTIVE SESSION 20-
## RESEARCH AND CLINICAL MANAGEMENT OF PATIENTS WITH TREATMENT-RESISTANT DEPRESSION

*Presenter: Carlos Zarate, M.D., 10 Center Dr CRC Unit 7 SE Rm 7-3465, Bethesda, MD 20892-1282 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to understand strategies for conducting therapeutic and biological research and clinical management in patients with severe refractory mood disorders.

**SUMMARY:**
Mood disorders (major depressive disorder and bipolar disorder) are serious, debilitating, life-shortening illnesses that affect millions of people worldwide. These disorders are typically chronic and characterized by multiple episodes of symptom exacerbation, residual symptoms between episodes, and functional impairment. Current pharmacotherapy for mood disorders is generally unsatisfactory for a large number of patients. Even with adequate modern pharmacological therapies, many afflicted individuals continue to have persistent depressive episode relapses, residual depressive symptoms, functional impairment, and psychosocial disability. This small interactive session in treatment-resistant depression will review case vignettes of patients with severe treatment-resistant depression (unipolar and bipolar) who were studied and treated on the Experimental Therapeutics Mood Disorders Research Unit at the National Institute of Health. Patients studied on the unit are typically quite severely ill having failed multiple pharmacological and somatic treatments. They are usually hospitalized for a period of 4-6 months for an experimental therapeutic trial and examination of biomarkers of illness and treatment response. After research, our patients receive clinical treatment with a series of novel strategies. Their stay on the mood disorders research unit has giving us ample time to test a series of novel interventions in the hope of improving their outcomes. This session will consist of a group discussion of case vignettes of patients with treatment-resistant depression who participated in research and their clinical management on the research unit. In addition, group participants are welcome to email me (zaratec@mail.nih.gov) ahead of the session case vignettes or questions on the research and pharmacological management of treatment-resistant depression to be discussed at the session. The goal of this session is to make participants familiar with conducting therapeutic and biological research and clinical management in patients with severe refractory mood disorders.

**REFERENCES:**

1. Sanacora G, Zarate CA Jr*, Krystal J, Manji HK. Targeting the glutamatergic system to develop novel, improved therapeutics for mood disorders. Nature Reviews Drug Discovery 2008;7:426-437.
2. Zarate CA Jr, Manji HK. Bipolar disorder: candidate drug targets. Mt Sinai J Medicine 2008;14:226-247.

SMALL INTERACTIVE SESSION 21-
## HOW TO GET YOUR PAPER PUBLISHED

*Presenter: Julio Licinio, M.D., Bldg 131 Garron Rd, Canberra, ACT 2601 Australia*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the key components of an academic article; 2) Prepare and target their article to the right journal; and 3) Address the peer review system; and 4) Handle negative outcomes of submitted articles.

**SUMMARY:**
The goal of this interactive session is to provide an informal forum to discuss how to best position a paper for publication. The session leader, Dr. Julio Licinio, edited 12 books and published over 200 articles. Importantly as Founding Editor of both Molecular Psychiatry (Impact Factor: 12.5, second highest in the field worldwide) and The Pharmacogenomic Journal (both by the Nature Publishing Group) he has made editorial decisions on suitability for publication on over 5,000 papers. This wealth of editorial experience has given Dr. Licinio considerable insight into the manuscript publication process, including key issues such as topic, scope, format, writing style, length, choice of journal, choice of reviewers, peer review process, dealing with revisions, negative editorial decisions, appeals, re-submissions and submissions to other venues. Participants will have the opportunity to ask questions and to inquire on any aspects of the publication process so

that they can improve the chances of publication for their articles.

**REFERENCES:**

1. Mimi Zeiger. Essentials of Writing Biomedical Research Papers. McGraw-Hill, 1999, ISBN-10: 0071345442
2. Licinio J. Update on Molecular Psychiatry: new publication guidelines and new ways to stay current. Mol Psychiatry 2009;14(5):463-464.

SMALL INTERACTIVE SESSION 22
**TREATMENT OF COMPLEX MOOD DISORDERS**

*Pedro L. Delgado, MD, 7703 Floyd Curl Drive, Mail Code 7782, San Antonio, TX, 78229-3900*

**EDUCATIONAL OBJECTIVES**

At the conclusion of the session, the participant should be able to: 1) Discuss and review diagnostic issues and disease models that might be applicable to patients with complex mood disorders; and 2) Discuss and review innovative treatment approaches to patients with complex mood disorders.

**SUMMARY:**

Growing evidence suggests that the illnesses that we categorize as mood disorders represent a very broad grouping of conditions with diverse causal antecedents. This suggests that most current treatments may target nonspecific mood regulating processes without necessarily modifying causal factors. Treatments that target very specific pathways which might only be abnormal in a small subset of patients will most likely fail to emerge as being efficacious since most patients will not respond. This theoretical background provides a model for the provision of treatment to patients with complex mood disorders and underscores the importance of personalizing treatment. For example, treatment of patients with co-existing general medical disorders needs to adequately address the co-existing condition and treatment of patients with a history of early life abuse and/or trauma needs to address the psychological and psychosocial aspects of these experiences. This model also raises the importance of considering non-traditional treatments in some patients when sufficiently strong clinical signs and symptoms are present to support it. For example, the use of nonsteroidal anti-inflammatory drugs may be helpful as primary or adjunctive treatments for patients with evidence of ongoing inflammatory disease such as rheumatoid arthritis, chronic fatigue, or inflammatory bowel disease. This interactive session will focus on treatment strategies for patients with complex mood disorders, emphasizing innovative treatment options that may only be effective in small subsets of patients.

**REFERENCES:**

1. Hofmann (2001). "The technological invention of disease." Medical Humanities 27(1): 10-19. Maes, M., R. Yirmyia, et al. (2009). "The inflammatory & neurodegenerative (I&ND) hypothesis of depression: leads for future research and new drug developments in depression." Metabolic Brain Disease 24(1): 27-53.
2. Risch, N. J. (2000). "Searching for genetic determinants in the new millennium." Nature 405(6788): 847-856.

**SATURDAY, MAY 22, 2010**
**9:00 A.M.-12:00 P.M.**

## SYMPOSIUM 1

## PTSD IN MILITARY POPULATIONS: TRANSLATING RESEARCH INTO PRACTICE

*Chairperson: Darrel A Regier, M.D., M.P.P., 1000 Wilson Blvd, Suite 1825, Arlington, VA 22209*
*Discussant: Elspeth C Ritchie, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, the participant should be able to: 1) Recognize the scope of mental health problems in military populations; 2) Discuss current evidence based approaches and challenges in the management of PTSD and other related conditions in military populations; and 3) Be familiar with innovative national approaches for improving care for service members with PTSD.

**OVERALL SUMMARY:**
A total of 103,788 new users of the VA health care systems were identified in 2001-2005; of those, 25% had one or more psychiatric diagnoses. Post Traumatic Stress Disorder (PTSD) accounted for 52% of those with any psychiatric diagnosis. The number of military service-members and veterans with a diagnosable mental disorder, and PTSD in particular, is expected to increase with the frequency and duration of troop deployments to the continuing wars in Afghanistan and Iraq. The scope of service members' mental health and cognitive problems associated with these two wars has been well documented. There is an urgent need to bolster evidence-based assessment and treatment for PTSD, depression, Traumatic Brain Injury (TBI) and other related conditions to avert the great individual and societal costs associated with war-related mental health conditions. This session will provide up-to-date information on the extent of mental health problems in military populations; address the role of gender and ethnicity in the development and the maintenance of PTSD; review evidence-based treatment recommendations; and discuss availability and access to care, and challenges to treating PTSD and other mental health conditions in military populations. Concrete examples of potential innovative national approaches for improving PTSD care in the primary care and specialty mental health sectors, including RESPECT-MIL and the Performance in Practice tools developed as a part of the PTSD Care Dissemination Project, will be presented.

No. 1-A
### PTSD IN MILITARY POPULATIONS: SCOPE AND TREATMENT CHALLENGES?
*Robert Ursano, M.D., Dept of Psychiatry Uniformed Services University 4301 Jones Bridge Rd, Bethesda, MD 20814*

**SUMMARY:**
Care for our country's Soldiers, Sailors, Airmen and Marines is a national challenge. Those exposed to the threats of war, the stress of deployment and return and the trauma if injury and loss are at increased risk of a range of psychiatric disorders. In addition the families of these military members face the stressors of loss, caregiving and loss of time, energy and resources for family care. Identifying those in need of care through surveillance and getting them to appropriate resources by addressing barriers to care and stigma is an important element of an effective veteran and military member health care system. In addition having a sufficient number of evidence based and well trained health care providers able to treat the behavioral and mental health needs requires a consistent, comprehensive, and adjusting health care plan. Behavioral risks such as motor vehicle accidents and family violence are additional important targets for care.

No. 1-B
### CURRENT EVIDENCE-BASED TREATMENT RECOMMENDATIONS FOR PTSD

*Matthew J. Friedman, M.D., Ph.D., HB 7900, Hanover, NH 03755*

**SUMMARY:**
This session will provide a review of the latest evidence-based recommendations for the assessment and treatment of PTSD in military and civilian populations. The Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of PTSD, the American Psychiatric Association Practice Guideline for the Treatment of Patients with ASD and PTSD, and the National Collaborating Centre for Mental Health PTSD Clinical Guidelines will serve as a source. Additionally, the Institute of Medicine (IOM) Posttraumatic Stress Disorder: Diagnosis and Assessment report and the APA's latest Guideline Watch Practice Guideline for the Treatment of Patients with ASD and PTSD will be discussed, examining the latest recommendations for first-line treatment for combat and non-combat-related PTSD. Potential strategies for a practical
approach to tailoring treatment to the needs of specific populations (e.g. military and civilian women) will be included.

No. 1-C
### WHAT IS KNOWN AND WHAT NEEDS TO BE LEARNED ABOUT SOCIODEMOGRAPHIC FACTORS IN PTSD?

*Paula Schnurr, Ph.D., 215 North Main St, White River Junction, VT 05009*

**SUMMARY:**
The risk of developing PTSD varies with a number of

pre-traumatic, peri-traumatic, and posttraumatic factors. These factors include sociodemographic characteristics such as age, gender, and race. This presentation will review the evidence on sociodemographic factors for the development and the maintenance of PTSD as well as the available evidence that may explain the observed findings. The presentation also will include discussion of the gaps in the literature and suggest future research directions along with implications for prevention and treatment.

No. 1-D
**TREATING PTSD AND OTHER MENTAL HEALTH CONDITIONS IN MILITARY POPULATIONS**

*Joshua Wilk, Ph.D., 503 Robert Grant Dr., Silver Spring, MD 20910*

**SUMMARY:**
Service members' exposure to events related to deployment to a combat zone place them at a high risk for the development of posttraumatic stress disorder (PTSD). Given the relatively high prevalence rates of PTSD and other mental health conditions in active duty military personnel, providing evidence-based treatments is essential. Despite the absence of strong evidence for effectiveness of standard treatment modalities recommended in clinical practice guidelines for PTSD, clinicians must decide how to treat individual service members and veterans suffering from combat-related mental health concerns. The current evidence indicates that exposure therapy (in-vivo and imaginal) is an essential ingredient of PTSD treatment. However, given the high co-morbidity of PTSD with other mental health problems after deployment, particularly depression and substance use disorders, clinicians need to utilize a range of evidence-based treatments beyond those designed for PTSD. Equally important is the monitoring of clinical services delivery and adoption of evidence-based best practices to assure that troops receive the highest level of care in a timely fashion. This presentation will describe activities designed to develop strategies to obtain clinically detailed, generalizable data on assessment and treatment practices for service members with PTSD and other mental health concerns. These efforts would potentially provide a clinical informatics platform to assess current best practices, training, and quality improvement needs; inform clinical resources allocation; facilitate decision support and real-time, continuous clinical quality improvement; and improve clinical practice.

No. 1-E
**RE-ENGINEERING SYSTEMS OF PRIMARY CARE TREATMENT FOR PTSD AND DEPRESSION IN THE US MILITARY: PROGRAM DESCRIPTION AND IMPLEMENTATION**

*Charles C. Engel, M.D., 4301 Jones Bridge Rd, Bethesda, MD 20814-4799*

**SUMMARY:**
Background: U.S. troops report high rates of anxiety and depression following deployment to armed conflicts in Iraq and Afghanistan. Those affected often do not receive needed services. Objective: Describe systems-level improvements in US Army primary care recognition and management of PTSD and depression ("Re-Engineering Systems of Primary Care for PTSD and Depression in the Military", RESPECT-Mil) and assess its implementation. Methods: RESPECT-Mil targets 43 US Army primary care clinics in 15 worldwide sites supporting soldiers that undergo frequent combat deployments. Clinical and administrative indicators of program feasibility, impact, and implementation are presented. Results: RESPECT-Mil includes universal primary care PTSD/depression screening, brief standardized primary care diagnostic assessment, and nurse care facilitation for those with unmet depression/PTSD needs. A care facilitator assists with symptom monitoring and treatment adjustment and enhances primary care contact with mental health specialists. Implementation is driven by Surgeon General directive and centralized multidisciplinary implementation team that works with site implementation teams. 31 of 43 targeted clinics are in implementing. Screening occurred in 58% visits to date, 68% in the most recent month. 10.6% of screened visits resulted in a diagnosis of depression or possible PTSD. 76% of visits involving patients with previously unrecognized needs are successfully referred to specialized mental health services. 901 visits (0.7% of screened visits) involved suicidality with no reported suicide completions or attempts to date. Most soldiers in facilitation for 6 or more weeks report important symptom improvements.

**No. 1-F APA/APIRE PTSD PERFORMANCE IN PRACTICE TOOLS**

*Farifteh Duffy, Ph.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

**SUMMARY:**
In current practice, clinicians are expected to maintain expertise in the face of an ever-expanding evidence base. However, traditional didactic approaches to continuing education have shown limited success in changing practice; a number of studies have demonstrated that a substantial gap still remains between recommended evidence-based best practices and actual clinical practice. Clinical practice guidelines provide clinicians with a valuable resource by compiling and synthesizing the most recent scientific knowledge and expert consensus. Although evidence-based practice guidelines are a rich fund of state-of-the-art information, their traditional narrative format does not provide clinicians with immediate opportunities to appraise and assimilate scientific evidence, making them difficult to translate and apply at the concrete patient or organizational

level. Hence, new methods are needed. In response to the American Board of Medical Specialties (ABMS) and the American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC) clinician self-assessments requirements, and to speed the adoption of evidence-based care into clinical practice, APA and APIRE clinical and research teams collaborated to develop two prototype Performance in Practice (PIP) clinical self-assessment tools for the management of PTSD and depression, guided by evidence-based recommendations from the latest practice guidelines. The PIP tools have multiple applications. In addition to helping clinicians prepare for MOC self-assessment requirements through chart reviews and real-time evaluation of new or existing patients, these tools can be used to inform improvement efforts at the clinician-, practice- or systems-level and acilitate detection of potential gaps in evidence-based care. The PIP tools provide clinicians with active learning experiences by translating conceptual information from practice guidelines into practical steps, supporting integration of evidence-based best practices into clinical care. These tools are applicable beyond psychiatry, as they can be used for self-assessment by other provider groups to support improvement activities for PTSD and depression care.

**SYMPOSIUM 2**

**RECENT RESEARCH ON EATING DISORDERS**

*Chairperson: James E. Mitchell, M.D., NRI, 120 8th St. S, 1375 Elm Circle NE, Fargo, ND 58107*
*Co-Chairperson: Walter Kaye, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, the participant should be able to: 1) Discuss the indications for bariatric surgery in adolescents; 2) Describe change in neurocircuitry in anorexia nervosa; and 3) Describe stress response changes in response to food in anorexia nervosa.

**OVERALL SUMMARY:**
This session will focus broadly on recent research on eating disorders and bariatric surgery. It will include two papers on anorexia nervosa: one focusing on stress response and as a neurocircuitry. It will also include two papers on bariatric surgery: one focusing on adolescent bariatrics and one on adult bariatrics.Individuals with anorexia nervosa (AN) have a relentless preoccupation with dieting and weight loss, which results in severe emaciation. New brain imaging technology provides insights into neural circuit dysfunction that contributes to puzzling symptoms. For example, altered insula activity could explain interoceptive dysfunction and altered striatal activity might shed light on altered reward modulation in AN patients. These findings suggest that there are alterations in those parts of the brain involved with bodily sensations, such as sensing the rewarding aspects of pleasurable foods. Anorexics may literally not recognize when they are hungry. Moreover, imaging studies suggest that individuals with AN have an imbalance between circuits in the brain that regulate reward and emotion (the ventral or limbic circuit) and circuits that are associated with consequences and planning ahead (the dorsal or cognitive circuit). Such findings may shed light on why people with AN tend to not experience pleasure and/or live "in the moment" but have exaggerated and obsessive worry about the consequences of their behaviors. AN has the highest mortality rate of any psychiatric disorder. It is expensive to treat and we have inadequate therapies. It is crucial to understand the neurobiologic contributions in order to develop more effective therapies.

No. 2-A
**RECENT FINDINGS IN THE LONGITUDINAL ASSESSMENT OF BARIATRIC SURGERY (LABS) STUDY**

*James Mitchell, M.D., NRI, 120 8th St. S, 1375 Elm Circle NE, Fargo, ND 58107*

**SUMMARY:**
This paper will present current data from LABS, on predictors of perioperative mortality and morbidity, surgery volume and outcome, and psychopathology in bariatric surgery candidates. Emphasis will be placed on psychiatric issues as risk factors for problematic outcomes. Also eating problems such as Binge eating disorder and night eating syndrome will be examined as risk factors.

No. 2-B
**NEUROCIRCUITRY OF ANOREXIA NERVOSA**
*Walter Kaye, M.D., 8950 Villa La Jolla Dr. Ste C207, La Jolla, CA 92037*

**SUMMARY:**
Individuals with anorexia nervosa (AN) have a relentless preoccupation with dieting and weight loss, which results in severe emaciation. New brain imaging technology provides insights into neural circuit dysfunction that contributes to puzzling symptoms. For example, altered insula activity could explain interoceptive dysfunction and altered striatal activity might shed light on altered reward modulation in AN patients. These findings suggest that there are alterations in those parts of the brain involved with bodily sensations, such as sensing the rewarding aspects of pleasurable foods. Anorexics may literally not recognize when they are hungry. Moreover, imaging studies suggest that individuals with AN have an imbalance between circuits in the brain that regulate reward and emotion (the ventral or limbic circuit) and circuits that are associated with consequences and planning ahead (the dorsal or cognitive circuit). Such findings may shed light on why people with AN tend to not experience pleasure and/or

live "in the moment" but have exaggerated and obsessive worry about the consequences of their behaviors. AN has the highest mortality rate of any psychiatric disorder. It is expensive to treat and we have inadequate therapies. It is crucial to understand the neurobiologic contributions in order to develop more effective therapies.

No. 2-C
**BARIATRIC SURGERY IN ADOLESCENTS: CLINICAL CHARACTERISTICS AND EATING BEHAVIOR**

*Michael Devlin, M.D., 1051 Riverside Dr. New York, NY 10032*

**SUMMARY:**
This paper will present results of a preliminary study of eating behavior in overweight adolescents, age 14-17,prior to and following laparoscopic adjustable band surgery for severe obesity, and normal weight controls. Participants consume a fixed size liquid breakfast meal and release of appetitive hormones (ghrelin, leptin, cholecystokinin, peptide YY, and insulin) is measured, they then consume an ad libitum buffet lunch, and amount eaten, macronutrient distribution and meal-related subjective responses are measured. Initial findings will be presented, including baseline differences in eating behaviors between overweight participants vs. controls and effects of surgery on study variables, as well as relationships between clinical characteristics, such as binge eating, and eating behavior and meal-related hormone release. The utility of feeding laboratory studies in characterizing eating behavior in this group, the clinical and prognostic significance of feeding laboratory studies, and the limitations of the feeding laboratory will be discussed.

No. 2-D
**STRESS RESPONSE TO FOOD PORTION SIZE IN ANOREXIA NERVOSA**

*Katherine Halmi, M.D., 21 Bloomingdale Road, White Plains, NY 10605*

**SUMMARY:**
In this study we measure the maximum tolerable food portion size, anxiety as portion size increase and effects of different foods with portion size changes. Food reponsivity is assessed for liking, healthiness, familiarity, and ideal portion size as well as above measures. We are measuring the change in tolerance and anxiety with portion size changes over treatment and determining if this is a predictor of outcome.

**SYMPOSIUM 3**

**SMOKING AND PSYCHIATRIC DISORDERS: CLUES ABOUT CAUSAL PATHWAYS AND INNOVATIVE TREATMENT**

***U.S. National Institute on Drug Abuse***

*Chairperson: Jeffrey D. Schulden, M.D., 6001 Executive Blvd, MSC 9589, Bethesda, MD 20892,*
*Co-Chairperson: Wilson M.Compton III, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe the high rates of comorbidity of smoking with other psychiatric and substance use disorders; 2) Understand some of the theories regarding the biological and non-biological underpinnings for this association; and 3) Better integrate psychosocial and medication treatments for tobacco dependence into psychiatric treatment programs; and 4) Better implement organizational/program changes to develop integrated treatment programs.

**OVERALL SUMMARY:**
Cigarette smoking among persons with comorbid mental illness or other substance use disorders remains highly prevalent and occurs at a much higher rate than in the general population. In addition, the pattern of cigarette use among persons with comorbid mental illness tends to be more harmful, with higher levels of nicotine dependence and associated cardiovascular and pulmonary disease. Persons with chronic mental illness or substance use disorders are roughly 20% of the U.S. population, but have been estimated to account for over 40% of cigarette consumption. Further, an estimated 200,000 of the 435,000 annual smoking-related deaths in the U.S. are thought to occur among those with comorbid psychiatric disorders. Recent research has suggested that increased rates of nicotine dependence among persons with comorbid mental illness may be biologically driven. For example, among persons with schizophrenia, research has suggested that nicotine can help relieve sensory-processing deficits and improve cognitive functioning. Those with mental illness or other substance use disorders likely are differentially able to quit tobacco, with some research suggesting they are generally less successful in cessation programs than those without comorbid conditions. This symposium will provide an update on the complex interrelationship between smoking and comorbid psychiatric disorders, including discussion of the medical and psychiatric treatment options for these clinically challenging comorbid conditions.

No. 3-A
**PSYCHIATRIC DISORDERS AS SIGNALS OF SENSITIVITY FOR NICOTINE DEPENDENCE**

*Lisa Dierker, Ph.D., 207 High Street, Middletown, CT 06073*

**SUMMARY:**
Although longitudinal research has in many cases established a temporal ordering between psychiatric disorders and a number of smoking outcomes, surprisingly little research has evaluated the specific ways in which disorders may play a role in the emergence of dependence. Notably, the vast majority of research has focused on their potential role in increasing the probability of smoking, either in terms of initiation or escalation, thereby elevating an individual's probability of dependence through increased smoking. Implicit in this theory is the primary role of smoking exposure in the emergence of dependence. A complementary or alternate role that psychiatric disorders may play is as a cause or signal of greater sensitivity to nicotine dependence at low levels of nicotine exposure. These early emerging dependence symptoms may in turn increase the likelihood of continued smoking and difficulty in quitting. This presentation will review an emerging body of empirical work by the authors based on cross-sectional and longitudinal data collected on young and novice smokers. Evidence suggests that major depression, anxiety and alcohol use disorders may be the clearest signals of greater sensitivity to the experience of nicotine dependence symptoms following earliest exposures to smoking. Furthermore, we will show that reports of early emerging symptoms by adolescents and young adults represent more than simple reporting biases. Rather, they have been found to be predictive of continued and increasing smoking behavior. These and related findings suggest that adolescents with psychiatric disorders who believe that they are "just experimenting" with cigarettes, may quickly find their smoking behavior difficult to control. We conclude that targeting these early emerging nicotine dependence symptoms among youth with psychiatric disorders may serve to reduce smoking behavior before more chronic, heavy smoking patterns are formed and become more difficult to break.

No. 3-B

**NICOTINE RECEPTORS AND THEIR GENES IN PSYCHOSIS**

*Robert Freedman, M.D., 13001 East 17th Place, Mail Stop E3251, Aurora, CO 88945*

**SUMMARY:**
One of the pathogenic features of schizophrenia and psychotic bipolar disorder is that part of the genetic risk involves nicotinic receptors, particularly the alpha 7-nicotinic receptor. Transmission of genetic risk at the chromosome 15q14 locus of CHRNA7, the gene for this receptor has been demonstrated in both illnesses. The pathophysiology may be partly expressed in the extremely heavy smoking of these patients. Nicotine itself is not a helpful therapeutic agent for schizophrenia, particularly when self-administered though cigarettes. However, safer, more selective nicotinic agonists have been developed and are in early stages of clinical trials. One of these, 3-(2,4 dimethoxybenzylidene)-anabaseine can be administered orally and reverses some of the pathophysiological and neurocognitive features of the illness. There are also modest effects on anhedonia and alogia, part of the negative symptom complex of schizophrenia. Psychotic patients' addiction to nicotine may thus indicate pathophsyiological mechanisms that are potential therapeutic targets.

No. 3-C

**INTEGRATING TOBACCO DEPENDENCE TREATMENT INTO MENTAL HEALTH AND ADDICTION TREATMENT**

*Douglas Ziedonis, M.D., M.P.H., 55 Lake Street, Worcester, MA 01655*

**SUMMARY:**
Integrating tobacco dependence treatment into existing mental health and addiction treatment is important and requires both clinician training on evidence-based practices and organizational change interventions. Studies demonstrate that mental health and addiction treatment providers can integrate tobacco dependence into their clinical practice as well as make appropriate referrals to existing resources. Most individuals with psychiatric disorders are nicotine dependent and have increased morbidity and mortality due to tobacco. There are unique treatment setting barriers and resources to consider for organizational change efforts; and clinicians must consider how psychiatric disorders contribute to the onset and maintenance of nicotine dependence. For example, tobacco use alters the metabolism of key psychiatric medications is an example of unique knowledge required in treatment. Evidence suggests that existing nicotine dependence treatments can be effective; however the length of treatment and adaptations can be helpful. This presentation will review research supporting medications and psychosocial treatments for this population, and suggest practical medication management strategies and innovative psychosocial interventions to enhance engagement, to motivate, and to help quit smoking. The Learning About Health Living and Motivational Enhancement Therapy approaches will be described. For integration to be successful and sustainable, program and system change is necessary, including patient, staff, and environmental goals and changes. Addressing Tobacco Through Organizational Change (ATTOC) is an effective model that was found effective in several studies, including a recent NIDA study. There is both an immediate need to address tobacco in this population and to expand research agendas for this population. Participants will learn about resources and training materials on this topic, including resources from the UMass ATTOC Consultation Service.

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## SYMPOSIUM 4

## SHARED DECISION MAKING IN MENTAL HEALTH CARE: A RECOVERY AND PERSON-CENTERED APPROACH

*Chairperson: Kenneth S. Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain a better understanding of what is SDM and how it relates to recovery-oriented and person-centered care; 2) Learn about common barriers and challenges to using shared decision making in practice and suggestions for overcoming them; 3) Learn about the benefits of using SDM in practice; 4) Learn about decision aids and decision support tools and how they can be used in the SDM process; and 5) Learn about current research.

### OVERALL SUMMARY:

Purpose: To inform the audience on 1) what is shared decision making in mental health care and how it can be used in practice; 2) personal experiences of using shared decision making from the perspective of a mental health consumer and a psychiatrist; 3) current research and literature on SDM; and 4) current federal activities surrounding SDM.
Content: Information on what is SDM and how decision aids and decision support tools can be used to help facilitate SDM; common challenges/barriers to using SDM in practice including capacity issues; personal experiences using SDM from the consumer and provider perspective; suggestions for implementing SDM into practice; summary of current research and federal activities around SDM.
Methodology: 4 presentations with PowerPoint and audience discussion/question & answer
Results: At the end of the symposium, audience members will 1) gain a better understanding of what is SDM and how it relates to recovery-oriented and person-centered care; 2) learn about common barriers and challenges to using shared decision making in practice and suggestions for overcoming them; 3) learn about what are the benefits of using SDM in practice; 4) learn about decision aids and decision support tools and how they can be used in the SDM process; 5) learn about current research and federal activities regarding SDM.
Importance: The process of SDM causes hesitation in some healthcare providers. It has been under-utilized in mental health services. Reasons for the non-adoption of SDM in mental health care include the notion that people with mental health diagnoses are unable to actively participate in a decision-making process with their provider. Research has shown that this is not true and furthermore, SDM in mental health care often facilitates a stronger clinical relationship and increases satisfaction and positive health outcomes for those receiving services.

No. 4-A

## SHARED DECISION MAKING: A KEY TO RECOVERY ORIENTED PRACTICE

*Kenneth Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206*

### SUMMARY:

The shift from institutional treatment and care of persons with psychiatric disorders to a community based approach has been accompanied by a growing awareness that the control of an individual's recovery was firmly in that individuals hands. The process of recovery is a process of learning how to make one's way in the world- both dealing with the symptoms of illness and the day to day struggles of life. Having ceded power over the lives of people with psychiatric disorders, and gradually learning that it has proven helpful for people to be able to make choices and

maintain hope, psychiatry is beginning to understand, like the rest of medicine, that our expertise is only one tool among many for people to use in dealing with illness. In fact, our expertise is negotiable- what a person wants from us may be choices and options rather then dictates. The movement toward shared decision making recognizes this. It hopes to capitalize on the evidence and experienced base knowledge of consumer and physician. This presentation will outline some of the under lying concepts and issues in incorporating shared decision making in a recovery oriented practice.

No. 4-B
**SUPPORTING CONSUMERS' RECOVERY THROUGH JOINT CONSUMER AND CLINICIAN USE OF SHARED DECISION MAKING TOOLS**

*James Schuster, M.D., M.B.A., 1 Chatham Center, Pittsburgh, PA 15219*

**SUMMARY:**
Integrating consumers' recovery goals into clinical assessments and interventions can be challenging, especially for psychiatrists, since their visits with consumers are often limited to 15 minute increments. This presentation will describe multiple toolkits, implemented in dozens of clinical settings in Pennsylvania, that are designed to facilitate the inclusion of recovery goals and assessments in clinical treatment. The tools, which were developed by Pat Deegan, Ph.D. with support from Community Care Behavioral Health Organization, a 501© 3 non profit managed care organization, elicit key recovery themes from consumers and make them part of a shared decision making process with their clinicians. Their implementation has been supported by the development of a learning collaborative model that includes all of the participating agencies. The presentation will describe the toolkits, the implementation process, and potential challenges in these efforts.

No. 4-C
**RESEARCH ON SHARED DECISION-MAKING: CURRENT STATUS AND NEXT STEPS**

*Celia Wills, Ph.D., 1585 Neil Avenue, 384 Newton Hall, Columbus, OH 43210*

**SUMMARY:**
There is keen interest in shared decision-making (SDM) as a means to fostering high level mental health recovery. Research on SDM is an emerging area of inquiry in mental health interventions and services research. As yet, evidence on SDM in the mental health context remains sparse. Nonetheless an accumulating body of descriptive and intervention studies highlight the potential of SDM to improve the process and outcomes of care. This presentation will overview the current status of research on SDM in mental health contexts and describe next steps for extending the evidence base on SDM.

No. 4-D
**SHARED DECISION MAKING IN MENTAL HEALTH CARE**

*Melody Riefer, M.S.W., 2392 Cardinal Way, Tucker, GA 30084*

**SUMMARY:**
Offering a consumer perspective on electronic supported shared decision making in public sector mental health centers.

No. 4-E
**SHARED DECISION MAKING: MAKING RECOVERY REAL IN MENTAL HEALTH**

*Laurie Curtis, M.A., 83 Davy Road, Middlesex, VT 05602*

**SUMMARY:**
This presentation will overview SAMHSA's project to develop and adapt shared decision making tools and resoruces for use by public mental health services. This includes print and media products as well as an interactive decision aid on antipsychotic medications that will be available on both a CD-ROM and the Internet. These materials are grounded on an extensive review of the literature and focus groups of people who use, provide, and administer mental health services. The products have been audience tested by mental health service providers and providers. The presentation will discuss audience reactions to both the concept of shared decision making in mental health as well as these specific tools.

**REFERENCES:**
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**SYMPOSIUM 5**

**NEW DEVELOPMENTS IN INTERPERSONAL PSYCHOTHERAPY (IPT)**

*Chairperson: John C Markowitz, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit #129, New York, NY 10032*
*Discussant: Myrna M. Weissman, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize some of the new diagnostic adaptations, treatment formats, and clinical settings in

which IPT is being used and receiving clinical testing in North America and Europe.

**OVERALL SUMMARY:**

Interpersonal psychotherapy (IPT), a time-limited, diagnosis-targeted treatment, was initially developed in the 1970s by the late Gerald L. Klerman, M.D. and Myrna M. Weissman, Ph.D. as an individual treatment for patients with major depressive disorder (MDD). Testing in randomized controlled trials has since demonstrated its efficacy for MDD and bulimia nervosa, its ineffectiveness for substance abuse disorders, and its promise for a variety of other conditions and in a range of formats. IPT continues to undergo research and to spread into clinical practice. This symposium continues an APA tradition of periodic presentations by IPT researchers about progress in their field. The symposium will include updates on adaptations in IPT diagnostic targets, formats, and clinical settings from around the world. In the initial presentation, Drs. Weissman and Verdeli will describe the use of a brief, three-session form of IPT for the evaluation, support, and triage by mental health workers in settings where more sustained treatment resources are scarce. Dr. Koszycki will then report promising preliminary findings from a randomized controlled trial of IPT and brief supportive psychotherapy for depressed women undergoing infertility treatment in Ottawa, Canada. Dr. Markowitz will present an adaptation of IPT as a non-exposure-based treatment for patients with chronic posttraumatic stress disorder in New York City. Dr. Peeters will describe a treatment trial in which patients at a mood disorders clinic in Maastricht, the Netherlands, were offered their choice of empirically validated antidepressant treatments, including IPT. Dr. Karlsson will describe the results of a pilot feasibility trial of IPT in municipal mental health clinics in Turku, Finland. Dr. Weissman will then discuss the studies. The audience will be encouraged to ask questions after each presentation at following the formal presentations.

No. 5-A

**INTERPERSONAL PSYCHOTHERAPY: A THREE SESSION EVALUATION, SUPPORT AND TRIAGE (IPT-EST)**

*Helena Verdela, M.D.*

**SUMMARY:**

We present the concept and preliminary pilot data of a three session adaptation of Interpersonal Psychotherapy (Weissman, Markowitz & Klerman, 2007) offering evaluation, support and triage (IPT-EST). During the three sessions, a diagnostic evaluation is made, the relationship between symptom onset and problem triggers (grief, disputes, transitions and deficits) is clarified in a supportive relationship and a treatment determination (triage) is conducted. The principle underlying this work is that a systematic but brief evaluation, support and triage approach may help to allocate a scarce commodity, full ambulatory psychiatric treatment, to those patients who may derive the greatest benefit and for whom it may be most appropriate. This approach can also offer supportive but less intensive intervention to the majority of patients with transient depressive symptoms in association with an immediate life stressor. These methods can be easily taught to mental health workers and to persons with little or no background in mental health, if the training is modified appropriately (Verdeli et al., 2003) and may be useful in primary care and other non-mental health settings. Finally, all interventions must be subjected to testing for efficacy before they are widely disseminated. While there is considerable evidence for the efficacy of IPT, this adaptation of IPT has not yet been tested in a controlled clinical trial.

No. 5-B

**INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSED WOMEN UNDERGOING FERTILITY TREATMENT: A RANDOMIZED CONTROLLED TRIAL**

*Diana Koszycki, Ph.D., 145 Jean-Jacques Lussier, Ottawa, K1N 6N5*

**SUMMARY:**

Infertility affects 8-12% of couples of reproductive age. Inability to conceive is a major life stressor, and an important risk factor for depression in women. Little is known about antidepressant efficacy in the context of infertility. IPT may be a useful intervention because it focuses on interpersonal issues common in infertile couples: disputes with others, loss of reproductive health and social role, grief post miscarriage, and social isolation from the "fertile" world. Methods: This study compared IPT to a non-specific control psychotherapy in depressed women in fertility treatment. Medication-free women with at least moderately severe major depression (CGI-S =4) were recruited via ads in infertility clinics, gynecologist offices, self-help groups, and newspapers. Fifty-one women were evaluated; 31 were randomly allocated to 12 sessions of IPT (n=15) or brief supportive psychotherapy (BSP) (n=16). Mean age and duration of infertility were 35.42 ±4.5 and 3.82 ±3.2 years, respectively. Twenty-four women had no biological children. Cause of infertility was unknown in almost half of cases. Results: Twenty-two women completed therapy: 12 IPT (80%) and 10 BSP (62.5%) (p=0.43). Baseline demographic and clinical characteristics were comparable in the groups. Blind evaluators rated change in MADRS score. Mean baseline and endpoint MADRS scores were 25.67 ±4.7 and 9.8 ±7.7 for IPT, 27.37 ± 6.49 and 17.4 ±12.7 for BSP. IPT endpoint MADRS scores trended lower (p=0.057). Response rate was 73.3% for IPT, 40% for BSP (p=0.065); remission, 53.3% for IPT and 31% for BSP (p=0.108). Eleven IPT (73.3%) and 5 BSP patients (31.1%) had CGI-S scores of 1-2 (p=0.019).Discussion:

Although findings are preliminary and sample size is small, study data suggest IPT has efficacy for depressed women struggling with infertility. Funded by Ontario Mental Health Foundation and the University Medical Research Fund.

No. 5-C

**INTERPERSONAL PSYCHOTHERAPY FOR PATIENTS WITH CHRONIC POSTTRAUMATIC STRESS DISORDER (IPT-PTSD)**

*John Markowitz, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit #129, New York, NY 10032*

**SUMMARY:**

Exposure to reminders of trauma underlies the theory and practice of most treatments for posttraumatic stress disorder (PTSD), yet exposure may not be the sole important treatment mechanism. Interpersonal features of PTSD influence its onset, chronicity, and possibly its treatment. This presentation briefly reviews interpersonal factors in PTSD, including the critical but underrecognized role of social support as both a protective posttrauma variable and a mechanism of recovery. The presenter will discuss Interpersonal Psychotherapy (IPT), which focuses on interpersonal issues, as an alternative PTSD treatment and present encouraging findings from two initial studies, one of which used IPT in individual (N=16) and one in group format (N=48). He will then describe an ongoing randomized controlled trial comparing IPT to Prolonged Exposure and Relaxation therapies. The importance of attachment and interpersonal relationships in PTSD suggests a potential mechanism to explain why improving relationships may ameliorate PTSD symptoms.

No. 5-D

**TREATING DEPRESSION WITH EVIDENCE-BASED INTERVENTIONS IN ROUTINE DAILY PRACTICE: RESULTS OF A PRAGMATIC EFFECTIVENESS TRIAL**

*Frenk Peeters, M.D., Ph.D., PO Box 5800, Maastricht, 6202 AZ*

**SUMMARY:**

The efficacy of some acute-phase treatments for major depressive disorder (MDD) is well established in randomized controlled trials (RCT's). However, for over a decade concerns have been expressed about the utility of generalizing the results of RCT's to daily clinical practice. A major doubt among many scientists and clinicians is if depressed patients respond to and remit equally well in evidence-based treatments outside the realm of a highly controlled study. The present naturalistic study was designed to examine the effectiveness of pharmacotherapy (PHT), Interpersonal Psychoherapy (IPT), and Cognitive Behavioral Therapy(CBT) (either alone or in combination with PHT) in the treatment of MDD in a community mental health center in the city of Maastricht, The Netherlands. After a diagnostic work-up, consisting of an open interview and the SCID-I, participants (n=166) were informed about treatment options in the mood disorders program. Typically as in a naturalistic treatment setting, choice of treatment was made in agreement by patient and therapist but predominantly patient-preference guided. The clinical course during treatment was assessed at 8, 16, and 26 weeks. In comparison, the effectiveness of these evidence-based treatments appeared to be equal and overall approached the effect-sizes reported in RCT's. In this presentation, we will (1) present these clinical outcomes in this naturalistic study, and (2) address possible predictors of outcome in the various treatments. Implementation of evidence-based treatments for MDD to routine daily practice is possible and seems, given it's good effectiveness, well justified.

No. 5-E

**INTERPERSONAL PSYCHOTHERAPY FOR COMMUNITY PATIENTS WITH MODERATE TO SEVERE MAJOR DEPRESSIVE DISORDER AND MULTIPLE COMORBIDITIES**

*Hasse Karlsson, M.D., Ph.D., Lehmustie 12 b, Turku, 20720*

**SUMMARY:**

Interpersonal psychotherapy (IPT) has shown efficacy in randomized controlled trials (De Mello et al. 2005), but no reports exist on IPT for depressed patients with severe psychiatric comorbidities in public outpatient clinics. This pilot study assessed the feasibility, effectiveness, and implementation of interpersonal psychotherapy for depressed patients with psychiatric comorbidities in municipal outpatient care. Seven clinicians were briefly trained to deliver IPT.Twenty-six patients with moderate to severe major depressive disorder received IPT for 16 weeks, and a control group (n=20) received treatment as usual (TAU). The majority of the patients also received antidepressant medication. Of the patients, 76% had concurrent anxiety disorders, over 80% personality disorders, and 20% alcohol dependence. Depressive symptoms, social functioning, and self-perceived health improved notably in both groups. The mean Hamilton Depression Rating Scale (HAMD) score decreased from 20 to 10. Using HAMD =7 as a cutoff, 28.3% of patients reached full remission. Patients receiving IPT reported significantly greater satisfaction with their treatment and were more often able to terminate treatment after 16 sessions. Both treatments were effective in this small, highly comorbid sample. Conducting IPT proved feasible in municipal outpatient clinics and offered some advantages to TAU. It was possible to train staff quickly.

These results, however, warrant a larger randomized trial.

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3.Stirman SW, DeRubeis RJ, Crits-Christoph P, Rothman A: Can the randomized controlled trial literature generalize to nonrandomized patients? J Consult Clin Psychol 2005;73:127-35

4.Verdeli H, Clougherty K, Bolton P, Speelman L, Ndogoni L, Bass J, et al. (2003). Adapting group interpersonal psychotherapy for a developing country: Experience in rural Uganda. World Psychiatry 2003;2:114-120

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**SATURDAY, MAY 22, 2010**
**9:00 AM-11:00AM**

**SYMPOSIUM 6**

**UPDATE ON TREATMENTS FOR CHILD AND ADOLESCENT EATING DISORDERS**

*Chairperson: James Lock, M.D., Ph.D., 401 Quarry Rd. Rm 1120, Stanford, CA 94305*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participant should be able to: 1) Demonstrate knowledge of family-based treatment for adolescent anorexia nervosa and bulimia nervosa; 2) Demonstrate knowledge of adolescent-focused individual therapy for anorexia nervosa; and 3) Demonstrate knowledge of cognitive-remediation therapy for cognitive inefficiencies in adolescent anorexia nervosa.

**OVERALL SUMMARY:**

This symposium will focus on three main treatments for adolescents with eating disorders. Each talk will describe the scientific support and rationale for the treatment approach and provide a summary description of the main strategies employed. The three talks are: 1) Family-based Treatment (FBT) is the treatment that currently has the largest evidence-base for adolescent AN and BN. The approach has been studied in seven RCTs. The treatment is primarily a behavioral therapy for outpatient use for medically stable adolescents with AN. The approach employs parents in weight restoration in AN and behavioral control in BN. 2) Adolescent Focused Therapy (AFT) is an developmentally tailored individual therapy aimed at supporting self-efficacy, self-esteem, and autonomy for adolescents with AN. This is therapy rooted in self-psychology and has been studied in 2 RCTs. The focus of the therapy is the supportive/authoritative dyadic relationship with the therapist. Parents are involved to support developmental goals. 3) Cognitive Remediation Therapy (CRT) is a novel therapy used in conjunction with other behavioral or psychological therapies focused on cognitive inefficiencies found in AN. The specific cognitive deficits addressed include flexibility (set-shifting) and weak central coherence. This treatment has been studied in adults with chronic AN and is currently being employed in an RCT. Data on feasibility and acceptability of the approach with adolescents will be presented.

No. 6-A

**FAMILY-BASED TREATMENT FOR CHILD AND ADOLESCENT EATING DISORDERS**

*Daniel le Grange, Ph.D., 5841 South Maryland, Chicago, IL 60637*

**SUMMARY:**

Family-based Treatment (FBT) is the treatment that currently has the largest evidence-base for adolescent AN and BN. The approach has been studied in seven RCTs. The treatment is primarily a behavioral therapy for outpatient use for medically stable adolescents with AN. The approach employs parents in weight restoration in AN and behavioral control in BN. The first stage of treatment is focused almost exclusively on helping parents take control of eating related behaviors of their child. Parents are encouraged to see AN as a disease and not a willful behavior through externalization of the disorder. Parents are explicitly told they are not to blame themselves for causing the disorder. Once weight is regained, parents are helped to transition eating related concerns back to the adolescent in an age appropriate manner. In the final stage of treatment the focus shifts to themes of general adolescent development without AN. Treatment lasts between 6 and 12 months.

No. 6-B

**ADOLESCENT FOCUSED INDIVIDUAL THERAPY FOR ANOREXIA NERVOSA**

*James Lock, M.D., Ph.D., 401 Quarry Rd. Rm. 1120, Stanford, CA 94305*

**SUMMARY:**

Adolescent focused therapy is rooted in self-psychology.17, 21 self-psychology, as it pertains to this patient group, posits that individuals with an manifests ego deficits and confuse self-control with biological needs. Aft posits that patients must develop sufficient autonomy to successfully separate and individuate from the family of origin in order to recover. To develop autonomy and self-efficacy, patients must first learn to identify and define their emotions,

and later, to tolerate negative (and even positive) affective states rather than numbing themselves with starvation. Aft sessions are 45 minutes in duration for a total of 32 sessions over the treatment year. Eight of these sessions are typically used for collateral sessions with parents only (45 minutes x 8 = 6 hours). In these collateral sessions the therapist assesses parental functioning, advocates for the patient's developmental needs, and updates the parents on the patient's progress. Parents are specifically asked to refrain from managing eating and weight issues. In the first phase (assessment and early treatment—sessions 1-13), the therapist establishes rapport and begins a formulation of the patient's psychological issues by obtaining a personal and developmental history. The therapist also assesses the patient's motivation for treatment and stage of denial. Next, the therapist begins to interpret behavior, emotions, and motives, and helps the patient distinguish emotional states from bodily needs. Discussion of targeted symptoms is undertaken, but sessions are not primarily focused on weight, calorie intake, or food. The therapist requires the patient to accept responsibility for food related issues as opposed to relinquishing authority to others (e.g. Parents). Early therapy phase goals include the initiation of assertiveness therapy. The middle therapy phase (sessions 14-26): the focus of the middle phase of therapy is the encouragement of the patient's separation and individuation and ability to tolerate negative affect. The termination phase (sessions 27-32): the main focus of this stage is termination.

No. 6-C

**COGNITIVE REMEDIATION THERAPY FOR ADOLESCENT ANOREXIA NERVOSA**

*Kathleen Fitzpatrick, Ph.D., 401 Quarry Rd, Stanford, CA 94305*

**SUMMARY:**

Adolescents with an appear similar to adults with an in terms of cognitive inefficiencies that distinguish them from normally developing adolescents. Although general measures of intellectual functioning are intact, consistent with observations that most adolescents with an are functioning within normal limits at school, areas related to some set-shifting tasks and to central coherence are clearly outside of the range of normal limits. Unlike adults, set-shifting difficulties appear limited in scope and are apparent only on more sensitive measures of cognitive flexibility. However, central coherence findings are similarly robust to those seen in adults. Pilot work using crt suggests that the approach is acceptable and feasible for adolescents with an and partial an on an inpatient service. Given the nature of these cognitive inefficiencies, the use of cognitive remediation therapy to potentially remediate these challenges provides a particularly compelling area for further exploration. If, as in adults, remediation exercises improve functioning in these areas of cognitive difficulty the use of these techniques with an adolescent population may assist with fuller recovery from an symptoms.

**SYMPOSIUM 7**

**NEURODEVELOPMENTAL DISORDERS IN *DSM-5:* AN UPDATE FROM THE WORK GROUP**

*Chairperson: Susan E Swedo, M.D., Building 10, Room 4N208, MSC 1255, 10 Center Drive, Bethesda, MD 20814*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identity the primary symptoms of autism and intellectual disabilities; 2) Describe the major diagnostic challenging facing autism and intellectual disorders; and 3) Recognize gender, age, and cultural aspects of neurodevelopmental diagnosis; and 4) Discuss the approaches under consideration in creating a category of autism spectrum disorders.

**OVERALL SUMMARY:**

Neurodevelopmental disorders (ND) have their onset in infancy or early childhood and cause life-long impairments in cognitive and behavioral functions. Diagnostic criteria for these disorders must be sensitive to age and developmental stage, as symptom expression frequently changes as children grow and develop, and the criteria also must be sensitive to male:female and cultural differences in symptom manifestations. In addition, the diagnostic criteria must serve adult patients, in whom early childhood histories may be lacking, while retaining diagnostic integrity by requiring evidence of onset in infancy or early childhood. The ND Workgroup was charged with considering all of these factors as they deliberated over recommendations for changes that would improve diagnostic sensitivity and specificity for the ND diagnostic criteria and text descriptions in DSM-V. The symposium will review briefly the procedures and process utilized by the ND Workgroup and will then present the draft recommendations for the DSM-IV diagnostic categories of mental retardation (MR), learning disorders (LD) and pervasive developmental disorders (PDD). The first presentation will discuss recommended name changes for the MR, LD and PDD categories, as well as presenting data to support changes in criteria for individual diagnoses. The remaining presentations will focus on autism spectrum disorders (ASD), including a discussion of possible changes to the "core" symptoms of autism: social and communication deficits and repetitive behaviors/fixated interests; the impact of developmental factors and intellectual disabilities on the clinical presentation of ASD; gender, cultural and lifespan issues in diagnosis and a discussion of the autism "spectrum"—how broad is it and what separates "normality" from disability? Participants will be encouraged to provide feedback to the draft recommendations, to suggest further issues for

consideration, and to provide input to the final draft of the criteria. Differences between sexes in autism spectrum disorders (ASD) have achieved increasing attention during the latest two decades with a constant increase of observed diagnosed ASD cases in most countries. Literature review and population-based cohort studies designs of children born in Denmark from 1980 through 2005 registered with ICD-8 and -10 diagnoses of ASD from national registries in Denmark. Persistent differences between girls and boys are found, when studying risk factors, changes over time, early signs, and core autism symptoms of e.g. ASD and childhood autism diagnoses. Early childhood infections are stronger risk factors for an ASD diagnose among boys than girls. When studying risk factor changes (including gestational age, birth weight, multiplicity, maternal and paternal age, and parental psychiatric history) over time distinct differences in patterns among boys and girls are identified. Certain early signs of ASD among girls are considerably more prone than in boys. Finally, consistently boys tend to meet more diagnostic criteria than girls. Sex is considered an effect modifier in studies of ASD. Girls and boys are different in their ASD profile; now and previously. One could ask, if we are talking of two different conditions.

No. 7-A

**THE NEURODEVELOPMENTAL DISORDERS IN *DSM-5:* WHAT'S CHANGED? WHAT'S STAYING THE SAME?**

*Susan Swedo, M.D., Building 10 - 4N208, 10 Center Drive-MSC1255, Bethesda, MD 20854*

**SUMMARY:**

In *DSM-IV*, the neurodevelopmental disorders include the Pervasive Developmental Disorders, Mental Retardation and Learning Disorders, among others. The Neurodevelopmental Disorders (ND) Workgroup has been charged with reviewing the DSM-IV definitions for these diagnoses, to determine "what works and what doesn't" and to recommend improvements for DSM-V diagnostic criteria and text in three main categories: 1) Mental retardation; 2) Learning Disorders; and 3) Pervasive Developmental Disorders. In DSM-V, the ND Workgroup recommends that the names be changed to the following: 1) Intellectual Disabilities; 2) Learning Disabilities and 3) Autism Spectrum Disorders (respectively). These recommendations were based on evidence obtained from literature reviews, secondary data analyses and expert consultations. The sources also served as support for recommended changes to diagnostic criteria and text revisions for individual disorders, such as autism. Recommendations for changes to the Intellectual Disabilities diagnostic criteria will be reviewed in the presentation, as will recommendations for changes to the criteria for the individual learning disabilities (such as dyslexia, dyscalculia and others). The presentation also will discuss the process and procedures utilized in determining what changes are needed for the criteria for autism and related disorders, and will serve as an introduction to the remaining presentations within the symposium.

No. 7-B

***DSM-5* AND THE CORE FEATURES OF AUTISM SPECTRUM DISORDERS**

*Catherine Lord, Ph.D., UMACC, 1111 E. Catherine St., Ann Arbor, MI 48109*

**SUMMARY:**

The syndrome of autism spectrum disorders has as its core the incisive observations of Leo Kanner about the particular deficits in affect and social relations as well as the maintenance of sameness in a small group of children 50 years ago. These observations have remained the central components of diagnostic criteria for autism but priorities and additional characteristics have varied over the years. One of the questions in the development of diagnostic criteria is the degree to which behaviors that differentiate autism from other disorders should be emphasized compared to behaviors that most accurately describe universal characteristics of the disorders. Results of analyses of several large data sets will be discussed as they pertain to proposed revised criteria for DSM V. A focus has been on appropriate criteria across developmental, chronological and language levels.

No. 7-C

**INTELLECTUAL DISABILITY IN DSM-5**

*Walter Kaufmann, M.D., 716 N. Broadway, Room 137, Baltimore, MD 21205*

**SUMMARY:**

The Intellectual Disability Subworkgroup of the DSM-V Neurodevelopmental Disorders Workgroup has been reviewing the diagnostic criteria for Intellectual Disability, attempting to develop a set of guidelines that takes into consideration similar efforts by the American Psychological Association and the American Association on Intellectual and Developmental Disabilities. Review of terminology has also considered other organizations' guidelines (e.g., Child Neurology Society). To date, the Subworkgroup has revised *DSM-IV* criteria in terms of terminology, specific criteria, age range, and level of severity. Preliminary recommendations include: (1) Replacement of the outdated term "Mental retardation" by "Intellectual Disability", for individuals older than 5 years, and Developmental Disability" for those below this age; (2) Definition of Intellectual/ Developmental Disability as a deficit of 2 or more standard deviations on an individualized, standardized, culturally appropriate, and psychometrically sound test; (3) Use of IQ and Adaptive functioning as diagnostic specifiers for Intellectual Disability; (4) Consideration of age of onset for Intellectual Disability as the developmental period

(birth to 18-21 years); and (5) Coding of Intellectual Disability no longer based on IQ level (usefulness of the four *DSM-IV* categories of severity is being examined). Other issues under evaluation include determination of specific domains of adaptive behavior to be included in the diagnostic guidelines and examination of the influence of cognitive impairment, directly or as language impairment, on diagnostic criteria for autism spectrum disorders (also to be discussed in this session). In addition to the current interaction with representatives of the APA and AAIDD, the Subworkgroup will seek feedback (through RFIs and meetings with stakeholder groups) on these changes in definition, as well as on the specific criteria to be proposed for Intellectual Disability in *DSM-5*.

No. 7-D
**THE AUTISM SPECTRUM: HOW DEEP AND HOW WIDE?**

*Bryan King, M.D., Seattle Children's Hospital, 4800 Sand Point Way NE, Seattle, WA 98105*

**SUMMARY:**
From the earliest descriptions of autism, the field has wrestled with the questions of how inclusive a net to cast, and how bright to define the boundaries around not only who is in and who is not, but whether the autism spectrum is made up of discreet entities or is continuous. These discussions have been particularly salient with respect to the application of categorical diagnoses within the autism spectrum in the DSM. The diagnoses of Asperger disorder, and of Pervasive Developmental Disorder NOS have not only grown dramatically but have seemingly also been used to capture dimensional or severity characteristics in affected individuals. This presentation will review the history of the diagnosis of autism, and the potential value of equipping diagnosticians with alternative strategies for capturing diversity of symptom presentation within the autism spectrum will be highlighted.

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**SYMPOSIUM 8**

**AGGRESSIVE BEHAVIORS IN GEROPSYCHIATRIC PATIENTS: NEUROBIOLOGY, ASSESSMENT AND MANAGEMENT**

*The American Association for Geriatric Psychiatry*

*Chairperson: Helen H. Kyomen, M.D., M.S., 115 Mill Street, Belmont, MA 02478-9106*
*Discussant: Mark E Kunik, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand models exploring the neurobiological basis for aggressive behaviors; 2) Specify the prevalence of aggressive behaviors in geropsychiatric patients and the clinical, financial, and ethno-cultural impact of these behaviors on the healthcare system; and 3) Assess and manage aggressive behaviors in geropsychiatric patients using targeted methods that incorporate non-pharmacologic and pharmacologic/somatic interventions.

**OVERALL SUMMARY:**
Aggressive behaviors may lead to injury or harm to self or others, patient disability and caregiver burden, early patient institutionalization, and higher healthcare costs. Aggressive acts may be verbally, physically, or sexually intrusive, resistive, and/or directed externally or at oneself. They are extremely complex and occur interactively, related to varied situations and conditions: perceived adaptive needs, conflicts, fear, pain, stress, or loss of impulse control. Intent to harm is associated with traditional definitions of aggression. However, this concept may not always be relevant, for example, in patients with delirium or severe dementia. Aggressive behaviors can occur as a component of anxiety, mania, depression, psychosis, personality disorders, substance abuse/dependence, delirium, brain damage and neurodegenerative conditions. Associated affective and behavioral manifestations include emotional lability, behavioral disinhibition, irritability, and agitation. Optimal treatment strategies to reduce or prevent aggression in geropsychiatric patients utilize multidisciplinary strategies encompassing nonpharmacologic and pharmacologic/somatic approaches.

No. 8-A
**THE NEUROBIOLOGY OF AGGRESSION**

*Randy Nelson, Ph.D., Ph.D., 4084 Graves Hall, Columbus, OH 43210*

**SUMMARY:**
Aggressive behavior is not a unitary process, but is the result of complex interactions among several physiological, motivational, and behavioral systems, with contributions from the social and physical environment. Dr. Nelson will discuss recent work with elderly mice, using genetically-manipulated mouse models of aggression. The effects of nitric oxide will be emphasized to highlight the interaction of various signaling molecules with the serotonergic system. The contribution of steroid hormones and nonserotonergic neurotransmitters will also be discussed. Multiple, and often unanticipated, effects of targeted gene disruption on aggressive behavior will be reviewed. Current treatment of reactive violence displayed by geriatric clinical populations with impaired brain function decreases arousal. Decreasing reactive aggression

without affecting arousal will require a multi-level approach to understanding the neurobiological, motivational, and behavioral systems involved.

No. 8-B
**NON-PHARMACOLOGIC ASSESSMENT AND MANAGEMENT OF AGGRESSIVE BEHAVIORS IN GEROPSYCHIATRIC PATIENTS**

*Patricia Arean, Ph.D., 401 Parnassus Avenue, San Francisco, CA 94143*

**SUMMARY:**
Dr. Arean will review the literature on behavioral methods for agitation management and talk about the Senior Behavioral Health Program, a SAMHSA funded project to train staff in residential care facilities methods for managing aggression and agitation. This talk will provide the nuts and bolts of effective management strategies including how to conduct a preference assessment, how to predict when aggression or agitation will occur, and how to create a prevention plan. In addition, Dr. Arean will discuss how to manage more complex behaviors, such as nocturnal vocalizations.

No. 8-C
**PHARMACOLOGIC/SOMATIC ASSESSMENT AND MANAGEMENT OF AGGRESSIVE BEHAVIORS IN GEROPSYCHIATRIC PATIENTS**

*Helen H. Kyomen, M.D., M.S., 115 Mill Street, Belmont, MA 02478-9106*

**SUMMARY:**
Geriatric patients often have complex neuropsychiatric and physical comorbid conditions that contribute to the development of aggressive behavioral disturbances. Dr. Kyomen will review the existing literature on patterns of aggressive behavioral disturbances in geropsychiatric patients and focus on the dimensional evaluation and pharmacologic/somatic management of aggressive behaviors in geropsychiatric patients with comorbid conditions. Acute and maintenance interventions as well as preventive strategies will be discussed using illustrative clinical data and case study vignettes.

**REFERENCES:**
1.Nelson RJ, Trainor BC: Neural mechanisms of aggression. Nat Rev Neurosci 2007; 8:536-46.
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63:21-26.

**SYMPOSIUM 9**

**ADVANCES IN THE MANAGEMENT OF TREATMENT-RESISTANT DEPRESSION**

*Chairperson: Charles B Nemeroff, M.D., Ph.D., 101 Woodruff Circle Suite 4000, Atlanta, GA 30322*
*Co-Chairperson: Michael E Thase, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify neurobiological distinct subtypes of depression that may respond selectively to specific pharmacological and psychotherapeutic interventions; 2) Recognize the use of combination and augmentation strategies in treatment-resistant depression; and 3) Identify the optimal treatment management of patients with comorbid major depression and substance abuse.

**OVERALL SUMMARY:**
Treatment resistant depression (TRD) is a major public health problem both in terms of its prevalence and individual suffering and cost to society. The traditional definition of treatment-resistant depression requires an inadequate response to an adequate course of treatment in a patient meeting criteria for major depressive disorder (MDD). Inadequate response has been operationalized by applying specific criteria for treatment response or, alternatively remission. The magnitude of TRD increases substantially if failure to achieve remission is used as the qualifying criterion. What constitutes an adequate course of treatment has been operationalized by delineating a TRD staging system. Criteria for stage 1 and 2 TRD require failure to respond, respectively, to 1 or 2 adequate antidepressant trials. Each trial must comprise antidepressants of distinctly different classes. Stage 3 requires a third trial which must include a course of treatment with a tricyclic antidepressant, if this class was not used in stage 1 or 2. Stage 4 TRD requires failure to respond to at least 4 different classes of antidepressants, one of which must be a monoamine oxidase inhibitor. Stage 5 TRD requires meeting all stage 4 criteria, in addition to which a patient must have failed an adequate course of electroconvulsive therapy (ect). Additional research is needed to characterize the extent to which TRD might be secondary to untreated comorbid disorders such as anxiety syndromes or other axis I disorders, axis II diagnoses, or

medical illness. Major depressive disorder (MDD) is one of the world's greatest public health problems because it is common, frequently runs a recurrent and/or chronic course, and can be disabling. There are many therapies with established efficacy in MDD and a case can be made that generic formulations of several of the selective serotonin reuptake inhibitors represent a strong standard for first-line antidepressants. Nevertheless, there continues to be a number of unmet needs in antidepressant therapy, which can serve as targets for therapeutic development. For example, there is the need for antidepressants with mechanisms of action other than serotonin or norepinephrine reuptake inhibition. Such medications would hold particular promise for patients who either do not benefit or who cannot tolerate existing first-line therapies. Another target would be development of antidepressants that exerted more rapid symptom relief. Even if such a medication was not ultimately more effective, a treatment that reliably delivered its effect within the first 7 to 14 days – as opposed to 4 to 8 weeks - would lessen suffering and might promote greater adherence. An additional advantage of a treatment with more rapid activity is that, if ineffective, the next trial could be undertaken in a more efficient manner. A final unmet need pertains to the ability to match specific medications to particular patients. As each unsuccessful course of antidepressant therapy results in a proportion of patients dropping out of the treatment process, an approach that would improve the matching of patients and medications would likewise reduce suffering and improve the efficiency of therapy.

No. 9-A

**THE NEUROBIOLOGY OF DEPRESSION: IMPLICATIONS FOR TREATMENT-RESISTANT DEPRESSION AND PERSONALIZED MEDICINE IN PSYCHIATRY**

*Charles Nemeroff, M.D., Ph.D., 101 Woodruff Circle Suite 4000, Atlanta, GA 30322*

**SUMMARY:**

The *DSM-IV* criteria for major depression is extraordinarily broad and undoubtedly contains pathophysiologically distinct endophenotypes. Although there is evidence that certain subtypes of depression such as psychotic and atypical depression respond better to one approved treatment than another, there are few well established predictors of antidepressant treatment response. This presentation will review the evidence for pathophysiologically distinct subtypes of depression including depression with early life trauma and vascular depression, and the current evidence for predictors of treatment response. Both genomic findings and functional structural brain imaging findings will be highlighted.

No. 9-B

**UNMET NEEDS IN THE TREATMENT OF DEPRESSION**

*Michael Thase, M.D., 3535 Market Street, Suite 670, Philadelphia, PA 19104*

**SUMMARY:**

Major depressive disorder (MDD) is one of the world's greatest public health problems because it is common, frequently runs a recurrent and/or chronic course, and can be disabling. There are many therapies with established efficacy in MDD and a case can be made that generic formulations of several of the selective serotonin reuptake inhibitors represent a strong standard for first-line antidepressants. Nevertheless, there continues to be a number of unmet needs in antidepressant therapy, which can serve as targets for therapeutic development. For example, there is the need for antidepressants with mechanisms of action other than serotonin or norepinephrine reuptake inhibition. Such medications would hold particular promise for patients who either do not benefit or who cannot tolerate existing first-line therapies. Another target would be development of antidepressants that exerted more rapid symptom relief. Even if such a medication was not ultimately more effective, a treatment that reliably delivered its effect within the first 7 to 14 days – as opposed to 4 to 8 weeks - would lessen suffering and might promote greater adherence. An additional advantage of a treatment with more rapid activity is that, if ineffective, the next trial could be undertaken in a more efficient manner. A final unmet need pertains to the ability to match specific medications to particular patients. As each unsuccessful course of antidepressant therapy results in a proportion of patients dropping out of the treatment process, an approach that would improve the matching of patients and medications would likewise reduce suffering and improve the efficiency of therapy.

No. 9-C

**AUGMENTATION AND COMBINATION STRATEGIES IN TREATMENT RESISTANT DEPRESSION**

*Linda Carpenter, M.D., Butler Hospital, Providence, RI 02806*

**SUMMARY:**

Major depression is a common and disabling disorder that is frequently resistant to initial antidepressant medication treatment. The star*d study demonstrated that only a third of patients with major depression remitted after a vigorous course of SSRI therapy, and nearly half the patients in that large multicenter study who undertook a second antidepressant trial still did not experience remission. Pharmacoresistant major depression appears to be the norm, rather than the exception, in current clinical practice settings. "optimization" (i.e., increase in antidepressant dose and/or duration), "substitution" (i.e., switching to a new drug), "augmentation" (i.e., addition of

a non-antidepressant drug to ongoing pharmacotherapy), and "combination" (i.e., simultaneously treating with two different antidepressants drugs) are strategies used to treat a depressive syndrome that has not remitted to initial antidepressant trial. While only one drug (aripriprazole) is currently FDA-approved for adjunct use in patients with treatment resistant depression (TRD), there is a considerable body of evidence that addresses the efficacy and safety of augmentation with other agents. Neuromodulation therapies, including electroconvulsive therapy (ect), transcranial magnetic therapy (TMS) and vagus nerve stimulation (VNS) are also FDA-approved device-based treatments for patients who do not respond to antidepressant medication. This presentation with review the available data and practical considerations for a broad range of treatments used for major depression when a single antidepressant trial has not produced full symptom remission.

No. 9-D

**MANAGEMENT OF COMORBID DEPRESSION AND SUBSTANCE ABUSE**

*Ihsan Salloum, M.D., M.P.H., 1120 NW 14th Street, Miami, FL 33136*

**SUMMARY:**

Major depression and alcoholism and other substance use disorders (suds) are among the most frequent conditions in the community and represent leading causes of disease burden worldwide. Epidemiological studies have consistently demonstrated that the association between unipolar major depression and alcoholism or other suds exceeds that is expected by chance alone by several folds. Furthermore, this comorbidity is associated with increased risk for suicide, recurrence of depressive illness, relapse to substance abuse, increased morbidity and mortality. Significant methodological challenges remains in conducting clinical trials for this comorbidity and the results of published clinical trials have been, for the most part, inconclusive. While a number of studies have demonstrated that unipolar depression in the context of alcoholism and substance use may respond to an adequate dose of antidepressant medications, treatment non-response has been rarely specifically addressed in this population. The current presentation will examine mediators and moderators of treatment response derived from a recently completed clinical trial of unipolar depression and alcoholism and it will review these results in the context of relevant clinical trials for comorbid unipolar depression and alcoholism and other suds. Supported USPHS grants R01 AA11929 and in part by R21 AA014396; R01 DA019992; R01 AA13370.

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**SYMPOSIUM 10**

**CLINICAL TRENDS IN BIPOLAR DISORDERS**

*Chairperson: Flavio Kapczinski, M.D., PO Box 7168, Pittsburgh, PA 15213,*
*Co-Chairperson: Benicio N Frey, M.D., Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the limitations and possibilities in clinical trials design in bipolar disorder; 2) Understand the use of current guidelines in treating bipolar disorders patients; and 3) Understand how gender may influence clinical management in bipolar disorder.

**OVERALL SUMMARY:**

The clinical management of bipolar disorder is frequently complicated by a complex clinical presentation. The use of differential strategies to treat patients in mania, depression and during euthymia is an example of the complexity of dealing with patients with bipolar disorder. The available information on treatment of bipolar disorders rely on data from clinical trials, that often require a careful interpretation. Many times, the data of clinical trials is not readily tranferred to the clinical setting. In order to deal with such challenges, guidelines for treatment are used by many clinicians. One of the main aims of guidelines is to summarize data from clinical trials and recommend its use in the light of available clinical experience, as well as patient's values. An important avenue to improve treatment in bipolar disorder would be the use of biomarkers as predictors of response to treatment and the course of illness. These data is not yet available for clinicians, but stands out as a promissing field. Another important area of interest is the acknowledgement that gender differences may play an important role in clinical response and management of patients. Finally, in the field of bipolar disorders, the importance of developing a constructive relationship with advocacy groups has been emphasized as a means to deal with disorder-related stigma and improving access of patient to treatment.

No. 10-A

**THE INTERNATIONAL SOCIETY OF BIPOLAR DISORDERS (ISBD) TASK FORCE ON THE NOMENCLATURE OF COURSE AND OUTCOME IN BIPOLAR DISORDERS**

*Mauricio Tohen, M.D., Eli Lilly & Co., Indianapolis, IN 35355*

**SUMMARY:**

Under the auspices of the International Society of Bipolar Disorders (ISBD), a Task Force was convened to examine report, discuss, and integrate findings from a review of historical and current literature related to observational and clinical trial studies and commonly used terminology describing the course and outcome in bipolar disorders. Consensus opinion was reached regarding the definition of 9 terms (response, remission, recovery, relapse, recurrence, switch, subsyndromal states, predominant polarity, and functional outcome) commonly used to describe course and outcomes in bipolar disorders. Further studies are needed in order to validate the proposed definitions.

No. 10-B

**EVIDENCE BASED TREATMENT GUIDELINES FOR BIPOLAR DISORDER**

*Lakshmi Yatham, M.B.B.S, UBC Hospital, Vancouver, V6T 2A1*

**SUMMARY:**
Several treatment guidelines exist for management of bipolar disorder. The Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines are the most comprehensive and upto date and this presentation will review these guidelines.The recommendations for the management of acute mania include Lithium, valproate and several atypical antipsychotics in monotherapy or in combination therapy. The combination of olanzapine or risperidone with carbamazepine is not recommended. For the management of bipolar depression, lithium, lamotrigine and quetiapine monotherapy, olanzapine plus SSRI, and lithium or divalproex plus SSRI/bupropion remain as first line options. New data support the use of adjunctive modafinil as a second line option, but also indicate that aripiprazole should not be used as monotherapy for bipolar depression. Lithium, lamotrigine, valproate, olanzapine, quetiapine, and risperidone and aripiprazole as well as adjunctive ziprasidone are recommended for maintenance therapy. The optimal management for long term treatment of bipolar disorder includes pharmacotherapy as well as psychosocial treatments as adjuncts to improve outcome.

No. 10-C

**THE USE OF BIOMARKERS IN BIPOLAR DISORDER**

*Flavio Kapczinski, M.D., PO Box 7168, Pittsburgh, PA 15213*

**SUMMARY:**
Our group and others have put forward a set of targets related to neurotrophins, inflammation and oxidative stress as key mediators of the cognitive and general health impairment that occur with recurrent mood episodes. Recently, we have reported a first en bloc assessment of this set of previously described markers of mood episodes in bipolar disorder. In order to make the point that all the described changes are potentially ominous we measure the same indicators in patients with sepsis, with extreme and massive peripheral illness. We termed this set of markers as a "systemic toxicity index - STI." This concept emerged from the fact that several biomarkers are altered in mood episodes and even in euthymic patients in early as well as in late stages of bipolar disorder. This approach is consistent with the notion that complex phenotypes as bipolar disorder may need a composite of markers in order to obtain a proxy of the systemic toxicity which is present in mood episodes. The research in the field of biomarkers may help in identifying the "activity" of bipolar disorders during episodes and to provide a biological basis for the notion of staging in Bipolar Disorder.

No. 10-D

**REDOX BIOLOGY AND GLUTATHIONE: FROM PATHOPHYSIOLOGY TO NOVEL TREATMENTS IN BIPOLAR DISORDER**

*Michael Berk, M.D., Ph.D., PO Box 281 Geelong, VIC 3220*

**SUMMARY:**
Objective: In major psychiatric disorders including bipolar disorder, there is evidence of oxidative stress and alterations of free radical defenses. Evidence for this includes reduction in glutathione, increased lipid peroxidation, alteration of antioxidant enzymes and brain changes compatible with oxidative damage. Medications in wide use including antidepressants, antipsychotics and mood stabilisers have substantive effects on oxidative pathways. Glutathione is the brains principal antioxidant. N-acetyl cysteine (NAC) is a precursor of glutathione, and has additional effects on glutamate and inflammatory processes. NAC increases neurogenesis, enhances neuronal sprouting and reverses animal models of oxidative stress. NAC raises peripheral and brain glutathione levels and reverses animal models of glutathione depletion. In two double blind randomised placebo controlled trials, NAC has shown clinical efficacy in the negative and general symptoms of schizophrenia, and in depression, functioning and quality of life in bipolar disorder.Methods: This presentation will highlight results from a recently completed double blind randomised placebo controlled trial of NAC compared to placebo as an add-on to treatment as usual in the maintenance treatment of individuals who have recently had an episode of depression. Results: Outcome measures including time to a mood episode and changes on symptomatic, functional and quality of life scales will be presented.
Conclusions: The accumulating data in the area implicates oxidative pathways in the pathophysiology of many diverse psychiatric disorders, and supports NAC as a novel adjunctive treatment.

No. 10-E
**WOMEN'S HEALTH ISSUES IN BIPOLAR DISORDER**

*Aysegul Ozerdem, M.D., Ph.D., Dept of Psychiatry, Narlidere, 35340*

**SUMMARY:**
Management of female patients with bipolar disorder is a field with a substantial amount of unmet needs. The gender based differences in treatment response, in endocrinologic and metabolic conditions between women and men with bipolar disorder constitute the challenging background. Although not specific to bipolar disorder, gender related differences in clinical as well as pharmacokinetic responses to antidepressants and antipsychotics have been reported. With regard to mood stabilizing agents in bipolar disorder, females and males were shown to differ little on lithium response. However, data is lacking on the sex difference in the effectiveness of anticonvulsants. Due to limited amount of relevant information on safety of psychotropic medications during pregnancy and lactation, the field is lacking treatment guidelines for these special periods. Association between psychotropic medications and reproductive endocrine function, specifically polycystic ovary syndrome and menstrual abnormalities has been addressed in a number of studies. Despite being influenced by the medications, evidence shows that the higher rate of hypothalamicpituitary-gonadal axis irregularity and related reproductive dysfunction in women with bipolar disorder exist prior to medications. On the other hand, many medications used in treatment of bipolar disorder have serious metabolic side effects which lead to further dysregulation in the neuroendocrine system and in turn create vulnerability for such serious medical problems as cardiovascular disease and diabetes in later life in women with bipolar disorder.

**SYMPOSIUM 11**

**CULTURALLY SENSITIVE ASSESSMENT OF PSYCHOLOGICALLY DISTRESSED ETHNIC AND NON-ENGLISH SPEAKING POPULATIONS**

*Chairperson: Devon Hinton, M.D., Ph.D., 15 Parkman Street, WACC 812, Boston, MA 02114*
*Co-Chairperson: Roberto Lewis-Fernández, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Evaluate idioms of distress in traumatized non-English speaking populations; 2) Specify key idioms of distress in Cambodian, Latino, and Nepali populations; and 3) Conduct culturally sensitive formulations, taking into consideration such variables as family dynamics.

**OVERALL SUMMARY:**
The United States is increasingly multicultural. To give one example, the Latino population in the United States is expected to represent 25% of the population by 2050 (U.S. census bureau, 2004). Treatment providers need to carefully determine how culturally sensitive assessment can be provided to ensure proper care. In this symposium, multiple aspects of culturally sensitive assessment will be discussed. One talk presents data from a study among a Latino population and non-Latino population at a psychiatric clinic, a study that shows that certain hallucinatory "perceptual alterations"—e.g., seeing shadows—are more common in Latino versus non-Latino whites, and that this may result from depersonalization mechanisms. Another describes an instrument, the Cambodian Idiom-of-Distress scale, that was developed to assess culturally salient symptoms of distress (e.g., neck pain, orthostatic dizziness, khyâl attacks) in that traumatized refugee population, and how that scale serves a useful assessment tool for that population. Another discusses the development of an instrument for assessing in a culturally sensitive way the mental health needs of child soldiers in Nepal. Another discusses how to perform culturally sensitive evaluation of older ethnic adults, and reveals how the DSM-IV cultural formulation can be made more appropriate for this population. Another talk shows how to assess distress on the family level, illustrated by a discussion of a qualitative and quantitative survey of family conflict in West African immigrant families in Manhattan. Through this symposium, participants will learn about how to assess various non-Western cultural groups, such as surveying for certain culturally salient symptoms. And the talks outline various optics (idioms of distress, key symptoms, cultural formulation, family assessment) that can be used to assess psychiatrically distressed non-Western individuals, and that are important tools to improve care.

No. 11-A
**CHANGE IN CULTURALLY SPECIFIC COMPLAINTS AND PTSD SEVERITY ACROSS INITIAL TREATMENT: RESULTS OF PSYCHIATRIC CLINIC SURVEY OF CAMBODIAN REFUGEE PATIENTS**

*Devon Hinton, M.D., Ph.D., 15 Parkman Street, WACC 812, Boston, MA 02114*

**SUMMARY:**
In this presentation, we report on the results of a survey at a psychiatric clinic using a culturally sensitive assessment tool, the Cambodian Idioms-of-Distress Scale, and a PTSD measure (PTSD Checklist). The Cambodian Idioms-of-Distress Scale assesses for culturally salient idioms of distress, both somatic symptoms (e.g., neck soreness, orthostatic dizziness) and cultural distress syndromes (e.g., khyâl attacks), among traumatized Cambodian refugees. We assessed patients (n = 60) at a psychiatric clinic in Lowell, MA, a city that is home to

over 30,000 Cambodian refugees. We assessed patients at the initial visit to the clinic, at 3 months, and at 6 months. We will report on the severity of both culturally salient complaints (Cambodian Idioms-of-Distress Scale) and PTSD symptoms (PTSD Checklist), and we will present data on the relationship between the two measures and how they change across treatment. The survey illustrates the importance of culturally sensitive assessment. PTSD symptoms are an important part of the response to trauma, but other symptoms also need to be surveyed for sensitive and effective treatment to be conducted. The study illustrates how PTSD and culturally specific symptoms change during initial medication and psychosocial treatment.

No. 11-B

**CULTURALLY SENSITIVE CARE FOR OLDER ADULTS: A CRITICAL EXAMINATION OF THE DSM-IV CULTURAL FORMULATION**

*Ladson Hinton, M.D., 2230 Stockton Blvd, Sacramento, CA 95817*

**SUMMARY:**
The inclusion of the cultural formulation (CF) in DSM-IV is a significant step towards taking culture into account in psychiatric diagnosis and improving the cultural sensitivity of care. However, the *DSM-IV* CF does not offer clinicians guidance on how to tailor the CF to better meet the needs of older adults, although this is an area being considered for revision in DSM-V. Because older adults - - those age 65 and above - - are a large, growing, and diverse segment of the population the U.S. and many other countries, there is a pressing need to critically examine the application of the CF in older adults and make recommendations to improve its utility. This presentation focuses on the use of the CF in older adults, highlighting aging-related issues and contexts that present challenges for the CF as currently configured. This presentation has two primary objectives. First, we briefly review key themes in the literature on use of the CF in older adults as well as a broader, relevant literature on assessment and treatment of ethnic minority elderly. Second and drawing upon this review, each part of the CF will be systematically examined, highlighting areas the adaptation of the CF for use in older adults, with particular emphasis on its use in the assessment of persons with Alzheimer's disease and associated disorders. Throughout this presentation, vignettes from clinical practice and research interviews with African Americans, Latinos, Asian Americans, and Caucasians are used to further illustrate the impact of aging on assessment of domains of the cultural formulation, including the cultural identity of the patient, idioms of distress and explanatory models, family and caregiver perspectives, and the need for culturally sensitive cognitive assessment. In addition, we highlight additional areas of clinical concern that are relevant to the cultural assessment of older adults, including end-of-life issues, maintaining dignity in the context of losses, and quality of life. At the end of this session, participants will be become knowledgeable about a set of practical strategies for adapting the CF for use in diverse older adults to improve the quality of mental health care. The material discussed in this presentation is broadly applicable to people in the second half of life who are viewed within their cultural context as "older" or "elderly" as well as persons who are experiencing geriatric clinical issues, such as the onset of a degenerative dementia.

No. 11-C

**CULTURAL SENSITIVITY AND EXTERNAL VALIDITY OF MENTAL HEALTH AND PSYCHOSOCIAL ASSESSMENTS FOR CHILD SOLDIERS IN NEPAL**

*Brandon Kohrt, M.D., Ph.D., Tufts House, 2004 Ridgewood Dr #218, Atlanta, GA 30322*

**SUMMARY:**
Psychosocial interventionists, typically employed by nongovernmental organizations and implementing programs in non-Western cultural settings, are often critical of standardized psychiatric questionnaires, favoring, instead, locally-developed and therefore presumed more culturally-sensitive tools. This study compares the process of transcultural translation/validation of standardized instruments (Depression Self Rating Scale-DSRS, Child Posttraumatic Stress Scale-CPSS, and Strength and Difficulties Questionnaire-SDQ) with the participatory development of a Child Led Indicator (CLI) of psychosocial wellbeing among child soldiers in Nepal. The CLI comprises items for both psychosocial wellbeing and problems including idioms of distress rooted in Nepali ethnopsychology/ethnophysiology. Employing focus groups discussions and an epidemiological study of 242 child soldiers and never-conscripted children, the cultural sensitivity and external validity of the tools were assessed. CLI items were more intelligible and acceptable for participants. Scores on all instruments associated with exposure to trauma, and trauma exposure entirely explained SDQ scores. The DSRS, CPSS, and CLI captured experiences beyond trauma. The CLI captured the presence of social support and protective factors. Ultimately, the most effective assessments should include locally-validated standardized measures and locally-developed psychosocial tools to encapsulate the information necessary for identifying high-risk children and evaluating interventions.

No. 11-D

**DISSOCIATION, TRAUMATIC EXPOSURE, AND SELF-REPORTED PSYCHOTIC SYMPTOMS IN U.S. LATINOS**

*Roberto Lewis-Fernández, M.D., NYSPI- Rm. 3200 (Unit*

*69) 1051 Riverside Dr., New York, NY 10032*

**SUMMARY:**
U.S. Latinos frequently endorse hallucinations and other psychotic-like symptoms that do not meet criteria for psychotic disorder. In regional studies, rates of self-reported psychotic symptoms among Latinos are higher than in other us ethnic groups, particularly reports of seeing visions that others do not see and of hearing voices that others do not hear. As in epidemiological studies with other ethnic/racial groups, however, the overwhelming majority of Latinos who endorse psychotic symptoms do not meet criteria for psychotic disorders when subjected to standardized diagnostic assessment. Yet endorsement of psychotic symptoms –whether identified by self-report or through administration of screener instruments—is not without clinical value in Latino individuals. After adjusting for demographic and clinical characteristics, including other psychiatric disorders, Latino primary care patients who endorse psychotic symptoms are more likely than those who do not endorse them to have current suicidal ideation, recent work loss, marital distress, overall impairment, and a history of in-patient and out-patient psychiatric care. It is unclear why regional studies of Latinos show this elevated endorsement of apparently psychotic symptoms that are clinically meaningful despite the absence of psychotic disorder.Self-reported psychotic symptoms among Latinos are associated with *ataques de nervios* (attacks of nerves), a Latino cultural expression of distress that is strongly related to dissociative capacity and disorder. One possibility for the clinical significance of self-reported psychotic symptoms among Latinos is that these symptoms are due to pathological dissociation, possibly connected to traumatic exposure, and that this accounts for their higher clinical morbidity. We assessed for the presence of four culturally defined hallucinatory "perceptual alterations"—seeing shadows, hearing your name called, feeling presences around you, experiencing the transmission of external energies—and depersonalization symptoms in a sample (n=471) of us Latinos and non-Latino whites who sought treatment at an outpatient psychiatric clinic. Participants also completed the dissociative experiences scale (des), the brief physical and sexual abuse questionnaire (BPSAQ), and a demographic instrument that assessed race/ethnicity, language fluency, and country of upbringing until age 16. Diagnoses were obtained with the structured clinical interview for DSM-5, and the few individuals with psychotic disorder were excluded, in order to focus on non-psychotic perceptual alterations. Overall, Latino patients endorsed perceptual alterations significantly more frequently than non-latino whites ($p<.001$). Endorsement of three perceptual alterations—auditory, visual, and tactile—was significantly associated with Latino status, Spanish-language dominance, or Latin American country of upbringing. Except for the association between tactile perceptual alterations and country of upbringing, these associations disappeared in the full model of demographic and clinical covariates, including the des and BPSAQ. Only des score was consistently associated with endorsement of perceptual alterations and depersonalization symptoms, with or's in the range of 2.7 to 3.9. BPSAQ score was not significantly associated with perceptual alterations when adjusting for des score, suggesting that it is the dissociative reaction, rather than the traumatic exposure *per se*, that is associated with psychotic-like symptoms. Dissociative pathology may be a possible explanation for the morbidity associated with self-endorsed psychotic symptoms in Latinos.

No. 11-E
**ASSESSING FAMILY CONFLICT IN WEST AFRICAN IMMIGRANT FAMILIES**

*Andrew Rasmussen, Ph.D., 462 1st Ave CD 710, New York, NY 10016*

**SUMMARY:**
This qualitative study examines how West African immigrants in New York discuss family-related conflict and stressors.While Africans have resided in the United States since its inception, voluntary African immigration is a relatively new phenomenon. Census data show that there are over a million African immigrants in the U.S. and 2000 census figures suggest that the African born population had doubled since 1990. There are good reasons to believe that conflict within immigrant African families shares many features with other new immigrant families. New migrants must negotiate a plethora of new cultural, social, and legal institutions, replete with their own—often very "foreign"—stressors. Children, who often acculturate faster than their parents, act as cultural brokers, upsetting traditional parent/child power dynamics. Along with many similarities there are also compelling reasons to believe that conflict within African families may be more common and more complex than that within other immigrant families. Many African families, particularly those from West and Central African nations, hail from conflict regions where both adults and children have been exposed to substantial dislocation, trauma, and associated stressors. Research among several posttrauma populations has shown that subsequent distress can have negative effects on parenting. These new African immigrants present new challenges to psychiatric practice. Language and cultural traditions play a role in how social suffering, psychopathology, and mental health needs are expressed, and can affect what services are offered as well as adherence to treatment. American psychiatry has paid little attention to the role of these factors in assessment of African immigrant families. What are the idioms of distress among the various African immigrant communities? What should we as practitioners attribute to culture, what to psychological distress, and what to language difficulty? Through an iterative open-axial coding of transcripts of focus groups we examine the cultural idioms of distress, conflict, and

meaning among West Africans living in New York City. Findings will be discussed in terms of their implications for treatment delivery as well as for further research into family stress related to migration and displacement. A key focus will be the distinction between distress related to past trauma and that related to current stressors, and thus whether interventions need to be trauma-focused or not.

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2.Lewis-Fernández, & F. Schneier (Eds.), Understanding Anxiety: Clinical and Research Perspectives From The Columbia University Department Of Psychiatry. Cambridge: Cambridge University Press.

3.Hinton, D. E., Lewis-Fernández, R., & Pollack, M. H. (2009). A Model of the Generation of Ataque de Nervios: The Role of Fear of Negative Affect and Fear of Arousal Symptoms. CNS Neuroscience and Therapeutics, 15, 264–275.

## SYMPOSIUM 12

## ANXIETY TREATMENT: NEW RESEARCH FINDINGS FOR THE CLINICIAN

*Chairperson: Peter Roy-Byrne, M.D., 325 9th Ave, Seattle, WA 98104*
*Co-Chairperson: Murray B Stein, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand beneficial outcomes produced by novel computerized delivery systems for CBT; 2) Be familiar with pharmacologic facilitation of cognitive behavioral treatments for anxiety; 3) Know how patient treatment preferences affect sertraline and exposure treatment outcome in PTSD; and 4) Know the predictors of response to pharmacotherapy in social anxiety disorder.

**OVERALL SUMMARY:**

While the spectrum of effective medication and psychosocial treatments for anxiety are well appreciated, less information is available about how treatment preference affects the comparative effectiveness of different treatment modalities, how to best identify responders to pharmacotherapy, the role of combination treatment and treatment adjuncts in speeding recovery and improving outcome, and new technologies for delivering treatment in clinical settings lacking specialists. The session will present new data on how treatment preference affects the comparative effectiveness of CBT and sertraline in PTSD, the efficacy of selective serotonin reuptake inhibitors for social anxiety disorder and predictors thereof, use of d-cycloserine to speed or augment CBT response in several anxiety disorders, and use of computerized CBT approaches to treat multiple anxiety disorders in primary care. Social anxiety disorder is a prevalent, often impairing anxiety disorder with selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) among the available, proven pharmacotherapies. Randomized controlled trials (RCTs) suggest that approximately 50% of patients with social anxiety disorder respond to SSRIs, but clinical experience suggests that fewer patients have robust responses to these pharmacotherapies. In this multicenter, NIMH-funded trial of Social Anxiety Pharmacotherapy Improvement (SAPIENT), patients with generalized social anxiety disorder (GSAD) and a Liebowitz Social Anxiety Scale (LSAS) score of 60 or higher initiated treatment with open-label sertraline (50 mg/d) which was increased as tolerated (to 200 mg/d) over a 10-week total duration of treatment. Patients who failed to respond (LSAS 50 or lower) at the end of 10 weeks were randomized to double-blind treatment with either (1) continuation of sertraline at the current dose; (2) addition of clonazepam to the current dose of sertraline; or (3) switch to venlafaxine extended-release. This presentation will focus on describing the characteristics ("predictors") of patients who responded to sertraline during the 10-week open-label treatment phase. Additionally, predictors of robust response (LSAS 30 or lower, often referred to as "remission") will be described. These data may be useful to clinicians in deciding who to treat with an SSRI, and for how long to continue such a therapeutic trial before changing to another treatment strategy.

No. 12-A

## ACUTE TREATMENT FOR CHRONIC PTSD: PROLONGED EXPOSURE VERSUS SERTRALINE

*Norah Feeny, Ph.D., 11220 Bellflower Rd, Cleveland, OH 44118*

**SUMMARY:**

Both sertraline (SER) and prolonged exposure (PE) are empirically supported treatments for chronic posttraumatic stress disorder (PTSD). While efficacious, these treatments are quite different in approach, and such differences may influence both treatment choice and treatment outcome. To date, we know very little about the relative efficacy of pharmacological and psychological treatments for chronic PTSD. Thus, we examined patient treatment preferences and the relative efficacy of SER and PE for PTSD and related difficulties. Utilizing a doubly randomized preference trial design, 200 men and women with chronic PTSD were first randomized to choice or no choice between PE and SER and then those in the no choice arm were re-randomized to either PE or SER. Prior to randomization, participants view detailed, counterbalanced videotaped treatment rationales of both PE and SER. After viewing these rationales, participants were asked for their treatment preference. Across all participants, the majority preferred PE over

SER. Following randomization, participants received either 10 weeks of PE or SER, after which responder status was determined. Participants were followed-up at 3, 6, 12, and 24 months. We will present outcome results from the acute phase of treatment. Overall, although results suggest that PE and SER are both efficacious, they also highlight the presence of clear treatment preferences for PTSD and their potential impact on outcome. Our results underscore the importance of understanding patient preferences and encourage a rethinking of one-size fits all approaches to treatment for PTSD.

No. 12-B
**SOCIAL ANXIETY PHARMACOTHERAPY IMPROVEMENT (SAPIENT): RESPONSE TO INITIAL SSRI TREATMENT**

*Murray Stein, M.D., M.P.H., 9500 Gilman Dr, La Jolla, CA 92093-0855*

**SUMMARY:**
Social anxiety disorder is a prevalent, often impairing anxiety disorder with selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) among the available, proven pharmacotherapies. Randomized controlled trials (RCTs) suggest that approximately 50% of patients with social anxiety disorder respond to SSRIs, but clinical experience suggests that fewer patients have robust responses to these pharmacotherapies. In this multicenter, NIMH-funded trial of Social Anxiety Pharmacotherapy Improvement (SAPIENT), patients with generalized social anxiety disorder (GSAD) and a Liebowitz Social Anxiety Scale (LSAS) score of 60 or higher initiated treatment with open-label sertraline (50 mg/d) which was increased as tolerated (to 200 mg/d) over a 10-week total duration of treatment. Patients who failed to respond (LSAS 50 or lower) at the end of 10 weeks were randomized to double-blind treatment with either (1) continuation of sertraline at the current dose; (2) addition of clonazepam to the current dose of sertraline; or (3) switch to venlafaxine extended-release. This presentation will focus on describing the characteristics ("predictors") of patients who responded to sertraline during the 10-week open-label treatment phase. Additionally, predictors of robust response (LSAS 30 or lower, often referred to as "remission") will be described. These data may be useful to clinicians in deciding who to treat with an SSRI, and for how long to continue such a therapeutic trial before changing to another treatment strategy.

No. 12-C
**DCS: A NOVEL PHARMACOLOGICAL STRATEGY TO ENHANCE CBT FOR ANXIETY**

*Mark Pollack, M.D., 185 Cambridge Street Suite 2200 2nd Floor, Boston, MA 02114*

**SUMMARY:**
Traditional strategies for combining pharmacologic and psychosocial interventions for the treatment of anxiety disorders have generally relied on the addition of two individually effective interventions with the hope that they will have additive benefits. However, results from studies of combined treatment have been mixed, and overall, the magnitude of the demonstrated positive benefits have been relatively modest. More recently a combined treatment strategy, derived from one of the apparent significant successes of translational research, has emerged and shown promise as an effective strategy for the treatment of anxiety disorders. Basic research on the neural circuitry underlying fear extinction, led to the use of a partial agonist at the NMDA receptor in the amygdala, D-cycloserine (DCS), to enhance extinction learning, first in animal models, and then when paired with exposure based cognitive-behavioral therapy for the treatment of a number of anxiety disorders in humans. In this presentation we will review both the pre-clinical rationale supporting the potential role of this pharmacologic strategy to enhance cognitive-behavioral therapy for anxiety disorders, and discuss the systematic studies to date examining its efficacy.

**No. 12-D**
**CALM: IMPROVING PRIMARY CARE ANXIETY OUTCOMES**

*Peter Roy-Byrne, M.D., 325 9th Ave, Seattle, WA 98104*

**SUMMARY:**
Improving the quality of mental health care requires continued efforts to move clinical interventions from controlled, research settings and homogeneous patient groups, into "real world" practice settings with greater variability in patient characteristics and provider skill. CALM ("coordinated anxiety learning and management"), is a flexible delivery model for primary care anxiety and its treatment, that simultaneously targets any of four common anxiety disorders in primary care (panic, generalized, and social anxiety disorders and PTSD); provides strategies to enhance patient engagement in treatment, including allowing choice of either CBT, medication, or both; and, to address the greater treatment-resistance of anxiety disorder patients, provides the option for additional treatment over the course of a year in three month "steps". It utilizes a web based outcomes system to optimize treatment decisions and a computer-assisted program to allow CBT-inexperienced care managers to optimize delivery of CBT. Medication is prescribed by primary care physicians with care manager assistance in promoting adherence, dose optimization, and medication switches/augmentation. In this way, CALM seeks to both approximate the complexity of real-world treatment and maximize fidelity to the treatment evidence-base, in the context of tailoring the intervention (phone or in person, treatment target, number of sessions, decisions to pursue a

second step of care) to a broad range of patients, providers, practice settings, and payers. CALM randomized 1004 patients with one of four anxiety disorders in 15 clinics at four US sites to the CALM intervention or care as usual for one year (medication or referral to specialty care). Over 85% of intervention patients elected to receive CBT either alone or with medication, with the remaining patients electing medication alone. Assessments at 6, 12, and 18 months showed patients randomized to CALM had significant greater improvement in symptoms (brief symptom inventory for anxiety), function (Sheehan disability and NCS "healthy days" ) and satisfaction with care, and received higher quality of psychosocial treatment (i.e. CBT elements) and medication (dose optimization or switches/additions) compared to usual care patients.

## SYMPOSIUM 13

## FAMILY AND BEHAVIORAL GENETIC STUDIES OF BPD

*Chairperson: Joel Paris, M.D., Institute of Community and Family Psychiatry 4333 Cote Ste-Catherine Rd, Montreal, H3T 1E4 Canada*
*Discussant: John M Oldham, M.D., M.S.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Present recent findings relevant to the understanding of the development of BPD in adolescence and adulthood; and 2) Present data relevant to understanding the roles of genes and environment in the etiology of this disorder.

**OVERALL SUMMARY:**
This symposium will examine recent research on the etiology of borderline personality disorder (BPD), focusing on family studies, adolescent data, and behavioral genetics. The presentations will cover recent data on the behavioral genetics of BPD; risk factors for BPD in adolescents; a follow-up of adolescents with BPD; risk factors in BPD patients compared to their sisters, and risks for children associated with BPD patients as mothers.

No. 13-A
### BEHAVIORAL GENETICS OF BORDERLINE PERSONALITY DISORDER

*Ted Reichborn-Kjennerud, M.D., PO Box 4404 Nydalen, Oslo, Norway 0403*

**SUMMARY:**
Until recently, few behavioral genetic studies of Borderline Personality Disorder (BPD) had been published. Results from an ongoing population-based twin study of the relationship between *DSM-IV* Axis I and Axis II disorders will be presented. Method: Axis I and Axis II disorders were assessed in 2801 Norwegian twins using structured interviews. Twin models were fitted to the data using the software package Mx. Dimensional representations of the PDs were used for analyses. Results: Confirmatory factor analysis supported a unidimensional structure for the nine BPD criteria. On the phenotypic level, BPD was strongly related to all the other DSM-IV PDs, with polychoric correlations ranging from 0.52 (Antisocial PD) to 0.30 (Schizoid PD). BPD was also strongly related to 14 common Axis I disorders with 10 correlations > 0.35, ranging from 0.60 (Dysthymia) to 0.20 (Eating disorders). The heritability of BPD was estimated to be 35%. No sex differences or shared environmental effects were found. Multivariate analysis of the 4 Cluster B PDs indicated that BPD is influenced by one latent genetic factor common to all cluster C PDs and one genetic factor shared in common only with antisocial PD. A similar pattern was found when all 10 PDs were included in the model: BPD was most strongly influenced by one genetic factor with high loadings on antisocial PD, but also influenced by a more general genetic factor with substantial loadings on all the other cluster B PDs, in addition to dependent and obsessive-compulsive PD from cluster C and paranoid PD from cluster A. BPD shares a substantial part of its genetic risk factors with major depressive disorder (genetic correlation of 0.56). Conclusion: BPD is modestly influenced by genetic factors. Multivariate analyses indicate that a substantial part of the genetic risk factors for BPD is shared in common with antisocial PD, but it is also influenced by genetic factors with high loadings on the other cluster B PDs as well as dependent, obsessive-compulsive and paranoid PD. Genetic risk factors for BPD and major depression are substantially correlated.

No. 13-B
### CHILDHOOD ADVERSITY ASSOCIATED WITH ADOLESCENT ONSET BORDERLINE PERSONALITY DISORDER

*Mary Zanarini, Ed.D., McLean Hospital 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**
Objective: The purpose of this study was to determine the prevalence of experiences of childhood abuse and neglect reported by those with adolescent onset borderline personality disorder (BPD). Method: Three groups of subjects were interviewed concerning childhood adversity: 70 hospitalized girls and boys aged 13-17 who met both DIB-R and DSM-IV criteria for BPD, 224 hospitalized patients with adult onset DIB-R and DSM-IV BPD, and 57 psychiatrically healthy adolescents from the community. Results: Those with adolescent onset BPD reported significantly higher rates of the four forms of abuse studied than adolescents without a history of psychiatric disorder.

They also reported significantly higher rates of six of the seven forms of neglect studied than psychiatrically healthy adolescents (i.e., all but physical neglect). However, they reported significantly lower rates of nine of the 11 forms of childhood adversity studied than those with adult onset BPD (i.e., all but physical neglect and emotional withdrawal). Conclusions: The results of this study suggest that childhood adversity is common among adolescents diagnosed with BPD. They also suggest that childhood adversity may play less of a role in the development of adolescent onset BPD than adult onset BPD.

No. 13-C

**OUTCOME IN WOMEN DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER IN ADOLESCENCE**

*Robert Biskin, M.D., B.S., 1033 Pine Ave W, Montreal, H3A 1A1*

**SUMMARY:**
Objective: Patients with BPD most commonly present in late adolescence, but there is a lack of data regarding the outcomes of patients diagnosed prior to that age. Methods: The current study followed a group of 25 adolescents with BPD vs. 20 who had not met criteria, who presented to an urban psychiatric hospital for treatment over a 10-year period. Baseline BPD diagnosis was confirmed with the retrospective version of the Diagnostic Interview for Borderlines. Current diagnosis was established using the Diagnostic Interview for Borderlines, Revised, and subjects were assessed for SCL-90 scores, SCID modules for mood disorders and substance abuse, as well as the Affective Lability Scale (ALS), the Barratt Impulsivity Scale (BIS), and the Continuous Performance Test (CPT). Results: Five years after initial presentation (mean age for sample=19.5) only 8/25 index patients still met criteria for BPD and no new cases developed in those who had not met criteria initially. Subjects who still met criteria scored significantly higher on the total score of the CPT, the hostility scale of the SCL-90, on the ALS, but not on the BIS. Conclusions: These findings tend to support the instability of an adolescent diagnosis of BPD, but suggest that continuation into young adulthood is moderated by affective instability and by neuropsychological factors.

No. 13-D

**TRAUMA AND PSYCHOPATHOLOGY IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND THEIR SISTERS**

*Joel Paris, M.D., Institute of Community and Family Psychiatry4333 Cote Ste-Catherine Rd,, Montreal, H3T 1E4*

**SUMMARY:**
Objective: To report findings of a study of risk factors for borderline personality disorder (BPD) comparing probands with sisters.
Method: The sample included 54 pairs of sisters (mean age=29; comparable on demographics) in which at least one met criteria for BPD on the Diagnostic Interview for Borderlines, Revised (DIB-R). Psychopathology was assessed with HAM-A, HAM-D, and SCL-90, personality traits with the Diagnostic Assessment of Personality Pathology (DAPP-BQ), the Barratt Impulsivity Scale (BIS), and the Affective Lability Scale (ALS), psychosocial adversity with the Childhood Trauma Interview (CTI), the Parental Bonding Instrument (PBI) and the Life Experiences Survey (LES).Results: Only three pairs were concordant for BPD, and most sisters reported no significant symptoms. 16/18 DAPP scores, BIS scores, and ALS scores, were higher in probands. Reported childhood abuse were high in both groups, with only a few differences in nature and severity, and there were no differences on LES or PBI. Multi-level analysis showed that personality traits of affective instability and impulsivity predicted DIB-R scores and SCL-90-R scores, above and beyond trauma. Conclusions: BPD patients and their normal sisters suffer similar childhood adversities but do not develop the same disorder. Outcome seems to be influenced by personality trait profiles.

No. 13-E

**VULNERABILITY TO DEPRESSIVE SYMPTOMS AMONG CHILDREN OF PARENTS WITH MAJOR DEPRESSIVE DISORDER WITH OR WITHOUT COMORBID BPD**

*John Abela, Ph.D., B.A., Livingston Campus, Tillett Hall, 53 Avenue E, Piscataway, NJ 08854-8040*

**SUMMARY:**
Introduction: The current study examined whether children of parents with major depressive disorder (MDD) and comorbid borderline personality disorder (BPD) report greater increases in depressive symptoms following the occurrence of negative events in their lives than do children of parents with MDD but no BPD. In addition, we examined whether negative attachment cognitions moderate the strength of this association such that the greatest increases in depressive symptoms following negative events are observed among children who have a parent with both MDD and BPD and who exhibit high levels of negative attachment cognitions. Method: During an initial lab based assessment, children of parents with MDD with or without comorbid BPD completed measures assessing negative attachment cognitions and depressive symptoms. Children were subsequently given a hand-held personal computer which they carried around with them for the next 2 months. The computer was programmed to signal them to complete measures assessing depressive symptoms and the occurrence of negative events every 5-9 days. Results: Children of parents with MDD and BPD

reported greater increases in depressive symptoms following negative events than did children of parents with MDD but no BPD. Unexpectedly, the strength of this association was moderated by negative attachment cognitions such that the largest increases in depressive symptoms following negative events were reported by children who had a parent with both MDD and BPD and who exhibited low levels of negative attachment cognitions. Conclusions: The current results suggest that children of parents with both MDD and BPD are more vulnerable to experiencing increases in depressive symptoms following the experience of stressors in their lives than are children with parents with MDD but no BPD. Results also suggest that within the context of having a parent with BPD, low levels of negative attachment cognitions (i.e., close parent-child relationships) may enhance children's vulnerability to depressive symptoms. Possible interpersonal, cognitive, and environmental mechanisms underlying these effects will be discussed.

**REFERENCES:**

1.Zanarini MC, Williams AA, Lewis RE, Reich DB, Vera SC, Marino MF, Levin A, Yong L and Frankenburg FR. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. American Journal of Psychiatry 154:1101-1106.

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**Saturday, May 22, 2010**
**2:00 pm- 4:00PM**

**SYMPOSIUM 14**

**EXAMINING THE OUTCOME CONTINUUM OF SCHIZOPHRENIA INTO LATER LIFE**

*Chairperson: Carl I. Cohen, M.D., 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203,*
*Co-Chairperson: Sukriti Mittal, M.D.*
*Discussant: Kenneth S. Thompson, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the elements comprising symptomatic and functional remission, community integration, successful aging, and subjective well-being; 2) Appreciate the prevalence of each of these outcome measures in older adults with schizophrenia; 3) Understand the factors associated with these outcomes; and 4) Identify potential points for clinical and policy interventions.

**OVERALL SUMMARY:**

For persons with severe mental illness, the ideal life trajectory can be viewed as a process moving from diminishing psychopathology and impaired functioning to normalization to positive health and well-being. The initial part of this trajectory may be conceptualized as "recovery," whereas the latter part may be conceptualized as "successful aging." The latter can be viewed as a state involving the absence of disability accompanied by high physical, cognitive, and social functioning. Recent studies suggest interplay between positive well-being and various physiological as well as psychological processes to maintain and extend capacities. Traditionally, schizophrenia has been viewed as having an unfavorable outcome. Recently, this view has been challenged, and symptom remission, functional recovery, and even positive mental health, are viewed as a legitimate outcomes for older adults with schizophrenia. The anticipated doubling of the older population with schizophrenia over the next two decades, coupled with a growing interest in recovery, makes an examination of the lifelong continuum especially compelling. In this symposium, we present findings from a sample of 198 older adults aged 55 with a history with schizophrenia beginning before age 45 living in New York City. We also use a matched comparison sample of 113 older adults drawn from randomly selected block groups. Four studies will be presented that examine various aspects of the wellness continuum: symptom remission, objective recovery, community integration, objective successful aging, and subjective well-being (i.e., quality of life and subjective successful aging). These outcome measures are largely independent of each other with shared variance ranging from 3 to 36 percent, with a median value of 7 percent. Outcomes range from 2% for objective successful aging to 49% for clinical remission. The studies identify a variety of clinical and social variables that may improve outcome in this population and that suggest potential points for intervention.Objective: There has been little research examining subjective well-being in older adults with schizophrenia. We use an adaptation of Lehman's Quality of Life (QOL) model and a subjective measure of successful aging derived from Rowe and Kahn's criteria in a multi-racial urban sample of older persons with schizophrenia. Methods: The schizophrenia (S) group consisted of 198 persons age 55+ living in the community who developed schizophrenia before age 45. A community comparison© group of consisted of 113 persons was recruited using randomly selected block-groups. We adapted Lehman's model with 4 predictor variable sets (demographic, objective, clinical, and subjective) comprising 19 variables, with the Quality of Life Index (QLI) as the dependent variable. To examine Subjective Successful Aging (SSA), we converted Rowe and Kahn's objective domains into 6 subjective indicators. Results: The S group had a significantly lower QLI score than the C group (21.7 vs. 24.2). In regression analysis, 6 variables were associated with higher QLI: fewer depressive symptoms, fewer acute life stressors, fewer medication side effects, lower financial strain, better self-rated health, and more cognitive deficits. The model explained 56% of the

variance in QLI and each variable set added significant variance. There was a significant difference in SSA scores between the S and C groups (3.5 vs. 4.4), and there was a significant difference in the distribution of scores with 27% and 13% of the C and S groups, respectively, meeting all 6 criteria. In logistic regression, high SSA was associated with fewer depressive symptoms and lower financial strain. Conclusions: Older persons with schizophrenia have lower subjective well-being than their community age peers, although absolute differences were not as appreciable as anticipated. Moreover, many of the factors adversely impacting on QOL and SSA are ameliorable and thereby provide an opportunity to enhance the well-being of this population.

No. 14-A

**COMMUNITY INTEGRATION AND ASSOCIATED FACTORS AMONG OLDER ADULTS WITH SCHIZOPHRENIA**

*Chadi Abdallah, M.D., 2044 Cropsey Ave Brooklyn, NY 11214*

**SUMMARY:**
Objective: Community integration has been increasingly recognized as an important element in recovery. There is a paucity of data on community integration among older adults with schizophrenia. This paper compares community integration among older persons with schizophrenia with their age peers in the community, and examines factors associated with community integration among the schizophrenia group. Methods: The schizophrenia group consisted of 198 community-dwelling persons aged >55 years who developed schizophrenia before age 45. A Community comparison group (n=113) was recruited using randomly selected block-groups. Wong and Solomon's (2002) conceptual framework was used to develop a 12-item community integration scale with 4 components: independence, psychological integration, physical integration, and social integration. Moos' Ecosystem Model was used to examine 15 personal and environmental factors associated with community integration.Results: As compared to the community group, the schizophrenia group had significantly lower total community integration scale scores and lower scores on each of the 4 components. Within the schizophrenia group, in regression analysis, 7 variables were significantly associated with community integration: being female, higher personal income, lower depressive symptoms, lower positive symptoms, lower AIMS score, higher CAGE lifetime scores, and greater control of one's life. The model was significant and explained 48.9% of the variance.Conclusion: Our data confirmed that older persons with schizophrenia have lower level of community integration than their community age peers, and that our model for community integration can identify potentially ameliorable clinical and social variables that may be targets for intervention research.

No. 14-B

**SUCCESSFUL AGING IN OLDER ADULTS WITH SCHIZOPHRENIA: PREVALENCE AND ASSOCIATED FACTORS**

*Fayaz Ibrahim, M.D., Brooklyn, NY 11238*

**SUMMARY:**
Objective: This study contrasts the prevalence of successful aging in older adults with schizophrenia with their age peers in the community, and examines variables associated with successful aging in the schizophrenia group.Methods: The schizophrenia group consisted of 198 community-dwelling persons aged >55 years who developed schizophrenia before age 45. A community comparison group (N = 113) was recruited using randomly selected block-groups. The three objective criteria proposed by Rowe and Kahn were operationalized using a 6-item summed score. The association of 16 predictor variables with the successful aging score in the schizophrenia group was examined. Results: The community group had significantly higher successful aging scores than the schizophrenia group (4.3 vs. 3.0; t =8.36, df =309, p< .001). Nineteen percent of the community group met all 6 criteria on the Successful Aging Score versus 2% of the schizophrenia group. In regression analysis, only two variables –fewer negative symptoms and a higher quality of life index—were associated with the successful aging score within the schizophrenia group. Conclusion: Older adults with schizophrenia rarely achieve successful aging, and do so much less commonly than their age peers. Only two significant variables were associated with successful aging, neither of which are easily remediable. The elements that comprise the components of successful aging, especially physical health, may be better targets for intervention.

No. 14-C

**CLINICAL REMISSION AND RECOVERY IN SCHIZOPHRENIA**

*Carl I. Cohen, M.D., 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

**SUMMARY:**
Objective: Symptomatic remission has been reported in younger patients withschizophrenia. This study aims to determine the prevalence of symptomatic remissionin older adults with schizophrenia. Methods: The Schizophrenia Group consisted of 198 persons aged 55+ years living in the community who developed schizophrenia before age 45 years. Our definition of remission was adapted from the criteria of the Remission in Schizophrenia Working Group. To attain remission, persons had to have scores of <3 on 8 domains of the Positive and Negative Symptom Scale and no hospitalizations within the previous year. We

used an adaptation of the recovery criteria suggested by Liberman that consisted of the remission criteria described above and psychosocial functioning criteria consisting of being able to independently manage their medications and money, having at least one confidante, and joining in activities with others. We did not include the duration criteria of 2 years and the vocational/educational criteria. Results: 49% of the sample met criteria for remission, and 17% met criteria for recovery. In logistic regression analysis, four variables—fewer total network contacts, greater proportion of intimates, fewer lifetime traumatic events, and higher cognitive scores—were significantly associated with remission. Recovery was significantly associated with 4 variables: higher cognitive scores, higher levels of cognitive coping strategies, more mental health services, and independent living. Conclusions: Remission rates were consistent with those reported in younger samples, whereas recovery rates were somewhat higher than those in younger samples. Our findings suggest that symptomatic remission and recovery are attainable goals and that treatments focused on those variables associated with remission and recovery may augment outcomes in older adults with schizophrenia.

No. 14-D

**WELL-BEING AND ASSOCIATED FACTORS: QUALITY OF LIFE AND SUBJECTIVE SUCCESSFUL AGING IN OLDER PERSONS WITH SCHIZOPHRENIA**

*Sukriti Mittal, M.D., 516, Prospect Avenue, Brooklyn, NY 11215*

**SUMMARY:**

Objective: There has been little research examining subjective well-being in older adults with schizophrenia. We use an adaptation of Lehman's Quality of Life (QOL) model and a subjective measure of successful aging derived from Rowe and Kahn's criteria in a multi-racial urban sample of older persons with schizophrenia. Methods: The schizophrenia (S) group consisted of 198 persons age 55+ living in the community who developed schizophrenia before age 45. A community comparison© group of consisted of 113 persons was recruited using randomly selected block-groups. We adapted Lehman's model with 4 predictor variable sets (demographic, objective, clinical, and subjective) comprising 19 variables, with the Quality of Life Index (QLI) as the dependent variable. To examine Subjective Successful Aging (SSA), we converted Rowe and Kahn's objective domains into 6 subjective indicators. Results: The S group had a significantly lower QLI score than the C group (21.7 vs. 24.2). In regression analysis, 6 variables were associated with higher QLI: fewer depressive symptoms, fewer acute life stressors, fewer medication side effects, lower financial strain, better self-rated health, and more cognitive deficits. The model explained 56% of the variance in QLI and each variable set added significant variance. There was a significant difference in SSA scores between the S and C groups (3.5 vs. 4.4), and there was a significant difference in the distribution of scores with 27% and 13% of the C and S groups, respectively, meeting all 6 criteria. In logistic regression, high SSA was associated with fewer depressive symptoms and lower financial strain. Conclusions: Older persons with schizophrenia have lower subjective well-being than their community age peers, although absolute differences were not as appreciable as anticipated. Moreover, many of the factors adversely impacting on QOL and SSA are ameliorable and thereby provide an opportunity to enhance the well-being of this population.

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3.Mittal S.,Bankole A.O., Cohen C.I., Vahia I., Divan, S., Kehn,M., Ramirez, P.M. Factors affecting quality of life in a multiracial sample of older persons with schizophrenia. American Journal of Geriatric Psychiatry 15:1015-1023, 2007.
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**SYMPOSIUM 15**

**SPIRITUALITY AND MENTAL HEALTH: WHAT IS THE PSYCHIATRIST'S ROLE?**

*Chairperson: John R Peteet, M.D., 75 Francis Street, Boston, MA 02115*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify several indications for approaching therapeutically the spiritual dimension of patient's lives; and 2) Recognize the potential benefits, limitations and challenges of each.

**OVERALL SUMMARY:**

Although misunderstanding persists between psychiatry and religion, most mental health professionals now regard spirituality as a potential resource. Examples include Twelve Step Programs and the mindfulness component of Dialectical Behavior Therapy. Yet the role of the

psychiatrist in working at the interface between spirituality and psychiatry has remained unclear. In this symposium, presenters explore several distinct ways to therapeutically approach the spiritual dimension of the patient's life: (1) using a therapeutic spiritual modality, e.g. mindfulness, to achieve treatment aims; (2) drawing on spiritual wisdom to foster positive emotions; (3) addressing spiritual concerns of psychiatric inpatients, e.g. in discussion groups; (4) increasing self-transcendence in the treatment of personality disorders; and (5) confronting negative spirituality in individual psychotherapy. Discussion will focus on the opportunities and limitations of each, and on how they overlap.

No. 15-A

**THE EVOLVING ROLE OF MEDITATION AND OTHER MINDFULNESS PRACTICES IN PSYCHOTHERAPY**

*William Greenberg, M.D., 65 North Maple Ave., Ridgewood, NJ 07450*

**SUMMARY:**
In recent years, the Eastern traditions of meditation and other mindfulness practices have not only entered mainstream Western culture, but have modified our therapeutic practices with patients. Many psychotherapists have discovered the healing and centering value of having a personal meditation practice in their own lives, and then in improving the quality of one's therapeutic work: in authentic presence, abiding attention, improved listening, limiting contamination of treatment with our own unresolved issues and reactions, modeling of a psychologically healthy state of being, etc. We have also started to see some patients who already have some familiarity with mindfulness practices, which has often facilitated their openly offering appropriate clinical material in sessions. Appreciating their general therapeutic value for ourselves, tension developed from not incorporating these practices more directly in our clinical work. Respecting a given patient's values wishes and belief system, one may teach patients meditation as a therapeutic practice, discuss related popular books they may have read (by Eckhart Tolle, Thich Nhat Hanh, the Dalai Lama, etc), or one may go further in working with a patient regarding the application of mindfulness in their lives. Several modern educational modalities and psychotherapies have been organized around such ideas, in part or whole, eg, Mindfulness-Based Stress Reduction, Dialectical Behavioral Therapy, Mindfulness-Based Cognitive Therapy and Acceptance and Commitment Therapy. These Eastern religious/spiritual practices can find great applicability for those stuck regretting the past or anxiously worrying about the future at the expense of living in the present, and for those having difficulty with forgiveness or with anger, among other issues.

No. 15-B

**POSITIVE EMOTIONS: PSYCHIATRY'S GREAT BLIND SPOT**

*George Vaillant, M.D., 1249 Boylston St. 3rd Floor, Boston, MA 02215*

**SUMMARY:**
Unlike the so-called negative emotions of anger, lust, grief and fear, positive emotions - like faith (trust not belief), hope, love, joy, compassion, forgiveness, gratitude and awe - free the self from the self. Positive emotions are ignored in major psychiatric textbooks. Unlike negative emotions, positive emotions are future oriented, prosocial and rarely "all about me". Many of these emotions, although tangibly demonstrable in fMRIs and, of course, given pride of place in all the great world religions, are nevertheless ignored by science and especially by dynamic psychotherapy. Indeed, psychodynamic psychotherapy often appears to be almost phobic of "positive psychology" and positive emotions, and ignores the experimental evidence in support. Clinically, this is a mistake because negative emotions involve the fight or flight sympathetic system and elevate cortisol and blood pressure. In contrast, the positive emotions—think of the physiology cuddling—involve the parasympathetic nervous system and lower blood pressure, BMR and cortisol even as they elevate the bonding hormone oxycotin.
This presentation will examine the neurophysiology of positive emotions in greater detail and offer clinical examples of their use in psychotherapy. I will argue that greater attention to positive emotions reflect the direction of dynamic psychotherapy of the future.

No. 15-C

**INTRODUCING SPIRITUALITY INTO PSYCHIATRIC EDUCATION AND CARE**

*Marc Galanter, M.D., 550 First Avenue, Room NBV20N28, New York, NY 10016*

**SUMMARY:**
Spirituality is important to many psychiatric patients, and these patients may be moved toward recovery more effectively if their spiritual needs are addressed in treatment. This, however, is rarely given expression in the psychiatric services of teaching hospitals. In order to develop this potential area of improved care and training, we (1) evaluated the differential attitudes of patients and psychiatric trainees toward the value of spirituality in the recovery process, (2) established a program of group meetings conducted by psychiatric residents and staff where patients can discuss how to draw on their spirituality in coping with their problems, and (3) established related training experiences for psychiatric residents. The results and implications of these three initiatives are presented.

No. 15-D

**SPIRITUAL ASPECTS OF THE TREATMENT OF PERSONALITY DISORDERS**

*C. Robert Cloninger, M.D., 660 South Euclid, St. Louis, MO 63110*

**SUMMARY:**
Personality Disorders are characterized by maladaptive worldviews that are often resistant to change by purely cognitive or behavioral approaches. The essence of forming a therapeutic alliance is for the patient and therapist to agree on a common goal that each values. Unless a patient feels they are being helped to do something they really want to do, then therapy is unlikely to be productive. As a result, the treatment of people with personality disorders must usually involve a spiritual approach broadly defined. The spiritual aspect of therapy is the identification of what a person values most or what brings the most satisfaction to their life (Cloninger, 2007). Helping a person to recognize more clearly and more coherently what they value has been shown to be beneficial in randomized controlled trials with diverse patient groups (Cloninger, 2006). Three general practices that enhance well-being are (1) letting go, (2) working in the service of others, and (3) growing in awareness (Cloninger, 2004). Non-stigmatizing approaches to assessment and treatment of personality disorders using these principles are available in the "Know Yourself" DVD series (http://anthropedia.org) as an adjunct to individual or group therapy. The use of these principles and materials will be described as a non-judgmental approach to motivating change in people with personality disorders.

No.15-E
**SPIRITUAL HEALING: THE PSYCHIATRIST AS A FACILITATOR OF INTEGRATION**
*Nadine Nyhus, M.D., M.A., 25 Hyland Road, Guelph, Ontario, Canada, N1E 1T2*

**SUMMARY:**
Many people of faith have access to support and spiritual healing resources within their faith communities and their faith traditions. Examples would be spiritual direction, inner healing, and prayer counseling. At times they may find these resources are not fully meeting their needs. Entering into therapy with a psychiatrist raises issues of how to integrate their spiritual experiences of healing with therapeutic modalities such as Cognitive Behavioral Therapy, dynamic therapies and therapy for trauma. This presentation will explore potential ways to build on and integrate a religious patient's spiritual healing in therapy. It will look at the potential pitfalls and resources available at the interface between spiritual healing and standard mental health treatments. Issues will be illustrated by case material drawn from dynamic and cognitive behavioral therapy in a private practice with individuals who have leadership roles in the Christian Church.

**REFERENCES:**
1. Galanter M. (2009) The concept of spirituality in relation to addiction recovery and general psychiatry. In Recent Developments in Alcoholism, New York, Springer, pp1-16.

**SYMPOSIUM 16**

**BURN PSYCHIATRY: TREATMENT AND OUTCOMES**

*Chairperson: Frederick J. Stoddard, M.D., SBH, 610 Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of these presentations, the participant should be able to: 1) Demonstrate knowledge of the history of burn psychiatry, as well as some of the pharmacological and psychosocial treatments available for adult and child burn survivors, across the acute, intermediate, and recovery phases.

**OVERALL SUMMARY:**
Specific Purpose: To educate psychiatrists about the history of burn psychiatry, the findings from a multi-center study of opiates in pain management, psychopharmacological treatment during adult burn care of delirium, PTSD and other disorders, and emerging results of a study to reduce stress in young burned children.Content: Burn injuries result in pain, delirium, PTSD, loss of function, and stigma from disfigurement. This symposium consists of two presentations on acute treatment of adult burn survivors—one based on the Cocoanut Grove and Station Nightclub fires, and the other on psychopharmacological interventions based on current evidence. The other papers present a multicenter study of opiate use in pediatric burns, and a randomized controlled trial of psychosocial intervention to reduce stress in 0-5 year olds with burns. Methodology: The criteria for inclusion in this Symposium were current relevance to treatment of patients with burn injuries. The papers utilize case reviews after massive fire disasters; the evidence base for psychopharmacological interventions for burned adults; a multicenter review of opiates from a 6 year pediatric burn survivor study; and findings from an RCT intervention study to reduce stress in 0-5 year old burned children. Results: Research is demonstrating resilience and positive outcomes from multidisciplinary treatments for survivors of severe burn injuries. Three phases for potential treatment have been identified: the acute, the intermediate, and the recovery phases. Psychiatric interventions benefit acute care and long-term outcomes. Importance of Proposed Presentation: The pain of burns and burn care causes both pain and stress, and increased risk of psychopathology especially PTSD. Evidence has accrued in support of the benefit of early psychiatric interventions in reducing

adverse psychosocial outcomes.

No. 16-A

**TRAUMA AND GRIEF AFTER THE COCOANUT GROVE AND STATION NIGHTCLUB FIRES 1942 AND 2003**

*Frederick Stoddard, M.D., SBH, 610 Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*

**SUMMARY:**

To educate psychiatrists about assessments, treatments, and lessons learned from burn survivors of the Cocoanut Grove and Station Nightclub Fires.Compared to Cocoanut Grove, the Station Nightclub fire survivors received modern assessment and care with interventions which vastly improved outcomes. Interventions now include early screening for preexisting pathology and management of pain and anxiety, sedation, neuropsychiatric problems including delirium, depression and PTSD. Nevertheless, there is major risk of pain, PTSD, loss of function and stigma.Data came from 2 sources 1) the articles of Erich Lindemann, Stanley Cobb and Alexandra Adler after the Cocoanut Grove Fire and 2) case reviews of those treated at a major hospital after the Station Nightclub Fire. To the extent feasible, the symptomatology, course, and management of patients were contrasted. Criteria for data selection: demographics, brain injury and delirium, pain, grief, depression, burn disfigurement, stress and end-of-life care. In the aftermath of the Cocoanut Grove Fire various psychiatric problems were reported including: "psychoneuroses" pre-burn, depression due to facial disfigurement, agoraphobia, reexperiencing, mood fluctuations including violence, "general nervousness" including irritability, nightmares, fatigue, insomnia; "anxiety neuroses," guilt, "reactions to bereavement" and "distorted grief." After the Station Nightclub fire symptoms including delirium, sleep disturbance, pain, concern over disfigurement, grief and traumatic reactions included GAD, PTSD and depression were diagnosed. From both fires 3 phases of treatment can be identified: acute, intermediate and rehabilitative. Each requires unique psychiatric approaches and treatment.The psychiatric responses to burn disasters have informed responses to massive trauma and disasters worldwide. These 2 disasters provide history and background helpful in preparing to assess, treat and follow-up patients with burn trauma and grief.

No. 16-B

**PSYCHOPHARMACOLOGY OF NEUROPSYCHIATRIC DISORDERS IN BURN PATIENTS**

*Shamim Nejad, M.D., 55 Fruit Street Warren 605, Boston, MA 02114*

**SUMMARY:**

SPECIFIC PURPOSE: To describe the common disorders diagnosed in adults after acute burn injury, and to present evidence for pharmacological treatments of these disorders.CONTENT: Common acute diagnoses include various pain syndromes, delirium, alcohol or drug withdrawal, acute stress reaction, mood and anxiety disorders, along with exacerbation of preexisting psychiatric disorders. METHODOLOGY: The available evidence for pharmacological treatments was reviewed, is briefly described, and will be referenced.RESULTS: Pharmacologic treatment of burn patients is based on the presenting symptoms, diagnosis, along with assessment of the patient's underlying medical condition(s), and potential adverse drug interactions. Pain syndromes: Pharmacologic options for acute pain, neuropathic pain, and phantom limb pain. Delirium: Use of neuroleptics, including intravenous haloperidol. Second-generation dopamine antagonists may also be useful. Dexmedetomidine may also help with severe agitation and post-operative delirium. Acute stress disorder and PTSD: Benzodiazepines are effective, as well as SSRIs, SNRIs, prazosin. Second-generation antipsychotics may also be helpful. Alcohol or drug withdrawal: Dosing of benzodiazepines for treatment of alcohol withdrawal, and adjunctive use of antipsychotic medications. Use of propofol or dexmedetomidine for complicated alcohol withdrawal may also be employed. Use of longer acting opioids such as methadone may be utilized for opioid withdrawal. Mood and anxiety disorders: Use of available antidepressants and benzodiazepines are often utilized. Pre-existing Psychiatry Disorder(s): If the medical condition permits, resumption of prior treatment or addition of adjunctive agents may be required. IMPORTANCE OF THE PROPOSED PRESENTATION: Psychopharmacological treatment is an integral component of acute burn care despite its limited evidence base.

No. 16-C

**AN INTERVENTION TO REDUCE STRESS IN 0-5 YEAR-OLDS WITH BURNS**

*Erica Sorrentino, M.A., 51 Blossom Street, Boston, MA 02114*

**SUMMARY:**

Objective: To test and validate an intervention to reduce pediatric burn traumatic stress in 0-5 year old children and their parents. The interventions are the Distress, Emotional Support, and Family Functioning ("DEF") protocol from the Pediatric Medical Traumatic Stress Toolkit for Health Care Providers (from the National Child Traumatic Stress Network), and COPE (Creating Opportunities for Parent Empowerment) program. Outcomes for participants in the Intervention Phase are compared to outcomes for participants in an earlier, Non-Intervention Phase of the study. Methodology: Families with children aged 0-5 years

admitted to the acute or reconstructive unit of Shriner's Hospital-Boston for a burn injury, and who speak English or Spanish, are eligible for the study. For both phases of the study, parents or guardians completed questionnaires during hospitalization regarding the child's and their own stress symptoms. Medical record reviews were conducted that included recording the interventions that patients and families received during hospitalization. Results: Eighteen families enrolled in the Non-Intervention Phase, and 42 families enrolled in the Intervention Phase. Patients and/or their families enrolled in the Intervention sample were more likely to receive psychiatric and pharmacological interventions for pain and anxiety than participants enrolled in the Non-Intervention Phase. Six months later, families enrolled in the Intervention reported fewer symptoms of posttraumatic stress in their child on the PTSDSSI (Posttraumatic Stress Disorder Semi-Structured Interview), and reported more perceived support on the HESF (Hospital Emotional Support Form). Conclusions: These findings lend credence to our belief that our intervention is reaching its two main goals: increasing supportive services for burned children and their families and reducing the symptoms of distress, particularly posttraumatic stress, in these children and families.

No. 16-D

**PAIN MANAGEMENT DURING ACUTE BURN TREATMENT IN CHILDREN: A MULTICENTER STUDY AND PSYCHOSOCIAL OUTCOME ANALYSIS**

*Tolga Ceranoglu, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114*

**SUMMARY:**

Specific Purpose:
Severe pain during acute phase treatment of burn injury increases the risk of psychopathology in children. Opiate medications are mainstay of pain management in acute burn care and may reduce the risk of long-term psychosocial stress. This presentation delivers the results of a multicenter study of opiate medications , the utilization patterns and outcome in pediatric burn injury. Methodology:Medical records of 83 burn patients aged 0–10 at 3 major burn hospitals across the nation were reviewed. Data on medication administration, demographics, burn-related factors and parent report stress outcomes as measured by the Parenting Stress Index Short Form (PSI-SF) were collected. Opiate medication doses were converted to oral morphine equivalents using standardized metrics (mg/kg/day).Results:Mean TBSA was 41.5% with a mean 3rd degree burn size of 32.3%. All patients were mechanically ventilated for at least 1 day and received at least one opiate medication. Morphine was most frequently prescribed opiate medication used in this sample. Morphine equivalent dose was significantly associated with larger TBSA, longer hospital stay and longer duration of mechanical ventilation. Higher morphine dose during the first 7 days of acute burn treatment was significantly associated with reduction in PSI-SF measured Parental Distress and Dysfunctional Parent-Child Interaction (r= -.28; p<.01 for both) over the course of 4+ years follow-up. Importance of the presentation:Opiates are used to treat most children during acute burn care. Findings in this study are congruent with previous literature that higher doses of opiates during acute care may have long-term psychosocial benefits. Further research on use of opiate and other classes of medications during treatment of burn injuries in children is needed.

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ized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. Arch Gen Psych 61(5): 498-506.

## SYMPOSIUM 17

## UPDATE ON INTERVENTIONS FOR ADULT EATING DISORDERS

*Chairperson: James Lock, M.D., Ph.D., 401 Quarry Rd Rm 1120, Stanford, CA 94305*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Demonstrate knowledge of cognitive behavioral therapy for adults with bulimia nervosa; 2) Demonstrate knowledge of dialectical behavioral therapy for adults with binge eating disorder; 3) Demonstrate knowledge of cognitive remediation therapy for adults with anorexia nervosa; 4) Demonstrate knowledge of prevention of eating disorders; and 5) Demonstrate knowledge of psychopharmacologic interventions with eating disorders.

### OVERALL SUMMARY:

This session will include 5 presentations providing a substantial update on treatment strategies for adults with eating disorders. Dr. Mitchell will discuss treatment of adults with bulimia nervosa with a specific focus on new research findings supporting a stepped care approach for the disorder. Dr. Lock will discuss cognitive remediation therapy as an adjunctive treatment for adults with anorexia nervosa. This novel approach focuses on addressing cognitive inefficiencies found in these patients in order to improve cognitive process, therapeutic relationships, and promote the take up specific therapies for the disorder (e.g., CBT). Discussion of an ongoing study examining cognitive remediation in adults with anorexia nervosa will be included. Dr. Safer will discuss the role of dialectical behavior therapy for binge eating disorder in adults. The therapeutic rationale, treatment model, feasibility, acceptability, and effectiveness of group DBT for adults with binge eating disorder will be discussed. Results of a recent randomized clinical trial examining group dialectical behavioral therapy will be described. Dr. Taylor will provide an overview of prevention studies of adults with eating disorders. He will discuss the two approaches to preventing eating disorders in older adolescents and college age women that have been shown to be effective In addition, new approaches to combining universal and targeted interventions, providing preventive and clinical stepped care programs, changing norms within defined populations and preventing anorexia nervosa will be presented. Dr. Kaplan will review the current evidence supporting psychopharmacological treatments for eating disorders and discuss the results of a large randomized clinical trial for relapse prevention using fluoxetine for anorexia nervosa. He will also describe new directions in psychopharmacological treatment for eating disorders.

No. 17-A

## STEPPED CARE VERSUS BEST AVAILABLE TREATMENT FOR PATIENTS WITH BULIMIA NERVOSA

*James Mitchell, M.D., 120 8th St S, Fargo, ND 58102*

### SUMMARY:

This study compared the best available treatment for bulimia nervosa, Cognitive Behavior Therapy (CBT), augmented by fluoxetine if indicated, to a stepped-care treatment approach in order to enhance treatment effectiveness. Subjects were randomized to: 1) Manual-based CBT delivered in an individual therapy format involving 20 sessions over 18 weeks. Subjects who were predicted to be non-responders after 6 sessions of CBT had fluoxetine added to treatment; 2) A stepped-care approach which began with supervised self-help, with the addition of fluoxetine in subjects who were predicted to be non-responders after 6 sessions, followed by CBT for those who failed to achieve abstinence with medication management and self-help. At the end of treatment, both in intent-to-treat and completer samples, there were no differences between the two treatment conditions in inducing recovery (no binge eating or purging behaviors for 28 days) or remission (no longer meeting DSM-IV criteria). At the end of one-year follow up, the stepped care condition was significantly superior to CBT. Therapist assisted self-help was an effective first level treatment in the stepped care sequence, and the full sequence was more effective than CBT suggesting that treatment is enhanced with a more individualized approach.

No. 17-B

## DIALECTICAL BEHAVIOR THERAPY FOR BULIMIA NERVOSA AND BINGE EATING DISORDER

*Debra Safer, M.D., 401 Quarry Rd, Stanford, CA 94305*

### SUMMARY:

Cognitive behavior therapy (CBT) is the best studied therapy for bulimia nervosa (BN) and binge eating disorder (bed). However, upon completion of cbt, approximately 50% of patients continue to be symptomatic. Considerable evidence links binge eating with negative emotions such that treatment of affect dysregulation may improve disordered eating. Dialectical behavior therapy (DBT), developed by linehan to treat borderline personality disorder, is currently the most empirically validated affect regulation therapy. Preliminary studies investigating an adaptation of DBT to target emotional dysregulation linked to disordered eating have been promising but limited. A recent large (n=101) randomized controlled group therapy trial comparing DBT for bed to an active group therapy control (ACGT)

showed DBT to have significantly fewer dropouts (4% versus 33.3%) and greater efficacy at post-treatment compared to ACGT (abstinence rates of 64% versus 33%). While the difference in abstinence rates between groups was smaller and non-significant at follow-up, moderators of a beneficial outcome at the 12 month follow-up were identified. Particularly, patients with high baseline levels of negative affect and emotion dysregulation had significantly improved outcomes at the 12 month follow-up if treated for bed with DBT compared to ACGT. Implications of the treatment findings will be presented

No. 17-C
**COGNITIVE REMEDIATION THERAPY FOR ADULTS WITH ANOREXIA NERVOSA**

*James Lock, M.D., Ph.D., 401 Quarry Rd Rm 1120, Stanford, CA 94305*

**SUMMARY:**
Documented cognitive abnormalities in AN include overall inflexibility of thinking and extensive attention to detail (difficulties with set-shifting, perseveration and focusing on details compromising context). Because many potentially effective psychological treatments (e.g., cognitive-behavioral therapy—CBT) depend on fundamentally intact executive cognitive functions, these impairments likely have a significant negative impact on both therapeutic engagement and the usefulness of such treatments. CRT for AN was developed after an evaluation of neuropsychological functioning in eating disorders underscored trait difficulties in executive functioning among adults with AN. The ego-syntonic nature of the disease and difficulties with treatment retention compelled use of a targeted, time-limited and narrowly focused treatment package. In addition, evaluation of cognitive inefficiencies in AN mirrored treatment resistant clinical symptomology: inflexibility in thinking, perceptual illusions/perseverations, and difficulties in redirecting thoughts (intrusive or perseverative thinking). Tchanturia and colleagues developed a cognitive flexibility module for the treatment of AN, providing remediation exercises targeting these domains, adapted from Wykes, Reeder, Delahunty, Morice & Frost's (1993) flexibility module for schizophrenia. The CRT treatment protocol consists of a baseline neuropsychological evaluation, followed by ten 30-45 minute sessions of manualized CRT over five to eight weeks. However, CRT has not yet been studied as a complementary treatment to a focused therapy (e.g., CBT) aimed at the specific problems of AN related to weight loss, self-starvation, and appearance and weight related cognitive distortions. Forty-six subjects (ages 16 and above) meeting DSM IV criteria for AN and medically stable for outpatient treatment are becoming randomized to either CBT-AN (28 sessions) for 6 months or CRT (8 sessions) followed by CBT-AN for (20 sessions) for 6 months, with 23 subjects in each group. Preliminary findings of this study will be discussed.

No. 17-D
**HOW TO PREVENT EATING DISORDERS**

*Craig Taylor, M.D., 401 Quarry Road, Rm 1324, Stanford, CA 94305-5722*

**SUMMARY:**
This talk will discuss the two approaches to preventing eating disorders in older adolescents and college age women that have been shown to be effective. In addition new approaches to combining universal and targeted interventions, providing preventive and clinical stepped care programs, changing norms within defined populations and preventing anorexia nervosa will be presented.

No. 17-E
**PHARMACOTHERAPY OF EATING DISORDERS: ESTABLISHED AGENTS AND NEW DIRECTIONS**

*Allan Kaplan, M.D., 250 College Street Room 832, Toronto, Ontario, M45T 1R8*

**SUMMARY:**
This talk will review the pharmacotherapy of anorexia nervosa (an), bulimia nervosa (bn) and binge eating disorder (bed); specifically focusing on established agents with proven efficacy as well as potential new investigational compounds that could be used to treat these disorders. There are currently no established evidence based drug treatments for acutely ill underweight patients with an. There are currently studies underway examining the efficacy of atypical antipsychotic for an patients and the results of these studies will be presented. In addition, the results of recent studies examining fluoxetine to prevent relapse in weight restored an subjects will be presented. This talk will also review the established agents with proven efficacy for bn and bed, including antidepressants and other drug classes, as well new investigational compounds that may be useful to treat these disorders in the future.

**SYMPOSIUM 18**

**TRANSLATING THE PSYCHOPHARMACOLOGY EVIDENCE BASE INTO PRACTICE: A SAMPLER FROM THE AMERICAN SOCIETY OF CLINICAL PSYCHOPHARMACOLOGY**

*Chairperson: Michael D Jibson, M.D., Ph.D., 1500 E. Medical Center Dr., Ann Arbor, MI 48109-5295, Co-Chairperson: Ira Glick, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should

be able to: 1) Identify the key aspects of a high quality psychopharmacology visit; 2) Apply evidence based psychopharmacology to treatment of the geriatric patient; and 3) Discuss important aspects of combined therapy (psychopharmacology and psychotherapy).

**OVERALL SUMMARY:**
Psychopharmacology is one of the keystones of psychiatry. However, training in psychopharmacology is not uniform, and the practice of psychopharmacology is more or less evidence based, depending on the practitioner. The mission of the American Society of Clinical Psychopharmacology (ASCP) is to educate physician practitioners in evidence based psychopharmacology and provide training in the day to day practice of psychopharmacology. To foster evidence based psychopharmacology in residency training, ASCP has developed a Model Curriculum, which is widely utilized in the U.S. and abroad. A medical student version has recently been released, and a primary care version is nearing completion. Also, ASCP has for many years provided a yearly fall meeting which focuses on (1) quality presentations on the evidence base, stressing new findings in the literature, and (2) the "nuts and bolts" of translating the evidence base into actual clinical practice. Recently ASCP has begun to co-sponsor (along with NIMH) the NCDEU meeting, which stresses the same formula. This symposium will also follow this formula, utilizing material from the Model Curriculum. It will include a sampler of presentations which cover several important aspects of psychopharmacology practice. First, an actual visit will be outlined, as the clinical situation is a key to quality practice. Because in the clinical setting psychopharmacology is often provided along with psychotherapy, "combination therapy" will be discussed. Third, a specific example from the evidence base will be given, with a focus on geriatric populations. Finally, the ethics involved in clinician/industry interactions will be outlined.At this point in time, a majority of patients with Axis I (and even Axis II) disorders receive combined treatment rather than medication alone or psychotherapy alone. This presentation, targeted to clinicians, will provide 1) the rationale for and 2) the controlled evidence for combined treatment. Next, we will provide general guidelines for how to combine treatments in the context of office practice including broadly conceptualizing the diagnosis, treatment goals, untoward effects, sequencing effects, indications and contraindications, advantages and disadvantages are reviewed. In summary, 1) biological and psychological factors are interactive; 2) psychotherapy added to medication may improve outcome above that produced by medication alone; and 3) psychotherapy plus medication may insulate better than medication alone against relapse in many disorders.

No. 18-A
**QUALITY OF CARE IN PSYCHOPHARMACOLOGY: DOING AN ACTUAL VISIT**

*John M. Kane, M.D., The Zucker Hillside Hospital75-59 263rd Street, Glen Oaks, NY 11004-1150*

**SUMMARY:**
It is critical to conduct a comprehensive initial psychiatric interview incorporating all essential elements (i.e., chief complaint; present illness; past psychiatric history; past medical history etc,). In the context of the past medical history it is important to garner as much information as possible regarding the patient's prior exposure to and experience with all classes of psychotropic medications. All sources of potential information should be sought, as patients may not be able to provide an accurate history. It is important to have a thorough discussion with the patient regarding the possible therapeutic medications, their risks and benefits, as well as the risks and benefits of no medication and alternative treatment options. Whenever possible, the physician should engage in shared decision-making with patients (and significant others as appropriate).It is particularly important to educate patients and families as to how to monitor and evaluate their own response and course in order to provide valuable feedback to the treating physician to inform optimum treatment planning. We encourage consideration of the use of quantitative assessments, either self-administered or physician-rated in order to facilitate measurement-based decision-making whenever possible.

No. 18-B
**COMBINATION THERAPY: PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY**

*Ira Glick, M.D., Departments of Psychiatry and Behavioral Sciences, and Psychopharmacology, Stanford University School of Medicine 300 Pasteur Drive, Stanford, CA 94305*

**SUMMARY:**
At this point in time, a majority of patients with Axis I (and even Axis II) disorders receive combined treatment rather than medication alone or psychotherapy alone. This presentation, targeted to clinicians, will provide 1) the rationale for and 2) the controlled evidence for combined treatment. Next, we will provide general guidelines for how to combine treatments in the context of office practice including broadly conceptualizing the diagnosis, treatment goals, untoward effects, sequencing effects, indications and contraindications, advantages and disadvantages are reviewed. In summary, 1) biological and psychological factors are interactive; 2) psychotherapy added to medication may improve outcome above that produced by medication alone; and 3) psychotherapy plus medication may insulate better than medication alone against relapse in many disorders.

No. 18-C
**FOCUS ON A SPECIFIC PATIENT GROUP: GERIATRIC PATIENTS**

*James Ellison, M.D., M.P.H., Geriatric Psychiatry ProgramMcLean Hospital 115 Mill Street Belmont, MA 02478*

**SUMMARY:**
In addition to the core content addressed in the ASCP Model Curriculum, several areas of specialized interest are also covered in order to provide instructors and students with current, evidence-based information that may be of use in an advanced psychopharmacology course or elective. This presentation focuses on the development of the ASCP geriatric psychopharmacology section, which includes a set of ten lectures, several of which have evolved in cooperation with the American College of Neuropsychopharmacology. Depression, Dementia, and Delirium are highlighted, and additional information is provided in lectures on geriatric anxiety disorders, psychosis, aggression, and drug/drug interactions in older patients. The focus is on material of use to general psychiatrists who may be called upon to diagnose and treat older adults in inpatient, outpatient, or long term care settings.

No. 18-D
**AN ETHICAL FRAMEWORK FOR CLINICIAN/ INDUSTRY INTERACTIONS**

*Michael Jibson, M.D., Ph.D., 1500 E. Medical Center Dr., Ann Arbor, MI 48109-5295*

**SUMMARY:**
Interactions between physicians and the pharmaceutical industry are essential to the both professions, but create the potential for conflicts of interest for physicians that may adversely affect academic and clinical activities. In order to address these conflicts, government regulatory agencies, professional organizations, healthcare institutions, and individual physicians each have a role to play. Physicians need to understand the risks and the benefits of collaboration with industry, including appreciation of the impact of marketing on clinical decision-making, the nature of self-serving bias, and their obligations when engaging in contract services with industry. Physicians involved in these activities have an obligation to know and follow legal regulations and ethical guidelines. Disclosure, peer review, and careful self-reflection are essential to maintain the integrity, objectivity, and credibility of the medical profession.

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**SYMPOSIUM 19**

**PATHOPHYSIOLOGY OF PSYCHOTIC AND MOOD DISORDERS: DO WE HAVE ANY SOLID EVIDENCE OF INTEREST TO CLINICIANS?**

*Chairperson: Mario Maj, M.D., Ph.D., Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, Naples, 80138 Italy*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify solid research evidence concerning the pathophysiology of schizophrenia; 2) Identify solid research evidence concerning the pathophysiology of mood disorders; and 3) Identify solid research evidence concerning the similarities and differences in the pathophysiology of schizophrenia versus mood disorders.

**OVERALL SUMMARY:**
There is now an extensive literature about the pathophysiology of psychotic and mood disorders. A variety of findings have been reported, and several models have been proposed. Almost every issue of any major psychiatric journal contains at least one paper providing new data relevant to the pathophysiology of schizophrenia, major depression or bipolar disorder. However, in the new edition of the two main diagnostic systems for mental disorders, the ICD and the DSM, none of these findings or models is likely to be mentioned in the descriptive or operational criteria for any psychotic or mood disorder. Furthermore, several findings appear contradictory, or seem to apply to both psychotic and mood disorders. It is perhaps time to have a critical look at the currently available evidence, and to identify those findings which may be regarded as really solid, and which may be of interest to clinicians for their potential implications for treatment choice or prediction of outcome.

No. 19-A
**WHAT DO WE KNOW FOR SURE ABOUT THE PATHOPHYSIOLOGY OF SCHIZOPHRENIA?**

*Stephen Lawrie, M.D., Royal Edinburgh Hospital, Edinburgh, EH10 5HF*

**SUMMARY:**
Schizophrenia is highly heritable. Current genetic evidence points strongly towards with a number of highly penetrant, but typically rare mutations as primary risk factors, plus a set of relatively common variants that can modify risk. There are several possible environmental risk factors (obstetric complications including starvation, urban birth, abnormal neurodevelopment, migration, stress, cannabis

use) of similarly small effect to most of the implicated genes. Abnormalities on structural and functional brain imaging, electrophysiology and cognitive testing are present in at risk populations. Some of these deficits may progress around onset and in a poor prognosis subgroup. Several lines of evidence implicate disturbances in dopamine and/or glutamatergic transmission in the symptoms of schizophrenia. Neuropathology studies demonstrate reduced neuronal size and dendritic arborisation in keeping with dysconnectivity models. These investigations remain research tools, but individual risk estimates based on genotyping and other assessments in clinical practice are foreseeable.

No. 19-B
**CLINICALLY RELEVANT NEUROBIOLOGICAL FINDINGS IN DEPRESSION**

*Gregor Hasler, M.D., Culmannstrasse 8, Zurich, 8091*

**SUMMARY:**
There is growing evidence that depression is caused by the cumulative impact of risk genes, adverse events in childhood and ongoing or recent stress. Most previous neurobiological studies in mood disorders have focused on monoaminergic neurotransmitter systems. Experimental depletion of monoamines induced depressive symptoms in subjects at risk of mood disorders. Positron emission tomography studies demonstrated that monoaminergic receptors (mainly the serotonergic and dopaminergic) may be hypofunctional in depression. Almost every compound that inhibits monoamine reuptake has been proved as a clinically effective antidepressant. Depressed patients, particularly those with a history of physical or sexual abuse, may have elevated plasma cortisol levels and elevated CRH levels in the cerebrospinal fluid. Although there is abundant evidence for the hypothalamic-pituitary-adrenal axis being involved in depression, compounds that modulate this stress axis have not been consistently proved effective as antidepressants. Imaging studies have linked mood disorders with abnormal brain function and reductions in central nervous system volume in the prefrontal cortex, mesiotemporal brain structures and other limbic brain areas. Structural changes may be associated with low levels of neurotrophic factors such as BDNF and CREB, glutamate-mediated toxicity and excessive release of corticosteroids. Histopathological studies showed that volume reductions in depression are associated with reductions in the numbers and sizes of glia (and later in the course of the disorders also neurons). These abnormalities are thought to contribute to the recurrence of depressive episodes and chronic illness. Studies using magnetic resonance spectroscopy, positron emission tomography and pharmacological challenges have provided evidence for altered glutamatergic neurotransmission and reduced GABAergic neurotransmission in depression. The many theories of depression and the relatively low response rate to antidepressant treatments suggest that depression is a clinically and etiologically heterogeneous disorder. As a result, the development of personalized medicine by means of imaging and genotyping for interindividual variability with respect to stress sensitivity, brain function, and drug action and metabolism may have the potential to considerably improve antidepressant effects of psychotherapeutic, pharmacological and other somatic approaches.

No. 19-C
**WHAT DO WE KNOW ABOUT THE CAUSES OF BIPOLAR DISORDERS?**

*Stephen Strakowski, M.D., 231 Albert Sabin Way (ML0583), Cincinnati, OH 45267-0583*

**SUMMARY:**
Bipolar disorder is a common psychiatric condition affecting up to 4% of the population. Despite being common, the specific neurophysiology underlying this illness remains unknown. Neuroimaging, particularly structural and function magnetic resonance imaging (sMRI and fMRI) and spectroscopic (MRS) techniques, has begun to inform functional neuroanatomic models of this illness. For example, recent fMRI studies suggest that loss of ventral prefrontal modulation of amygdala, through iterative prefrontal-striatal-thalamic networks, may underlie the expression of affective episodes during the course of bipolar disorder. Indeed, these anterior limbic networks are known to modulate mood and may also reciprocally affect cognitive (attentional) function. Neuroanatomic (sMRS) studies provide additional evidence of abnormal development or progressive changes within these networks. Some of this progression appears to be related to the affective episodes themselves. MRS studies suggest excessive glutamatergic neurotransmission that may either reflect or cause hypermetabolism within the anterior limbic networks, thereby destabilizing control of mood. Taken together, MRS studies suggest mitochondria-based metabolic abnormalities in bipolar disorder. Moreover, bipolar disorder has been recognized as a familial (genetic) illness for many years, although the specific genes underlying the disorder remain ill defined. Recently, several candidate genes offer promise for potentially clarifying the etiology of this condition. In particular, abnormalities in genes related to mitochondrial function may contribute to the development of bipolar disorder in some persons. These abnormalities may be related to the neuroimaging findings, helping to integrate possible models of bipolar illness. As we refine neurophysiological models of bipolar disorder, new targets for treatment development may alter how clinicians approach this condition.

No. 19-D
**SHARED AND DISTINCT NEUROGENETIC MECHANISMS FOR SCHIZOPHRENIA AND**

**BIPOLAR DISORDER**

*Andreas Meyer-Lindenberg, M.D., Gesundheit J-5, Mannheim, 68159*

**SUMMARY:**

A dichotomy between schizophrenia and affective psychoses would predict separable genetic risk architectures. Conversely, a continuum hypothesis would predict convergence of genetic risk. Data from genetic epidemiology increasingly support a continuum. While recent genome-wide association studies support a large overlap of common genetic risk variants for schizophrenia and bipolar disorders, evidence from candidate genes suggests the existence of risk variants associated either with one diagnostic category or both. This provides the opportunity to investigate neural mechanisms associated with separable and overlapping genetic risk. Here, we investigate common risk variants in BDNF, COMT as well as a recently identified genome-wide significant variant associated with schizophrenia and bipolar disorder (ZNF804A), using imaging genetics. Neural circuits mediating risk for variants associated with both schizophrenia and bipolar disorder are contrasted and related to findings in patients with manifest disease, as well as genetically high-risk subjects. Both common variants in candidate genes (COMT and BDNF) and genome-wide significant variants impact on the structure and function of neural circuits implicated in executive cognition and emotional regulation that are converging on prefrontal control, yet dissociable in terms of their subcortical components and disease-related heritability. We conclude that common genetic risk factors bridging the Kraepelinian divide impact on several separable neural mechanisms individually implicated in the pathophysiology of affective psychoses and schizophrenia, respectively.

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**SYMPOSIUM 20**

**UPDATING THE APA GUIDELINES FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER**

*The Association for Research in Personality Disorders*

*Chairperson: James H Reich, M.D., M.P.H., 2255 North Point Street #102, San Francsico, CA 94123*
*Discussant: Donald W. Black, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Have increased understanding of the treatment of Borderline Personality Disorder; and 2) Know how treatment approaches have evolved over the last decade.

**OVERALL SUMMARY:**

Borderline Personality Disorder (BPD) represents a continuing treatment challenge for clinicians. As the last comprehensive set of APA guidelines for treatment was in 2000, this symposium will revisit this issue with knowledge gained over the last decade. We will start with a review of our increased knowledge of biology and genetics. This will lead int a discussion of how this new knowledge affects our treatment approaches. This will be followed by a discussion of the challenging area of treatment of the Borderline when the patient is in crisis. This will include both emergency room and outpatient settings. Borderline personality disorder seldom appears without associated Axis I and Axis II disorders. The issue of dealing with multiple disorders in the same patient with differing guidelines will be discussed, including the difficult area of conflicting guidelines. Drug treatment of BPD is subtle complex area but one where the treatment is highly used. The state of the art for drug therapy treatment of BPD and controversies will be reviewed. Finally, the many advances in psychotherapy for BPD will be discussed. This will be focused on identifying the most effective aspects of the different developing and existing approaches.

No. 20-A

**UPDATING THE APA GUIDELINES FOR THE TREATMENT OF BPD: NEUROBIOLOGY AND GENETICS OF BORDERLINE PERSONALITY PATHOLOGY**

*Simone Kool, Ph.D., M.D., Frederik Hendrikstraat 47, Amsterdam, 1052HK*

**SUMMARY:**

Fundamental neurobiological and genetic issues underlie the development of borderline personality pathology. For example, in patients with impulsive aggression, the serotonin system has been extensively studied and plays a clear and consistent role. Additionally, neuroimaging techniques show reduction in frontal lobe volume in borderline patients with emotional dysregulation. In twin studies, high heritability factors were found for borderline traits such as aggressiveness and mood dysregulation. Also, specific environmental factors such as abuse in childhood can play a major etiological role and interact with neurobiological and genetic factors, contributing to the manifestation of specific borderline traits. One

of the consequences of this knowledge for the treatment of borderline personality disorders is that a combined biological, psychotherapeutic and environmental treatment is indicated. In the Netherlands, research has been done into the effectiveness of short-term inpatient programs for patients with personality disorders. All relevant evidence in literature concerning neurobiological and genetic findings in patients with BPD will be presented. Implications for diagnosis, clinical practice and the results of inpatient psychotherapy will be offered.

No. 20-B

**EMERGENCY MANAGEMENT OF SUICIDAL CRISES IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER (BPD)**

*Paul Links, M.D., 30 Bond St., Rm 2010d Shuter St., Toronto, M5B 1W8*

**SUMMARY:**
Purpose: The purpose of this presentation is to describe an approach to improve the acute manage of suicide crises in patients with BPD. Methodology: Our emergency management of suicide crises resulted from our development of a manualized therapy for BPD utilized in a randomized controlled trial (RCT) to evaluate the clinical and cost-effectiveness of DBT versus General Psychiatric Management. General Psychiatric Management (GPM) is derived from the APA Practice Guideline for the Treatment of Patients with Borderline Personality Disorder, a comprehensive set of 'best practice' recommendations for the psychiatric community. Our emergency management is also informed by involvement of patients' input, a learning needs assessment and pilot testing of an educational intervention with emergency department staff. Results: The results of the RCT after one year of treatment based on GEE analyses, both DBT and GPM groups showed statistically significant decreases in the frequency of suicide episodes and non-suicidal self-injurious episodes. There were no between-group differences in the frequency of suicide episodes or non-suicidal self-injurious episodes. Both groups demonstrated statistically significant reductions in the number of emergency room visits for suicidal behavior; there were no between-group differences. Emergency management in GPM differed significantly from DBT in that there was no after hours coverage by the therapists, early warning signs for increased suicidal crises were utilized, hospitalizations were considered indicated for crises and a liaison with emergency staff was developed to address their specific learning needs.Conclusion: Attending to the care received by patients with BPD in the emergency department appears to be a successful way to improve the management of suicidal crises in these patients.

No. 20-C

**APPROACHES TO PRIORITIZING TREATMENT OF BORDERLINE PERSONALITY DISORDER IN THE PRESENCE OF OTHER SIGNIFICANT AXIS I AND AXIS II DISORDER**

*James Reich, M.D., M.P.H., 2255 North Point Street #102, San Francsico, CA 94123*

**SUMMARY:**
Treatment guidelines such as the APA guidelines for Borderline Personality Disorder (BPD) tend to focus on the disorder itself. However, empirical evidence indicates that it is very seldom that BPD is present without another personality disorder or Axis I emotional disorder being present as well. Usually if BPD is diagnosed at least an additional Axis I and Axis II disorder is also diagnosed (often more.) One important aspect of this comorbidity is that of state aspects of personality disorder – personality symptoms that will disappear after treatment of an Axis I disorder or removal of stress. The treater must decide whether some of the personality symptoms will resolve with resolution of the Axis I disorder and reduction of patient stress. Another aspect is co-existing disorders whose treatment may or may not dovetail with treatment of BPD. For example, an anxiety disorder might indicate use of a benzodiazepine whereas that would be relatively contra indicated in BPD. This would involved deciding which aspect of the patient to treat first and at what cost to the interpersonal relationship. Other disorders might not necessarily conflict with BPD treatment recommendations, for example treatment of substance abuse, but there could be question as to which treatment to deploy at what time. Which route do you take if the patient's decision on treatment priorities is at odds with your own? Although there is no one right way to approach these treatment decisions I will discuss approaches to decide how to prioritize treatment among symptoms. I will also discuss risk benefit analyses of approaches where treatment guidelines conflict.

No. 20-D

**NEW CONSIDERATIONS IN THE PHARMACOLOGIC TREATMENT OF BORDERLINE PERSONALITY DISORDER**

*Kenneth R. Silk, M.D., 4250 Plymouth Road, Box 5769, Ann Arbor, MI 48109-2700*

**SUMMARY:**
Drug treatment of borderline personality disorder (BPD) has been driven primarily by the algorithms in the APA Practice Guidelines for treatment of BPD. While there remains scant empirical evidence for pharmacological treatment of any of the personality disorders save for schizoptypal, borderline or avoidant, there is a growing body of empirical evidence that can provide us with some direction for pharmacologic interventions in BPD.

Almost 2 dozen RCTs have been performed that deal with drug treatment of BPD with more than half of those RCTs having been conducted after the APA Guidelines were published. Nonetheless, many of these RCTs have small numbers of subjects, and there is no consistency in specific types of medications within a class that were studied. Outcome measures are also inconsistent from study to study. The empirical evidence suggests that mood stabilizers and antipsychotics medications, both typical and atypical, appear to be most effective for a wide array of symptoms found in BPD, while the antidepressants, in particular the SSRIs, have little empirical evidence to support their effectiveness, even in the face of depression. This presentation will review the RCTs for the treatment of BPD, and it will update and modify the algorithms in the APA Guidelines which are now more than a decade old.

No. 20-E
**PSYCHOTHERAPY FOR BORDERLINE BERSONALITY DISORDER**

*John Livesley, M.D., 2255 Wesbrook Mall, Vancouver, V64 1L1*

**SUMMARY:**

Psychotherapy for borderline personality disorder has changed substantially since treatment guidelines were formulated: a series of randomly controlled trials showing that several different therapies are effective have created a variety of treatment options. Evidence of treatment outcome also suggests that a combination of psychotherapy and medication is the optimal way to treat borderline personality disorder. Unfortunately, the results of outcome studies do not help the clinician to make an informed decision about which form of psychotherapy to use because outcome does not differ substantially across treatments. Moreover, effective treatments tend to focus on a specific aspect of borderline pathology such as emotional dysregulation, impaired object relationships, or mentalizing problems and to view this problem as the central impairment associated with the disorder. However, borderline personality disorder typically encompasses all these problems. Consequently, the decision to adopt a given therapy may mean that effective treatment methods are not used simply because they "belong" to a different model. Given these conclusions, it will be argued that a contemporary set of guidelines for psychotherapy for borderline personality disorder should emphasize an integrated approach that combines effective interventions from different therapeutic models. Such an approach would base treatment on principles and methods common to all effective treatments. Interventions based on these common principles would form the basic structure of an evidence-based approach. More specific interventions selected from the different therapies based on evidence of what works would then be added to this structure as needed to treat the various components of borderline pathology. A framework for organizing integrated treatment will be discussed.

**REFERENCES:**

1. Oldham JM, Gabbard GO, Goin MK et al. Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder. American Psychiatric Association, 2001.

**SYMPOSIUM 21**

**HOW TO GET THE CORNER OFFICE: PRACTICAL LEADERSHIP STRATEGIES FOR WOMEN PSYCHIATRISTS**

*The Association of Women Psychiatrists*

*Chairperson: Tana A Grady-Weliky, M.D., OHSU-SOML-102; 3181 SW Sam Jackson Pk. Rd., Portland, OR 97221*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify essential factors for success in a research career; 2) List strategies for making a difference in global health; 3) Identify key components for success in psychiatric education; and 4) Recognize challenges and opportunities in leadership of national organizations.

**OVERALL SUMMARY:**

Over the past decade there has been an increasing number of women applying to and getting accepted to medical school. In fact, in most medical schools women comprise 50% of medical school classes. A similar phenomenon has been observed with a rise in the number of women selecting psychiatry as a career. Although there has been an increase in the number of women in the pipeline, there continues to be a limited number of women in leadership roles in academic medicine, in general, and psychiatry, in particular. Leadership takes on many forms. One can be a leader within a group clinical practice, a student mental health center or a community mental health center. There are opportunities for women psychiatrists to take on leadership roles within psychiatric research and medical education. Given the increased interest among medical students and residents in global health, women psychiatrists from around the country and world have an opportunity to consider leadership roles in this venue. Another are for women to consider leadership is within organized medicine. In recent years there have been several women presidents of the American Psychiatric Association, who serve as role models and mentors for other women who may aspire to these types of positions. This symposium includes nationally recognized speakers with expertise in psychiatric research and education, organized medicine and global health. The symposium is designed for women psychiatrists who have an interest in leadership and would like to gain practical skills in

how to get the "corner office."

No. 21-A
**THRIVING NOT JUST SURVIVING AS A CLINICAL RESEARCHER**

*Eva Szigethy, M.D., Ph.D., Children's Hospital Drive, Pittsburgh, PA 15201*

**SUMMARY:**
A career in clinical research can be a challenging endeavor given stiff competition for shrinking pool of research funding, competing roles as clinician and caretakers, and the rigors of planning and executing a sound research plan. In addition, often standard clinical training during psychiatry residency does not provide sufficient emphasis on research methodology or administrative skills training necessary to succeed as a clinical researcher. This presentation will provide several models of building a successful joint clinical and research program for early and mid-career psychiatrists with emphasis on: 1) Balancing life and work; 2) Developing a sound longitudinal research plan; 3) Procuring research funding from a variety of sources; 4) Building a network of collaborators, mentors, and staff necessary for success; and 5) Developing a sound business plan to allow for long-term program growth. The basis for these models will be provided by a very successful integrated clinical and research program developed over the past 10 years by the speaker, including the procurement of a prestigious NIH Innovator Award. The sharing of such strategies will help foster the growth of research leaders of the future.

No. 21-B
**DITCHING THE CORNER OFFICE TO ADDRESS GLOBAL HEALTH**

*Mary Kay Smith, M.D., 3000 Arlington Ave., MS 1193 (RHC, Rm. 0004), Toledo, OH 43614*

**SUMMARY:**
Occasionally, professional development leads women psychiatrists to places they could never have imagined. Some find fulfillment by providing health care to those in need around the world. Others do so by partnering with people in cultures different from their own in order to implement empowering initiatives. Still others travel to developing countries in response to regional requests for health care and medical education. During this presentation, a number of approaches to getting involved in global heath will be discussed, as will some alternatives to occupying 'the corner office' as a measure of professional success.

No. 21-C
**WOMEN IN ORGANIZATIONAL LEADERSHIP: WHAT, WHEN, AND HOW**

*Carolyn B. Robinowitz, M.D., 5225 Connecticut Avenue, NW, #514, Washington, DC 20015*

**SUMMARY:**
Women leaders face many challenges and opportunities in clinical medicine and in health policy and particularly in national medical organizations. By their size and scope as well as tradition, national organizations mirror academic medicine and other settings in which women are well represented at entry levels, but are disproportionately under-represented in more senior leadership positions. Sadly, the absence of women leaders represents a loss or major talent and contributions for the organizations as well as lost opportunities for the women themselves. This presentation will focus on the special issues affecting women's participation and leadership in psychiatric organizations including women's roles and leadership styles, as well as the characteristics of the organizations themselves. It will address the role of the volunteer and the relation to staff, traits/skills needed for effective leadership, early challenges, and mid and late-career issues, as well as working within systems, conflict management, and mentoring. Emphasis will be on identifying "take home" practical strategies for successful leadership.

**REFERENCES:**
1.Olarte S. Women Psychiatrists: Personal and Professional Choices -- a Survey. Acad Psychiatry. 28(4): 321-324, 2004

**SYMPOSIUM 22**

**CULTURE AND PSYCHIATRIC DIAGNOSIS: IMPLICATIONS FOR THE INTERNATIONAL IMPACT OF *DSM-5***
*Chairperson: Renato D. Alarcon, M.D., 200 First Street, SW, Rochester, MN 55905*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, the participant should be able to: 1) Identify cultural variables pertinent to comprehensive psychiatric diagnosis, and their implications in defining and operationalizing *DSM-5*; 2) Recognize the relevance and value of an improved cultural formulation by including clinical information, explanatory models, and therapeutic implications; and 3) Evaluate potential "culture bound syndromes" as local expressions of universal phenotypes, to expand the international scope of *DSM-5.*

**OVERALL SUMMARY:**
The current development process of APA's fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) counts on the input of a Gender and Cultural Issues Study Group where a number of items are being actively discussed. This Symposium will examine the various cultural aspects of DSM-5, both the

clinical and research contributions to the field, and the overall implications of forthcoming secondary analyses of databases and results of planned field trials. Specific issues include cultural components in the definition of mental disorder, the need for a renewed and enriched cultural formulation, measurements of cultural variables, current status of "culture-bound syndromes" vis-à-vis existing nomenclatures (and their eventual incorporation into the regular classification or maintenance as "independent" entities). Preventive and therapeutic considerations from the cultural perspective will also be discussed. The cultural implications of the World Health Organization's 11th version of the International Classification of Diseases (ICD-11) as well as its connections with DSM-5 will be examined. Particular attention will be paid to the international implications of *DSM-5*, considering the history of its predecessors and their impact across the world, which create both high expectations on the part of governments, professional organizations, practitioners, patients, families and communities, and significant responsibilities for APA and its *DSM-5* Committee. Throughout the Symposium, the presenters will request systematic audience feedback through specific questions to be immediately answered on the screen by the use of electronic voting devices.

No. 22-A

**CULTURAL PERSPECTIVES ON THE CURRENT *DSM-5* WORK**

*Renato Alarcon, M.D., 200 First Street, SW, Rochester, MN 55905*

**SUMMARY:**
After a quick narrative of the *DSM-5* development process, the main areas of interest in psychiatric diagnosis, from a cultural perspective, will be presented. Emphasis will be placed on a list of relevant cultural variables, their definitions and weight on the evolvement of the clinical evaluation process. Next, a general presentation of topics of debate in different DSM-V committees, the Cultural Issues Study Group in particular, will analyze a definition of mental disorder that could include "cultural discordances" as a criterion, and critically examine texts already under consideration. An introduction to the topics of cultural formulation and "culture-bound syndromes" will contain information on history, conceptualization and definitions that will be elaborated by the other speakers. Finally, personal reflections on the mixed, almost ambiguous receptivity to cultural issues in psychiatry in general, and psychiatric diagnosis in particular, will be shared. Throughout the presentation, the audience will be asked specific questions on the themes under discussion, providing interactive feedback.

No. 22-B

**THE OUTLINE FOR CULTURAL FORMULATION: CURRENT STATUS AND DSM-V REVISION**

*Roberto Lewis-Fernández, M.D., NYSPI- Rm. 3200 (Unit 69) 1051 Riverside Dr., New York, NY 10032*

**SUMMARY:**
The phenomenology of psychiatric disorders shows both commonalities and differences across cultures. Cultural groups, for example, may describe psychopathology in more psychological or more somatic terms, or cluster syndromes in alternate ways, connecting symptoms together that other cultures do not acknowledge as related. This diversity raises several questions: What is the best way of including cultural variation in a universalistic nosology, as represented by *DSM-5*? What kind of contextual information does the clinician need in order to improve the accuracy of his/her diagnostic assessment of culturally diverse presentations? How can this process be streamlined for busy clinical practices? This talk will illustrate an approach for incorporating cultural variation and cultural context in *DSM-5* that is based on a revision of the *DSM-IV* Outline for Cultural Formulation (OCF). The OCF describes cultural factors that should be assessed during a clinical evaluation in order to help guide clinical assessment and treatment planning. These are grouped under five subheadings: (a) cultural identity, (b) cultural explanations of illness, © cultural factors related to psychosocial environment and levels of functioning, (d) cultural elements of the relationship between the individual and the clinician, and (e) overall cultural assessment. As part of the process for the preparation of *DSM-5*, the Gender and Culture Study Group prepared a literature review on published research on the OCF and conducted a secondary analysis of over 300 administrations of the OCF. We will review this material and examine how it is being used to revise the OCF, including increasing the utilization of the OCF in clinical practice. Audience feedback will be solicited on how to improve this revision process for DSM-V.

No. 22-C

**CULTURAL SYNDROMES AROUND THE WORLD AND IN *DSM-5*: WHY AND HOW SHOULD THEY BE INCLUDED?**

*Joseph Westermeyer, M.D., Ph.D., 1 Veterans Dr, Minneapolis, MN 55417*

**SUMMARY:**
The first issue related to the connections between cultures and clinical occurrences is whether the traditional name "culture-bound syndromes" should be maintained. After a brief historical review, the need to change it for a more generic "cultural syndromes"(CSs) is presented and substantiated. The second area of interest is the eventual inter-relationship between cultural syndromes throughout history and in different parts of the world and the existing conventional labels in DSM-IV TR. Different options are examined, among them the posible incorporation of CSs as full DSM V-sanctioned entities, the proposal

of additional criteria in DSM-V as a way to incite the clinician's interest in further evaluations, consultations and use of a renewed cultural glossary that can lead to the full diagnosis of an authentic cultural syndrome. The international scope of DSM-V will be undoubtedly broadened by a well organized updating of CSs in the new text. Several examples of the different alternatives will be presented, as well as an updated list of CSs about which solid clinical and anthropological research has been conducted in different parts of the world. The audience will be asked to actively participate in the discussion of alternatives and cases, as well as offering opinions and recommendations for the consideration of CSs and other cultural areas in the forthcoming DSM.

**REFERENCES:**

1.Kirmayer LJ, Rousseau C, Jarvis GE et al. The cultural context of clinical assessment. In: Tasman A, Kay J, Lieberman JA (eds.) Psychiatry, 2nd. Ed. Chichester: Wiley, 2003: 19-29.

2.Alarcón RD, Becker AE, Lewis-Fernández R et al. Issues for DSM-5: The role of culture in psychiatric diagnosis. J Nerv Ment Dis 2009; 197: 559-560

**SYMPOSIUM 23**

**RECENT CHANGES TO ACUTE PSYCHIATRIC CARE: AN INTERNATIONAL PERSPECTIVE**

*Chairperson: Julian Beezhold, M.D., Drayton High Road, Norwich, NR6 5BE United Kingdom,*
*Co-Chairperson: Abigail L. Donovan, M.D., Mass General Hospital, 55 Fruit St Yawkey Ste 6A, Boston, MA 02114*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe recent approaches and innovations in the provision of acute psychiatric care in five different countries with differing resources and health care systems; 2) Participants will understand what the key issues are that have driven changes in the way each country approaches acute psychiatric care; and 3)Participants will be able to describe the use of hard outcome measures to evaluate the impact of new acute care approaches.

**OVERALL SUMMARY:**

This session aims to provide an international perspective on recent changes in Acute Psychiatric Care. It focuses on developments in five countries, namely Italy, Romania, Turkey, United States, and United Kingdom that each has very different health care systems and resources. Yet each country shares the common experience of significant changes to the provision of Acute Psychiatric care. Presentations will both describe services in each country and also discuss factors that drive changes. Some examination of the use of hard outcome measures to evaluate service change will be made. An attempt will be made to draw out common themes, and to identify factors associated with success and with problems encountered in each country. Over the past 20 years in the US, emergency psychiatry has developed into an independent subspecialty practice within psychiatry. The emergence of emergency psychiatry as a specialized practice parallels the dramatic increase in patient volume in urgent and emergency care settings over the past decade. In 2001, there were over 2 million visits to United States emergency departments (EDs) for mental health–related chief complaints, accounting for more than 6% of all ED visits, and representing an increase in the percentage of all visits by 28% over the previous decade 1 Psychiatric emergencies encompass a range of clinical presentations and diagnoses. Crises may be understood and addressed from a variety of perspectives, including medical, psychological, interpersonal, and social. Increasing numbers of patients seek treatment at EDs for urgent conditions, routine conditions, or outpatient referrals because of lack of coverage for routine outpatient care, lack of community health care resources, or an inability to access health care. As volume and acuity continue to increase in Emergency Psychiatry, the practice is faced with a variety of new challenges and demands.

No. 23-A

**COERCIVE MEASURES IN ACUTE PSYCHIATRIC CARE: AN ITALIAN PERSPECTIVE**

*Andrea Fiorillo, M.D., Ph.D., Largo Madonna delle Grazie, Naples, 80138*

**SUMMARY:**

Coercive measures represent a common clinical problem throughoutEurope, since they are applied with heterogeneity across the different European countries. Aim: To provide a comprehensive review of past and current implementation of coercive measures in Italy. Methods: Literature review (cross-referencing in PubMed, Embase, and Index Medicus) concerning the application of coercive measures in Italy. Description of the past and current regulations as well as of the routine implementation of coercive measures in Italy has beenalso empirically summarized. Results: The Italian 1978 reform law on mental health care clearly established that medical treatment and tests are mainly voluntary. Only under special circumstances, the medical authority can order a patient involuntary admission and the physician is obliged to provide necessary tests and medical treatment. However, even if coercive measures are usually placed without patient's consent, the first objective should remain to protect patient's interest and rights, in accordance to the Italian Constitution. In Italy,there are no officially recognised protocols on coercive measures for acute inpatient care and each psychiatric ward adopts its own rules and internal norms. Conclusions: In Italy, patients with aggressive or dangerous behaviours are approached by the staff according to a "de-escalating" model, in which physical and mechanical restraint should be adopted only when any other therapeutic

options previously failed. Proposals aimed to improve the implementation of coercive measures in clinical practice will be provided.

No. 23-B

**RECENT CHANGES IN ACUTE PSYCHIATRIC CARE: A ROMANIAN PERSPECTIVE**

*Adriana Mihai, M.D., Ph.D., Muncii 46 ap 10, Targu Mures, 540474*

**SUMMARY:**
Acute psychiatric care in Romania slowly changed in the last years in concordance with new legislation, accessibility of psychiatric services and openness to community, availability of pharmacological and/or psychotherapeutic treatment. The presentation will offer an actual view of acute psychiatric care in Romania and will underline the differences with the past. The role of Mental Health Law in admission rate and type (voluntary or compulsory) will be underlined on an evaluation of last 5 years. Hospitalization length depends on complexity of diagnosis, co-morbidities, severity of disease, evolution and recommendation of medical assurance.In concordance with recommendation of EU the structure of psychiatric services changed, the large chronic hospital were closed or transformed in smaller acute psychiatric settings. The ambulatory settings were organized in connection with in-beds departments. The accessibility to psychiatric services showed increasing collaboration with general practitioner and with other specialists. Changing from a system of paternalistic type of care to a model of sharing decision making involved a changing of approaches and new skills in create a therapeutically alliance. Many international experts consider the interest of combining psychotherapy and pharmacotherapy in acute psychiatric care, availability of pharmacotherapy depends on funds and availability on psychotherapy depends on interest of medical staff and local rules.

No. 23-C

**ACUTE PSYCHIATRIC CARE IN TURKEY**

*Defne Eraslan, M.D., Maslak Acibadem Hastanesi Psikiyatri Bolumu, Istanbul, 34330*

**SUMMARY:**
The standards of acute psychiatric settings are very different across various cities and institutions in Turkey. There is a lack of crisis resolution teams that can carry out acute interventions at home or that can transfer the acutely ill patient to hospitals. On the other hand, there's a growing knowledge and interest in general emergency care practitioners about the management of psychiatric emergencies. This presentation will focus on the current situation in acute psychiatric care in Turkey, comparing it to international standards and highlighting the needs.

No. 23-D

**ACUTE PSYCHIATRIC CARE IN THE UNITED STATES**

*Abigail Donovan, M.D., Yawkey Suite 6A, 55 Fruit Street, Boston, MA 02114*

**SUMMARY:**
Over the past 20 years in the US, emergency psychiatry has developed into an independent subspecialty practice within psychiatry. The emergence of emergency psychiatry as a specialized practice parallels the dramatic increase in patient volume in urgent and emergency care settings over the past decade. In 2001, there were over 2 million visits to United States emergency departments (EDs) for mental health–related chief complaints, accounting for more than 6% of all ED visits, and representing an increase in the percentage of all visits by 28% over the previous decade.1 Psychiatric emergencies encompass a range of clinical presentations and diagnoses. Crises may be understood and addressed from a variety of perspectives, including medical, psychological, interpersonal, and social. Increasing numbers of patients seek treatment at EDs for urgent conditions, routine conditions, or outpatient referrals because of lack of coverage for routine outpatient care, lack of community health care resources, or an inability to access health care. As volume and acuity continue to increase in Emergency Psychiatry, the practice is faced with a variety of new challenges and demands.

No. 23-E

**NTRODUCTION OF A HOSPITALIST SYSTEM IN A LARGE ACUTE PSYCHIATRIC SERVICE: EVALUATING THE IMPACT**

*Julian Beezhold, M.D., Drayton High Road, Norwich, NR6 5BE*

**SUMMARY:**
This presentation aims to describe the introduction and evaluate the outcomes of the introduction of a hospitalist model of acute psychiatric care in a large non-academic hospital in Norfolk, United Kingdom.Data will be presented describing the service before and after the changes.An examination will be made of factors that were challenges, and reasons for success or obstacles to change. Hard outcome data will be presented on the impact of service change describing for example a reduction in deliberate self harm incidents of 81% and reduction in length of stay of 19 days, both per patient.

**REFERENCES:**

1.'Don't they call it Seamless care?: A Study of Acute Psychiatric Discharge Simons et al, Scottish Executive Social Research, Glasgow 2002

2.Improving the quality of care in acute psychiatric wards Sainsbury Centre for Mental Health, London 2006

**SYMPOSIUM 24**

**PREVENTION OF PTSD: RECENT ISRAELI PRACTICES**

*Chairperson: Haim Y Knobler, M.D., M.A., 16 Hazait St., Rehovot, 76349 Israel,*
*Co-Chairperson: Yoram Barak, M.D., M.H.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Demonstrate familiarity with recent programs for the prevention and the immediate treatment of acute and chronic Post-Traumatic Stress Disorders, formed in the Israeli Defense Forces and Magen David Adom (the "Israeli Red Cross"); 2) Demonstrate knowledge of primary prevention, preparing for traumatic events; 3) Demonstrate knowledge of secondary prevention, after the events; and 3) Demonstrate knowledge of tertiary prevention, following up groups at risk; and 4) Discuss the implementation of the programs at the workplace and in the community.

**OVERALL SUMMARY:**
1.The IDF PTSD prevention program for combat medical teams Yoram Barak, Yoram Ben Yehuda,M.A., Nathaniel Laor, Haim Y. Knobler Discussion: The findings reflect the importance of PTSD prevention programs for first responders, as a part of comprehensive responders' safety and health programs, preparing for future combats, disasters and other traumatic events. The program may be modified for PTSD prevention in the workplace and the community, replacing the medical team by the work-team or the community unit, and the commanders by the work-place directors and the community leaders.
2.Follow-up of an acutely traumatized reserve unit for the prevention of combat PTSDNathaniel Laor, Yoram Ben Yehuda, Yoram Barak, Leo Wolmer, Haim Y. Knobler Discussion: The findings emphasize the importance of ongoing secondary PTSD prevention programs for severely traumatized combat units. Such programs recruit the peer- support and feed on unit cohesion, especially when led by the units' commanders. A return for active combat reserve duty, such as in this platoon's case, is an explicit indicator of regained resilience by traumatized soldiers.
3.Follow-up of chronicly traumatized reserve units for prevention and treatment of combat PTSD.Haim Y. Knobler, Yoram Ben Yehuda, Yoram Barak, Leo Wolmer, Nathaniel LaorDiscussion:The findings emphasize the importance of ongoing tertiary PTSD prevention programs for severely traumatized units. Such programs can use the powers of peer-help and rebuild unit cohesion, and therefore must be led by the units' original commanders. Such interventions identify veterans with ntreated PTSD, and may prevent "anniversary" and other types of late-onset combat PTSD.
4.A model for preventing PTSD symptoms among adolescent volunteers on ambulance teams exposed to terrorismEli Jaffe, Avishy Goldberg, Einat Aviel,Moshe Z. Abramowitz, Haim Y. Knobler
Discussion:The study led to a prevention model that identified sub-populations of volunteers who are in a greater risk to develop post traumatic symptoms. Primary prevention among such sub-groups includes an emphasize on their preparedness. Secondary Prevention includes ensuring their participation in post-action debriefing, and further monitoring to identify post traumatic reactions – if and when they occur. The long-standing wars and terrorist attacks traumatizing Israelis have resulted in post traumatic mental sequelae among soldiers and civilians. During the last decade, several programs for the prevention of PTSD were developed, aimed at specific risk groups, such as "first responders" in traumatic events. Prevention of Post Traumatic Stress Disorders (PTSD) includes primary prevention (before the traumatic event), secondary prevention (immediately after the event), and tertiary prevention (prompt and effective treatment to symptomatic subjects during a long-term follow up of traumatized units). The recent understanding that combat medical teams are at a special risk of PTSD led to the development of the IDF Medical Corps PTSD prevention program. The program includes elements of primary prevention, such as: pre-induction screening; a comprehensive professional training course, including the study of combat PTSD and its treatment; drill exercises of stressful traumatic events. It includes elements of secondary prevention, such as: immediate post-event team debriefing sessions, led by the unit's commander – the medical officer, and of tertiary prevention: immediate treatment by mental health officers when symptomatic team members are identified during and after the secondary prevention stage.The heightened emphasis on PTSD prevention has already yielded two observable results: a lower rate of PTSD among IDF combat medics, and a faster detection time of PTSD symptoms among them. The findings reflect the importance of PTSD prevention programs for first responders, as a part of comprehensive responders' safety and health programs, preparing for future combats, disasters and other traumatic events. The program may be modified for PTSD prevention in the workplace and the community, replacing the medical team by the work-team or the community unit, and the commanders by the work-place directors and the community leaders.

No. 24-A
**THE IDF PTSD PREVENTION PROGRAM FOR COMBAT MEDICAL TEAMS**

*Yoram Barak, M.D., M.H.A., 15 KKL Street, Bat-Yam, 59100*

**SUMMARY:**
The long-standing wars and terrorist attacks traumatizing

Israelis have resulted in post traumatic mental sequelae among soldiers and civilians. During the last decade, several programs for the prevention of PTSD were developed, aimed at specific risk groups, such as "first responders" in traumatic events. Prevention of Post Traumatic Stress Disorders (PTSD) includes primary prevention (before the traumatic event), secondary prevention (immediately after the event), and tertiary prevention (prompt and effective treatment to symptomatic subjects during a long-term follow up of traumatized units). The recent understanding that combat medical teams are at a special risk of PTSD led to the development of the IDF Medical Corps PTSD prevention program. The program includes elements of primary prevention, such as: pre-induction screening; a comprehensive professional training course, including the study of combat PTSD and its treatment; drill exercises of stressful traumatic events. It includes elements of secondary prevention, such as: immediate post-event team debriefing sessions, led by the unit's commander – the medical officer, and of tertiary prevention: immediate treatment by mental health officers when symptomatic team members are identified during and after the secondary prevention stage.The heightened emphasis on PTSD prevention has already yielded two observable results: a lower rate of PTSD among IDF combat medics, and a faster detection time of PTSD symptoms among them. The findings reflect the importance of PTSD prevention programs for first responders, as a part of comprehensive responders' safety and health programs, preparing for future combats, disasters and other traumatic events. The program may be modified for PTSD prevention in the workplace and the community, replacing the medical team by the work-team or the community unit, and the commanders by the work-place directors and the community leaders.

No.24-B

**FOLLOW-UP OF AN ACUTELY TRAUMATIZED RESERVE UNIT FOR THE PREVENTION OF COMBAT PTSD**

*Nathaniel Laor, M.D., Ph.D., 9 Hatzvi street, Tel-Aviv, 67197*

**SUMMARY:**

Introduction An IDF reserve infantry platoon experienced a severe traumatizing event, in which many fighters were killed, including the platoon's commander. Allegations were raised that the unit was involved in committing atrocities. An "Immediate Intervention Program" was devised for the whole unit, and has been endorsed since than as a model for secondary-prevention intervention on the psycho-social and the cultural levels. Method The program included four stages: 1. Assessment of the soldiers' needs, as well as of their rate of post traumatic symptoms. 2. Planning of the meetings with the commanders and the professional team. 3. Meetings within organic units, led with the help of the commanders. 4. Evaluation and on-going follow-up. Results Most of the soldiers who participated in the meetings, and all those with post-traumatic symptoms, emphasized the importance of peer-help as the most therapeutic factor in the process. In spite of a preliminary high rate of post-traumatic symptoms, the soldiers' resilience was recovered, and the platoon reunited after a year for an active reserve duty. Discussion The findings emphasize the importance of ongoing secondary PTSD prevention programs for severely traumatized combat units. Such programs recruit the peer- support and feed on unit cohesion, especially when led by the units' commanders. A return for active combat reserve duty, such as in this platoon's case, is an explicit indicator of regained resilience by traumatized soldiers.

No. 24-C

**CHRONIC FOLLOW-UP OF TRAUMATIZED RESERVE UNITS FOR PREVENTION AND TREATMENT OF COMBAT PTSD**

*Haim Knobler, M.D., M.A., 16 Hazait St., Rehovot, 76349*

**SUMMARY:**

Haim Y. Knobler, M.D., M.A., Yoram Ben Yehuda, M.A., Yoram Barak, M.D., MHA, Leo Wolmer, M.A., Nathaniel Laor, M.D., Ph.D

Introduction IDF veterans who served in units who were engaged in severe fighting during the 1973 war, asked for professional guidance during the units' reunion meetings, commemorating their lost comrades 30 years later. Long-term - "chronic" psycho-historic interventions were prepared with these units' former commanders, tailoring the programs for the veterans' needs. An intervention with veterans of an infantry battalion who was traumatized in the 1973 war became a model for such meetings. Method The intervention included first an evaluation of the reserve soldiers' needs, focusing on one of the battalion's platoons. An intervention program for the platoon was prepared, with the veterans' original commanders including the battalion's commander. Following this program, who ended in a 2 days meeting in the unit's original battle ground, the program was extended to all the battalion's veterans from the 1973 war. Results A high rate of post-traumatic symptoms was discovered among the veterans, and some had chronic non-resolving combat PTSD. Most of the veterans emphasized the importance of peer-help as the most influential positive factor in the process. Following the professionally-led intervention, the veterans continued to meet on their own, reuniting also with families of their dead comrades. Some veterans were referred for individual psychiatric care.Discussion The findings emphasize the importance of ongoing tertiary PTSD prevention programs for severely traumatized units. Such programs can use the powers of peer-help and rebuild unit

cohesion, and therefore must be led by the units' original commanders. Such interventions identify veterans with untreated PTSD, and may prevent "anniversary" and other types of late-onset combat PTSD.

No. 24-D

**A MODEL FOR PREVENTING PTSD SYMPTOMS AMONG ADOLESCENT VOLUNTEERS ON AMBULANCE TEAMS EXPOSED TO TERRORISM**

*Eli Jaffe, Ph.D., 60 yigal alon tel aviv, tel aviv, 62261*

**SUMMARY:**

Eli Jaffe,*Avishy Goldberg., Einat Aviel,.Moshe Z. Abramowitz,., Haim Y. Knobler *Head of Instruction, Public Relations and International Relations Wing, Magen David Adom, Israel Introduction In the ambulance service of Magen David Adom (MDA), the national first aid organization in Israel, there are 16 to 18 years old young volunteers who work as assistant paramedics. Between the years 2000-2002, the ambulance teams of MDA treated thousands of victims of terrorist attacks. This study examined the factors affecting Post Traumatic symptoms among these ambulance teams, in order to develop a model for prevention of PTSD. Method
The study included 620 young volunteers (mean age: 17) from around the country who have been volunteering for about a year. They responded anonymously to the study's questionnaire, which included demographic information, motivation to volunteer, exposure variables (including exposure to terror attacks and other traumatic events), and Post Traumatic and other psychiatric symptoms. Results None of the volunteers had a clinically significant psychiatric disorder, including PTSD. More vulnerability to post traumatic symptoms was found among non-religious female volunteers, volunteers who's motivation was defensive (self-centered), those from regions with low level of terrorist attacks, and those who witnessed dead bodies during such attacks.Discussion
The study led to a prevention model that identified sub-populations of volunteers who are in a greater risk to develop post traumatic symptoms. Primary prevention among such sub-groups will include an emphasize on their preparedness. Secondary Prevention will include ensuring their participation in post-action debriefing, and further monitoring to identify post traumatic reactions – if and when they occur.

**SYMPOSIUM 25**

**PSYCHIATRY ACROSS BORDERS: WORKING FOR THE U.S. GOVERNMENT IN THE DEPARTMENT OF STATE AS A PSYCHIATRIST**

*Chairperson: Herbert L Campbell, M.D., M.P.H., 9000 New Delhi Place, Dulles, VA 20189-9000*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Know the role of a regional psychiatrist; 2) Realize how a psychiatrist can be an essential tool in traumatic situations; 3) Understand the process of evacuating a mentally ill patient from overseas to the US to receive care and; 4) Be affirmed that psychiatrists are a good communication tool to promote healthy communities.

**OVERALL SUMMARY:**

The U.S. Government in the Department of State has fourteen psychiatrists working overseas tending to the mental health needs of our U.S. embassy and consulate communities. The role of these regional psychiatrists is clarified in the introduction. Then four case vignettes are presented. The first and second are given as one set since they both demonstrate the psychiatrist's perspective of working in a war zone. The third exemplifies through a case study the two components of caring for a patient being evacuated from overseas to receive care in the United States. The last affirms the listener's belief that there is a primary role in psychiatry to heal a community after a traumatic event. Overall these presentations show how psychiatry has expanded from the armchair to be a modern tool of communication to promote health throughout the world.

No. 25-A

**MANAGING A WORLD OF TROUBLE: PSYCHIATRISTS AT THE STATE DEPARTMENT 1978-2008**

*Samuel Thielman, M.A., Ph.D., American Embassy, 24 Grosvenor Sq, London, W1A 1AE*

**SUMMARY:**

In 1979, Elmore Rigamer, a former Peace Corps volunteer, happened to be working as a psychiatrist at the American Embassy in Kabul when the U.S ambassador, Spike Dubs (1920-1979), was assassinated. Rigamer spent large amounts of time with members of the embassy community helping to heal the wounds of the trauma. In the years following this incident, the Department of State expanded the psychiatry program from one psychiatrist working at one embassy, to a group of overseas psychiatrists responsible for covering the entire U.S. Foreign Service. This network of psychiatrists arrange for the care of the U.S. embassy personnel in a wide array of health care delivery systems under a range of unusual cultural and economic environments. This paper outlines the forces that led to the development of the regional psychiatrist program, and the political and clinical factors that have shaped the program during three decades.

No. 25-B

**MENTAL HEALTH RESPONSE TO A TERRORIST ATTACK, SANA'A, YEMEN**

*Joseph Rawlings, M.D., M.B.A., Unit 6050 Box 48, DPO, 09892-0048*

**SUMMARY:**
The U.S. Embassy in Sana'a, Yemen was the site of a terrorist attack with multiple deaths in September, 2008. The Embassy had been targeted in attacks earlier in the year as well. This session will review the implementation of lessons learned from earlier attacks, the initial response to this incident, and the monitoring of Embassy employees after the event.

No. 25-C
**PSYCHIATRY ACROSS BORDERS: WORKING FOR THE US GOVERNMENT IN THE DEPARTMENT OF STATE AS A PSYCHAITRIST**

*Paul Beighley, M.D., Unit 64900 Box 19, APO, NY 09839*

**SUMMARY:**
In July 2008 the U.S. Consulate in Istanbul was attacked by a group of four terrorists. During my portion of the symposium I will discuss how the psychosocial impact on the community and how the Department of State responded to provide mental health support to those affected.

No. 25-D
**MANAGING A PSYCHIATRIC MEDICAL EVACUATION FROM OVERSEAS**

*Kenneth Dekleva, M.D., 9900 Vienna Place, Dulles, VA 20189-9900*

**SUMMARY:**
Despite providing medical and mental health support to US diplomats and their families overseas, there are times when the patient's condition requires immediate and extensive evaluation and treatment resources that are best provided in the United States. Once that decision is reached by the Regional Psychiatrist and the supporting post's health unit, a medical evacuation can be utilized to deliver optimal care to the patient and family. A signficant amount of medical and logistical expertise is required to:
1.Develop rapport with the patient and family
2.Determine aeromedical travel and safety requirements
3.Identify knowledgeable providers that can accept a patient urgently
4.Coordinate treatment scheduling
5.Assure thorough evaluation
6.Assess follow on treatment requirements
7.Decide (with the regional psychiatrist) the ability for the patient and family to return to post.
This part of the symposium will discuss the challenges of implementing a successful psychiatric medical evacuation to the US from an overseas diplomatic posting.

No. 25-E
**MANAGING A PSYCHIATRIC MEDICAL EVACUATION FROM OVERSEAS**

*Christopher Flynn, M.D., 2401 'E' Street, NW/L223, Washington, DC 20522*

**SUMMARY:**
Despite providing medical and mental health support to officers and families overseas, there are times when the patient's condition requires immediate and extensive evaluation and treatment resources that are best provided in the United States. Once that decision is reached by the Regional Psychiatrist and the supporting post's health unit, a medical evacuation can be utilized to deliver that care to the patient and family. Although from an 'overview' position, it would seem simple to implement this program, in execution—a signficant amount of work is required to:
1. Develop rapport with the patient and family
2. Determine travel safety requirements
3. Identify knowledgeable providers that can accept a patient urgently
4. Coordinate treatment scheduling
5. Assure thorough evaluation
6. Assess follow on treatment requirements
7. Decide (with the regional psychiatrist) the ability for the patient and family to return to post.

This part of the symposium will provide time for a Regional Psychiatrist and Washington (coordinating psychiatrist) to discuss the challenges of making this program work, successfully.

**SYMPOSIUM 26**

**TRANSCULTURAL PSYCHIATRY FOR MENTAL HEALTH IN A CHANGING WORLD**

*Chairperson: Richard L Merkel, M.D., Ph.D., HSC Box 800623, Charlottesville, VA 22908*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1)Outline the importance of transcultural psychiatry to the field of mental health; 2)Identify three contributions of transcultural psychiatry; 3) Understand the role of culture in the etiology and course of Schizophrenia; 4)Identify the key issues in working with refugee populations in relation to trauma and torture survival; and 5)Understand the role of culture in shaping suicidal behaviors;

**OVERALL SUMMARY:**
Mental health concerns are primary causes of disability throughout the world due to massive population

shifts, economic globalization, cultural conflict, and geopolitical strife. Mental illnesses are the result of both biological vulnerabilities and interpersonal stress within a sociocultural context that gives meaning to this process. Transcultural psychiatry research questions many of the basic assumptions of western psychiatry. The study of mental health concerns in non-Western societies provides an avenue for the deeper understanding of the role of culture and society in psychiatric conditions. Consequently, there has been a world-wide effort to develop models of mental health care that may be applied in diverse settings. Schizophrenia and the Psychoses will examine recent evidence which demonstrates cultural variation in rates and prognosis of schizophrenia. This will be related to neurophysiological theories of schizophrenia. Suicide and Parasuicide Behavior will examine how cross-cultural studies of self-destructive behavior demonstrate that assumptions about suicide based on western examples are not universal. An anthropological perspective on suicide demonstrates that suicidal behaviors are culturally scripted responses to interpersonal conflicts. PTSD in Refugees and Torture Survivors will examine cultural variation in definitions, frequency and consequences of trauma. Concerns for the medicalization of human suffering and minimization of political and ethical responsibility, call for the development of treatment initiatives that build on the neurobiological understanding of the consequences of trauma while not ignoring the human and moral consequences. Integrating Traditional and Western Mental Health Care will summarize and give illustrative examples of successful efforts in integration. Both in the US and abroad culturally sensitive treatment methods combine western psychiatric and local care models.

No. 26-A

**CULTURAL PSYCHIATRY ISSUES IN SCHIZOPHRENIA**

*Robert Kohn, M.D., Miriam Hospital, 164 Summit Avenue, Fain Building Suite 2B, Providence, RI 02906*

**SUMMARY:**

Schizophrenia has a special place in cultural psychiatry, as it was the first psychiatric condition studied across cultures under the auspices of the World Health Organization. Kraeplin in 1903 conducted one of the first cross cultural comparisons in schizophrenia between Javaese and Europeans, concluding that dementia praecox in the Javanese was essentially clinically similar as that seen among Europeans except for modifications due to racial characteristics, religion and customs. No ethnic or racial group has been found to be free of schizophrenia, and the overall clinical presentation has been found to be remarkably similar in their positive and negative symptoms across cultures. However, acute and catatonic subtypes may appear to be more common in traditional rural communities. There area a number of areas that will be highlighted where culture appears to play an important factor. One, of the best studied areas is immigration and mental health. There is strong evidence internationally to support the finding of higher rates of schizophrenia among immigrants. The issue of risk of schizophrenia and second-generation immigrants is controversial. Two, stigma, social distance, and the understanding of the cause of illness is highly variable cross-culturally. For example, a recent study suggests that traditional communities with little contact with Western mental health concepts may have less stigma for schizophrenia and have increased stigma for depression. Third, the course of illness has been shown to have a better outcome in developing compared to developed countries.

No. 26-B

**CULTURAL CONTEXTS OF PATIENT AND FAMILY EXPLANATIONS OF SUICIDAL BEHAVIOR**

*Mitchell Weiss, M.D., Ph.D., Ochsengasse 14, Allschwil, CH4123*

**SUMMARY:**

Explaining and preventing suicide and deliberate self-harm (DSH) are priorities in psychiatric practice and planning for the mental health of populations. Sociological and mental health studies of suicidal behavior typically focus on sociodemographic patterns and psychopathology, especially high-risk psychiatric disorders, such as depression and schizophrenia. Although ways of explaining suicidal behavior may vary across cultures and within cultures from clinicians' and patients' vantage points, literature based on experience in Europe and North America asserts that 90% of all suicides results from such pre-existing psychiatric disorders. As an alternative to sociological and psychiatric explanations, patients' accounts, explanations in the popular press, and literary and cinematic productions may emphasize underlying problems, life circumstances, social stressors, and triggers of suicidal behavior that require consideration for community mental health programs to prevent suicide and for culturally sensitive clinical practice. A cultural epidemiological approach to study of suicide recognizes the impact of not only psychiatric disorders but also more locally conceived social, emotional, and mental health problems with potentially fatal consequences. Research in India and Switzerland demonstrates a distinctive respective emphasis on social and psychiatric determinants. Findings from study of patients surviving deliberate self-harm and family survivors of people who died by suicide are relevant not only for preventing suicide but also for recognizing social and cultural features of suicidal behavior. Broader implications beyond suicide prevention are also applicable for effective community mental health planning and psychiatric practice.

No. 26-C

**TRANSCULTURAL PSYCHIATRY**

*John David Kinzie, M.D., 3181 SW Sam Jackson Park Rd - UHN80, Portland, OR 97239*

**SUMMARY:**

Civil war, ethnic cleansing, political violence, and even clan and religious wars have caused huge problems, with deaths, starvation, dislocation, untreated disease, and psychiatric and medical illnesses. Psychiatrists have an obligation to treat the psychiatric and social disruptions, especially among refugees. What is needed is a commitment to develop programs for reconciliation and even prevention of further conflicts. The understandings and manifestations of the impact of violence vary among cultures. Therefore, it is important that treatment be sensitive to cultural issues and builds on traditional cultural resources. My presentation will present information on psychiatric disorders among refugees, their personal reactions to the evil encountered, and an appeal to non-violence approaches to conflicts.

No. 26-D

**INTEGRATING TRADITIONAL AND WESTERN MENTAL HEALTH CARE**

*Richard Merkel, M.D., Ph.D., HSC Box 800623, Charlottesville, VA 22908*

**SUMMARY:**

Integrating Traditional and Western Mental Health Care will summarize and give illustrative examples of successful efforts in integration. Both in the US and abroad, there is an increasing need to combine these treatment approaches so as to make psychiatric care acceptable and understandable to various populations, who traditionally would not accept western psychiatric treatment. In the US there are large disparities in the psychiatric care of most minority populations and one effort to over come these gaps involves the development of culturally competent psychiatric care. In order to further these efforts and to detail the contributions of cultural psychiatry in this area, culturally sensitive treatment methods combining western psychiatric and local care models will be examined. Empirical research as to the effectiveness of these programs will be reviewed. I will review Culturally Adapted Therapies, which is an effort to make evidenced-based therapy amenable to minorities in the US, as well as examples of non-Western therapies that have been incorporated into western treatment, such as acupuncture. Efforts to combine traditional ritual treatment with standard psychiatric care, for example with American Indians, will be outlined. Furthermore, efforts to develop culturally specific treatment services or treatment teams will be described. Much of the research in this area is descriptive in nature; therefore, the strengths and weaknesses of this area of research will be reported. Certain broad lessons for developing successful integrated programs will be presented. Future directions, from both clinical and research perspectives will be highlighted.

**SYMPOSIUM 27**

**NON-PSYCHOTIC ISSUES OF SCHIZOPHRENIC PATIENTS**

*Chairperson:* S. *Charles Schulz, M.D., 2450 Riverside Avenue F282/2A West, Minneapolis, MN 55454*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize the importance of cognition, cigarette smoking, substance abuse and suicide in the life of a schizophrenic person; and 2) be aware of new interventions for these important problems.

**OVERALL SUMMARY:**

Non-Psychotic Issues of Schizophrenic Patients

Schizophrenia is a severe psychotic psychiatric illness. The reduction of hallucinations, delusions, and thought disorder by antipsychotic medications has been a substantial help to many people with the illness, but may have overshadowed a number of problems the schizophrenic patient faces. Many of the issues have a major effect on functional outcome, morbidity and even mortality. It is the purpose of this symposium to focus on these problems and to provide an update on current interventions. The role of cognition in social and functional outcome is now well known. Dr. Raquel Gur will present data on research on the underpinning of cognition and approaches to improving cognitive function. This presentation will be followed by a review of research on smoking in schizophrenia (Dr. Hossein Fatemi). Despite a reduction of smoking in the general population, the rates and amounts of smoking in schizophrenia remain high, thus it is important for psychiatrists to understand new approaches. Similarly, substance abuse is common and can be debilitating in schizophrenia. Dr. Alan Green, a leader in this field, will provide and update of physiology and treatment in this area. To conclude the symposium, Dr. Schulz will present an update to the understanding of suicide in schizophrenia. Although the rate of suicide is high in schizophrenia, research on signs and treatment have not been forthcoming. New understanding and approaches are emerging and may lead to useful interventions.

No. 27-A

**COGNITIVE REHABILITATION OF SCHIZOPHRENIA: TREATMENT AND RESEARCH**

*Raquel Gur, M.D., Ph.D., 3400 Spruce, Philadelphia, PA 19104*

**SUMMARY:**

The well-established cognitive deficits in schizophrenia and their impact on functioning have led to an effort to apply remediation methods. Several systematic strategies have

been applied most deriving from methods developed for rehabilitation from acute brain injury. The presentation will outline the main approached and the attempt to summarize available data on their relative efficacy. Methodological limitations and challenges will be highlighted. The advent of computerized approaches has broadened the capabilities of rehabilitative methods and can yield novel interventions with inherent capacity to document progress. The future is encouraging also from the standpoint that increased understanding of the neurobiological basis of schizophrenia can help guide further refinements and multimodal approaches that focus on impaired brain systems through combined pharmacologic and rehabilitation approaches.

No. 27-B

**SMOKING AND SCHIZOPHRENIA: EFFICACY OF NEW TREATMENTS**

*S. Hossein Fatemi, M.D., Ph.D., MMC 392 Mayo, 420 Delaware, Minneapolis, MN 55455*

**SUMMARY:**

Objective: There is a strong association between smoking and schizophrenia with prevalence rates ranging from 74% to 90%, versus a national average of 30% in nonschizophrenic individuals. A number of hypotheses have been proposed to explain the relationship between high smoking rates and schizophrenia, mostly relating to self-medication primarily for the negative symptoms of schizophrenia. The negative health effects of smoking increase the morbidity and mortality in schizophrenic patients. Available treatments for smoking cessation have had mixed results in this population. Method: A literature search was conducted examining the efficacy and safety of current smoking cessation treatments for schizophrenics. Results: Studies with nicotine patches have yielded a quit rate only half that of healthy subjects. The smoking cessation agent bupropion HCl has been tested in schizophrenics and appears to be safe, but the results on its efficacy are inconclusive. Varenicline, a partial a4ß2 and full a7 nicotinic acetylcholine receptor agonist, is a newer smoking cessation agent. Varenicline has proven efficacy in healthy, non-psychiatric subjects and is more effective than bupropion HCl. A series of case reports have suggested that varenicline may exacerbate neuropsychiatric symptoms including changes in behavior, agitation, depressed mood, suicidal ideation, and attempted and completed suicide, in subjects with bipolar disorder or schizophrenia, leading to an FDA warning and a black box warning. However, a large study of the efficacy and safety of varenicline in subjects with mental illness found that varenicline successfully reduced smoking and led to no exacerbation of symptoms. Conclusion: Further study of varenicline in schizophrenics is needed as it may offer a new treatment for smoking cessation in this vulnerable population. Grant support by National Institutes of Health (1R01DA024674-01A1) is appreciated.

No. 27-C

**SCHIZOPHRENIA AND SUBSTANCE ABUSE**

*Alan I. Green, M.D., One Medical Center Drive, Lebanon, NH 03756*

**SUMMARY:**

Substance use disorders are common in patients with schizophrenia and are associated with poor outcomes. Cannabis use disorder occurs in up to 50% of first episode patients; alcohol use disorder is the most common substance use disorder in patients beyond the first episode. The basis of such co-occurring substance use disorders in patients with schizophrenia is unclear. While self-medication hypotheses have been proposed, a number of studies have been unable to confirm that self-medication of psychiatric symptoms is causally related to use of substances in these patients. We and others have suggested that a dysregulation of the mesocorticolimbic brain reward circuitry may underlie substance use disorders in schizophrenia. Research has suggested that treatment of co-occurring substance use disorders should be undertaken in an integrated fashion, where treatment of both disorders can be implemented by one clinical team. Evidence-based psychosocial interventions include stage-based motivational interviewing, group therapy and cognitive behavioral therapy; in addition, contingency management approaches appear quite promising. The evidence-base for pharmacologic strategies is evolving. While typical antipsychotics do not appear to lessen substance use in patients with schizophrenia, emerging data suggest that some of the atypical antipsychotics, particularly clozapine, do so. In addition, naltrexone and disulfiram have been shown in preliminary studies to limit alcohol abuse in patients with schizophrenia. This presentation will review the characteristics of substance use disorders in patients with schizophrenia, as well as the evidence base regarding treatment of these co-occurring disorders. It will also describe on-going research in animals that is attempting to elucidate the actions of clozapine responsible for its apparent ability to limit substance use in these patients.

No. 27-D

**APPROACHES TO SUICIDE IN SCHIZOPHRENIA**

*Lawrence Adler, M.D., 2450 Riverside Avenue, Minneapolis, MN 55454*

**SUMMARY:**

One percent of the population across the globe suffers from schizophrenia. Over their lifetime, ten percent of these patients will die by suicide. Almost three times as many make single or multiple suicide attempts. There are multiple risk factors that affect the risk of suicide in schizophrenic patients. Furthermore, approaches to suicide reduction or reducing long term suicide risk is not likely to be accomplished by one single approach. For

example, younger age of onset increases risk of suicide. Specific pharmacologic treatments may reduce the risk of suicide. Social supports and frequency of contact with a clinician, particularly after a hospitalization, may reduce risk. Cognitive deficits affect not only social support, but ability to work, to follow treatment plans and to feel part of a community. Specific endophenotypes may also affect the risk of suicide. Thus, it is unlikely that one specific approach will reduce suicide risk in patients, but there is much the individual clinician can use to assess suicide risk and to reduce risk in treating individual patients. This presentation will review basic risk factors, recent studies, and implications for reducing suicide risk in schizophrenic patients.

**REFERENCES:**

1. Green, M.F. (1996). What are functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry, 153, 321-330.

**SYMPOSIUM 28**

**DOPING IN ATHLETES--THE ROLE OF THE SPORT PSYCHIATRIST**

*The International Society for Sport Psychiatry*

*Chairperson: Antonia L Baum, M.D., 5522 Warwick Place, Chevy Chase, MD 20815*
*Discussant: Richard Hilderbrand, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Iidentify the areas in which a sport psychiatrist plays a role in doping in athletes; 2) They will learn about the therapeutic use exemption process (TUE's) from both the clinician's and athlete's perspective; and 3) The participant will also understand doping control from a sport psychiatric perspective, and the ethical considerations in performance enhancement.

**OVERALL SUMMARY:**

Doping in sports has become an emotionally charged topic with medical, psychiatric, and psychological relevance. We will explore and discuss the ethical considerations in an athlete's choice to engage in performance enhancement, attempting to define what constitutes performance enhancement. There is an enormous range of tools at the athlete's disposal which can affect performance; some are merely discriminatory, in that they are not available to all, and others are frankly dangerous. Who is responsible for policing this? Sport psychiatry is at the cutting edge of the therapeutic use exemption process, in large part because of the occurrence of ADD/ADHD in athletes, often governed by sporting bodies in which psychostimulants are banned substances. We will examine this process from both the clinician's and from the athlete's perspective. Sport psychiatrists have also been involved in the brass tacks of doping control, and this procedure will be delineated. We will have sport psychiatrist and athletes present in each of these areas.

No. 28-A

**THE ETHICS IN DOPING CONTROL**

*Eric Morse, M.D., 8300 Health Park, Suite 201, Raleigh, NC 27615*

**SUMMARY:**

The professional boundaries and ethics involved in helping athletes maintain their health and best performing abilities in Sports Medicine and Sport Psychiatry must be examined and followed. Many pressures from the athletes, teams, coaches, front offices, colleagues, trainers, and leagues need to be balanced. The individual practioner should search his or her own desire to assist athletes, build one's reputation, countertransference, and internal/external motivations in the Sportsworld. Sport psychiatrists may be influenced by the "team-first" and "us against them" mentality in sports to alter one's professional boundaries. Sport psychiatrist may have to deal with requests for prescribing performing-enhancing drugs or ways to treat their side effects from athletes, coaches, trainers, etc. They may also ask for information regarding avoiding drug testing, urine half-lives, masking agents and other doping control issues. WADA and the ISSP policy statements will be reviewed.

No. 28-B

**HELPING THE ATHLETE THROUGH THE THERAPEUTIC USE EXEMPTION PROCESS**

*David Conant-Norville, M.D., 15050 SW Koll Parkway Suite 2A, Beaverton, OR 97006*

SUMMARY:

With the development of anti-doping rules and procedures in organized sport, many important critical pharmaceutical agents have been listed on the banned substance list. In order to make certain that physically and mentally ill athletes have access to efffective and safe treatments that can bring them back to an improved level of health, a special Therapeutic Use Exemption (TUE) has been developed to permit banned substances use by athletics when other acceptable treatments are not available. Psychiatrists who treat athletes with banned substances, such as psychostimulants for ADHD treatment, must be aware of these rules in order to help their athlete-patients continue necessary treatments while participating in competitive athletics in which doping controls are in place. This section of the symposium will educate psychiatrists about the history of the TUE, especially related to psychostimulant usr for ADHD treatment. David Conant-Norville M.D., psychiatric consultant to the United States Anti-Doping

Agency (USADA) and PGA Tour anti-doping program, will introduce the topic with a clinical case of what can go wrong when the athlete and physician are uninformed about the anti-doping rules in sport. Richard Hilderbrand PhD, former Science Director of the USADA and manager of the USADA TUE program, will describe the workings and mechanics of the USADA Anti-doping effort, including the process, rules and possible sanctions for doping violations. Then Drs Conant-Norville and Hilderbrand will discuss how psychiatrists can help athletes submit an optimal TUE request packet to an anti-doping agency. Specific examples will be be used as illustrations to help treating psychiatrists understand how important their evaluation and treatment documentation is in order to secure a TUE for a needy athlete.

No. 28-C

**DOPING CONTROL IN ELITE ATHLETICS**

*Saul Marks, M.D., North York General Hospital, Toronto, M2K1E1*

**SUMMARY:**

Accounts of Doping in Sport have been present since antiquity, with a modern resurgence in the late 1800's. Attempts at anti-doping began from 1920-1979, especially regarding the stimulants. The death of Danish Cyclist Knut Jensen at the 1960 Summer Olympics in Rome, deaths of athletes in the Tour de France over the years and the East German Woman's Swimming Team at the 1976 Summer Olympics in Montreal, has brought much controversy to Elite Athletics. This presentation will highlight the approach to Doping Control at the present time. The objective will be for attendees to gain an understanding of the World Anti-Doping Agency (WADA), the International Standards for testing in Doping Control as well as the latest Prohibited Substance List. The presentation will include a description of how the WADA conducts doping control testing, both in and out of competitive situations, to ensure "clean" testing of athletes at all times during the year. There will also be a discussion of "Therapeutic Use Exemption" forms, which allow athletes with a legitimate medical illness to use prescribed medications on the prohibited substance list, thus creating a "level playing field". The result is a system which is always working with the goal of having current tests that can detect any new "substance", "method" or "genetic" means of doping. This presentation will be an overview of modern day Doping Control. With the continued efforts of WADA, the collaboration of International and National Sport Governing Body Federations and educated medical personnel involved with elite athletes, one will see the continued success of Doping Control in athletes on the World Stage.

**REFERENCES:**

1. Hendrickson, TP and Burton, R, Athlete's Use of Performance Enhancing Drugs, pp 142-158: in Sport Psychiatry, Theory and Practice, eds Begel, D and Burton, R, WW Norton & Co., NY, 2000.

**SYMPOSIUM 29**

**EXECUTIVE FUNCTION AS A BRAIN SYSTEM FOR SELF-CONTROL: THE NEUROCIRCUITRY OF PSYCHIATRIC DISORDERS AND ADDICTION**

*The U.S. National Institute on Drug Abuse*

*Chairperson: Mary A Kautz, Ph.D., 6001 Executive Blvd, Suite 3155, Bethesda, MD 20892-9593*
Co-*Chairperson: Minda R Lynch, Ph.D.*
*Discussant: Trevor W Robbins, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Understand that similar neural circuits, involving cortical modulation of cognitive and emotional functions, may be disrupted across multiple psychiatric illnesses and addiction; and 2) Disruptions in these general domains, and the changes seen over human development, should be considered in treatment approaches for these, and co-morbid disorders.

**OVERALL SUMMARY:**

Cortico-subcortical neurocircutry provides important substrates for cognitive functions, emotional processes and the regulation of goal-oriented behavior. Several circuits have been investigated, with links made to individual differences in self-regulation, emotional control, empathy, social perception, and disruptions of these processes seen in neuropsychiatric disorders. The balance of cortico-subcortical behavioral control shifts over development and has been linked with a dichotomy between rational/reasoned behavioral control versus more automated, implicit processes. Frontal modulation is important for flexible, adaptive behavior and disturbances of top-down regulation have been associated with cognitive and emotional impairments in Huntington's and Parkinson's diseases, schizophrenia, ADHD and drug addiction. Presenters in this symposium will discuss executive functions regulated by the frontal portion of this circuit, in relation to psychopathology, emotional regulation, changes over development, and implications for treatment. Additional discussion will include measurement approaches to assess subtle cognitive functions linked to this frontal region, monoaminergic circuitry involved in flexible behavior, and animal behavioral approaches to understanding behavioral regulation.

No. 29-A

**PREFRONTAL CIRCUITS FOR RULES, CONCEPTS, AND COGNITIVE CONTROL.**

*Earl Miller, Ph.D., 77 Massachusetts Ave, Cambridge, MA*

*02139*

**SUMMARY:**
What controls your thoughts? How do you focus attention? How do you know how to act while dining in a restaurant? This is cognitive control, the ability to organize thought and action and direct them toward goals. Results from our laboratory have shown how cognitive control may arise from rhythmic interactions between neurons in the prefrontal cortex (the brain area that is most highly developed in the primate brain) and related brain areas. These neurons are involved in directing attention, in recalling stored memories, and predicting reward value, and they synthesize the diverse information needed for a given goal. Perhaps most importantly, they transmit acquired knowledge. Neurons in the prefrontal cortex reflect learned task contingencies, concepts and rules. I will present results and discuss ideas about how dopamine-guided interactions between prefrontal cortex and basal ganglia underlie our ability to learn the "rules of the game" needed for goal-directed behavior.

No. 29-B
**BASIC NEUROBIOLOGY OF SELF-CONTROL IN DECISION-MAKING**

*Todd Hare, M.D., 1200 E. California Blvd., MC 228-77, Pasadena, CA 91125*

**SUMMARY:**
Every day, individuals make dozens of choices between an alternative with higher overall value and a more tempting but ultimately inferior option. Optimal decision-making requires self-control. We propose two hypotheses about the neurobiology of self-control: (i) Goal-directed decisions have their basis in a common value signal encoded in ventromedial prefrontal cortex (vmPFC), and (ii) exercising self-control involves the modulation of this value signal by dorsolateral prefrontal cortex (DLPFC). We used functional magnetic resonance imaging to monitor brain activity while dieters engaged in real decisions about food consumption. Activity in vmPFC was correlated with goal values regardless of the amount of self-control. It incorporated both taste and health in self-controllers but only taste in non–self-controllers. Activity in DLPFC increased when subjects exercised self-control and correlated with activity in vmPFC. The implications of this findings for addiction and other psychiatric diseases are also discussed.

No. 29-C
**KEY CIRCUITS AND REGIONS IMPLICATED IN EXECUTIVE DYSFUNCTION AND DISRUPTIONS OF COGNITIVE CONTROL IN SCHIZOPHRENIA: GENETIC INFLUENCES AND DOPAMINE REGULATION**

*Karen Faith Berman, M.D., 9000 Rockville Pike Bldg 10, Rm 4C101, Bethesda, MD 20892-1365*

**SUMMARY:**
The precise synaptic interconnections between prefrontal cortex (PFC) and subcortical dopamine (DA) neurons form the neurobiological basis of motivated behavior, working memory, and reward-related learning, and contribute to the pathogenesis of schizophrenia. Using multitracer PET, we directly tested this regulatory system in schizophrenia and examined the effect of a common, functional polymorphism in the catechol-O-methyl transferase (COMT) gene on the PFC-midbrain circuit. To test the hypothesis that DA neurotransmission and PFC function (both known to be abnormal in schizophrenia) are related, we measured both presynaptic DA function with fluorine-18 fluorodopa and, with oxygen-15 water, regional cerebral blood flow during the Wisconsin Card Sorting Test (WCST) in unmedicated schizophrenic subjects. We demonstrated that striatal DA synthesis was significantly elevated and WCST-related activation in PFC was less in patients, and the two parameters were strongly linked in patients, but not controls. The tight within-patient coupling of these values, with decreased PFC activation predicting exaggerated striatal fluorodopa uptake, supports the hypothesis that PFC dysfunction may lead to abnormal DA transmission. Next, again using multitracer PET, this time in healthy controls, we demonstrated that a common valine(108/158)methionine substitution in the gene coding for COMT, an important enzyme regulating prefrontal DA turnover, affects midbrain DA synthesis. Individuals carrying the valine allele, which is associated with inefficient PFC function and with schizophrenia, had increased DA synthesis in midbrain compared to individuals with methionine alleles; moreover, this genetic variation qualitatively affected the direction of the correlation between midbrain and PFC. Taken together, these data implicate a dopaminergic tuning mechanism in prefrontal cortex and suggest a systems-level mechanism for cognitive and neuropsychiatric associations with COMT.

No. 29-D
**CORE COGNITIVE SYSTEMS FOR CONTROLLING CRAVING AND NEGATIVE EMOTION IN SUBSTANCE ABUSE AND PSYCHIATRIC DISORDERS**

*Kevin Ochsner, Ph.D., 1190 Amsterdam Avenue, New York, NY 10027*

**SUMMARY:**
A common hypothesis is that both substance abusers and psychiatric patients suffer from failures to effectively regulate affective impulses. For substance abusers, these impulses often take the form of appetitive cravings triggered by environmental cues that in turn promote substance use.

For psychiatric patients, these impulses may be triggered by disorder-specific cues that trigger maladaptive and context inappropriate responses such as anxiety, fear and affective instability. In this talk I will review recent evidence from functional imaging that examines the ability of smokers and patients with borderline personality disorder (BPD) to regulate troublesome affective responses. This work is informed by studies of the cognitive control of emotion in healthy adults that show effective regulation depends upon the use of prefrontal and cingulate control systems to modulate affective responses generated by subcortical systems, like the amygdala. Here we will show 1) that smokers are able to down-regulate cravings for cigarettes, engaging prefrontal regions that down-regulate activity in the ventral striatum and other reward-related systems and 2) that BPD patients fail to effectively down-regulate amygdala activity in response to aversive social stimuli, in part because they fail to recruit specific control systems. These data converge with similar findings from other laboratories to suggest that dysfunctional prefrontal-subcortical dynamics may lie at the heart of dysfunctional emotional responses. These dynamics could be used as models for understanding mechanisms of dysfunction, markers of abnormal affective response and regulation ability, and targets for treatment.

**SYMPOSIUM 30**

**ADDICTION RESEARCH, PREVENTION AND TREATMENT IN THE U.S. AND FRANCE: VIVE LA DIFFERENCE!**

*Chairperson: John A Talbott, M.D., 110 S Paca St 4th Floor, Baltimore, MD 21201,*
Co-*Chairperson: Francois C Petitjean, M.D.*
*Discussant: Alexandra B. McLean, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand contemporary prevention, research and treatment of addiction disorders in the United States and France.

**OVERALL SUMMARY:**
The French Psychiatric Association and American Psychiatric Association have held joint symposia at the Annual meeting of the APA for over a decade on the subject of differences in approaches to psychiatric issues. This year's symposium is entitled "Addiction Research, Prevention & Treatment in the US and France: Vive la difference!"Dr John A Talbott (US) will chair the symposium and introduce the session. Dr Francois Petitjean (FR) will co-chair the session and lead the discussion.
Dr Nora Volkow (US), Director of the National Institute on Drug Abuse will begin by summarizing the achievements, agenda and new developments regarding addictive disorders from the standpoint of the NIDA She will be followed by Dr. M.A.Crocq (FR) who will present his work on addiction in a student population.
Then Dr Joshua Sharfstein (US), Deputy Commissioner of the US Food and Drug Administration will discuss the implications of Congress giving the FDA control over tobacco products and Dr Renaud de Beaurepaire (FR) will discuss smoking among persons suffering from schizophrenia.Finally, Dr David Oslin (S) of the University of Pennsylvania will summarize the state of treatment of addictive disorders in the United States and Dr Benyamina will present "Organization and health care networks for cannabis treatment in France. The prepared discussant will be Dr Alexandra MacLean, also from the University of Pennsylvania in Philadelphia, a psychiatrist trained in both France and the US, who will discuss bridging the cross-cultural differences. There will be ample time for questions and answers.John A Talbott MD Chair (USA) Francois Petitjean MD Co-chair (France)

No. 30-A
**PROGRESS IN ADDICTION RESEARCH**

*Nora Volkow, M.D., 6001 Executive Blvd. Rm 5274, MSC 9581, Bethesda, MD 20892*

**SUMMARY:**
Addiction is a disorder that involves complex interactions between genes, development and the social environment. Studies employing neuroimaging technology paired with behavioral measurement have led to extraordinary progress in elucidating many of the neurochemical and functional changes that occur in the brains of addicted subjects. Although large and rapid increases in dopamine have been linked with the rewarding properties of drugs, the addicted state, in striking contrast, is marked by significant decreases in brain dopamine function. Such decreases are associated with dysfunction of prefrontal regions including orbitofrontal cortex, cingulate gyrus and dorsolateral prefrontal cortex. In addiction, disturbances in salience attribution result in enhanced value given to drugs and drug-related stimuli at the expense of other reinforcers. Dysfunction in inhibitory control systems, by decreasing the addict's ability to refrain from seeking and consuming drugs, ultimately results in the compulsive drug intake that characterizes the disease. Discovery of such disruptions in the fine balance that normally exists between brain circuits underling reward, motivation, memory and cognitive control have important implications for designing multi-pronged therapies for treating addictive disorders.

No. 30-B
**PATTERNS OF ADDICTION IN HIGH SCHOOL AND UNIVERSITY STUDENTS**

*Marc-Antoine Crocq, M.D., Centre Hospitalier, BP29, Rouffach, 68250*

**SUMMARY:**
Background and methods—This presentation discusses the current patterns, trends and correlates of drug abuse among high school and university students in Alsace, France. Data were collected at a psychiatric counseling department at the University of Upper Alsace, and also at a central social and medical facility serving all adolescents and young adults (aged 12 to 25) for the whole area of Upper Alsace (a so-called House of the Adolescent). Among other measures, university students were assessed with the SF-36 health questionnaire and the Audit (Alcohol Use Disorders Identification Test), and high school students were evaluated with Coopersmith's self-esteem inventory (SEI). Results—Tobacco consumption among high school students was associated with lower self-esteem scores ($p=0.039$), especially when nonsmokers were compared with adolescents with moderate or high nicotine dependence (i.e. Fagerström Test for Nicotine Dependence scores = 4). In university students, problematic alcohol use and cannabis use in the past month were associated with lower mental health scores on the SF-36 inventory ($p=0.03$ for cannabis). Internet dependency is an increasing reason of referral by high school nurses. Binge drinking is fairly frequent among students in some university departments. Discussion—Common psychoactive substances like alcohol, tobacco and cannabis are largely abused by French youths. The onset of addiction is partly influenced by psychological and cultural factors, which may be amenable to educational intervention. Binge drinking, a major concern in the United States, is a more recent worry in France where regular drinking was a more traditional cultural pattern. Recently, resources have been allocated to the treatment of cyber addiction, even though questions have been raised about the reality, prevalence, and significance of this phenomenon.

No. 30-C

**DO PSYCHIATRIC PATIENTS SMOKE TO SELF-MEDICATE, OR IS IT FOR OTHER REASONS?**

*Renaud de Beaurepaire, M.D., Ph.D., 54 av de La Republique, Villejuif, 94806*

**SUMMARY:**
It is well established that cigarette smoking is associated with mental disorders. It is generally believed that patients with mental disorders smoke to self-medicate a variety of deficits, including negative symptoms, inability to activate reward circuits and deficits in cognition, as well as in an attempt to reduce the negative psychomotor effects of antipsychotics. However, clinical studies devoted to that topic have been generally unable to provide support to the self-medication hypothesis. We will present a study which shows that smoking in psychiatric patients is associated with psychotic symptoms. In that study, the urinary cotinine/creatinine ratio referred to the number of cigarettes smoked per day (nicotine extraction index) was measured in 492 consecutively admitted patients, and compared to the 18 items of the BPRS. The results show that the nicotine extraction index correlates with the items "unusual thought content" ($p<0.01$) and "grandiosity" ($p<0.02$), and not with any of the other items. The possible theoretical consequences of these findings will be discussed.

No. 30-D

**THE STATE OF TREATMENT OF ADDICTIVE DISORDERS IN THE UNITED STATES**

*David Oslin, M.D., Room 228 B MIRECC, PVAMC, University and Woodland Ave, Philadelphia, PA 19104*

**SUMMARY:**
Traditionally addiction treatment in the US has focused almost exclusively on 12 step oriented programs. Based on a growing evidence base demonstrating both environmental and biologic components of addiction, the monolithic treatment model is being challenged. Increasingly biomarkers, pharmacotherapy, continuing care, and adaptive treatment strategies are being used to treat addiction. This session will focus on the use of personalized pharmacotherapy approaches to addiction and the need to consider treatment algorithms to maximize outcomes. Other topics to be covered include measuring outcome and long term care.

No. 30-E

**ORGANIZATION AND HEALTH CARE NETWORKS FOR CANNABIS TREATMENT IN FRANCE**

*Amine Benyamina, M.D., 12-14 Avenue Paul Vaillant Couturier, Villejuif, 75013*

**SUMMARY:**
Cannabis dependence is a significant problem in France. With nearly 1.2 million French men and women have use cannabis at least twice a week and 550,000 who use it daily, France is a European leader in terms of cannabis consumption.
The management of addictive disorders in France has undergone a major revision with its Addictions Plan for 2007-2011. The plan includes integrated health care for any addiction, regardless of its nature. It also provides for the development of medico-social structures, local care units and specialised care units and the means to coordinate actions among the different structures. Research and training for medical and para-medical personnel are also planned.The Addictions Plan recognizes the need for specialized treatment of cannabis addiction. Paul Brousse University Hospital's Addictology Center is one of the first French hospitals to create a cannabis consultation backed by a comprehensive care program for cannabis dependent patients. This presentation examines the various aspects of the Addictions Plan and the Cannabis Care and Consultation Program.

**SUNDAY, MAY 23, 2010**
**9:00 AM-12:00PM**

**SYMPOSIUM 31**

## UNDERSTANDING PERSONALITY DISORDERS IN CHILDREN AND ADOLESCENTS: CURRENT STATUS AND FUTURE DIRECTIONS

*Chairperson: Paul S Links, M.D., 30 Bond St., Rm 2010d Shuter St.,Toronto, M5B 1W8 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understanding the role of early detection and intervention in young people with personality disorders; 2) Appreciating the link between PD precursors and Axis I problems; and 3) Describing the appropriate place for using PD diagnoses in children and adolescents.

**OVERALL SUMMARY:**

The past decade has seen growing empirical support for the reliability and validity of personality disorder (PD) in adolescents and young people. To better understand personality disorders in children and adolescents; three important issues are the focus of this symposium. Dr. Chanen discusses early detection of young people with borderline personality disorder and how early detection and intervention has the potential to develop and apply phase specific interventions that might be simpler or have fewer adverse effects than those required for later phases of the disorder. Dr. Tackett discusses precursors to personality disorders (PDs) in childhood and adolescence. The precursors have been gaining increasing attention in recent years with advances made in both theory and measurement. Finally, Dr Paris argues that diagnoses are justified in children and adolescents and highlights the circumstances where this step is necessary and appropriate.

No. 31-A

### ADVANCING FROM UNDERSTANDING PERSONALITY DISORDERS IN YOUNG PEOPLE TOWARD EARLY DETECTION AND INTERVENTION

*Andrew Chanen, M.B.B.S, 35 Poplar Road, Parkville, Melbourne, 3052*

**SUMMARY:**

The past decade has seen growing empirical support for the reliability and validity of personality disorder (PD) in young people, especially borderline personality disorder (BPD). However, diagnosing PDs in young people is still not common practice and few suitable interventions exist for this age group. Clinical interventions for BPD tend to be directed toward those adults with already entrenched and/or severe forms of the disorder and it would be misguided to apply these interventions to young people unmodified or to restrict intervention in young people to only those who resemble 'adult' BPD. Sanctioning the diagnosis of BPD in young people also allows for early detection of the emerging BPD phenotype and early intervention. Early intervention has the potential to develop and apply phase specific interventions that might be simpler or have fewer adverse effects than those required for later phases of the disorder. Early intervention not only aims to avert the various adverse functional and psychopathological sequelae of borderline pathology in young people but also provides a platform to investigate developmental processes, including neurobiology, earlier in the course of the disorder, thereby reducing the confounding influence of 'duration of illness' factors.

No. 31-B

### MEASUREMENT AND ASSESSMENT OF PD PRECURSORS: LINKS TO NORMAL PERSONALITY AND AXIS I PROBLEMS

*Jennifer Tackett, M.D., 100 St. George Street, Toronto, M5S 3G3*

**SUMMARY:**

Precursors to personality disorders (PDs) in childhood and adolescence have been gaining increasing attention in recent years with advances made in both theory and measurement. In this presentation, I will review critical developmental periods for PDs, including infancy and early toddlerhood (associated with the initiation of attachment style), middle childhood (associated with pubertal transitions) and late adolescence (associated with the transition into adulthood). I will then discuss potential clinical manifestations of PD precursors in childhood and adolescence. Finally, I will present preliminary analyses from an ongoing study of a large community-based sample of participants from a metropolitan area in southern Ontario. In this study, both parents (N=330) and youth (N=224) provided information on PD traits, normal personality traits, and Axis I behavioral problems. Target children ranged in age from 3-18. Results suggest that PD traits can be reliably measured in both children and adolescents and with both parent and self-report (self-report was obtained for youth age 11 and older). High reliability was found for higher- and lower-order PD traits. Relations to normal personality revealed generalized connections to Neuroticism with more specific patterns demonstrated for other personality traits. Relations to Axis I behavioral problems revealed similarities and differences with established connections in the adult literature. For example, somatic complaints in children and adolescents appear to be a strong marker of related PD trait levels including pathological Disagreeableness, Emotional Instability, and Introversion. Pathological Disagreeableness showed the strongest connection to overall behavioral problems in children and adolescents. Results are discussed

in the context of the importance for future work on the measurement and assessment of PD precursors and greater attention to the influence of critical developmental periods on the onset and course of PD traits.

No. 31-C

**WHY AND UNDER WHAT CIRCUMSTANCES SHOULD WE MAKE THE DIAGNOSIS OF PERSONALITY DISORDERS IN CHILDREN AND ADOLESCENTS**

*Joel Paris, M.D., Institute of Community and Family Psychiatry 4333 Cote Ste-Catherine Rd,, Montreal, H3T 1E4*

**SUMMARY:**
Research data shows that PDs can be reliably diagnosed in adolescence, and that adolescence is also the typical age of onset for these disorders. While follow-up studies do not always demonstrate diagnostic stability, these cases in no way correspond to a normal process such as "adolescent turmoil". Thus reluctance to diagnose PDs at this stage is not justified, and it may be important for early recognition and treatment to identify such cases.

**SYMPOSIUM 32**

**TREATMENT OF DEPRESSION IN ETHNIC MINORITIES**

*Chairperson: Julio Licinio, M.D., Bldg 131 Garron Rd, Canberra, ACT 2601 Australia,*
*Co-Chairperson: William B. Lawson, M.D., Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize treatment disparities along ethnic lines; 2) Identify critical treatment issues in depression among ethnic minorities; and 3) Diagnose and treat depression in African American, Asian Americans and Latinos.

**OVERALL SUMMARY:**
The goal of this session is to present data on disparities in antidepressant treatment and to discuss the evidence-based literature on diagnosis, treatment, and service utilization for depression in African Americans, Chinese Americans, Latinos and Caucasians in the United States. Results from STAR*D show that the overall outcomes of antidepressant treatment are rather grim, with less than 40% after initial treatment. Outcomes are even more limited in members of ethnic minority groups. It is therefore necessary to specifically identify treatment barriers in specific treatment groups, so that treatment outcomes can be improved. This symposium brings together national experts in the diagnosis, treatment, and understanding of health care utilization patterns across under-represented minority groups in the US.African Americans (AA) are less likely to be diagnosed and more likely to be misdiagnosed when depressed. As a consequence they have less access to mental health services which may lead to poorer outcomes. Socioeconomic factors, racism, and lack of a cultural perspective certainly are factors. While large scale epidemiological studies suggest depression may be less common in AA, lack of access and sampling issues suggest that these differences may still be a result of under-recognition. Racial and ethnic factors may contribute to a different presentation among AA. However socioeconomic factors, treatment delay, and focus on non-salient symptoms such as psychosis suggest that current diagnostic systems may valid if these factors are taken into account. Elements of DSM IV may need to be reexamined, but cross-cultural studies support the validity of current conceptions of depression. It is important to recognize the role of culture both because AA in the US are more often immigrants or first generation and because the current diagnostic system is used world-wide despite lack of representation of people of African descent in field trials.

No. 32-A

**DISPARITY IN DEPRESSION TREATMENT AMONG RACIAL AND ETHNIC MINORITY POPULATIONS IN THE UNITED STATES**

*Alegria Margarita, Ph.D., 760 Westwood Plaza Box 62, Los Angeles, CA 90024*

**SUMMARY:**
Using nationally representative data for 8,762 persons, the authors evaluated differences in access to and quality of depression treatments between patients in racial-ethnic minority groups and non-Latino white patients. Access to mental health care was assessed by past-year receipt of any mental health treatment. Adequate treatment for acute depression was defined as four or more specialty or general health provider visits in the past year plus antidepressant use for 30 days or more or eight or more specialty mental health provider visits lasting at least 30 minutes, with no antidepressant use. For persons with past-year depressive disorder, 63.7% of Latinos, 68.7% of Asians, and 58.8% of African Americans, compared with 40.2% of non-Latino whites, did not access any past-year mental health treatment (significantly different at $p<.001$). Disparities in the likelihood of both having access to and receiving adequate care for depression were significantly different for Asians and African Americans in contrast to non-Latino whites. Simply relying on present health care systems without consideration of the unique barriers to quality care that ethnic and racial minority populations face is unlikely to affect the pattern of disparities observed. Populations reluctant to visit a clinic for depression care may have correctly anticipated the limited quality of usual care.

No. 32-B
## DIAGNOSING DEPRESSION IN PEOPLE OF AFRICAN ANCESTRY: NATIONAL AND INTERNATIONAL PERSPECTIVES

*William Lawson, M.D., Ph.D., 2041 Georgia Avenue, Washington, DC 20060*

**SUMMARY:**
African Americans (AA) are less likely to be diagnosed and more likely to be misdiagnosed when depressed.
As a consequence they have less access to mental health services which may lead to poorer outcomes. Socioeconomic factors, racism, and lack of a cultural perspective certainly are factors. While large scale epidemiological studies suggest depression may be less common in AA, lack of access and sampling issues suggest that these differences may still be a result of under-recognition. Racial and ethnic factors may contribute to a different presentation among AA. However socioeconomic factors, treatment delay, and focus on non-salient symptoms such as psychosis suggest that current diagnostic systems may valid if these factors are taken into account. Elements of *DSM IV* may need to be reexamined, but cross-cultural studies support the validity of current conceptions of depression. It is important to recognize the role of culture both because AA in the US are more often immigrants or first generation and because the current diagnostic system is used world-wide despite lack of representation of people of African descent in field trials.

No. 32-C
## ETHICAL AND CULTURAL CONSIDERATIONS IN TREATING DEPRESSION IN PATIENTS OF CHINESE BACKGROUND

*Albert Yeung, M.D., Sc.D., Suite 401, 50 Staniford St., Boston, MA 02114*

**SUMMARY:**
Talking to patients from diverse cultural backgrounds about their psychiatric disorders requires knowledge of one's own culture, the patients' cultures, and the ways in which they might interact, both in positive and unexpectedly negative ways. We discuss the issues raised by discussing psychiatric diagnoses with Chinese-Americans who hold traditional illness beliefs and are not familiar with Western conceptions of psychiatric disorders. We explore how cultural values influence this aspect of medical practice, and suggest practical approaches to communicating the diagnosis of major depressive disorder in a culturally sensitive manner. Our clinical approach is to develop co-constructed illness narratives with patients, and to aid this process by reframing different elements of the clinical process into more culturally resonant forms. The following steps are suggested: 1) elicit patient's illness beliefs; 2) understand and acknowledge multiple explanatory models; 3) contextualize depressive symptoms into patient's physical health and social system; 4) introduce western psychiatric theories in ways that reflect assumptions shared by traditional Chinese medicine (TCM); 5) involve patients' families whenever possible; and 6) use terminology that avoids unintended stigma.

No. 32-D
## DEPRESSION CARE IN THE UNITED STATES AMONG ETHNIC AND RACIAL MINORITIES

*Hector Gonzalez, Ph.D., 87 E Ferry St Napp Bldg Rm 234, Detroit, MI 48202*

**SUMMARY:**
Objective: To determine the prevalence and adequacy of depression care among different ethnic and racial groups in the United States.
Methods: Collaborative Psychiatric Epidemiology Surveys (CPES) data were analyzed to calculate nationally representative estimates of depression care.
Setting: The 48 coterminous United States.
Participants: Household residents ages 18-years and older (N=15,762).
Main Outcomes: Past-year depression pharmacotherapy and psychotherapy using American Psychiatric Association Guideline concordant therapies.
Primary Predictors: Major ethnic/racial groups (Mexican Americans, Puerto Ricans, Caribbean Blacks, African Americans and non-Latino Whites). World Mental Health Composite International Diagnostic Interview 12-month major depressive episode.
Results: Mexican Americans and African Americans meeting 12-month major depression criteria consistently and significantly had lower odds for any depression therapy and Guideline concordant therapies despite depression severity ratings not significantly differing between ethnic/racial groups. All groups reported higher use of any past-year psychotherapy and Guideline concordant psychotherapy compared to pharmacotherapy; however, Caribbean Blacks and African Americans reported the highest proportions of psychotherapy use.
Conclusion: Few Americans with recent major depression have used depression therapies and Guideline concordant therapies; however, the lowest rates of use were found among Mexican Americans and African Americans. Ethnic/racial disparities in care were found despite comparable depression care need. More Americans with recent major depression used psychotherapy over pharmacotherapy, and these differences were most pronounced among Mexican Americans and African Americans. Our findings underscore the importance of disaggregating ethnic/racial groups and depression therapies to understand and guide efforts to improve depression care in the United States.

**REFERENCES:**
1. Disparity in depression treatment among racial and ethnic

minority populations in the United States. Alegría M, Chatterji P, Wells K, Cao Z, Chen CN, Takeuchi D, Jackson J, Meng XL. Psychiatr Serv. 2008 Nov;59(11):1264-72
2. Antidepressant use in black and white populations in the United States. González HM, Croghan T, West B, Williams D, Nesse R, Tarraf W, Taylor R, Hinton L, Neighbors H, Jackson J. Psychiatr Serv. 2008 Oct;59(10):1131-8

## SYMPOSIUM 33

## APPROACHES TO SCHIZOPHRENIA THROUGH PHASES OF THE ILLNESS

*Chairperson: S. Charles Schulz, M.D., 2450 Riverside Avenue F282/2A West, Minneapolis, MN 55454*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be aware of the different approaches for different phases of schizophrenia; and 2) be able to adjust their interventions to meet the patient's individual needs.

### OVERALL SUMMARY:

Schizophrenia is known to be a common (1% prevalence) and significantly debilitating illness as measured by functional disability and mortality. Many articles and books are published about the illness that focus on the disease as monolithic entity rather than describing approaches to different phases of the illness. As research has progressed on schizophrenia unique characteristics of the prodrome, first-episode, mid-life illness, and issues of the older, poorly responsive patient have been uncovered. The purpose of this symposium is to focus attention on different stages of schizophrenia so that clinicians and researcher can refine their approaches. The symposium will begin with a description of the characteristics of the prodrome, the rates of conversion to schizophrenia, and the treatment approaches that are being developed (Dr. Cadenhead). This will be followed with emerging data on the first episode of the illness and the treatment strategies to meet the specific issues of the initial year of treatment (Dr. Kane). Patients with schizophrenia in the next phases of their lives face different issues in their personal and occupational lives and the treatment team faces challenges of adherence and engagement (Dr. Weiden). Lastly, not all patients are responsive to the treatments discussed in the first three presentations; so that a discussion of issues facing the persistently ill patient will conclude the symposium (Dr. Schulz).

No. 33-A
### EARLY IDENTIFICATION OF THE PSYCHOSIS PRODROME AND CLINICAL PRACTICE

*Kristin Cadenhead, M.D., Department of Psychiatry 0810, University of California San Diego, 9500 Gilman Drive,, La Jolla, CA 92093-0810*

### SUMMARY:

Early identification of individuals at clinical high risk and potentially in the prodromal phase of a psychotic illness can lead to earlier treatment and perhaps prevention of many of the devastating effects of a first psychotic episode. International research efforts have demonstrated the success of community outreach and education regarding the schizophrenia prodrome and it is now possible to use empirically defined criteria to identify individuals at a substantially increased risk for a psychotic illness. The clinical high-risk sample meets criteria for 1 of 3 prodromal syndromes defined by the Structured Interview for Prodromal Syndromes (SIPS) based on subsyndromal psychotic symptoms and/or a family history of psychosis and deterioration in functioning. Individuals who meet the SIPS criteria are clinically heterogeneous but help-seeking and have often received a range of different treatments prior to entry into prodromal research programs. Less than 40% of those who meet the SIPS criteria are likely to become psychotic but those with additional risk factors such as a family history of psychosis, more severe ratings on delusional-like symptoms, social functioning deficits or substance abuse are even more likely to develop schizophrenia or an affective disorder. Given the many potential clinical presentations, treatments, and ethical issues connected with the clinical high risk syndrome, it is not surprising that clinicians administer a broad range of interventions. Preliminary treatment studies have demonstrated initial success in reducing the severity of symptoms and improving functional outcome in clinical high-risk samples but these studies are underpowered. Large scale clinical trials of both psychosocial and pharmacologic interventions are needed to better inform treatment decisions. Translational studies are needed to better understand the neuropathological changes in the early stages of psychosis and to assess neuroprotective strategies that might be beneficial in the prodormal period. For now the best recommendation for clinicians is to treat the clinical high risk state using a needs based approach, recognizing that the prodromal syndrome may be transient or evolve into a more serious condition with a range of diagnostic and functional outcomes.

No. 33-B
### MANAGEMENT OF FIRST EPISODE SCHIZOPHRENIA

*John M. Kane, M.D., The Zucker Hillside Hospital75-59 263rd Street, Glen Oaks, NY 11004-1150*

### SUMMARY:

The early phase of a schizophrenia illness poses many challenges. Patients and families need enormous support and psychoeducation. Engagement and retention in treatment is critical and appropriate medication management is an

important element in successful treatment. First episode patients are particularly vulnerable to adverse effects, and in the presence of considerable ambivalence toward medication-taking, success in preventing or managing such side effects is critical. Shared decision-making is important to ensure patient acceptance. The careful and consistent integration of psychopharmacologic and psychosocial treatment modalities is essential in facilitating optimum outcome and ideally recovery. This presentation will include the evidence base for specific treatment approaches and how these data informed an intervention model being implemented in a large NIMH sponsored clinical trial-Recovery After An Initial Schizophrenia Episode (RAISE).

No. 33-C
**APPROACHES TO SCHIZOPHRENIA**

*Peter Weiden, M.D., 912 S Wood Street, Chicago, IL 60612-7327*

**SUMMARY:**
If there were an easy answer to the problem of medication adherence in schizophrenia, we would have found it by now. Before adherence problems can be addressed, it needs to be understood. One of the complexities is that no one single definition or concept of adherence and nonadherence is completely satisfactory. In terms of finding interventions that work, there is no one single intervention approach or model that will work all the time for all patients. First, there are many causes of poor outcome besides nonadherence. Clinicians need to be careful not to automatically attribute unsatisfactory outcome to poor adherence without other confirmatory evidence. The tendency for clinicians to misattribute the inadequate efficacy problems to adherence problems can mean a lost opportunity to find a more effective pharmacological treatment regimen. Another challenge is that medication adherence can be viewed as a behavior or an attitude. While these are sometimes related, they are different and need to be evaluated differently. Behavior refers to what we do. Attitude refers to what we do. When it comes to whether or not patients take their medication, there is behavior (is the medication taken?) and there is attitude (what does the patient think of the medication?). While attitude and behavior can be aligned (patient wants to take medication and is actually taking medication) there can be a misalignment as well (patient does not want to take medication but is taking it despite unfavorable attitude) and the reverse (patient wants to take medication but does not). This presentation will focus on patient attitude and acceptance of antipsychotic medication. One implication of this research is to better define the role of long-acting route of antipsychotic medication as a means to improve long-term outcomes in patients with schizophrenia. The simple notion that long-acting antipsychotics are only useful in patients who are currently nonadherent is outdated, and needs to be replaced with a more sophisticated understanding of how to match route of medication with the patient's specific adherence and medication response profile. This research also has broader implications that include the feasibility of using alternate (non medical model) psychoeducation approaches, and highlighting the importance of developing a working therapeutic alliance, as being aspects of successful long-term treatment of schizophrenia.

No. 33-D
**EVALUATION AND INTERVENTION FOR THE PERSISTENTLY ILL SCHIZOPHRENIC PERSON**

*S. Charles Schulz, M.D., 2450 Riverside Avenue F282/2A West, Minneapolis, MN 55454*

**SUMMARY:**
Treatment at various stages of schizophrenia can lead to significant reduction in symptoms and new social skills treatment and cognitive approaches are enhancing outcomes. However, as patients grow older, it appears some patients are less responsive to treatment. The purpose of this presentation is to describe the evaluation of persistent symptoms of schizophrenia and then to review approaches to this challenging group of patients. An initial step in approaching the persistently ill schizophrenic person is an evaluation of lack of response. These factors can range from family/living situations, to medical causes to pharmacokinetics. Utilization of standardized rating scales can be useful at this point to evaluate severity of illness and provide an anchor to further progress.Many studies have examined augmentation strategies to antipsychotic medication utilizing agents such as lithium, anticonvulsants or benzodiazepines. These interventions are generally safe, but more recent data is less encouraging than when first reported. Clozapine trials have demonstrated efficacy in the previously non-responsive patient over the last 25 years. The current status of use and side-effect issues will be examined.

**REFERENCES:**
1.Barnes TRE, Buckley P, Schulz SC. Treatment-resistant schizophrenia. In Hirsch SR, Weinberger DR (Ed.), Schizophrenia, Blackwell Science, Ltd., Malden, MA, 2003, pp. 489-516.

**SYMPOSIUM 34**

**DIAGNOSINGANDTREATINGTHENARCISSISTIC PERSONALITY DISORDER: AWAITING *DSM-5***

***The International Society for the Study of Personality Disorders***

*Chairperson: Elsa Ronningstam, Ph.D., 115 Mill Street, Belmont, MA 02478,*

*Co-Chairperson: Giuseppe, Giancarlo Dimaggio, M.D.*
*Discussant: Kenneth N. Levy, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize narcissistic personality disorder, NPD; 2) Discuss the diagnostic models for pathological narcissism in DSM V; and 3) Identify treatment objectives and strategies for NPD.

**OVERALL SUMMARY:**
Diagnosing and Treating the Narcissistic Personality Disorders - Awaiting DSM VChanges in the diagnostic approach to personality disorders in the upcoming DSM V will influence the diagnostic conceptualization and potentially also the treatment of pathological narcissism and narcissistic personality disorder NPD. Dr. Horowizt will discuss the present range and diagnostic features of narcissistic pathology and NPD. Dr. Bender will outline how pathological narcissism could be assessed in the proposed *DSM-V* personality psychopathology model and how this model can specifically inform aspects of treatment. Dr. Ronningstam will discuss a self-regulatory model and therapeutic strategies in treatment of patients with pathological narcissism and NPD with specific focus on self-esteem regulation, and empathic ability nd functonl fluctuations. Dr. Dimaggio will summarize results from psychotherapy research on treatment of pathological narcissism and propose a series of formalized strategies, i.e. eliciting autobiographical episodes with focus on interpersonal relational epiodes and identifying the patient's experiences and assessment of triggers of affects and behavior. Specific focus is on recognizing that anger and self-enhncement arise in response to patient's anticipation that goals will be unmet because of hostility and rejection from others. The aim of the symposium is to summarize and integrate the current knowledge with upcoming changes and advances in diagnosis and treatment of NPD with specific focus on a dimensional diagnostic approach and a self-regulatory model for treatment.Narcissistic personalities are difficult to treat and present problems in many aspects of the personality system. Among the most dysfunctional aspects of NPD are: a) extreme self-enhancement and perfectionistic standards; b) a tendency to build abstract and overgeneralized representations of the self and others and to act accordingly; c) poor access to inner states and lack of understanding of the psychological and environmental triggers for their emotions and actions; d) disturbed interpersonal relationship, with others represented are hostile or rejecting; in response to obstacles and social exclusion they react angrily or withdraw; e) poor ability to understand the mind of the others and being empathic. All these aspects of pathology need to be treated in order for therapy to be successful. We describe here a series of operations aimed at: 1) eliciting specific autobiographical episodes instead of accepting generalized and abstract statements 2) focus on the details of these relational episodes to discover how a patient felt, thought and acted and what the triggers for their emotions and actions were 3) help them recognize that anger and self-enhancement often arise as a response to the anticipation their goal will be unmet because the others will be hostile and rejecting 4) support their non-grandiose wishes.Only in later stages of therapy therapists attempt at building a more integrated self-representation instead of resorting to the grandiose one only, help patients to take a critical distance from biased self-others representations and to form a mature theory of the others' mindDimaggio G, Semerari A, Carcione A, Nicolò G., Procacci, M. Psychotherapy of Personality Disorders: Metacognition, States of Mind and Interpersonal Cycles. London, Routledge, 2007.

No. 34-A
**OBSERVING NARCISSISTICALLY VULNERABLE TRAITS**

*Mardi Horowitz, M.D., 401 Parnassus, San Francisco, CA 94143-0984*

**SUMMARY:**
Abstract:
The observation of persons meeting criteria for Narcisstic Personality Disorder goes beyond the listed criteria. A configurational analysis approach to case formulation assembles common patterns in terms of four levels, from more superficial pattern observations to deeper inferences about what causes the pattern recurrence in spite of maladaptive consequences. The four levels covered in this 20 minute presentation are 1) Common complaints and interpersonal difficulties , 2) States of Mind that contain maladaptive patterns ( for example self righteous rages), 3) Common conflictual or irrational themes and emotional controls during these themes ( for example sliding meanings so that others are to blame, not self , for the interpersonal difficulties, and 4) person schemas ( for example viewing self as dissociative great and inferior self images, or chaotic, and others as necessary extensions of self rather than independent agents of initiatives and intentions).

No. 34-B
**TREATMENT IMPLICATIONS OF THE PROPOSED DSM-5 REPRESENTATION OF NARCISSISM**

*Donna Bender, Ph.D., 4031 E. Sunrise Drive, Suite 101, Tucson, AZ 85718*

**SUMMARY:**
In DSM-IV, narcissism is represented categorically as Narcissistic Personality Disorder, which captures primarily the grandiose "overt" manifestations of the phenomenon. However, it has been demonstrated theoretically, clinically and empirically that underlying aspects of pathological

narcissism would be better represented dimensionally to capture the natural variation of narcissistic difficulties within and across various personality styles. The draft proposal for the personality component of DSM-5 includes a dimension for assessing levels of self and interpersonal functioning ranging from healthy to severe impairment. Inherent in this continuum is the degree to which narcissistic impairment is present. In addition, other components of the proposed model allow narcissistic expressions of character to be identified in the form of narrative types and trait constellations. The ability to more completely and accurately characterize narcissistic issues using the *DSM* can only serve to better assist clinicians in formulating and implementing treatment approaches, and in anticipating the nature of the therapist-patient relationship and alliance issues. The current presentation will detail how narcissism could be assessed in the proposed *DSM-5* personality psychopathology model, and how this model can specifically inform aspects of treatment.

No. 34-C

**A SELF-REGULATORY MODEL AND STRATEGIES FOR TREATMENT OF NARCISSISTIC PERSONALITY DISORDER**

*Elsa Ronningstam, Ph.D., 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**
Presently there are both clinical and empirical indications for identifying narcissism in terms of self-regulation. A self-regulatory treatment approach to pathological narcissism focuses on the impact of self-enhancement on self-esteem and self-regulation. People with pathological narcissism and narcissistic personality disorder use various self-enhancing and self-serving strategies to support both realistic and exaggerated aspects of their self- esteem, and to protect against external threats as well as internal self-critical attacks and feelings of inferiority or being undeserving. Their emotional dysregulation is guided by aggression, shame and envy, by their intense reactions to threats to self-esteem and by their efforts to maintain internal and external control. The level of empathic capability and superego functioning, i.e., ideals and values, play a major role in forming each individual's specific narcissistic character pattern. This presentation will outline strategies to address pathological narcissism. Exploring and clarifying narcissistic vulnerabilities and regulatory strategies, and identifying the patient's accompanying imbalances in self-esteem regulation, and interpersonal and social functioning are some of the main tasks and vehicles in the treatment towards change in narcissistic personality functioning. The focus is foremost on the individual's subjective, internal experiences both vis-à-vis him/her self when alone, such as self-shaming and self-criticism, and in the interpersonal interactive contexts, especially on reactions and experiences when perceiving and being perceived by others.

No. 34-D

**PROMOTING AWARENESS OF MENTAL STATES AND THEIR TRIGGERS AND REDUCING FEELINGS OF REJECTION IN TREATMENT OF NARCISSISTIC PATHOLOGY**

*Giuseppe, Giancarlo Dimaggio, M.D., Via Ravenna 9/c, Rome, 00161*

**SUMMARY:**
Narcissistic personalities are difficult to treat and present problems in many aspects of the personality system. Among the most dysfunctional aspects of NPD are: a) extreme self-enhancement and perfectionistic standards; b) a tendency to build abstract and overgeneralized representations of the self and others and to act accordingly; c) poor access to inner states and lack of understanding of the psychological and environmental triggers for their emotions and actions; d) disturbed interpersonal relationship, with others represented are hostile or rejecting; in response to obstacles and social exclusion they react angrily or withdraw; e) poor ability to understand the mind of the others and being empathic. All these aspects of pathology need to be treated in order for therapy to be successful. We describe here a series of operations aimed at: 1) eliciting specific autobiographical episodes instead of accepting generalized and abstract statements 2) focus on the details of these relational episodes to discover how a patient felt, thought and acted and what the triggers for their emotions and actions were 3) help them recognize that anger and self-enhancement often arise as a response to the anticipation their goal will be unmet because the others will be hostile and rejecting 4) support their non-grandiose wishes.Only in later stages of therapy therapists attempt at building a more integrated self-representation instead of resorting to the grandiose one only, help patients to take a critical distance from biased self-others representations and to form a mature theory of the others' mindDimaggio G, Semerari A, Carcione A, Nicolò G., Procacci, M. Psychotherapy of Personality Disorders: Metacognition, States of Mind and Interpersonal Cycles. London, Routledge, 2007.

No. 34-E

**IMPLICATIONS OF RESEARCH ON TRAIT NARCISSISM FOR THE CONCEPTUALIZATION OF NARCISSISTIC PERSONALITY DISORDER (NPD)**

*W. Keith Campbell, Ph.D., Dept of Psychology, Athens, GA 30602*

**SUMMARY:**
Narcissistic Personality Disorder (NPD) has generated tremendous interest as of late, but there are still many

fundamental questions about the construct that need to be answered. We present a series of recent studies on narcissistic personality (i.e., the trait of narcissism rather than the disorder) that might be useful to understanding and refining the conceptualization of NPD. Based on this research, three important insights about NPD are suggested. 1. There is a continuum between narcissistic personality and NPD. This is based on taxonomic data and also research showing similar basic personality profiles between narcissistic personality and NPD assessments in both clinical and normal populations. 2. There are two primary forms of narcissism, a grandiose-agentic form and a vulnerable form. This is based on broad assessments of the nomothetic network of the different narcissism measures. 3. The link between grandiose-agentic narcissism and psychological distress is small and often negative. Nonetheless, grandiose-agentic narcissism is associated with considerable psychopathology when the definition of psychopathology is expanded to include negative social and societal consequences. This is based on several studies examining the intrapersonal distress and interpersonal consequences associated with both forms of narcissism. The relevance of this work for *DSM-5* is discussed.

## SYMPOSIUM 35

## SEX/GENDER DIFFERENCES AND WOMEN-SPECIFIC ISSUES IN DRUG ABUSE: PREDICTING AND IMPROVING TREATMENT OUTCOMES

*The U.S. National Institute on Drug Abuse*

*Chairperson: Cora Lee Wetherington, Ph.D., 6001 Executive Blvd, Rm 4282, Bethesda, MD 20892,*
*Co-Chairperson: Shelly F Greenfield, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this symposium, participants should be able to describe: 1) gender differences in co-occurring psychiatric disorders and substance use disorders; 2) sex-specific neurobiological changes related to drug abuse and their effects on addiction relapse; 3) outcome differences between a new women-focused WRG and GDC; 4) evidence supporting matching group trauma therapy for women in drug treatment; and 5) the efficacy of motivational interventions for pregnant substance users.

**OVERALL SUMMARY:**
The symposium will open with Dr. Kathleen Brady who will speak on the role of gender differences in psychiatric comorbidity with substance use disorders, including the relationship to course of illness and the implications for treatment. She will also discuss the phenomenon of female "telescoping" in substance use and its relationship to comorbidity. Next, Dr. Rajita Sinha will speak on sex differences in responses to drugs and stress and the role of sex-based biology (including steroid hormones) in predicting relapse and treatment outcome. Her presentation will be followed by Dr. Shelly Greenfield who will discuss the issue of "women-focused" substance-abuse treatment, what it means, when and why it may be needed, and present data on outcomes from the Women's Recovery Group study comparing outcomes from a women-only treatment group and a mixed-gender treatment group. Dr. Denise Hien will then speak on the issue of trauma and PTSD among drug-dependent women and its effects on treatment outcomes, and present data from a clinical trial in which the effectiveness of Seeking Safety, a form of CBT, was compared to that of a control program, Women's Health Education, when added to standard substance abuse outpatient treatment. Lastly, Dr. Theresa Winhusen will speak on the challenges of retaining pregnant substance abusers in treatment and will present data from studies examining the effectiveness of motivational enhancement therapy and the use of vouchers in improving treatment engagement and outcomes.Gender differences in substance abuse treatment and gender-specific treatment interventions have been an area of increased focus and attention for clinicians and researchers. While there are a number of existing treatments for specific sub-groups of women with substance use disorders, there is scant information regarding the effectiveness of delivering generic substance abuse treatment in single-gender vs. mixed-gender group therapy format. The Women's Recovery Group Study, a Stage I Behavioral Therapies Development Trial, was designed to develop a manual-based 12- session Women's Recovery Group (WRG) and to pilot test this new treatment in a randomized controlled trial against mixed-gender Group Drug Counseling (GDC), an effective manual-based treatment for substance use disorders. After initial manual development, two pre-pilot groups of WRG were conducted to determine feasibility and acceptability of the treatment among subjects and therapists. In the pilot stage, women were randomized to either WRG (N=16) or GDC (N=7 women, N=10 men). No significant differences in substance use outcomes were found between WRG and GDC during the12-week group treatment. However, during the 6-month post-treatment follow-up, WRG members demonstrated a pattern of continued reductions in substance use while GDC women did not. Differences between groups had medium to large effect sizes. In addition, pilot WRG women with alcohol dependence had significantly greater reductions in average drinks/drinking day than GDC women 6 months post-treatment. While satisfaction with both groups was high, women were significantly more satisfied with WRG than GDC. Moderators of treatment outcome included high psychiatric severity and low self-efficacy. A women-focused single-gender group treatment may enhance longer-term clinical outcomes among women with substance use disorders. (This research was supported by grants R01DA15434 and K24DA019855 from the

National Institute on Drug Abuse)

No. 35-A

**GENDER DIFFERENCES IN PSYCHIATRIC COMORBIDITY WITH SUBSTANCE USE DISORDER: IMPLICATIONS "TELESCOPING" AND TREATMENT**

*Kathleen Brady, M.D., Ph.D., 171 Ashley Avenue, Charleston, SC 29425*

**SUMMARY:**
There are a number of important gender differences in presentation, course of illness and treatment outcomes for substance use disorders. Many of these differences are related to the fact that substance-dependent women are significantly more likely to have co-occurring mood and anxiety disorders as compared to men. In this presentation, recent data concerning gender differences in the prevalence of co-occurring psychiatric and substance use disorders will be reviewed. Gender differences in the course of illness, including the "telescoping" of the consequences of addictions in women and the potential relationship of this phenomenon to comorbidity will be discussed. Finally, treatment implications of the gender differences in co-occurring psychiatric and substance use disorders will be discussed.

No.35-B

**SIGNIFICANT ROLE OF SEX-BASED BIOLOGY IN PREDICTING RELAPSE AND CLINICAL OUTCOMES IN DRUG ABUSE**

*Rajita Sinha, Ph.D., 2 Church Street South, Suite 209, New Haven, CT 06511*

**SUMMARY:**
Background: Sex differences exist in responses to drugs and to stress. Chronic drug abuse sensitizes stress and reward pathways in a sexually dimorphic manner, and such mechanisms likely play an important role in the high relapse rates associated with drug abuse. The goal of this presentation is to examine sex differences in stress and chronic drug related neurobiological changes in brain stress and reward pathways that are associated with increased distress, drug craving and addiction relapse. Method: Laboratory manipulations of stress, drug cues and sex hormones, and brain imaging are used to study treatment engaged recently abstinent addicted patients compared to healthy controls. Prospective follow-up data are obtained to assess relapse risk and clinical outcomes in recovering drug abusing patients. Results: Data from addicted patients shows a persistent compulsive drug seeking state is induced by stress and rewarding cue exposure, that is marked by sex-specific alterations in increased negative emotion, anxiety, and altered autonomic and hypothalamic-pituitary-adrenal (HPA) axis response as well as other biochemical responses as compared to controls. Sex differences in HPA axis responses are significantly affected by sex hormones such as progesterone. Differential corticostriatal brain responses to stress and drug cue exposure is also observed in addicted men and women. Measures of basal stress tone and altered stress and cue responsivity, and prefrontal responses each confer differential relapse risk in addicted men and women. Discussion: Findings indicate that stress and sex steroid hormones interact to differentially affect relapse risk and clinical outcome in drug abusing men and women. The results support the need for gender-specific treatment strategies to address stress dysregulation and the compulsive reward seeking state in order to decrease relapse risk and improve drug abuse treatment outcomes.
(Supported by NIH Grant: P50-DA016556)

No. 35-C

**WOMEN-FOCUSED TREATMENT FOR SUBSTANCE USE DISORDERS: RESULTS FROM THE WOMEN'S RECOVERY GROUP STUDY**

*Shelly Greenfield, M.D., M.P.H., 115 Mill Street, Belmont, MA 02458*

**SUMMARY:**
Gender differences in substance abuse treatment and gender-specific treatment interventions have been an area of increased focus and attention for clinicians and researchers. While there are a number of existing treatments for specific sub-groups of women with substance use disorders, there is scant information regarding the effectiveness of delivering generic substance abuse treatment in single-gender vs. mixed-gender group therapy format. The Women's Recovery Group Study, a Stage I Behavioral Therapies Development Trial, was designed to develop a manual-based 12- session Women's Recovery Group (WRG) and to pilot test this new treatment in a randomized controlled trial against mixed-gender Group Drug Counseling (GDC), an effective manual-based treatment for substance use disorders. After initial manual development, two pre-pilot groups of WRG were conducted to determine feasibility and acceptability of the treatment among subjects and therapists. In the pilot stage, women were randomized to either WRG (N=16) or GDC (N=7 women, N=10 men). No significant differences in substance use outcomes were found between WRG and GDC during the12-week group treatment. However, during the 6-month post-treatment follow-up, WRG members demonstrated a pattern of continued reductions in substance use while GDC women did not. Differences between groups had medium to large effect sizes. In addition, pilot WRG women with alcohol dependence had significantly greater reductions in average drinks/drinking day than GDC women 6 months post-treatment. While satisfaction with both groups was high, women were significantly more satisfied with WRG than GDC. Moderators of treatment outcome

included high psychiatric severity and low self-efficacy. A women-focused single-gender group treatment may enhance longer-term clinical outcomes among women with substance use disorders. (This research was supported by grants R01DA15434 and K24DA019855 from the National Institute on Drug Abuse)

No. 35-D

**SUBSTANCE-ABUSING WOMEN WITH PTSD: HOW BEST TO TREAT?**

*Denise Hien, Ph.D., 160 Convent Avenue, New York, NY 10031*

**SUMMARY:**

Traumatic stress exposures among women in community substance use treatment reveal a significant need for therapeutic approaches which can be effectively utilized with this population. The Women and Trauma study of the National Institute on Drug Abuse Clinical Trials Network examined the ability to train drug counselors to implement trauma therapy groups (Seeking Safety Najavits, 2002) with safety and efficacy. A total of 353 women were recruited at seven outpatient CTPs across the United States. The study used a randomized, controlled, repeated measures design to assess the effectiveness of Seeking Safety (SS) plus standard substance abuse treatment in comparison to a control treatment (Women's Health Education, WHE) plus standard substance abuse treatment. Participants received an eligibility assessment and a comprehensive baseline assessment and, if eligible, were randomized into SS or WHE in rolling admission groups for 6 weeks (12 sessions) stratified by alcohol use disorders. Follow up assessments were conducted 1-week, 3-, 6-, and 12-months post treatment. Overall findings support the effectiveness of conducting group trauma treatments for women in drug treatment in the reduction of PTSD symptoms. In addition to presenting the primary outcome findings, this presentation will review a number important secondary outcome analyses which focus on subgroups in the sample for whom the trauma therapy was clearly superior to the health education program including hazardous drinkers, stimulant users, and those with more severe PTSD. The relationship between PTSD symptom cluster changes over the course of treatment and substance misuse will also be presented. Findings support the chronic disease model of addiction and its comorbidity with trauma, as well as the need for more comprehensive treatment paradigms for patients with PTSD and substance use disorders.

No. 35-E

**THE USE OF MOTIVATIONAL ENHANCEMENT THERAPY AND VOUCHERS TO IMPROVE TREATMENT UTILIZATION AND OUTCOME IN PREGNANT SUBSTANCE USERS**

*Theresa Winhusen, Ph.D., 3210 Jefferson Avenue, Cincinnati, OH 45220*

**SUMMARY:**

An estimated 4% of women use illicit substances during pregnancy, with 22% of illicit users also reporting the use of tobacco or alcohol. Research suggests that substance abuse treatment is effective in decreasing substance use and improving birth outcomes for pregnant women but that retaining pregnant women in treatment can be difficult. Motivational techniques, such as Motivational Enhancement Therapy (MET) and contingency management, may be effective for improving treatment outcomes in pregnant substance users. The NIDA Clinical Trials Network has completed a randomized, parallel, two group study comparing MET to treatment as usual (TAU) for improving treatment utilization and outcomes in pregnant substance users. Two hundred pregnant substance users, recruited from four substance abuse community treatment programs, were randomized to MET or TAU. Outcome measures included treatment utilization according to clinic records, qualitative urine toxicology measures, and self-report of substance use. One hundred and sixty two participants (i.e., 81%) completed the 1 month active phase. Participants attended 62% of scheduled treatment on average and reported decreased substance use during the first month of treatment, with no differences between treatment groups. There was evidence that the efficacy of MET varied between sites and that MET might be more beneficial than TAU in decreasing substance use in minority participants. In the trial, participants received $25 - $30 vouchers for research visit attendance. A post-hoc analysis evaluated the hypothesis that this monetary reinforcement would result in greater attendance of research versus non-incentivized treatment visits. Findings indicate that participants attended more research than treatment visits overall and were nearly three times as likely to attend four consecutive weeks of research visits versus treatment sessions. Implications for future research will be discussed. Supported by a series of NIDA CTN grants.

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**SUNDAY, MAY 23, 2010**
**2:00 PM- 4:00PM**

**SYMPOSIUM 39**

## THE MEDICAL HOME: IS THERE A PLACE FOR PSYCHIATRY IN IT?

*The APA Council on Children, Adolescents & Their Families*

*Chairperson: Eliot Sorel, M.D., 2301 E St NW Ste A1011, Washington, D.C. 20037*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the challenges and opportunities that currently exist for psychiatry, in the process of health care reform in the United States; and 2) Make a substantive contribution through the integration of psychiatric medicine and primary care in the context of the medical home and across life cycle, including chidren, adolescents and their families.

**OVERALL SUMMARY:**

Psychiatry can make a substantive contribution to health care reform through developing and implementing integrative models of care in the context of the medical home in collaboration with family medicine and pediatrics. Participation in clinical demonstration projects as well developing a new integrated curricula together with our colleagues as well as joint research projects based on these integrative models are the concrete contributions Psychiatry can make to health system reform in the United States. The symposium will address these challenges and opportunities from three perspectives, that of a primary care educator and practitioner, a child and adolescent psychiatrist and an adult psychiatrist, public health educator and health policy advisor who was part of the APA Board of Trustees Work Group on Psychiatry and Primary care integration. Clinica, educational,research andd health policy challenges and opportunities are adressed through specific examples derived from the scientific literature as well as from the panelists direct involvement with these issues as clinicians, educators, researchers and health policy advisors.

No. 39-A

### A PRIMARY CARE PERSPECTIVE

*Frank Degruy, M.D., 12631 East 17th Avenue, Room 3613, Aurora, CO 80045*

**SUMMARY:**

Over half of the visits made to primary care clinicians are made by patients who have a mental disorder or psychological symptoms that are seriously disabling, even though this is usually not the reason for the visit. Moreover, the likelihood that patients with chronic medical diseases will have a comorbid psychiatric condition is greatly increased, and this renders the formulation and implementation of personal care plans within the Patient-Centered Medical Home (PCMH) more difficult. Moreover, almost all personal care plans include a component of health behavior change, which itself is sometimes complicated and difficult, irrespective of the presence of comorbid mental disorders. Thus, primary care clinicians generally manage the psychosocial dimension of primary care inadequately, yet access to mental health professionals who can participate in the creation of a collaborative personal care plan is compromised by financial and professional barriers. We believe that the resources for a proper PCMH include mental health professionals who are available at the time care is being rendered, who know the primary care clinician and the patient, and can work collaboratively as a member of the PCMH team. Psychiatrists are ideal as participants and leaders on the PCMH team. This symposium will address the potential value, roles, and barriers to psychiatrists on the PCMH.

No. 39-B

### THE PEDIATRIC MEDICAL HOME: WHERE DOES THE CHILD & ADOLESCENT PSYCHIATRIST FIT IN?

*Michael Houston, M.D., 4812 Falstone Avenue, Chevy Chase, MD 20815*

**SUMMARY:**

Within Pediatrics the Medical Home model of healthcare delivery offers economic benefits with regards to improved efficiency and increased access to basic healthcare services. When implemented with appropriate attention to the screening, diagnoses, and treatment of the common mental health issues encountered in children and adolescents the model has the potential to dramatically improve access to care for a vulnerable population. This presentation will review the epidemiology and economics of mental health issues in children and adolescents with a focus on the potential advantages of the traditional medical home model within pediatrics. Using clinical examples of children and adolescents with varying severity of psychiatric illness, the presentation will explore an expanded application of the medical home model through an integration of

primary care and child and adolescent psychiatric services. The current economic roadblocks to such models will be discussed together with the potential changes that may come with proposed healthcare reform.

No. 39-C
**PSYCHIATRY & PRIMARY CARE INTEGRATION: CHALLENGES & OPPORTUNITIES**

*Eliot Sorel, M.D., 2301 E St NW Ste A1011, Washington, D.C., DC 20037*

**SUMMARY:**
The Mental Health Parity and Addiction Equity Act of 2008, will not resolve the multifactorially determined, markedly deficient access to mental health care in our fragmented, discriminatory health system. The National Co-morbidity Survey Replication study completed four years ago indicated that PCPs treat many more psychiatric patients than psychiatrists but that only 12.7% of those patients receive adequate care. Millman, in a recent study demonstrated that psychiatric physicians are paid less than other physicians for the same usual and customary outpatient services. Diminished access, fragmentation, lack of integration, minimal quality of psychiatric care in primary care settings and discriminatory payments, coupled with shame, stigma and discrimination, result in significant augmentation of co-morbidity, chronicity, disability, premature death and dying. The costs of co-morbid and untreated depression with other chronic diseases augments the health care and disability costs for the US patient population between $130B and $350B annually. Randomized controlled trials and clinical research evidence produced in the last decade clearly and convincingly indicate that psychiatric care and primary care, integrated and collaborative, effectively enhance access, quality and outcomes. In the primary care population, it is likely that 25% have co-morbid and diagnosable psychiatric disorders in need of psychiatric and integrated care. The gap between the numbers seen by psychiatric professionals and the numbers in need is over 368,000 potential visits. These individual visits are rarely, if ever, identified and addressed in the current fragmented health system with the consequences aforementioned. The integration of psychiatric care and primary care has consistently demonstrated it can enhance access, improve quality, enhance individual outcomes and diminish costs.

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**SYMPOSIUM 40**

**PRIVACY IN ELECTRONIC MEDICAL RECORDS**

*Chairperson: Zebulon Taintor, M.D., 19 East 93rd Street, New York, NY 10128,*
*Co-Chairperson: Laura Fochtmann, M.D.*
*Discussant: Edward Pontius, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe how electronic health record policies on privacy and fraud detection and prosecution are evolving; 2) The roles of the National Health Information Policy Committee, the Office of the National Coordinator on Health Information Technology, the Certification Commission on Health Information Technology, privacy advocates, and other national bodies; and 3) Privacy risks and chances to withhold some data from some other clin

**OVERALL SUMMARY:**
The electronic health record (EHR) and privacy issues have grown apace from what one's physician would put in an EHR and what would be kept out. Security issues were confined to the physician's computer. Demands for electronic billing required that more and more personal data be transmitted. Now we are in an era that promotes the exchange of clinical data via regional health information organizations (RHIOs) and health information exchanges (HIEs). Data should be kept as secure as money in a bank, yet the same data may be available in several places to people who do not have primary ownership. Patients expect their information will be kept private unless they consent to sharing specific items with specific other people. Physicians are required to keep such data private, while at the same time participating in electronic billing, HIEs, and RHIOs that require some data to be shared.This symposium will start with a review of security and confidentiality violations of different types, such as negligence, fraud, identity theft, and personal interest. describing the sanctions and their effects so far. A psychiatrist running a RHIO will describe privacy issues in how data are kept and used. A psychiatrist who has served on the NAMI Board and as a state mental health commissioner will review issues from the family and public mental health perspectives. A privacy advocate who serves on the national Health Information Technology Policy Committee will explain efforts to accommodate the wide range of patient desires from posting personal data on the web, to those who want to nothing shared. Those in between want some information withheld from some clinicians and data repositories ("granularity"). HIPAA has been amended to promote prosecution and state privacy laws vary. A psychiatrist active in general medical informatics will describe other efforts to promote EHRs and preserve privacy. The discussant is a member of the CCHIT behavioral health work group. A major goal of nationwide implementation of electronic health records has been to reduce the fragmentation of patient's health information across settings of care, facilities and

geographical regions with the aim of improving the quality of delivered care. Protecting the privacy of specific pieces of health care information, by its very nature, restricts access to that information by others and may place limits on information available for medical decision-making. Such restrictions can also limit the value of decision support such as drug interaction checking. Other concerns expressed about privacy protections have included the potential difficulties and costs involved in modifying software to support granular controls on accessing portions of the electronic medical record as well as time and cost involved in entering patients' individual privacy preferences into the electronic system. These issues and dilemmas will be discussed from the context of a large academic hospital setting, but are equally relevant to discussions of electronic record policies nationally as well as in smaller organizations and multispecialty practices.

No. 40-A
**PRIVACY VIOLATIONS AND CONSEQUENCES**

*Zebulon Taintor, M.D., 19 East 93rd Street, New York, NY 10128*

**SUMMARY:**
Privacy violations are reported weekly in the press. Typically data on hundreds or thousands of patients was on a stolen laptop Usually there has been no prosecution, because of the evident lack of criminal intent, Consequences are rarely reported. There are few reports in the press of medical identity theft, yet estimates range upward from the 250,000 cases annually estimated by the Federal Trade Commission in 2006. One problem is that laws against identity theft typically exist at the state, rather than the federal, level. A report to the Office of the National Coordinator of Health Information Technology in recommended ongoing study, a public-private commission, including identity theft in health literacy education, and a variety of other educational activities. It also recommended different business practices and technologies and policy and legislative changes. Despite hundreds of complaints of HIPAA violations since medical privacy rules went into effect in 2003, only the fourth criminal case was brought in August 2008. A clinic nurse pled guilty to wrongfully accessing a patient's protected health information to share with her husband to use in a legal proceeding against the patient. While law enforcement has used other laws (e.g., fraud) instead of HIPAA to prosecute those who used protected health information for personal gain, the HHS Inspector General reported in October 2008 that enforcement was lax and that delegation of enforcement to CMS was ineffective in that CMS had no conducted compliance reviews and had no effective mechanism for verifying that protected health information was actually protected. One hospital was audited and found to have several vulnerabilities. HIPAA enforcement changes in the economic stimulus package included prosecution by state attorneys-general and other tightening of provisions, but efficacy has yet to be determined.

No. 40-B
**PRIVACY AND CONTROL IN HEALTH INFORMATION EXCHANGES, MORE THAN AN ILLUSION?**

*Glenn Martin, M.D., 1 Ascan Ave Apt #24, Forest Hills, NY 11375-6084*
**SUMMARY:**
It has become a touchstone of plans to improve healthcare in the Unites States that individuals' health information must become available to healthcare providers and patients in an easily accessible real time electronic format. To that end health care organizations have established Regional Health Information Organizations (RHIOs) to build and govern Health Information Exchanges (HIEs). These exchanges usually link information obtained from individual physicians, large group practices and hospitals, as well as pharmacy benefit managers, laboratories, imaging centers and some insurance carriers including Medicaid. Information is shared among these providers, public health authorities and eventually will be shared with the patients themselves through internet portals or personal health records. Privacy challenges occur at the level of technology, usability, law and expectations. Most psychiatrists and their patients are concerned about the privacy of information. By law and custom psychiatric records are considered sensitive and are not readily shared in the paper world with all healthcare providers, and is almost always disclosed with the explicit consent of the patient. In the electronic world sensitive information has already left the silo and the doctor's direct oversight. The psychiatric visit may not appear directly, but it is likely that any purchased medications, or any ordered labs would be accessible through an HIE, and there is currently no practical means to assure its segregation and special handling. Consent to disclose information has been de facto replaced by consent to access, at best.This presentation will provide real life examples of the challenges faced by a functioning RHIO and HIE in Queens, NY and how they have been met, postponed or missed. Experience gained participating in the public-provider-vendor-governmental consortium in New York State that has grappled with these issues, including the privacy issues around mental health data, research, public health reporting, and services for minors will be highlighted. Pragmatic solutions from the real world that hope to advance the promise of improved health care, without sacrificing the privacy rights and expectations of physicians and their patients will be presented.

No. 40-C
**THE PERSPECTIVE OF FAMILY MEMBERS ON PRIVACY IN ELECTRONIC MEDICAL RECORDS**

*Edward Foulks, M.D., Ph.D., 940 Chartres, New Orleans, LA 70116*

**SUMMARY:**
Families are very clear that they want a) necessary information available on their loved ones in emergencies, b) psychiatric care integrated with medical care,c) no privacy violations, d0 no unnecessary spreading about of information that can lead to stigmatization. For a0, data would have to be available through clinicians ot at the level of a health information exchange (HIE) or regional health information exchange (RHIO), bur families will encourage their loved ones to examine the participants in HIEs and RHIOs and determine if they don"t want data going to certain entities and would want "break the glass" use only. For b), it is essential that all subscibers know what medication a patient may be receiving from all sources, why ir has been ordered, doses modified, and why why medication may have been discontinued. For c), families are daunted by the casual and sloppy way most violations have occurred and have pushed for stricter penalties. We welcome the new HIPPA privacy enforcement provisions of the stimulus package. For d), we favor "granularity", with full access to all physical health data and restricted access to mental health data. Control of who gets access to what should be first in the hands of the patient with decision available from the family. State public menatl health systems have had there own electronic systems for years, starting with statistical counts and reports from hospitals and clinics. Admission-discharge -transfer systems allowed retievalof previous treatment and diagnoses. Now many have patient-cetered file structures. Their main uses have been medication ordering and tracking and maintaining assessments, treatment plans, progress notes and discharge summaries. These provide very useful longitudinal views of patients over time.

No. 40-D

## HEALTH IT AND PRIVACY – CRITICAL PATHWAYS TO IMPROVING MENTAL HEALTHCARE

*Deven McGraw, J.D., M.P.H., 1634 I Street, NW #1100, Washington, DC 20006*

**SUMMARY:**
Health information technology (health IT) has enormous potential to improve the quality of physical and mental health care, both in terms of care provided to individuals as well as population health. But until very recently, little progress had been made to advance widespread adoption of health IT and electronic health information exchange to improve health. Among the obstacles was lack of funding to support technology adoption; lack of interoperability among disparate record systems; and failure to effectively address the complex privacy and security issues raised by the e-health technologies.But last February, Congress broke the "logjam" and enacted significant provisions supporting health IT as part of the economic stimulus legislation. The legislation (a) strengthened the federal infrastructure leading national efforts to promote health IT; (b) dedicated significant funds to support health IT adoption through payments to individual providers and grants for health information exchange infrastructure; and © strengthened privacy and security protections for health information by filling significant gaps in the privacy and security regulations under HIPAA. The legislation provided unprecedented opportunities to realize the potential of health IT – but the implementation challenges are enormous. The workshop will assess the progress to date in realizing the promise of ARRA, focusing on: (1) whether the financial incentives provided in ARRA are pointed in the right direction - will they lead to more widespread adoption of health IT and generate improvements in care; (2) what are we doing (and what should we be doing) to resolve health IT privacy and security issues.For each topic above, the discussion, which will actively involve the participants, will focus particularly on the role of health IT in improving mental health care and the complex privacy issues that arise with respect to electronic access and exchange of mental health data.

No. 40-E

## GENERAL MEDICAL VIEWS OF ELECTRONIC MEDICAL RECORD PRIVACY

*Laura Fochtmann, M.D., Department of Psychiatry and Behavioral Science, Stony Brook University School of Medicine, HSC-T10, Stony Brook, NY 11794-8101*

**SUMMARY:**
A major goal of nationwide implementation of electronic health records has been to reduce the fragmentation of patient's health information across settings of care, facilities and geographical regions with the aim of improving the quality of delivered care. Protecting the privacy of specific pieces of health care information, by its very nature, restricts access to that information by others and may place limits on information available for medical decision-making. Such restrictions can also limit the value of decision support such as drug interaction checking. Other concerns expressed about privacy protections have included the potential difficulties and costs involved in modifying software to support granular controls on accessing portions of the electronic medical record as well as time and cost involved in entering patients' individual privacy preferences into the electronic system. These issues and dilemmas will be discussed from the context of a large academic hospital setting, but are equally relevant to discussions of electronic record policies nationally as well as in smaller organizations and multispecialty practices.

**REFERENCES:**

1.McGraw D: Health IT: Protecting Americans' privacy in the digital age. Senate Judiciary Committee Testimony, January 27, 2009. www.cdt.org/testimony/20090127/_mcgraw.pdf

2.Rosenfeld S, Koss S, Siler S: Privacy, Security and the Regional Health Information Organization. Avalere Health LLC, prepared for California HealthCare Foundation, June 2007 http://www.chcf.org/topics/view.cfm?itemID=133288
Hampton T: Groups push physicians and patients to embrace electronic health records. JAMA 2008;2999(5):507-509.
3.Dimitropoulus LL (project director): Privacy and Security Solutions for Interoperable Health Information Exchange. Research Triangle International, Research Triangle Park, NC, prepared for the Office of the National Coordinator for Health Information Technology, July 20, 2007
4.McCue, Colleen (project director): Recommended Requirements for Enhancing Data Quality in Electronic Health Records. (115p) Research Triangle Park, NC, Research Triangle International,, August 25, 2007.

**SUNDAY, MAY 23, 2010**
**2:00 PM- 5:00PM**

**SYMPOSIUM 36**

**TREATING CHRONIC PAIN AND CO-OCCURRING ADDICTION IN SUBSTANCE ABUSE PATIENTS**

*Tthe U.S. National Institute on Drug Abuse*

*Chairperson: Richard A Denisco, M.D., M.P.H., 6001 Executive Blvd., Bethesda, MD 20892,*
*Co-Chairperson: Will M. Aklin, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify patients with recent or remote histories of substance abuse as it relates to their chronic or acute pain problem; 2) List and understand definitions of many of the terms commonly used in the care of these patients; 3) Identify the uses of buprenorphine and methadone in patients with chronic pain and co-occuring addiction and 4) Identify risk management stratigies to take with patients undergoing opioid therapy.

**OVERALL SUMMARY:**

Opioid analgesics are among the most powerful treatments available to relieve human suffering from various disease processes. However, they have equally powerful potential adverse effects including addiction. This creates a quandary for physicians, psychiatrists, and psychologists caring for patients with remote or current histories of substance abuse or current opioid maintenance therapy, and the need for analgesia for relief of acute or chronic pain conditions, including pain from malignant and non-malignant origins. Empirical evidence for treating these patients is limited, but useful experience has been gained. This symposium will present this experience and recent research findings that may open new pathways of care that both reduce addiction and under-treatment of pain in this population. Specifically definitions of many of the terms commonly used in the care of these patients will be discussed, the different types of pain will be discussed including the specific management concerns of patients presenting with a wide variety of addiction histories. Conversely, how each of these addiction histories should be considered by the clinician in setting a patient specific treatment plan will be explored. A significant number of patients with opioid dependence beginning buprenorphine detoxification or maintenance treatment also report chronic pain. Integrated treatment models are effective for treating medical comorbidities; however, better models of care for chronic pain and co-occuring addiction are needed. For example, with regard to pharmacological treatments, what are the advantages and disadvantages of buprenorphine and methadone used to treat acute pain and addiction concurrently? In addition to these pharmacological approaches, what are the common features of integrated treatments for both chronic pain and opioid addiction? Specifically, given the shortage of empirically-based protocols in therapies for persisting pain, this session also will highlight the role of acute pain among those in treatment for opioid addiction and ways to improve the efficacy and effectiveness of combined treatment, including behavioral, physiological, emotional reactivity and cognitive restructuring. Results from the Prescription Opioid Addiction Treatment Study (POATS) conducted by the NIDA Clinical Trials Network will be presented for the first time. Results from this important study will inform the attendees about the effectiveness of buprenorphine/naloxone and counse

No. 36-A

**WHY DO SOME PATIENTS HAVE PERSISTENT PAIN AND PERSISTENT OPIOID USE FOLLOWING SURGERY: AN INCEPTION COHORT STUDY**

*Ian Carroll, M.D., M.S., 780 Welch Rd, Palo Alto, CA 94304*

**SUMMARY:**

Context: 31% to 84% of prescription opioid addicts seeking inpatient treatment report that they had legitimately been given opioids for pain by a physician that they later went on to abuse, and as many as 61% described a chronic pain problem. Thus pain, analgesic use of opioids, and non-analgesic use of opioids co-occur in a complex, poorly understood manner. In patients with pain it is conceptually attractive, but impossible in practice, to objectively define when use of opioids represents appropriate analgesic use versus addictive behavior. Pain and opioid abuse can both be functionally debilitating and drive opioid seeking behavior; therefore both clinicians and patients are forced to make subjective attributions regarding the sources of a patients role dysfunction, and causes of opioid consumption. We sought to identify the factors leading to persistent pain and persistent opioid use (an objective behavior that is prerequisite for progressing to addiction).

Design: We conducted a pilot cohort study of patients undergoing surgery with preoperative measurements of recognized risk factors for chronic pain and addiction such as affective distress. Following surgery, opioid use and pain were assessed daily until patients discontinued their opioids and ceased having pain. Patients: 77 of 95 consecutively approached patients scheduled to undergo mastectomy, lumpectomy, thoracotomy, total knee replacement, or total hip replacement consented to participate. Main Outcome Measure: The primary endpoint was time to opioid cessation, secondary endpoint was time to pain resolution. Results: Nine percent of patients continued to take new prescription opioids 150 days after surgery. Pre-operative depression symptoms strongly predicted persistent opioid use: each 10 point increase on a Beck Depression Inventory II was associated with a 57% reduction in the rate of opioid discontinuation. ($p<0.002$). Pre-operative, self-perceived susceptibility to addiction was also associated with marked increases in persistence of opioid. In contrast PTSD symptoms predicted delayed pain resolution.
Conclusions: These findings may help identify patients at high risk of persistent opioid use or persistent pain following injury.

No. 36-B
**CLINICAL ASPECTS OF RISK MANAGEMENT IN OPIOID THERAPY**

*Steve Passik, Ph.D., Memorial Sloan Kettering Hospital, New York, NY 10010*

**SUMMARY:**
Over the past 20 years there has been a dramatic increase in the use of opioids for non-cancer pain. While originally fueled by activism from the pain management community that was well-intentioned but also somewhat trivializing of addiction and other negative outcomes of increased opioid prescribing, the paradigm has changed. The new paradigm is one of risk stratification and then matching of the delivery of opioid therapy to patients with safeguards appropriate to their level of risk. This talk will discuss this process and make suggestions for management strategies especially for the highest risk patients - those with histories of substance abuse.

No. 36-C
**BEHAVIORAL TREATMENT FOR CO-OCCURRING CHRONIC PAIN AND OPIOID ADDICTION**

*Barry Declan, Ph.D., 34 Park Street, CMHC/SAC Room S220,, New Haven, CT 06519-1187*

**SUMMARY:**
Co-occurring chronic pain and opioid dependence (POD) is prevalent and associated with adverse treatment outcomes in patients entering opioid agonist maintenance treatment (OMT) with methadone or buprenorphine and in primary care and physician office settings. OMT may reduce non-prescribed opioid use in patients with POD, but continued problematic opioid use may persist, especially if pain is not addressed successfully, and strategies for treating chronic pain during OMT have not been systematically evaluated. This presentation will describe recent research regarding the development of integrated cognitive behavioral therapy (CBT for POD) for treating the dual, interrelated problems of chronic pain and opioid dependence during OMT. CBT for POD is based on 5 CBT pain modules with the strongest empirical support in non-addict populations and of greatest relevance to patients with POD. These modules include: 1) Education to provide a rationale for the other specific CBT modules; 2) Cognitive Control to identify and challenge dysfunctional cognitive errors (e.g., catastrophizing); 3) Exercise and Behavioral Activation to counter deconditioning and increase flexibility and social functioning; 4) Coping with Pain or Craving without illicit drug use; and 5) Relaxation Training.

No. 36-D
**RESULTS OF THE PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY: A MULTI-SITE TRIAL OF THE NIDA CLINICAL TRIALS NETWORK**

*Roger Weiss, M.D., 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**
Prescription opioid dependence has become a national public health priority; prescription opioids are now the most common form of drug initiation. Most treatment studies of opioid-dependent populations have focused exclusively or predominantly on heroin users, and thus do not adequately address those with prescription opioid dependence. This symposium will provide an opportunity to review findings from the Prescription Opioid Addiction Treatment Study – the first multi-site randomized controlled trial to specifically examine treatments for individuals with prescription opioid dependence, including those with chronic pain. This study, part of the NIDA Clinical Trials Network, compared the efficacy of different lengths of buprenorphine/naloxone in combination with different intensities of medical and psychosocial counseling. The study contained two treatment phases: 1) 4 weeks of buprenorphine/naloxone, including a 2-week dose taper; and, for those who relapsed during this phase, 2) a 3-month buprenorphine/naloxone treatment, followed by a one-month taper. In both phases, participants were randomized to standard medical management (SMM) alone or SMM plus individual drug counseling. A total of 653 participants at 10 sites were randomized to Phase 1; 360 entered Phase 2. The study is completed, and results will be available by January 2010.This presentation will review the primary study outcomes and key secondary outcomes (such as response among patients with current

chronic pain) regarding treatment response in Phase 1 and Phase 2 of this multi-site study. Clinical implications of these study results for the treatment of prescription opioid dependence will be discussed.

No. 36-E

**OVERVIEW OF THE TREATMENT OF ACUTE AND CHRONIC PAIN IN THE PATIENT WITH A HISTORY OF ADDICTION**

*Sean Mackey, M.D., Ph.D., 780 Welch Road Suite 208F, Stanford, CA 94304*

**SUMMARY:**

Patients with a history of addiction experience trauma, acute painful medical illnesses, may have to undergo surgery and suffer chronic pain – much like patients who are not addicted. These patients require treatment for pain. Under treatment of these patients is a particular problem in patients with opioid dependency and/or methadone maintenance. This talk will review the strategies for management of acute and chronic pain in the addicted patient – focusing on patients with opioid addiction. We will discuss the importance of maintaining the patient on their baseline opioids, the methods of assessing a patient's pain, use of non-opioid adjuvants for pain management, and the importance of non-pharmacologic pain management therapies.

**SYMPOSIUM 37**

**CULTURALLY SENSITIVE TREATMENT OF PSYCHOLOGICALLY DISTRESSED ETHNIC AND NON-ENGLISH SPEAKING POPULATIONS**

*Chairperson: Devon Hinton, M.D., Ph.D., 15 Parkman Street, WACC 812, Boston, MA 02114, Co-Chairperson: Roberto Lewis-Fernández, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to 1) Know how to adapt treatments for ethnic and non-English speaking populations; 2) Know how to increase compliance for ethnic and non-English speaking populations and 3) Know how to create treatments that target the families of ethnic and non-English speaking and ethnic populations.

**OVERALL SUMMARY:**

The United States is increasingly multicultural. Treatment providers need to tailor pharmacological and psychological treatments to optimize their efficacy in ethnic and non-English speaking populations. In this symposium, several culturally tailored treatments and related treatment trials will be discussed. One talk presents data on the efficacy of a parent training program for the prevention of conduct disorder that was adapted for Black and Latino families of young children living in low-income, urban communities. Another describes a culturally sensitive treatment for traumatized non-English speaking patients (Emotion Regulation Therapy for PTSD), which has been show in randomized controlled trials to be effective for Cambodian and Vietnamese refugees as well as for non-English speaking Latinos. Another presentation details the outcome of a treatment trial of a culturally adapted, family-based intervention designed to promote treatment adherence among Mexican-Americans with schizophrenia. Another reports on the outcome of a trial using Motivational Antidepressant Therapy (MADT) to increase treatment compliance and outcome among less-acculturated Latinos. Another presentation delineates a family-focused interventions for refugee families that fits the complex real-life contexts where they live, an approach informed by a protective resources approach, ecodevelopmental theory, and community collaboration. Through this symposium, participants will learn about cutting-edge examples of treatment adaptation. These culturally sensitive treatments aim to reduce distress in ethnic and non-English speaking populations by many culturally tailored methods—using cognitive-behavioral techniques, increasing medication compliance, educating families, improving family dynamics, and increasing access to care. Compared to non-Latino whites, US racial/ethnic minorities underutilize antidepressant therapy (ADT), as evidenced by lower rates of treatment acceptability, initiation, retention, and adherence. Socioeconomic factors and unequal quality of mental health care play a role, but cultural factors are also important. Likely cultural factors in Latinos include stronger preference for psychotherapy than medication, higher stigmatization of psychopharmacotherapy, illness constructions inconsistent with ADT, and less proactive communication style with clinicians.Interventions to improve ADT utilization in underserved groups must attend to cultural factors or risk perpetuating disparities. Calls for cultural competence, however, usually offer insufficient detail on how to tailor ADT across cultures, especially given the brevity of psychopharmacology sessions. Motivational interviewing (MI) enhances treatment retention across diverse settings, but has not been applied to psychopharmacotherapy. We developed motivational antidepressant therapy (MADT) for this purpose, combining pharmacotherapy for MDD and MI, to be delivered by psychiatrists without need for ancillary personnel. MADT was culturally adapted to the views and concerns about ADT among less-acculturated Latinos. This presentation will focus on the cultural adaptations to MADT that were tested in a pilot study with a sample of low-income Spanish-dominant Latino migrants from multiple national origins. The goal of the pilot study was to examine the impact of MADT on ADT retention and response among depressed Latinos in outpatient psychiatric care.Fifty low-acculturated, depressed Latino outpatients received 12 weeks of MADT, which incorporated MI elements into psychopharmacological therapy. Outcome

measures included retention, and treatment response across symptoms, functioning, and quality of life. Visit length and response and remission rates were also assessed. Twenty percent of patients discontinued treatment by 12 weeks, with a mean therapy duration of 74.2 days out of a possible 84. Patients' symptoms, psychosocial functioning, and quality of life improved significantly. Visit length was acceptable for community clinics, at 37 minutes for the first visit and 24 min for subsequent visits. Responder and remitter rates were 82% and 66%.

No. 37-A

**EFFICACY OF A CULTURALLY ADAPTED PARENT-TRAINING PROGRAM FOR ETHNIC MINORITY FAMILIES FROM LOW-INCOME COMMUNITIES**

*Esther Calzada, Ph.D., 215 Lexington Ave 13th Fl, New York, NY 10016*

**SUMMARY:**
Mental health interventions for ethnic minority populations are of considerable interest as researchers and clinicians tackle issues such as high rates of violence, substance use and depression among Black and Latino youth. Given a lack of empirical data, however, questions regarding the efficacy of evidence-based treatments (EBTs) with ethnic minority populations remain unresolved. Some studies suggest that EBTs are likely to be appropriate and efficacious with ethnic minority individuals, while others have found culturally adapted programs to be superior in terms of effect sizes on target outcomes. Proponents of cultural adaptation, or the process of modifying EBTs to incorporate aspects of culture, argue that such modifications are necessary to increase the transportability of treatments to ethnic minority populations. Findings that ethnic minority populations underutilize mental health services bolster this argument. According to critics, though, cultural adaptations risk compromising key ingredients and therefore reducing the efficacy of EBTs. The present study examined the efficacy of a parent training program for the prevention of conduct disorder adapted for Black and Latino families of young children living in low-income, urban communities. In a school randomized controlled trial, we evaluated the short-term effects of a family universal intervention in 10 schools with 1040 ethnic minority Pre-Kindergarten students. The social/behavioral intervention is culturally, ecologically, and developmentally-informed, theoretically-based, and designed to promote effective parenting practices and parent-school involvement and reduce conduct problems. The intervention includes an after-school family intervention for Pre-K families that is co-facilitated by mental health professionals and Pre-K teachers. The intervention was shown to be feasible, highly acceptable, and accessible to ethnic minority families from low-income, urban communities. Results indicate medium to large intervention effects on parenting practices, parent-school involvement and child conduct problems during Pre-K. Moreover, results suggest that the intervention results in lower rates of teacher-rated conduct problems by the end of kindergarten in intervention children relative to controls, and these intervention effects are most pronounced for children who enter Pre-K with high rates of aggression. Findings are discussed in light of the debate on cultural adaptation.

No. 37-B

**CULTURALLY SENSITIVE TREATMENT OF TRAUMATIZED REFUGEES AND ETHNIC POPULATIONS: EMOTION REGULATION THERAPY FOR PTSD**

*Devon Hinton, M.D., Ph.D., 15 Parkman Street, WACC 812, Boston, MA 02114*

**SUMMARY:**
In this presentation, we will describe a culturally sensitive treatment for traumatized refugees, a treatment we refer to as Emotion Regulation Therapy (ERT) for PTSD because of its emphasis on emotion regulation techniques. The treatment has been shown to be effective for treating PTSD in several randomized controlled trials: three with Cambodian refugees in the United States, one with Vietnamese refugees in the United States, and one with Spanish-speaking patients in the United States. The treatment involves multiple emotion regulation techniques—a visualization that promotes emotional and cognitive flexibility, practice in mindfulness, yoga-like stretching exercises paired with self-statements of flexible adjustment, a trauma-processing protocol—that are adapted for the culture in question. It also includes standard cognitive-behavioral techniques: education, modifying catastrophic cognitions, and interoceptive exposure. The results of the treatment trials and basic aspects of the treatment will be described.

No. 37-C

**PSYCHOSOCIAL TREATMENTS FOR MEXICAN AMERICANS WITH SCHIZOPHRENIA**

*Alex Kopelowicz, M.D., 14445 Olive View Dr Rm 6D-119, Sylmar, CA 91342*

**SUMMARY:**
Upwards of 50% of individuals with schizophrenia do not adhere to their medication and psychosocial treatment regimens. This failure to participate in mental health services as prescribed by treatment providers often results in the utilization of mental health services disproportionately weighted on the side of more costly, inpatient treatment and has a negative impact on the long term outcome of the disorder. Because of the additional socioeconomic, language, immigration, and cultural barriers in accessing

mental health services, Mexican-Americans have a lower utilization rate of outpatient psychiatric services in comparison with non-Hispanic whites and the rate of non-adherence to treatment among Mexican-Americans with schizophrenia approaches 70%. Given that Mexican-Americans make up well over 60% of the Hispanic population of the United States and that Hispanics are the largest ethnic minority group, failure to overcome this barrier to treatment constitutes a mental health crisis. This project evaluated a culturally adapted, family-based intervention designed to promote treatment adherence among Mexican-Americans with schizophrenia. The conceptual foundation for the intervention was Ajzen's theory of planned behavior. This conceptual model was selected for study because its emphases on the important roles of subjective norms and perceived behavior control are highly germane to the study population and to the proposed intervention.One hundred and seventy four Mexican-American patients with schizophrenia and their families were randomly assigned to either: 1) one year of standard multi-family groups (MFG-S) that focused on psychoeducation, communication skills training and problem-solving added to ongoing customary outpatient care; 2) one year of multi-family groups adapted to emphasize the importance of attitudes towards adherence, subjective norms, and self-perceived and actual adherence skills in maintaining adherence, added to ongoing customary outpatient care (MFG-A); or 3) treatment as usual only (TAU; monthly pharmacotherapy sessions and additional services as clinically needed). Evaluations were made of patients and their key relative at baseline and every four months for the first year with follow up evaluations at 18 months and 24 months.

No. 37-D

### USING CULTURALLY ADAPTED MOTIVATIONAL INTERVIEWING TO IMPROVE RETENTION OF LATINO OUTPATIENTS IN ANTIDEPRESSANT THERAPY

*Roberto Lewis-Fernández, M.D., NYSPI- Rm. 3200 (Unit 69) 1051 Riverside Dr., New York, NY 10032*

**SUMMARY:**

Compared to non-Latino whites, US racial/ethnic minorities underutilize antidepressant therapy (ADT), as evidenced by lower rates of treatment acceptability, initiation, retention, and adherence. Socioeconomic factors and unequal quality of mental health care play a role, but cultural factors are also important. Likely cultural factors in Latinos include stronger preference for psychotherapy than medication, higher stigmatization of psychopharmacotherapy, illness constructions inconsistent with ADT, and less proactive communication style with clinicians.Interventions to improve ADT utilization in underserved groups must attend to cultural factors or risk perpetuating disparities. Calls for cultural competence, however, usually offer insufficient detail on how to tailor ADT across cultures, especially given the brevity of psychopharmacology sessions. Motivational interviewing (MI) enhances treatment retention across diverse settings, but has not been applied to psychopharmacotherapy. We developed motivational antidepressant therapy (MADT) for this purpose, combining pharmacotherapy for MDD and MI, to be delivered by psychiatrists without need for ancillary personnel. MADT was culturally adapted to the views and concerns about ADT among less-acculturated Latinos. This presentation will focus on the cultural adaptations to MADT that were tested in a pilot study with a sample of low-income Spanish-dominant Latino migrants from multiple national origins. The goal of the pilot study was to examine the impact of MADT on ADT retention and response among depressed Latinos in outpatient psychiatric care.Fifty low-acculturated, depressed Latino outpatients received 12 weeks of MADT, which incorporated MI elements into psychopharmacological therapy. Outcome measures included retention, and treatment response across symptoms, functioning, and quality of life. Visit length and response and remission rates were also assessed. Twenty percent of patients discontinued treatment by 12 weeks, with a mean therapy duration of 74.2 days out of a possible 84. Patients' symptoms, psychosocial functioning, and quality of life improved significantly. Visit length was acceptable for community clinics, at 37 minutes for the first visit and 24 min for subsequent visits. Responder and remitter rates were 82% and 66%.

No. 37-E

### PREVENTIVE INTERVENTIONS FOR REFUGEE FAMILIES IN RESETTLEMENT

*Stevan Weine, M.D., 1601 W Taylor St Rm 589, Chicago, IL 60612*

**SUMMARY:**

In refugee resettlement so much depends on the families. Yet providers, organizations, and academics in the refugee field could be doing more to build family focused interventions for refugee families that fit the complex real-life contexts where they live. This presentation offers model for how this can be approached through incorporating a protective resources approach, ecodevelopmental theory, community collaboration, mixed methods, and the comprehensive dynamic trial. It presents findings from a program of research on refugees for which the overall aim is to develop, implement, and evaluate psychosocial interventions that are feasible, acceptable, and effective with respect to the complex real-life contexts where refugees and migrants live. It will discuss examples of services research work with families from Bosnia-Herzegovina, Kosovo, Liberia, Burundia, and Tajikistan. It will describe several different trajectories for developing preventive interventions for refugee families, including interventions that focus on educational disparities, family support, and services access

in refugee youth. Because survey and randomized controlled trial methods are often inadequate to design interventions in diverse cultures and contexts, it is necessary to develop appropriate methodologies, such as focused ethnographic methods, engagement and retention strategies for "hard to reach" populations, and a knowledge-based to inform multilevel interventions.

**REFERENCES:**

1. Hinton, D. E. (2006), Editor, Special Issue, "Culturally Sensitive Cognitive Behavior Therapy." Cognitive And Behavioral Practice, Volume 13 (4).

**SYMPOSIUM 38**

## NEUROENDOCRINE AND NEUROIMMUNOLOGICAL CORRELATES OF BIOPOLAR DISORDER IN WOMEN

*Chairperson: Natalie L Rasgon, M.D., Ph.D., 401 Quarry Road Ste 2368, Stanford, CA 94305-5723,*
*Co-Chairperson: Roger S McIntyre, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to 1) Enumerate three metabolic factors that mediate allostatic change in bipolar disorder; 2) Enumerate three comorbid conditions in bipolar disorder that share points of pathophysiological commonality with bipolar disorder; and 3) Introduce three novel 'metabolic-based therapies' in bipolar disorder.

**OVERALL SUMMARY:**

This symposium will discuss and review new evidence ofendocrine, metabolic and neuroimmunological dysfunction in women with BD and will propose algorithms for minimizing potential adverse effects on the endocrine health of women treated for BD.Disturbances in insulin glucose homeostasis may play a critical role in both physiological and pathophysiological functions in bipolar disorder. Individuals with bipolar disorder exhibit regional abnormalities in brain structure and function as well as neurocognitive deficits. Moreover, individuals with bipolar disorder exhibit a broad array of neurocognitive deficits that persist during periods of euthymia. Epidemiological studies suggest that populations of individuals with bipolar disorder are at risk for Mild Cognitive Impairment as well as Alzheimer's disease. Undoubtedly health systems, medication, as well as behavioural factors are contributory. Neurobiological studies implicate disturbances in insulin as well as associated interacting networks (immuno-inflammation, oxidative stress) as perhaps a critical pathophysiological abnormality and possible therapeutic target. This presentation will review this hypothetical position and discuss treatment opportunities that are not only symptom suppressing but possibly disease modifying.

No. 38-A

### REPRODUCTIVE ENDOCRINE FUNCTION IN WOMEN WITH BIPOLAR DISORDER AND CONTROLS

*Natalie Rasgon, M.D., Ph.D., 401 Quarry Road Ste 2368, Stanford, CA 94305-5723*

**SUMMARY:**

We and others have previously reported high rates of menstrual and endocrine dysfunction in women with Bipolar Disorder (BD). Controversy exists as to whether these abnormalities are caused by the mood stabilizing medications used in the treatment of BD, or by the illness itself. The present study examined reproductive function in 77 reproductive-aged women with clinically confirmed BD, compared to 35 age-matched healthy control women. All women participants were aged 18-40 and were free of steroidal contraceptives. Participants completed questionnaires about their menstrual cycles and provided early follicular blood samples for measurement of hormone levels. Menstrual abnormalities (MAS) considered were Oligomenorrhea, Amenorrhea, and Menorrhagia. In addition, a subset of participants (52 BD women and 29 control women) tracked their ovulation for 3 consecutive months via urinary ovulation kits and mid-luteal phase blood draws to measure serum progesterone levels, with levels >4NG/ML in at least two of three consecutive cycles considered indication of positive ovulation. Results: History of menstrual abnormalities (MAS) was reported by 66% of women BD and 44% of control women. Among BD women with history of MAS, 38% experienced onset of MAS prior to diagnosis of BD. Compared to control women, BD women had significantly higher body mass index (BMI) and fasting plasma insulin and significantly lower dehydroepiandrosterone sulfate (DHEA-S) and 17 hydroxyprogesterone confirmed polycystic ovary syndrome (PCOS) was observed in 5 (6.5%) of BD women and none of the controls. Confirmed ovulation was observed in 81% of BD women and 86% of control women. Women treated with mood stabilizing medication for >3 months had a greater rate of MAS than untreated women. Conclusion: BD women have more MAS, which in many cases precede the diagnosis and treatment of BD. Further, MAS in BD women appear to be further exacerbated by the use of mood stabilizing medication.

No. 38-B

### SHOULD BIPOLAR DISORDER BE RECLASSIFIED AS METABOLIC SYNDROME TYPE II?

*Roger McIntyre, M.D., 399 Bathurst St MP 9-325, Toronto, M5T 2S8*

**SUMMARY:**

Disturbances in insulin glucose homeostasis may play a critical role in both physiological and pathophysiological

functions in bipolar disorder. Individuals with bipolar disorder exhibit regional abnormalities in brain structure and function as well as neurocognitive deficits. Moreover, individuals with bipolar disorder exhibit a broad array of neurocognitive deficits that persist during periods of euthymia. Epidemiological studies suggest that populations of individuals with bipolar disorder are at risk for Mild Cognitive Impairment as well as Alzheimer's disease. Undoubtedly health systems, medication, as well as behavioural factors are contributory. Neurobiological studies implicate disturbances in insulin as well as associated interacting networks (immuno-inflammation, oxidative stress) as perhaps a critical pathophysiological abnormality and possible therapeutic target. This presentation will review this hypothetical position and discuss treatment opportunities that are not only symptom suppressing but possibly disease modifying.

No. 38-C

**INFLAMMATORY AND OXIDATIVE PATHWAYS IN MOOD DISORDERS: NOVEL MECHANISMS AND THERAPEUTIC OPPORTUNITIES**

*Michael Berk, M.D., Ph.D., PO Box 281 Geelong, VIC 3220, Geelong, 3220*

**SUMMARY:**
The brain is the most metabolically active tissue, and disruptions in mitochondrial regulation are well described in mood disorders. Related to this is evidence of inflammatory and oxidative stress. There is evidence of increased inflammatory activity in mood disorders, including cytokines. Administration of pro-inflammatory cytokines is amongst the best models of depression. Oxidative stress is similarly documented in mood disorders, as are the sequelae of inflammatory and oxidative stress. These include lipid peroxidation, DNA fragmentation and an increased vulnerability to apoptosis. Inflammatory and oxidative stress leads to decreased BDNF and other trophic factors. Established antidepressants and mood stabilisers including lithium and valproate have a role in ameliorating oxidative stress. N-acetyl cysteine (NAC) is a precursor of glutathione, has anti-inflammatory properties and has been shown to reverse animal models of oxidative stress. Clinical data shows a significant benefit of NAC on measures of depression, quality of life and functioning at endpoint. Effect sizes were in the moderate to large range. Equally, cytokines provide some novel therapeutic targets, which are clinically accessible. These will be discussed.

No. 38-D

**SERUM B12 LEVELS AND THYROID FUNCTION IN BIPOLAR DISORDER - IS THERE A GENDER DIFFERENCE?**

*Aysegul Ozerdem, M.D., Ph.D., Dept of Psychiatry, Narlidere, 35340*

**SUMMARY:**
Thyroid hormones are known to play a role in mood regulation and cognitive functioning. Previously reciprocal relationships between thyroid hormones and hormones of the hypothalamo-pituitary-adrenal (HPA) and hypothalamo-pituitary-gonadal (HPG) axes have been suggested. In addition, vitamin B12 is crucial for cognitive performance. Patients with bipolar disorder (BD) frequently exhibit altered thyroid functioning and B12 levels, which may underlie deficits in cognitive functioning observed in this population. Despite evidence that gender may influence neurocognitive functioning, few studies have examined its effects in BD. The aim of the present study was to determine the serum thyroid and B12 levels in patients with bipolar disorder and to evaluate or potential gender differences in biomarkers of thyroid function and vitamin B12. Dokuz Eylul University Hospital laboratory database covering the last two years was searched for serum thyroid hormone and B12 levels. Results for patients with bipolar disorder diagnosis and patients with non-psychiatric diagnosis are compared with a special consideration for gender difference in both groups. Findings from the ongoing statistical analysis will be presented.

**MONDAY, MAY 24, 2010**
**9:00 AM-12:00PM**

**SYMPOSIUM 41**

**HEALTH AND MENTAL HEALTH AROUND THE WORLD? ARE ALL SYSTEMS GO?**

*Chairperson: Gisèle Apter, M.D., Ph.D., 14 Rue de l'Abbaye, Antony, 92160 France,*
*Co-Chairperson: Nada L. Stotland, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Have knowledge of different health systems across the world and compare their advantages and disadvantages; and 2) The use of this knowledge to promote the ameloration of the health system will be underlined.

**OVERALL SUMMARY:**
The aim of this symposium will be to present different health and mental health care systems around the world in Canada, France, Switzerland and the US. Each speaker will describe the way their country provides (or does not) care for its citizens, emphasizing the pros and cons in their countries. The description will include bullet points on patient's access to care whether for acute or chronic conditions, organization of integrative care for families and special age groups (infants, adolescents, pregnancy, special needs, elderly) and financial and social management of illness within the healthcare system (%of out of pocket financing, rehab facilities, restrictions due to status of

residents will be among these issues). Physicians' means of practice, private and public, hospital and independent practice will be described in each setting. How medical education and research are organized in each country and their adequacy to actual and future needs will be discussed. The impact of each system on the population's health expectancies and quality of life as assessed by themselves and international studies will then conclude each presentation. A general discussion enhancing how each country might learn from other settings will follow the different presentations. Considering cultural, legal and financial issues in each country, how integration of different points from any system could be implemented will be open for debate.

No. 41-A

**THE CANADIAN HEALTH CARE SYSTEM: PROS AND CONS**

*Gail Robinson, M.D., Toronto General Hospital8-231 EN200 Elizabeth St.,Ontario, Toronto,M4W 3M4*

**SUMMARY:**
In Canada, healthcare is provided to all citizens, landed immigrants and refugees free of charge. Programs are administered by the provinces, leading to some differences in what is covered and fees paid to providers. Most medical assessments and treatments are covered although individuals may have supplementary insurance to cover the cost of medications or to pay for private hospital accommodation. Specifically for psychiatry, any patient may see a psychiatrist without cost. Psychotherapy and medication management are covered. Psychologists are not covered by provincial plans but may be paid for by some supplemental plans. Provincial plans to not pay for routine meds but many provinces have programs to limit the amount an individual should have to pay per year for medications. The downside is that there is no way to pay for special attention or more rapid service so there may be waiting lists, especially for procedures such as heart surgery. However, no ones goes bankrupt because they cannot afford to pay their medical bills. From the physicians' standpoint, one gets paid for every patient who is seen, the physician makes the decision as to the type and length of treatment and there is no time spent arguing with bureaucrats. Although more money is spent for per capita for healthcare in the US, Canadians live longer and have a lower neonatal death rate. The presenter will discuss a variety of advantages and disadvantages of the Canadian system

No. 41-B

**THE SWISS HEALTH SYSTEM: PRIVATE INSURANCE AND SOLIDARITY ARE POSSIBLE**

*Olivier Halfon, M.D., Bugnon 23 a, Lausanne, 1094*

**SUMMARY:**
The Swiss health system has flirted in recent years with elements of price-based consumer choice, albeit within a framework of strictly regulated competition. The Swiss, for example, have experimented with consumer choice in the market for health insurance: it delivers a superior, more cost-effective, and more equitable performance than does the US system. The positive results achieved by the Swiss system may be attributed to its consumer control, price transparency of the insurance plans, risk adjustment of insurers, and solidarity. First we will describe the Swiss health system and secondly we will focus on the psychiatric health system.

No. 41-C

**THE FRENCH SYSTEM: "HEALTH SECURITY" FOR ALL?**

*Gisèle Apter, M.D., Ph.D., 14 rue de l'Abbaye, Antony, 92160*

**SUMMARY:**
The French National Health system is in fact part of a general National Social Security system, born in the aftermath of World War 2 so that :"The National Social Security System will guarantee each and everyone, in all circumstance that they will be enabled to ensure their family and themselves decent living conditions". ( A Parodi initiator of French Sécurité Sociale). It is a system funded by the whole population, originally employers and employees, based on solidarity. The funds are not capitalized but redistributed in what is called a "repartition system". The health branch of SS covers more than 75% of all medical expenses and 100% of selected major acute or chronic conditions (AIDS, Cancer, cardiac surgery, diabetes, schizophrenia and autism are some examples). Coverage is universal and includes illegal populations for severe illness. Physicians have inalienable rights: freedom of prescription, fee-for-service, and confidentiality-privacy. Choice of physicians and hospitals public or private, non-for-profit or for-profit is consumer-based. Mental health is specifically organized in such a way that the whole population has access to pubic funded free-of-fee psychiatric care on a geographically-based sector. Medical education is university based and schools are all publicly funded with very low tuition. Medical research is disseminated across diverse institutions. Public funds originate from both ministries of Health and of Research but also from the System itself.
This generous system is always under evaluated by the population whose expectancies are extremely high.
Health comes up as the number one preoccupation in times of economic stability in the French population. Long considered number one worldwide, the system has gained enormous complexity and shown extreme fragility in times of economic recession since it is indexed to gain in GDP. It needs to reorganize if it is not to be swept away

by political ideology backed by economic crisis.

No. 41-D
**MENTAL HEALTH CARE IN THE UNITED KINGDOM**

*Dinesh Bhugra, M.B.B.S, Ph.D., 17 Belgrave Square, London, SW1X 8PG*

**SUMMARY:**
National Health Service in the UK was established in 1948 and the principle is that all mental health and physical treatment is free at .the point of delivery. Each employee and employer contributes National Insurance for specific purposes of education and health care.Over the decades services have moved from asylums to community care and increasing specialisation.,National Service Framework was launched in 1999 and after 10 years an increasing emphasis on public mental health is in place..Over the 60 years there have been a range of changes in the models of mental health care delivery but the funding system has remained the same but the demand has continued to increase exponentially. In this lecture, a brief history of the development of the NHS is given followed by its strengths and shortfalls. It is inevitable that NHS is the largest employer of people in Europe and the management costs have been increasing. Mental health Trusts are separate organisations and the only link between them and acute care hospitals are consultation-liaison mental health staff. Some suggestions for future improvement and lessons will be described.

**REFERENCES:**
1.L. D. Brown, Comparing Health Systems in Four Countries: Lessons for the United States American Journal of Public Health 52-56;January 2003, Vol 93, No. 1

**SYMPOSIUM 42**

**UPDATE ON MEDICATIONS DEVELOPMENT: PROMISING NEW TREATMENTS FOR DRUG ADDICTION**

***The U.S. National Institute on Drug Abuse***

*Chairperson: Nora D Volkow, M.D., 6001 Executive Blvd. Rm 5274, MSC 9581, Bethesda, MD 20892, Co-Chairperson: David J McCann, Ph.D.*
*Discussant: Herbert D Kleber, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Demonstrate a working knowledge of some of the most promising medications in clinical testing for the treatment of addiction to cocaine, methamphetamine, cannabis, and tobacco; and 2) Gain an understanding of the potential impact of these medications on the field of drug addiction treatment.

**OVERALL SUMMARY:**
Medications can play an important role in the treatment of substance use disorders but there remain many areas of unmet clinical need. Most notably, FDA-approved medications for the treatment of cocaine, methamphetamine and cannabis use disorders are lacking. In addition, although multiple medications are available for smoking cessation, they are not effective for many smokers and relapse is common. Basic research has greatly increased our knowledge of the biochemical events linked to drug addiction and, as a result, many new biological targets are being pursued in medication development efforts. Unfortunately, projects that are currently at the library screening or animal testing stage may be more than a decade away form clinical impact. Today's physicians are most interested in late-stage development projects that may yield new treatment options in the near future. The purpose or this symposium is to provide an update on the status of some of the most promising new medications in clinical testing. Presenters will describe evaluations of modafinil for the treatment of cocaine dependence, evaluations of d-cycloserine for the treatment of both cocaine and tobacco dependence, evaluations of bupropion for the treatment of methamphetamine dependence, evaluations of dronabinol for the treatment of cannabis dependence, and evaluations of a nicotine vaccine for the treatment of tobacco dependence. The discussant will comment on the potential impact of these medications on the drug addiction treatment field and will lead an interactive discussion.Although no medication has received regulatory approval for the treatment of methamphetamine addiction, bupropion has shown promising results. In experienced methamphetamine users, bupropion (150 mg twice daily) was shown to significantly decrease ratings of drug craving and to significantly blunt ratings of feeling "high" or "stimulated" following intravenous infusions of methamphetamine (Newton et al., 2006). In a double-blind, placebo-controlled, 12-week efficacy trial (Elkashef et al., 2008), bupropion (150 mg twice daily) was shown to significantly increase the weekly percentage of patients with methamphetamine-free urines in a subset of patients who reported a low level of baseline methamphetamine use (not more than18 days use during the 30 days prior to screening); however, this method of data analysis revealed no significant effect of bupropion in the total sample of patients. A recent success/failure-based reanalysis of this trial has revealed a significant effect of bupropion in the total population of patients. With success defined as a patient being in treatment and providing at least two clean urines and no dirty urines per week during the last two weeks of the trial, and with failure defined as a patient either not being in treatment or giving one or more dirty urines during the last two weeks of the trial, 20.3% of patients receiving bupropion were successful in quitting methamphetamine

use while only 6.9% of patients receiving placebo were successful (P=0.02). Similar comparisons using longer periods of end-of-study abstinence to define successful quit attempts also showed a significant bupropion effect in the total population of patients. Results of the completed bupropion/methamphetamine studies will be summarized and the design and progress of an ongoing, confirmatory multi-site study will be described.

No. 42-A

**MODAFINIL AS A NOVEL MEDICATION IN THE TREATMENT OF COCAINE ADDICTION**

*Charles O'Brien, M.D., Ph.D., 3900 Chestnut Street, Philadelphia, PA 19104*

**SUMMARY:**
Modafinil is a medication developed for the treatment of narcolepsy. It promotes alertness and reduces the occurrence of sleep attacks in patients with narcolepsy. Although modafinil does inhibit the reuptake of dopamine and thus has mild stimulant properties, it also increases synaptic glutamate. In human laboratory studies and in clinical trials it has been found to have a low abuse potential. It has been found to reduce the euphoria produced by cocaine and to reduce the self-administration of cocaine in human cocaine addicts. In double blind trials, it has been found to produce significantly more clean urines than placebo. There was no evidence of abuse among cocaine addicts in these trials. This medication is being studied further to determine whether it has a role as an adjunctive medication in the treatment of cocaine addiction.

No. 42-B

**D-CYCLOSERINE IN THE TREATMENT OF COCAINE AND NICOTINE DEPENDENCE**

*Kathleen Brady, M.D., Ph.D., 171 Ashley Avenue, Charleston, SC 29425*

**SUMMARY:**
Acute treatment with D-cycloserine (DCS), a partial glutamate NMDA receptor agonist, enhances associative learning processes underlying extinction of conditioned fear responding in animal studies. Several recent clinical studies have demonstrated that DCS enhances extinction of response to fear-eliciting cues in individuals with anxiety disorders. Preliminary support DCS-enhancement of extinction of conditioned response to drug related cues in drug-dependence comes an investigation in which DCS accelerated extinction of cocaine conditioned place preference (CPP) in rodents. A recent trial in humans found that DCS enhanced extinction of response to nicotine cues in nicotine-dependent individuals. Data from these trials and studies exploring the impact of DCS on extinction of response to cocaine cues in cocaine-dependent individuals will be presented. Issues concerning the dosing and timing of DCS administration relative to the extinction training session will be discussed.

No. 42-C

**BUPROPION FOR THE TREATMENT OF METHAMPHETAMINE ADDICTION**

*David McCann, Ph.D., 6001 Executive Blvd., Room 4123, Bethesda, MD 20892-9551*

**SUMMARY:**
Although no medication has received regulatory approval for the treatment of methamphetamine addiction, bupropion has shown promising results. In experienced methamphetamine users, bupropion (150 mg twice daily) was shown to significantly decrease ratings of drug craving and to significantly blunt ratings of feeling "high" or "stimulated" following intravenous infusions of methamphetamine (Newton et al., 2006). In a double-blind, placebo-controlled, 12-week efficacy trial (Elkashef et al., 2008), bupropion (150 mg twice daily) was shown to significantly increase the weekly percentage of patients with methamphetamine-free urines in a subset of patients who reported a low level of baseline methamphetamine use (not more than18 days use during the 30 days prior to screening); however, this method of data analysis revealed no significant effect of bupropion in the total sample of patients. A recent success/failure-based reanalysis of this trial has revealed a significant effect of bupropion in the total population of patients. With success defined as a patient being in treatment and providing at least two clean urines and no dirty urines per week during the last two weeks of the trial, and with failure defined as a patient either not being in treatment or giving one or more dirty urines during the last two weeks of the trial, 20.3% of patients receiving bupropion were successful in quitting methamphetamine
use while only 6.9% of patients receiving placebo were successful (P=0.02). Similar comparisons using longer periods of end-of-study abstinence to define successful quit attempts also showed a significant bupropion effect in the total population of patients. Results of the completed bupropion/methamphetamine studies will be summarized and the design and progress of an ongoing, confirmatory multi-site study will be described.

No. 42-D

**DRONABINOL FOR CANNABIS ADDICTION TREATMENT**

*Frances Levin, M.D., 1051 Riverside Drive, New York City, NY 07666*

**SUMMARY:**
Cannabis preparations are the most commonly used illicit substances in the United States. Heavy and chronic use of marijuana carries with it substantial morbidity. Further,

documented increases in the potency of cannabis suggest a greater probability of developing dependence among those who regularly use cannabis. Separate lines of evidence also point to a growing need for cannabis-specific treatment. While adolescents are over-represented in substance abuse treatment admissions that report cannabis as the primary drug of abuse, a large percentage of primary marijuana admissions are adults. Further, treatment admissions for primarily cannabis use disorders exceed heroin or cocaine. Together this evidence suggests that developing effective cannabis specific interventions may help address a growing public health concern. While there are several psychosocial treatments that have shown to be effective in treating adolescent and adult cannabis abusers, a substantial proportion continue to abuse marijuana, implying the need for additional treatment strategies. Pharmacological interventions may provide another option for treating cannabis dependence. Most of the published pharmacologic research has been conducted in laboratory or controlled outpatient settings. Recent animal and human laboratory studies have characterized substantial withdrawal symptoms associated with the abrupt cessation of marijuana. Laboratory studies have found positive effects of orally administered tetrahydrocannabinol (THC) in reducing cannabis withdrawal symptoms and the positive subjective effects of smoked marijuana. The symptoms associated with marijuana withdrawal resemble those of anxiety and depressive disorders as well as nicotine withdrawal, suggesting the utility of a pharmacological intervention and psychotherapy. Therefore, a double-blind placebo-controlled 12-week treatment trial testing the agonist dronabinol in conjunction with a psychosocial intervention was initiated. The trial is near completion, with over 150 cannabis-dependent individuals randomized. At the time of presentation, treatment retention, treatment efficacy and safety data will be presented. Results from this trial are likely to suggest future areas of investigation.

No. 42-E

**NICVAX: AN INNOVATIVE VACCINE TREATMENT FOR NICOTINE ADDICTION**

*Raafat Fahim, Ph.D., 12276, Wilkins Avenue, Rockville, MD 20852*

**SUMMARY:**

Smoking is the leading preventable cause of mortality and morbidity in the world. A recent WHO report identifies tobacco use as an epidemic. Current smoking cessation therapies have modest short term efficacy but the relapse rates are very high. This is because nicotine is a highly addictive molecule. In addition, non-nicotine replacement therapies have significant undesirable psychological side effects. Clearly, new innovative approaches are needed to help smokers quit and remain abstinent. Nicotine is a small molecule that is non-immunogenic and does not elicit the production of antibodies. However, when nicotine is conjugated to a large globular protein, the immune system is able to recognize it as foreign and develop anti-nicotine antibodies. Nabi has pioneered the development of NicVAX to help smokers quit. NicVAX is a proprietary innovative vaccine candidate consisting of a nicotine hapten covalently bound to recombinant exoprotein A of pseudomonas aeruginosa. NicVAX has been studied in several animal models as well as multiple phase I/II clinical trials and has shown to be safe and highly immunogenic producing high levels of specific anti-nicotine antibodies upon immunization. In a phase II proof-of-concept study, anti-nicotine antibodies produced in response to NicVAX had a statistically significant direct correlation with smoking cessation; the higher the antibody level, the higher the quit rate. It is postulated that the mechanism of action of NicVAX entails the generation of specific anti-nicotine antibodies in response to vaccination, which serve to bind nicotine and preventing it from crossing the blood-brain barrier and reaching the nicotinic receptors in the brain. These antibodies which can persist for a long period may help break the addiction cycle, and can help smokers achieve long term abstinence. Further schedule optimization showed that higher and earlier antibody levels can be achieved. A Special protocol Assessment has been agreed to by the FDA. A phase III study, partially funded by NIDA is underway based on the optimized schedule to test the efficacy of NicVAX and its safety in a larger population.

**MONDAY, MAY 24, 2010**
**2:00 PM-5:00PM**

**SYMPOSIUM 43**

**EARLY DETECTION AND INTERVENTION IN SCHIZOPHRENIA: AN IDEA WHOSE TIME HAS COME**

*Chairperson: Jeffrey Lieberman, M.D., New York State Psychiatric Institute,1051 Riverside Dr, Unit 4,, New York, NY 10032-1007*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be knowledgeable of: 1) Recent evidence and studies on the effects of early detection and intervention in limiting morbidity and disability for people with schizophrenia and evaluate the translational value of the research presented to clinical practice; and 2) The current understanding of the prospect of forestalling the onset of schizophrenia through detection and treatment of persons prodromal for psychosis

**OVERALL SUMMARY:**

In recent years the prospect of early detection and intervention to forestall the onset or limit the morbidity

and disability associated with schizophrenia has taken hold and generated great enthusiasm. Although much remains to be done to develop the methodology and evidence for effective intervention strategies, initial results of studies show considerable promise for this strategy. This symposium will focus on presenting the most recent results of key projects that have been conducted to evaluate the effects of early detection/intervention strategies. Each speaker will comment on work in their particular area of interest and present the results of their most current studies.

No. 43-A

**EARLY INTERVENTION IN PSYCHIATRY: LESSONS FROM PSYCHOSIS**

*Patrick McGorry, M.D., Ph.D., University of Melbourne, Parkville, 3052*

**SUMMARY:**

Mental and substance use disorders are the key health issue for emerging adults, which if persistent, may constrain, distress and disable for decades. Epidemiological data indicate that 75% of people with mental disorders have an age of onset by 24 years of age, with new onsets peaking in the early twenties. In recent years, a worldwide focus on the early stages of psychotic disorders has improved understanding of these complex disorders and their outcomes. This reform paradigm has also illustrated how a staging model may assist in interpreting biological data and refining diagnosis and treatment selection. We now have a strong evidence base supporting early intervention in psychosis including robust cost effectiveness data and growing evidence that intervention even prior to full expression of the psychosis phenotype is feasible and effective. This paradigm can now be extended to mood and other major mental disorders. Furthermore the critical developmental needs of emerging adults are poorly met by existing service models. Young people need a different culture of service provision to engage with and benefit from interventions. The need for structural reform and a new research agenda is clear.

No. 43-B

**WHY TREATING EARLY, TREATING WELL, AND TREATING FOR LIFE IS IMPORTANT IN SCHIZOPHRENIA**

*Rene Kahn, M.D., Ph.D., University Medical Center Utrecht, Utrecht*

**SUMMARY:**

Studies emphasizing functional decline in schizophrenia as a clue to its pathogenesis, suggest that brain abnormalities in schizophrenia could be expected to reflect this clinical progression. We, and others, have reported brain abnormalities to increase over time in schizophrenia. Interestingly, not all patients show changes in brain volumes over time: we demonstrated that the changes are particularly pronounced in those patients with a poor prognosis in the first years of illness. Moreover progressive changes are most pronounced in the frontal and temporal areas as postulated by Kraepelin over a hundred years ago. We found that brain loss over time was most pronounced in patients who had been psychotic longest. Finally, the progression in these frontal brain changes appeared to be attenuated by treatment with atypical, but not by typical antipsychotics. Thus, not only are brain changes progressive in schizophrenia, they are clinically relevant since they are related to outcome and may be reversed by some of the atypical antipsychotics. With the evidence pointing to a link between progressive disease and patient outcomes, it is becoming increasingly clear that every effort should be made to prevent psychotic relapses. Using medications with maximal effect is therefore warranted.

No. 43-C

**SELECTIVE AND INDICATED PREVENTION FOR SCHIZOPHRENIA: AN NIMH PERSPECTIVE ON CURRENT AND FUTURE POSSIBILITIES**

*Robert Heinssen, Ph.D., 6001 Executive Blvd, Bethesda, MD 20892*

**SUMMARY:**

The National Institute of Mental Health Strategic Plan calls for research to chart the course of mental disorders over the lifespan in order to understand stages of risk as well as opportunities and methods for preemptive intervention. Two current NIMH-funded research initiatives in early phase schizophrenia illustrate complementary strategies for achieving risk prediction and preemption goals. The North American Prodrome Longitudinal Study (NAPLS) explores clinical high-risk states that precede the onset of psychosis using genetic, neurobiological, cognitive neuroscience, and behavioral research methods. NAPLS' goal is to identify robust and malleable risk factors for psychosis onset, and then to develop and pilot innovative risk reduction strategies. Recovery After an Initial Schizophrenia Episode initiative (RAISE) tests approaches for treating first episode psychosis within the context of the U.S. health system, using evidence-based interventions that can be implemented on a population-level basis. RAISE emphasizes multimodal treatment packages to be delivered in community settings by well-integrated treatment teams within a recovery-oriented, personalized framework. Early findings from these two initiatives will be discussed in relation to the NIMH Strategic Plan, particularly the goal of developing targeted, impactful interventions that will alter the course of schizophrenia.

No. 43-D

**PORTLAND IDENTIFICATION AND EARLY REFERRAL (PIER): PREVENTION OF PSYCHOSIS AS A PUBLIC HEALTH INTERVENTION**

*William McFarlane, M.D., 295 Park Avenue, Portland, ME 04102*

**SUMMARY:**
Portland Identification and Early Referral (PIER) is a population-based system for early detection and treatment for the prodrome to psychosis in people ages 12-35. PIER educated the community-at-large and trained over 7300 health, education and youth-related professionals to identify young people at high-risk of psychosis. Eligibility was established by the SIPS criteria. Treated cases received a comprehensive, evidence-based and prodrome-specific combination of psychoeducational multifamily group, supported education/employment, assertive community treatment and psychotropic medication. Outcome measures were first episodes of psychosis and changes in GAF during one year of intervention, and differences in clinical incidence rates (first hospitalizations for a psychosis) in experimental vs. control catchment areas before (1994-2000) vs. during (2001-2007) the intervention study. Over seven years, there were 780 referrals, of which 274 (35%) were assessed and 148 (19%) were admitted to study. 13 (9%) experienced >30 days of psychosis during one year of treatment. Mean GAF was 38.3 at baseline and 56.4 at 12 months (pre-post, p<0.01). The net pre-post difference in clinical incidence between control and experimental areas was 22.8/100,000 (ARIMA, p<0.0001). The relative difference in incidence between treatment and control areas is consistent with a community-wide prevention effect, simultaneously confirming accuracy of identification and preventive effect for treatment.

No. 43-E
**AT CLINICAL HIGH RISK FOR PSYCHOSIS – WHAT IS THE OUTCOME?"**

*Jean Addington, Ph.D., Centre for Addiction and Mental Health, 250 College Street,, Toronto, M5T1R8*

**SUMMARY:**
There has been increasing interest in early detection during the prodromal phase of a psychotic disorder. A major focus is on determining the risk of conversion to psychosis and on developing algorithms of prediction. To date a few treatment studies have been published with some promising results for both pharmacological treatments using second-generation antipsychotics and psychological interventions mainly with a focus on cognitive behavioral therapy (CBT). This talk will present data from a treatment trial of CBT versus supportive therapy for individuals at clinical high risk of developing psychosis. In this study conversions to psychosis only occurred in the group who received supportive therapy. Although this is an important result it is necessary to review subsequent changes in comorbid diagnoses, symptoms and functioning to better understand the outcome of those who are seen to be at clinical high risk beyond the outcome of conversion to psychosis. Further results from our studies with this clinical high-risk group demonstrate that although improvements in clinical symptoms are often observed, improvements in functioning are much less frequent. These results have implications for early detection and intervention in the pre-psychotic phase and for designing future treatments.

No. 43-F
**EARLY DETECTION AND INTERVENTION IN PSYCHOTIC DISORDERS: MAKING IT READY FOR PRIME TIME**

*Jeffrey Lieberman, M.D., New York State Psychiatric Institute,1051 Riverside Dr, Unit 4,, New York, NY 10032-1007*

**SUMMARY:**
This presentation will describe studies attempting to develop biological measures to aid in the diagnosis of patients in the prodromol phase or who are at high risk for developing schizophrenia or related psychotic disorders. Specifically, I will review the limitations of current diagnostic approaches and the problem with false positive case identification. Then I will describe the most promising ongoing lines of investigation using neuroimaging methodology including functional MRI and PET scanning to access pathophysiological processes indicative of an incipient psychotic disorder. Finally, therapeutic strategies that may be tested in the context of an identified at-risk patient population will be considered. The rationale and goals of the ongoing NIMH funded RAISE project (Recovery After an Initial Schizophrenia Episode) will be presented in this context.

**SYMPOSIUM 44**

**AN EXAMINATION OF CNS TRIAL METHODOLOGIES**

*Chairperson: Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114,*
*Co-Chairperson: Steven D Targum, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to discuss: 1) the variables affecting drug and placebo response in clinical trials; 2) the factors affecting baseline efficacy measures in clinical trials; and 3) innovative strategies for improving the integrity of clinical trial data.

**OVERALL SUMMARY:**
In recent years, there has been increasing concern about failed CNS clinical trials and its impact upon new drug development. Among the issues attributed to the lack of success of these trials has been inappropriate patient

selection, inaccurate ratings, and poor study compliance. Numerous studies suggest that the accuracy of baseline assessments are critical for successful CNS trials. Both academic and industry leaders are evolving innovative methodologies to address the issues of patient validation and ratings accuracy during clinical trials. This symposium will present five distinct approaches to improve the precision of CNS clinical trials. The use of centralized, remote ratings has been proposed as a better alternative to on-site clinician ratings, although there is limited supportive evidence.We used centralized, remote ratings as part of an investigator-initiated study conducted by MGH for BrainCells Inc. This was a 6-week, double-blind, placebo-controlled study followed by 6 weeks of open-label treatment conducted at 9 clinical trial sites. On-site raters and 7 remote raters from United Biosource Corporation (Wayne, Pennsylvania) administered paired IDSc30 and HAM-A interviews at Baseline, 6 weeks, and 12 weeks. These instruments were secondary measures in the study. The remote raters were blinded to both patient visit and protocol, and administered interviews via live video hook-up.129 subjects participated in the remote rating assessments. The Intra Class Correlation (ICC) for the IDSc30 between remote raters and on-site raters was 0.53 at baseline, 0.86 at 6 weeks, and 0.88 at 12 weeks. Baseline and endpoint IDSc30 scores, as well as response and remission analyses were not significantly different between remote and on-site clinician raters. The ICC for the Ham-A between remote raters and on-site raters was 0.45 at baseline, 0.75 at 6 weeks, and 0.77 at 12 weeks. The baseline Ham-A score was significantly higher in the remote, centralized rater group compared to the on-site clinician ratings (p=0.008). However, mean Ham-A changes from baseline to endpoint were not significantly different between these raters. Individual Ham-A item analyses revealed highly significant score differences between remote and on-site raters at baseline but not at week 6, particularly on Ham-A items 3 (Fears) and 14 (Behavior at the interview).In this study, remote raters offered no advantage over the traditional method of on-site clinician ratings. The HAM-A item analysis suggests that remote assessments may precipitate transient anxiety that may be unrelated to the underlying disease state.

No. 44-A

**PLACEBO RESPONSE IS NOT NECESSARILY RESPONSE TO PLACEBO: FACTORS INFLATING PLACEBO RESPONSE IN CNS TRIALS**

*Armin Szegedi, M.D., Schering-Plough Corporation 556 Morris Avenue, Summit, NJ 07901*

**SUMMARY:**
The success rates for new CNS molecular entities (NME) to enter phase 1 development and finally gain regulatory approval are below industry averages relative to other therapeutic areas indicating a substantially increased risk of failure during clinical development in CNS trials. A fundamental peril of CNS trials is that subjective assessments are still mandatory as primary efficacy parameters since validated surrogate marker are not available. This process is inherently vulnerable to methodological problems especially in large randomized clinical trials. Increasing placebo response rates endanger every drug development program. Rates of failed CNS trials or negative trials with established compounds have increased with placebo response showing a tendency to be more pronounced than 1-2 decades ago (1,2). It has been argued that placebo response is not necessarily response to placebo alone. Some aspects of placebo response likely reflect artifacts in the conduct of clinical trials rather than a true response to placebo. The factors contributing to placebo response in clinical trials tend to fall into three general categories: 1) patient-related factors including issues such as expectancy, hope, and natural disease variation; 2) site and investigator-related factors including patient selection, staff oversight, and infrastructure efficiency issues; 3) rater-related factors, including rater expectancy/bias, interview skills, scoring accuracy, and rater drift. Several methods have been proposed in recent years to address these factors, such as improved rater training and oversight strategies, enhanced patient selection methods, and alternate designs aimed at minimizing placebo response (1,3).We will review the patient-related and rater-related factors which may be amenable to intervention, as well as strategies for addressing each factor in future clinical trials. Novel methods will be discussed, including Expert Rater Assisted Subject Evaluation (ERASE*), which aims to monitor rater performance in individual patients during an ongoing clinical trial.

No. 44-B

**DOES DE-COUPLING OF ENTRY CRITERIA IMPROVE OUTCOMES IN CNS TRIALS?**

*Charlotte Kremer, M.D., M.B.A., 219 East 42nd Street, New York, NY 10017*

**SUMMARY:**
Several recent CNS clinical trials have failed to show a satisfactory drug-placebo difference. Several hypotheses related to patient selection, diagnostic procedures, protocol design, site selection, and ratings accuracy have been generated to better understand these trial failures. In light of this, we have reviewed recently completed Pfizer-sponsored placebo-controlled CNS to further understand the potential reasons these studies did not show the expected drug-placebo difference. Two similarly designed 6-week, randomized, double blind, multicenter, placebo-controlled trials evaluating the efficacy and safety of ziprasidone in adults with bipolar depression were examined. To mitigate potential baseline inflation, different scales were used for entry criteria and primary endpoint. The primary analysis method was MMRM.928

subjects were randomized to treatment. There was no statistically significant difference in the primary outcome measure between ziprasidone and placebo in either study. Although all subjects met entry criteria for HAM-D, 36% and 31% of patients had baseline MADRS scores in the 2 studies that did not correspond to the moderate severity indicated by their HAMD scores. Using a conversion factor from Zimmerman et al, divergence was noted between the derived MADRS scores from the HAM-D and the actual MADRS scores in the direction of lower MADRS scores compared to those derived from the HAM-D scores.Many potential solutions have been presented to explain the decreasing drug-placebo difference. While different scales were used for entry and primary endpoint to mitigate potential baseline inflation, this may have allowed for inclusion of patients with depression severity below what is considered moderate to severe. Given the recent challenges in psychopharmacologic drug development, it is of utmost importance to examine studies that did not demonstrate a difference between drug and placebo and better understand contributory factors in order to move the field from recommendations based on hypotheses to 'evidence-based' recommendations.This study was supported by Pfizer Inc

No. 44-C
**COMPARISON OF SITE-BASED VERSUS CENTRALIZED RATINGS IN A STUDY OF GENERALIZED ANXIETY DISORDER (GAD)**

*Judith Dunn, Ph.D., 300 Trade Center, Woburn, MA 01801*

**SUMMARY:**
The success of psychiatric trials depends upon accurate, standardized evaluation of symptomatic change (i.e. ratings accuracy). One approach to improve ratings accuracy utilizes live, remote, centralized raters instead of site-based clinicians performing traditional in-person assessments. Few studies have evaluated site-based versus centralized ratings in a prospectively defined direct comparison. In this 8-week, double-blind, placebo-controlled GAD study, site based vs. centralized ratings were compared at Baseline and Week 6.472 subjects were enrolled at 30 sites. Entry criteria was determined by a site based rating at baseline of the Hamilton Rating Scale for Anxiety (HAM-A) Total = 20. Centralized ratings were administered via telephone by MedaVante Centralized Expert Rating Service. Two groups emerged: 47% of subjects had both site and centralized HAM-A Baseline scores = 20 (dually qualified for entry) whereas 53% met only site-based HAM-A entry criteria and would have been excluded from the study if centralized ratings determined eligibility. At Week 6, site and centralized HAM-A total scores were essentially equivalent. Further, neither site nor centralized raters separated study drug from placebo. Among dually qualified subjects, change in HAM-A total score from Baseline to Week 6 in the placebo group was relatively equivalent between site and centralized ratings; 8.3 ± 6.5 and 7.3 ± 6.1. Among site only qualified subjects, change in HAM-A total score was 10.3 ± 6.3 for site and 4.2 ± 5.5 for centralized raters, reflecting the lower baseline HAM-A from the centralized raters. The data suggest that these rating methodologies are equivalent after baseline if there is agreement on subject selection. Agreement on subject selection was associated with equivalent magnitudes of change and placebo response. Accurate baseline ratings defining study populations are of paramount importance; more reliable subject selection may improve interpretation of trial outcomes.

No. 44-D
**EVALUATION OF CENTRALIZED RATINGS IN A CLINICAL TRIAL OF MAJOR DEPRESSIVE DISORDER (MDD)**

*Steven Targum, M.D., 222 Berkeley St., Ste. 1650, Boston, MA 02116*

**SUMMARY:**
The use of centralized, remote ratings has been proposed as a better alternative to on-site clinician ratings, although there is limited supportive evidence.We used centralized, remote ratings as part of an investigator-initiated study conducted by MGH for BrainCells Inc. This was a 6-week, double-blind, placebo-controlled study followed by 6 weeks of open-label treatment conducted at 9 clinical trial sites. On-site raters and 7 remote raters from United Biosource Corporation (Wayne, Pennsylvania) administered paired IDSc30 and HAM-A interviews at Baseline, 6 weeks, and 12 weeks. These instruments were secondary measures in the study. The remote raters were blinded to both patient visit and protocol, and administered interviews via live video hook-up. 129 subjects participated in the remote rating assessments. The Intra Class Correlation (ICC) for the IDSc30 between remote raters and on-site raters was 0.53 at baseline, 0.86 at 6 weeks, and 0.88 at 12 weeks. Baseline and endpoint IDSc30 scores, as well as response and remission analyses were not significantly different between remote and on-site clinician raters. The ICC for the Ham-A between remote raters and on-site raters was 0.45 at baseline, 0.75 at 6 weeks, and 0.77 at 12 weeks. The baseline Ham-A score was significantly higher in the remote, centralized rater group compared to the on-site clinician ratings (p=0.008). However, mean Ham-A changes from baseline to endpoint were not significantly different between these raters. Individual Ham-A item analyses revealed highly significant score differences between remote and on-site raters at baseline but not at week 6, particularly on Ham-A items 3 (Fears) and 14 (Behavior at the interview).In this study, remote raters offered no advantage over the traditional method of on-site clinician ratings. The HAM-A item analysis suggests that remote assessments may precipitate transient anxiety that may be unrelated to the underlying disease state.

No. 44-E
**THE USE OF INDEPENDENT ASSESSMENTS FOR PATIENT ELIGIBILITY FOR CNS TRIALS**

*Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114*

**SUMMARY:**
CNS trials are influenced by subjective measurements and inconsistent ratings that can adversely affect patient enrollment and eligibility for entry into the trials. Converging evidence from numerous studies suggests that the accuracy and precision of baseline assessments are critical for successful trial outcomes. The inherent issues confronted when conducting large clinical trials at multiple trial sites with a wide range of raters challenges this requirement for precision. Further, the possibility of misplaced incentives at the clinical trial site may compromise the integrity of some of the baseline assessments. Consequently, we have explored the potential benefit of adding independent diagnostic verification, confirmation of sufficient acute symptom severity, and establishment of patient validity standards as part of the entry criteria for clinical trials. The evolving method for establishing patient validity, called the SAFER criteria and inventory, will be described within the context of the earlier papers presented at this symposium. In addition, trial outcome data derived from recently completed studies utilizing the SAFER criteria will be presented. We have found that the addition of independent ratings assessments conducted by live, remote interviews using the SAFER inventories improves the accuracy of patient selection for clinical trials and may reduce some of the noise contributing to failed clinical trials.

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**SYMPOSIUM 45**

**INTERPERSONAL AND SOCIAL RHYTHM THERAPY (IPSRT) FOR BIPOLAR DISORDER: NEW APPLICATIONS, NEW POPULATIONS, AND NEW EVIDENCE**

*Chairperson: Holly Swartz, M.D., WPIC - 8th Fl. Bellefield Towers, Pittsburgh, PA 15213,*
*Co-Chairperson: Ellen Frank, Ph.D.*
*Discussant: John C Markowitz, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) - Identify new populations in which IPSRT may be an appropriate treatment for mood symptoms; 2) Recognize the importance of social rhythm regularity in individuals with affective disorders as well as the putative value of this strategy in those at risk for these disorders; and 3) Evaluate the evidence supporting the expansion of IPSRT to new populations and in new settings.

**OVERALL SUMMARY:**
Interpersonal and social rhythm therapy (IPSRT), developed by Frank and colleagues at the University of Pittsburgh as a treatment for bipolar (BP) disorder, combines elements of Klerman and Weissman's interpersonal psychotherapy with a behavioral intervention aimed at enhancing circadian system integrity through regularizing daily routines. The goals of the treatment are the recognition of the relation of stable social rhythms and interpersonal problems to mood, the achievement and maintenance of stable social rhythms and the resolution of interpersonal problems related to grief, role transitions or role disputes. IPSRT's efficacy was demonstrated in a single-site acute and maintenance trial in patients with BP I disorder who were suffering from mania, depression or mixed episodes and in large a multi-site acute trial in patients with BP I and II disorder who were suffering from depression. Despite the demonstration of efficacy in these well-defined patient populations, IPSRT's role in other populations and settings has not been established. Because of its clinical appeal and compelling evidence-base to date, investigators have begun the process of systematically evaluating IPSRT for groups who were necessarily excluded from the original trials. The current symposium, in addition to providing a brief overview of the treatment by its creator, presents five novel applications of IPSRT. Although at early stages of investigation, these proof of concept trials demonstrate the feasibility of using IPSRT in new populations (adolescents, at-risk offspring of adults with BP disorder, perinatal BP disorder) and in new formats (inpatient and outpatient groups, as monotherapy for BP II disorder). This symposium will give clinicians an understanding of the importance of circadian rhythm entrainment to promote mood stability as described in IPSRT across an expanding range of conditions.Introduction: Empirically validated psychotherapies such as IPSRT—despite showing benefit in randomized controlled trials—rarely transition to typical practice settings where they are likely to have broader impact. To make IPSRT available to more patients, researchers and clinicians collaborated to develop group models of IPSRT for individuals receiving treatment across multiple levels of care within a single hospital system. Methods: IPSRT was adapted for delivery as daily inpatient (IP) groups, thrice-weekly intensive outpatient (IOP) groups, and weekly outpatient (OP) groups. IP groups

focus primarily on developing skills required to promote social rhythm regularity and are highly structured/didactic. OP groups consist of 12 weekly closed sessions followed by open and open-ended weekly maintenance groups. Group content focuses on illness history timeline, interpersonal communication strategies, psychoeducation about BP, and maintenance of regular social rhythms. IOP groups are intermediate in content and structure to outpatient and inpatient groups. In all groups, members complete the Social Rhythm Metric to monitor and modulate social rhythms to promote biologic rhythm stability. Results: On the IP unit, rates of participation in all IP groups increased significantly during the 6 months following initiation of IPSRT compared to 6 months prior to IPSRT [t(388)=4.08; p=0.0001]. In the OP groups, among those who entered the group with elevated depression scores on the Quick Inventory of Depressive Symptoms (QIDS) (n=8), there was a statistically significant decline in mean scores over time [F(1,7)=14.84, p=0.006]. Similarly, analyses of data from individuals participating in the intensive outpatient (IOP) groups (n=55), using a mixed effect model,indicated a significant decline in QIDS scores (p=.0045). Conclusions: Group IPSRT is a feasible and promising approach to care in routine practice settings.

No. 45-A

**COMPARISON OF IPSRT MONOTHERAPY AND QUETIAPINE FOR THE TREATMENT OF BIPOLAR II DEPRESSION: A PROOF OF CONCEPT TRIAL**

*Holly Swartz, M.D., Western Psychiatric Institute and Clinic 3811 O'Hara Street, Pittsburgh, PA 15213*

**SUMMARY:**
Introduction: Bipolar II disorder is a common psychiatric illness associated with marked morbidity and impairment, yet few treatments for this disorder have been systematically evaluated. Psychotherapy may play an important role in the management of this disorder as there may be some individuals with the bipolar II phenotype (in contrast to the bipolar I phenotype) who can be successfully managed with psychotherapy alone. We conducted a proof of concept study to determine the feasibility of using Interpersonal and Social Rhythm Therapy (IPSRT) as monotherapy for the acute treatment of bipolar II depression. Methods: Unmedicated individuals (n=17) meeting DSM-IV criteria for bipolar II disorder, currently depressed, were randomly assigned to receive 20 weeks of treatment with IPSRT (n=9) or quetiapine (n=8) Subjects were followed for 20 weeks. Results: Subjects were 65% female (n=11). Mean age was 34.4. At baseline, mean Hamilton Rating Scale Depression scores (17 item) was 18.5 and mean Young Mania Rating Scale scores was 6.6. Seventy-four percent (n=7) of subjects assigned to IPSRT and 50% (n=4) of subjects assigned to quetiapine completed the protocol. Conclusions: IPSRT was acceptable to patients. Drop-out rates with quetiapine were high. It appears feasible to treat a subset of individuals with bipolar II depression with IPSRT monotherapy. We concluded that an adequately powered, randomized, controlled trial is indicated to systematically evaluate the efficacy of IPSRT as an acute monotherapy for bipolar II disorder.

No. 45-B

**EARLY INTERVENTION FOR ADOLESCENT OFFSPRING OF PARENTS WITH BIPOLAR DISORDER: PILOT STUDY OF INTERPERSONAL AND SOCIAL RHYTHM THERAPY (IPSRT)**

*Tina Goldstein, Ph.D., 3811 O'Hara Street BFT 531, Pittsburgh, PA 15213*

**SUMMARY:**
Objective: To describe an open treatment development study of Interpersonal and Social Rhythm Therapy (IPSRT) for adolescents at-risk for bipolar disorder by virtue of having a parent with the illness.
Methods: Participants include adolescent (age 12-18) offspring of parents with bipolar disorder. Adolescents were evaluated for Axis I disorders via the K-SADS at intake. Those who met criteria for current or past bipolar disorder were excluded. The manualized IPSRT intervention consisted of 12 weekly individual sessions delivered over 3 months. Outcome variables including mood and sleep were assessed via objective (actigraphy) and subjective (interview, self-report) methods at intake, 3, and 6 month follow-up.
Results:Of 17 eligible adolescents assessed, 13 (7 males; mean age = 15.2) attended at least one IPSRT session. Diagnostic heterogeneity characterized the treatment sample at intake: 3 participants met criteria for major depressive disorder, 1 oppositional defiant disorder, 2 anxiety disorder, 2 attention deficit hyperactivity disorder, 1 substance abuse, 6 denied Axis I disorder.Pre-treatment actigraphy data support significant sleep disruptions in this high-risk sample. Specifically, we observed high rates of short sleep, frequent awakenings, and low sleep efficiency. Feasibility data indicate high satisfaction with the treatment approach, yet participants only attended 50% of scheduled sessions (M=6.3, range=2-10). Over half of missed sessions were associated with parental illness severity (e.g., parent hospitalized). Although limited conclusions can be drawn from this small sample, it appears that adolescents had fewer nights of short sleep (75% pre-treatment to 25% post-treatment), improved sleep efficiency, and decreased weekday-weekend bedtime variability following IPSRT.
Conclusions: The IPSRT treatment focus on stabilizing sleep and social rhythms and interpersonal relationships may be beneficial for adolescents at-risk for bipolar disorder.

No. 45-C

**INTERPERSONAL AND SOCIAL RHYTHM THERAPY FOR ADOLESCENTS WITH BIPOLAR**

**DISORDER: TREATMENT DEVELOPMENT AND RESULTS FROM AN OPEN TRIAL**

*Stefanie Hlastala, Ph.D., 4800 Sand Point Way NE (W-3636), Seattle, WA 98105*

**SUMMARY:**
In adolescents and adults, bipolar disorder (BD) is associated with significant morbidity, mortality, and impairment in psychosocial and occupational functioning. Interpersonal and Social Rhythm Therapy (IPSRT) is an empirically-supported adjunctive psychotherapy for adults with BD which has been shown to help delay relapse, speed recovery, and increase occupational and psychosocial functioning in adults with BD. Because of the documented efficacy in adults and the developmental relevance of the targets of IPSRT to adolescents, we have adapted IPSRT to meet the developmental needs of adolescents with bipolar spectrum disorders. Method: The current study will describe the adolescent-specific adaptations made to IPSRT (i.e., IPSRT-A) and will report the results from an open trial of IPSRT-A with 12 adolescents with a bipolar spectrum disorder. Twelve adolescents (mean age 16.5 + 1.3 years) diagnosed with a bipolar spectrum disorder participated in 16-18 sessions of adjunctive IPSRT-A over 20 weeks. Manic, depressive, and general symptoms and global functioning were measured at baseline, monthly during treatment, and at post-treatment. Adolescent satisfaction with treatment was also measured. Results: Feasibility and acceptability of IPSRT-A were high; 11/12 participants completed treatment, 97% of sessions were attended, and adolescent-rated satisfaction scores were high. IPSRT-A participants experienced significant decreases in manic, depressive and general psychiatric symptoms over the 20 weeks of treatment. Participants' global functioning increased significantly as well. Conclusions: IPSRT-A appears to be a promising adjunctive treatment for adolescents with bipolar disorder. A current randomized controlled trial is underway to examine effects of adjunctive IPSRT-A on psychiatric symptoms and psychosocial functioning. Preliminary findings from this trial will also be discussed.

No. 45-D

**IPSRT FOR BIPOLAR DISORDER IN THE PERINATAL PERIOD**

*Suzanne Luty, Ph.D., M.B.B.S, Box 4345, Christchurch, 8002*

**SUMMARY:**
Purpose: IPT for depression is efficacious for women in the perinatal period (pregnancy and 1 yr postpartum) but IPSRT has not been evaluated. Up to 75% of women with BD develop symptoms/episodes of mania or depression postpartum, and the risk of postpartum psychosis (PP) is markedly increased. Good management is crucial to preserve maternal well being and the mother infant relationship, but since there are many concerns about prescribing medication because of teratogenic risks and exposing infants to medication in breast milk, psychotherapy may be a useful alternative/adjunct. Unstable sleep patterns and routines in the perinatal period are thought to play a role in the development of symptoms. An emphasis on stablising circadian rhythms and addressing functioning are integral components of IPSRT and this may be useful for both preventing and treating mood episodes hence improve outcomes for mother and infant.
Content: To descibe the adaptation of IPSRT in the perinatal period and present data from a subgroup of patients who received IPSRT in a psychotherapy research study.
Methodology: 100 patients enrolled in the psychotherapy for bipolar disorder study received IPSRT or Specialist Care plus medication over 18 months. All sessions were audiotaped for integrity, and measures of manic and depressive symptoms recorded at each session. Baseline measures included prior number and type of episode, hospitalisations, diagnoses, medication and age of onset. Follow up measures included measures of episodes, symptoms, medication use and hospitalisation. Data was extracted on the subgroup of 13 patients who were within one year postpartum or became pregnant during therapy and for whom the focus of IPSRT was adapted accordingly.
Results: The group had significantly lower than expected symptoms, episodes (incluing PP), medication use and hospitalizations
Importance: IPSRT can improve outcomes for mother and infant during the high risk perinatal period

No. 45-E

**GROUP INTERPERSONAL AND SOCIAL RHYTHM (IPSRT) THERAPY ACROSS THE CONTINUUM OF CARE IN ROUTINE PRACTICE SETTINGS**

*Ellen Frank, Ph.D., 3811 O'Hara Street, Pittsburgh, PA 15213*

**SUMMARY:**
Introduction: Empirically validated psychotherapies such as IPSRT—despite showing benefit in randomized controlled trials—rarely transition to typical practice settings where they are likely to have broader impact. To make IPSRT available to more patients, researchers and clinicians collaborated to develop group models of IPSRT for individuals receiving treatment across multiple levels of care within a single hospital system.
Methods: IPSRT was adapted for delivery as daily inpatient (IP) groups, thrice-weekly intensive outpatient (IOP) groups, and weekly outpatient (OP) groups. IP groups focus primarily on developing skills required to promote social rhythm regularity and are highly structured/didactic. OP groups consist of 12 weekly closed sessions followed by

open and open-ended weekly maintenance groups. Group content focuses on illness history timeline, interpersonal communication strategies, psychoeducation about BP, and maintenance of regular social rhythms. IOP groups are intermediate in content and structure to outpatient and inpatient groups. In all groups, members complete the Social Rhythm Metric to monitor and modulate social rhythms to promote biologic rhythm stability.
Results: On the IP unit, rates of participation in all IP groups increased significantly during the 6 months following initiation of IPSRT compared to 6 months prior to IPSRT [t(388)=4.08; p=0.0001]. In the OP groups, among those who entered the group with elevated depression scores on the Quick Inventory of Depressive Symptoms (QIDS) (n=8), there was a statistically significant decline in mean scores over time [F(1,7)=14.84, p=0.006]. Similarly, analyses of data from individuals participating in the intensive outpatient (IOP) groups (n=55), using a mixed effect model,indicated a significant decline in QIDS scores (p=.0045).
Conclusions: Group IPSRT is a feasible and promising approach to care in routine practice settings.

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## SYMPOSIUM 46

## ENSURING A PUBLIC HEALTH IMPACT: PARTNERING WITH CONSUMERS AND COMMUNITY STAKEHOLDERS TO IMPROVE ACCESS AND QUALITY OF CARE FOR MENTAL DISORDERS

*Chairperson: Kenneth B. Wells, M.D., M.P.H., 10920 Wilshire Blvd., Suite 300, Los Angeles, CA 90024-6523*
*Discussant: Diana Meyers, B.S.N.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the rationale for engaging broad community stakeholders and consumers around the importance of improving quality and access to care; 2) To explain key principles to develop a multi-stakeholder partnership; and 3) To cite specific examples of how community academic partnerships have been developed to improve access and quality of mental health care.

**OVERALL SUMMARY:**
Purpose: Engaging consumers and community stakeholders through partnership principles is an approach recommended for physicians to enhance the public health impact of evidence-based interventions for mental disorders. There is a growing literature on how to utilize to utilize partnership approaches as a way of developing intervention approaches to reflect the values and priorities of the consumers of mental health services. Methods: Presenters in this symposium will describe five examples of community-academic mental health research partnerships that have as their goal – improving access to and the quality of mental health services in underserved populations. Results: One example from Arkansas will describe a partnership to implement evidence-based practices for anxiety disorders in rural community health clinics. The second example will describe the development of community health workers as an approach to screen and to educate local New Orleans communities about care options for depression and post-traumatic stress disorder. A third example will focus the development of partnerships to improve outreach and engagement around the importance of seeking care for mental disorders in returning veterans from Afghanistan and Iraq. A fourth example focuses on how a partnership is developing an infrastructure to identify resources and to explore approaches to assist local residents cope with stress and violence in Philadelphia. An example from Los Angeles will describe a randomized trial of community engagement to activate a multiple-agency network versus support for individual agencies to implement an evidence based depression quality improvement program in two underserved, communities Conclusions: Community Academic Partnerships are feasible and useful way of engaging communities and consumers around the importance of improving access to and the quality of mental health services in local communities.

No. 46-A

## A PUBLIC HEALTH INITIATIVE TO ADDRESS DEPRESSION AND POST-TRAUMATIC STRESS DISORDER IN A POST-DISASTER SETTING

*Benjamin Springgate, M.D., M.P.H., 1430 Tulane Ave., Box SL17, New Orleans, LA 70112*

**SUMMARY:**
We will discuss how community-based participatory research principles may be applied to build public health coalitions for mental health in a post-disaster setting. Content: Post traumatic stress disorder and depression represent significant public health challenges in post-disaster environments.1 Recovering communities with limited, rebuilding health and mental health services may struggle to affect public awareness, to improve access

to care, and to ensure appropriateness and quality of the services that are delivered for depression and post-traumatic stress disorder.2 We describe a public health approach to mental health in post-Katrina New Orleans that builds on models of evidence-based care (e.g. collaborative care for depression, and cognitive behavioral therapy), and engages a wide range of non-clinical and clinical stakeholders in a partnered manner to improve access and quality of care for depression and post-traumatic stress disorder. Methods/Results: We will discuss how we involved a wide range of community and clinical stakeholders in development and implementation of a community health worker outreach initiative; a learning collaborative for cognitive behavioral therapy; and an enhanced network of services across community agencies for persons with depression and post-traumatic stress disorder in a post-disaster environment. Summary: This discussion will explore development of public health approaches to address depression and post-traumatic stress disorder in a post-disaster environment.

No. 46-B

**CBPR IN THE ARKANSAS DELTA: DEVELOPING AN IMPLEMENTATION PARTNERSHIP WITH RURAL UNDERSERVED COMMUNITY HEALTH CENTERS**

*Justin Hunt, M.D., M.S., 33 Bristol Court, Little Rock, AR 72211*

**SUMMARY:**

The presenter will discuss the ongoing development of an implementation partnership that focuses on the adoption of mental health evidence-based practices (EBPs) by rural community health centers (CHC's) in Arkansas that provide safety net services to 120,000 low-income residents, primarily in the Mississippi Delta and Ozark Highlands. To more effectively eliminate disparities in health status among various groups, scholars and policy makers have recommended forming partnerships to engage underserved communities in research so that it might be more relevant to their needs. This partnership is structured on the principles of evidence based medicine, continuous quality improvement, and community-partnered participatory research (CPPR). Because few EBPs have been tested in rural Primary Care (PC) clinics serving disadvantaged populations, successful implementation will require considerable effort to tailor current EBP's to fit local needs and resources. Therefore, it is paramount to develop an implementation partnership in which CHC staff and UAMS research faculty work together to adapt EBPs. A major strength of the proposed partnership is that the community partners (CHCs of Arkansas) are representative of hundreds of rural clinics throughout the U.S. CHCs are one of the largest and fasting growing PC systems in the nation, and currently provide services to 10% of rural Americans, 14% of minorities, and 20% of the uninsured. Mental health and substance abuse are the most commonly reported reasons for visits to CHCs. In 2003, 800,000 CHC patients had mental health or substance abuse disorder diagnoses. Yet, only 5.5% of encounters are with on-site behavioral health specialists. Findings from the proposed implementation partnership will have relevance to hundreds of primary care clinics and millions of underserved patients, and could promote the sustained adoption of mental health EBPs across rural America using CPPR principles as a facilitator.

**No. 46-C**

**A PARTNERSHIP FOR WELLNESS: ADDRESSING STRESS AND VIOLENCE IN WEST AND SOUTHWEST PHILADELPHIA**

*Glenda Wrenn, M.D., 423 Guardian Drive Blockley Hall 13th Floor, Philadelphi, PA 19104*

**SUMMARY:**

A Partnership for Wellness is a project addressing resources that help people cope with stress and violence building on community strengths. During the summer of 2008, a seven member multi-specialty physician cohort of Robert Wood Johnson Foundation Clinical Scholars at the University of Pennsylvania, in partnership with the Health Annex, conducted background research, field interviews, and iterative data collection from key academic experts in order to identify resources that may help people cope with of stress and violence in West and Southwest Philadelphia, and explored ways for the Health Annex to build on community strengths. This summer project was designed as part of the community based participatory research training curriculum, and has evolved into an ongoing academic-community partnership. Key elements of the scholars report and proposal involve community engagement around mental health issues related to urban violence and facilitating formal help-seeking. This experience may serve as a model to engage academic faculty, students, community members and organizations in a bidirectional process of learning that can produce tangible resources and spark community resilience in the face of adversity.

No. 46-D

**GROOVI CARE: A COMMUNITY COALITION TO ENGAGE WITH VETERANS OF OPERATIONS ENDURING FREEDOM AND IRAQI FREEDOM (OEF/OIF) ABOUT THEIR MENTAL HEALTH**

*Patrick Link, M.D., M.P.H., 911 Broxton Ave, Los Angeles, CA 90024*

**SUMMARY:**

PURPOSE: Neuropsychiatric disorders are prevalent

among veterans of the conflicts in Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom), yet many such veterans do not seek mental health care. This presentation presents Phase 1 of a community-based participatory research (CBPR) program to improve appropriate mental health care seeking by OEF/OIF veterans.
METHODS: Community-based participatory research principles were used to develop a community coalition focused on engaging with OEF/OIF veterans about their health.
RESULTS: Each coalition organization participated in developing a list of engagement concerns important to improving appropriate health care seeking by OEF/OIF veterans. From this, we developed conceptual models of high-quality engagement and planned a formal multi-stakeholder assessment. The multi-stakeholder assessment explored the themes felt to be most important to engaging with OEF/OIF veterans about their health: (1) subpopulations of OEF/OIF veterans with similar health-care-seeking influences; (2) the social influences on health-care-seeking by OEF/OIF veterans; (3) outreach strategies perceived to be most effective at engaging OEF/OIF veterans; and (4) the organizational factors affecting current outreach activities.
CONCLUSIONS: The health care needs of OEF/OIF veterans demand significant changes to our health care system, outreach programs, and community support services. Despite the need for swift action, CBPR is possible with this population. Our main challenges in establishing a successful CBPR program in this environment have been the following: (1) identifying the general goal of the program; (2) engaging with stakeholders most influential to that goal; and (3) framing our research in a way that allows for rapid collection of data comprehensive enough to be useful to a rapidly evolving health care system.

No. 46-E

**USING A COMMUNITY PARTNERED PARTICIPATORY RESEARCH APPROACH TO IMPLEMENT A RANDOMIZED CONTROLLED TRIAL: DESIGNING OF COMMUNITY PARTNERS IN CARE**

*Bowen Chung, M.D., M.S., 10920 Wilshire Blvd Suite 300, Los Angeles, CA 90024*

**SUMMARY:**

Purpose: Community Partnerships have been recommended as an approach to enhance the relevance of bio-medical research to stakeholders such as mental health service service providers, mental health consumers, and local communities. Quality improvement (QI) programs for depression in primary care can reduce ethnic disparities in patient outcomes. We describe how community-partnered participatory research (CPPR) was used to design Community Partners in Care (CPIC), a randomized trial of community engagement to activate a multiple-agency network versus support for individual agencies to implement depression QI in two underserved Los Angeles, minority communities, South Los Angeles and Hollywood. Methods. Community-partnered participatory research was used to design CPIC's study goals, sampling frame, intervention design, and outcome measures. Community input was documented through meeting minutes and field notes.
Results. Community partnership influenced study design in community boundaries definitions; types of agencies, providers, and clients to be sampled; intervention conditions; and outcome measures. Modifications were identified through leadership discussions, a policy advisory board meeting, and open community forums. For example, participants in community forums requested trusted locations such as churches and parks be included to expand community capacity to address depression. Also, community boundary definitions were modified to include county service planning areas to enhance relevance to mental health, primary care, and social service agencies. Conclusion. Randomized trials designed under CPPR can enhance a study's relevance and community ownership while maintaining scientific rigor.

**REFERENCES:**

1. Wells KB, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging community intervention and mental health services research. Am J Psychiatry. 2004;161(6):955-963.
2.Jones L, Wells K. Strategies for academic and clinician engagement in community-participatory partnered research. JAMA. Jan 24, 2007 2006;297(4):407-410.
3.Chung B, Jones L, Jones A, et al. Using Community Arts Events to Enhance Collective Efficacy and Community Engagement to Address Depression in an African American Community. American Journal of Public Health. 2009;99(2):237.
4.Wells K, Jones L. "Research" in Community-Partnered, Participatory Research. JAMA. 2009;302(3):320.

**SYMPOSIUM 47**

**NEW STUDIES TO APPEAR IN THE JUNE ISSUE OF THE AMERICAN JOURNAL OF PSYCHIATRY: PRESENTATIONS BY THE AUTHORS AND EDITORS**

*Chairperson: Robert Freedman, M.D., 13001 East 17th Place, Mail Stop E3251, Aurora, CO 88945*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) To learn latest findings of relevance to clinical practice today; 2) To learn latest findings about the cause and course of mental illness; and 3) To learn how new findings may impact future clinical practice.

**OVERALL SUMMARY:**

The latest research findings that will appear in the American Journal of Psychiatry monthly print issue are released biweekly online throughout the year on the Journal's website http://ajp.psychiatryonline.org. Authors of papers that are released online during the Annual Meeting and authors whose work appears in the May print issue will be invited to present their work in the Symposium. The Journal's Editor, Robert Freedman, M.D., will lead a discussion of their papers, including the reasons that these papers were selected for publication. Papers that potentially impact clinical practice and papers that represent a distinct advance in understanding mental disorders will be featured. The authors will be identified on a poster in the Journal's section of the American Psychiatric Publishing Institute display booth.

No. 47-A

**EMOTION MODULATION IN PTSD: CLINICAL AND NEUROBIOLOGICAL EVIDENCE FOR A DISSOCIATIVE SUBTYPE**

*David Spiegel, M.D.*

**SUMMARY:**

The author presents evidence regarding a dissociative subtype of PTSD, with clinical and neurobiological features that can be distinguished from nondissociative PTSD. The dissociative subtype is characterized by overmodulation of affect, while the more common undermodulated type involves the predominance of reexperiencing and hyperarousal symptoms. The article focuses on the neural manifestations of the dissociative subtype in PTSD and compares it to those underlying the reexperiencing/hyperaroused subtype. A model that includes these two types of emotion dysregulation in PTSD is described. In this model, reexperiencing/hyperarousal reactivity is viewed as a form of emotion dysregulation that involves emotional undermodulation, mediated by failure of prefrontal inhibition of limbic regions. In contrast, the dissociative subtype of PTSD is described as a form of emotion dysregulation that involves emotional overmodulation mediated by midline prefrontal inhibition of the same limbic regions. Both types of modulation are involved in a dynamic interplay and lead to alternating symptom profiles in PTSD. These findings have important implications for treatment of PTSD, including the need to assess patients with PTSD for dissociative symptoms and to incorporate the treatment of dissociative symptoms into stage-oriented trauma treatment.

No. 47-B

**TIME TO ATTAINMENT OF RECOVERY FROM BORDERLINE PERSONALITY DISORDER AND STABILITY OF RECOVERY: A 10-YEAR PROSPECTIVE FOLLOW-UP STUDY**

*Mary C. Zanarini, Ed.D.*

**SUMMARY:**

The purposes of this study were to determine time to attainment of recovery from borderline personality disorder and to assess the stability of recovery. A total of 290 inpatients who met both DSM-III-R and Revised Diagnostic Interview for Borderlines criteria for borderline personality disorder were assessed during their index admission using a series of semistructured interviews and self-report measures. The same instruments were readministered every 2 years for 10 years. Over the study period, 50% of participants achieved recovery from borderline personality disorder, which was defined as remission of symptoms and having good social and vocational functioning during the previous 2 years. Overall, 93% of participants attained a remission of symptoms lasting at least 2 years, and 86% attained a sustained remission lasting at least 4 years. Of those who achieved recovery, 34% lost their recovery. Of those who achieved a 2-year remission of symptoms, 30% had a symptomatic recurrence, and of those who achieved a sustained remission, only 15% experienced a recurrence. Taken together, the results of this study suggest that recovery from borderline personality disorder, with both symptomatic remission and good psychosocial functioning, seems difficult for many patients to attain. The results also suggest that once attained, such a recovery is relatively stable over time.

No. 47-C

**REWARD/PUNISHMENT REVERSAL LEARNING IN OLDER SUICIDE ATTEMPTERS**

*Alexandre Y. Dombrovski, M.D.*

**SUMMARY:**

Suicide rates are high in old age, and the contribution of cognitive risk factors remains poorly understood. Suicide may be viewed as an outcome of an altered decision process. Impairment in reward/punishment-based learning, a component of affective decision making, may be associated with attempted suicide in late-life depression. Researchers expected that suicide attempters would discount past reward/punishment history, focusing excessively on the most recent rewards and punishments. They further hypothesized that this impairment could be dissociated from executive abilities, such as forward planning. Reward/punishment-based learning was assessed using the probabilistic reversal learning task in 65 individuals age 60 and older: suicide attempters, suicide ideators, nonsuicidal depressed elderly, and nondepressed comparison subjects. A reinforcement learning computational model was used to decompose reward/punishment processing over time. The Stockings of Cambridge test served as a control measure of executive function. Suicide attempters but not suicide ideators showed impaired probabilistic reversal learning compared to both nonsuicidal depressed elderly

and nondepressed comparison subjects, after controlling for effects of education, global cognitive function, and substance use. Model-based analyses revealed that suicide attempters discounted previous history to a higher degree relative to comparison subjects, basing their choice largely on reward/punishment received on the last trial. Groups did not differ in their performance on the Stockings of Cambridge test. Since older suicide attempters display impaired reward/punishment-based learning, they may make overly present-focused decisions, ignoring past experiences. Modification of this "myopia for the past" may have therapeutic potential.

No. 47-D
**INTERNATIONAL CONSENSUS STUDY OF ANTIPSYCHOTIC DOSING**

*David Gardner, Pharm.D., M.Sc.*

**SUMMARY:**
Potency equivalents for antipsychotic drugs are required to guide clinical dosing and for designing and interpreting research studies. Available dosing guidelines are limited by the methods and data from which they were generated. With a two-step Delphi method, a diverse group of international clinical and research experts were surveyed to seek consensus regarding antipsychotic dosing. Median clinical dosing equivalents and recommended starting, target range, and maximum doses for 61 drugs were determined, adjusted for selected clinical circumstances. Participants (N=43) from 18 countries provided dosing recommendations regarding treatment of psychotic disorders for 37 oral agents and 14 short-acting and 10 long-acting parenteral agents. With olanzapine 20 mg/day as reference, estimated clinical equivalency ratios of oral agents ranged from 0.025 for sulpiride to 10.0 for trifluperidol. Seventeen patient and treatment characteristics, including age, hepatic and renal function, illness stage and severity, sex, and diagnosis, were associated with dosing modifications. In the absence of adequate prospective, randomized drug-drug comparisons, the present findings provide broad, international, expert consensus-based recommendations for most clinically employed antipsychotic drugs. They can support clinical practice, trial design, and interpretation of comparative antipsychotic trials.

**SYMPOSIUM 48**

**REDUCING HARM: SAFER INJECTION AND OTHER STRATEGIES**

*Chairperson: Curtis N. Adams, Jr., M.D., 701 West Pratt Street, #564, Baltimore, MD 21201*
*Discussant: David A Pollack, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) List several strategies for reducing harm in their patients with addictions.

**OVERALL SUMMARY:**
In the treatment of addictions, Harm Reduction has become an accepted strategy for helping people who continue to use substances. The aim is to offer treatment of the addiction, but also to reduce the negative impact of substance use such as blood-borne infections and accidental overdose. In this syposium, we will explore harm reduction strategies including safer injection facilities, institutions that allow injection drug users to use their drug of choice in a safe setting under the supervision of a health professional. We will address the benefits of such an approach and the many perils, including political, that one might encounter in implementing a harm reduction initiative.

No. 48-A
**CREATING AN INCLUSIVE DRUG STRATEGY - THE EXPERIENCE OF ESTABLISHING VANCOUVER'S SUPERVISED INJECTION SITE**

*Liz Evans, B.S.N., 20 West Hastings St., Vancouver, V6A 1Y8*

**SUMMARY:**
In Vancouver's Downtown Eastside Community (one of Canada's poorest neighbourhoods), the experience of a high rate of HIV infection and drug overdose deaths led the community, the City and the Province to develop the first stand alone supervised injection site in North America, "Insite". The journey to open this site was in the context of a community with a high degree of poverty, marginalized drug addicts, and policies that had traditionally excluded this group from service. The site was established in 2003 as a "pilot study", and remains open, subject to an exemption from the Federal Drug Laws. Research results have shown that "Insite" has a positive contribution to make in a comprehensive drug strategy. The site has seen over 11,000 injection drug users through it's doors since it opened, and has seen over 1 Million injections take place on it's premises. The PHS Community Services Society Executive Director Liz Evans will present the story of how the Injection site grew out of the community's situation, and what the impact has been. The PHS is the community non profit partner responsible for operating "Insite" in partnership with Vancouver Coastal Health Authority, the Provincial Government's Health Funding body.

**REFERENCES:**
1. Wood,E Kerr, T, Lloyd-Smith, E, Buchner, C, Marsh, D, Montaner,J, Tyndall, M. Wood E, Kerr T, Spittal PM, Li K, Small W, Tyndall MW, Hogg RS, O'Shaughnessy MV, Schechter MT: The potential public health and community impacts of safer injecting facilities: evidence from a cohort of injection drug users. J Acquir Immune Defic

Syndr 2003, 32:2-8.

## SYMPOSIUM 49

## ADVANCES IN THE TREATMENT OF BIPOLAR DISORDER

*Chairperson: Terence A Ketter, M.D., 401 Quarry Rd Rm 2124, Stanford, CA 94305-5723,*
*Co-Chairperson: Po W Wang, M.D.*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) provide evidence-based state-of-the-art pharmacotherapy for patients with bipolar disorders across all phases of the illness; and 2) recognize the therapeutic implications of bipolar disorder occurring in children and adolescents, pregnant women, and older adults.

### OVERALL SUMMARY:

Therapy of Bipolar Disorders is rapidly evolving. The development of multiple new FDA-approved treatments has yielded important new management options. Mood stabilizers (lithium, divalproex, carbamazepine, and lamotrigine) and second-generation antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, and asenapine) have the most evidence supporting their utility. These agents vary with respect to potential benefit profiles, as they have differential efficacy across illness phases. These medications also have differential risk profiles, as tolerability varies across medications. Clinicians and patients thus face an increasingly complex process of decision-making when selecting pharmacotherapies. At the same time, there is an increasing appreciation for the need for evidence-based, personalized care. Quantitative (numerical) as opposed to qualitative (non-numerical) approaches have the potential to yield more reproducible outcomes. Number Needed to Treat (NNT) is a quantitative measure of potential benefit representing how many patients need to be treated to expect one more favorable outcome. Number Needed to Harm (NNH) is an analogously defined potential risk metric. This symposium includes presentations of NNT and NNH analyses of approved pharmacotherapies for various phases (acute mania, acute depression, and maintenance) of bipolar disorder, to facilitate assessment of risks and benefits in individual patients. In addition, this symposium includes presentations regarding the treatment of bipolar disorder in children and adolescents, pregnant women, and older adults to facilitate treatment decisions in these important special populations. Taken together, the information in this symposium should facilitate clinicians' efforts to translate the latest advances in research into evidence-based personalized state-of-the-art care for patients with bipolar disorder.Depression is the most pervasive problem in bipolar disorder, with patients spending at least twice as much time enduring depressive symptoms compared to manic, hypomanic, or mixed symptoms. Mood stabilizers have been considered foundational agents for bipolar disorder. Historically, they are important treatment options for all phases of bipolar illness, but efficacy for acute bipolar depression may be less robust than for other aspects of the illness. Lithium and lamotrigine have limited evidence of utility for acute bipolar depression, and carbamazepine and divalproex have even more sparse evidence of efficacy. Emerging data suggest certain atypical antipsychotics provide benefit in acute bipolar depression, with the strongest evidence supporting the use of the FDA approved agents quetiapine monotherapy and the olanzapine plus fluoxetine combination, which have single-digit Numbers Needed to Treat (NNTs) for response compared to placebo. Unfortunately, these agents also have single-digit Numbers Needed to Harm (NNHs) for sedation and clinically significant (>= 7%) weight gain, respectively, indicating that the likelihood of benefit (efficacy) is comparable to that of risk (side effects). In patients with chronic (rather than acute), mild (rather than moderate to severe) bipolar depression, the poorer efficacy of an agent like lamotrigine (with a low double digit NNT for response) may be mitigated by enhanced tolerability (an even higher double-digit NNH). The utility of antidepressants in acute bipolar depression is controversial, as in some patients these agents may not relieve depression and could yield switching into mania or hypomania. Emerging data suggest that adjunctive pramipexole and adjunctive modafinil may yield benefit in acute bipolar depression. This presentation focuses on evidence-based methods using NNT and NNH to aid in selecting optimal pharmacotherapies for bipolar depression.

No. 49-A
## ADVANCES IN MAINTENANCE TREATMENT OF BIPOLAR DISORDER

*Terence Ketter, M.D., 401 Quarry Rd Rm 2124, Stanford, CA 94305-5723*

### SUMMARY:

The recurrent episodic nature of Bipolar Disorders, and the dysfunction, morbidity, illness progression, and mortality associated with acute episodes, make prevention of new episodes a crucial management goal. As of mid-2009, the FDA approved longer-term treatments for bipolar disorders included five monotherapies (lithium, lamotrigine, olanzapine, aripiprazole, and risperidone), and two adjunctive (added to lithium or valproate) therapies (quetiapine and risperidone). In addition, controlled data indicated that monotherapy with quetiapine and divalproex and adjunctive (added to lithium or valproate) therapy with ziprasidone were effective. The above-mentioned longer-term treatments, like approved treatments for other aspects of Bipolar Disorders, have single-digit Numbers Needed to Treat (NNTs) for preventing overall relapse/

recurrence compared to placebo, indicating that treating less than 10 patients with an approved agent compared to placebo can be expected to yield one less relapse/recurrence. In general, mood stabilizers (lithium, lamotrigine, and divalproex) compared to second generation antipsychotics (olanzapine, aripiprazole, quetiapine and risperidone) have slightly higher NNTs, reflecting slightly less efficacy, but also have higher NNHs (Numbers Needed to Harm), indicating mitigating tolerability advantages. Medications differ not only in overall efficacy, but also in efficacy in preventing manic as compared to depressive relapse/recurrence, as well as in profiles of specific adverse effects, with there being important unmet needs for treatments that prevent depressive relapse/recurrence, and well-tolerated treatments that prevent manic/mixed episode relapse/recurrence. This presentation focuses on using NNT and NNH to aid clinicians' in selecting pharmacotherapies with the optimal balance of benefits (efficacy) and risks (adverse effects), taking into account individual illness characteristics, vulnerability to adverse effects, and patient preferences.

No. 49-B
**ADVANCES IN TREATMENT OF BIPOLAR DEPRESSION**

*Po Wang, M.D., 401 Quarry Road, Stanford, CA 94304*

**SUMMARY:**
Depression is the most pervasive problem in bipolar disorder, with patients spending at least twice as much time enduring depressive symptoms compared to manic, hypomanic, or mixed symptoms. Mood stabilizers have been considered foundational agents for bipolar disorder. Historically, they are important treatment options for all phases of bipolar illness, but efficacy for acute bipolar depression may be less robust than for other aspects of the illness. Lithium and lamotrigine have limited evidence of utility for acute bipolar depression, and carbamazepine and divalproex have even more sparse evidence of efficacy. Emerging data suggest certain atypical antipsychotics provide benefit in acute bipolar depression, with the strongest evidence supporting the use of the FDA approved agents quetiapine monotherapy and the olanzapine plus fluoxetine combination, which have single-digit Numbers Needed to Treat (NNTs) for response compared to placebo. Unfortunately, these agents also have single-digit Numbers Needed to Harm (NNHs) for sedation and clinically significant (>= 7%) weight gain, respectively, indicating that the likelihood of benefit (efficacy) is comparable to that of risk (side effects). In patients with chronic (rather than acute), mild (rather than moderate to severe) bipolar depression, the poorer efficacy of an agent like lamotrigine (with a low double digit NNT for response) may be mitigated by enhanced tolerability (an even higher double-digit NNH). The utility of antidepressants in acute bipolar depression is controversial, as in some patients these agents may not relieve depression and could yield switching into mania or hypomania. Emerging data suggest that adjunctive pramipexole and adjunctive modafinil may yield benefit in acute bipolar depression. This presentation focuses on evidence-based methods using NNT and NNH to aid in selecting optimal pharmacotherapies for bipolar depression.

No. 49-C
**TREATMENT OF CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER**

*Kiki Chang, M.D., 401 Quarry Road, Stanford, CA 94305-5719*

**SUMMARY:**
Bipolar disorder begins before age 18 years in half to two-thirds of cases. Children and adolescents diagnosed with bipolar disorder (BD) are particularly at risk for poor psychosocial outcome, with increased risk for suicide attempts, self-injurious behaviors, recurrent syndromal or subsyndromal mood symptoms, co-occurring psychiatric disorders, psychosocial and academic problems, and substance use. The presentation and developmental course of pediatric BD vary with age and pubertal status. Due to these complexities, children and adolescents with BD require a multifaceted treatment approach including pharmacotherapy, psychotherapy, and family and educational intervention. Early identification and treatment of pediatric BD is essential to prevent the chronicity of symptoms and associated complications. By proper and timely administration of medications and therapy, children and adolescents with BD may benefit by acute improvement of mood and functioning and prophylaxis from future episodes and worsening of the disorder.Evidence-based treatments that guide clinical decision-making for pediatric mood disorders are emerging. This presentation will provide a summary of the clinical manifestations and controlled therapeutic trials for the treatment of bipolar disorder in children and adolescents, in order permit clinicians to make treatment decisions that provide optimal balance between benefits and risks for individuals with pediatric bipolar disorder.

No. 49-D
**TREATMENT OF PREGNANT WOMEN WITH BIPOLAR DISORDER**

*Mytilee Vemuri, M.D., M.B.A., 401 Quarry Road, Stanford, CA 94305*

**SUMMARY:**
In pregnant bipolar patients, the potential for the development of fetal or neonatal adverse effects should be considered when assessing the use of medications. Potential side effects include intrauterine death,

perinatal toxicity, teratogenicity, growth retardation and neurobehavioral toxicity. Other considerations include special treatment issues associated with pregnancy (e.g., the need for dosage adjustments) and risk of recurrence and exacerbation of mood episodes. Substantial risk for relapse has been found to exist during the pregnancy period following discontinuation of mood stabilizing medication. However, information remains limited regarding the risk of recurrence of bipolar disorder in pregnant women after discontinuation of lithium or other mood stabilizers. While teratogenic effects of lithium (Epstein's anomaly in 0.1 %), valproate (neural tube defects and other major malformations in as many as 10%), and carbamazepine (spina bifida in 3%, craniofacial defects in 11%, fingernail hypoplasia in 26 %, and developmental delay in 20 %) are fairly well documented, the same cannot be said for most second generation antipsychotics and other anticonvulsants. Recent data indicate that the malformation risk with valproate is greater than had previously been appreciated, but that with lamotrigine the malformation risk may be comparable to that with no anticonvulsant exposure and lower than that with valproate. Although limited data suggest that lithium discontinuation during pregnancy carries similar relapse rates compared to other times, further studies are needed to assess discontinuation of medication and resulting acute psychiatric illness on fetal development. This presentation will provide a summary of issues regarding the treatment of bipolar disorder in pregnant women, in order permit clinicians to make treatment decisions that provide optimal balance between benefits for individual patients.

No. 49-E

**MANAGEMENT OF BIPOLAR DISORDERS IN OLDER ADULTS**

*John Brooks, Ph.D., M.D., 760 Westwood Plaza, B8-233b NPI 175919, Los Angeles, CA 90024-1759*

**SUMMARY:**

Older adults are a rapidly expanding portion of the U.S. population with specific mental health and medical care needs. Bipolar disorder has a significant impact on many areas (e.g., functional decline, cognition, quality of life) in older adults, yet as of mid-2009, no large-scale multi-center treatment study had been published. Pharmacological interventions in older adults diagnosed with bipolar disorder can be very challenging because of comorbid medical conditions, altered metabolism, and potential drug interactions. This presentation reviews challenges in the differential diagnosis of bipolar disorder in older adults, especially in the context of complicating factors, and discusses the basic principles of pharmacotherapy of bipolar disorder in older adults. Although evidence-based guidelines are largely lacking, guidelines for initiating and titrating mood stabilizers (lithium, valproate, carbamazepine, and lamotrigine) and second-generation antipsychotics will be reviewed. Finally, there will be discussion of important metabolic and treatment challenges in the context of bipolar disorder in older adults.

**REFERENCES:**

1. Ketter TA (ed): Handbook of Diagnosis and Treatment of Bipolar Disorder. Washington, DC, American Psychiatric Publishing 2010.

**SYMPOSIUM 50**

**CHALLENGES IN PROVIDING MENTAL HEALTH CARE FOR COLLEGE AND UNIVERSITY STUDENTS**

***The APA Council on Children, Adolescents & Their Families***

*Chairperson: Jerald Kay, M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State University Elizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401,*
*Co-Chairperson: Victor I Schwartz, M.D.*
*Discussant: Beverly J Fauman, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the reasons for increased numbers of college students requiring mental health services; 2) Recognize the critical ethical and legal issues in college mental health care; 3) Identify critical components of hospitalizatin and follow up care for the disturbed student; and 4) List the important clinical and administrative considerations in the assessment of violent/self destructive behavior on the college campus.

**OVERALL SUMMARY:**

There have been increasing challenges to the provision of mental health services to college and university students. These include a growing number of matriculating students with the diagnoses of previous substantial psychiatric disorders and treatment who often require more episodic and continuous care after arriving on campus. Epidemiologic studies and surveys have also documented an increased need to care for larger numbers of students with more significant psychopathology who lack a previous history of mental health problems. Substance abuse continues to be a significant issue on many campuses as well. Unfortunately, mental health treatment resources have not increased proportionately. Sixty percent of all colleges and universities in the US have available psychiatric services and of this number, most have only part time psychiatrists. This presentation will critically review these studies supporting these findings as well as elucidating the critical, but often misunderstood ethical and legal issues in the provision of college mental health care. The clinical and administrative challenges is treating significantly disturbed and suicidal students will

be presented as well as the assessment and administrative response to violent behavior on the college and university campus.We will describe and explore the complex interaction between legal principles relating to privacy and autonomy and those principles that seem to encourage the sharing of information and control of college student life. Important relevant legal cases will be reviewed along with a discussion of how imbedded in these cases is an attempt to grapple with the complex relationship between privacy, autonomy, parental communication and campus safety.

No. 50-A
**THE MAGNITUDE OF CLINICAL DEMANDS**

*Jerald Kay, M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State UniversityElizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401*

**SUMMARY:**
Epidemiological studies of the prevalence of mental health issues amongst college students are becoming more scientifically rigorous. So However, much of the early and continuing indications of increasing college mental health problems have been elucidated by two significant survey mechanisms. The first survey is one conducted annually since 2000 by the American College Health Association and the second long-standing survey, The National Survey of Directors, has been conducted annually since 1981 by Dr Robert Gallagher. The relevant findings from these most recent reports will be presented. From the 43 000 participants in the 2001–2002 National Epidemiological Survey on Alcohol and Related Condition (NESARC), data was abstracted for a subsample of 5092 young adults between the ages of 19 and 25. A group of nearly 2200 college students (studying full-time or part-time within the previous year) was compared to a peer group of approximately 2900 not attending college. Significant numbers of students were found to have mood, anxiety, substance abuse and personality disorders. The results of this study and its implications for college mental health services will be explicated. Additional data on alcohol abuse and dependence and its relationship with ongoing adolescent and young adult brain development will be considered as well.

No. 50-B
**THE ETHICAL AND LEGAL ISSUES IN PROVIDING COLLEGE MENTAL HEALTH CARE**

*Victor Schwartz, M.D., 500 W 185th st., New York, NY 10033*

**SUMMARY:**
We will describe and explore the complex interaction between legal principles relating to privacy and autonomy and those principles that seem to encourage the sharing of information and control of college student life. Important relevant legal cases will be reviewed along with a discussion of how imbedded in these cases is an attempt to grapple with the complex relationship between privacy, autonomy, parental communication and campus safety.

No. 50-C
**PSYCHIATRIC HOSPITALIZATION AND FOLLOW-UP CARE OF THE COLLEGE STUDENT**

*Rachel Glick, M.D., University of Michigan Medical School1500 E. Medical Center DriveF6321 MCHC Box 0295, Ann Arbor, MI 48109*

**SUMMARY:**
While most college students are considered adults by law, they remain dependent on both their families and their school. So when psychiatric hospitalization of a college student is needed, a number of questions arise.
How does the college campus counseling center interface with local hospitals to facilitate student admissions? Is it better for hospitalization to take place near school or near home? If the student is under or uninsured, who will pay? Who should be told when a student is hospitalized? What if the student refuses to tell his/her parents? How much should the psychiatric facility communicate and work with the campus? What if the student refuses hospitalization when campus administration thinks he/she is a threat? And after hospitalization has occurred, what follow-up care is needed and how can it be arranged? Is the counseling center enough? Should students be sent home? In this session, these and other challenges will be outlined and ideas for how to address them will be discussed.

No. 50-D
**VIOLENCE ASSESSMENT AND ADMINISTRATIVE RESPONSES**

*Gregory Eells, Ph.D., Ho Plaza, Ithaca, NY 14853*

**SUMMARY:**
This part of the symposium will address the increased attention and expectation for violence assessment in higher education settings and some of the ways that colleges and universities are responding. Initially legal and ethical considerations will be explored with attention given to the difficult task of balancing the rights of individual students with the rights and well-being of the community at large. There will be a brief review of confidentiality and other pertinent issues. General principles for responding to students who are displaying disturbing behavior will be reviewed with an examination of institutional responses such as leaves of absence and involving family members and significant others. The presentation will then review the development and functioning of behavioral intervention teams and threat assessment processes that are being implemented in higher education settings. The

presentation will conclude with recommendations for reducing the risk of violence on campus.

No. 50-E
**MANAGING THE SUICIDAL COLLEGE STUDENT**

*Morton Silverman, M.D., 4858 S. Dorchester Ave., Chicago, IL 60615-2012*

**SUMMARY:**
Managing the suicidal college student can be very challenging both professionally and personally. Issues of counter-transference are often present, as are concerns about liability and overall responsibility for the student's health and welfare. This presentation will address these concerns as well as provide some theoretical frameworks for working with suicidal college students. Evidence-based techniques, procedures and protocols for effectively managing the suicidal student will be presented. Criteria for dismissing as well as re-instating students at risk will be discussed.

**REFERENCES:**
1. Kay J and Schwartz V. The Textbook of College Mental Health. Chichester, England, John R. Wiley and Sons,2010
2.Blanco, C., Okuda, M., Hasin, D.S. et al. (2008) Mental health of college students and their non-college-attending peers. Archives of General Psychiatry, 65 (12), 1429–1437
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**SYMPOSIUM 51**

**GERIATRIC PSYCHOPHARMACOLOGY OF LATE-LIFE MOOD DISORDERS: FOCUS ON THE USE OF BIOMARKERS AS PREDICTORS OF RESPONSE**

*Chairperson: Helen Lavretsky, M.D., M.S., 760 Westwood Plaza Rm C9-948A, Los Angeles, CA 90095*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Basic principles of geriatric psychopharmacology; 2) The diagnosis and treatment approaches to geriatric mood disorders (unipolar and bipolar); 3) The applications of structural and functional neuroimaging (MRI, fMRI and PET) to developing understanding of pathophysiology and treatment response in geriatric mood disorders; and 4) Potential use of biomarkers to develop personalized treatments.

**OVERALL SUMMARY:**
The Symposium on Psychopharmacology of Geriatric Mood Disorders will focus on the diagnosis and psychopharmacological treatment of late-life mood disorders and the development of biomarkers specific for aging to understand individual differences in treatment response. The Sympoisum will target broad audience of clinicians, researchers and trainees at various levels of training in psychiatry. The Symposium will provide in-depth discussion of the basic principles of geriatric psychopharmacology and pharmacokinetic changes associated with aging, as well as the latest advances in the understanding of the genetic, structural and functional neuroimaging biomarkers associated with late-life mood disorders that can be used to develop personalized treatments. Participants will gain familiarity with the applications of translational neuroscience research and understand the effect of aging on neurobiological mechanisms in late-life mood disorders.

No. 51-A
**PSYCHOPHARMACOLOGY OF GERIATRIC DEPRESSION: THE USE OF AGING BIOMARKERS TO PREDICT TREATMENT RESPONSE**

*Helen Lavretsky, M.D., M.S., 760 Westwood Plaza Rm C9-948A, Los Angeles, CA 90095*

**SUMMARY:**
This presentation will provide a general overview of physiological changes occurring with aging that are responsible for different pharmacokinetics and pharmacodynamics of the drugs. Basic principles of geriatric psychopharmacology will be reviewed. A brief overview of the clinical features of late-life unipolar mood disorders and pharmacological treatment approaches will be provided.

No. 51-B
**GERIATRIC BIPOLAR DISORDER: CLINICAL DIAGNOSIS AND TREATMENT**

*Martha Sajatovic, M.D., W.O. Walker Building 10524 Euclid Ave. Pyschiatry Department 7th Floor, Cleveland, OH 44106*

**SUMMARY:**
Bipolar disorder is a complex genetically and neurochemically- based illness which affects approximately 5.7 million Americans or 2.6% of the population aged 18 and older. A growing body of evidence has identified biomarkers that are associated with disease, disease trajectory or duration, and with aspects of treatment response both in mixed-age and elderly populations. Neurocognitive functioning, structural brain abnormalities and genetic analyses have all been implicated in bipolar presentation and outcomes. Bipolar depressed elderly may be under-detected and under-treated. Comorbidity such as anxiety, substance abuse and medical illness may complicate

bipolar diagnosis and treatment. While treatment data specific to geriatric bipolar populations remains limited, traditional mood stabilizing drugs, antipsychotics, and antidepressants are effective and widely utilized in clinical settings. Adverse drug effects which occur in the context of multiple chronic medical disorders, use of multiple concomitant medications, and the pharmacokinetic and pharmacodynamic changes that accompany aging must be considered when initiating and titrating bipolar treatments in the elderly. Preliminary trials in bipolar elders have suggested a beneficial role for lithium and the novel anticonvulsant lamotrigine and the atypical antipsychotics quetiapine, olanzapine, and aripiprazole. There is a need to move the treatment of geriatric bipolar disorder into the arena of personalized medicine using available biomarkers.

No. 51-C

**THE USE OF STRUCTURAL MRI AS PREDICTOR OF ANTIDEPRESSANT RESPONSE IN OLDER ADULTS**

*Yvette Sheline, M.D., 4940 Children's Pl Ste 8134, St Louis, MO 63110*

**SUMMARY:**
Research on "vascular depression" has used two approaches to subtype late life depression (LLD) based on degree of either executive dysfunction or severity of white matter hyperintensities (WMH). To evaluate the relationship of neuropsychological performance and wmh to clinical response in LLD we designed a 2-site prospective nonrandomized controlled trial. The study was conducted at outpatient clinics at Washington University and Duke University. 217 subjects age = 60 met DSM-IV criteria for major depression, scored = 20 (madrs), received vascular risk factor (VRF) scores, neuropsychological testing and MRI scan; were excluded for cognitive impairment or severe medical disorders. Fazekas rating was conducted to grade WMH lesions. Intervention consisted of 12 weeks of sertraline treatment, titrated by clinical response and the Montgomery-Asberg depression rating scale (MADRS) score was ascertained at each visit. All baseline neuropsychological factor scores were negatively correlated with baseline categorical Fazekas scores. Baseline episodic memory; language; working memory; processing speed; executive function factor scores, and categorical Fazekas ratings predicted MADRS scores, controlling for age, education, age of onset and race. Episodic memory, language, processing speed and executive function remained significant predictors of decrease in MADRS scores when controlling for baseline MADRS scores. 33% of subjects achieved remission (MADRS = 7). Remitters differed from non-remitters in baseline cognitive processing speed, executive function, language, episodic memory and VRF scores.

No. 51-D

**AMYGDALA ACTIVATION TO EMOTIONAL FACES IN GERIATRIC DEPRESSION AS A MARKER OF TREATMENT RESPONSE**

*Howard Aizenstein, M.D., 3811 Ohara St, Pittsburgh, PA 15213*

**SUMMARY:**
Previous studies have demonstrated amygdala activation when individuals view emotional faces. In mid-life depression the amygdala shows increased activation pre-treatment, which predicts treatment response, and 'normalizes' in response to treatment. With aging, the amygdala appears to have a diminished response to emotional faces. Our goal was to identify the pattern of amygdala response in geriatric depression. A diminished response would account for the 'accelerated aging' brain changes in geriatric depression, while an increased response would emphasize the neurobiological similarities to midlife depression. Subjects included 27 individuals with late-life major depression and 21 elderly individuals without depression. Depressed subjects underwent fmri scanning with a facial expression task before starting pharmacotherapy, and 12-16 weeks later. Non-depressed subjects were scanned at 2 time-points. Robust bilateral amygdala activation was observed across the whole group. Contrary to the results in mid-life depression, there was lower amygdala activation in the patients relative to the controls. Despite, the relatively low amygdala activation prior to treatment, amygdala activity predicted treatment response, and showed decreased activation after treatment. In conclusion, the amygdala reactivity to emotional faces appears less prominent in late-life than in midlife depression, signaling changes due to aging. The relative decrease in amygdala reactivity following successful treatmentis a marker of antidepressant treatment response.

No. 51-E

**SEROTONIN TRANSPORTER OCCUPANCY AND THE FUNCTIONAL NEUROANATOMIC EFFECTS OF CITALOPRAM IN GERIATRIC DEPRESSION**

*Gwenn Smith, Ph.D., 5300 Alpha Commons Dr 4th Fl, Baltimore, MD 21224*

**SUMMARY:**
Positron emission tomography (PET) imaging of cerebral glucose metabolism has been integrated into antidepressant treatment studies to identify the functional neuroanatomy of geriatric depression and antidepressant treatment response. Increased pre-treatment metabolism was observed in patients relative to controls in anterior (superior frontal gyrus) and posterior (precuneus, inferior parietal lobule) cortical regions. Decreased metabolism was observed in similar cortical and limbic regions during antidepressant treatment that correlated with improvement in mood and cognitive symptoms. Functional connectivity analyses (using partial least squares) have shown that

a subcortical-limbic-frontal network was associated with improvement in mood and anxiety, while a medial temporal-parieto-frontal network was associated with improvement in cognition (attention, verbal memory and verbal fluency). Subsequent studies have used neuroreceptor studies to investigate the mechanisms underlying the functional neuroanatomic alterations observed. The logical initial focus for such studies is the serotonin transporter (SERT). Studies thus far have shown lower sert in patients than controls and that greater sert occupancy correlated with greater mood symptom improvement in similar cortical (anterior cingulate, superior and middle frontal, precuneus) and limbic regions (parahippocampal gyrus) that were hypermetabolic and normalized during citalopram treatment. These data suggest that serotonin functional integrity (as measured by SERT) may be altered in geriatric depression and related to treatment response.

**REFERENCES:**

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2.Sajatovic M. Treatment of bipolar disorder in older adults. Int J Geriatr Psychiatry. 2002 Sep;17(9):865-73.
3.Smith GS, Gunning-Dixon FM, Lotrich FE, Taylor WD, Evans JD. Translational research in late-life mood disorders: implications for future intervention and prevention research. Neuropsychopharmacology. 2007 Sep;32(9):1857-75.
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## SYMPOSIUM 52

## INNOVATIONS IN INTEGRATED TREATMENT OF SUBSTANCE USE AND PSYCHIATRIC DISORDERS

*The U.S. National Institute on Drug Abuse*

*Chairperson: Ivan D Montoya, M.D., M.P.H., 6001 Executive Blvd., Bethesda, MD 20892,*
*Co-Chairperson: Wilson M Compton III, M.D.*
*Discussant: Stanley Sacks, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize innovative models of integrated treatments for comorbid SUD and psychiatric disorders; and 2)Their applicability in clinical practice.

**OVERALL SUMMARY:**

Comorbid substance use and other psychiatric disorder are frequently observed in general and clinical populations. The treatment of these comorbid conditions represents a challenge for the clinician. Often, treatment programs separate the treatment of substance use disorders (SUD) and the treatment of other psychiatric disorders, sometimes even in different physical facilities. Furthermore, clinical trials of interventions for one group of disorders tend to exclude the other disorders, which limit the applicability of results to the other population. Recent studies are showing that the integrated treatments of SUD and psychiatric disorders are not only safe and efficacious but also cost-effective. Moreover, given the overlap of symptoms between SUD and psychiatric disorders, interventions developed for one disorder may result efficacious for other comorbid conditions. For example, depression and substance use disorders are often associated and efficacious treatments for depression may improve the outcome of SUDs. The purpose of this symposium is to review models of integrated treatments for comorbid SUD and psychiatric disorders and their applicability in clinical practice. The presentations will include review of 2) Integrated delivery of treatment for adolescents with depression and SUD (Paul Rohde), 3)Concurrent Treatment of PTSD and Drug Abuse (Kathleen Brady), 4)Integrated treatments of bipolar disorder and addiction (Roger Weiss), 5) Treatment approaches for comorbid depression and cocaine addiction (Ned Nunes), and 6) Concurrent treatment of cannabis dependence in patients with schizophrenia (Alan Green). The discussant (Stan Sacks) will focus on reviewing models of integrated treatment in light of the presentations by the rest of the panel and suggest some directions for future research.

No. 52-A

## INTEGRATED TREATMENT OF DEPRESSION AND SUBSTANCE USE DISORDERS IN ADOLESCENTS

*Paul Rohde, Ph.D., 1715 Franklin Blvd, Eugene, OR 97403*

**SUMMARY:**

The co-occurrence of psychopathology complicates the conceptualization and provision of treatment and is generally associated with higher drop-out, lower recovery, and poorer maintenance of gains. Little is known regarding effective treatment delivery for comorbid conditions, however, because individuals with comorbidity have often been excluded from clinical trials. This talk will present initial data from an ongoing study that is evaluating the optimal service delivery method for integrating empirically supported interventions for adolescents with comorbid depressive disorders and non-nicotine substance use disorders (SUD) in an effort to improve treatment engagement, response, and maintenance of gains. The two examined interventions are the Adolescent Coping With Depression course (ACWD) and Functional Family Therapy (FFT). We are currently recruiting adolescents (ages 13-17) with depression/SUD and their guardians

and randomly assigning them to 1 of 3 conditions: (a) FFT followed by ACWD (Sequenced Treatment 1), (b) ACWD followed by FFT (Sequenced Treatment 2), or © an intervention combining and augmenting FFT and ACWD (Integrated Treatment; IT). Treatment in each arm consists of 24 sessions provided over 20 weeks. Participants are assessed at intake, at four points during the provision of services, and at 6-, and 12-month follow-up. We currently have recruited 80 adolescents and anticipate having approximately 120 families by the time of the meeting. The presentation will describe rates of treatment engagement and completion for the three methods of delivering services. In addition, preliminary data on depression and substance use outcomes will be presented. The ultimate goal of this study is to provide essential information regarding the influence of each disorder on the other and methods for delivering services to multi-disordered individuals in a data-driven manner.

No. 52-B
**POST-TRAUMATIC STRESS DISORDER AND DRUG ABUSE: ETIOLOGY AND TREATMENT LINKAGES**

*Kathleen Brady, M.D., Ph.D., 171 Ashley Avenue, Charleston, SC 29425*

**SUMMARY:**
The relationship between post-traumatic stress disorder (PTSD) and substance use disorders (SUDs) is complex. A number of epidemiologic studies demonstrate that PTSD and SUDs co-occur more commonly that would be expected by chance and that the odds ratio of having a SUD for an individual with PTSD is in the range of 4.0-5.0. Studies also indicate that a high percentage (25-60%) of individuals seeking treatment for SUDs have lifetime PTSD. There are a number of potential etiologic connections between SUD and PTSD. Studies exploring the etiologic connection between these disorders will be reviewed including some focused on self-medication of PTSD symptoms by drugs of abuse, studies focused on exacerbation of PTSD symptoms by drugs of abuse and studies exploring common neurobiology across disorders. The implications for treatment of various etiologic connections between PTSD and SUDs will be discussed.

No. 52-C
**INTEGRATED GROUP THERAPY FOR PATIENTS WITH CO-OCCURRING BIPOLAR DISORDER AND SUBSTANCE USE DISORDER**

*Roger Weiss, M.D., 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**
Bipolar disorder (BD) is the Axis I disorder with the highest risk of a coexisting substance use disorder (SUD); however, treatments for this population have been understudied. We have eveloped a manualized therapy for these patients, Integrated Group Therapy (IGT), using a cognitive-behavioral model focused on similarities in thoughts and behaviors in recovery from BD and SUD. We report here on three studies of IGT: 1) a pilot study that demonstrated the promise for IGT in reducing substance use; 2) a randomized controlled trial, in which IGT was more effective than standard Group Drug Counseling (GDC) in reducing substance use, with similar mood outcomes; and 3) our most recent study. The third study tested a "community-friendly" version of IGT, designed to be more amenable for adoption in community drug abuse treatment programs. We attempted to replicate our previous findings in an effectiveness trial using substance abuse counselors with no previous CBT training; the treatment was reduced from 20 to 12 sessions to increase feasibility. Again, IGT had better substance use outcomes than did GDC, particularly in promoting total abstinence. We also developed a unified outcome measure, called "good clinical outcome," which assesses substance use and mood outcomes simultaneously; IGT had significantly more patients with good clinical outcomes at the end of treatment than did GDC. IGT was named in a National Institute on Drug Abuse report on psychiatric comorbidity as one of five "examples of promising behavioral therapies for adult patients with comorbid conditions. This presentation will review the theoretical foundation of IGT, describe a typical group, report the results of the three studies described above, and will discuss potential mechanisms of action of this promising treatment.

No. 52-D
**ADVANCES IN PHARMACOTHERAPY FOR COMORBID DEPRESSION AND ADDICTIONS**

*Edward Nunes, M.D., 1051 Riverside Drive, Unit 51,, New York, NY 10032*

**SUMMARY:**
Depression is one of the most common co-occurring psychiatric disorders among drug-dependent and alcohol-dependent patients. A series of clinical trials and a meta-analysis (Nunes and Levin 2004) have shown that major depression in substance-dependent patients, when carefully diagnosed along the lines suggested by DSM-IV, responds to antidepressant medication treatment. The results of this meta-analysis and more recent studies, as well as the DSM-IV criteria for primary and substance-induced depression, will be reviewed. Many clinical trials show high placebo response rates, which may represent either responsiveness to concurrent psychosocial treatments or response of mood to reduction in substance use. The most consistent and strong effects of antidepressant medication have been observed in studies in which patients are abstinent for at least a week before depression was diagnosed. Implications for clinical practice and future

research will be discussed.

No. 52-E
**TREATMENT OF CANNABIS USE DISORDER IN PATIENTS WITH SCHIZOPHRENIA**

*Alan I. Green, M.D., One Medical Center Drive, Lebanon, NH 03756*

**SUMMARY:**
Cannabis and other substance use disorders are common in patients with schizophrenia and are associated with poor clinical outcomes. Cannabis use disorder, in particular, is associated with earlier age of onset of schizophrenia, as well as poor response to treatment with antipsychotic medications. Individuals in their first episode of schizophrenia tend to have a high rate of cannabis use disorders, and increasing evidence implicates adolescent cannabis use as an important risk factor in the development of schizophrenia. Treatment approaches for these patients are evolving. Integrated dual diagnosis treatment programs, in which psychosocial treatments and pharmacologic treatments, aimed at both the cannabis use and the psychiatric disorder, are most likely to deliver effective treatment for these patients. Psychosocial approaches, including motivational interviewing and cognitive behavioral therapy are often used; contingency management techniques have been shown in pilot studies to limit cannabis use in these patients. Pharmacologic approaches are based primarily on the effects of the antipsychotic medications. Unlike the typical antipsychotics, which are not thought to limit substance use in these patients, the atypical antipsychotic clozapine has been shown in case reports, as well as in naturalistic and retrospective studies, to limit alcohol and cannabis use in patients with schizophrenia. In addition, certain other atypical antipsychotic medications may also be useful in this population. We have proposed that clozapine's ability to decrease cannabis use in patients with schizophrenia may relate to its broad spectrum pharmacologic profile, which includes actions at dopaminergic and particularly noradrenergic systems. This presentation will describe the current evidence-based approaches to the treatment of patients with schizophrenia and co-occurring cannabis use disorder, and will also review new data regarding the effects of clozapine in this population.

**REFERENCES:**
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2.Nunes EV, Levin FR. Treatment of Co-occurring Depression and Substance Dependence: Using Meta-analysis to Guide Clinical Recommendations. Psychiatr Ann. 2008 Nov 1;38(11):nihpa128505.

**SYMPOSIUM 53**

**GENOTYPES AND BIOMARKERS: THE NEW DECISION MAKERS FOR TAILORED TREATMENT**

*Chairperson: Florian Holsboer, M.D., Kraepelinstr 2 + 10, Muchen, D-80804 Germany,*
*Co-Chairperson: Julio Licinio, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the completion of this session participants will be able to demonstrate knowledge of: 1) Advances in personalized medicine in the area of mental health; and 2) Promising biomarkers for psychiatric disorders.

**OVERALL SUMMARY:**
Today, progress in neuroscience allowed discovery of a huge number of new signaling transmitters and unprecedented targets paving the way for much more specific treatments. For example, more recent genome-wide pharmacogenetic studies revealed that polymorphisms are present in genes that were not previously considered to be involved antidepressant mechanisms. It has also become apparent that the genome is not a tidy collection of common disease causing genes that act independently from each other but rather appear to operate in a complex network. Nevertheless, promising genetic markers predictive for vulnerability for psychiatric disorders or treatment outcome have been identified. In addition, external factors have a major impact upon gene regulation. Life events, trauma, infection and the disease-process itself all can change the way how the genome responds to an external signal. Therefore, future pharmacogenomics will not rely on genotypes only, but need to be complemented by biomarkers. Ideally, these biomarkers reflect the pathophysiological process not only in the diseased patient, but already in the premorbid state. The current phenotype of a patient is determined by a complex interaction of genes and environment that can be observed at molecular, cellular, systems and behavioral levels. Without strategies that intertwine genomics with multiple levels of the phenotype, the advances in genetics will not be fully utilized. This symposium brings together experts in the field of personalized medicine.

No. 53-A
**GENETIC AND OTHER BIOMARKERS OF ANTIDEPRESSANT OUTCOME**

*Francis McMahon, M.D., 9000 Rockville Pike, Bethesda, MD 20892*

**SUMMARY:**
Major depression is a large and growing public health problem worldwide. Available treatments are effective, but many patients fail to respond to the first antidepressant they try, only a minority fully recovers with treatment, and some suffer adverse events. Biomarkers that could help predict treatment outcome might be of great value in treatment planning. The Sequenced Treatment Alternatives

to Relieve Depression (STAR*D) study has afforded an unprecedented opportunity to identify genetic predictors of antidepressant treatment outcome. Published studies of the STAR*D sample have shown that genetic variation in several genes can influence outcome: Treatment response and remission have so far been associated with markers in genes encoding the serotonin 2A receptor (HTR2A), the kainate-sensitive glutamate receptor subunit, GRIK4, the neurotrophin-related gene BCL2, and the stress-related gene, FKBP5. Adverse events have been associated with markers in genes encoding the serotonin transporter (SLC6A4), and the glutamate receptor subunits GRIK2 and GRIA3. Taken together, these genes account for only a small part of the individual variation in antidepressant treatment outcome, and their clinical utility is as yet unknown. In this talk, the published literature will be reviewed, along with a discussion of ways to improve predictive power and assess clinical utility.

No. 53-B

**INDIVIDUALIZED ANTIPSYCHOTIC THERAPY FOR SCHIZOPHRENIC PATIENTS**

*Edwin van den Oord, Ph.D., McGuire Hall, Room 216A, PO Box 980533, Richmond, VA 23298*

**SUMMARY:**

Understanding individual differences between schizophrenic patients in their response to antipsychotics is critical to enhance drug efficacy and minimize toxicity. To identify relevant genetic variants we have conducted a series of genome-wide association studies (GWAS) in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE). After applying QC filters, a panel of 492K SNPs was available for 738 schizophrenia patient. A wide variety of efficacy (e.g. disease symptoms, neurocognition) and toxicity (e.g. QT interval prolongation, movement and metabolic side effects) measures were analyzed. To obtain these measures, we developed a systematic method to estimate treatment effects in CATIE that combines information from all assessments in an optimal and empirical fashion. Several signals reached genome-wide significance at our pre-specified threshold ensuring that no more than 10% of our significant findings are expected to be false discoveries. Many other signals were found for genes that are good candidates for further study.

Although these results are promising, a considerable number of challenges remain before we can begin developing algorithms to predict antipsychotic response. First, maximizing statistical power in the GWAS remains critical and an important method to achieve this is to collect and incorporate additional information about relevant pathways and genes. For this purpose we are conducting bioinformatics analyses of pharmacological networks relevant to antipsychotics and are studying all drug induced metabolomic changes in brain using a panel of inbred mice. Second, because clinical trials such as CATIE are unique, it is practically infeasible to systematically "organize" and perform replication efforts. Instead, to facilitate replication efforts we developed a user-friendly database with GWAS results and started to set up a functional validation pipeline that will enable a relatively quick and cost-effective first line validation effort. Finally, careful attention will need to be paid to the prediction algorithms themselves that, for example, will need to account for the fact the there are different forms of drug nonresponse.

No. 53-C

**GENE EXPRESSION PROFILE IN PERSONS EXPOSED TO THE WTC WITH AND WITHOUT PTSD**

*Rachel Yehuda, Ph.D., 130 W. Kingsbridge Road, Bronx, NY 10468*

**SUMMARY:**

The events and sequelae of the 9/11 attack on New York City provided opportunities to improve understanding of why posttraumatic stress disorder (PTSD) occurs in only a small proportion of those exposed to traumatic events. Several risk factors have been implicated in the development of PTSD, including genetic factors. Susceptibility genes have not yet been confirmed in PTSD and genetic risk factors for PTSD in similarly-traumatized cohorts can be confounded with risk for type of exposure that precipitated the symptoms. However, since the primary risk for exposure to the 9/11 attack was proximity, study of PTSD risk in a sample of exposed individuals was not confounded by exposure-related risk. 40 individuals (20 who developed PTSD following 9/11 and 20 who did not) were selected from a sample of persons exposed to the attack. Whole blood gene expression and cortisol levels were obtained from the participants.Analysis found 25 probe sets that were differentially expressed in PTSD. Genes that expressed differentially were generally involved in hypothalamic-pituitary-adrenal (HPA) axis, signal transduction, or in brain and immune cell function. Findings indicate that some genes are associated with both lifetime and current PTSD, suggesting enduring markers. Those markers present in current PTSD may reflect state measures, while those present only in lifetime PTSD may suggest markers of recovery.

No. 53-D

**GENE X ENVIRONMENT INTERACTIONS UNDERLYING RISK VS. RESILIENCE FOR STRESS-RELATED DISORDER**

*Christine Heim, Ph.D., Department of Psychiatry & Behavioral Sciences Emory University School of Medicine 101 Woodruff Circle, WMRB, Suite 4311, Atlanta, GA 30322*

**SUMMARY:**
This presentation will describe genetic and environmental data examining differential risk for stress-related disorders focusing on posttraumatic stress disorder (PTSD) and depression, following childhood and adult trauma. In addition to trauma exposure, a number of other factors contribute to the risk for development of PTSD and depression in adulthood. Both genetic and environmental factors are contributory, with the genetic heritability for both ranging from 30-40% and early life stress such as child abuse also providing significant risk liability. Gene x environment interactions of child abuse, level of non-child abuse trauma exposure and genetic polymorphisms at the stress-related gene, FKBP5 (a co-chaperone that regulates the glucocorticoid receptor), and the corticotrophin releasing hormone receptor (CRHR1) were examined to predict level of adult PTSD and depression symptomatology. We found that level of child abuse and non-child abuse related trauma exposure separately predicted level of adult PTSD and depression symptomatology. Interestingly, FKBP5 SNPs interacted with the severity of child abuse to predict level of adult PTSD symptoms (p <.001). Conversely, CRHR1 SNPs interacted with level of child abuse to predict depression symptoms (p<.001). These data will be discussed in the context of a model for the role of emotional neural circuit development in the potential pathophysiology of mood and anxiety disorders in adults. These data suggest that careful analysis of the individual's trauma history is critical in understanding the genes and biomarkers which differentiate risk and treatment outcome.

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**SYMPOSIUM 54**

**SUBSTANCE RELATED DISORDERS IN DSM-5: PROGRESS REPORT**

*Chairperson: Charles O'Brien, M.D., Ph.D., 3900 Chestnut St., Philadelphia, PA 19104,*
*Co-Chairperson: Deborah S. Hasin, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Learn the issues being discussed regarding the goal of improving the clinical utility of the substance related disorders section in DSM-V; and 2) Know which changes are likely to be recommended and which are still being discussed.

**OVERALL SUMMARY:**
The multidisciplinary working group was charged with making improvements that were data-based, that moved the classification towards clinical neuroscience, and above all, improved the utility of the system for clinicians. The changes being considered are in keeping with these goals, and we are on schedule for a 2012 publication. Each speaker in this symposium will address in detail the areas that are under consideration. Should we continue to have two categories of disorder, "abuse" and "dependence"? Can we clarify the nomenclature between two states of neuro-plasticity induced by drugs of abuse: "physical dependence", which is a normal adaptation to repeated dose of several categories of CNS active medications, and "dependence", meaning addiction or compulsive drug-seeking as used in DSM-IV? Do we have the data to incorporate non-substance compulsive behaviors such as gambling which have clinical and neuro-imaging similarities to drug use disorders into our classification? Can we create a severity dimension that can inform clinicians about progress in treatment? Should we continue to use the same symptoms created in DSM-IIIR and continued in DSM-IV or should some be added or deleted? What is the threshold for a diagnosis? How can we best incorporate co-morbidity, a significant issue for a severity rating of substance use disorder as well as for the co-existing disorder such as depression or anxiety?BACKGROUND. The Dependence Syndrome was originally conceptualized as part of a bi-axial system, with dependence (impaired ability to control alcohol/drug use) as one axis and consequences of use as a distinct yet correlated axis. This concept influenced the DSM-III-R and DSM-IV division of dependence and abuse, but has since been questioned. Across alcohol and other drugs, dependence is highly reliable and valid, while abuse is not. Due to the types of methodologies used, studies on whether dependence and abuse criteria should be combined tend to merge two questions: (1) Are dependence and abuse separate disorders? and (2) Can substance disorders be represented as dimensional as well as binary conditions? METHOD. Many studies have examined the relationship of DSM-IV abuse and dependence criteria to each other, using following types of analyses: factor, MIMIC, IRT, and discontinuity. Substances have included alcohol and illicit drugs. Data come from general population, family and clinical samples in the U.S., Mexico, Argentina, Poland and Israel. RESULTS. Studies consistently show evidence for a single dimension that includes both abuse and dependence criteria. Further, abuse criteria are interspersed with dependence criteria across the severity spectrum, with some abuse and dependence criteria consistently falling at the low end of severity, and other abuse and dependence criteria falling at the high end of severity. CONCLUSIONS. A decision to combine abuse and dependence into a single category is supported by a strong empirical base of evidence. This change in DSM-V would also increase parsimony, as it would reduce the number of disorder categories.

No. 54-A
**THE SEARCH FOR SPECIFIC CRITERIA: A REPORT**

**FROM THE CRITERION SUBCOMMITTEE**

*Marc Schuckit, M.D., 8950 Villa La Jolla Drive, Suite B218, San Diego, CA 92037*

**SUMMARY:**
The Criterion Subcommittee's charge is to report recommendations to the full committee regarding: (1) Consideration of any new criterion items to be added; (2) Consideration of items from the DSM-IV list to exclude; (3) The optimal threshold for a diagnosis; and (4) Suggestions regarding whether different wording or criterion items are needed for different substances.
The group began by setting guidelines and goals that included: an emphasis using data for decisions rather than global impressions; the goal that any new criterion items must show significant improvement in coverage of patients and/or improvements in coherence or predictive validity of the criteria set; and the decision that deletion of an item must demonstrate no significant loss in coverage, coherence, or predictive validity. The subcommittee began with an extensive discussion of several potential new diagnostic criterion items. The first was the possibility of adding an item related to the quantity and/or frequency of substance intake. After a review of available data, we recommend that this important item be carefully covered in the text describing the DSM criteria, though it might not be optimal as a criterion item itself. The latter half of our decision reflected, in part, the difficulty in establishing use patterns for some substances. A second suggested new item focused on was craving, with data demonstrating good performance of this item across substances and across cultures, but marginal increases in either coverage or coherence over current abuse/dependence items. The committee is still in the process of discussing the pros and cons of a new item related to craving, and no final decision has been made.Several prior DSM diagnostic items are also being evaluated for possible deletion, including the item related to legal problems associated with substances. A field trial utilizing proposed criterion changes is being planned.

No. 54-B
**ABUSE AND DEPENDENCE: COMBINING THE DISORDERS INTO A SINGLE CATEGORY**

*Deborah S. Hasin, Ph.D., 1051 Riverside Drive, Box 123, New York, NY 10032*

**SUMMARY:**
BACKGROUND. The Dependence Syndrome was originally conceptualized as part of a bi-axial system, with dependence (impaired ability to control alcohol/drug use) as one axis and consequences of use as a distinct yet correlated axis. This concept influenced the *DSM-III-R* and DSM-IV division of dependence and abuse, but has since been questioned. Across alcohol and other drugs, dependence is highly reliable and valid, while abuse is not. Due to the types of methodologies used, studies on whether dependence and abuse criteria should be combined tend to merge two questions: (1) Are dependence and abuse separate disorders? and (2) Can substance disorders be represented as dimensional as well as binary conditions? METHOD. Many studies have examined the relationship of DSM-IV abuse and dependence criteria to each other, using following types of analyses: factor, MIMIC, IRT, and discontinuity. Substances have included alcohol and illicit drugs. Data come from general population, family and clinical samples in the U.S., Mexico, Argentina, Poland and Israel. RESULTS. Studies consistently show evidence for a single dimension that includes both abuse and dependence criteria. Further, abuse criteria are interspersed with dependence criteria across the severity spectrum, with some abuse and dependence criteria consistently falling at the low end of severity, and other abuse and dependence criteria falling at the high end of severity. CONCLUSIONS. A decision to combine abuse and dependence into a single category is supported by a strong empirical base of evidence. This change in *DSM-5* would also increase parsimony, as it would reduce the number of disorder categories.

No. 54-C
**NON-SUBSTANCE RELATED ADDICTIONS: THEIR PLACE IN *DSM-5***

*Nancy M. Petry, Ph.D., 263 Farmington Ave MC-3944, Farmington, CT 06030-3944*

**SUMMARY:**
A number of potentially new disorders have been proposed for the *DSM-5* that may overlap with substance use disorders (SUD). These include internet or gaming, eating, shopping, work, and sexual "addictions." In addition, pathological gambling has considerable crossover with substance use disorders. This workgroup considered the available data regarding these potentially new diagnoses and their associations with substance use disorders. Although case reports and some empirical data exist regarding excessive gaming, eating, shopping, work, and sexual activities, we concluded that sufficient data were not currently available to recommend their inclusion as new diagnoses in *DSM-5*. In particular, data regarding the reliability and validity of these diagnoses are lacking at this time. However, after reviewing the literature, we propose that pathological gambling, which is classified as an impulse control disorder in *DSM-IV*, is better considered as a non-substance "addiction" disorder. Pathological gambling has symptom similarity with SUD diagnostic criteria. Some neural substrates, biomarkers, temperamental antecedents, cognitive and emotional process abnormalities, and causal environmental risk factors are shared with SUD. Further, empirical data suggest high rates of comorbidity between SUD and

gambling disorders along with similar genetic risk factors. The course of illness and treatment response also overlaps with those of SUD. The classification of pathological gambling as a non-substance related "addictive" disorder may pave the way for additional research on other behavioral "addictions," which in turn may ultimately improve their diagnosis, treatment and prevention.

No. 54-D
**TERMINOLOGY OF SUBSTANCE USE DISORDERS FOR DSM-V**
*Wilson Compton III, M.D., 6001 Executive Blvd., MSC5153, Bethesda, MD 20892-9589*

**SUMMARY:**
Starting with DSM III, the major substance use disorder categories have been called "abuse" and "dependence" in each successive version of the diagnostic manual. In DSM IV, the categories of abuse and dependence were designed to be non-overlapping entities where the dependence diagnosis supersedes abuse. In preparation for DSM-V, the substance disorders workgroup has taken up the challenge of considering alternative terminology. Because of the likely elimination of the categorical distinctions between abuse and dependence, the change in terminology takes on particular importance. In addition, potential confusion about multiple competing uses of the term "dependence" by DSM and pharmacologists (for whom the term dependence refers specifically to tolerance and withdrawal) has motivated the workgoup to consider alternatives. Input from organizations such as the American Society of Addiction Medicine and the Academy of Pain Medicine provided reasons against continued use of the term "dependence" for compulsive drug seeking. In contrast, others recommended against any changes to the current terminology. Also, the decision was made to include non substance disorders such as gambling in the overall category. Following a series of conference calls and consultations, the workgroup considered several alternatives for the main disorder (e.g. "dependence", "addiction", "substance use disorder", "appetitive disorder", etc.) as well as three major alternatives for the name of the DSM-V Chapter on substance disorders (which is likely to encompass gambling-related and possibly other non-substance related "addictive" behaviors). Methods for studying the potential stigma and bias associated with different terminology will be reviewed. This presentation will also review the major alternatives and provide an opportunity for the audience to participate in discussion about their strengths and weaknesses.

No. 54-D
**SEVERITY OF SUBSTANCE USE DISORDERS**
*Thomas Crowley, M.D., 12469 E 17th Pl, Mail Stop F478, Aurora, CO 80045*

**SUMMARY:**
The Workgroup recommends two ways to assess severity for Substance Use Disorders (SUD). Long-Term Severity assesses between-subject differences in severity, for example, over the last year, or over the year of heaviest use, or across one's lifetime. The Workgroup recommends that Long-Term Severity of SUD for each substance used will be defined as the number of DSM-V SUD criteria met by that individual for that substance during the specified duration (more criteria met = more severe disorder). The Workgroup considered that, first, clinical course is heavily influenced by comorbid disorders; e.g., amphetamine dependence is severely complicated by comorbid schizophrenia. However, the Workgroup recommends that severity of SUD be assessed alone; severity related to cross-disorder comorbidity should be addressed in DSM-V's GAF-like scaling. This is because treatment planning, while influenced by comorbid disorders, also must be guided heavily by the severity of, e.g., the person's alcohol dependence. Second, the course of any one SUD is complicated by other, comorbid SUDs; e.g., amphetamine dependence is likely to have a worse course when combined with heroin dependence. However, the Workgroup recommends that severity of each SUD be assessed independently, since treatment planning may be different for moderate alcohol dependence plus heroin dependence, vs. severe alcohol dependence plus heroin dependence. The Workgroup recommends further research on cross-substance scaling of severity.

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**SYMPOSIUM 55**

***DSM-5* UPDATE SERIES, PART I: REPORTS FROM THE WORK GROUPS**

*Chairperson: Darrel A Regier, M.D., M.P.H., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) List the major developmental considerations under discussion by the DSM-V Eating Disorders; Sexual and Gender Indentity Disorders; Sleep-Wake Disorders; Somatic Distress Disorders; and Neurocognitive Disorders Work Groups.

### OVERALL SUMMARY:

The forthcoming fifth edition of the DSM will be released in May 2012. Over the past three years, members of the 13 DSM-V Work Groups have been steadily compiling the evidence to address problems in the current diagnostic system and inform potential revisions. In this three-part symposia series, chairs from the work groups will provide brief updates on their progress to date. In this session, presenters from the *DSM-V* Eating Disorders, Sexual and Gender Identity Disorders, Sleep-Wake Disorders, Somatic Distress Disorders, and Neurocognitive Disorders Work Groups will highlight current discussions from their work group. This will include identification of problems and challenges among the present diagnostic scheme, explanations of how recent evidence from research and epidemiology have informed the decision-making process, and descriptions of strategies for field testing new and revised criteria. Presentations will conclude with a summary of anticipated revisions and areas of continued interest.

No. 55-A

### APPROACHES TO THE DIAGNOSIS AND CLASSIFICATION OF EATING DISORDERS IN *DSM-V*

*B. Timothy Walsh, M.D., 1051 Riverside Drive, Unit #98, New York, NY 10032-2603*

### SUMMARY:

In DSM-IV, there are only two recognized eating disorders: Anorexia Nervosa and Bulimia Nervosa, in addition to the residual category of Eating Disorders Not Other Specified (EDNOS). A major problem is that a large proportion of individuals presenting for treatment do not meet criteria for Anorexia Nervosa or Bulimia Nervosa, and therefore must be assigned a diagnosis of EDNOS. It is apparent that, in order to reduce the use of EDNOS, the DSM-IV criteria must be broadened in some fashion and/or new disorders must be added. Literature reviews addressing such topics as the validity and utility of proposed entities such as Binge Eating Disorder, Purging Disorder and Night Eating Syndrome have been conducted. The Work Group has also examined information on more modest options such as modifications to the existing DSM-IV criteria. For example, some questions under consideration are whether the criterion requiring amenorrhea for the diagnosis of Anorexia Nervosa should be eliminated and whether the criterion for Bulimia Nervosa requiring binge/purge episodes to occur, on average, twice weekly for the last three months should be revised.The Work Group has also considered the utility of including dimensional assessments (e.g., body mass index, frequency of binge eating and of inappropriate compensatory behavior, level of concern regarding shape and weight.). Field trials, currently underway, will help in assessing the feasibility and clinical utility of dimensions, and providing information on the impact of changes in the criteria on the frequency of diagnoses. Finally, the Work Group has been charged with reviewing options for revisions of the *DSM-IV* category Feeding and Eating Disorders of Infancy and Early Childhood. The advantages and disadvantages of possible revisions will be reviewed.

No. 55-B

### KEY RECOMMENDATIONS FROM THE *DSM-5* SEXUAL AND GENDER IDENTITY DISORDERS WORKGROUP

*Kenneth Zucker, Ph.D., 250 College St., Tornoto, M5T 1R8*

### SUMMARY:

The DSM-V Sexual and Gender Identity Disorders Workgroup has now published its narrative reviews of the major diagnoses that it appeared in the *DSM-IV* chapter on Sexual Identity Disorders. In this presentation, I will summarize the key recommendations for *DSM-5* put forth by the Sexual Dysfunctions, Paraphilias, and Gender Identity Disorders subworkgroups. These recommendations address key terminology, diagnostic naming, proposals for diagnostic "mergers," and proposals for the reform of diagnostic criteria based on empirical research. The Sexual Dysfunctions subgroup has, for example, recommended, at least for women, a merger of two *DSM-IV* diagnoses, Hypoactive Sexual Desire Disorder and Sexual Arousal Disorder, into one overarching diagnosis, Sexual Arousal/Interest Disorder, because the empirical evidence suggests substantial overlap between these two conditions and theoretical argumentation that arousal and desire are, in essence, two sides of the same coin. The Paraphilias subgroup has, for example, recommend modification to the diagnosis of Pedophilia that sharpens the age-related category of pedophilic sexual arousal; as a result, it has recommended a new term, Pedohebephilic Disorder, to better capture its phenomenology. The Paraphilias subworkgroup has also advanced a model to better distinguish between the ascertainment of a paraphilia and the criteria for Paraphilic Disorder. The Gender Identity Disorder subworkgroup has, for example, recommend a new term, Gender Incongruence, as the diagnostic label and has advance various proposals to reform the diagnostic criteria for children and adolescents/adults.

No. 55-C

### UPDATE FROM THE SOMATIC SYMPTOMS WORKGROUP

*Joel Dimsdale, M.D., 9500 Gilman Drive, La Jolla, CA 92093-0804*

### SUMMARY:

Somatoform disorders are commonly encountered in primary care settings, but patients with these disorders are relatively uncommon in psychiatric settings. The

diagnostic codes are not used widely. Many physicians and patients regard the existing terminology as confusing and/or offensive. In particular, terms such as "medically unexplained symptoms" pose problems as key constructs of such disorders. Such a term defines a diagnosis on the basis of a "negative"; it fosters a dualism between mind and body; and it tends to lock patient and physician into an antagonistic stance.The Workgroup has been exploring a different way of describing and organizing such disorders. We propose the overall term of "Somatic Symptom Disorders." This group of disorders is characterized predominantly by somatic symptoms that are associated with significant distress and/or dysfunction. These disorders typically present first in non-psychiatric settings. Somatic symptoms are common in every day life and may be initiated, exacerbated or maintained by combinations of biological, psychological, and social factors. Somatic symptom disorders can accompany diverse general medical as well as psychiatric diagnoses. When criteria are fulfilled, for example, for major affective disorder and for complex somatic symptom disorder, both diagnoses should be coded (i.e. there is no implicit hierarchy of diagnoses).
The Workgroup is defining how the existing Somatoform Disorders may be affected by viewing them in the context of this new rubric. This presentation will describe the Workgroup's current thinking on this important group of disorders.

No. 55-D
**TOWARDS A BETTER, PRACTICAL UNDERSTANDING OF SLEEP DISTURBANCES IN PEOPLE LIVING WITH OR AT RISK FOR MENTAL ILLNESS**

*Charles Reynolds, M.D., 3811 O'Hara Street, Pittsburgh, PA 15213*

**SUMMARY:**
Improved recognition of sleep disturbances is fundamental to advancing psychiatric practice. Insomnia, for example, can foretell the onset of a new episode of mental illness, complicate its treatment, and, if not adequately addressed in its own right, compromise the quality and durability of treatment response. Sleep disturbances may signal vulnerability to mental illness, enhance distress and impairment, and represent persistent risk for subsequent relapse.Sleep disturbances comorbid with psychiatric illness may also signal the presence of coexisting medical illness in need of additional clinical management. Following this presentation, participants will be able to: (1) discuss the interrelationships between sleep disturbances such as insomnia and mental illnesses such as major depression; (2) identify user-friendly instruments for assessing the diagnosis of insomnia disorder, measuring its severity, and monitoring response to treatment; (3) identify practical strategies for helping patients sleep better and measuring their progress; and (4) understand how sleep disturbances may provide a tip off to coexisting medical or neurologic disorders. Each of these objectives represent major areas of focus of the *DSM-5* Sleep Wake Disorders Workgroup.

No. 55-E
**NEUROCOGNITIVE DISORDERS IN *DSM-V***

*Dilip Jeste, M.D., 9500 Gilman Drive, #0664, La Jolla, CA 92093*

**SUMMARY:**
This section includes Neurocognitive Disorders that were labeled in *DSM-IV* as "Dementia, Delirium, Amnestic, and Other Cognitive Disorders". The disorders included here are, by definition, acquired disorders – i.e., characterized by a decline in previously attained cognitive abilities. Cognitive dysfunction is a feature of a number of mental disorders (e.g., schizophrenia, depression), but it is not the most prominent or the defining feature. The Neurocognitive Disorders will be divided into Delirium (with acute or subacute disturbance of awareness, arousal, and alertness, with a fluctuating course) and Neurocognitive Disorders without such alteration. In defining delirium, the old term "consciousness" was thought to be too vague. An etiology-based subclassification of Delirium would be appropriate. Neurocognitive Disorders other than delirium would be subdivided based on severity of functional and neurocognitive impairment into: Minor Neurocognitive Disorder (mNCD; often called Mild Cognitive Impairment or MCI), and Major Neurocognitive Disorder (MNCD) or Dementia. Unlike *DSM-IV*, memory impairment would not be necessary for diagnosing either condition. Both mNCD and MNCD may be subclassified according to etiology – e.g., Alzheimer disease, vascular neurocognitive disorder, Mixed. The criteria for non-Alzheimer dementing disorders are being developed by independent subspecialty groups (e.g., Lewy Body Disease group, vascular dementia groups, etc.), which we will incorporate as appropriate. The issues still being discussed include possible subtypes of delirium, specification of neurocognitive and functional domains (and relevant tests) for diagnosing mNCD and MNCD, role of biomarkers in the diagnosis, and use of other specifiers to better define the clinical condition in a given patient - e.g., course (transient, remitting, persistent but stable, persistent and worsening, persistent with fluctuations), and associated behavioral disturbances (e.g., psychosis, agitation, depression). Field trials are being planned at this stage.

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**SYMPOSIUM 56**

**FOCAL BRAIN STIMULATION FOR PSYCHIATRIC DISORDERS: CLINICAL UPDATE**

*Chairperson: Paul Holtzheimer, M.D., 101 Woodruff Circle NE, Suite 4000, Atlanta, GA 30322*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe the relative strength of data supporting each focal brain stimulation therapy in the treatment of psychiatric disorders; 2) Understand the differences in clinical populations enrolled in studies of each treatment; and 3) Appreciate how each treatment may have a unique place in the management of various psychiatric disorders.

**OVERALL SUMMARY:**
Focal brain stimulation therapies – transcranial magnetic stimulation (TMS), magnetic seizure therapy (MST), vagus nerve stimulation (VNS), direct cortical stimulation (DCS), deep brain stimulation (DBS) – are emerging as potentially valuable treatment options in psychiatry. The development of these therapies has been guided in part by a search for treatments that might achieve or exceed the efficacy of electroconvulsive therapy (ECT) but overcome its limitations (cognitive side effects, high relapse rate). VNS and TMS devices have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of depression. A DBS device recently received a humanitarian device exemption (HDE) from the FDA for the management of treatment-resistant obsessive-compulsive disorder (OCD). At least two industry-sponsored trials are currently underway to test DBS as a potential therapy for treatment-resistant depression. As these treatments become more accepted and more available, it will be critical for clinicians to understand their similarities and differences with respect to safety, efficacy, and target patient populations. This three-hour symposium will provide a clinical update on several focal brain stimulation therapies. Individual presentations will focus on the latest clinical data supporting each treatment. A panel discussion and question/answer period will allow participants to better appreciate where each of these treatments might eventually fit into the management of psychiatric disorders (using the current application of ECT as a reference point).

No. 56-A
**THE CLINICAL SAFETY AND EFFICACY OF TRANSCRANIAL MAGNETIC STIMULATION: RESULTS FROM RECENT PIVOTAL CLINICAL TRIALS**

*William M. McDonald, M.D., 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

**SUMMARY:**
Repetitive transcranial magnetic stimulation (rTMS) is a noninvasive method to excite neurons in the brain and is perhaps the least invasive, yet effective, neuromodulation technique. rTMS was approved for clinical use by the FDA in October of 2008 for the treatment of major depression. The approval was restricted to patients who had failed one adequate antidepressant trial and is based on the data from a multisite industry trial. The data from this trial will be reviewed. An NIMH multicenter trial was recently completed and the paper outlining the results of this trial is presently under review and would be anticipated to be published in time for the results to be presented at this meeting. The data from these two studies and other smaller trials should provide guidance for clinicians in determining which patients can optimally benefit from rTMS. The appropriate work up, side effects and safety profile of rTMS will also be discussed. Finally recommendations for future clinical trials in rTMS will be outlined.

No. 56-B
**CLINICAL UPDATE ON MAGNETIC SEIZURE THERAPY (MST)**

*Sarah Lisanby, M.D., 1051 Riverside Drive Unit 21, New York, NY 10032*

**SUMMARY:**
Electroconvulsive therapy (ECT) continues to play a vital role in the treatment of severe, acute, and medication resistant psychiatric disorders such as major depression and treatment resistant schizophrenia. However, the side effects of ECT limit its clinical utility and remain a source of concern for patients and their families. Magnetic seizure therapy (MST) was introduced as a means of improving the side effects profile of ECT by achieving enhanced control over seizure expression, taking advantage of the focality of magnetic fields. Unlike the transcranial electrical application in ECT, magnetic fields are not impeded by scalp and skull and thus can be more precisely targeted.

MST-induced electrical currents are confined to superficial cortex, while ECT induces radial currents that penetrate more deeply in the brain. It has been proposed that with MST it may be possible to induce seizures that originate in superficial cortex, sparing deeper brain structures such as the medial temporal lobes that might be related to cognitive side effects. Studies to date suggest the cognitive sequelae appeared to favor MST relative to ECT. Across a series of translational studies, we have demonstrated that seizure induction with MST is feasible; that there is no evidence of neuropathological damage from MST; that the induced fields are more superficial, weaker, and less affected by anatomical variation than those seen with ECT; that the induced seizures are weaker and less generalized than ECT; that cognitive outcomes are superior to ECT; and we have shown preliminary evidence of antidepressant benefits. This presentation will review the current status of MST, including the results randomized controlled trials on its safety and efficacy in treating depression.

No. 56-C

**CLINICAL UPDATE ON VAGUS NERVE STIMULATION (VNS)**

*Linda Carpenter, M.D., Butler Hospital, Providence, RI 02806*

**SUMMARY:**

Treatment-resistant depression (TRD) is a major public health concern. Vagus Nerve Stimulation (VNS) is one of the recently developed, device-based approaches for the treatment of TRD. VNS implantation surgery is considered a procedure of low complexity and is typically performed in an outpatient surgical setting under general anesthesia. A pulse generator is placed subcutaneously into the left wall of the chest and is connected to electrodes attached to the left vagus nerve within the neck. Therapeutic brain stimulation through delivery of pulsed electrical impulses to the left cervical vagus nerve has established safety and efficacy as an adjunct treatment for medication-resistant epilepsy. In 2005, VNS was FDA-approved as an adjunct long-term treatment for chronic or recurrent major depression. There is considerable evidence from both animal and human neurochemical and neuroimaging research laboratories that the vagus nerve and its stimulation influence limbic and higher cortical brain regions implicated in mood disorders, providing a rationale for its possible role in the treatment of psychiatric disorders. Clinical studies (open-label and comparator with treatment in naturalistic setting) in TRD patient samples have produced promising results, especially when response rates at longer term (one- and two-year) follow-up time points are considered. Limited reimbursement by third party payors remains an obstacle for patients seeking access to VNS therapy for TRD. Ongoing research efforts will help determine the place of adjunct VNS in the armament of therapeutic modalities available for major depression resistant to standard antidepressant treatments.

No. 56-D

**THE PROMISE OF DIRECT EPIDURAL CORTICAL STIMULATION (DCS) IN REFRACTORY MDD: THE PROSPECT EXPERIENCE AND FUTURE DIRECTIONS**

*Jerry Halverson, M.D., 6001 Research Park Blvd, Madison, WI 53719*

**SUMMARY:**

Background: Imaging studies have suggested that decreased activity in the left dorsolateral prefrontal cortex (DLPFC) are present in individuals suffering from major depressive disorder (MDD). Transcranial magnetic stimulation has been approved by the FDA for treating depressed patients after showing efficacy by stimulating the DLPFC. These findings prompted an investigational study of an implanted epidural direct cortical stimulation (DCS) system that delivers targeted stimulation to the left DLPFC.
Methods: 12 people with refractory MDD were implanted with an epidural CS system (Northstar Neuroscience, Seattle, WA - now St. Jude Medical). Patients were randomized to single blind active or sham stimulation for 8 weeks, all subjects then received active stimulation.
Results:One subject was excluded from analysis due to a protocol deviation. At Week 8, HDRS decreased by 22% (active; n=6) vs. 3% (sham; n=5). ; MADRS decreased 22% (active) vs. 8% (sham); GAF increased 23% (active) vs. 12% (sham). Across all subjects, continued improvement was seen at 6 months (average HDRS:
20%) and 12 months (average HDRS: 33%).
At 12 months, subjects (n=5) whose electrodes were implanted =20 mm from the precentral sulcus averaged a 59% improvement in HDRS compared to a 12% improvement for those subjects (n=6) with electrodes <20mm from the precentral sulcus. Four subjects with electrodes <20mm from the precentral sulcus elected electrode revision surgery. Updated results will be presented.
Conclusion:Results suggest that DCS has a therapeutic benefit in treating MDD patients. The effect appears to increase over time and seems related to electrode placement. Most recent results, effects of the revision surgeries, depression circuitry insights and implications for further studies will be discussed.

No. 56-E

**DEEP BRAIN STIMULATION FOR PSYCHIATRIC DISORDERS: CLINICAL UPDATE**

*Paul Holtzheimer, M.D., 101 Woodruff Circle NE, Suite 4000, Atlanta, GA 30322*

**SUMMARY:**

For over 100 years, brain surgery has been used to treat the

most severely ill and treatment-resistant psychiatric patients. Ablative neurosurgical approaches to treating mental illness have been largely limited by a lack of evidence supporting safety and efficacy, potentially serious side effects (including cognitive impairment, personality change and seizures) and stigmatization. However, with the development of non-ablative approaches for focal neuromodulation (with lower risk and fewer side effects), a renewed focus on surgical interventions for severely ill patients has emerged. Deep brain stimulation (DBS) is currently approved by the U.S. Food and Drug Administration (FDA) for the treatment of Parkinson's Disease, Essential Tremor and dystonia. Recently, DBS received a Humanitarian Device Exemption (HDE) for the treatment of severe, treatment-refractory Obsessive-Compulsive Disorder (OCD). There are currently two, multi-center studies underway to test DBS in patients with treatment-resistant depression (TRD). DBS has also been proposed or used to treat Tourette's Syndrome, Alzheimer's Dementia, obesity, and addiction among other conditions. This presentation will present and critically evaluate the available clinical data for DBS in the treatment of various psychiatric disorders. The primary focus will be on findings in studies of OCD and TRD patients, though the reported safety and efficacy of DBS for other psychiatric conditions will be briefly reviewed.

## SYMPOSIUM 57

## DEPRESSION, METABOLIC SYNDROME AND OBESITY

*Chairperson: Julio Licinio, M.D., Bldg 131 Garron Rd, Canberra, ACT 2601 Australia,*
*Co-Chairperson: Anand Kumar, M.D.*

### EDUCATIONAL OBJECTIVES:

At the completion of this session participants will be able to: 1) Identify the metabolic consequences of depression; 2) Diagnose cardiovascular risk factor in depressed patients; and 3) Understand the risks and consequences of the co-morbidity of depression and diabetes, particularly in geriatric patients.

### OVERALL SUMMARY:

Depression has metabolic consequences, which can be worsened by antidepressant treatment. Eight lines of evidence support the inter-relationship between depression and obesity: (i) Depression and obesity frequently co-exist. (ii) Both disorders are substantial health problems worldwide. (iii) Depressed mood can be a side effect of obesity treatments. (iv) Weight gain can be a side effect of antidepressant treatments (v) Several neuropeptidergic and neurotransmitter systems, involving molecules such as CRH, NPY, serotonin, and norepinephrine, are involved in the regulation of both mood and body weight. (vi) Drugs used to treat either depression or obesity regulate central serotonin or norepinephrine. (vii) Genetic polymorphisms may underlie the predisposition both to depression and to cardiovascular disease. (viii) Depression and obesity are important risk factors for cardiovascular disease, potentially worsening the metabolic syndrome. Not only is cardiovascular disease more prevalent in depressed patients, once a cardiovascular event occurs, depression worsens the risk of death. Moreover, the co-morbidity of depression and diabetes is particularly worrisome, as the outcomes can be devastating. In this symposium we cover the full spectrum of the interface of depression, metabolic syndrome and obesity. First, Dr. Brenda Penninx, from the Netherlands, will discuss the co-morbidity of depression, abdominal obesity and the resulting metabolic consequences. Two complementary presentations will cover the co-morbidity of depression and diabetes. Dr. Wayne Katon will discuss the increased lethality of this combination, while Dr. Anand Kumar will present brain image data on the correlates of depression and diabetes in the elderly. Dr. Mohamed Ali will examine the often overlooked association of depression with increased severity of co-morbidities in bariatric surgical candidates. Finally, Dr. Roger McIntyre, from Canada, will present the interesting and provocative idea that because depression has such marked metabolic consequences, it should perhaps be classified as a subtype of metabolic syndrome. A general discussion will engage the audience in an interactive dialogue with presenters to answer questions and promote exchange in this key are at the intersection of psychiatry and medicine. Type 2 diabetes is a common metabolic disorder and 20-30 percent of patients diagnosed with diabetes have a concurrent mood disturbance. Depression is associated with adverse clinical outcomes in patients diagnosed with diabetes and responds to pharmacological and psychotherapeutic interventions. However, the biological basis of depression in patients with diabetes remains unknown. Neuropsychological approaches demonstrate executive function impairment in patients with diabetes and depression when compared with non-depressed diabetics. Physiological studies using magnetic resonance spectroscopy (MRS) indicate striking changes in glutamine/glutamate levels primarily in the subcortical region in patients with diabetes and depression. Collectively, these studies suggest frontal-subcortical physiological aberrations in patients with diabetes and depression. These observations have broad pathophysiological significance for mood disorders associated with metabolic aberrations.

No. 57-A
## DEPRESSION AND ABDOMINAL OBESITY

*Brenda Penninx, Ph.D., VU University Medical Ctr, Amsterdam, 1081 HL*

### SUMMARY:

CONTEXT: Depression has been hypothesized to result

in abdominal obesity through the accumulation of visceral fat. No large study has tested this hypothesis longitudinally. OBJECTIVE: To examine whether depressive symptoms predict an increase in abdominal obesity in a large population-based sample of well-functioning older persons. DESIGN: The Health, Aging, and Body Composition Study, an ongoing prospective cohort study with 5 years of follow-up. SETTING: Community-dwelling older persons residing in the areas surrounding Pittsburgh, Pennsylvania, and Memphis, Tennessee. PARTICIPANTS: A total of 2088 well-functioning white and black persons aged 70 to 79 years. MAIN OUTCOME MEASURES: Baseline depression was defined as a Center for Epidemiological Studies Depression score of 16 or higher. At baseline and after 5 years, overall obesity measures included body mass index (calculated as weight in kilograms divided by height in meters squared) and percentage of body fat (measured by dual-energy x-ray absorptiometry). Abdominal obesity measures included waist circumference, sagittal diameter, and visceral fat (measured by computed tomography). RESULTS: After adjustment for sociodemographics, lifestyle, diseases, and overall obesity, baseline depression was associated with a 5-year increase in sagittal diameter (beta = .054; P = .01) and visceral fat (beta = .080; P = .001). CONCLUSIONS: This study shows that depressive symptoms result in an increase in abdominal obesity independent of overall obesity, suggesting that there may be specific pathophysiological mechanisms that link depression with visceral fat accumulation. These results might also help explain why depression increases the risk of diabetes and cardiovascular disease.

No. 57-B

**DEPRESSION AND DIABETES: A POTENTIALLY LETHAL CO-MORBIDITY**

*Wayne Katon, M.D., Department of PsychiatryUniversity of Washington Medical CenterP.O. Box 356560, Seattle, WA 98195-6560*

**SUMMARY:**

Purpose: Recent evidence suggests that depression is linked to increased mortality among patients with diabetes. This study examines the association of depression with all-cause and cause-specific mortality in diabetes. Methods: we conducted a prospective cohort study of primary care patients with type 2 diabetes at group health cooperative in Washington state. We used the patient health questionnaire (phq-9) to assess depression at baseline and reviewed medical records supplemented by the Washington state mortality registry to ascertain the causes of death. Results: Among a cohort of 4,184 patients, 581 patients died during the follow-up period. Deaths occurred among 428 (12.9%) patients with no depression, among 88 (17.8%) patients with major depression, and among 65 (18.2%) patients with minor depression. Causes of death were grouped as cardiovascular disease, 42.7%; cancer, 26.9%; and deaths that were not due to cardiovascular disease or cancer, 30.5%. Infections, dementia, renal failure, and chronic obstructive pulmonary disease were the most frequent causes in the latter group. Adjusting for demographic characteristics, baseline major depression (relative to no depression) was significantly associated with all-cause mortality (hazard ratio [HR] =2.26, 95% confidence interval [CI], 1.79-2.85), with cardiovascular mortality (HR = 2.00; 95% CI, 1.37-2.94), and with non-cardiovascular, non-cancer mortality (HR = 3.35; 95% CI, 2.30-4.89). After additional adjustment for baseline clinical characteristics and health habits, major depression was significantly
associated only with all-cause mortality (HR = 1.52; 95% CI, 1.19-1.95) and with death not caused by cancer or atherosclerotic cardiovascular disease (HR = 2.15; 95% CI, 1.43-3.24). Minor depression showed similar but non-significant associations. Conclusions: Patients with diabetes and coexisting depression face substantially elevated mortality risks beyond cardiovascular deaths

No. 57-C

**BRAIN CORRELATES OF CO-MORBID DIABETES AND GERIATRIC DEPRESSION**

*Anand Kumar, M.D., CS 1601 W Tucker Ste 573 MC 912, Chicago, IL 60612*

**SUMMARY:**

Type 2 diabetes is a common metabolic disorder and 20-30 percent of patients diagnosed with diabetes have a concurrent mood disturbance. Depression is associated with adverse clinical outcomes in patients diagnosed with diabetes and responds to pharmacological and psychotherapeutic interventions. However, the biological basis of depression in patients with diabetes remains unknown. Neuropsychological approaches demonstrate executive function impairment in patients with diabetes and depression when compared with non-depressed diabetics. Physiological studies using magnetic resonance spectroscopy (MRS) indicate striking changes in glutamine/glutamate levels primarily in the subcortical region in patients with diabetes and depression. Collectively, these studies suggest frontal-subcortical physiological aberrations in patients with diabetes and depression. These observations have broad pathophysiological significance for mood disorders associated with metabolic aberrations.

No. 57-D

**DEPRESSION IS ASSOCIATED WITH INCREASED SEVERITY OF CO-MORBIDITIES IN BARIATRIC SURGICAL CANDIDATES**

*Mohamed Ali, M.D., 2221 Stockton Blvd Cypress Bldg Ste E, Sacramento, CA 95817*

**SUMMARY:**

Background: Depression is prevalent among bariatric surgical patients, and previous studies have suggested a link between depression and quality of life. Our objective was to examine the relationship between depression and other co-morbidities of obesity at a university hospital in the United States. Methods: Data were collected from 1368 consecutive patients evaluated for bariatric surgery. The demographic and co-morbidity profiles of these patients were compared between the depressed and non-depressed individuals. Depression was defined as an assessment of obesity-related co-morbidities score of > or = 3, signifying that the patient required medical treatment for (score of 3) or had complications of (score of 4-5) depression. Results: The prevalence of depression among these patients was 36%. The mean age of the patients with depression was older (44.3 + or - 9.4 versus 42.2 + or - 9.6, p <.05), but the mean body mass index was similar. Depression was more prevalent among the female patients (37.4% versus 29.6%, p <.05). Diabetes mellitus, hypertension, polycystic ovarian syndrome, idiopathic intracranial hypertension, and obesity hypoventilation syndrome occurred with similar frequency and severity in persons with and without depression. The analysis revealed a significantly greater prevalence and severity of dyslipidemia (p <.05), gastroesophageal reflux disease (p <.05), back pain (p <.0001), joint pain (p <.05), sleep apnea (p <.01), stress incontinence (p <.01), and hernia (p <.05) among patients with depression. Overall, patients with depression had more co-morbidities per patient (5.46 versus 4.55) and a greater likelihood of severe or complicated co-morbidities (2.67 versus 1.89 per patient). Conclusion: This report has characterized a link between depression and other co-morbidities in bariatric surgical patients. This association was independent of the body mass index. Although a causal relationship could not yet be identified, our findings indicate that depression, in this patient population, is associated with a greater prevalence and increased severity of medical co-morbidities that express distinct physical symptoms.

No. 57-E

**SHOULD MOOD SYNDROMES BE RE-CLASSIFIED AS METABOLIC SYNDROME TYPE II?**

*Roger McIntyre, M.D., 399 Bathurst St MP 9-325, Toronto, M5T 2S8*

**SUMMARY:**

Background: A nascent explanatory theory regarding the pathophysiology of major depressive disorder posits that alterations in metabolic networks (e.g., insulin and glucocorticoid signaling) mediate allostasis. Method:
We conducted a pubmed search of all English-language articles published between January 1966 and September 2006. The search terms were: neurobiology, cognition, neuroprotection, inflammation, oxidative stress, glucocorticoids, metabolic syndrome, diabetes mellitus, insulin, and antidiabetic agents, cross-referenced with the individual names of DSM-III-R/IV/-TR-defined mood disorders. The search was augmented with a manual review of article reference lists; articles selected for review were determined by author consensus. Results: Disturbances in metabolic networks: e.g., insulin-glucose homeostasis, immuno-inflammatory processes, adipokine synthesis and secretion, intra-cellular signaling cascades, and mitochondrial respiration are implicated in the pathophysiology, brain volumetric changes, symptomatic expression (e.g., neurocognitive decline), and medical comorbidity in depressive disorders. The central nervous system, like the pancreas, is a critical modulator of the metabolic milieu and is endangered by chronic abnormalities in metabolic processes. We propose the notion of "metabolic syndrome type ii" as a neuropsychiatric syndrome in which alterations in metabolic networks are a defining pathophysiological component. Conclusion: A comprehensive management approach for depressive disorders should routinely include opportunistic screening and primary prevention strategies targeting metabolically mediated comorbidity (e.g., cardiovascular disease). Innovative treatments for mood disorders, which primarily target aberrant metabolic networks, may constitute potentially novel, and disease-modifying, treatment avenues.

**REFERENCES:**

1. Focal subcortical biophysical abnormalities in patients diagnosed with type 2 diabetes and depression. Kumar A, Gupta R, Thomas A, Ajilore O, Hellemann G. Arch Gen Psychiatry. 2009 Mar;66(3):324-30.
2. Vogelzangs N, Kritchevsky SB, Beekman AT, Newman AB, Satterfield S, Simonsick EM, Yaffe K, Harris TB, Penninx BW. Depressive symptoms and change in abdominal obesity in older persons. Arch Gen Psychiatry. 2008 Dec;65(12):1386-93.

**SYMPOSIUM 59**

**NEUROBIOLOGY OF OBESITY: WHY WE CAN GET TOO MOTIVATED TO EAT**

*The U.S. National Institute on Drug Abuse*

*Chairperson: Nora D Volkow, M.D., 6001 Executive Blvd. Rm 5274, MSC 9581, Bethesda, MD 20892, Co-Chairperson: Joseph Frascella, Ph.D.*
*Discussant: Nora D Volkow, M.D*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should have a good understanding of some of the important neurobiologic and behavioral parallels between substance abuse/addiction and overeating/obesity. Given that obesity for a subpopulation of individuals shares some critical neurobehavioral aspects of addiction, recognizing these commonalities might influence treatment approaches.

**OVERALL SUMMARY:**

Obesity is a major health problem in the United States, as well as globally, and this disease is having a devastating impact on overall health. Importantly, the number of overweight children continues to increase. Obesity results from a number of different social, environmental, and biobehavioral factors. The brain, however, clearly controls how and what we eat. A complex interaction of processes dictates basic drives to eat, when to stop, the sensory and emotional aspects associated with eating, the decisions guiding food choices, and the central control of metabolism. The neurobiological mechanisms, brain circuitry and systems underlying excessive, compulsive eating behavior are beginning to be elucidated and are revealing many parallels between obesity and substance addiction. This symposium will explore the specific commonalities between obesity and substance addiction and will discuss neurobiologic and neurobehavioral processes that are shared.
This presentation will integrate findings from PET imaging studies on dopamine's role in drug abuse/addiction and in obesity and propose a common model for these two conditions. Both in abuse/addiction and in obesity there is an enhanced value of one type of reinforcer (drugs and food respectively) at the expense of other reinforcers, which is a consequence of conditioned learning and resetting of reward thresholds secondary to repeated stimulation by drugs (abuse/addiction) and by large quantities of palatable food (obesity) in vulnerable individuals (i.e. genetic factors). In this model, during exposure to the reinforcer or to conditioned-cues, the expected reward (processed by memory circuit) overactivates the reward and motivation circuits while inhibiting the cognitive control circuit resulting in an inability to inhibit the drive to consume the drug or food despite attempts to do so. These neuronal circuits, which are modulated by dopamine, interact with one another so that disruption in one circuit can be buffered by another, highlighting the need of multiprong approaches in the treatment of addiction and obesity.

No. 59-A

**OVEREATING AND OBESITY**

*David Kessler, M.D., 513 Parnassus Ave Box 0110 Med Sci 224, San Francisco, CA 94143*

**SUMMARY:**

Compulsive eating and excessive overeating often lead to obesity, and despite the desire to stop this behavior, many people find it difficult to resist certain foods. Overeating often leads to obesity and can persist in the face of adverse health and other consequences, much like the relationship between drug taking and addiction. This presentation will provide a general overview of overeating and obesity. It will set the stage for the other presentations in this symposium that will show how the neurobiology of obesity has clear parallels with substance addiction. Discussed will be the interactions between food (and its salient components) and the brain and how these relate to the behavior of eating, and more importantly, overeating. Also, discussed will be the key elements to the irresistible nature of certain foods and the "formulation" to make them highly palatable and easily over consumed. Some discussion will focus on treatment approaches and strategies for obesity and the necessary steps to end overeating.

No. 59-B

**CENTRAL CONTROL OF FOOD INTAKE: APPETITE CONTROL AND THE REWARD-DRIVEN BRAIN**

*Hans-Rudolf Berthoud, Ph.D., 6400 Perkins Road, Baton Rouge, LA 70808*

**SUMMARY:**

Under mostly restrictive environmental conditions, powerful biological mechanisms evolved to defend adequate nutrient supply, levels of adiposity, and body weight. Many of these mechanisms involve cognitive and emotional-affective functions of the brain involved in goal-directed motivated behavior. For example, there is now evidence that low leptin levels and reduced leptin-signaling does not only affect the mediobasal hypothalamic energy balance regulator, but also acts directly and indirectly on other brain areas to enhance sensory perception, reward expectancy, and memorial representations of foods and their cues in the environment. The combined effect is the signature of a "hungry" brain. In contrast and as a result of thrifty adaptation and/or random drift in the genetic predisposition, only weak mechanisms exist to defend against weight gain in some individuals. In the modern environment with its increased availability of large amounts of energy dense foods, presence of powerful food cues, minimal physical food procurement costs, and a sedentary lifestyle, such predisposed individuals develop obesity, just like some laboratory animals and pets develop diet-induced obesity. Thus, in prone individuals, motivation to eat is strongly guided by cortico-limbic mechanisms of reward and emotion that can easily override metabolic repletion signals, while in resistant individuals the balance between these two systems is maintained. Therefore, the discussion about possible differences in brain functions underlying common obesity has shifted from the hypothalamus to include cortico-limbic systems, particularly those processing pleasure, reward, satisfaction, cost-benefit calculations, and conscious decision making. Better understanding of how these systems are organized and how they interact with the metabolically-driven controls in the hypothalamus and brainstem will go a long way in the search for behavioral and pharmacological tools to counteract the modern environmental pressures.
Supported by NIDDK 47348 and NIDDK 072081.

No. 59-C

**SWEETNESS AS A SUPER REWARD: COMPARISON WITH COCAINE AND HEROIN**

*Serge Ahmed, Ph.D., 146 rue Léo-Saignat, Bordeaux, 33000*

**SUMMARY:**
Refined sugars (e.g., sucrose, fructose) were absent in the diet of many people until very recently in human history. Today overconsumption of diets rich in sugars contributes, together with other factors, to drive the current obesity epidemic. Overconsumption of sugar-dense foods or beverages is initially motivated by the pleasure of sweet taste and is often compared to drug addiction. Though there are many biological commonalities between sweetened diets and drugs of abuse, the addictive potential of the former relative to the latter is currently unknown. In my talk, I will present experimental evidence in rats – the most frequently used animal model in drug addiction research – showing that water sweetened with saccharin or sucrose is more rewarding, and thus probably more addictive, than intravenous cocaine or heroin – the two most dangerous and addictive substances currently known. Sweet preference was expressed by the majority of individuals, no matter how intense was the severity of past drug use. How taste sweetness can override cocaine or heroin reward is currently unknown. Nevertheless, these findings are consistent with the concept of sugar addiction and with the experience of many people who find it hard to abstain from sweet foods and/or drinks.

No. 59-D

**FUNCTIONAL NEUROIMAGING IN OBESE AND HEALTHY WEIGHT GROUPS: FOOD MOTIVATION AND MONETARY REWARD**

*Cary R. Savage, Ph.D., University of Kansas Medical Ctr., Hoglund Brain Imaging Center, 3901 Rainbow Blvd, MS 1052, Kansas City, KS 66160*

**SUMMARY:**
Obesity arises from chronic imbalances between energy intake and expenditure. Health-related decisions impacting energy balance are influenced by a convergence of processes in the brain, as individuals weigh the perceived balance between immediate reward and long-term goals. Functional neuroimaging is proving to be a powerful tool for understanding brain mechanisms contributing to energy intake. Dr. Savage will review functional magnetic resonance imaging (fMRI) studies of food motivation in obese and healthy groups documenting increased brain activation in obese groups during states of high and low food motivation. Previous neuroimaging work in obesity has focused on food reward, but there is no reason to believe that reward centers of the brain distinguish between reward types. Accordingly, Dr. Savage will describe preliminary results from a study using fMRI and a monetary reward paradigm in obese and healthy weight groups.

No. 59-E

**NEUROCIRCUITRY OF ADDICTION AND OBESITY**

*Nora Volkow, M.D., 6001 Executive Blvd. Rm 5274, MSC 9581, Bethesda, MD 20892*

**SUMMARY:**
This presentation will integrate findings from PET imaging studies on dopamine's role in drug abuse/addiction and in obesity and propose a common model for these two conditions. Both in abuse/addiction and in obesity there is an enhanced value of one type of reinforcer (drugs and food respectively) at the expense of other reinforcers, which is a consequence of conditioned learning and resetting of reward thresholds secondary to repeated stimulation by drugs (abuse/addiction) and by large quantities of palatable food (obesity) in vulnerable individuals (i.e. genetic factors). In this model, during exposure to the reinforcer or to conditioned-cues, the expected reward (processed by memory circuit) overactivates the reward and motivation circuits while inhibiting the cognitive control circuit resulting in an inability to inhibit the drive to consume the drug or food despite attempts to do so. These neuronal circuits, which are modulated by dopamine, interact with one another so that disruption in one circuit can be buffered by another, highlighting the need of multiprong approaches in the treatment of addiction and obesity.

**TUESDAY, MAY 25, 2010**
**9:00 AM-11:00AM**

**SYMPOSIUM 63**

**ADOLESCENT POTENTIAL: EXPLORING THE DEVELOPING BRAIN AND UNDERSTANDING PATHWAYS OF ADDICTION**

***The U.S. National Institute on Drug Abuse***

*Chairperson: Cheryl Anne Boyce, Ph.D., 6001 Executive Blvd, Rm 6200, Bethesda, MD 20011,*
*Co-Chairperson: Joseph Frascella, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand brain development during adolescence; 2) Recognize differential clinical neuroscience and behavioral pathways to addiction for adolescent youths; and 3) Identify gender differences that affect addiction among adolescents.

**OVERALL SUMMARY:**

Adolescence is a critical period of development of the brain when the formation of brain circuitry and behavioral responses may affect pathways to addiction. This session will explore the latest data on brain imaging and behavioral functioning among adolescents to identify adolescent brain development, gender differences and relationships for substance use risk and involvement. Through neuroimaging techniques, the developing adolescence brain reveals dynamic brain functioning activity. As an evolutionary skill, the sensation seeking of adolescence may be rooted in the need to encourage independence from parents in order to increase social competence. Yet during adolescence, cognitive controls are necessary to balance sensation seeking which is characteristic of this developmental stage. The consequences of such sensation-seeking behaviors may include increased risk for substance use. Gender differences also demonstrate interesting insights into adolescence brain functioning, behavior and risk. Understanding the adolescent brain through neuroscience discoveries reminds us that adolescence is not only a critical period for brain and behavior development and pathways for addiction; but also an opportune time for effective brain and behavioral interventions among diverse populations.

No. 63-A

**THE DEVELOPING BRAIN, ADOLESCENCE AND ALCOHOL/DRUG USE: AN EVOLUTIONARY APPROACH**

*Linda Spear, Ph.D., Dept. of Psychology Box 6000 Binghamton University, Binghamton, NY 13902-6000*

**SUMMARY:**

Adolescence is characterized by a variety of hormonal, neural and behavioral alterations that have been evolutionarily conserved across mammalian species, although the ultimate adaptive significance of these adolescent behaviors is not always obvious. Even in a very simple animal model, adolescent rats, like their human counterparts, often exhibit elevations in peer-directed social interactions, risk-taking/novelty seeking, and alcohol and drug use relative to adults, along with notable changes in mesocorticolimbic neurocircuitry implicated in modulating these behaviors and in assigning hedonic affect and attaching incentive salience to natural and drug rewards. The relatively high levels of drug/alcohol use and elevated peer- and risk-directed behaviors by adolescents may be promoted in part by age-associated attenuations in sensitivity to the aversive properties of alcohol, other drugs and natural rewards, along with evidence for an enhancement in the sensitivity of adolescents to the positive rewarding properties of these substances. Limitations and potential implications of this approach will be discussed. An evolutionarily conserved shift in the hedonic properties of drugs and other stimuli during adolescence toward attenuated aversive and enhanced rewarding properties may serve to permit and encourage high levels of drug/alcohol use during adolescence that, when combined with other vulnerability factors, may set the stage for the emergence of abuse and addiction.

No. 63-B

**THE TEEN BRAIN: INSIGHTS FROM NEUROIMAGING**

*Jay Giedd, M.D., Child Psychiatry Branch, NIMH, Building 10, Room 4C110, 10 Center Drive,, Bethesda, MD 20892*

**SUMMARY:**

The outward physical changes associated with puberty are conspicuous and well described. The brain changes are every bit as dramatic but less obvious to the unaided eye. The advent of magnetic resonance imaging (MRI) which combines a powerful magnet, radio waves, and sophisticated computer technology to provide exquisitely accurate pictures of brain anatomy and physiology, has opened an unprecedented window into the biology of the adolescent brain. Three themes emerge from the cumulative neuroimaging research of adolescents, each buttressed by behavioral, EEG, and postmortem studies: These themes are: (1) childhood peaks followed by adolescent declines gray matter volumes; (2) increased connectivity - reflected by increases in white matter volume and coactivation of disparate brain regions during fMRI tasks, and (3) a changing balance between earlier maturing limbic system networks and later maturing frontal lobe networks. Frontal lobe circuitry mediates a broad array of abilities, including attention, response inhibition, regulation of emotion, organization, and long-range planning. These changes are usually healthy and optimize the brain for the challenges ahead, but may also confer a vulnerability to certain types of psychopathology. Many aspects of the complicated and reciprocally interconnected development trajectories may go awry predisposing people to the wide variety of disorders noted from epidemiological studies. A greater understanding of the relationship between specific adolescent changes and the specific cognitive, behavioral, and emotional consequences may provide insight into preventive or treatment interventions.

No. 63-C

**VULNERABILITIES IN ADOLESCENT DECISION MAKING: NEUROIMAGING EVIDENCE OF IMMATURITIES IN COGNITIVE CONTROL, REWARD PROCESSING, AND BRAIN CONNECTIVITY**

*Beatriz Luna, Ph.D., 121 Meyran St., Pittsburgh, PA 15213*

**SUMMARY:**

While core aspects of brain maturation and cognitive

control are established by adolescence, there is continued specialization that results in specific limitations in their ability to flexibly generate controlled voluntary responses. Access to adult-level decision making in the presence of continued immaturities can result in vulnerabilities to poor decision making and risk taking behavior, such as substance abuse. The purpose of our studies is to characterize the status of cognitive control and underlying neural substrate during the transition through adolescence to adult-level function. Children, adolescents, and adults' cognitive control was examined by using a well-characterized basic neuroscience task, allowing us to examine brain-behavior relationships. Participants performed an executive inhibitory response task, the antisaccade task, requiring the suppression of a prepotent automatic response to gaze at a visual stimulus in favor of a voluntary response towards the opposite location. Results indicated that adolescents have limitations in recruiting brain regions that monitor performance, undermining their ability to processes information regarding inhibitory errors. Adolescents also demonstrated limitations in the ability to recruit regions crucial to maintain a 'state' of cognitive control. Studies examining reward contingency effects on inhibitory control demonstrated that adolescents have immaturities in the assessment of reward valence and show particular sensitivity to the effects of reward on cognitive control. Finally, diffusion tensor imaging and functional connectivity analyses demonstrated continued immaturities in top-down systems including frontostriatal integration. Together, these results suggest that adolescents' continued immaturities in top down integration may underlie their failures in cognitive control, and their particular sensitivity to reward contingencies that may make them vulnerable to risk taking behavior, such as substance abuse.

No. 63-D

**BRAIN FUNCTIONING IN ADOLESCENT SUBSTANCE USING BOYS AND GIRLS**

*Susan Tapert, Ph.D., 9500 Gilman Drive, San Diego, CA 92093-0603*

**SUMMARY:**

The prevalence of heavy drinking and cannabis use increases rapidly during adolescence. At the same time, critical neuromaturational processing continue. The neural sequelae of heavy substance use during adolescence has been unclear. This presentation will share data from two ongoing longitudinal studies of adolescent substance users, with a focus on neuropsychological, structural magnetic resonance imaging (MRI), functional MRI (fMRI), and diffusion tensor imaging (DTI) outcomes. First, we present a prospective examination of the influence of substance use on neuropsychological functioning in 76 boys and girls initially characterized prior to starting drinking. Adolescents who transitioned into heavy drinking (n=36; 13 girls, 23 boys) were compared with matched controls who remained nonusers throughout a 3-year follow-up (N=40; 16 girls, 24 boys). For girls, more past year drinking predicted a greater reduction in visuospatial task performance, above and beyond performance on this measure at baseline (R2 change=10%, p<.05). For boys, more past year hangover symptoms predicted worsened sustained attention (R2 change=7%, p<.05). Second, MRI data showing differential influence of adolescent substance use on prefrontal and cerebellar volumes will be presented, suggesting that, for many brain indices, female adolescents may be particularly vulnerable to adverse neural effects. fMRI data using inhibitory and working memory tasks suggest altered activation patterns in male and female adolescent substance users. DTI results (N=72) comparing non-using, heavy drinking, and alcohol plus marijuana using adolescents will be presented, suggesting that those who drink heavily during adolescence may have poorer quality white matter. These preliminary findings suggest that initiating moderately heavy substance use during adolescence may adversely influence neurocognition, which would in turn lead to changes in neuromaturational course.

**TUESDAY, MAY 25, 2010**
**9:00 A.M. TO 12 NOON**

**SYMPOSIUM 60**

**THE POTENTIAL AND PITFALLS OF CREATING A BIPOLAR GENOMIC BIOBANK**

*Chairperson: Mark Frye, M.D., Mayo Clinic, Rochester, MN 55905*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Better understand the devleopmental process of creating a genomic bipolar biobank including organizational overview, phenotype assessment for both diagnosis and treatment response, data base managment, community advocacy, and informed consent.

**OVERALL SUMMARY:**

The primary goal of the Mayo Clinic Individualized Medicine Biobank for Bipolar Disorder is to build a genomic biobank from 2,000 patients who live with bipolar I disorder. This repository will have DNA matched to clinical data. Identification of genetic risk factors associated with bipolar disorder can lead to earlier clinical observation in at risk individuals and / or more selective, pharmacogenomically-based treatment. In the process of building this bank, significant organizatinal and development issues arose. The purpose of this symposia is to review the overall study design highlightling key elements in diagnostic and phenotype assessment. The need for rigorous phenotyping will be presented as it relates to preliminary pharmaoc- genomic studies of

antidepressant induced mania and lithium response. Community advocacy and collaboartion has been critical for the development of this biobank and will be reviewed not only from the standpoint of informed consent but community engagement at the national and local level. Finally, genomic biobanking and the unique ethical challenges it brings to the scientific, legal, and general communities will be reviewed.

No. 60-A

**MAYO CLINIC INDIVIDUALIZED MEDICINE BIOBANK FOR BIPOLAR DISORDER: OVERVIEW**

*Joachim Benitez, M.D., 1000 1st Drive, NW, Austin, MN 55912*

**SUMMARY:**
Although the genetic contribution to bipolar disorder has been unequivocally demonstrated, no specific genetic risk factors have yet been confirmed. To enable genomic and pharmacogenomic studies of Bipolar I Disorder (BP I), blood samples and extensive demographic and clinical data will be collected from 2,000 BP I patients from four sites: Mayo Clinic, Austin Medical Center- Mayo Health System, Lindner Center of HOPE, and University of Minnesota. This will be stored in the Mayo Biospecimens Accessioning and Processing (BAP) laboratory to comprise the Bipolar Disorder Biorepository at the Mayo Center of Individualized Medicine. The Biorepository will have DNA matched to clinical phenotype determined by structured diagnostic interview, course of illness measures, antidepressant history (i.e., treatment-emergent mania, or TEM+/TEM-), psychopharmacology treatment history, and family history. Approximately 40 mL of blood will be collected from each subject in two 10 mL EDTA tubes: a no-additive serum tube, and a Heparin tube. When the blood samples arrive at the BAP laboratory, they will be logged into the Research Laboratory Information Management System (RLIMS). After the initial infrastructure is developed, this repository will be made available to researchers everywhere to broaden the clinical and biological scope of phenotype of the repository, and to conduct genomic disease risk studies and/or pharmacogenomic probe studies.

No. 60-B

**ANTIDEPRESSANT INDUCED MANIA: THE NEED FOR RIGOROUS PHENOTYPIC ASSESSMENT**

*Mark Frye, M.D., Mayo Clinic, Rochester, MN 55905*

**SUMMARY:**
Mania is a volatile mood state which can lead patients to engage in highly unsafe or personally damaging behaviors often resulting in hospitalization, arrest, and/or incarceration. Antidepressants, in some individuals with bipolar disorder, have been associated with antidepressant induced mania (AIM). While newer agents and more conservative methodologies would suggest that this occurrence is less frequent now, in comparison to the tricyclic antidepressant era, the rate is not zero. Identifying risk factors assocaited with AIM can be clinically valuable. The serotonin transporter polymoprhism and specifically the s allele and ss genoopytpe have been associated with AIM+ in some but not all studies. This presentation will review theses studies and the current phenotypic assessment for AIM in the Mayo Clinic Bipolar Biobank.

No. 60-C

**RETROSPECTIVE PHARMACOGENOMIC TREATMENT RESPONSE**

*Susan McElroy, M.D., 4075 Old Western Row Road, Mason, OH 45040*

**SUMMARY:**
Pharmacogenomically-based treatment algorithms would enhance outcome and reduce ineffective or suboptimal treatment trials for patients who live with Bipolar I disorder. As an example, this talk will review the current literature that has examined pharmacogenomic (i.e. candidate genes, genome wide association study or GWA's) patterns of lithium response. The limitations to these early preliminary findings include: patient selection and heterogeneity (i.e broad bipolar phenotype) and lack of assessment of control for non-adherence, subsyndromal symptoms, and relative change in thyroid economy associated with mood relapse. Furthermore, for future pharmacogenomics studies, clinical outcome measures need to be standardized as exemplified by the consortium on Lithium Genetics (ConLiGEn), and Alda Scale (2002). Biobanking with this degree of scientific rigor could potentially contribute to future new drug development with highly targeted indications for selected individuals who could be identified by low cost genotyping. These goals are the essence of individualized medicine.

No. 60-E

**ADVOCACY COLLABORATION INTO BIOBANKS**

*Allen Daniels, Ed.D., 222 Piedmont Avenue, Cincinnati, OH 45219*

**SUMMARY:**
There are many challenges that face the advancement of science, clinical services, and person centered care for mental illness. At the core of person centered care is the notion that the recipient of care and where desirable their family and support systems, are active participants in treatment planning and recovery. Historically, consumers of mental health services have not been as actively involved in the evolving scientific exploration for understanding of the illnesses and possible cures. Stigma and discrimination have led to unfortunate tensions between consumers,

providers, scientists, and public policy makers. This discussion in the symposia on Creating a Bipolar Genomic Bio bank- Intended Purpose and Potential Pitfalls will focus on the role of how advocacy organizations can collaborate in the development, operation and support of bio banks. A review of important issues to consumers will focus on both the positive and negative aspects of participation. Suggestions for consumer engagement, participation, operations, and ethical oversight will be included in the presentation. Additionally, the role of consumers in research will provide a framework for trusted source reviews of participation in clinical research by consumers.

No. 60-E
**BIO-BANKING: NEW ETHICAL CHALLENGES?**

*Barbara Koenig, Ph.D., 200 1st Street SW, Rochester, MN 55902*

**SUMMARY:**
Mayo Clinic has established a "Bio-specimen Trust Oversight Group" to aid the institution's stewardship of biological samples, including DNA. This paper describes the process of establishing a collection of bio-banks for Mayo Clinic (disease focused and generic). The Bioethics Research Program, with funding from NIH and international collaborators, initiated a process of community engagement as the first step in bio-bank planning. A specific engagement technique informed by the theoretical premises of "deliberative democracy" was employed. An explicit goal of deliberative processes is a focus on making trade-offs among competing values, such as weighing privacy concerns against potential scientific benefit. We will describe the procedures used, the results of the deliberative community engagement, the process of setting up the bio-bank, and the establishment of an ongoing community advisory board. Topics addressed include contentious issues such as mandated government data sharing and whether results should be returned to research participants. An exploration of the limitations of individual informed consent will be presented, along with arguments in favor of models for protecting human subjects in bio-repositories based on governance, rather than individual control. Special issues for participants enrolled in psychiatric biobanks – including the inherent identifiability of DNA – will be addressed.

**SYMPOSIUM 61**

**PSYCHIATRISTS IN THE WORLD: ADVOCATING FOR LGBT MENTAL HEALTH**

*Chairperson: Mary E. Barber, M.D., 140 Old Orangeburg Road, Building 57, Orangeburg, NY 10962-1154*
*Discussant: Annelle B Primm, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify three different ways in which a psychiatrist can take on the advocacy role in their community; 2) Identify steps an organization may take to become more effective in its advocacy work; 3) Recognize differences in approach when communicating with the public rather than colleagues or patients; and 4) Identify ways to use traditional and new media in communicating a message.

**OVERALL SUMMARY:**
There are a number of ways in which mental health professionals can advocate for mental health issues. The presenters will use case examples to illustrate the advocate's role, all involving education and advocacy about lesbian gay bisexual and transgender (LGBT) mental health issues. The projects described involved working within organizations such as the Group for Advancement of Psychiatry (GAP) or the Association of Gay and Lesbian Psychiatrists (AGLP), and working independently. A variety of media were used to convey the message, including internet-based education, documentary film, television, and print media. Challenges and successes with respect to each project are discussed. These examples could be broadly applicable to advocacy on a range of issues within psychiatry and mental health.

No. 61-A
**THE PSYCHIATRIST AS ADVOCATE: THE CASE OF AGLP**

*Mary Barber, M.D., 140 Old Orangeburg Rd Bldg 57, Orangeburg, NY 10962-1154; Ublado Leli, M.D., 15 E 40th St Ste 403, New York, NY 10036*

**SUMMARY:**
The Association of Gay and Lesbian Psychiatrists (AGLP) is an Allied organization of the APA. Through a process over a few years, the organization rewrote its mission and vision statements, set goals, and changed its logo and web site appearance. The process of examining its mission led to successful grant requests and helped inform projects the organization undertook. This talk will discuss the process by which such organizational work takes place, the purpose behind it, and strategies for effectively moving a professional organization such as AGLP forward into doing more effective education and advocacy.

No. 61-B
**THE GAP ONLINE CURRICULUM ON LGBT MENTAL HEALTH**

*Serena Volpp, M.D., M.P.H., 170 W. 23rd St. #3A, New York, NY 10011; Vernon A. Rosario, M.D., 10850 Wilshire Blvd, Suite 1210, Los Angeles, CA 90024*

**SUMMARY:**

The Association of Gay and Lesbian Psychiatrists (AGLP) is an Allied organization of the APA. Through a process over a few years, the organization rewrote its mission and vision statements, set goals, and changed its logo and web site appearance. The process of examining its mission led to successful grant requests and helped inform projects the organization undertook. This talk will discuss the process by which such organizational work takes place, the purpose behind it, and strategies for effectively moving a professional organization such as AGLP forward into doing more effective education and advocacy.

No. 61-C

**A PICTURE'S WORTH A THOUSAND WORDS: USING FILM FOR MENTAL HEALTH ADVOCACY AND ACTIVISM**

*Alicia Salzer, M.D., 9 Barrow St #8F, New York, NY 10014*

**SUMMARY:**

The Director and Producer of the short documentary film Abomination: Homosexuality and the Ex-Gay Movement, will discuss the genesis, execution and distribution of the film as a vehicle for teaching about a human rights issue that pertains to psychiatry. Media has a unique power to reach non-clinical populations in a way that research and position statements, perhaps, can not. But as psychiatrists take on an advocacy role we must be clear about the points we really want to make and to whom. In the making of any documentary a balance must be struck between journalistic neutrality vs. pure propaganda. Using target audience as a guide to content and style this decision-making process will be explored. A discussion will follow of the many avenues in which film can be used for advocacy including new media, national and local television, film as a training tool for professionals vs. as a launching pad for discussion among non-professionals, etc.

No. 61-D

**TALKING TO THE MEDIA: TEACHING PSYCHIATRISTS TO EMBRACE THE SOUND BITE**

*Jack Drescher, M.D., 420 West 23rd Street, # 7D, New York, NY 10011-2174*

**SUMMARY:**

The 24 hour a day, 7 days a week (24/7) news cycle generates a ravenous hunger for newsworthy stories. As a result, psychiatrists and other mental health professionals are often sought out by both traditional journalists and new media writers (bloggers). Psychiatrists and other mental health professionals are often asked to provide commentary and clarification of complex stories either involving the publicized actions of high profile individuals or the publication of scientific studies.Using ethical guidelines that avoid direct comments about the psychological states of individuals one has not personally examined (The Goldwater Rule), it is nevertheless possible to educate the general public about complex psychiatric issues. Doing so, however, requires both knowledge of how to speak to journalists (media training) as well as honing one's ability to translate complex subjects into sound bites comprehensible to the average media consumer (messaging). This presentation will draw upon the presenter's experience in talking to media outlets to illustrate how mental health professionals can improve their own communication skills for purposes of elevating the public affairs profile of psychiatry and the mental health needs of the patients for whom psychiatrists advocate.

**REFERENCES:**

1.Barber, ME: The role of the psychiatrist as advocate. Psychiatric Quarterly 2008; 79(4):287-292

2.Group for Advancement of Psychiatry (GAP), LGBT Mental Health Curriculum. 2008; www.aglp.org/gap

3.Salzer, A., director and producer, Salamon, A., co-producer and editor. Abomination: Homosexuality and the Ex-Gay Movement. documentary, DVDformat, 35 mins. Frameline, distributor, 2006.

**SYMPOSIUM 62**

**WITHDRAWN**

**SYMPOSIUM 64**

**THE 2010 APA TASK FORCE REPORT ON THE PRACTICE OF ELECTROCONVULSIVE THERAPY: EVIDENCE-BASED GUIDELINES FOR THE PRACTICING CLINICIAN**

*APA Council on Research & Quality Care*

*Chairperson: William M. McDonald, M.D., 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand the evidenced based literature on the efficacy and safety of ECT and how this literature impacts on the practice of ECT. The discussants will outline the critical studies in ECT since the last published guidelines in 2001 and describe how these studies can be used to guide clinical practice in ECT. The forum will allow audience participation using an audience response system (ARS).

**OVERALL SUMMARY:**

In 2008 the ECT Task Force was established to revise the Guidelines for the Practice of ECT which were last updated in 2001. This symposium will focus on the work of the APA Taskforce on ECT to revise these guidelines and provide symposium attendees with an opportunity to comment on the revisions to the 2001 guidelines. Task force

members will present data on recent studies that have an impact on the clinical practice of ECT. These presentations will focus on the diagnostic work up, safety and efficacy of ECT including new data on ECT anesthesia, concomitant medication during ECT, management of patients in the post ictal period, electrode placement and pulse width and maintenance therapy to prevent recurrence of symptoms. The final thirty minutes of the symposium will allow the attendees to comment on the work of the taskforce using an ARS.

No. 64-A
**THE HISTORY OF THE CLASSIFICATION OF ECT AND THE CHALLENGES FOR THE FUTURE**

*Richard Weiner, M.D., Ph.D., Box 3309, DUMC, Durham, NC 27710*

**SUMMARY:**
APA has, for more than three decades, provided recommendations for the practice of ECT. In addition, APA has, through components such as the Task Force on ECT, influenced FDA policy on ECT device regulation. This work continues to the present, with the most recent Task Force revising 2001 practice recommendations and providing input into an ongoing FDA regulatory process for ECT devices. Dr. Weiner will provide an historical perspective of the APA's involvement in these areas, as well as outlining the present relevant challenges to the ECT community in maintaining ECT as a viable treatment for our patients.

No. 64-B
**THE MEDICAL EVALUATION AND CONSENT PROCESS FOR PATIENTS UNDERGOING ECT**

*Husain Mustafa, M.D., The University of Texas Southwestern Medical Center at Dallas Department of Psychiatry5323 Harry Hines Blvd, Dallas, TX 75390*

**SUMMARY:**
The use of ECT in patients with significant medical comorbidities has increased and there is data that supports the clinical efficacy and safety of patients with comorbid medical problems being treated with ECT. The evaluation and treatment of patients with comorbid medical problems will be discussed in detail. The treatment of patients with comorbid medical and neurological disease also raises concerns about the consent process particularly when patients who are being treated with concomitant cognitive difficulties. The consent process will be discussed including the appropriate consent for patients with concomitant cognitive difficulties.

No. 64-C
**OPTIMAL ELECTRODE PLACEMENT IN THE ADMINISTRATION OF ECT**

*Sarah Lisanby, M.D., 1051 Riverside Drive Unit 21, New York, NY 10032*

**SUMMARY:**
In the practice of electroconvulsive therapy (ECT), there are several choices to be made regarding dosage. These dosing parameters include electrode placement, method of individualizing the electrical dose, and the selection of the stimulus parameters. Controlled trials demonstrate that each of these features can have a significant effect on outcome, and that these various aspects of dosage interact in determining efficacy and side effects. For example, studies suggest that right unilateral (RUL) ECT is more effective at higher dosages relative to seizure threshold, but that bilateral (BL) and bifrontal (BF) ECT can be effective when given at lower dosages relative to seizure threshold. Recent work also suggests that BL is highly effective when given at conventional pulse widths, but its efficacy is reduced when using an ultrabrief pulse width. On the one hand, these complex interactions between electrode placement and other treatment parameters make the dosing of ECT critical. On the other hand, contrasting the neurobiological effects of forms of ECT that differ markedly in clinical outcomes presents an opportunity to examine the mechanisms of action of this highly effective treatment for severe depression and other disorders. This presentation will review the current literature on the safety and efficacy of the various electrode placements in the treatment of depression. It will also present new data on the modeling of the electric fields induced by the various electrode placements that may help to explain the clinical differences observed across electrode placements. Finally, it will present a novel paradigm for the rational dosing of ECT, informed by electric field modeling and empirical studies on the individualization of dosage and optimization of pulse parameters to improve clinical outcomes with ECT.

No. 64-D
**EMERGING DATA ON THE IMPORTANCE OF PULSE WIDTH IN ECT**

*Joan Prudic, M.D., NYSPI 1051 Riverside Drive, Unit 126, New York, NY 10032*

**SUMMARY:**
The ECT pulse width may have important treatment implications in the efficacy and safety of ECT. The rationale and data on the use of ultra-brief pulse will be discussed and the extant studies supporting the clinical use of brief-pulse width ECT will be discussed in detail.

No. 64-E
**MAINTENANCE TREATMENT IN ECT**
*Charles Kellner, M.D., Behavioral Health Sciences Building 183 South Orange Avenue Floor F, Room 1557,*

*New York, NY 10029*

**SUMMARY:**
The literature on maintenance antidepressant treatments after a successful course of ECT will be discussed in detail, with specific attention to the data supporting the efficacy of maintenance ECT and the data comparing maintenance medication and maintenance ECT. An ongoing study, examining the use of a flexible dosing schedule for maintenance ECT will be discussed.

**REFERENCES:**
1. McDonald WM, Meeks TW, McCall WV, Zorumpski C: Electroconvulsive therapy. Textbook of Psychopharmacology, Fourth Edition. Schatzberg AF and Nemeroff CB (Eds). Am Psych Press, Washington, DC: 861- 902, 2009

**SYMPOSIUM 65**

## *DSM-5* EXAMINED: NOSOLOGY OF MOOD DISORDERS

*Chairperson: S. Nassir Ghaemi, M.D., M.P.H., 800 Washington Street #1007, Boston, MA 02111*
*Discussant: Michael B. First, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize likely directions for the diagnosis of mood disorders in *DSM-5*, especially the use of dimensional approaches; 2)Critically appreciate strengths and weaknesses of such proposed approaches to the diagnosis of mood disorders.

**OVERALL SUMMARY:**
Mood disorders have always been an area of notable diagnostic controversy. This symposium will present the current perspective of likely revisions in diagnostic approaches for mood disorders in *DSM-5*, as presented by Trisha Suppes, one of the members of the Mood Disorders Workgroup. One major change likely is the addition of a dimensional perspective to the *DSM-III* based categorizations. Such dimensionality may include the assessment of anxiety or manic symptoms on continuous scales in persons who may meet criteria for a major depressive episode; or alternatively, the assessment of depressive symptoms on a continuous scale in persons who may meet criteria for a hypomanic or manic episode. Greater criteria-based clarification of subsyndromal manifestations of major depressive disorder (MDD) or bipolar disorder (BD) may also occur. The following presentations will analyze such proposed changes and their clinical and conceptual bases. Peter Zachar will present a conceptual approach to understanding the reality of mental disorders that takes us beyond the usual "positivist" assumptions of "carving nature at its joints" as well as the "atheoretical" view that these syndromes are purely descriptive, with little or no basis in biological reality. Dr. Zachar will present a model based on the philosophy of pragmatism in science, with the notion of "practical kinds" rather than "natural kinds." He will apply this model to the controversy surrounding childhood BD. Nassir Ghaemi will examine the history of the development of the MDD/BD dichotomy in *DSM-III* and argue that this split was limited in its scientific validity and has since been disconfirmed in many ways. The MDD definition is much too broad and heterogeneous, he will suggest, and includes conditions that are not disease-entities (what used to be called "neurotic depression") and those that are (recurrent unipolar major depressive episodes and depressive mixed states). He will propose that we need much more rigorous and narrow definitions of unipolar depression and that the concept of neurotic depression should be revived. Peter Kramer will examine the biological validity of depressive illness and discuss the need to appreciate depression within the biological paradigm. He will also examine the diagnostic relevance of the distinction between severe versus mild depression. Michael First, active in the development of *DSM-IV*, will provide critical commentary.

No. 65-A
### HOW DO WE CLASSIFY THE MOOD DISORDERS?

*Michael Schwartz, M.D., 1106 Blackacre Trail, Austin, TX 78746*

**SUMMARY:**
How do we classify the mood disorders? The method of this presentation will be historical and hermeneutic The modern era of psychiatric nosology begins in the middle of the nineteenth century with Griesinger's claim that depression, mania and other forms of madness are manifestations of a single brain disease. Analogizing from the new neurophysiology of spinal reflex arcs, Griesinger postulated a 'mental reflex' in the brain, which, when "retarded" caused melancholia, and "overactive," mania. By the turn of the century, directly observing patients and building on Griesinger's biologism, Kraepelin hypothesized at least two, not one, brain-based disorders, dementia praecox and manic depression. Decades later, emphasizing methodology, Jaspers was able to describe three still-valid broad domains of mental illness (even without modern genetics, molecular biology, brain imaging, or statistics): 1. Somatic processes, such as neurosyphilis. 2. Disruptive events which overwhelm healthy life and produce psychic change, such as schizophrenia and manic depression, when a somatic process is suspected but not yet known. 3. Variations of human life that are far from the average and qualify for treatment because they cause psychic distress. Focusing upon affective disorders, efforts to classify mental disorders will be re-examined in light of observations of nosologists from Griesinger, Kraepelin and Jaspers' time to psychiatric and medical experts of the present-day. Special

attention will be paid to notions of the norm; lumping vs splitting; disease vs disorder; and category vs dimension. Today, the great bulk of cases of affective disorder remain in Jaspers domains 2 and 3. Efforts to relocate domain 2 disorders (a somatic process is suspected) to domain 1 (a somatic process is known) have not succeeded. While he may look like a rabbit, hop like a rabbit, sniff like a rabbit and LOVE carrots – Bugs Bunny remains a virtual rabbit and not yet the "real thing."

No. 65-B

**DEPRESSION: WHEN SADNESS IS "LOST," WHAT IS GAINED?**

*Peter Kramer, M.D., 196 Waterman Street, Providence, RI 02906*

**SUMMARY:**
Critics of the current diagnostic system claim that the criteria for depressive disorders are so expansive that they create a "loss of sadness," that is, a threat to long-established understandings of despair as an ordinary and expectable response to loss or adversity. At the same time, research into the harmful consequences of even minor mood disorder suggests room for broad definitions of illness. This dialectic is being played out at time when philosophers of science are expressing serious doubts about the possibility of crafting any stable, well-justified nosology for mental illnesses. In this session, I will ask what is "lost" and what is "gained" as medical considerations of risk compress the realm of the normal.

No. 65-C

**PEDIATRIC BIPOLAR DISORDER: MORE THAN A SOCIAL CONSTRUCTION, LESS THAN A NATURAL KIND**

*Peter Zachar, Ph.D., Department if Psychology Auburn University Montgomery, Montgomery, AL 36117*

**SUMMARY:**
The first part of this talk will introduce the social constructionist approach to psychiatric disorders. One important aspect of a constructionist analysis is the view that the essence of a disorder construct cannot be abstracted from the social and cultural context in which it is described. Also important to social constructionism is the looping effect. Looping refers to people's awareness of the classifications that are applied to them and how they are affected by this knowledge. Diagnosed individuals may change as a result of the institutional and social practices that are implemented following the introduction of new classifications. For example, constructionist critics of pediatric bipolar disorder have attended to how the education of the public over the past ten years has been funded by the pharmaceutical companies and how people's beliefs about mental illness have been channeled to cohere with industry interests. The second part of the talk will describe a strong version of a natural kind approach to pediatric bipolar disorder as inspired by the kindling model. The induction of spontaneous seizures in rats (kindling) has been used to understand how each episode of mania raises the risk for additional episodes and to explain why later episodes of mania are less likely to have precipitants. The kindling model is also used to justify aggressive pharmacological the treatment of first-episode mood disorders that occur in childhood. In the final part of the talk, it will be argued that both the social constructionist and the kindling approach to conceptualizing pediatric bipolar disorder are scientifically inadequate. A third approach to pediatric bipolar disorder is associated with the pluralistic model of Nassir Ghaemi. I will specifically explore the notion of the bipolar spectrum and its implications for classification, particularly Ghaemi's claim that pediatric bipolar disorder is being over-diagnosed in some cases and under-diagnosed in others.

No. 65-D

**MAJOR DEPRESSIVE DISORDER DECONSTRUCTED: NEUROTIC DEPRESSION AND MIXED STATES**

*S. Nassir Ghaemi, M.D., M.P.H., 800 Washington Street #1007, Boston, MA 02111*

**SUMMARY:**
I will examine the history of the development of the major depressive disorder (MDD)/bipolar disorder (BD) dichotomy in DSM-III and will argue that this split was limited in its scientific validity and has since been disconfirmed in many ways. Using the Robins and Guze nosological validity criteria (phenomenology, family history, course, biological markers, and treatment response) I will show that the MDD definition is much too broad and heterogeneous, and includes what conditions that are not disease-entities (what used to be called "neurotic depression") and those that are (recurrent unipolar major depressive episodes, and depressive mixed states that are similar to bipolar disorder). I will also show that there is reasonable evidence with those nosological validators to support a return to the older concept of neurotic depression, but now based on descriptive and personality foundations, rather than prior psychoanalytic perspectives. In summary, I will propose that we need much more rigorous and narrow definitions of unipolar depression and that the concept of neurotic depression should be revived.

No. 65-E

**AN UPDATE FROM THE DSM-V WORKGROUP ON MOOD DISORDER - A FOCUS ON BIPOLAR SYMPTOMS**

*Trisha Suppes, M.D., Ph.D., 3801 Miranda Ave (151T), Palo Alto, CA 94304*

**SUMMARY:**
This presentation will consider the boundaries of unipolar and bipolar illness being discussed as part of the development of the *DSM-5* update currently in progress. I will focus on the boundaries and continuity of major depression and bipolar disorder as conceptualized and considered by the Mood disorders Workgroup for *DSM-5*. One of the key areas of consideration is how the presence of hypomanic symptoms during a depressive episode in patients with unipolar illness should be recognized. Does the presence of any hypomanic symptom(s) imply a given patient will develop well-defined bipolar disorder? Is there a clear way to more accurately describe and capture with improved nosology what is observed clinically? Discussion will address our current nosological system and potential changes to our approach to bipolar disorder in the future. The risks and possible benefits of making change will be discussed. The role of possible dimensional measures in *DSM 5* will be considered.

**REFERENCES:**
1.Ghaemi SN. Why antidepressants are not antidepressants: STEP-BD, STAR*D, and the return of neurotic depression. Bipolar Disorders 2008 Dec;10(8):957-68.
2.Kramer P. Against Depression. New York: Penguin Press, 2006.
3.Zachar P, Kendler KS. Psychiatric disorders: A conceptual taxonomy. American Journal of Psychiatry 2007 Apr;164(4):557-65.

**SYMPOSIUM 66**

**_DSM-5_ UPDATE SERIES, PART II: REPORTS FROM THE WORK GROUPS**

*Chairperson: David J Kupfer, M.D., Dept of Psychiatry University of Pittsburgh School of Medicine Western Psychiatric Institute and Clinic 3811 O'Hara Street, Suite 279, Pittsburgh, PA 15213*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) List the major developmental considerations under discussion by the *DSM-5* ADHD and Disruptive Behavior Disorders, the Childhood and Adolescent Disorders, and the Personality and Personality Disorders Work Groups.

**OVERALL SUMMARY:**
The forthcoming fifth edition of the *DSM* will be released in May 2012. Over the past three years, members of the 13 *DSM-5* Work Groups have been steadily compiling the evidence to address problems in the current diagnostic system and inform potential revisions. In this three-part symposia series, chairs from the work groups will provide brief updates on their progress to date. In this session, presenters from the *DSM-5* ADHD and Disruptive Behavior Disorders, the Childhood and Adolescent Disorders, and the Personality and Personality Disorders Work Groups will highlight current discussions from their work group. This will include identification of problems and challenges among the present diagnostic scheme, explanations of how recent evidence from research and epidemiology have informed the decision-making process, and descriptions of strategies for field testing new and revised criteria. The integration of dimensional assessment measures into the current categorical system are particularly relevant for clarifying diagnostic areas of importance within disorders, such as severity criteria and comorbid conditions, as well as across disorders, such as a "psychiatric review of mental systems" for all patients. Presentations will conclude with a summary of anticipated revisions and areas of continued interest.

No. 66-A
**BALANCING CONSERVATION AND INNOVATION IN _DSM5_: UPDATE ON ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER**

*F. Xavier Castellano, M.D., 215 Lexington Avenue Suite 1417, New York, NY 10016*

**SUMMARY:**
Although ADHD remains the most frequently diagnosed mental disorder in children and adolescents, it is now established that ADHD commonly extends throughout the lifespan. A voluminous scientific literature supports the fundamental validity of the core features of the diagnosis, but the 'goodness of fit' of *DSM-IV-TR* criteria for adults has been questioned. Specifically, several criteria may benefit from being contextualized for adults; the number of criteria required for casenesss will also likely need adjustment. Additionally, improved coverage of impulsivity and executive function deficits in adults and older adolescents are also being considered. Most compelling is the lack of evidence supporting the validity of three distinct subtypes codified by *DSM-IV*. What remains unspecified is how best to retain distinctions between combined type ADHD and individuals who have never exhibited hyperactivity or impulsivity. Additional targets for possible revision include the criterion that impairment occurs before age 7, and the hierarchical exclusion of ADHD in the presence of autism spectrum disorders. Field trials scheduled to begin in July 2010 will assist the workgroup on ADHD and Disruptive Behavior Disorders in a process that is intended to be more incremental and evolutionary than revolutionary.

No. 66-B
**RECONSIDERING THE DISRUPTIVE BEHAVIOR DISORDERS FOR _DSM-5_**

*David Shaffer, M.D., 1051 Riverside DriveNYSPI - Unit*

*78New York, New York 10032, New York, NY 10032*

**SUMMARY:**
Oppositional Defiant Disorder: The *DSM IV* diagnosis: A substantial literature review (Drabick, 2008) indicated that the current diagnosis designates individuals with significant current impairment and who are at risk for future problems independently of any co-morbidities. Perceived problems: 1) recent research suggesting important symptom clusters within the ODD criteria (e.g., anger/irritability; defiance; vindictiveness) that have different associations with other disorders and need to be recognized in the criteria; 2) Reliance on a vague adverb "often" to define most symptoms; 3) Questionable applicability in very young children; 4) No reference to cross-situationality a potential predictor of severity. The diagnosis is being modified to address these problems. Conduct Disorder:The *DSM III-IV* diagnoses: The introduction of subtypes relating to age of onset has been supported by epidemiological and other studies (Moffitt, 2006). However, recent research indicates that lack of empathy and guilt, present in earlier DSM definitions, designates an important subgroup and relates to definitions of psychopathy often used with antisocial adults (Frick and White, 2008). Among CD youth, those with these traits show different biological and social correlates, differences in short-term and long-term prognosis, and different responsiveness to treatment. We are now proposing a specifier to the diagnosis that will attempt to capture these characteristics. Other efforts involve trying to formalize the relationship between CD and ASPD (in particular to better emphasize that CD may continue after age 18 and that it doesn't automatically become ASPD), to develop a way to capture variations in the severity of the disorder using a dimensional approach, and to determine whether the overlap between Intermittent Explosive Disorder and Conduct Disorder can be better defined.

No. 66-C
**DEVELOPING A NEW MODEL OF PERSONALITY DISORDERS FOR *DSM-5***

*Andrew Skodol, M.D., 6340 N. Campbell Avenue, Suite 130, Tucson, AZ 85718*

**SUMMARY:**
In 2007, the Personality and Personality Disorders Work Group was appointed to consider the future of personality disorder assessment and classification in *DSM-5*. Key questions were articulated to inform potential revisions: what is the core definition of a personality disorder that distinguishes it from other types of psychopathology; is personality psychopathology better described by dimensional representations of diagnostic categories or by extremes on dimensions of general personality functioning than by the categories themselves; is a separate Axis II for personality assessment valuable; and what is the clinical importance (for risk, treatment, or prognosis) of assessing personality or personality disorders in other diagnostic domains, such as mood, anxiety, substance use, or eating disorders?The current proposal under consideration for the *DSM-5* assessment of personality and personality disorders consists of five parts: 1) an overall rating of personality (self and interpersonal) functioning ranging from normal to severely impaired; 2) prototype descriptions of major personality (disorder) types; 3) personality trait assessment, on which the prototypes are based, but which can also be used to describe major personality characteristics of patients who either do not have a personality disorder or have a personality disorder that does not conform to one of the prototypes; 4) generic criteria for personality disorder consisting of severe deficits in self differentiation and integration and in the capacity for interpersonal relatedness; and 5) measures of adaptive functioning. This presentation will review the development of this "hybrid model" and options for the integration of its parts.

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**SYMPOSIUM 67**

**REVISITING PHARMACOLOGICAL TREATMENTS TO PREVENT SUICIDE**

*Chairperson: Stephen Koslow, M.D., : AFSP, 129 Wall Street, 22nd, Fl, New York, NY 10005,*
Co-*Chairperson: Paula J Clayton, M.D.*
*Discussant: Joseph R Calabrese, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Safe and effective treatments for Suicide prevention; 2) Mechanisms of action of pharmacological agents used to prevent suicide; and 3) Genetic approaches to the study of molecular mechanisms underlying suicide.

**OVERALL SUMMARY:**
In 2006 (latest available data), there were 33,300 reported suicide deaths. Suicide is the fourth leading cause of death for adults between the ages of 18 and 65 years in the United States, with 27,321 suicides. Suicide is often characterized as a response to a single event or set of

circumstances. But from approximately 120 psychological autopsies we know that more than 90 percent of the people who kill themselves have a psychiatric disorder. The factors that lead to an out come of suicide are diverse and complex, so our efforts to understand it must incorporate many approaches. Currently there is discussion on the effectiveness of using different pharmacological approaches to prevent suicide in the mentally ill patient. Questions have been raised about the safety of using antidepressants, lithium, anticonvulsants and antipsychotic medications. The presentations will show data supporting the safety and efficacy of treating patients with clozapine, lithium and anticonvulsants. Lastly, quantitative measures of neurobiological function on the mechanism of lithium will be presented from experiments using an endophenotype approach in mice, which have the potential to unravel the pathways germane to lithium's protective action.

No. 67-A

**THE EVIDENCE FOR AND POTENTIAL IMPACT OF CLOZAPINE ON SUICIDE RISK IN SCHIZOPHRENIA: SO HOW DO WE GET PSYCHIATRISTS TO PRESCRIBE IT?**

*Herbert Meltzer, M.D., 1601 23rd Avenue South, Suite 3035, Nashville, TN 37212*

**SUMMARY:**
Clozapine, the prototypical antipsychotic drug, was first reported to be effective to reduce the risk for suicide in a mirror image study of 88 patients with schizophrenia or schizoaffective disorder (Meltzer and Okayli, 1993). The reduction in suicide attempt rate over a 2-3 year period was 85%, from 22/88 (25%) to 3/88 (3%) in a group of patients not selected for risk of suicide. A review of deaths due to suicide in the Clozaril® national registry found a comparable reduction in completed suicide compared to the expected rate. A subsequent formal epidemiologic study requested by the FDA to examine all causes of death due to clozapine found that the overall death rate was significantly less with clozapine than for patients not taking clozapine or who had discontinued clozapine (walker et al. 1997). To provide evidence acceptable to FDA for an approved indication for clozapine to reduce the risk for suicide, a randomized, blinded 2 year study of clozapine compared to olanzapine, in 980 patients who were at high risk for suicide by virtue of prior attempts or history was initiated (the Intersept study) by the manufacturer, Novartis. The primary end point was time to suicide event, which might be hospitalization to prevent an attempt, an attempt, or a completion. Patients were mostly non-treatment resistant. Clozapine was significantly superior to olanzapine in limiting the number of attempts (Meltzer et al. 2003). The FDA accepted this as evidence for the ability of clozapine to reduce the risk for suicide. There have been additional studies since then, all of which support the advantage of clozapine. The striking fact is that neither the publication of the Intersept study in a prestigious journal, the FDA approval of the indication, or the extensive and expensive marketing effort Novartis made to promote the use of clozapine for the new as well as the old indication had any impact on sales. This talk will consider why this well-documented comparative effectiveness research was not implemented to the extent it should have been, AND what should be done to improve its adoption. We will also discuss other disorders in which clozapine should be studied as potential means to decrease the risk for suicide, e.g. Bipolar disorder and post-traumatic stress syndrome.

No. 67-B

**MORTALITY IN SCHIZOPHRENIA: AN 11-YEAR FOLLOW-UP STUDY OF THE TOTAL FINNISH POPULATION (FIN11 STUDY)**

*Kristian Wahlbeck, M.D., PO Box 30, Helsinki, FIN-00271*

**SUMMARY:**
Background: The introduction of second-generation antipsychotic drugs during the 1990s is widely believed to have adversely affected mortality of patients with schizophrenia. Our aim was to establish the long-term contribution of antipsychotic drugs to mortality in such patients.Methods: Nationwide registers in Finland were used to compare the cause-specific mortality in 66,881 patients versus the total population (5.2 million) between 1996, and 2006, and to link these data with the use of antipsychotic drugs. We measured the all-cause mortality of patients with schizophrenia in outpatient care during current and cumulative exposure to any antipsychotic drug versus no use of these drugs, and exposure to the six most frequently used antipsychotic drugs compared with perphenazine use.Results: Although the proportional use of second-generation antipsychotic drugs rose from 13% to 64% during follow-up, the gap in life expectancy between patients with schizophrenia and the general population did not widen between 1996 (25 years), and 2006 (22.5 years). Compared with current use of perphenazine, the highest risk for overall mortality was recorded for quetiapine (adjusted hazard ratio [hr] 1.41, 95% ci 1.09–1.82), and the lowest risk for clozapine (0.74, 0.60–0.91; p=0.0045 for the difference between clozapine vs. Perphenazine, and p<0.0001 for all other antipsychotic drugs). Clozapine treatment was associated with the lowest risk of suicide (hr 0.34, 0.20–0.57). Long-term cumulative exposure (7–11 years) to any antipsychotic treatment was associated with lower mortality than was no drug use (0.81, 0.77–0.84). In patients with one or more filled prescription for an antipsychotic drug, an inverse relation between mortality and duration of cumulative use was noted (hr for trend per exposure year 0.991; 0.985–0.997). Discussion: Long-term treatment with antipsychotic drugs is associated with lower mortality compared with no antipsychotic use. Second-generation drugs are a highly heterogeneous group, and clozapine seems to be associated with a substantially

lower mortality than any other antipsychotics. Restrictions on the use of clozapine should be reassessed.

No. 67-C
**TRANSLATING SUICIDE ENDOPHENOTYPES SHARED BY HUMANS AND MICE - NOVEL STRATEGIES TO UNDERSTAND THE MECHANISM OF LITHIUM'S ANTI-SUICIDAL EFFICACY**

*Todd Gould, M.D., 685 W Baltimore St, Baltimore, MD 21201*

**SUMMARY:**
Few treatments have shown convincing reductions in the rates of suicide. An evidence-based exception is that lithium is effective in reducing the risk of both attempted and completed suicide. However, the mechanisms underlying lithium's antisuicidal actions are unknown, limiting the development of improved treatment approaches. Suicide is a complex behavior that is often difficult to study in humans, and impossible to reproduce in animal models. The endophenotype approach, by which quantitative measures of neurobiological function are used to assess and subclassify psychiatric illness, may present a path to new discoveries. Aggression and impulsivity are candidate endophenotypes with known genetic connections and strong associations with suicide; the evidence supporting aggression and impulsivity as suicide endophenotypes, as well as the effects of lithium on these constructs in both humans and rodents will be reviewed. The mouse may be useful as a model organism to elucidate points of convergence between the actions of lithium on mouse behaviors and known biobehavioral factors associated with human suicide. However, rather than attempting the infeasible task of modeling suicide per se in mice, we will focus on approaches that assess mouse behavior in tests relevant to well validated endophenotypes associated with suicide including aggression and impulsivity. These endophenotypes can be used in combination with human genetic, biochemical, and pharmacological findings in suicide research. In particular, data from preclinical and human genetic studies indicate that lithium may exert some of its mood stabilizing effects through inhibition of the enzyme glycogen synthase kinase-3 (gsk-3). This presentation will discuss current knowledge of lithium pharmacology (including gsk-3) that may be used to dissect the molecular and neurobiological mechanisms mediating lithium's efficacy. Ultimately, the data derived from this line of investigation should promote the development of improved pharmacological interventions to modify aggressive and impulsive behaviors and in turn decrease the risk of suicide.

No. 67-D
**ASSOCIATION BETWEEN CONSISTENT PURCHASE OF ANTICONVULSANTS OR LITHIUM AND SUICIDE RISK: A LONGITUDINAL COHORT STUDY FROM DENMARK, 1995–2001**

*Eric Smith, M.D., M.P.H., 8 Hultin Circle, Holden, MA 01520*

**SUMMARY:**
Background: Prior studies suggest anticonvulsants purchasers may be at greater risk of suicide than lithium purchasers.
Methods: Longitudinal, retrospective cohort study of all individuals in Denmark purchasing anticonvulsants (valproic acid, carbamazepine, oxcarbazepine or lamotrigine) (n=9952) or lithium (n=6693) from 1995–2001 who also purchased antipsychotics at least once (to select out nonpsychiatric anticonvulsant use). Poisson regression of suicides by medication purchased (anticonvulsants or lithium) was conducted, controlling for age, sex, and calendar year. Confounding by indication was addressed by restricting the comparison to individuals prescribed the same medication: individuals with minimal medication exposure (e.g., who purchased only a single prescription of anticonvulsants) were compared to those individuals with more consistent medication exposure (i.e., purchasing =6 prescriptions of anticonvulsants). Results: Demographics and frequency of anticonvulsant, lithium, or antipsychotic use were similar between lithium and anticonvulsant purchasers. Among patients who also purchased antipsychotics at least once during the study period, purchasing anticonvulsants more consistently (=6 prescriptions) was associated with a substantial reduction in the risk of suicide (rr=0.22, 95% ci=0.11–0.42, pb0.0001), similar to patients consistently purchasing lithium (rr=0.27, 95% ci=0.12–0.62, p=0.006). Absolute suicide risks of consistent anticonvulsant and consistent lithium purchasers were similar. Limitations: Lack of information about diagnoses and potential confounders, as well as other covariates that may differ between minimal and consistent medication purchasers, are limitations to this study. Conclusions: In this longitudinal study of anticonvulsant purchasers likely to have psychiatric disorders, consistent anticonvulsant treatment was associated with decreased risk of completed suicide.

**SYMPOSIUM 68**

**REWARD NEUROCIRCUITRY IN SUBSTANCE DEPENDENCE AND OTHER PSYCHIATRIC DISORDERS: WHAT DOES BRAIN RESEARCH TELL US?**

***The U.S. National Institute on Drug Abuse***

*Chairperson: Susan Volman, Ph.D., 6001 Executive Blvd, Suite 4282, Bethesda, MD 20892,*
*Co-Chairperson: James M Bjork, Ph.D.*

*Discussant: James M Bjork, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the brain circuitry involved in processing rewards and losses; and 2) How aberrations in this incentive/motivational neurocircuitry may underlie symptoms of psychiatric disorders.

**OVERALL SUMMARY:**

Our understanding of the brain's reward systems has rapidly advanced based on preclinical, neuropsychological, and human neuroimaging studies in both normal subjects and those with substance dependence and other psychiatric diseases. Fundamentally, the cortico-basal ganglia reward network is involved in the learning, motivation, and execution of behaviors that increase attainment of goals and rewards. However, because of the demands for behavioral flexibility in response to internal states and external factors, this system is at the nexus of a highly complex neural circuit. Disruption of this circuitry at many levels can produce the dysfunctional behaviors characteristic of substance abuse and other psychiatric disorders, and possibly their high incidence of comorbidity. Our emerging understanding of these neural circuits can help reconcile divergent views of the causes of behavior dysfunction. For example, substance dependence (SD) is viewed by some theorists as a compensatory response to insensitive reward circuitry. By this theory, the powerful acute effects of alcohol or other drugs uniquely stimulate incentive-motivational circuits, thus conferring vulnerability to addiction. Alternatively, personality-based accounts of SD, including twin studies, attribute SD to a general behavioral impulsivity, which may be characterized by oversensitivity to rewarding prospects with insufficient behavior control or consideration of negative consequences. Recent preclinical and human neuroimaging studies have assessed whether chronic drug exposure is characterized by alterations in incentive-motivational neurocircuitry. This symposium aims to provide practitioners with a concept of how patients with substance-use, mood, or attention deficit disorders may have altered responses to cues for, or delivery of rewards, and what this may imply for therapeutic approaches.

No. 68-A

**REWARD NEUROCIRCUITRY IN PRECLINICAL MODELS: FOUNDATIONS AND ALTERATIONS WITH DRUG USE**

*Susan Sesack, Ph.D., R.Ph., Langley Hall, Room 210, Pittsburgh, PA 15260*

**SUMMARY:**

This presentation will provide an overview of the corticostriatal reward network derived from functional anatomical and neurophysiological studies in animal models. The data will focus on the contribution of midbrain dopamine neurons to motivated behaviors and the regulation of this system by excitatory and inhibitory afferents. New data will especially highlight the role of ascending brainstem projections to dopamine neurons and their likely function in driving both approach behaviors to natural and drug rewards as well as avoidance of aversive stimuli. Finally, the presentation will consider current theories of how the normal function of reward circuitry is disrupted by drugs of abuse and associated psychiatric disorders. Research data is supported by USPHS grant MH067937.

No. 68-B

**FUNCTIONAL NEUROIMAGING OF NEURAL CIRCUITS REGULATING AVERSIVE EMOTIONAL REACTIONS AND EXPECTATIONS OF REWARD**

*Mauricio Delgado, Ph.D., 101 Warren Street, Newark, NJ 07006*

**SUMMARY:**

Human behavior often abides by simple rules of reinforcement. That is, actions that lead to positive consequences tend to be repeated at a greater frequency, while actions that lead to negative consequences tend to be avoided. Central to this tenet is how the human brain learns to assign value to stimuli and actions and how decision-making can be influenced by changes in these learned values based on prior experience, new information or contextual changes to the environment. In this talk, we will first consider foundational neuroimaging studies investigating the recruitment of the healthy human brain by positive and negative behavioral contingencies. These studies take advantage of a rich body of research using non-human animals which has delineated a basic neurocircuitry underlying affective learning and motivated behaviors, identifying circuits linking cortical structures and the basal ganglia, particularly its input unit - the striatum - as an interface for the processing of motor, cognitive and motivational information. We will then discuss how the expectation of positive or negative outcomes can influence corticostriatal circuitry and sway decision-making in maladaptive ways (e.g., craving elicited by conditioned stimulus or fearing withdrawal symptoms leads to increased drug use). Specifically, we will highlight the potential benefits of cognitive strategies in the regulation of aversive reactions and reward expectations, further investigating how emotion regulation can modulate risky decision-making.

No. 68-C

**NEUROIMAGING STUDIES OF REWARD PROCESSING IN MAJOR DEPRESSIVE DISORDER**

*Wayne Drevets, M.D., NIH/NIMH/Mood and Anxiety Disorders Program, Bethesda, MD 20892*

**SUMMARY:**
A deficit in central reward processing is thought to underlie the diminished ability of individuals with major depressive disorder (MDD) to derive pleasure from activities once deemed enjoyable. Notably, the corticolimbic networks shown to mediate and modulate the neural processing of reward and behavioral incentive in studies of experimental animals also have been implicated in the pathophysiology of MDD by data from neuroimaging and neuropathological studies. These networks involve the orbitofrontal cortex (OFC), amygdala, hippocampus and anatomically related areas of the striatum where reductions in grey matter volume and alterations in neurophysiological activity exist in some MDD subgroups. Using PET and fMRI imaging my colleagues and I investigated patterns of neural activity and dynamic neurotransmitter function within these circuits in depressed subjects as they performed reward processing tasks. While performing a monetary incentive delay (MID) task, depressed MDD subjects showed altered hemodynamic activity in the OFC, hippocampus, amygdala and accumbens, as they anticipated initiating behavioral responses aimed at acquiring rewards or avoiding losses. These physiological abnormalities were associated with impaired modulation of the behavioral response to changing incentive levels. Currently remitted subjects with MDD showed an abnormal diathesis to develop both this same behavioral pattern on the MID task and abnormal glucose metabolism in the OFC and accumbens area under catecholamine depletion. Converging with these data, depressed patients also showed abnormally reduced dopamine release during reward processing and reduced dopamine D1 receptor binding in the anteroventral striatum. The results of these studies will be integrated with relevant neurobiological data from preclinical studies into circuitry-based models that may elucidate the neural basis of the anhedonia, amotivation and mood-congruent processing biases manifest clinically in MDD.

No. 68-D
**ASSOCIATION OF NICOTINE ADDICTION AND NICOTINE'S ACTIONS WITH SEPARATE CINGULATE CORTEX FUNCTIONAL CIRCUITS**

*Elliot Hong, M.D., PO Box 21247, Baltimore, MD 21228*

**SUMMARY:**
Understanding the mechanisms underlying nicotine addiction in order to develop more effective treatment is a public health priority. Research consistently shows that nicotine transiently improves multiple cognitive functions. However, using nicotine replacement to treat nicotine addiction yields generally inconsistent results. Using region-specific resting-state fMRI method in a double-blind, placebo-controlled design, we found clearly separated pathways that correlated with nicotine addiction vs. nicotinic action. The severity of nicotine addiction was associated with the strength of dorsal anterior cingulate cortex (dACC)-ventral striatal circuits, which were not modified by nicotine patch administration. In contrast, acute nicotine enhanced cingulate-neocortical functional connectivity patterns. Therefore, nicotine addiction was strongly associated with functional circuits interconnecting dACC and the ventral striatum. Acute nicotine administration had no significant effect on these circuits. Rather, nicotine enhanced several cingulate-neocortical functional connectivity circuits that were not associated with the severity of nicotine addiction, but may play a role in nicotine's cognitive enhancing properties. On-going studies also showed that the resting state dACC-ventral striatum functional circuit is modulated by a leading nicotinic gene that is associated with smoking. Resting state dACC-striatum functional connectivity may serve as a circuit-level biomarker for nicotine addiction, and the development of new therapeutics aiming to enhance the dACC-ventral striatum functional pathways may be effective for nicotine addiction treatment.

No. 68-E
**PET EVALUATION OF NEUROCIRCUITRY RELATED TO ETIOLOGY AND TREATMENT OF ADHD**

*James M. Swanson, Ph.D., 19722 MacArthur Boulevard, Irvine, CA 92612*

**SUMMARY:**
An ADHD Network (organized by Jeffery Newcorn) conducted studies from 2000 to 2009 at Brookhaven National Laboratory using PET imaging of stimulant-naive ADHD adults. C11 raclopride was used as a marker of D2/D3 receptor availability at baseline and for monitoring DA changes with methylphenidate (MPH), and C11 cocaine was used to measure DA transporter density. Following a modern trend, the focus was on brain circuitry related to reward as well as attention by defining regions of interest for the ventral (nucleus accumbens) and the dorsal (caudate and putamen) striatum. Stimulant naïve adults with ADHD had decreased DA release as evidence by attenuated DA changes when given MPH, and the effect was associated with symptom severity (Volkow et al, 2007a,b) and significantly lower DAT and D2/D3 receptor availability in caudate and nucleus accumbens (Volkow et al, 2009). After long-term MPH treatment for a year and medication discontinuation for 1 day (to avoid an artifact of acute occupancy of DAT by MPH), DAT density was increased compared to DAT density before treatment (Wang et al, 2009). These studies confirm in an unexpected way the DA deficit theory of ADHD. We hypothesize that stimulant-naïve individuals with ADHD may have low DAT density that reflects homeostatic adaptation to compensate for low tonic DA levels, and that MPH treatment elicits the opposite adaptation to compensate for high DA levels that result from DAT

blockade by stimulant medication. Thus DAT density may be low in stimulant naïve subjects but high in subjects with a history of treatment with stimulant medication. Deficits in neural circuitry related to reward may contribute to the increased risk for substance use disorders in adolescents and adults with a childhood history of ADHD (Molina et al, 2007 and 2009). These preliminary findings highlight the importance of the investigation of reward/motivation deficit as well as attention deficit to better understand the neurobiology of ADHD.

**TUESDAY, MAY 25, 2010**
**2:00 PM- 5:00PM**

**SYMPOSIUM 69**

**IMPLEMENTING THE STEPPS* PROGRAM FOR BORDERLINE PERSONALITY DISORDER (*SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY AND PROBLEM SOLVING)**

*Chairperson: Donald W. Black, M.D., Psychiatry Research MEB, Iowa City, IA 52442*
*Discussant: Paul S Links, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to 1) list the treatment options for persons with borderline personality disorder; 2) recognize the role of STEPPS in the treatment armamentarium for BPD; 3) understand the evidence base underlying STEPPS; and 4) learn how STEPPS can be implemented in diverse settings.

**OVERALL SUMMARY:**
The focus of this symposium will be to discuss the STEPPS group treatment model for borderline personality disorder (BPD)and its implementation in various settings, populations, and countries. STEPPS, or Systems Training for Emotional Predictability and Problem Solving, was developed to address the cognitive distortions and behavioral dyscontrol typical of patients with BPD, and combines this with skills training and a systems component. The latter involves patients with BPD and those in their system, including family members, significant others, and health care professionals. STEPPS is fully manualized and involves 20 two-hour weekly group meetings with two facilitators. Data have acccumulated through both controlled and uncontrolled studies supporting its effectiveness and ease of administration. In this symposium, symposium Chair Dr. Donald Black will review the evidence base supportive of STEPPS; Ms. Nancee Blum will discuss the model and its use in the Iowa prison system. Dr. Bas Van Wel will describe the dissemination of STEPPS in The Netherlands under the acronym VERS. Ms. Renee Harvey will discuss its use in the United Kingdom and its adoption by the National Health Service. Dr. Marieke Schuppert will discuss STEPPS/VERS in the adolescent population and present results from a clinical trial. Dr. Paul Links will synthesize the presentations and provide perspective.

No. 69-A
**IMPLEMENTING THE STEPPS PROGRAM IN IOWA PRISONS**

*Nancee Blum, M.S.W., L.C.S.W., Department of Psychiatry1-189 MEBLucille A. and Roy J. Carver College of MedicineThe University of Iowa, Iowa City, IA 52242*

**SUMMARY:**
Borderline Personality Disorder (BPD) is highly prevalent among offenders in US prisons, with estimates ranging from 27% of men to 55% of women. BPD also presents significant behavioral and management problems in the prison setting; offenders with BPD also are more likely to be convicted of serious and violent crimes. Experts have observed that any treatment that lessens the symptoms of a personality disorder is likely to lessen the individual's offending behavior. Currently, there are few effective, data-based, easily-implemented manualized programs to treat BPD in prisons. We have used the STEPPS program in Iowa prisons and believe it fills this service gap. The Iowa Department of Corrections has recognized that offenders with BPD have special needs that were not being addressed, and have been instrumental in implementing STEPPS. In this presentation, we describe the implementation of the STEPPS program in two women's and two men's prisons in Iowa. The program has also been implemented in community corrections for paroled offenders. With appropriate supervision STEPPS can be implemented with a minimum of training and expense. Our experience demonstrates the feasibility of training and providing supervision of prison-based mental health professionals and prison-based STEPPS groups via telemedicine. Data collected in the prisons indicate that men and women participating in STEPPS experience significant improvements in BPD-related symptoms, negative affectivity, and depression. The program also has achieved high levels of acceptance from offenders with BPD and therapists.

No. 69-B
**VERS: A RANDOMIZED CONTROLLED TRIAL OF A DUTCH VERSION OF STEPPS FOR BORDERLINE PERSONALITY DISORDER**

*Bas van Wel, M.D., Pikeursbaan 3, Deventer, 7411RP*

**SUMMARY:**
Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a group treatment for persons with borderline personality disorder (BPD) that is relatively easy to implement. We investigated the efficacy of a Dutch version of this treatment (VERS). Seventy-nine DSM-IV

BPD patients were randomly assigned to STEPPS plus an adjunctive individual therapy, or to treatment as usual (TAU). Assessments took place before and after the intervention, and at a 6-month follow-up. STEPPS recipients showed a significantly greater reduction in general psychiatric and BPD-specific symptomatology than subjects assigned to TAU; these differences remained significant at follow-up. STEPPS also led to greater improvement in quality of life, especially at follow-up. No differences in impulsive or parasuicidal behavior were observed. Effect sizes for the differences between the treatments were moderate to large. The results suggest that the brief STEPPS program combined with limited individual therapy can improve BPD-treatment in a number of ways. Key Words: Personality disorder, psychotherapy, randomized controlled trial, psychopathology, quality of life.

No. 69-C

**IMPLEMENTING STEPPS IN THE UNITED KINGDOM**

*Renee Harvey, M.A., Horsham Hospital, Hurst Rd, Horsham, RH 12 2DR*

**SUMMARY:**

Since its introduction into the UK in 2006, STEPPS groups have begun in five sites in the UK. A pilot study has been completed in one of these areas and preliminary results from six groups is being presented here. The general applicability of STEPPS to the UK context is being considered, including issues such as cultural differences, the need for variations in the programme dependent on context, and the advantages of the UK healthcare system. Its effectiveness in different service provision settings is discussed, for example day hospital versus community team environments. Quantitative methodology has been applied to measure changes in symptomatology of borderline personality disorder and levels of service use. These are considered in the light of research carried out in the USA and Netherlands. The impact of introducing the programme will also be discussed, including implications for multidisciplinary teams, and feedback from families and carers and service users. This is particularly relevant in the light of the systemic nature of the programme, and the need for referring treatment teams to remain involved. The presentation will consider the future of STEPPS in the UK as a viable addition to the recommended and evidence-based treatments for borderline personality disorder.

No. 69-D

**EMOTION REGULATION TRAINING (AN ADAPTATION OF STEPPS) FOR ADOLESCENTS WITH BORDERLINE PERSONALITY SYMPTOMS**

*Marieke Schuppert, M.D., Postbox 660, Groningen, 9700 AR*

**SUMMARY:**

It has long been argued that personality lacks cohesiveness and durability prior to age 18, what resulted in lack of attention to BPD symptoms in adolescence. However, there is growing evidence for the reliability and validity of BPD at this age. Considering the serious long term consequences and the high prevalence rate, there is a need for early intervention programs. There are hardly any treatment protocols for adolescents with BPD symptoms. At the outpatient clinic of Accare the Emotion Regulation Training (ERT) for adolescents was developed, based on a course for adults (STEPPS). A variety of emotional and behavioral management skills are taught with which the adolescents can bear more responsibility for their own behavior. During the course, adolescents more and more realize they have a choice in how to (re)act in case of emotional distress. ERT is a group training for 6-9 adolescents and contains of 17 weekly sessions and two follow-up sessions, as well as one session with relatives. ERT is given in addition to treatment as usual. Accare conducted a pilot study on the efficacy of the ERT. 43 Adolescents participated in the study and were randomised to ERT plus treatment as usual (TAU) or TAU only. Contrary to expectations, BPD symptoms decreased equally in the ERT group and in the control group (p=0,79). Adolescents in the ERT reported a significantly higher level of internal locus of control than adolescents in the control group (p=0,006). 39% Of the experimental group dropped out of the study, versus 15% of the control group. The drop-outs scored significantly lower on internalizing behavior (p=0,027). In conclusion, ERT wants to give adolescents with BPD symptoms an impulse in changing their complex way of living. This pilot study gave some evidence that ERT has additional effect. Based on these findings, the measures were made more specific for adolescents and the ERT manual has been modified. Accare is now conducting a multi-centre RCT.

**REFERENCES:**

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2.Eichinger L, McCormick B, Allen J, Sieleni B: Systems Training for Emotional Predictability and Problem Solving (STEPPS) in women offenders with borderline personality disorder in prison: a pilot study. CNS Spectrums 2008; 13: 881-886.

**SYMPOSIUM 70**

**EVIDENCE-BASED TREATMENTS (EBT) FOR**

## BORDERLINE PERSONALITY DISORDER: EMPIRICAL CLARITY MEETS CLINICAL REALITY

*Chairperson: Lois W Choi-Kain, M.D., M.Ed., 115 Mill Street,, Belmont, MA 02478*
*Discussant: John G Gunderson, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand practical challenges to and ways of implementing scientific knowledge about evidence based treatments for borderline personality disorder in clinical practice.

**OVERALL SUMMARY:**
In the last two decades, a significant body of research has been introduced on the treatability of BPD. During that time, multiple new treatments for BPD have been empirically validated. However, understanding of and access to these treatments in usual clinical practice remains limited. This symposium will include presentations on the application of the existing empirical knowledge base on treatments for BPD in actual clinical practice. Issues of implementation, modification, and integration of EBTs for BPD as well as practical clinical concerns such as limiting reimbursement by insurance to EBTs will be discussed.

No. 70-A
### DEVELOPMENT AND IMPLEMENTATION OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY (TFP)

*Otto Kernberg, M.D., 21 Bloomingdale Road, White Plains, NY 10605*

**SUMMARY:**
This presentation will discuss the next step in our research program, the study of neurobiological correlates of TFP changes in mentalization and identity structure in borderline patients. Our overall focus, however, is on the long-term effects of TFP. Our methods for implementation of TFP in various locations will be outlined: the basic training of therapists by expert TFP clinicians, the intensity and duration of clinical training experiences required, and the specific focus on changes in personality structure of patients in contrast to symptomatic improvement alone. We also shall summarize our clinical experience with indications, contraindications and modifications in the frequency of sessions with these patients, and the integration with alternative treatment modalities, application to group therapy, and experience with drop out.

No. 70-B
### INTEGRATING MENTALIZATION BASED TREATMENT WITH OTHER EVIDENCE BASED TREATMENTS FOR BORDERLINE PERSONALITY DISORDER. LETHAL COCKTAIL OR SUPER THERAPY?

*Anthony Bateman, M.B.B.S, M.R.C., St Ann's Hospital, London, N15 3TH*

**SUMMARY:**
The aim of MBT is to increase the mentalizating capacity of an individual particularly in interpersonal relationships and during states of high emotional intensity. MBT specifically focuses on techniques that enhance mentalization and yet other therapies may also enhance mentalizing even though it is not their primary aim. In this presentation it will be suggested that all therapies that have been shown to be effective for BPD are successful because they enhance mentalizing and minimise harmful effects. There is considerable overlap between therapies in the structure of treatment and their emphasis on emotional states and self-harming behaviours but therapists are required to adhere carefully to specific techniques. Yet patients may obtain additional benefit from an integration of clinical techniques from different models depending on their constellation of symptoms which in itself would lead them to be non-adherent to their particular model. MBT has minimal training and supervision demands because it uses a commonsense view of the mind and incorporates generic ideas from different models of psychotherapy, blending them into a healthy ecumenism relevant to borderline personality disorder. This suggests that MBT could be used as a generic base for all clinicians engaged in treatment of BPD. The integration of techniques from other models could lead to a more efficacious therapy as long as the treatment remained theoretically and clinically coherent and therapists avoided the danger of unfettered eclecticism. The former has the potential to be a 'super therapy' whilst the latter could become a 'lethal cocktail'. Some examples of the potential benefits and the possible dangers of such integration will be outlined.

No. 70-C
### THE TRIALS AND TRIBULATIONS OF IMPLEMENTING DIALECTICAL BEHAVIOR THERAPY

*Joan Wheelis, M.D., 218 Garden St, Cambridge, MA 02138*

**SUMMARY:**
Dialectical Behavior Therapy (DBT) developed by Marsha Linehan PhD is now well established as an effective evidence based treatment for borderline personality disorder. Implementation of DBT into a variety of intensive outpatient clinical settings, however, continues to face many hurdles. Staff training, clinical adherence to the model, working with anxillary services and clinicians in the community pose significant challenges. Use of the consultation team, psychoeducation,, and supervision help staff organize cohesive programs. The benefits of

milieu based treatment settings, work and school related rehabilitation and family involvement will be examined as important program components to help consolidate the gains of DBT treatment.

No. 70-D

**DIALECTICAL BEHAVIORAL THERAPY AND MENTALIZATION BASED TREATMENT: AN INTEGRATION OF TWO EMPIRICALLY VALIDATED TREATMENTS FOR BPD**

*Lois Choi-Kain, M.D., M.Ed., 115 Mill Street,, Belmont, MA 02478*

**SUMMARY:**
Dialectical Behavioral Therapy (DBT) and Mentalization Based Treatment (MBT), are two major evidence based treatments for BPD proven to be more efficacious in decreasing suicidality, self-harm, depression, anxiety, and utilization of emergency and inpatient services than standard psychiatric care. DBT is a cognitive behavioral therapy focused on behavioral change through application of a variety of skills in mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. MBT is a psychoanalytically oriented treatment which aims to stabilize the variety of symptoms in BPD by enhancing patients' ability to reflect on their own and other's mental states in more flexible, plausible, and complex ways While derived from different psychotherapeutic traditions and distinct in their approaches, DBT and MBT are theoretically compatible treatments that can be soundly integrated in a clinical setting. To illustrate how such an integration can be accomplished we will review the following topics in comparing the two treatments: 1)theories of BPD pathogenesis; 2) organization of treatment; 3)central techniques; 4)therapist stance; and 5) proposed mechanisms of change. This presentation will examine the overlaps and divergences between these two important approaches to treating BPD and propose ways in which clinicians can think about implementing a combined approach in practice.

**SYMPOSIUM 72**

**THE NUTS AND BOLTS OF THE PERINATAL PSYCHIATRIC CONSULTATION**

*Chairperson: Allison S Baker, M.D., 1051 Riverside Drive, Box 97, New York, NY 10032,*
Co-*Chairperson: Carolyn A Broudy, M.D., M.S.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Diagnose mood, anxiety, and psychotic disorders during the perinatal period; 2) Demonstrate an understanding of how to search the literature for safety data on treatment options in the perinatal period; 3) Recognize the importance of the informed consent process in treatment selection; and 4) Treat pregnant and postpartum patients should the risks of her illness outweigh the risks of medications.

**OVERALL SUMMARY:**
According to the Centers for Disease Control and Prevention (CDC), postpartum depression affects affects 10%-15% of mothers within the first year after giving birth. Furthermore, recent studies suggest that up to 20% of women suffer from mood and anxiety disorders during pregnancy. Currently, knowledge regarding the risks of prenatal exposure to the psychotropic medications called for in these illnesses is incomplete. As such, many patients discontinue or avoid psychopharmacologic treatment during the perinatal period, often putting themselves at higher risk for recurrence or new onset of mood and anxiety disorders. Given the incomplete knowledge of safety data for the use of psychotropic medications in pregnancy, women with histories of psychiatric illnesses often seek consultations regarding treatment in the perinatal period. The current availability of clinicians with an expertise in this area is sparse, which often leaves psychiatrists facing challenges when making recommendations regarding the treatment of psychiatric illness during the perinatal period. The purpose of this symposium is to provide general psychiatrists with an opportunity to learn about the special considerations needed when diagnosing and treating pregnant, postpartum and lactating women with mental health concerns. By gathering leading researchers in the field of Women's Mental Health, we aim to provide an expert and comprehensive overview of the process involved in treating such patients. Specifically, the symposium will be divided into five sections in which expert participants will speak about history taking and diagnosis, keeping up to date with the literature, and medication and psychotherapy treatments. We will then consolidate this information by discussing a case and applying the knowledge and research skills just acquired. This exercise should prove to be invaluable in educating psychiatrists about a large and growing percentage of our patient population.

No. 72-A

**EVALUATION OF MOOD AND ANXIETY DISORDERS DURING PREGNANCY AND THE POSTPARTUM PERIOD**

*Ruta Nonacs, M.D., Ph.D., 15 Fruit St., Wang 812, Boston, MA 02114*

**SUMMARY:**
While some studies have suggested that pregnancy may protect women from psychiatric morbidity, findings from several recent prospective cohort studies indicate that women are at high risk for mood and anxiety disorders during pregnancy and the postpartum period. In the

general population, about 10 to 15% of women suffer from significant mood symptoms during pregnancy. The risk is particularly high in women with a history of major depression or bipolar disorder, with recent studies indicating recurrence rates of around 70 to 85% among women who discontinue maintenance treatment during pregnancy. During the postpartum period, women are not only at risk for new onset of mood and anxiety disorders, but they may also experience recurrence of pregravid psychiatric illness. While there is data to indicate that both pharmacologic and non-pharmacologic interventions may substantially reduce the risk of perinatal mood and anxiety disorders, there are many obstacles to the identification and treatment of psychiatric disorders in this population. Systematic screening for mood and anxiety symptoms during pregnancy and the postpartum period is not commonly performed. In addition, symptoms which emerge during pregnancy or the postpartum period may be overlooked or misunderstood, and many women are reluctant to seek treatment given the risks associated with pharmacologic treatment. Women who present with mood or anxiety symptoms during pregnancy or the postpartum period must be carefully evaluated to determine whether the symptoms are (1) normative or pathologic, (2) evidence of new onset of psychiatric illness, or (3) an exacerbation of a pregravid mood or anxiety disorder. The objectives of this presentation will be to review a) screening for and diagnose mood and anxiety disorders during pregnancy and the postpartum period, b) recent studies of the epidemiology of perinatal psychiatric illness.

No. 72-B

**STAYING INFORMED AND AFLOAT: HOW TO APPROACH EVIDENCE-BASED PRACTICE IN THE PSYCHIATRIC TREATMENT OF PREGNANT AND POSTPARTUM PATIENTS**

*Elizabeth Fitelson, M.D., 710 West 168th Street, 12th Floor, New York, NY 10032*

**SUMMARY:**
A crucial component of providing expert clinical care to pregnant and postpartum women is the ability to stay up to date on the latest information on the course and treatment of psychiatric illness during pregnancy and lactation. Fortunately and unfortunately, the data in this field is ever-expanding and rapidly changing. Studies on the safety and monitoring of psychotropic medications in pregnancy, for example, often have contradictory results or unclear significance, making clinical decision-making about the risks of treatment vs. the risks of untreated illness a challenge. It is crucial to maintain basic skills in performing literature searches on Medline, Embase, Reprotox and other biomedical databases, but the vast amount of information can be daunting to many clinicians. The purpose of this talk is to provide a framework for how to approach the evidence in the treatment of pregnant and lactating women, including how to frame the right questions, where to look for the answers, and how to integrate the information into clinical decision-making with the patient. The presentation will include a typical case presentation, an overview of the leading medication safety databases, as well as resources for reliable information for clinicians and patients. We hope to help clinicians hone their skills in reviewing the literature and developing a systematic way to incorporate the most current safety data into treatment, thereby promoting informed, thoughtful and safe clinical care to pregnant and postpartum patients and encouraging more evidence-based clinical practice.

No. 72-C

**PSYCHOTHERAPY TREATMENTS**

*Margaret Spinelli, M.D., 1051 Riverside Drive (Box 123), New York, NY 10032*

**SUMMARY:**
It is now well established that in the general population about 10 to 15% of women suffer from significant depressed mood symptoms during pregnancy. This prevalence of Antepartum Depression (APD) increases twofold in women who have poor social supports and low socioeconomic status. Treating depression during pregnancy is a method of primary and secondary prevention by treating parents of children at risk. Interpersonal psychotherapy is an effective method of antidepressant treatment during pregnancy and a first-line treatment in the hierarchy of treatment guidelines for non-psychotic antepartum depression. In this section, we will present results of a 16-week controlled trial of Interpersonal Psychotherapy (IPT-P) vs. Parenting Education Program (PEP). Preliminary results of an ongoing larger, multi-ethnic/racial IPT-P study will also be presented. The first study sample was comprised of a majority of depressed indigent Spanish speaking immigrant women with multiple psychosocial and financial stressors. The IPT-P group demonstrated significant improvement in mood compared to the PEP group. In addition, there was a significant correlation between maternal mood and mother-infant interaction. Preliminary results in the ongoing trial demonstrate that IPT-P is an effective treatment for antepartum depression. However, PEP has had similar efficacy in some subjects although final outcomes have not been determined. In summary, treating antenatal depression has the potential for far-reaching effects such as maintaining the well being of the maternal-fetal environment, preventing postpartum depression and promoting maternal infant attachment, with the added benefit of avoiding an unnecessary exposure to medications in utero.

No. 72-D

**THE PERINATAL PSYCHIATRIC CONSULTATION: MEDICATION TREATMENT**

*Adele Viguera, M.D., M.P.H., 9500 Euclid Avenue, Desk P57, Cleveland, OH 44195*

**SUMMARY:**

Although the postpartum period has been identified as a time of increased vulnerability to mood and anxiety disorders, pregnancy has often been considered a time of emotional well-being. A growing literature, however, suggests that relapse of an existing mood or anxiety disorder or the emergence of a new disorder is often seen during pregnancy. Mood and anxiety disorders are highly prevalent among women of childbearing age as is psychopharmacologic treatment of these disorders. Despite the increasing evidence for significant morbidity associated with pregnancy, most pregnant women with mood or anxiety disorders are either untreated or under treated. Moreover, clinical practice appears to favor discontinuation of maintenance pharmacotherapy during pregnancy in order to avoid potential adverse effects. Substantial progress has been made in several areas including accumulating information on the reproductive safety of psychotropic drugs, a better understanding of the course of these disorders during pregnancy, and quantification of risk of recurrence during pregnancy and the postpartum In this presentation, we will consider the course of mood and anxiety disorders during pregnancy and review the reproductive safety data for the major categories of psychotropic medications including antidepressants, mood stabilizers, and antipsychotics. We will also review the most recent recommendations from published guidelines sponsored by the American Psychiatric Association and the American College of Obstetricians and Gynecologists, as well as discuss the risk-benefit assessment process for the treatment of psychiatric illness in pregnant women.

No. 72-E

**PUTTING IT ALL TOGETHER: THE LAST MOVEMENT OF THE PERINATAL PSYCHIATRIC CONSULTATION**

*Kristin Leight, M.D., 50 West 88th Street, Apartment 9, New York, NY 10024*

**SUMMARY:**

Part of working with the pregnant or postpartum patient in a psychiatric consultation involves a risk: risk analysis. At every step of the consultation - including treatment planning and ultimately implementation - there is a careful shared decision-making process that takes place among the patient, her family, the mental health provider and obstetrician alike. As a psychiatrist, one must perform a comprehensive evaluation including the assessment of current illness severity, history of illness severity, and then take a history of treatment response. Then one must review the treatment options available, including non-pharmacologic and pharmacologic options alike. In so doing, the mental health provider and the patient engage in a risk: risk (vs. risk/benefit) analysis, wherein one balances the risk of untreated illness against risk of medication exposure. Data suggests that the risks of untreated or undertreated maternal depression to mothers and their offspring during and after pregnancy currently outweigh any known adverse effects of the SSRIs . In this final presentation of the symposium, we will review the major steps involved in a perinatal psychiatric consultation with an eye towards how a psychiatrist arrives at the treatment recommendations they will make after gathering adequate data.

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**SYMPOSIUM 74**

**THE TREATMENT OF PSYCHIATRIC DISORDERS WITH RTMS: NEW RESEARCH AND CLINICAL FINDINGS**

*Chairperson: Allan S. Kaplan, M.D., 250 College Street Room 832, Toronto, Ontario, M45T 1R8 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the evidence based research supporting the use of rTMS in major depression (MDD), schizophrenia( SCZ) , OCD and anorexia nervosa (AN); and 2) Demonstrate an understanding of the rationale for using rTMS as a treatment modality for MDD, SCZ, OCD and AN and recognize the relative efficacy of this intervention for each disorder.

**OVERALL SUMMARY:**

This symposium will review the rationale for the use of repetitive transcranial magnetic stimulation ( rTMS) in four distinct psychiatric disorders: major depression(MDD), schizophrenia (SCZ), obsessive compulsive disorder(OCD) and anorexia nervosa(AN). Each presenter will review the evidence based research supporting the use of rTMS in the particular disorder

being considered and describe the rationale for the use of rTMS in that disorder. New treatment research findings supporting the efficacy of rTMS for each of these disorders will be presented

No. 74-A
**REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION FOR AUDITORY HALLUCINATIONS IN SCZ**

*Zafiris Daskalakis, M.D., Ph.D., 250 College Street, Toronto, M5T1R8*

**SUMMARY:**
Objective: To examine the efficacy repetitive transcranial magnetic stimulation (rTMS) as a treatment for refractory auditory hallucinations (AH) in schizophrenia (SCZ). Background: Persistent AH are a common problem in SCZ and are often a source of significant distress and morbidity. Low frequency (i.e., 1 Hz) rTMS has been shown to be effective for refractory AH, however, some trials have reported negative results. In this study we compared the efficacy of high and low frequency rTMS delivered treatment to the primary auditory cortex (i.e., Heschl's gyrus) for refractory AH to identify the optimal parameters needed to achieve a therapeutic response. Design/Methods: Fifty-four patients with refractory AH were randomized to receive 1 Hz, priming (i.e., 6 Hz followed by 1 Hz rTMS) or sham rTMS 5 days per week for 4 weeks. The severity of AH were indexed through the hallucinations change scale. Of these 54 patients, 47 completed the 4 week treatment protocol. Results: One Hz rTMS resulted in a 30.1 percent decrease on the HCS while priming stimulation and sham stimulation resulted in am 18.8 and 18.7 percent decrease on the HCS, respectively. These differences were not statistically different. Conclusions: These data suggest that neither low nor high frequency rTMS targeting the primary auditory cortex in patients with SCZ were effective at reducing AH. Methods to optimize treatment efficacy will be discussed

No. 74-B
**TRANSCRANIAL MAGNETIC STIMULATION (TMS) FOR MAJOR DEPRESSION: PAST, PRESENT AND FUTURE CHALLENGES**

*Yechiel Levkovitz, M.D., 50 Staniford Street, Boston, MA 02114*

**SUMMARY:**
Repetitive transcranial magnetic stimulation (TMS) is a novel, noninvasive, device technology that delivers focused stimulation to the cortex of the brain by means of magnetic pulses. Recent metanalyses and more recent large multicenter studies provided evidence suggesting that rTMS is indeed a promising treatment: however, its efficacy has often been shown to be modest, compare with sham stimulation. We will review these lines of evidence and discuss several reasons that may explain the modest therapeutic efficacy, including: suboptimal frequency, intensity, and duration of treatment; limited depth of direct stimulation; stimulation of the left-sided compare with right-sided or bilateral stimulation. We will shed light on novel strategies and tools that could improve the effectiveness of rTMS, including: the recent improvement in stimulating parameters, the Theta burst (TB) rTMS mimicking TB protocols used in animal models and the newly developed deep rTMS system. Specifically, we will present data from our recent studies used H-coils rTMS over the left PFC ifor acute (65 pts.) and maintenance (30 pts.) treatment in depressed patients. The results from these studies in depression indicate that stimulation with the novel H-coils was well tolerated, with no major side-effects or adverse physical outcomes. Compared with the value prior to the start of TMS therapy (31.29 +/- 4.98), the average HAM-D scale dropped significantly to 16.24 +/- 9.91 on the day after completion of the therapy. In the maintenance study we found that 50% of the patients maintained there response for 22 weeks. To summarize, this presentation is intended to review and discuss the data that emerged from the clinical studies that used rTMS for depression and present exciting advanced methods and approaches that will most likely become a significant part of clinical practice in the future.

No. 74-C
**CAN RTMS HELP OBSESSIVE-COMPULSIVE DISORDER?**

*Peggy Richter, M.D., 2075 Bayview Avenue, FG21a, Toronto, ON, M4N 3M5*

**SUMMARY:**
Obsessive-compulsive disorder (OCD) is a chronic and severe psychiatric disorder for which current available first line treatments have limited benefits. Repetitive transcranial magnetic stimulation (rTMS) is increasingly being recognized as a useful treatment for a variety of psychiatric conditions, however utility in OCD is unclear. Previous published work is limited and inconsistent in terms of treatment parameters used, but suggests that rTMS may be potentially helpful for OCD. In this presentation, the available literature regarding rTMS in OCD will be reviewed. In addition, preliminary data will be presented from the authors' ongoing double-blind sham-controlled trial of rTMS in OCD using high frequency bilateral stimulation of the dorsolateral prefrontal cortex. In conclusion, suggestions will be made regarding ideal rTMS treatment parameters for OCD going forward, and important considerations that should be considered in investigations of novel treatments for this condition discussed.

No. 74-D

### A META-ANALYTIC STUDY EVALUATING BRAIN ACTIVATION AND RESPONSE TO RTMS IN ANOREXIA NERVOSA

*Allan Kaplan, M.D., 250 College Street Room 832, Toronto, Ontario, M45T 1R8*

**SUMMARY:**

Many imaging studies have investigated brain regions implicated in the pathophysiology of Anorexia Nervosa (AN). We present a quantitative meta-analysis of these studies with the intention of identifying potential target regions for future treatment with brain stimulation techniques (transcranial magnetic stimulation (TMS) or deep brain stimulation (DBS)). Analysis was performed using the Activation Likelihood Estimation Technique on two types of studies: (1) those conducted at rest comparing brain activation in AN vs healthy subjects; and (2) those comparing brain activation following exposure to emotionally aversive stimuli in AN vs healthy subjects. A complex pattern of brain regions were indentified. In resting conditions there was consistent hypoactivity in frontal and limbic circuits (subcallosal, cingulate gyrus). Following exposure to emotionally aversive stimuli, subcortical regions (insula, thalamus) were associated with hyperactive functioning. By contrast, the dorsolateral prefrontal cortex demonstrated hypoactive functioning. The results are consistent with previous research suggesting that AN is associated with dysregulation of emotional and reward pathways. Overactivity in insular regions may contribute to a disturbed sense of self awareness relating to body image and interoception, as well as the reinforcing properties of pursuing starvation. Deactivation of these networks with brain stimulation (rTMS or DBS) may lead to effective treatment options for AN. The preliminary results of a pilot study examining the response of AN to rTMS will be presented.

No. 74-E

### A META-ANALYTIC STUDY EVALUATING BRAIN ACTIVATION AND RESPONSE TO RTMS IN ANOREXIA NERVOSA

*Kate Strasburg, M.D., U of Toronto, Toronto, M5S 1A1*

**SUMMARY:**

Many imaging studies have investigated brain regions implicated in the pathophysiology of Anorexia Nervosa (AN). We present a quantitative meta-analysis of these studies with the intention of identifying potential target regions for future treatment with brain stimulation techniques (transcranial magnetic stimulation (TMS) or deep brain stimulation (DBS)). Analysis was performed using the Activation Likelihood Estimation Technique on two types of studies: (1) those conducted at rest comparing brain activation in AN vs healthy subjects; and (2) those comparing brain activation following exposure to emotionally aversive stimuli in AN vs healthy subjects. A complex pattern of brain regions were indentified. In resting conditions there was consistent hypoactivity in frontal and limbic circuits (subcallosal, cingulate gyrus). Following exposure to emotionally aversive stimuli, subcortical regions (insula, thalamus) were associated with hyperactive functioning. By contrast, the dorsolateral prefrontal cortex demonstrated hypoactive functioning. The results are consistent with previous research suggesting that AN is associated with dysregulation of emotional and reward pathways. Overactivity in insular regions may contribute to a disturbed sense of self awareness relating to body image and interoception, as well as the reinforcing properties of pursuing starvation. Deactivation of these networks with brain stimulation (rTMS or DBS) may lead to effective treatment options for AN. The preliminary results of a pilot study examining the response of AN to rTMS will be presented.

**REFERENCES:**

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### SYMPOSIUM 75

### THE TATTERED SAFETY NET: THE PUBLIC MENTAL HEALTH CRISIS IN AN ECONOMIC RECESSION

***APA Council on Minority Mental Health & Health Disparities***

*Chairperson: Russell F Lim, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817*
*Discussant: Jeffrey Geller, M.D., M.P.H.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1)Describe the relationship between Medicaid funding, state budgets, and public mental health funding; 2)Describe the consequences of decreased mental health services to the medically indigent and Medicaid, patients with chronic mental illnesses; 3) Describe the impact of mental health budget cuts in California and Ohio; and 4) Describe how community psychiatrists can advocate for patients and provide key services for SPMI consum

**OVERALL SUMMARY:**

The United States is experiencing a Public Mental Health crisis due to a nationwide economic downturn. Community mental health services have been cut following a cycle of foreclosed adjustable rate mortgages, unemployment, decreased state revenues due to decreased spending, and decreased county revenues due to lost property taxes.Funding for Community Mental Health has been linked to state budgets by matching federal funds

for state mental health allocations, and these budgets have been decimated by the economic recession, leaving public mental health vulnerable to budget cuts. One state has implemented furloughs, while others have implemented layoffs and service cuts, such as reducing the capacity of outpatient community mental health centers by fifty percent, inpatient psychiatric beds by fifty percent and closing programs such as transitional housing for the homeless, homeless shelters, consumer-self help centers, even including essential services such as psychiatric crisis centers.

On average, Medicaid programs account for about 20% of all state budgetary expenditures, and they represent the second biggest line item on most state budgets, surpassed only by education, which few legislators want to touch. State budget allocations for Medicaid are usually the first place that state budgets are cut. Medicaid accounts for between 30% and 50% of funding for state mental health programs, meaning that significant Medicaid cuts can be devastating to the most ill, least wealthy segment of the mentally ill population, those least able to recover if public mental health services are unavailable. Cuts in mental health services can result in increased criminal offenses, homelessness, and suicides. As many as 32 states are enacting mental health funding cuts. States hit by cuts in community mental health funding due to the economic recession include California, Michigan, Ohio, and Illinois. Despite the crises, community mental health organizations —the frontline safety net providers — are struggling to meet the increasing need for mental health services, exacerbated by the economic downturn. Our panel will address how public mental health services are funded, and how medically indigent and Medicaid patients are affected by these service cuts. We will then present two case examples from two different states, and have a discussion on an action plan for public mental health in today's difficult economic times.

No. 75-A

**WHO CARES? CAN WE AFFORD TO REDUCE EXPENDITURES FOR MENTAL HEALTH SERVICES IN TIMES OF NEED?**

*Anita Everett, M.D., 3563 Cattail Creek Drive, Glenwood, MD 21738*

**SUMMARY:**

It has clearly been established that the burdon of mental illness in our society is great. This was determined in 1990 with the WHO, Global Burden of Disease study. In the US and other nations with established market economies, unipolar major depression is the leading cause of years lived disabled. The Global Burdeon of Disease work was conducted in a time of relative wealth and in an era of cultural wellbeing and optimism that is accociated with economic good fortune. Time have changed for the world and the US economy and we are now in an economic recession. We are experiencing high rates of unemployment and other stagnating economic indicators that have tangible and psychologic impact on all individuals and particularly those with increased vulnerability. Individuals with established mental illness are likely to be more vulnerable to decompensation in times of economic recession. Additionally it is likely that many individuals will experience new heights of stress that will destabilize mental and emptional wellbeing. This talk will revew the projected impact of reducing mental healthcare funding in times of national economic distress.

No. 75-B

**THE ECONOMIC DOWNTURN, MENTAL HEALTH, MENTAL ILLNESS:PROSPECTS FOR RECOVERY**

*Kenneth Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206*

**SUMMARY:**

Unemployment, debt, housing foreclosures and loss of assets all threaten the mental health of the nation. Areas of the country where the economy has been hardest hit shoulder the greatest burden. Given the reliance of mental health services on state funding its not unusual to find the need for services increasing while the capability to provide those services is being cut. Unfortunately, little is known about the scale and scope of the impact of economic downturns on mental health so its has been difficult to inform policy development. This paper reviews some of what is known and will discuss new information coming in from the field, all with an eye to developing appropriate policy to address the needs of the country.

No. 75-C

**MENTAL HEALTH CONSEQUENCES OF THE U.S. ECONOMIC DOWNTURN: WHAT DO WE KNOW AND WHAT CAN BE DONE?**

*Lisa Bates, S.M., D.Sc., 722 West 168th Street 15th Fl., New York, NY 10032*

**SUMMARY:**

On December 1, 2008, the National Bureau of Economic Research announced that the U.S. has been in a recession dating back to December 2007, making the current economic crisis the longest contraction since the Great Depression. With Federal attention and dollars focused on mitigating the immediate consequences of the downturn in labor and housing markets, the near and long term health impacts are easily overlooked. Despite anecdotal evidence that the current economic crisis is taking a toll on health, and long-standing empirical research suggesting that socioeconomic shocks are associated with poor health outcomes, there are critical gaps in the knowledge

base regarding both the nature and scope of the health consequences and what can be done to ameliorate them. Mental health and substance use are particularly important outcomes as they are likely to be among those most acutely impacted by socioeconomic shocks. Research suggests negative effects of job loss and unemployment on mental health and substance use. However, there is a relative dearth of information on the health impacts of other dimensions of economic contraction and little that examines the effects of socioeconomic shocks in the context of widespread economic recession. The objective of this paper is to present evidence on the broad mental health impacts of economic contractions. We review systematically the literature on the health impacts of multiple dimensions of economic recession, including: job loss, unemployment, underemployment, and job insecurity; deterioration of workplace conditions and benefits; foreclosure and residential/geographic dislocation; loss of income, assets, and savings; debt and bankruptcy; and overall downward social mobility. We focus on the consequences for mental disorders and substance use/abuse, as well as broader outcomes that may reflect processes of psychological strain, such as mental distress, sleep disturbances, family violence and marital dissolution.

No. 75-D

**SACRAMENTO COUNTY, CALIFORNIA-BUDGET CUTS, WORK-AROUNDS, AND UNINTENDED CONSEQUENCES**

*Russell Lim, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817*

**SUMMARY:**
Sacramento County contains the state capital, and its 1,394,154 residents receive mental health services from the County Department of Public Health, Division of Mental Health. Sacramento was named the most diverse city in the United States by Time Magazine in 2002. It is second only to Los Angeles county with 8 as having the most threshold languages, 7, including Spanish, Hmong , Russian, Vietnamese, Cantonese, Mien , and Lao, of all 58 counties in California, as defined by having 3,000 MediCal recipients or 5% of the MediCal recipients speak that language. The Mental Health Division consisted of a Psychiatric Crisis Center, a 100 bed inpatient psychiatric hospital, one Medi-Cal sub-threshold clinic, called Adult Psychiatric Support Services Clinic (APSSC), and four Regional Support Teams run by 4 different CBO's with county contracts. Dwindling state revenues caused by decreased property tax revenues due to foreclosed homes, and decreased sales tax revenue due to decreased spending, and increasing unemployment led the state to issue IOU's in July of 2009. Sacramento county anticipated the loss in State revenue, and began to terminate and cut as many contract agencies as possible and shift patients from RST's to the Primary Care Center, APSSC, and two other county run agencies, TCORE and APSSC Aftercare. Future plans involve the closing of the psychiatric emergency room and cutting the number of inpatient beds to 50. The presentation will show summarized data from law enforcement, public health, and the Division of Mental Health to illustrate the unintended consequences of Mental Health budget cuts, such as increased crime, incarcerations, and suicides. We will also look at the impact on Sacramento Counties' medical emergency rooms by detailing the number of 5150's and transfers to psychiatric hospitals.

No. 75-E

**ADDING INSULT TO INJURY: THE PUBLIC MENTAL HEALTH CRISIS IN REGIONS OF LONG TERM ECONOMIC STAGNATION**

*Patrick Runnels, M.D., W.O. Walker Bldg, 13th Floor, 10524 Euclid Ave, Cleveland, OH 44106*

**SUMMARY:**
Certainly, every state in the country has been hit hard by the current recession, resulting in massive cuts to mental health care budgets. However, states like Ohio and Michigan, whose economies had been built around manufacturing, have been in decline or stagnation for decades as manufacturing jobs have increasingly been shipped over seas, leaving mental health departments to absorb budget cuts even during years of national economic expansion. As a result, the current economic crisis has left these states with huge holes that can only be filled by heavily cutting the most essential services, including public mental health care. To compound the problem, the rising in unemployment has yielded a rise mental illness, leading to an increased demand for public mental health services at the very time when they are being cut back. This presentation will explore the impact of the recession on mental health service provision and utilization in this region by taking a closer look at its impact on Ohio and Michigan.

No. 75-F

**AN ACTION PLAN FOR PUBLIC MENTAL HEALTH DURING AN ECONOMIC RECESSION**

*David Pollack, M.D., UHN-80, Oregon Health and Science University, 3181 SW Sam Jackson Park Rd.,
Portland, OR 97239*

**SUMMARY:**
The prospect of health reform during times of great economic upheaval poses great hope and challenges for patients and providers in the public mental health system. On the one hand, it is essential to prevent any major loss or deterioration of the existing service system or levels of care provided. On the other, it is equally essential to make sure that mental health and addiction services are sufficiently represented in the newly designed system. The presenter

will review the key components of preserving and advancing behavioral health services in the newly emerging system. In particular, it is important to address the four following concerns: 1. Parity for mental health and addiction services and patients as part of an essential benefits package 2. Effective integration of behavioral health and primary care services 3. Promotion and implementation of effective integrated primary health homes, irrespective of the clinical setting (e.g., primary care, specialty behavioral health, residential) 4. Preservation and improvement of public health (including mental health and addiction) functions and their interconnections and interdependence with clinical services These concepts will be discussed with reference to the issues and challenges raised by the other presenters in this symposium.

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**SYMPOSIUM 76**

**LESSONS FROM HURRICANE KATRINA: RESPONSE, RECOVERY AND REBUILDING**

*Chairperson: Howard J Osofsky, M.D., Ph.D., 1542 Tulane Avenue, New Orleans, LA 70112*
*Discussant: James H Scully, Jr., M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify mental health responses and allowable services provided under the Stafford Disaster Act; 2) Identify the role that SAMSHA provides in oversight and interventions in disaster response; and 3) Identify expectable mental health symptoms and illness following disasters, as well as steps to aid in rebuilding

**OVERALL SUMMARY:**

Almost 5 years ago Hurricane Katrina struck New Orleans and the Gulf South. The ferocity of the storm, the breach of the levees, the flooding, the severe devastation, and the complex recovery are important parts of our regional and national identity. As we celebrate the return of the American Psychiatric Association Annual Meeting, this symposium will focus on knowledge gained and lessons learned that can help in meeting future disasters.

Dr. Kessler will provide longitudinal data on the psychiatric sequelae from an epidemiological perspective including post traumatic symptoms, mental illness and factors influencing persistent mental health needs in metropolitan New Orleans and the Gulf South.

Dr. Thompson will describe SAMSHA's mandate, its oversight, interventions beginning at the command center and continuing in meeting the crisis and recovery, and its overall role for disaster planning and response.

Dr. Speier will focus on LA Spirit, Louisiana's mental health crisis response program under the Stafford Disaster Act, its accomplishments and limitations, innovative efforts and standards emanating from components of the program.

Drs. Joy and Howard Osofsky will provide longitudinal data on children and adolescents in St. Bernard Parish, which was devastated by the hurricane and a toxic oil spill, including mental health symptoms, resilience recovery and rebuilding programs.

Dr. Scully will serve as discussant and will describe APA's efforts in addressing needs following Hurricane Katrina as well as prepare for its role in future disasters.

No. 76-A

**CHARTING THE COURSE OF RECOVERY FROM MENTAL DISORDERS IN HURRICANE KATRINA**

*Ronald Kessler, Ph.D., Department of Health Care Policy Harvard Medical School 180 Longwood Avenue, Boston, MA 02115*

**SUMMARY:**

The Hurricane Katrina Community Advisory Group (CAG) is a representative sample of over 3,000 individuals who lived in the areas affected by Hurricane Katrina at the time of the hurricane and who agreed to be interviewed repeatedly over the next few years in order to chart the pace of community recovery efforts. Surveys had been carried out with the CAG one, two, three, and, most recently, four years after the hurricane. While clear evidence of improvements in both objective life circumstances and mental health can be seen in the CAG as a whole, important segments of the sample continue to experience hurricane-related stressors and hurricane-related mental disorders. A small proportion of CAG members have also developed delayed-onset hurricane-related mental disorders. Data on these patterns of onset, persistence, and recovery are reported in this presentation. We also study predictors of these patterns. We show that these predictors include pre-hurricane risk-and resilience factors,

characteristics of the stressors to which the individual was exposed during and in the aftermath of the hurricane, and experiences that occurred in the years subsequent to the hurricane. The presentation closes with a discussion of the implications of this complex series of influences for intervention targeting.

No. 76-B
**THE FEDERAL CRISIS COUNSELING PROGRAM: LESSONS FROM NEW ORLEANS**

*Kenneth Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206*

**SUMMARY:**
The Crisis Counseling Assistance and Training Program (CCP) is one of a number of programs funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974 (Stafford Act). The Stafford Act was designed to supplement the efforts and available resources of State and local governments in alleviating the damage, loss, hardship, or suffering caused by a federally delcared disaster. Specifically, section 416 of the Stafford Act authorizes FEMA to fund mental health assistance and training activities in affected areas for a specified period of time. The mental health assistance element is called crisis counseling. This presentation will describe the underlying approach taken by CMHS to crisis counseling and the lessons that have learned in New Orleans and elsewhere.

No. 76-C
**LOUISIANA SPIRIT: CATASTROPHIC IMPACT AND PSYCHOLOGICAL RECOVERY**

*Anthony Speier, Ph.D., P.O. Box 4049, Baton Rouge, LA 70821*

**SUMMARY:**
Hurricane Katrina, a storm of historic dimensions has provided the nation with a precious lesson regarding the impact and consequence of a catastrophic event involving mass casualties and the internal displacement of over 400,000 persons from Louisiana. This presentation will examine the recovery trajectory of survivors and the implications of an incident of extraordinary magnitude on residents, responders, and communities as they struggle with recovery. Particular emphasis of the session will focus on the ramifications of a prolonged and complicated recovery process and how lives and culture are forever changed.

No. 76-D
**MENTAL HEALTH AND RECOVERY FOLLOWING HURRICANE KATRINA**

*Howard Osofsky, M.D., Ph.D., and Joy Osofsky, Ph.D., 1542 Tulane Avenue, New Orleans, LA 70112*

**SUMMARY:**
Hurricane Katrina and the breaching of the levees resulted in unprecedented community devastation and displacement in Metropolitan New Orleans and the Gulf South. More than 80% of New Orleans and neighboring St. Bernard Parish was flooded. In 2005-2006 following Hurricane Katrina, schools, in collaboration with the LSUHSC trauma team, carried out 2,362 screening assessments of children in grades 4-12 in highly impacted parishes. Assessments were based on the NCTSN Hurricane Assessment and Referral Tool for children and adolescents. Forty-nine percent of students met the cut off score for further mental health evaluation. In 2006-2007, 4,396 assessments were carried out and 41.6% met the cut off. Trauma exposure, separation from family, prior traumatic exposure, and living circumstances contributed to difficulties. Long term follow-up data will be presented from heavily devastated St. Bernard Parish. Although the population decreased, a dedicated school system rapidly restored schools, at first in temporary structures so children and families could return. While remaining higher than expected in a non-impacted population, symptoms of post traumatic stress and depression continue to decline. Consistent with overall data, younger children and females report more difficulties. At the same time, most of the children followed longitudinally report positive patterns of resilience and recovery; over 70% demonstrate normal response and recovery patterns. Factors contributing to positive outcomes, including youth leadership programs, will be discussed as well as innovative destigmatized approaches to meeting mental health and behavioral needs following a major disaster.

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## SYMPOSIUM 77

## TOWARD A NEW MODEL FOR MENTAL HEALTH SERVICES IN THE UNIVERSITY COMMUNITY

*APA Council On Children, Adolescents & Their Families*

*Chairperson: Jerald Kay, M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State University Elizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401,*
*Co-Chairperson: Victor I Schwartz, M.D.*
*Discussant: Victor I Schwartz, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to 1) Identify the contributions of the community mental and public health approaches for clinical care and student wellbeing; 2) Understand the integration of families of students into a clinical care model; and 3) Identify effective strategies for clinical-administrative collaboration and 4) recognize the educational attractiveness of resident rotations in college.

**OVERALL SUMMARY:**
Colleges are confronted with the challenge to provide comprehensive mental health and counseling services to a growing number of undergraduate and graduate students. By every measure, the number of students with complex needs seeking counseling and mental health services is increasing. While many explanations are offered to account for this increase in demand, there is no doubt about the consequences: neither the scope nor the structure of traditional services is adequate to meet the level of need. As a result, many counseling and psychological programs feel pressured to abandon or drastically reduce education, prevention, outreach, and more traditional counseling in order to provide clinical care. The symposium will provide alternative approaches to broaden the capabilities of mental health services on college and university campuses. The appeal for community mental health and public health models will be described. Enhanced collaboration with campus administration contributes to more efficient care for students and mechanisms for achieving this goal will be addressed. The role of a student's family in the provision of mental health services has been controversial and confusing. The lack of family involvement in many cases may contribute to less than adequate care. Approaches will be described to remedy this problem. Last, as only 60% of all campuses have psychiatrists on their staff, and many of these with considerably limited hours, it is imperative to develop a cadre of young psychiatrists who are adequately trained in college mental health. The virtues of resident rotations in college mental health will be highlighted. The components of effective educational and clinical experiences will be elucidated.

No. 77-A
### THE NEED FOR A COMMUNITY MENTAL HEALTH MODEL

*Paul Barreira, M.D., 7 Linden St, Cambridge, MA 02138*

**SUMMARY:**
Colleges are confronted with the challenge of providing comprehensive counseling and mental health services to a growing number of students requesting them. By every measure, the number of students seeking counseling and mental health services is increasing. In addition, more students arrive at college with conditions which have been treated with medication and therapy prior to enrollment. As a result, many counseling and psychological programs feel pressured to abandon or drastically reduce education/outreach and more traditional counseling in order to provide clinical care. In the absence of a conceptual model that helps to explain the need for retaining education, prevention, developmental counseling and psychiatric treatment, it is likely that some services will be provided at the expense of others. Another consequence of the increased pressure to provide services and the absence of a model is the growing tension between disciplines (counselors versus clinical psychologists and psychiatrists), as well as debates about the best models to understand and serve students (developmental versus clinical). The original community mental health model offers the potential to reconcile these conflicts by presenting a coherent model that explains and validates each approach. The original community mental health model endorses the principle that a combined developmental, educational, and clinical approach is necessary to ensure that students flourish in college. We will present the basic principles of the community mental health model and demonstrate its applicability to the college community.

No. 77-B
### CONTRIBUTIONS FROM THE PUBLIC HEALTH ORIENTATION

*Laurie Davidson, M.A., 55 Chapel St., Newton, MA 02458*

**SUMMARY:**
There is wide agreement that there is a problem of untreated mental illness on the nation's campuses. The majority of students who report being depressed are not in treatment, and most students who die by suicide have not been seen by the counseling center, fueling frequent calls for more clinical counseling staff. However, an approach

that focuses solely on getting more and more students into treatment, no matter how effective the services, relies on the assumption that counseling centers will be provided the resources to support an expanding number of students seeking care. Campuses would be well-served by recognizing that student mental illness is a public health problem and that promoting the mental wellness of students is the responsibility of everyone on campus. This presentation will detail the key elements of a campus-wide public health approach to mental health promotion and suicide prevention.

No. 77-C

**INTEGRATING THE STUDENT'S FAMILY INTO COLLEGE MENTAL HEALTH**

*Kristine Girard, M.D., 77 Massachusetts Ave., E23-368, Cambridge, MA 02139*

**SUMMARY:**
Societal, generational and cultural issues contribute to beliefs about and expectations for mental health care in the higher education environment Baby boomer parents have patterns of communication and interaction differing from generations past, and the millennial generation attending college demand incorporation of technology and team approaches, both of which challenge higher education faculty, administrators and clinicians. Solid understanding of the Fan1ily Educational Rights and Privacy Act (FERP A) which governs communication restrictions in the educational environment is essential for work with students and families while negotiating mental health care in this complex environment. Thoughtful and collaborative decision making between the university mental health service, parents, outside clinicians, faculty and administrative deans may be an effective way to support the administration while providing appropriate mental health care to college students. Case examples help to illustrate some of the benefits and challenges of working with families of young adults in the university setting.

No. 77-D

**THE CAMPUS AS COMMUNITY: WORKING WITH ADMINISTRATION**

*Lorraine Siggins, M.D., 17 Hillhouse Ave, P.O.Box 208237,, New Haven,, CT 06520-8237*

**SUMMARY:**
This presentation addresses the issues raised in the relationship of the mental health service to the university community. It is emphasized that care is provided by the entire community and not just by the mental health service. The education of the university community with regard to student development, the identification of troubled students, and the referral to the mental health service, are integral to providing this co-ordinated care. Out reach and educational initiatives are addressed to the following; faculty, administration,students,residential advisors, athletic departments, cultural centers,international student offices, chaplains, security departments, press offices and legal office. The personal relationships with these members of the wider university community are essential to the effective operation of the university mental health service. In all these situations, the importance of maintaining confidentiality for the clinical endeavor is of paramount importance.

No. 77-E

**PSYCHIATRY RESIDENTS IN THE COLLEGE MENTAL HEALTH SERVICE**

*Jerald Kay, M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State UniversityElizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401*

**SUMMARY:**
Because psychiatric services are increasingly in demand, and are not available on many campuses, it is imperative that a cadre of new psychiatrists become familiar with the professional opportunities in college mental health. This is best accomplished through the provision of electives for advanced psychiatric residents and the development of post graduate fellowships in college mental health. This presentation discusses the central components of these educational and training experiences with emphasis on clinical supervision, theoretical approaches to student development and developmental psychopathology, and the benefits to the trainee, the residency training program, and college mental health service of offering these experiences. The attractiveness of college mental health experiences for the psychiatry resident regarding opportunities for brief dynamic psychotherapy and split treatment will be detailed. This type of clinical-educational experience is an example, par excellence, of a remarkably beneficial collaboration between psychiatric graduate medical education and a college or university. Gains to the institution of higher learning, the college mental health service, the trainee, and, of course, the patient, are well worth the effort of providing these rich experiences. Hopefully, all college and university mental health services will provide these opportunities in the future.

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## SYMPOSIUM 78

## *DSM-5* UPDATE SERIES, PART III: REPORTS FROM THE WORK GROUPS

*Chairperson: Darrel A Regier, M.D., M.P.H., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: List the major developmental considerations under discussion by the *DSM-5* Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders; Mood Disorders; and Psychotic Disorders Work Groups.

**OVERALL SUMMARY:**
The forthcoming fifth edition of the *DSM* will be released in May 2012. Over the past three years, members of the 13 *DSM-5* Work Groups have been steadily compiling the evidence to address problems in the current diagnostic system and inform potential revisions. In this three-part symposia series, chairs from the work groups will provide brief updates on their progress to date. In this session, presenters from the *DSM-5* Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders; Mood Disorders; and Psychotic Disorders Work Groups will highlight current discussions from their work group. This will include identification of problems and challenges among the present diagnostic scheme, explanations of how recent evidence from research and epidemiology have informed the decision-making process, and descriptions of strategies for field testing new and revised criteria. The integration of dimensional assessment measures into the current categorical system are particularly relevant for clarifying diagnostic areas of importance within disorders, such as severity criteria and comorbid conditions, as well as across disorders, such as a "psychiatric review of mental systems" for all patients. Presentations will conclude with a summary of anticipated revisions and areas of continued interest.

No. 78-A
### *DSM-5* UPDATE ON ANXIETY DISORDERS AND OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

*Katharine Phillips, M.D., The Coro Center, One Hoppin Street, Providence, RI 02903*

**SUMMARY:**
The Anxiety, Obsessive-Compulsive (OC) Spectrum, Post-Traumatic, and Dissociative Disorders Work Group has three Sub-Workgroups: 1) Anxiety Disorders, 2) Obsessive-Compulsive (OC) Spectrum Disorders, and 3) Post-Traumatic and Dissociative Disorders. This presentation will discuss key issues being considered by the Anxiety and OC-Spectrum Sub-Workgroups. Literature reviews, secondary data analyses, surveys of experts, and input from advisors and the field are informing possible changes. Final recommendations have not been made; some options being considered are: 1) Modifying diagnostic criteria, subtypes, and specifiers for individual disorders. 2)Adding compulsive hoarding, olfactory reference syndrome, and skin picking disorder (most likely to the Appendix). Separation anxiety disorder may be modified to include adults. 3) Deleting transient tic disorder, and combining panic disorder with agoraphobia and panic disorder without agoraphobia into one disorder. 4) Adding dimensional approaches – for example, adding dimensional ratings of insight/delusionality to some disorders; adding disorder-specific dimensions to OCD; rating severity of fear, anxiety, and avoidance for anxiety disorders; and including anxiety as a "supraordinate," or "cross-cutting," dimension that (with other dimensions) would be used to assess all patients. 5) Enhancing the developmental sensitivity of diagnostic criteria (although developmental subtypes/specifiers will probably not be recommended, with the likely exception of PTSD). 6) Considering how disorders might optimally be grouped in DSM-V to best reflect evidence on their relationship to one another and to enhance clinical utility. Options include a category of OC-Spectrum Disorders or a combined category of Anxiety and OC-Spectrum Disorders.These and other options will be further informed by additional secondary analyses, *DSM-5* field trials, and further input from the field.

No. 78-B
### MAJOR ISSUES CONCERNING MOOD DISORDERS IN DSM-5

*Jan Fawcett, M.D., 2400 Tucker NE, Albuquerque, NM 87131*

**SUMMARY:**
The Mood Disorders Workgroup has been reviewing the *DSM-IV*, and considering areas of possible improvements in subworkgroups and as a whole in biweekly conference calls and meetings every six months for almost two years. The major issues that have emerged from this process include the overlapping borderland of MDD and Bipolar Depression, the Bereavement exclusion for MDD, the question of Anxious Depression as a clinically relevant

category, a more clinically useful clinical definition of mixed features across the spectrum of Bipolar Disorder, and a search for a more clinically useful specification of the Depression and Bipolar NOS categories. We are raising questions about the need for some diagoses like cyclothymia and discussing across disorder workgroups to find a better definition of schizoaffective disorder that might improve reliability. Recommendations for new diagnoses such as Complicated Bereavement and Pre-Menstrual Dysphoric Disorder are being considered, as well as where they would be appropriately placed in *DSM-5*. We have considered, but not endorsed Melancholia and Seasonal Affective Disorder as separate categories. The clinical advantages of adding several behavioral severity dimensions to mood disorder categories such as current anxiety and alcohol/substance abuse severity, is being considered. Also the possile advantages of adding a single dimension suicide risk factor assessment scale utilizing demonstrated chronic and acute risk factors, to mood and perhaps other diagnoses, is under study. These issues will be discussed from the standpoint of possible clinical advantages, reasons for suggested changes, unintended consequences as well as the data supporting them.

No. 78-C

**ANTICIPATING DSM-V: SCHIZOPHRENIA AND RELATED PSYCHOSES**

*William Carpenter, M.D., PO Box 21247, Baltimore, MD 21228*

**SUMMARY:**

One of 13 DSM-V Work Groups is assigned Schizophrenia and Related Psychoses. Issues addressed are: add or delete categories; change criteria; formulate dimensions; and design field trials. May, 2010 is timely for reporting to the field on recommendations and planned trials.Anticipated major changes include: 1] drop schizophrenia subtypes; 2] modify criteria A for schizophrenia; 3] remove catatonia to be a separate disorder co-morbid with schizophrenia, mood, and other disorders; 4] modify criteria for schizoaffective disorder; and 5] develop a risk syndrome category for high risk for psychosis. Minor modifications will also be noted. *DSM-IV* and *V* classes of disorders represent a long-standing paradigm. The Work Group is also introducing a second and new paradigm based on domains of pathology. Dimensions in this paradigm will address the heterogeneity of schizophrenia and other psychotic disorders. Each patient will be assessed for the psychopathologies central to clinical management and therapeutics. Proposed dimensions are: reality distortion, disorganization, restricted affect, avolition, impaired cognitive capacity, depression, mania and anxiety.Field trials to ascertain reliability for dimensions, schizoaffective criteria and the risk syndrome are anticipated.

No. 78-D

**LOOKING TOWARDS *DSM-5:* PTSD AND DISSOCIATIVE DISORDERS**

*Matthew Friedman, M.D., Ph.D., VA Medical Center, 215 North Main Street, White River Junction, VT 05009*

**SUMMARY:**

*DSM-5* is addressing three major questions regarding PTSD and dissociative disorders. First, given the prominence of trauma exposure among many individuals who suffer from dissociative disorders and given the prominence of dissociative symptoms among people with PTSD, *DSM-5* has established a joint Trauma/PTSD/Dissociative Disorders Sub-Work Group. Furthermore, although PTSD shares many overlapping symptoms with other anxiety disorders, the prominence of dysphoria, dissociation and, in some cases, externalizing features, has suggested the possible utility of classifying posttraumatic/dissociative disorders as either a separate diagnostic cluster in its own right or as a distinct sub-category within the Anxiety Disorders. Second, the Sub-Work group has considered a number of key questions regarding the current PTSD diagnostic criteria. These include addressing current concerns about the A1 (stressor) criterion); the utility of the A2 ("fear helplessness and horror") reaction to such events, the coherence of the current menu of re-experiencing, avoidance/numbing and arousal symptoms, and where to draw the line between acute and chronic PTSD. The Sub-Work group has also addressed Acute Stress Disorder (ASD), other posttraumatic syndromes and their relationship to adjustment disorder. Third, the following have been major considerations regarding dissociative disorders. Dissociative Identity Disorder may be redefined to emphasize fragmentation of identity in a sense more salient to various manifestations around the world, including two or more distinct personality states or an experience of possession. Dissociative Amnesia may include Dissociative Fugue as a subtype with amnesia for the past or personal identity coupled with sudden, unexpected travel away from home or work. Proposed revisions in diagnostic criteria for PTSD, ASD, Dissociative Identity Disorder, Dissociative Amnesia and Dissociative Fugue will also be presented.

No. 78-E

**UPDATE FROM THE MOOD DISORDERS WORKGROUP, BIPOLAR DISORDER SUBCOMMITTEE**

*Trisha Suppes, M.D., Ph.D., 3801 Miranda Ave (151T), Palo Alto, CA 94304*

**SUMMARY:**

Two of the areas the *DSM 5* Mood Disorders, Bipolar Subcommittee has focused on are 1) the boundaries between unipolar and bipolar disorder and 2) potentially better ways to handle the "not otherwise specified"

category. A number of important questions have been raised. For example, how would it be best to label and recognize hypomanic symptom(s) occurring during a course of illness consistent with unipolar illness? What does research data suggest regarding hypomanic symptoms that differentiate "pure" unipolar versus "classic" bipolar disorder? Also an important area of emphasis for the Mood Disorder Workgroup has been to refine and specify the content of bipolar presentations that do not meet criteria for bipolar disorder I or II, and are currently within the "not otherwise specified" category in *DSM IV-TR.* What is an appropriate threshold for identifying bipolar "spectrum" disorder currently labeled "not otherwise specified" category? In addition to these questions, the role dimensional measures may play in our future evaluation of mood disorders will be discussed.

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## SYMPOSIUM 79

## THE CHALLENGE OF COGNITIVE ENHANCERS IN MEDICINE

***The U.S. National Institute on Drug Abuse***

*Chairperson: Nora Volkow, M.D., 6001 Executive Blvd, Bethesda, MD 20892,*
*Co-Chairperson: Ruben D Baler, Ph.D., M.S.C.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the clinical and ethical implications that stem from the availability of an ever expanding family of psychotropic compounds displaying a diverse array of cognitive enhancing properties.

**OVERALL SUMMARY:**

The development of newer better psychotropic medications with the potential to improve various cognitive functions offers renewed hope for a large number of patients whose diseases are associated with substantial declines or impairments in specific cognitive domains. Predictably, the very availability of this class of drugs, often referred to as Cognitive Enhancers or COGS, has generated growing pressure on the medical community to expand their range of use to address conditions or situations not necessarily associated with a disease state; a situation with profound, and rapidly evolving clinical and ethical implications. This symposium is structured in a way that highlights the slippery slope that doctors face when trying to harness the clinical promise of COGS to a spectrum of situations that will increasingly include some patently gray areas.

No. 79-A

### 5-HT RECEPTORS AS TARGETS FOR COGNITIVE ENHANCEMENT IN SCHIZOPHRENIA

*Herbert Meltzer, M.D., 1601 23rd Avenue South, Suite 3035, Nashville, TN 37212*

**SUMMARY:**

Up to 85% of patients with schizophrenia have a clinically significant deficit in a variety of domains of cognition. This deficit is independent of positive and negative symptoms. Among the hypotheses regarding its etiology are deficits in cortical and hippocampal dopamine, acetylcholine, and glutamate function. These three neurotransmitters are regulated, in part, through various serotonin receptors, especially 5-HT1A, 5-HT2A, 5-HT2C, 5-HT3, 5-HT4, 5-HT6 and possibly 5-HT7 receptors. Several clinical studies have suggested that augmentation of antipsychotic drugs with 5-HT1A partial agonists, e.g. tandospirone, may improve some domains of cognition in patients with schizophrenia. There is evidence that atypical antipsychotic drugs such as clozapine, quetiapine, and risperdione improve verbal memory and fluency, in particular, in patients with schizophrenia. These and related atypicals increase cortical dopamine and acetylcholine release, in rodents and primates by mechanisms which involve direct or indirect 5-HT1A receptor stimulation and 5-HT2A receptor antagonism. The 5-HT2A receptor nntagonism of the atypical antipsychotic drugs has been shown to be a crucial component of the ability of atypical antipsychotic drugs to reverse the deleterious effects of phencyclidine on a test of declarative-type memory in rodents, the novel object recognition test. The transport of NMDA receptors in pyramidal neurons been shown to be regulated by 5-HT1A and 5-HT2A receptors. Further, mutations in various serotonin genes have been found to affect some cognitive function in patients with schizophrenia. Taken together, these types of studies suggest the serotonin system deserves further scrutiny as therapeutic target for improving cognition in schizophrenia.

No. 79-B
**ADHD TREATMENT, COMORBIDITY WITH SUDS, AND COGS RELATED DIVERSION**

*Nora Volkow, M.D., 6001 Executive Blvd, Bethesda, MD 20892*

**SUMMARY:**
Attention deficit hyperactivity disorder (ADHD) is the most prevalent psychiatric disorder of childhood. Recent research suggests that dopamine dysfunction underlies symptoms of inattention characteristic of ADHD and may also contribute to an increase in vulnerability to substance abuse co-morbidity found in some individuals with this disorder. Stimulant medications (such as methylphenidate), are commonly used to treat this ADHD with great success. The use of stimulants (methylphenidate and amphetamine) as cognitive enhancers by the general public, however, is increasing and is controversial. Recent research has shown that stimulant medications can reduce the magnitude of regional activation to a task and can "focus" the activation. This effect may be beneficial when neuronal resources are diverted (i.e., mind-wandering) or impaired (i.e., attention deficit hyperactivity disorder), but it could be detrimental when brain activity is already optimally focused. This may explain why methylphenidate has beneficial effects in some individuals and contexts and detrimental effects in others. This presentation will highlight recent research findings in this area.

No. 79-C
**MODAFINIL'S ABUSE POTENTIAL AND POSSIBLE ROLE IN COCAINE DEPENDENCE**

*Charles Dackis, M.D., 3900 Chestnut Street, Philadelphia, PA 19104*

**SUMMARY:**
Modafinil is currently prescribed for a number of approved and off-label indications, and misused as a cognitive enhancer to some degree. Studies investigating the addictive potential of this Schedule IV agent in humans report little or no evidence of euphoric amphetamine-like effects. The abuse potential of oral modafinil is limited by its slow onset, and its instability at high temperatures and relatively insolubility make modafinil unsuitable for intrapulmonary and intravenous administration. In addition, post-marketing surveillance has not revealed significant evidence of abuse. Animal studies likewise show little evidence of abuse potential. We have studied modafinil extensively in cocaine-addicted patients, and we found no difference in pill hoarding between modafinil and placebo in two large outpatient trials. Modafinil's promise in cocaine dependence was initially based on its ability to block cocaine-induced euphoria, which has been reported in three controlled human laboratory studies. Modafinil has also been reported to promote abstinence in cocaine-dependent patients in a randomized, placebo-controlled pilot study (n=62) and a recent multi-center study (n=210), with the latter also demonstrating improvement in craving scales. It is noteworthy that alcohol-dependent patients in the multi-center study did poorly on modafinil. We recently completed a third controlled study (n=210) that was negative. However, when women were excluded from the analysis, modafinil-treated patients showed a strong trend toward increased abstinence. A final randomized controlled study of modafinil in cocaine dependence is currently nearing completion.

No. 79-D
**NON-IMPAIRED ELDERS, COGNITIVE ENHANCERS, AND THE BOUNDARIES OF USUAL AND CUSTOMARY PRACTICE**

*James Ellison, M.D., M.P.H., Geriatric Psychiatry ProgramMcLean Hospital 115 Mill Street Belmont, MA 02478, Belmont, MA 02478*

**SUMMARY:**
The availability of pharmaceuticals alleged to improve cognition in impaired elders has led some non-impaired elders to request treatment in hopes of sharpening cognition, preventing decline, or counteracting normative cognitive effects of aging. The prescribing of medications for enhancement of normal functioning, rather than for the treatment of a conventionally diagnosable illness, pushes the boundaries of the clinician-patient relationship. The use of prescribed and over-the-counter putative cognitive enhancers by non-demented individuals will be reviewed in light of the evidence regarding their efficacy and safety and in the context of "usual and customary medical practice".

No. 79-E
**PHARMACOLOGICAL COGNITIVE ENHANCEMENT IN NEUROPSYCHIATRIC DISORDERS AND IN HEALTHY PEOPLE**

*Barbara Sahakian , M.D., Behavioural and Clinical Neuroscience Institute, Cambridge*

**SUMMARY:**
Neuropsychiatric disorders, such as Alzheimer's disease, depression, schizophrenia and attention deficit hyperactivity disorder (ADHD) are debilitating to the individual and place stress on the family and a financial burden on society. For example, 16% of adults in Britain have a common mental disorder such as depression at any one time and the annual costs from mental ill-health in England alone are about £36 billion. Whilst the psychotic symptoms of schizophrenia, such as delusions and hallucinations, can be relatively well treated with antipsychotic medication, these patients are still left with profound cognitive impairments which impact on their

functioning and quality of life. Therefore, key targets for treatment are the cognitive symptoms of neuropsychiatric disorders, including for example memory dysfunction in Alzheimer's disease (AD) and executive dysfunction in ADHD. There are current cognitive enhancing drugs, such as the cholinesterase inhibitors for AD and the stimulants, such as methylphenidate for ADHD. However, newer drugs are also becoming available. Therefore, the prospect of being able to take safe and effective drugs to improve cognitive functioning is fast becoming a reality. Cognitive enhancement is of great interest to the general public and has implications for society, particularly in regard to the increasing use of cognitive enhancing drugs in school age children, and in young adults and academic staff at University. Therefore, it is important to consider the potential harms of these drugs, for example unknown effects on the developing brain or coercion at school or work. Nevertheless, the benefits of safe and effective cognitive enhancing drugs to society, including the ageing population and people with neuropsychiatric disorders, are great. These potential benefits have been recognised in the Foresight Mental Capital and Wellbeing Report (2008) as "Novel pharmacological cognitive enhancers (PCEs) may prove of great benefit in the future, particularly given the rapidly developing field of pharmacogenomics and the ageing population". Ultimately, a rational approach to the use of PCEs is required in order to gain maximum benefits with minimum harms to the individual and to society as a whole.

## SYMPOSIUM 80

## SEX AND PSYCHODYNAMICS: CONTEMPORARY APPROACHES TO CLINICAL ISSUES THROUGH THE LIFECYCLE

*The American Academy of Psychoanalysis & Dynamic Psychiatry*

*Chairperson: Sherry P Katz-Bearnot , M.D., 263 West End Ave Suite 1F, New York, NY 10023*
*Discussant: Richard C Friedman*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participant should be able to: 1) Identify transference and countertransference themes that obstruct candid discussions about sexuality between therapist and patient; 2) Recognize neurobehavioral and psychodynamic contributions to the development of hypersexuality in children and adults with bipolar disorder; and 3) Treat common psychological and sexual sequelae of menopause by the application of psychodynamic principles, psychoeducation, and pharmacotherapy.

### OVERALL SUMMARY:

From its inception, psychoanalysis concerned itself with sex. Freud's earliest and (still) controversial observations about sexual aspects of childhood were central to his formulations about personality and symptom development. Over the past hundred years our understanding of human sexuality has expanded, as has our knowledge of the neuropsychiatric basis of mental illness, but sex has receded as an object of theoretical interest. In the consulting room, sexual experience remains relevant to the clinical endeavor. This panel will present modern psychodynamic contributions to the understanding and treatment of sexual symptomatology. Dr. Beresin will present common developmental issues in adolescent sexuality as well as a framework to assist clinicians to engage in productive, non-defensive discourse about sexuality with their patients. Drs. Adelson and Downey will be exploring the connection between the biological and psychological determinants of hypersexuality in patients with bipolar disorder. Dr. Adelson will be discussing the psychodynamics of hypersexuality in children and adolescents. Dr. Downey will extend it to include adults who have sexual lives characterized by "driven" and impulsive behaviors. Our ECP Dr. Neltner will describe a psychotherapeutic treatment enriched by the process and content of taking a sexual history. He learned about taking a sexual history (including its transference and counter-transference implications) through the mentorship of Dr. Downey, who visited the U Kentucky program as a result of the Teichner Scholar program initiated by the AAPDP in 2008. Dr. Katz-Bearnot will discuss depression and decreased sexual desire during the transition to menopause. The newest (Basson) model of female sexuality will be presented, as well as the role of psychodynamic psychotherapy in the treatment of such patients.Dr. Friedman, distinguished scholar in the field of psychodynamics and sexuality, will discuss the papers presented.

No. 80-A
## BREAKING THE SILENCE: DISCUSSING SEX WITH TEENS IN PSYCHOTHERAPY

*Eugene Beresin, M.D., 80 School Street, Acton, MA 01720*

### SUMMARY:

Adolescents often have a difficult time talking about deeply personal matters in the context of psychodynamic psychotherapy. While "drugs, sex and rock 'n roll" should invariably arise, it is surprisingly easier for many teenagers to discuss drugs and rock 'n roll than sexual fantasies and actions. To compound matters, even the most seasoned therapist finds it hard at times to sit with frank discussion about adolescent sexuality. Therapist discomfort may result from countertransference, current life events, or a teen's provocative narrative or seductive behavior in the office. This talk presents common developmental issues in adolescent sexuality as well as a framework that may assist therapist and their teenage patients engage in productive, non-defensive discourse about sexuality.

No. 80-B
**PSYCHODYNAMICS OF HYPERSEXUALITY IN CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER**

*Stewart Adelson, M.D., 117 West 17th Street, Ste. 2B, New York, NY 10011*

**SUMMARY:**
Bipolar disorder in children and adolescents has received increasing attention in recent years. Increased sexual behavior has been reported in children and adolescents with symptoms of bipolar disorder. The association of hypersexuality with bipolar disorder in childhood and adolescence must be confirmed, and its relevance to the disorder clarified. If associated with pediatric bipolar disorder, hypersexuality may be intrinsic to the neuropathophysiology of the syndrome, or may be associated with it as the result of psychosocial influences, psychodynamic factors, or generally disruptive behavior. This presentation will discuss the possible causes of hypersexuality in bipolar children. It is proposed that a developmental, psychodynamically informed model is necessary to understand sexuality in children and adolescents with bipolar disorder.

No. 80-C
**DRIVEN SEXUAL BEHAVIOR IN ADULTS WITH "SOFT BIPOLARITY:" A PSYCHODYNAMIC PERSPECTIVE**

*Jennifer Downey, M.D., 108 E 91 Street #1A, New York, NY 10128*

**SUMMARY:**
Individuals with bipolar features which do not meet DSM IV-TR criteria for Bipolar Disorder may number as much as 5% of the general population. These people are often assumed to have disturbed sexuality in keeping with their general impulsivity and impaired judgment. Although sexuality in these cases may be the product of the same biological influences that cause bipolar disorder, maladaptive sexual behavior may also be defensive. This presentation will discuss how to use a psychodynamic perspective to understand and address therapeutically the driven sexual behavior of patients with bipolar spectrum disorders.

No. 80-D
**THE ROLE OF SEXUAL HISTORY-TAKING IN IMPROVING PSYCHOTHERAPEUTIC TREATMENT**

*Matthew Neltner, M.D., 830 Limestone Street, Lexington, KY 40536*

**SUMMARY:**
The discussion of a patient's sexual history can be a difficult, but important learning process for psychiatric residents. This is illustrated in a case discussion of a middle-aged married female patient who displayed a sexualized interaction, which in turn brought forth an uncomfortable countertransference. One important factor in being able to take a sexual history in the context of a patient's personal history is for the clinician to be cognizant of his or her own reactions to the patient. This case explores the notion that the process of properly exploring a patient's sexual history can reveal otherwise missed issues which require clinical attention. In this case the sexual problem began concurrently with a traumatic lost pregnancy. Feeling wronged by a spouse who was nonchalant about this loss, contributed to ongoing conflict in the relationship many years later. Exploring these feelings proved to be insightful for the patient, and an understanding of how sexuality later became a means of leverage in the relationship was also helpful to address the lack of sexual enjoyment which followed. This case should provide an opportunity for the panel to discuss the process of taking a sexual history.

No. 80-E
**MENOPAUSE, DEPRESSION, AND DECREASED SEXUAL DESIRE: A PSYCHODYNAMIC CONTRIBUTION**

*Sherry Katz-Bearnot , M.D., 263 West End Ave Suite 1F, NY, NY 10023*

**SUMMARY:**
The clinical constellation of menopause, depression, and a decrease in sexual desire is extremely common, and extremely vexing to diagnose and treat successfully in women 'of a certain age'. This paper will review the current (2009) epidemiological data on the physiological and mental health sequelae of menopause, as well as present the contemporary model for female sexual response (the 'Basson' model) both before and after the menopausal transition. In addition, the author will review modern psychodynamic thinking about menopause. A psychodynamic formulation which synthesizes all these contributions will be presented and illustrated with a clinical case presentation.

**REFERENCES:**
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3.Friedman RC & Downey JI: Sexual differentiation of behavior: the foundation of a developmental model of psychosexuality. Journal of the American Psychoanalytic Association 2008;

56:147-175
4.Geller B, Zimerman B, Williams M, DelBello MP, Frazier J, Beringer L (2002a), Phenomenology of prepubertal and early adolescent bipolar disorder: Examples of elated mood, grandiose behaviors, decreased need for sleep, racing thoughts and hypersexuality. J Child Adolesc Psychopharm 12(1), 3-9

## SYMPOSIUM 81

## PROGRESS AND PROMISE: PREVENTING THE FIRST EPISODE OF PSYCHOSIS

*Chairperson: William R McFarlane, M.D., 295 Park Avenue, Portland, ME 04102*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the value of current methods being employed and tested for and precautions associated with early intervention as indicated prevention for psychosis and psychotic disorders.

### OVERALL SUMMARY:

As in cancer research and treatment, preventing chronic psychotic disorders offers the only current and realistic hope for a major advance in their treatment and prognosis. Two decades ago, this prospect was only a hope, though some scientific leads held promise for some of the new methods that are being tested today. This symposium presents recent progress in developing methods for identifying and then treating youth and young adults who are at risk for an initial episode of psychosis. Variously termed prodromal psychosis, clinical high-risk state or the pre-psychotic phase, the earliest evidence of psychosis has been shown to be a relatively accurate indicator of high likelihood of onset. Presentations will describe research efforts that are completed or underway, including progress in predictive power, measuring cognitive impairments, structural and molecular alterations in brain, and clinical constellations associated with high risk for schizophrenia and other psychotic disorders. Also described are interventions at the earliest stage of onset that are practical, effective and ethical. These are evidence-based approaches for first-episode psychosis that have been successful not only in preventing onset in up to 90% of those deemed at risk, but also in restoring functional deficits that are all but universal in the prodromal phase. They include family psychoeducation, assertive community treatment, cognitive therapy, second-generation antipsychotic and anti-depressant drugs, and supported education and employment. One major approach being tested nationally involves community-wide education of professionals most likely to observe early symptoms among youth and young adults. The Early Detection and Intervention for the Prevention of Psychosis Project (EDIPPP) will be described, with results for accuracy and efficiency of early identification. This symposium offers a window into one of the most promising areas of clinical research in psychiatry today.

No. 81-A

## COGNITIVE & FMRI STUDIES IN CLINICAL-HIGH-RISK AND EARLY PSYCHOSIS: UNDERSTANDING MECHANISMS AND PREDICTING RISK

*Carter Cameron, M.D., 4701 X Street, Davis, CA 95817*

### SUMMARY:

Dorsolateral prefrontal cortex (DLPFC) deficits are consistently observed in schizophrenia. There is evidence that PFC structural abnormalities pre-date and predict onset; however, it remains unclear to what degree functional deficits manifest prior to psychosis onset. We will present data individuals identified as clinical-high-risk for psychosis (CHR), first-episode schizophrenia (SZ), early psychosis (EP), help-seeking psychiatric controls (PC), and healthy controls (HC). CHR participants from both studies met SIPS Syndrome criteria for a high-risk state. Study 1: A large cohort of CHR (n=111), EP (n=13), and PC (n=30) participants were identified through referrals to one of six Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) sites within the United States. All participants completed a cognitive test battery including the AX-CPT. Study 2: A subset of CHR (n=13) individuals from UC Davis were compared to a demographically-matched sample of first-episode SZ (n=25) and healthy controls . Similar to previous studies in first episode and chronic schizophrenia, EP participants were impaired on the AX CPT while CHR participants showed an intermediate deficit . Study 2: Consistent with previous findings, first-episode SZ participants also demonstrated reduced cognitive control-related activation of the DLPFC when compared to controls. UHR activation was at a level intermediate between SZ and HC. Conclusions: Results from Study 1, which includes a large cohort of at-risk youth, demonstrate that individuals who have experienced less than 30 days of psychotic illness (EP) show deficits in cognitive control similar to those seen in first episode schizophrenia (SZ), providing additional evidence that cognitive impairments appear early in the development of psychotic illness. Furthermore, results of both studies suggest that CHR individuals show impairment in cognitive control and reduced DLPFC activation when compared to controls, in a manner that is similar to but less severe than individuals in the early phase of psychosis.

No. 81-B

## PATTERN OF NEUROCOGNITIVE DEFICITS IN INDIVIDUALS AT CLINICAL HIGH RISK FOR PSYCHOSIS

*Barbara Cornblatt , Ph.D., M.B.A., Zucker Hillside Hospital*

*75-59 263rd Street, Glen Oaks, NY 11004*

**SUMMARY:**
Introduction: Impaired cognition is considered one of the core characteristics of schizophrenia. Although the presence of cognitive deficits has been well established in genetically high risk offspring, few studies have yet reported the severity of cognitive abnormalities in individuals at clinical high risk (CHR) for psychosis. Methods: Six neurocognitive domains were assessed in subjects participating in the 6-site Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP). Z-scores were calculated using 100 normal controls recruited as part of one site, the Recognition and Prevention (RAP) program in NY. EDIPPP participants were divided into patients undergoing their first episode of psychosis (n=23), CHR subjects (n=102), and patient controls (n=37). CHR subjects were characterized by at least one of five attenuated positive symptoms (i.e. suspiciousness, grandiosity, unusual thoughts, abnormal perceptions, conceptual disorganization). Subjects falling above a selected severity cut point were classified as CHR, below were patient controls.Results: On most measures, patient controls were similar to normal controls in neurocognitive performance. CHR patients displayed moderate deficits across most domains, typically about ½ a standard deviation below normal performance levels. CHR subjects were particularly impaired on the speed of processing domain. First episode patients showed a similar pattern to CHR individuals, but displayed deficits of greater magnitude, closer to 1 SD below normal. Conclusions: CHR individuals display moderate cognitive disturbances, comparable to those established for other psychoses risk populations. While performances are more impaired than observed for controls, deficits are not as severe as those displayed by subjects with full psychosis. This suggests that with early intervention, neurocognitive deficits in at-risk individuals might be remediated before onset of severe psychosis.

No. 81-C
**TRANSITIONING FROM FIRST EPISODE TO PRODROME: LEARNING FROM THE EAST PROGRAM**

*Robert Wolf, M.D., Psychiatric Medical Center 1127 Oak Street SE, Salem, OR 97301*

**SUMMARY:**
Mid-Valley Behavioral Care Network's Early Assessment and Support Team (EAST) was the first U.S. effort to integrate early intervention for schizophreniform and bipolar psychosis into a public managed mental health system. In 2001, EAST began first episode services in five Oregon counties, based on guidelines from the Early Psychosis and Prevention and Intervention Center in Australia. In 2007, EAST joined a four-year study sponsored by The Robert Wood Johnson Foundation, called the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP). This study focused on high-risk and very-early first episode. EAST's expansion from first episode to high-risk services provides insight into the clinical and programmatic differences involved in serving the "high-risk" population. The high-risk group is younger, and less likely to have major functional consequences. Still, the high risk group are at significant risk for functional decline, social network loss and suicidality. Diagnosis of the high risk group is more ambiguous, and determining criteria for inclusion in a real-world setting versus a pure research setting requires significant reliance on current research and clinical knowledge. Inclusion of the high-risk group has required significant modifications in the clinical interventions and needed staff skill set. EAST data suggests that a high risk versus first episode focus has significant benefits, such as reduced acuity, improved early outcomes, easier engagement, and the ability to intervene when symptoms such as cognitive impairment begin to impair functioning. These benefits must be weighed against concerns about over-identification and possible iatrogenic treatment. In addition, further research is needed to help clarify which treatment is most helpful and least potentially harmful based on clinical presentation and progression of symptoms.

No. 81-D
**PORTLAND IDENTIFICATION AND EARLY REFERRAL (PIER): CONVERSION AND INCIDENCE OUTCOMES IN A CATCHMENT-AREA-WIDE PSYCHOSIS PREVENTION PROGRAM**

*William McFarlane, M.D., 295 Park Avenue, Portland, ME 04102*

**SUMMARY:**
Objective: Portland Identification and Early Referral (PIER) is a population-based system of early detection and treatment for the prodrome to psychosis in people ages 12-35. The goal was to reduce the incidence of psychotic disorders in Portland, Maine, U.S.A. (population 330,000). Materials and Methods: PIER educated the community-at-large and trained over 7300 health, education and youth-related professionals to identify young people at high-risk of psychosis. Eligibility for treatment was established by Structured Interview for the Prodromal Syndrome (SIPS) criteria. Treated cases received comprehensive evidence-based treatment and rehabilitation, a prodrome-specific combination of psychoeducational multifamily group, supported education-employment, assertive community treatment and psychotropic medication prescribed by symptom indication. Outcome measures were first episodes of psychosis and changes in GAF during one year of

intervention, and differences in clinical incidence rates (first hospitalizations for a psychotic disorder) in experimental vs. control catchment areas before (1994-2000) vs. during (2001-2007) the intervention program. Results: Over seven years, there were 780 referrals, of which 274 (35.1%) were assessed and 148 (19.0%) were admitted to study. 13 (8.8%) experienced >30 days of psychosis during one year of treatment. Mean GAF was 38.3 at baseline and 56.4 at 12 months (pre-post, $p<0.01$). The net pre-post difference in clinical incidence between control and experimental areas was 22.8/100,000 (ARIMA, $p<0.001$). Conclusions: This is the first U.S. attempt to reduce clinical incidence of first-episode psychosis by indicated prevention. Community-wide early detection and treatment was feasible and achieved low conversion rates. The relative difference in incidence between treatment and control catchment areas is consistent with a community-wide prevention effect, confirming both accuracy of identification and a preventive effect for treatment.

## SYMPOSIUM 82

## REPRODUCTIVE ISSUES AND WOMEN'S MENTAL HEALTH: HOW TO UNTIE THE GORDIEN KNOT?

*Chairperson: Gisèle Apter, M.D., Ph.D., 14 rue de l'Abbaye, Antony, 92160 France*
*Discussant: Carol Nadelson, M.D.*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize women's mental health issues linked to reproduction; 2) Organize and manage care in case of pregnancy loss or peripartum depression; and 3) Support patients choices on reproductive issues, combat stigma and dissipate the myth of abortion trauma.

### OVERALL SUMMARY:

Women's reproductive mental health issues have lived through many misunderstandings through the ages. Pregnancy long considered a blessed time for women during which mental illness could not strike is now known as high-risk period for women's mental health. Termination whether elective or unwanted has also been studied focusing on what was expected to be the trauma of pregnancy loss. If early unwanted termination of pregnancy too often occurs when parenthood is a wished- for-state, how can its circumstances be identified with the elective abortion of unwanted unplanned pregnancies? Abortion has then been extensively researched and has no negative mental health outcome even though the myth of the abortion trauma syndrome is reappearing. This symposium aims to dissipate false declarations concerning women's mental health as concerns reproductive issues. Each talk will describe the situation of women's mental health at a different time, during and after abortion, early termination of pregnancy, the pre and the immediate postpartum. Each of the speakers will expand on the different aspects and representations linked to these issues in different cultural settings in Western Europe, North and South America. How cultural representations, medical systems and access to care influences mental health reproductive issues will be discussed.

No. 82-A

### WHY PSYCHIATRY AND ABORTION?

*Nada L. Stotland, M.D., M.P.H., 1000 Wilson Blvd, Arlington, VA 22209*

### SUMMARY:

Abortion arouses many, sometimes conflicting, often changing, emotions in each woman. Many of these feelings result from the situation that led to the abortion. There is no valid empirical evidence that abortion, in and of itself, causes mental illnesses. However, there has been a concerted and articulated effort to convince policy-makers and the public that there is a causal association. Since approximately one-third of women in the United States will have an abortion at some time in their lives, and many others will be touched by abortion, it is essential that psychiatrists and other medical and mental health professionals are equipped both to work with women who are considering or have had abortions and to provide scientifically accurate information about its psychiatric aspects. The American Psychiatric Association adopted a revised position statement about abortion in September, 2009.

No. 82-B

### DILEMMAS CONCERNING MISCARRIAGE AND GENETIC TERMINATIONS

*Gail Robinson, M.D., Toronto General Hospital8-231 EN200 Elizabeth St.,Ontario, Toronto, M4W 3M4*

### SUMMARY:

Approximately 20% of pregnancies miscarry in the first trimester. The psychological impact is often ignored or minimized. Others may not understand why the woman is grieving for a child she never knew. Male partners may not express grief openly, leaving the woman to feel isolated and alone. Often there is no clear reason for the miscarriage, leaving women to feel responsible and guilty. Often, there are no institutional policies in place as there would be to help parents who suffered a stillbirth. Some researchers see the resulting emotions as resolving in the first six months whereas others have found long-lasting grief reactions. There is also a debate as to whether the best psychological outcomes are obtained by quickly doing a D&C or adopting a policy of expectant waiting to see if the embryo is absorbed. With a termination for genetic indications, the decision to end the pregnancy is often a difficult one. Couples worry about how others may judge their decision.

This may result in their not explaining what has happened, thereby, not obtaining needed emotional support.

No. 82-C
**THE RIGHT TO HEALTH: THE NEED TO UPHOLD SEXUAL AND REPRODUCTIVE HEALTH TO PROMOTE MENTAL HEALTH IN LATIN AMERICA**

*Marta Rondon, M.D., Jose de la Torre Ugarte 471 (302), Miraflores Lima, lima 18*

**SUMMARY:**

Most Latin American countries have restricted access to abortion, due to the great influence of the Catholic Church in state matters and to the patriarchal view that ultimately holds women punishable for exerting their sexuality. Peru has a maternal mortality rate of about 185 for 100000 live births, one of the highest in the region, and has not been successful in reducing it, despite robust economic growth and advances in other areas of human development. In the past few years, several women's and professional organizations have been advocating for change. A case involving a teenager pregnant with an anencephalic fetus in Peru has been paradigmatic, as it prompted a resolution from the UN Human Rights Commission urging the government to protect mental health in the same level as physical health, and therefore asking the state to provide clear guidelines to perform abortion on mental health grounds. I will discuss the broad implications of this resolution for the health provision system and, specifically for the weak mental health care system in the country. The intricate relationship among patriarchal ideologies, inequity and women's lack of agency will be examined in order to explain the inability of the state to provide both good sexual and reproductive health care and modern, good quality mental health service.

No. 82-D
**WHAT IF MOTHERHOOD CANNOT CHASE ALL THE BLUES AWAY?**

*Gisèle Apter, M.D., Ph.D., 14 rue de l'Abbaye, Antony, 92160*

**SUMMARY:**

Fertility and choice of parenting have been major issues for centuries. Representation of motherhood has often been adorned with bliss and marvel. Women could only wish to be mothers even though birth control has long been seeked for and abortion regularly practiced even when maternal death was high. And if, today, women have more freedom of choice of when to start a family, should they not be in an even greater state of happiness and wonder? How can they be overwhelmed by mental health disorders during pregnancy and the postpartum when having a baby should be enough to keep them well ? However, numerous studies now show that not only can mental health disorders occur during the peripartum, it is in fact a period of fragility. Becoming a parent is not only a formidable challenge; it is accompanied by physical and endocrine upheaval with the linked risk of mood and anxious disorders. A number of previous life events, trauma abuse or past mood episodes may also trigger anxieties, or recurrence of past disorders. Management and care during this period is tricky. It seems imperative to respect the patients' choices and weigh the benefits and risk of treatment (or none) in view of past history and available support and resources. Unwanted pregnancy is often considered a stressful event putting future mothers at risk of perinatal mood disorder and therefore increasing risk of interactive distortion when the infant is born. Management and specific care will be presented in the French Health care system. French society and its seemingly paradoxical situation, highest fecundity rate in Europe with major contraceptive uses and stable abortion service uses may well be showing the importance its population attaches to parenting and children.

**SYMPOSIUM 83**

**TREATMENT OF DEPRESSION WITH TMS: AN OVERVIEW OF FINDINGS FROM THE OPTIMIZATION OF TMS FOR THE TREATMENT OF DEPRESSION TRIAL (OPT-TMS)**

*Chairperson: William M. McDonald, M.D., 1841 Clifton Road, 4th Floor, Atlanta, GA 30329, Co-Chairperson: Mark S. George, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the latest findings with respect to using TMS to treat depression; 2) Recognize the strengths and the limitations of the findings from the OPT-TMS trial; 3) Recognize how to potentially use TMS in clinical practice or know who would and would not be good candidates for treatment; and 4) Be aware of findings regarding how TMS works to treat depression.

**OVERALL SUMMARY:**

Daily left prefrontal rTMS for the treatment of depression is one of the more exciting, and controversial, recent advances in the field of psychiatric treatments. Beginning with small studies over 15 years ago, the literature has now grown to over 30 randomized controlled trials of TMS to treat depression. This technique was given FDA approval in October of 2008. TMA as a treatment for depression theoretically offers many advantages over medications, as it is a focal, non-systemic treatment without drug-drug interactions or medication side effects. It is non-invasive and relatively side effect free. TMS also differs substantially from ECT as TMS does not induce a seizure and thus does not require an IV, or general anesthesia. There have been no cognitive side effects with TMS. Despite this

promise, TMS as a treatment for depression has remained controversial perhaps in part because it has challenged the dogma that a seizure is needed to treat depression and it is not a medication-based or talking therapy. Many of the initial TMS studies in depression were small, single site, and the control condition, or sham, was not sufficient to keep the TMS treater blind to the patient status. Thus considerable skepticism, and interest, remains. Because of this promise, and controversy, the NIMH funded an industry independent trial to rigorously address the question of whether TMS can treat depression. This Optimization of TMS for the Treatment of Depression trial (called OPT-TMS) completed enrollment in March 2009 and the results of the trial have been emerging over the past year and are now ready for full presentation. This symposium is the first full presentation of these important results with an attempt to place the findings in the proper scientific and clinical context. This presentation will set the stage for the symposium, updating the audience on what is known about using TMS for depression, and highlighting the current controversies and knowledge gaps. Particular attention will be focused on many of the problems in prior clinical trials, and how the OPT-TMS trial was designed to address them. These include a duration-adaptive design to help determine how long to treat, a new sham method to keep patients, treaters and raters blind, and an offsite independent rater and certifier.

No. 83-A

**NTRODUCTION AND STATE OF THE CURRENT PRACTICE AND KNOWLEDGE**

*Mark S. George, M.D., 67 President Street, Room 502 North, Charleston, SC 29425-0720*

**SUMMARY:**

This presentation will set the stage for the symposium, updating the audience on what is known about using TMS for depression, and highlighting the current controversies and knowledge gaps. Particular attention will be focused on many of the problems in prior clinical trials, and how the OPT-TMS trial was designed to address them. These include a duration-adaptive design to help determine how long to treat, a new sham method to keep patients, treaters and raters blind, and an offsite independent rater and certifier.

No. 83-B

**CLINCIAL RESULTS FROM THE RANDOMIZED OPT-TMS TRIAL**

*Paul Holtzheimer, M.D., 101 Woodruff Circle NE, Suite 4000, Atlanta, GA 30322*

**SUMMARY:**

Context: Daily left prefrontal repetitive transcranial magnetic stimulation (rTMS) has been studied as a potential treatment for depression, but prior work had mixed outcomes and failed to mask adequately sham conditions.

Objective: To test whether daily left prefrontal rtms safely and effectively treats major depressive disorder (MDD).

Design: Prospective, multi-site, randomized, active sham-controlled (1:1 randomization), duration-adaptive design - with 3 weeks of daily weekday treatment (fixed dose phase) followed by continued blinded treatment for up to another 3 weeks in improvers. Setting: Four U.S. university hospital clinics.

Patients: Approximately 860 outpatients were screened yielding 199 antidepressant-free patients with unipolar, non-psychotic, MDD. Intervention: rTMS delivered to the left prefrontal cortex at 120% motor threshold, 10 hz, 4 s train duration, 26 s inter-train interval, for 37.5 min (3000 pulses/session) with a figure-eight solid core coil. Sham rTMS used a similar coil with a metal insert, blocking the magnetic field, and scalp electrodes that delivered matched somatosensory sensations.

Main outcome measure: In the intent-to-treat sample (n=190) remission rates were compared for the two treatment arms using logistic regression and controlling for site, treatment resistance, age and duration of current depressive episode.

Results: Patients, treaters, and raters were effectively masked. Minimal side effects did not differ by treatment arm, with an 88% retention rate (90% sham; 86% active). The primary efficacy analysis revealed a significant effect of treatment (p=0.015) on the proportion of remitters (14% active rtms, 5% sham). The odds for attaining remission were 4.2 times greater with active rtms than sham (95% confidence interval, 1.3 – 13.2). The number needed to treat was 12. Most remitters had low antidepressant treatment resistance.

Conclusions: Daily left prefrontal rTMS as monotherapy produced clinically meaningful antidepressant effects greater than sham.

No. 83-C

**HOW DO THESE RESULTS RELATE TO CLINICAL PRACTICE AND HOW DO WE DECIDE WHO TO TREAT, AND FOR HOW LONG?**

*William M. McDonald, M.D., 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

**SUMMARY:**

In Phase II of the OPT-TMS trial, non-remitters in Phase I were offered open label treatment for up to 6 additional weeks, without breaking the blind. In this presentation Dr. McDonald will present the open-phase clinical response data, comparing it to how these results compare to similar studies done with medications (STAR-D) or ECT. In the open-label phase of this study (Phase II), there were 43/144 (29.9%) remitters (19/63 (30.2%) from the Phase I active TMS arm, 24/81 (29.6%) from the Phase I sham arm).

In particular we will present analyses about who is most likely to respond (response predictors) to TMS within this cohort. Additionally, we will address the important question of how long to treat, and when it makes sense to either stop TMS treatment, or alter the methods.

No. 83-D
**HOW DO YOU CREATE A TMS SHAM?**

*Sarah Lisanby, M.D., 1051 Riverside Drive Unit 21, New York, NY 10032*

**SUMMARY:**
An important part of any clinical trial is determining the proper control condition. In much of psychopharmacology, this consists of an inert or inactive dummy pill, or placebo. Relatively few medication trials attempt to make the placebo medication match the active treatment in terms of the side effect profile. In therapeutic devices, where a clinician is often near or beside the patient during treatments, the control device must fool not only the patient but the treater, and the rater. In this presentation, Dr. Lisanby will review the history of TMS sham systems, showing how some of the early devices were actually 'active' in changing brain activity. She will review the literature of different proposed solutions, and will then overview the solution used in the OPT-TMS trial. In this trial, patients were randomized to active TMS or a sham system that attempted to match the active TMS in terms of scalp discomfort and facial twitching, while also masking any acoustic differences. Patients, treaters and raters were assessed about the integrity of the blind. She will discuss how well this system worked, and the attempt to assess the integrity of the blind in the setting of a clinical effect, where patients, treaters and raters note clinical improvement and then base their guesses on clinical outcome. She will end with suggestions for future TMS shams, and sham systems for other proposed psychiatric therapeutic devices.

No. 83-E
**HOW LONG DO THE TMS CLINICAL EFFECTS LAST?**

*Antonio Mantovani, M.D., Ph.D., 1051 Riverside Dr Unit 21 Rm 5100, New York, NY 10032*

**SUMMARY:**
Following the randomized and open treatment phases, any remitters were offered to enroll in an open label followup study for 6 months, where patients were tapered from the TMS and placed on a combination of lithium and venlafaxine. They were seen each month for 6 months. Dr. Montavani will present the results of this followup phase, and then compare these results to followup studies after ECT or medications. He will then also overview the very small literature on using TMS as a maintenance treatment for depression following an initial acute response.

No. 83-F
**HOW DOES PREFRONTAL TMS WORK TO TREAT DEPRESSION?**

*Ziad H. Nahas, M.D., 67 President Street, Room 502N, Charleston, SC 29425*

**SUMMARY:**
All patients in the OPT-TMS trial received baseline MRI scans with markers showing where they were treated. The OPT-TMS trial also used an MRI-guided adjustment to help make sure that the coil was over the prefrontal cortex. 33% of patients had a 1 cm adjustment of the coil position based on MRI. Computerized post-hoc analysis reveals that even with this, 15% of patients were not treated over the appropriate regions. Dr. Nahas will present these findings from baseline MRI imaging, along with followup imaging after the acute phase in some patients and discuss potential changes that might be response predictors or explain the clinical outcomes. All patients at all sessions also had EEG recordings during treatment and Dr. Nahas will overview these data which may offer clues as to early prediction of later clinical response.

**REFERENCES:**
1.Schlaepfer TE, George MS, Mayberg H. WFSBP Guidelines on Brain Stimulation Treatments in Psychiatry. World J Biol Psychiatry 2009:1-17.
2.O'Reardon JP, Solvason HB, Janicak PG, et al. Efficacy and safety of transcranial magnetic stimulation in the acute treatment of major depression: a multisite randomized controlled trial. Biological Psychiatry 2007;62:1208-16.

**SYMPOSIUM 84**

**MOOD, MEMORY AND MYTHS: WHAT REALLY HAPPENS AT MENOPAUSE?**

*Chairperson: C. Neill Epperson, M.D., 19 Ridgewood Ter, North Haven, CT 06473-1256,*
*Co-Chairperson: Ellen Freeman, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Distinguish normal menopausal symptoms from onset or exacerbation of psychiatric disorders; 2) Demonstrate that they know how to advice their menopausal patients regarding the impact of aging on mood, memory and sexuality; and 3) Demonstrate knowledge regarding common treatments for symptoms frequently experienced by menopausal women such as: hotflashes, sleep disturbance, depression and sexual dysfunction/decreased libido.

**OVERALL SUMMARY:**

For many women, the "menopause" is shrouded in mystery and misconceptions. The lay media is full of recommendations for and against various products, life style choices and gimmicks all aimed at reducing common menopausal symptoms and delaying the process of aging. Menopausal women frequently experience hot flashes, night sweats, insomnia, low or labile mood, fatigue, memory difficulties and sexual dysfunction. These symptoms can adversely impact a woman's sense of well-being whether she has never had a mental illness or is already engaged in treatment for a psychiatric disorder that predates the menopause transition. Thus, psychiatrists routinely treating women who are in their 4th and 5th decades are likely to be confronted by several clinical conundrums. First, to what degree are the patients presenting symptoms related to normal menopause transition and its associated hormonal changes? Of their on-going patients, who is likely to experience the greatest difficulties with the menopause transition? How best are these symptoms handled in the mental health care setting, particularly if they contribute to an exacerbation of an on-going psychiatric disorder? This symposium seeks to examine these issues in a practical manner through lectures and open discussion. In addition, attendants will gain an appreciation of the complexity of hormonal/brain interaction as it relates to menopause, mood and memory.Women and clinicians identify the approach of menopause by changes in menstrual bleeding and the appearance of hot flashes, which are considered the cardinal symptom of menopause. Mood symptoms, poor sleep, aches, and changes in cognition and libido are also frequent complaints in this transition period, but whether these symptoms are associated with ovarian aging is controversial. The risk of depression is important because of its significant disability that may be improved with appropriate diagnosis and treatment and its associations with other diseases in mid-life women such as cardiovascular diseases, metabolic syndrome and osteoporosis. Recent approaches for staging the menopausal transition have provided increased information about the associations of depression and other symptoms with ovarian aging. Menopausal stages are defined by changes in bleeding patterns that reflect reproductive hormone levels. The prevalence of depressed mood, hot flashes, headache, aches and joint pain is associated with these transition stages and with underlying changes in reproductive hormones. The strongest risk factor for depression in the menopausal transition is a history of depression, although observed associations of depression with menopausal stage, increasing FHS levels and variability in estradiol implicate the changing hormonal milieu in perimenopausal women. Another strong risk factor for a diagnosis of depression in perimenopausal women is race, with African American women about 50% more likely to meet MDD criteria than Caucasian women in our population-based cohort. Women with no previous depression history also show an increased risk of depression in the menopausal transition. A woman with no history of depression is more than 5 times more likely to report depressive symptoms in the menopausal transition compared to her premenopausal status. Other risk factors for depression in women with no history of the disorder include greater BMI, smoking, hot flashes and greater variability in estradiol levels. These observations of an increased risk of depression in perimenopausal women support the concept that the menopausal transition is a "window of vulnerability" that is framed by the changing hormonal milieu of ovarian aging.

No. 84-A

**DEPRESSION AND OTHER SYMPTOMS: RISKS IN THE TRANSITION TO MENOPAUSE**

*Ellen Freeman, Ph.D., 3701 Market St 8th Fl, Philadelphia, PA 19104*

**SUMMARY:**
Women and clinicians identify the approach of menopause by changes in menstrual bleeding and the appearance of hot flashes, which are considered the cardinal symptom of menopause. Mood symptoms, poor sleep, aches, and changes in cognition and libido are also frequent complaints in this transition period, but whether these symptoms are associated with ovarian aging is controversial. The risk of depression is important because of its significant disability that may be improved with appropriate diagnosis and treatment and its associations with other diseases in mid-life women such as cardiovascular diseases, metabolic syndrome and osteoporosis. Recent approaches for staging the menopausal transition have provided increased information about the associations of depression and other symptoms with ovarian aging. Menopausal stages are defined by changes in bleeding patterns that reflect reproductive hormone levels. The prevalence of depressed mood, hot flashes, headache, aches and joint pain is associated with these transition stages and with underlying changes in reproductive hormones. The strongest risk factor for depression in the menopausal transition is a history of depression, although observed associations of depression with menopausal stage, increasing FHS levels and variability in estradiol implicate the changing hormonal milieu in perimenopausal women. Another strong risk factor for a diagnosis of depression in perimenopausal women is race, with African American women about 50% more likely to meet MDD criteria than Caucasian women in our population-based cohort. Women with no previous depression history also show an increased risk of depression in the menopausal transition. A woman with no history of depression is more than 5 times more likely to report depressive symptoms in the menopausal transition compared to her premenopausal status. Other risk factors for depression in women with no history of the disorder include greater BMI, smoking, hot flashes and greater variability in estradiol levels. These observations of an increased risk of depression in perimenopausal women support the concept that the menopausal transition is a

"window of vulnerability" that is framed by the changing hormonal milieu of ovarian aging.

No. 84-B

**HOT FLASHES AND SLEEP DISTURBANCES DURING MENOPAUSE TRANSITION: EXPLORING EFFECTIVE TREATMENT STRATEGIES**

*Claudio Soares, M.D., Ph.D., 208 Queens Quay W, Toronto, M5J 2Y5*

**SUMMARY:**
For some women, the menopausal transition is characterized by the occurrence of sleep disturbances, mood swings, and the presence of vasomotor symptoms (VMS, e.g., hot flashes and/or night sweats); this constellation of symptoms can adversely affect quality of life and overall functioning. Menopausal women commonly report sleep complaints, with sleep disruption being associated with the occurrence of VMS. Some studies suggest a more direct association between the presence of hot flashes and frequent awakenings, particularly in the first half of the night; others attributed sleep disruption to sleep apnea, restless legs syndrome, and the presence of depression/anxiety. Menopause-associated fluctuations in estrogen and progesterone levels may also lead to insomnia by impacting GABA regulation or contributing to the occurrence of obstructive sleep apnea syndrome (OSAS) and changes in body weight. In addition, the presence of VMS provoked by hormonal fluctuations also contribute to poorer cognitive performance, including attention, working and verbal memory, although the underlying mechanisms by which vasomotor symptoms may directly influence brain functioning are still largely unknown. This presentation will briefly explore existing evidence on the underlying mechanisms associated with poorer sleep, presence of VMS and impaired functioning in menopausal women. We will discuss how to better assess functional outcomes in this vulnerable population. Most importantly, we will review hormonal, psychotropic and over-the-counter treatment strategies that can be tailored for the management of symptomatic, menopausal women.

No. 84-C

**SEXUALITY IN TRANSITION: MENOPAUSE AND AGING**

*Anita Clayton, M.D., 2955 Ivy Rd, Northridge Suite 210, Charlottesville, VA 22903*

**SUMMARY:**
Variations in sexual interest and activity during the menopausal transition may be associated with psychosocial changes, hormonal fluctuations/decline, effects of co-morbid medical conditions, or substance use including medications. Although the prevalence of low desire increases with age, the rate of distressing low desire (HSDD) remains between 10 – 15% of women due to a decline in levels of sexual distress with aging. While declining sex steroid levels in the perimenopause may be associated with arousal difficulties and reduced capacity for orgasm, no specific levels of androgens have been linked to low sexual interest. Other factors affecting sexual functioning include partner sexual problems or absence of partner, relationship difficulties, surgical menopause at a young age, severe vasomotor symptoms, socioeconomic issues, and lifestyle factors. Diagnosis of sexual disorders is complicated by reluctance on the part of patients and physicians to discuss sexuality, as well as confounding variables such as the comorbidity of sexual disorders, and the co-occurrence of other conditions affecting libido such as depression. Identifying sexual problems in mid-life women allows for interventions to re-establish satisfactory sexual functioning, and include lubricants, hormonal therapy, phosphodiesterase-5 inhibitors, bupropion, lifestyle changes, and psychotherapy.

No. 84-D

**WHERE DID I PUT MY KEYS? THE ON-GOING SAGA OF ESTROGEN, SEROTONIN, MOOD AND MEMORY AT MENOPAUSE**

*C. Neill Epperson, M.D., 19 Ridgewood Ter, North Haven, CT 06473-1256*

**SUMMARY:**
During the menopause transition, many women report a worsening of their mood and subjective impairment in memory. While dwindling ovarian production of estrogen is clearly related to the most common menopausal symptoms, namely hot flashes and genitourinary atrophy, the mechanism by which estrogen may influence behavioral changes during menopause is unclear, although of great interest. A growing preclinical literature indicates that estrogen interactions with neurotransmitters such as serotonin are likely, and serotonin function is believed to decline with age. However, there is a dearth of research in humans regarding how estrogen and serotonin may interact to modulate mood and cognition. The primary focus on this presentation will be to help the participant appreciate the complex interaction between estrogen and serotonin and how novel research techniques are being employed in human subjects to unravel this mystery.

**REFERENCES:**

1.Symptoms in the Menopausal Transition: Hormone and Behavioral Correlates. Freeman EW. Sammel MD. Lin H. Garcia CR. Kapoor S. Obstetrics & Gynecology. 111(1):127-36, 2008.

2.Practical Strategies for Diagnosing and Treating Depression in Women: Menopausal Transition. Soares CN. Journal of Clinical Psychiatry. 69(10):e30, 2008.

**WEDNESDAY, MAY 26, 2010**
**9:00 AM-12:00PM**

**SYMPOSIUM 85**

## WOMEN'S MENTAL HEALTH IN LATIN AMERICA: PRESENT AND FUTURE RESEARCH

*Chairperson: Wilma I. Castilla-Puentes, M.D., Rincon de La Floresta Club # 208, Duitama, Boyaca Colombia*
*Co-Chairperson: Silvia Gaviria, M.D.*
*Discussant: Maria Adelaida Rueda-Lara, M.D.*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Become familiar with a sample of recent studies on women's mental health in Latinamerican Countries.

### OVERALL SUMMARY:

This symposium will review studies of girls, adolescents and women mental health, carried out in Latin America over the past years. Also will consider the issue of how to meet the needs of women who may present mental health problems in Latin America, given that most of them live in economies that are underdeveloped, providing limited resources. The authors will present studies designed and conducted in Latin American countries, highlighting methodological features that may account for differences in the results obtained. Prevention and treatment strategies will be discussed and the peculiarities of the delivery of mental health services for women will also be presented. Future research needs to focus on understanding of resilience and formal and informal mental health delivery systems of care available in different Latin American countries. Such research has high potential for ameliorating the prevention and treatment of women mental health problems in this region of the world.

No. 85-A

## DEPRESSION AMONG WOMEN WITH CANCER IN ECUADOR

*Carlos León-Andrade, M.D., Hospital Metropolitano, Quito, 593*

### SUMMARY:

Depression in cancer patients in general is common and occurs throughout the course of their cancer illness. This study reported the frequency of depression observed in patients who have been treated for breast carcinoma, 33.3%, ovarian cancer, 25%; lymphomas 16.6%, and pancreatic cancer, abdominal sarcoma and neuroendocrine cancer 8.3%, each. Women with cancer (range age 44-72 y.o) who were patients at a General Hopsital in Quito, Ecuador were recruited to participate. The majority of women were married (75%) and more than a half (66.7%) were receiving corticosteroids as adjunctive treatment. Using the most conservative cut-off point of the Zung Scale the prevalence of depression was 41.7%, and the prevalence increased to 66.7% when borderline cases were included. A history of major depression prior to their cancer diagnosis was reported for 16.7% of the patients and hypothyroidism in more than 40% of the whole group. The presence of metastasis, fatigue, pain, and use of corticosteroids was significantly associated with depression. No one of the depressed women was treated with antidepressants. Since depression is significantly associated with shorter survival, independent of the influence of the biomedical prognostic factors, early recognition and intervention of depression may play an important role for prognosis in these women.

No. 85-B

## CHILDHOOD SEXUAL AND PHYSICAL ABUSE HISTORY IN A GYNECOLOGY OUTPATIENT CLINIC IN COLOMBIA: HOW ABUSE IMPACTS MENOPAUSAL SYMPTOMS

*Ruby Castilla-Puentes, M.D., D.P.H., 530 South 2nd. St. Suite 743, Philadelphia, PA 19147*

### SUMMARY:

Objective: This study was aimed to determine:a) prevalence of childhood abuse history in Colombian menopausal women, and b) relationship between childhood abuse history and clinical manifestations, symptom reporting, functioning and psychosocial characteristics during menopause. Methods: Consecutive 408 (45-55 years) out-patients women during their annual gynecological visit in an out-patient clinic in Duitama, Boyaca, Colombia, filled in a self-administered standardized questionnaire, made up of two separate sections: (1) a medical section inquiring on menopausal symptoms, and (2) a section on abuse inquiring on the presence and type of abuse suffered during their childhood. Associations between number of symptoms and abuse history were evaluated using univariate and multivariate logistic models. Results:The prevalence of reported childhood abuse was 19%. Among women reporting abuse, physical abuse was reported by 48 (12%), sexual abuse by 20 (3%) and both sexual and physical abuse were reported by a total of 10 women (2%). Women who report childhood abuse compared to those who do not have showed: More severe physical and psychological symptoms, more sleep problems, greater bodily pain, more genitourinary symptoms, are less physically active and poor function and low quality of life. Women who report childhood abuse: are more anxious and pessimistic, have lower self esteem, have more chronic problems in relationships or in family members are more likely to have a history of recurrent depression. Furthermore, physical and sexual abuse were associated with a significantly ($p<0.001$) greater number of menopausal symptoms. Conclusions:Women's childhood experiences with abuse influences their long-term health

and may have implications for their assessments and treatment during menopause.

No. 85-C
**IMPROVING THE TREATMENT OF DEPRESSION IN CHILEAN WOMEN**

*Enrique Jadresic, M.D., Avenida La Paz, Santiago, 1003*

**SUMMARY:**
In the last 18 years Chile has made considerable progress incorporating mental health to public policies. From 2000 to 2002 the first randomized controlled trial in primary care clinics to compare the effectiveness of a stepped care program with usual care to treat depressed women was carried out. The stepped care program included a structured psycho educational group, systematic monitoring of clinical progress and structured pharmacotherapy executed by trained general practitioners. A total of 240 adult women participated in this trial and the results showed a large and significant difference in favour of the stepped care program compared with the usual care. This program was more effective and marginally more expensive than usual care for the treatment of depressed women in primary care. The results of this trial were well received by policy makers at the Ministry of Health and contributed to the National Program for the Detection, Diagnosis and Treatment of Depression that started in 2001 in primary care clinics. About 90% of those treated in this program are women and most of them with a history of previous depressive episodes and low social support network. A second randomized controlled trial carried out in primary care revealed that treatment of depressed postpartum women is not only possible but also effective. This study demonstrated that a multi-component intervention can attain better outcome results after three months when compared to a usual care control group. The intervention included psycho-educational groups, medical consultations, structured pharmacotherapy and systematic monitoring and maintenance of treatment adherence. At three months recovery was 61% (95% CI 51-71%) in the study group versus 34% (95% CI 25-44%) in the usual care group. After adjusting for baseline EPDS, the mean EPDS at three months was approximately one standard deviation lower for the postnatal depression multicomponent intervention group compared with usual care. The results are promising for acute treatment of socially disadvantaged postpartum depressed women especially in a primary care setting. This study shows that it is possible to improve the acute treatment of PPD in resource-poor settings, even though many obstacles remain to achieving more lasting improvements.

No. 85-D
**CLINICAL PRESENTATION AND TREATMENT OF GIRLS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER IN CHILE AND ARGENTINA**

*Arturo Grau, M.D., Jorge VI 414 -Las Condes,Santiago de Chile, Santiago, 5620008*

**SUMMARY:**
This study explore the clinical presentation and treatment of attention-deficit/hyperactivity disorder (ADHD) in girls (7-17 y.o) selected from the Children's Hospital Luis Calvo Mackena, in Sanitago, Chile, and from the Hospital Infanto-Juvenil Dra. Carolina Tobar García in Buenos Aires, Argentina. ADHD presents differently in girls from in boys, and that this is a likely reason for missed or delayed diagnoses in girls. Symptoms such as inattentiveness, poor school performance, and depressive affect were seen as the typical signs of ADHD in girls, yet they elicit less attention from teachers and parents than characteristic ADHD symptoms seen in boys, such as disruptive behavior and "acting out." This is partly because girls' symptoms are not recognized as typical indications of ADHD and partly because these symptoms are less noticeable and less troublesome to adults than are boys' symptoms. The cultural influences, and tendency of girls to "suffer silently" often means that they bear the burden of untreated ADHD for a much longer time than do boys. In this study on the clinical features and treatment of ADHD, female gender was a barrier to appropriate diagnosis. The failure to recognize ADHD symptoms in girls results in significant undertreatment. The findings of this study suggest that gender has important implications for the diagnosis and treatment of ADHD in this pediatric population.

No. 85-E
**WOMEN'S MENTAL HEALTH IN LATIN AMERICA: PRESENT AND FUTURE**

*Elvia Velásquez, M.D., Asociación Latinoamericana de Adicciones, Medellin, 22618*

**SUMMARY:**
In the last three or four decades, there have been significant efforts of Women's mental health promotion and prevention in several Latin American countries. In response to several pronouncements by international organizations, particularly the Pan American Health Organization (PAHO), 64.5% of Latin American countries have specific mental health policies. What is not well documented is whether such instruments are effectively implemented and utilized to promote Women's Mental Health. Countries such as Mexico, Chile, Costa Rica and Brazil have made some advances in this area.Women's Mental Health research in Latin America has made some progress, but much remains to be done. The absence of solid financial support seems to be at the root of this discouraging reality. In this presentation we will discuss the significant research contributions Latin American psychiatry has

produced in women's mental health, particularly in the areas of epidemiology, clinical studies, cultural issues, and psychopharmacology.

No. 85-F

**DIFFERENCES AND SIMILARITIES IN MENTAL HEALTH ISSUES BETWEEN MEN AND WOMEN IN LATIN AMERICA**

*Jorge Forero, M.D., Instituto Colombiano de Investigacion en Salud Mental, Bogota, 22618*

**SUMMARY:**
The study of women's mental health concerns more than mental, childbirth and reproductive health, and extends beyond biological differences between the sexes. Approaches that treated this concept as mainly an obstetrical term relied on an understanding of the female life cycle that wrongly assumed the centrality of reproduction to women's lives. Fertility does mark women's lives, but the understanding of women's health should not be confined to it. Economic status, the nature of the national health system she relies on, as well as a woman's role in the family or community affect her health. Clearly, the relation between medical, social, cultural, political, and economic issues alike are critical to understanding the varied needs of women mental health. This presentation examines differences and similarities in mental health issues between men and women in Latinamerica. Specifically, it discusses conditions that predominantly affect women, the bio¬psycho¬social factors affecting gender differences, disorders with onset or exacerbation related to reproductive life events, and considerations for therapeutic management of psychiatric illness synopsis including effects of hormonal changes, comorbidity, chronicity, and response to treatment/outcomes.

No. 85-G

**SUICIDAL BEHAVIOR AND SUBSTANCE ABUSE AMONG SEXUALLY ABUSED GIRLS IN ECUADOR**

*Emma Saad, M.D., Hospital Psiquiatrico-Guayaquil, Guayaquil, 22618*

**SUMMARY:**
Childhood sexual abuse can have a profound impact on a girl during adolescence, resulting in lessened self-esteem, inability to trust, academic failure, depression, teen pregnancy, and other maladaptive outcomes that can extend far into adolescence and adulthood. Two of the most significant are suicidal ideation/behavior and substance abuse disorders. This presentation explores suicidal behaviour and the development of substance abuse disorders, in 400 girl adolescents (range age 11-18 y.o), recruited in a psychiatric hospital in Guayaquil, Ecuador who were abused as children. The frequency and impact of a familial history of sexual abuse (e.g. by biological father) is also examined. Clinicians working with children or adolescents who have experienced or are experiencing sexual abuse should take a preventative approach, identifying and treating those at risk for suicide and/or substance misuse. Practitioners working with girl adolescents who are already abusing drugs and/or are suicidal should work with the patient to identify and examine life events such as abuse that may be responsible. By identifying factors that have led to the misuse of alcohol and/or suicidal ideation, adolescents can obtain appropriate treatment and deal in a more productive and beneficial manner with the pain that underlies their self-destructive impulses.

**REFERENCES:**

1.Increasing access to Latin American social medicine resources: a preliminary reportHolly Shipp Buchanan, Howard Waitzkin, Jonathan Eldredge, Russ Davidson, Celia Iriart, and Janis Teal J Med Libr Assoc. 2003 October; 91(4): 418–425

**SYMPOSIUM 86**

**HOW DYSFUNCTION OF LEARNING AND MEMORY CIRCUITS CONTRIBUTE TO SUBSTANCE ABUSE AND OTHER PSYCHIATRIC DISORDERS**

***The U.S. National Institute on Drug Abuse***

*Chairperson: Roger G Sorensen, Ph.D., M.P.A., 6001 Executive Blvd, Bethesda, MD 20892-9555,*
*Co-Chairperson: Steven Grant, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Appreciate the diversity of learning and memory processes within the brain, the range of brain circuits that contribute to the various modes of learning and memory, and the strengths and vulnerabilities inherent in these memory systems and brain circuits; and 2) Recognize the similarities and differences in the dysregulation of these brain circuits among psychiatric and behavioral disorders.

**OVERALL SUMMARY:**
The progression from voluntary to compulsive drug use involves stages of learning and memory, for example, reward/reinforcement learning as drug abuse behavior escalates and associative/cue-response learning that contributes to relapse after prolonged abstinence. Extinction training, a form of inhibitory learning, may be useful for reducing drug-craving and drug-seeking in response to drug-related environmental cues. Furthermore, psychiatric disorders and drug addiction alter and disrupt the neural circuitry involved in learning and memory. This session will discuss the neural circuits involved in the formation and extinction of memories in addictive behaviors, and discuss and compare the cognitive deficits in learning and

memory that underlie neurological disorders and addictive behaviors.

No. 86-A

**SELECTIVE IMPAIRMENTS IN REWARD VERSUS PUNISHMENT LEARNING IN PSYCHIATRIC DISORDERS**

*Mark Gluck, Ph.D., Center for Molecular and Behavioral Neuroscience, Rutgers University - Newark, 197 University Avenue, Newark, NJ 07102*

**SUMMARY:**
In studies of drug addiction, Parkinson's disease, and schizophrenia, we show how dopamine-mediated changes in selective biases for learning from reward versus punishment in a probabilistic categorization task provide insights in the cognitive bases of these psychiatric disorders. Some of this work may suggest novel methods for identifying meaningful patient group subtypes. These studies are informed by parallel research using functional brain imaging in healthy normals and related neurocomputational modeling of fronto-striatal function in learning.

No. 86-B

**ADDICTION AS DYSFUNCTION IN LEARNING-AND-MEMORY-BASED DECISION SYSTEMS: MULTIPLE POTENTIAL FAILURE POINTS LEADING TO MULTIPLE ADDICTION ENDOPHENOTYPES**

*A. David Redish, Ph.D., 6-145 Jackson Hall / 321 Church St. SE, Minneapolis, MN 55455*

**SUMMARY:**
Current theories of decision-making suggest that action-selection arises from the interaction of four learning and memory systems: (1) a situation categorization and recognition system, (2) a Pavlovian incentive system, (3) a model-based system based on the online evaluation of predictions of outcomes of forward models, and (4) a model-free decision-system based on the learning of valuations of situation-action pairs. Taking an engineering approach to these interacting systems identifies multiple "vulnerabilities" or "failure-modes" within each system and in the interaction between systems. Learning or recalling incorrect information in any one of these systems can produce incorrect decision-making. We propose that addiction entails the dysfunction of one or more of these systems and identify 16 vulnerabilities which can drive incorrect decisions. We propose that these 16 failure-modes encompass endophenotypes which need to be identified and treated separately within patient populations.

No. 86-C

**IMPAIRED MODULATION OF LEARNED MOTIVATIONAL RESPONSES TO CUES: COMMON CORE DYSFUNCTIONS IN ADDICTION -- AND IN PTSD**

*Anna Rose Childress, Ph.D., 3900 Chestnut Street, Philadelphia, PA 19104-6178*

**SUMMARY:**
Addicted individuals' struggles in recovery may reflect two (interactive) core vulnerabilities: 1) learned activation of the brain's limbic motivational ("GO!") circuitry to cues signaling drug arrival, and 2) dysfunction of the brain's prefrontal inhibitory ("STOP!") circuitry, critical for modulating the downstream limbic ("GO!") regions. Intriguingly, research suggests individuals with PTSD have parallel vulnerabilities: 1) learned activation of limbic fear circuitry to cues signaling danger, and 2) dysfunction of the prefrontal regions critical for modulating the downstream fear circuitry. Neuroimaging tools have enabled considerable progress in characterizing the dysfunctions for both disorders. With regard to the first vulnerability, imaging research in both addiction and in PTSD has shown that learned cues (for drug or for danger, respectively) trigger strong motivation (i.e., desire or fear) and activate interconnected limbic regions critical in appetitive and aversive motivation (e.g., amygdala, striatum/pallidum, OFC, insula, etc.). This learned brain response, in both disorders, is rapid, pathologically persistent (difficult to extinguish), and does not require conscious awareness. As the learned limbic response (in both disorders) begins rapidly and outside awareness, it represents a very difficult target for modulation: it occurs before the prefrontal inhibitory ("STOP!") regions can fully participate. Compounding this difficulty, the prefrontal modulatory circuits in individuals with addiction and/or PTSD often show structural (reduced gray matter density) and functional (poor inhibition) deficits – a problem that may pre-date, and pre-dispose, both disorders. The identified core dysfunctions suggest a range of novel, brain-guided interventions. Shared core dysfunctions may help explain the high psychiatric co-morbidity of addictions and PTSD. Though these co-morbidities often present a difficult clinical challenge, their overlapping substrates may also offer a unique clinical opportunity: brain-guided strategies could offer "one-stop-shopping" for individuals with addiction and PTSD – with the hope of improved clinical efficacy.
Supported by: NIDA (P50-DA12756, P60-DA-005186, R21-DA026114, R01DA025906), VA VISN 4 MIRECC, and The Alexander Foundation

No. 86-D

**NEUROPLASTICITY IN PREFRONTAL REGULATION OF THE BASAL GANGLIA UNDERLIES VULNERABILITY TO RELAPSE**

*Peter Kalivas, Ph.D., 171 Ashley Ave, BSB410, Charleston, SC 29425*

**SUMMARY:**
The vulnerability to relapse can be characterized as an inability for addicts to use the negative contingencies associated with drug use (i.e. loss of family, job, etc) to inhibit drug seeking. The prefrontal cortex is responsible for integrating environmental contingencies with previous experience (memories) to initiate and guide adaptive behavioral responses via projections to the basal ganglia. A primary site of drug-induced impairment in this circuit is in the glutamatergic projection from the prefrontal cortex to the nucleus accumbens. Using animal models of relapse, drug seeking has been found to be associated with an imbalance between synaptic and nonsynaptic glutamate release, and this imbalance results in an inability of these synapses to undergo neuroplasticity. Thus, the projection from the prefrontal cortex to the accumbens that normally helps guide adaptive behavior demonstrates a marked deficit in the ability to undergo classic forms of neuroplasticity such as long-term potentiation, which may be the basis for why the prefrontal cortex has such difficulty in modifying habitual drug seeking in addicts. Importantly, restoration of the glutamatergic imbalance can be achieved by administering the cystine-glutamte exchange agonist N-acetylcysteine. Thus, repeated N-acetylcysteine treatment produces an enduring restoration of neuroplasticity in the prefrontal input to the accumbens that is paralleled by an enduring inhibition of relapse in animal models. Moreover, in preliminary double-blind clinical trials N-acetylcysteine has proven beneficial not only in cocaine and nicotine addiction, but also in treating other compulsive disorders such as gambling and trichotillomania. In this presentation we will review the primary findings supporting the role of the prefrontal projection to the accumbens in addiction, and how the restoration of neuroplasticity within this projection diminishes the vulnerability to relapse.

No. 86-E
**EMOTIONAL INFLUENCES ON MEMORY CIRCUITS IN POSTTRAUMATIC STRESS DISORDER AND HEALTHY ADULTS**

*Kevin LaBar, Ph.D., Box 90999, LSRC Building, Research Dr., Durham, NC 27708-0999*

**SUMMARY:**
Recent advances in functional neuroimaging have elucidated how emotional factors modulate learning and memory systems in the healthy brain. For instance, synergistic activity in the amygdala and the medial temporal lobe memory system boosts declarative memory for emotional events under moderate levels of arousal. However, when prepotent emotional signaling is not task-relevant, it can disrupt memory functions by detracting processing resources from goal-directed behaviors. Reciprocal interactions between dorsal frontoparietal and ventral frontolimbic regions mediate the active maintenance of goal-directed cognitive processing in the face of emotional distraction. In posttraumatic stress disorder, these mechanisms of emotional memory and resilience to emotional distraction are impaired via aberrant signaling in prefrontal-amygdala-hippocampal circuits. Neuroimaging studies investigating the effects of emotion regulation on reactivity and memory formation suggest possible routes of intervention though the implementation of cognitive strategies to restore the balance in these neural systems.

**SYMPOSIUM 87**

## ADVANCES IN PSYCHIATRIC ETHICS: NEW APPROACHES THAT INFORM PSYCHIATRIC PRACTICE

*Chairperson: Philip J. Candilis, M.D., 55 Lake Avenue North, Worcester, MA 01655,*
*Co-Chairperson: Jinger G Hoop, M.D., M.F.A.*
*Discussant: Laura W. Roberts, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, participants will be able to: 1) Identify recent trends in genetics, geriatric, child/adolescent, military, forensic, and general psychiatry that influence psychiatric ethics and practice; 2) Participants will recognize recent concerns for "vulnerability" among patients, for social justice in access to new treatments, and for new conflicts of interest among practitioners; a nd 3) Practitioners will learn specific skills for addressing these new ethical dilemmas.

**OVERALL SUMMARY:**
Recent advances in psychiatric treatment and research raise new concerns for the ethical boundaries of practice. From the development of new genetic markers to the early recognition of illness, from the requirements of military and forensic settings to the concerns for patients who are vulnerable because of age or impairment, modern psychiatry has evolved into a profession requiring facility with numerous ethical approaches and models. This symposium updates ethical scholarship in psychiatry by surveying advances in psychiatric thinking across the life cycle and across the different roles psychiatrists fulfill. Highlighting key ethical considerations raised by new findings in neurology and genetics, presenters will first frame evolving concerns with confidentiality, risk/benefit assessment, and social fall-out from identifying persons at risk with new and evolving scientific tools. Then, ethical considerations arising from the military and forensic setting will be addressed from the context of recent war-time controversies, from fitness-for-deployment dilemmas to an update on the use of mental health professionals in interrogations. The relevance to the ethics

of small communities and dual agency conflicts will be described. Further analysis of ethical problems from psychiatric research will be presented to assist practitioners in recognizing and addressing ethical problems in clinical practice, especially role conflicts (e.g., research vs treatment) and surrogate decision-making (e.g., for adolescents or elders).The rapid pace of research advances in neuroscience and genetics has given rise to a new field of study, neuroethics, which seeks to explore the moral questions that arise from our growing understanding of the biology of human behavior, cognition, and emotion. Brain-based technologies hold potential for improving many aspects of psychiatric care—enabling early diagnosis, more effective treatments, and even prevention. These innovations are accompanied by a wide range of ethical objections, however. Some may object on theological grounds—i.e., that these innovations are a type of "playing God." Others object due to concerns about the poorly understood risks of the technologies, or the potential impact on human dignity and society as a whole. Clinical psychiatry has much at stake in these ethical debates, because they are likely to shape public perceptions of emerging technologies and of the patients who use them. It has therefore become increasingly important for psychiatrists to be informed about neuroethics, as they have valuable expertise to offer as professionals with intimate knowledge of the human brain and mind. This presentation will briefly describe the emerging technologies and then focus on how the ethical issues surrounding them may complicate clinical care.

No. 87-A

**NEUROETHICS: AN INTRODUCTION FOR THE CLINICAL PSYCHIATRIST**

*Jinger Hoop, M.D., M.F.A., Department of Psychiatry and Behavioral MedicineMedical College of Wisconsin 8701 Watertown Plank Road, Milwaukee, WI 53226*

**SUMMARY:**

The rapid pace of research advances in neuroscience and genetics has given rise to a new field of study, neuroethics, which seeks to explore the moral questions that arise from our growing understanding of the biology of human behavior, cognition, and emotion. Brain-based technologies hold potential for improving many aspects of psychiatric care—enabling early diagnosis, more effective treatments, and even prevention. These innovations are accompanied by a wide range of ethical objections, however. Some may object on theological grounds—i.e., that these innovations are a type of "playing God." Others object due to concerns about the poorly understood risks of the technologies, or the potential impact on human dignity and society as a whole. Clinical psychiatry has much at stake in these ethical debates, because they are likely to shape public perceptions of emerging technologies and of the patients who use them. It has therefore become increasingly important for psychiatrists to be informed about neuroethics, as they have valuable expertise to offer as professionals with intimate knowledge of the human brain and mind. This presentation will briefly describe the emerging technologies and then focus on how the ethical issues surrounding them may complicate clinical care.

No. 87-B

**ETHICAL CONSIDERATIONS FROM MILITARY PSYCHIATRY**

*Christopher Warner, M.D., 373 Steeple Chase Lane, Richmond Hill, GA 31324*

**SUMMARY:**

Psychiatrists have been serving in uniform since World War I, caring for service members both in times of war and peace. In the early years, military psychiatrists perceived that the rationale for the military's activities sufficiently satisfied the criteria for a "just" war and saw little role conflict or moral dilemma associated with encouraging the service member-patient to return to combat. However, during the Vietnam War the psychiatric community began to debate the appropriate role for psychiatrists during time of war, especially for those serving in the military. At the root of this issue was the question, "for whom does the psychiatrist work - the individual service member-patient or the military organization?" This paper will review several key ethical challenges that military psychiatrists have been facing in ongoing military operations and how they may apply to general practice; including limits to confidentiality, informed consent, dual agency, establishing boundaries, detainee care, deployment fitness, use of psychotropic medications in the combat zone, and military separation. Discussions will focus on current and recent policy initiatives and evidence-based treatment practices aimed at reducing the ambiguity faced by military psychiatrists such as the U.S. Army's "Dealing with Detainee course" and the Army Medical Department's "Combat Operational Stress Course." The applicability of such developments to ethics of practice in small communities, to disability assessments in general, and to administrators or team leaders with responsibilities to their institutions will be addressed. Additional discussion will address the need for new ethical approaches to informed consent, to protecting confidentiality, to measuring outcomes of care, to medication use in the field or community, and training for mental health care providers who deal with similar ethical challenges.

No. 87-C

**WHAT DO FORENSIC ETHICS MEAN FOR GENERAL PSYCHIATRY?**

*Philip Candilis, M.D., 55 Lake Avenue North, Worcester, MA 01655*

**SUMMARY:**

Technically, generalists practice forensic psychiatry whenever they enter the public "forum"—hence the term "forensic." Civil commitments, guardianships, and courtroom testimony raise specific ethical issues that have been explored by modern forensic psychiatrists for the past 50 years. Commentators have struggled with the seminal question of who they serve, the law or medicine? It is the law, after all, that privileges psychiatric experts in the courtroom, but it is psychiatry that grounds them in the medical ethics of care and cure. This question has important implications for practitioners, the values that take precedence in their work, the definitions that are applied, and the goals that are most important. This paper reviews the newest developments in forensic ethics, from the advent of narrative ethics, the role of compassion, to the development of a "robust professionalism" that does more than meet minimal requirements for ethical practice. The weaknesses of strict role theory (where psychiatrists act merely within the parameters of a specific job-description or institutional role) are presented, including the inability to remove personal, community, or professional influences from one's work or to account satisfactorily for the subjectivities of historical, cultural, and professional influence.Specific habits and skills useful in general and forensic practice will be presented, from recognizing the vulnerabilities of patients/evaluees and being sensitive to role misperceptions to practicing self-reflection to overcome bias, openness and transparency to expose one's clinical or forensic thinking, and balance in integrating the values of individuals, professionals, and community.

No. 87-D

**RESEARCH ETHICS AND THE PRACTICING PSYCHIATRIST— THE BRAVE NEW WORLD OF RESEARCH IN ONE'S PRIVATE PRACTICE**

*Donna Chen, M.D., M.P.H., Box 800758, Charlottesville, VA 22908*

**SUMMARY:**

Consider the following: A psychiatrist is asked to join a research network and wonders if she should. Another psychiatrist tries to untangle research rules about parental permission, consent, and assent for an adolescent patient who is receiving psychotherapy without her parents' knowledge. Because much future research will occur in the offices of private–practice psychiatrists, practitioners need to know how to approach the ethical challenges of the rapidly changing world of research in psychiatry. Even psychiatrists who are not directly involved in research, will be asked for advice by patients or parents considering whether to enroll in a study they have found online or been recruited to by letters or advertising. Thus, it is becoming essential that all practicing psychiatrists understand the basics of research ethics. This talk will use case discussions to identify some important decision points for treaters, with emphasis on some of the unique ethical concerns that arise in this setting. Although the focus will be on private-practice settings, the concerns discussed, from conflicts of interest to laws of consent, are present in research conducted throughout psychiatry.

No. 87-E

**PSYCHIATRIC ETHICS THROUGH THE PRISM OF GERIATRIC RESEARCH**

*Sahana Misra, M.D., 3710 SW U.S. Veterans Hospital Road, Portland, OR 97239*

**SUMMARY:**

Geriatric psychiatry research seeks to elucidate the etiology, course, and modifying factors of mental disorders affecting older people and to develop treatment options with greater safety, tolerability and effectiveness than those currently available. With an aging population, and the prevalence of psychiatric illness in the older population expected to rise dramatically in coming decades, advances in geriatric psychiatry research are increasingly relevant. Clinical psychiatrists, while not directly involved in the conduct of research, may be called upon by older patients, families and researchers to weigh in on treatment issues and capacity of their patients to consent to research; and therefore, will benefit from an awareness of related ethical issues.

Ethical issues in the design, conduct, and monitoring of research involving older adults parallel similar issues in human subjects research and treatment generally. Yet a number of ethical issues relevant to geriatric psychiatry research merit special discussion. These pressing ethical issues include the assessment of decision-making capacity in populations where cognitive disorders are more prevalent, the role of surrogate decision makers, the legal status of surrogate consent, and the use of advanced directives.

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**SYMPOSIUM 89**

**AUTONOMY IN THE PROLONGATION AND CURTAILMENT OF LIFE**

*Chairperson: Norman B Levy, M.D., 1919 San Ysibro Drive, Beverly Hills, CA 90210*
*Co-Chairperson: James J Strain, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant will be able to: 1) Understand how patient autonomy in support groups may be a factor causing the prolongation of life of patients with metastatic cancer; and 2) Demonstrate knowledge of why and in what situation and setting intentional shortening of life in those undergoing chronic dialysis occurs, and the Judeo-Christian attitude toward

long prolongation and its early termination.

**OVERALL SUMMARY:**

This sympsoium epxolores the role of autonomy in extending life in patients with metastatic cancer as well as its role in curtailing and ending life when the stress of chronic and terminal illness holds no promise for the future. Specifically, the grandbreaking investigator, David Spiegel will present data of his study of 86 patients with metastatic breast cancer in which 90- minute support groups were associated with life extension. He postulates these outcomes to the result of patients utiilizing their autonomy to facilitate emotional expression, improving commuincation skills, dealing with fears of death and dying, reordering life prioritities and self- hyposis for pain control. In the converse situations, patients chose to end their lives as seen in those stopping treatment by dialysis for kidney failure and people suffering from irreversible terminal illness. Presenters will show clinical data of the life siturations and settings in which this occurs and its justifications. Concerning the ethics of these endeavors, a presentation will be made as to its Judeo-Christian underpinnings.Spiegel et al suggest that treatment, education, support may undo the need for avoidance behavior (one of which is suicide) in the terminally ill cancer patient. They propose that the National Comprehensive Cancer Network (NCCN) Palliative Care Guidelines offer an appropriate intervention. Spiegel has admonished the price others may have to pay when there is a suicide in their midst. We have no quarrel with the suggestions that care takers should: 1) treat psychiatric illness; 2) make every attempt to help patients adapt; 3) employ cognitive restructuring; 4) provide adequate pain control; and 5) enhance supportive bonds including the doctor–patient–relationship. A residual cohort remains who will want to end their lives by physician assisted suicide despite all these efforts. Mr. K. wanted to die as he could not tolerate his respirator dependent life and Palliative Care was willing to take him off the ventilator. The 42 year old man had pulmonary failure after a bone marrow transplant, demonstrated a clinical depression, had not been placed on the respirator unit with skilled personnel to see if he could be weaned, and never encouraged to see if he could manage with a respiratory depended life, e.g. go to the park, attend a movie theater or watch his 5 and 7 year old sons in the playground. His depression was treated, he was moved to the respiratory care unit without success, and attempts to get Christopher Reeves to talk with him did not materialize. After 6-8 weeks of enormous medical and psychological effort the patient still wanted to die. Palliative Care officiated in terminating his respirator after a last visit from his two young sons. The Patient Self-Determination Act which Congress passed November 5, 1990 gives patients the right to refuse or discontinue life-preserving medical treatment. This bill acknowledges that some persons in some circumstances, e.g., Mr. K above, consider continued living to be worse than death, and our commitments to liberty and respect for autonomy requires us to allow others to act on their own values. Respect for autonomy and "others" values offer a mentally competent individual the right to make the decision to end his/her life.

No. 89-A

**THE BALANCE BETWEEN SUICIDE AND AUTONOMOUS END-OF-LIFE DECISIONS: A MODEL BASED ON CHRONIC KIDNEY DISEASE AND DIALYSIS**

*Lewis Cohen, M.D., 51 Harrison Ave., Northampton, MA 01060*

**SUMMARY:**

Until recently refusal to submit to recommended care was considered to be suicide. Physicians must now decide how to respond to requests for hastened dying and whether these reflect autonomous decision-making. A four-square grid is proposed to distinguish true suicide from phenomena like autonomous treatment termination and lethal non-compliance. One axis characterizes whether actions hasten death. The other identifies how the deceased's social and medical network collaborate in the decision-making process. Using chronic kidney disease to model intent and collaboration, death is framed within a paradigm that reflects both end-of-life decision-making complexities and contemporary suicide conceptualizations. Approximately 300,000 American are maintained with dialysis, and there are 70,000 deaths within this population each year. Nationally, about one-in-five of the deaths are preceded by withdrawal of dialysis, although there are regional variations, i.e., in New England the figure is closer to one-in-three deaths. A demographic profile of patients who discontinue dialysis finds they are generally elderly, white, diabetic, and severely ill. Between one-third and one-half of the deaths likely occur in situations where patient capacity is impaired and family members or other proxies assist the medical team in arriving at the decision. Dialysis termination decisions are now aided by published guidelines.Death has become exponentially more complex as society wrestles with the dilemma that technological wizardry in sustaining life does not necessarily ensure acceptable quality of life, and one-sided paternalism no longer passes for reasonable clinical practice. Under the bioethical banner of autonomy, Americans are increasingly demanding to make their own choices about living and dying, and unfounded accusations of suicide will only exacerbate acrimony.

No. 89-B

**EXISTENTIAL RESILIENCE IN METASTATIC BREAST CANCER: CHOOSING LIFE WHILE FACING DEATH**

*David Spiegel, M.D., Room 2325 Department of Psychiatry*

*& Behavioral Studies 401 Quarry Road, Palo Alto, CA 94305-5718*

**SUMMARY:**
Cancer is an assault on autonomy in both physical and emotional terms. Some patients seek control over the course of their disease and their death by considering assisted suicide. Typically such requests are associated with a high rate of depression, and they change over time if the request is not granted. We investigated the relationship between psychosocial adaptation and medical outcome for 86 patients with metastatic breast cancer who participated in an earlier randomized psychosocial intervention study. The intervention consisted of weekly 90-minute support groups for one year aimed at enhancing group support, facilitating emotional expression, improving communication skills, dealing with fears of death and dying, reordering life priorities and self-hypnosis for pain control. All subjects received an initial psychosocial assessment involving six coping domains and six subscales of Profile of Mood States (POMS)and were reevaluated every 4 months for one year. Survival was assessed after ten years. Baseline existential coping was inversely associated with total mood disturbance ($r=-.46$, $p<.012$ for the treatment and $r=-.47$, $p<.019$ for the control group). Increased existential coping over time was correlated with an enhancement of vigor for the treatment group ($r=.39$, $p<.05$) and reduced anxiety for the control group ($r=-.53$, $p<.01$). For the control subjects, a decease in avoidance coping over the course of cancer was associated with an increase in vigor ($r=.73$, $p<.001$) and longer survival time ($r=-.52$, $p<.05$). Our results suggest that changes in psychosocial adaptation over the course of cancer may have a modulating effect on mood and survival and point toward a need to encourage cancer patients to face the threat of their illness and to mobilize their resources.We present the NCCN Palliative Care Guidelines regarding response to requests for assisted suicide as an appropriate response to the question of autonomy in suicide among cancer patients.

No. 89-C

## ETHICS AND JUDAO-CHRISTIAN VIEWS OF SUICIDE AND LIFE EXTENSION

*Norman Levy, M.D., 1919 San Ysibro Drive, Beverly Hills, CA 90210*

**SUMMARY:**
The underpinnings of Western ethics concerning this theme are grounded in Judeo-Christian attitudes toward death and dying. Both Christianity and Judiasm accord on the subject of life extention and agree t hat tall should be done that can be done to extend life. As to the premature curtailment of life the two religions generally agree with some differences. According to the theology of the Catholic Church, death by suicide is considered a grave or serious sin. The chief Catholic Christian argument is that one's life is the property of God and a gift to the world, and to destroy that life is to wrongly assert dominion over way is God's and is a tragic loss of hope. Conservative i.e. fundamentalist Christians have often argued that because suicide involves self-murder , then anyone who commits it is sinning and is the same as if the person murdered another human being.Judaism views suicide as one of the most serious of sins. Suicide has always been forbidden by Jewish law, except according to some interpreters of scirptors for three specific cases. If one is being forced by someone to commit murder, forced to commit an act of idolatry, or forced to commit adultery or incest, then in those cases alone would suicide be permissible. However, outside those cases, suicide is forbidden, and this includes taking part in assisted suicide. One may not ask someone to assist in killing themselves for two separate reasons: (a) killing oneself is forbidden, and (b) one is then making someone else an accomplice to a sin.

No. 89-D

## ETHICS IN SUICIDE NOT ASSOCIATED WITH PSYCHIATRIC ILLNESS

*James Strain, M.D., 1 G. L. Levy Place, NYC, NY 10029*

**SUMMARY:**
Spiegel et al suggest that treatment, education, support may undo the need for avoidance behavior (one of which is suicide) in the terminally ill cancer patient. They propose that the National Comprehensive Cancer Network (NCCN) Palliative Care Guidelines offer an appropriate intervention. Spiegel has admonished the price others may have to pay when there is a suicide in their midst. We have no quarrel with the suggestions that care takers should: 1) treat psychiatric illness; 2) make every attempt to help patients adapt; 3) employ cognitive restructuring; 4) provide adequate pain control; and 5) enhance supportive bonds including the doctor–patient–relationship. A residual cohort remains who will want to end their lives by physician assisted suicide despite all these efforts. Mr. K. wanted to die as he could not tolerate his respirator dependent life and Palliative Care was willing to take him off the ventilator. The 42 year old man had pulmonary failure after a bone marrow transplant, demonstrated a clinical depression, had not been placed on the respirator unit with skilled personnel to see if he could be weaned, and never encouraged to see if he could manage with a respiratory depended life, e.g. go to the park, attend a movie theater or watch his 5 and 7 year old sons in the playground. His depression was treated, he was moved to the respiratory care unit without success, and attempts to get Christopher Reeves to talk with him did not materialize. After 6-8 weeks of enormous medical and psychological effort the patient still wanted to die. Palliative Care officiated in terminating his respirator after a last visit from his two young sons. The Patient Self-Determination Act

which Congress passed November 5, 1990 gives patients the right to refuse or discontinue life-preserving medical treatment. This bill acknowledges that some persons in some circumstances, e.g., Mr. K above, consider continued living to be worse than death, and our commitments to liberty and respect for autonomy requires us to allow others to act on their own values. Respect for autonomy and "others" values offer a mentally competent individual the right to make the decision to end his/her life.

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1.Spiegel, D. Giese-davis, J Depression and cancer: mechanisms and disease progression. Biol Psychiatry:54(3)269-282, 2003

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## SYMPOSIUM 90

## NEW PERSPECTIVES ON INTERGENERATIONAL TRANSMISSION OF BPD

*Chairperson: John G Gunderson, M.D., 115 Mill Street, Belmont, MA 02478*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize the contributions of different types of research and to understanding transmission of BPD across generations; and 2) identify overlapping and distinctive characteristics of competing models.

**OVERALL SUMMARY:**

BPD is entering a new era where previous psychologically and environmentally based models about its etiology are being replaced by more complex models that include genetically-based vulnerabilities interacting with more interpersonally specific developmental stressors. This symposium recognizes a variety of these new models of BPD's etiology and the research on which they are based. This symposium's presenters use three difference data sources to shed new light on how BPD gets transmitted: John Livesley will use twin-data, Mary Zanarini, Lois Choi-Kain, and John Gunderson will use new family study data including deployment of a statistical method by which heritabilities can be estimated, and Peter Fonagy will use observations made of parent-child interactions. Each presenter will discuss what their data indicates might be the pre-borderline child's biological, psychological, or developmental signs of vulnerability and how that might have been acquired.

No. 90-A

### GENETIC AND ENVIRONMENTAL CONTRIBUTIONS TO BORDERLINE PERSONALITY DISORDER

*John Livesley, M.D., 2255 Wesbrook Mall, Vancouver, V64 1L1*

**SUMMARY:**

This paper will propose a model of borderline personality disorder based on the results of family and heritability studies. Data from twin studies will be presented showing that the disorder and constituent traits are highly heritable. The structure of genetic influences will be discussed based on the results of multivariate studies. These data suggest a complex genetic etiology to the disorder: although a general genetic factor appears to contribute to all borderline traits there are also genetic influences specific to each trait. Based on these findings, an evolutionary model of the disorder will be proposed that suggests that borderline traits are related to, and regulated by, an adaptive stystem that evolved to deal with threat. It will be argued that borderline personality disorder involves dysfunction in the threat meanagement system due to a combination of genetic and environmental factors. The model with be used to explore the interplay between genetic and psychosocial factors in the development of borderlne pathology and the factors that account for observed transmission across generations.

No. 90-B

### FAMILIAL AGGREGATION AND HERITABILITY OF BORDERLINE PERSONALITY DISORDER AND ITS COMPONENT TRAITS

*Mary Zanarini, Ed.D., McLean Hospital 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**

Objective: The purpose of the study was to assess the familial aggregation of BPD, using two sets of diagnostic criteria, and its core component traits of affective instability, impulsivity, and interpersonal instability. Method: The sample consisted of three groups of female probands (BPD [N=132], non-BPD [N=134], and major depression [N=102], either with [N=15] or without BPD [N=87]) and their first-degree relatives (N=314, N=337, and N=234, respectively). All participants were personally interviewed using semi-structured interviews of demonstrated reliability to assess the lifetime diagnosis of BPD by DIB-R and DSM-IV criteria and the presence of affective instability, impulsivity, and interpersonal instability. Relatives were assessed while blinded to proband status. Results: Among the 348 relatives of probands with BPD, 47 (13.5%) met both DIB-R and DSM-IV criteria for BPD vs. only 32 (6.0%) of the 537 [337 from non-BPD proband group; 200 from MDD group] relatives of non-BPD probands. The risk ratio for familial aggregation was high and statistically significant: 2.8. The results were almost the same when only the DIB-R criteria for BPD in a relative were considered (risk ratio of 2.7). By contrast, 16.7% of the relatives of probands with BPD and 12.1% of the

relatives of probands without BPD met DSM-IV criteria for BPD, with a risk ratio of 1.5. The component traits all showed significant familial aggregation, with estimated increases in level of trait of 0.23 for affective instability, 0.16 for impulsivity, and 0.21 for interpersonal instability. The heritability estimates were: 55% for BPD meeting both DIB-R and DSM-IV criteria; 48% for affective instability, 34% for impulsivity, and 45% for interpersonal instability. Conclusion: The results of this study demonstrate that BPD and its core component traits, particularly as defined by the more specific DIB-R criteria, aggregate strongly in families, with substantial heritability.

No. 90-C

**REJECTION SENSITIVITY AS A CORE TRAIT OF BORDERLINE PERSONALITY DISORDER**

*Lois Choi-Kain, M.D., M.Ed., 115 Mill Street,, Belmont, MA 02478*

**SUMMARY:**

Though rejection sensitivity (RS) is not a diagnostic criterion of borderline personality disorder (BPD), it is considered a core trait of the disorder. Clinical experience and research suggest that individuals with BPD tend to interpret minor interpersonal disagreements and conflicts as personal attacks and react to them by engaging in self-destructive impulsive behaviors (Downey & Feldman, 1996; Klonsky et al., 2003; Ayduk et al., 2008). Attachment literature proposes that early experiences of rejecting responses by caregivers may be the root of this perpetuated sensitivity to rejection. Data collected in the Family Study of Personality was used to evaluate the hypotheses that 1) RS (as measured by the RS Questionnaire (RJSQ; Gunderson, 2003) is associated with BPD, 2) RS is associated with dismissing attachment style (as measured by the Relationship Questionnaire (RQ; Bartholomew and Horowitz, 1991) which has been associated with rejecting caretaking experiences, and 3) RS is influenced by familial factors, as reflected by a significant familial aggregation and heritability. We found that RS 1) was associated with BPD (? = 0.34; difference [95% CI] in RJSQ between individuals with and without BPD: 0.5 [0.3, 0.7], $p < 0.001$); 2) was positively associated with preoccupied style ($r = 0.46$; change in RJSQ for each 1-unit increase in RS: 1.2 [1.0, 1.3], $p < 0.001$) and fearful style ($r = 0.38$; 1.1 [0.9, 1.3], $p < 0.001$), was negatively associated with secure style ($r = -0.0.25$; -0.7 [-0.9, -0.5], $p < 0.001$), and was only weakly associated with dismissing style ($r = 0.08$; 0.2 [-0.01, 0.4], $p = 0.067$); and 3) aggregated in families (change in RJSQ in a relative for each 1-unit increase in RJSQ in a proband: 0.08 [0.00, 0.16], $p = 0.052$) with modest heritability (19%); familial aggregation was independent of the familial aggregation of BPD, as assessed by an analysis that controlled for the presence of BPD in probands and relatives (change in RJSQ in a relative for each 1-unit increase in RJSQ in a proband: 0.07 [-0.01, 0.15], $p = 0.094$). These results suggest that RS is associated with BPD and that it is caused in part by familial factors that are independent from those causing BPD. Our results did not support the hypothesis that there is a close relationship between RS and the dismissing attachment style.

No. 90-D

**FAMILIALITY OF CANDIDATE PHENOTYPES**

*John Gunderson, M.D., 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**

Whether personality traits observed in borderline patients reflect underlying genotypes and can thereby be considered as key intermediary variables can be tested then by examining whether the traits aggregate in families and by examining whether they aggregate more in relatives of BPD probands than in relatives of probands without BPD. This presentation will report on the familiality of seven personality traits measured by self reports, Assessment of Personality Problems – Basic Questionnaire (DAPP-BQ), each considered to be potential marker of vulnerability to BPD using the dimensional, i.e., affective instability, stimulus seeking, deliberate self-harm, insecure attachment, anxiousness, cognitive dysregulation, and suspiciousness. All traits aggregated in families except stimulus seeking, and cognition coaggregated more in families of BPD probands. Estimated heritabilities for the traits were all moderate to modest, ranging from a high of 40% (anxiousness) to a low of 19% (insecure attachment and deliberate self-harm). These results only inconsistently confirm results attained from interview-based measures and with results attained when traits were assessed with previous studies of heritability (Jang et al. 2003). Reasons for this will be explored.

No. 90-E

**INFANTILE HYPERSENSITIVITY TO THE SOCIAL ENVIRONMENT AND POTENTIAL DEVELOPMENTAL FAILURE IN AFFECT REGULATION, EFFORTFUL CONTROL AND MENTALIZATION**

*Peter Fonagy, Ph.D., University College London, Gower Street, London WC1 6BT, London, WC1 6BT*

**SUMMARY:**

Evidence is strong for genetic vulnerability in the etiology of BPD and some early speculations concerning psychosocial causation based on retrospective evidence have appropriately been brought into question. Does the absence of strong shared environmental effects in the behavior genetics models imply lack of parenting influence? In our view, behavior genetics data across a range of domains of inquiry call for more subtle psychosocial models where specific social influences are seen to interact

with genetic vulnerabilities that are coded for specific types of environmental influence. The presentation will present a developmental model of affect regulation which we consider to be critical in generating the social hypersensitivity that may be a core feature of borderline personality disorder. The presentation will present evidence from experimental studies of infant development consistent with these ideas and link the notion of a biologically coded environmental hypersensitivity to failures of social development assumed in mentalization based treatment model for BPD.

**REFERENCES:**

1. Livesley John: Theoretical models of borderline personality disorder; Part II, Introduction. J Personal Disord 22(1):1-3, 2008

## SYMPOSIUM 91

## NEW CANMAT GUIDELINES FOR DEPRESSION AND BIPOLAR DISORDER: COMBINING EVIDENCE WITH CLINICAL PRACTICE

*Chairperson: Roumen V Milev, M.D., Ph.D., 752 King Street West, Kingston, K7L 4X3 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize the CANMAT role in developing evidence-based clinical guidelines; 2) Identify the new aspects of the guidelines for treatment of Major Depressive Disorder; and 3) Identify the new aspects of the guidelines for treatment of Bipolar Disorder.

**OVERALL SUMMARY:**

Canadian Network for Mood and Anxiety Treatment (CANMAT) was formed in 1995 and established itself as a leading research and educational organization. In 2009, the update for the second edition of Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with Bipolar Disorder: Update 2009 (ref # 1: Yatham LN, Kennedy SH, Schaffer A, et al., Bipolar Disorders 2009; 11:225-255.) was updated. Also, the second edition of the Canadian Network for Mood and Anxiety Treatment (CANMAT) Clinical guidelines for the management of Major Depressive Disorder in adults was published (ref 2: Kennedy SH, Lam RW, Parikh SV, et al, J Affect Dis 2009; 117:S1-S2). This symposium will focus on these 2 new sets of guidelines and will illustrate how evidence-based psychiatry combines with clinical practice.

No. 91-A

### CANMAT CLINICAL GUIDELINES FOR MOOD & ANXIETY DISORDERS – HISTORY AND DEVELOPMENT

*Sidney H. Kennedy, M.D., 200 Elizabeth Street, EN8-222, Toronto, M5G 2C4*

**SUMMARY:**

In 2001, the Canadian Network for Mood and Anxiety Treatments (CANMAT), a not-for-profit scientific and educational organization, published the first Canadian guidelines for the management of Major Depressive Disorder (MDD) and Bipolar Disorder. The revisions to these recommendations started with meetings among the CANMAT working committee 2008, and have culminated into the published depression guidelines (Kennedy et al, 2009) and bipolar guidelines (Yatham et al, 2009). This presentation will review the development of the current depression guidelines, which are comprised of 5 sections: 1) Classification, burden and principles of management; 2) Psychotherapy alone or in combination with antidepressant medication; 3) Pharmacotherapy; 4) Neurostimulation therapies; and 5) Complementary and alternative medicine treatments. Systematic literature searches were conducted to identify relevant studies between January 1, 2000 to December 31, 2008. Level 1 evidence requires at least 2 randomized controlled trials (RCTs) with adequate samples sizes, placebo control, and/or a meta-analysis with narrow confidence intervals. Levels of evidence for recommendations are based on criteria from the 2001 guidelines, but now also include consensus opinions about quantitative reviews. In addition recommendations, are graded depending on a treatment's balance of efficacy, tolerability and clinical support. The guidelines are comprehensive in the varieties of treatments assessed, although there are more data available for psychotherapeutic and pharmacologic interventions in comparison to complementary and alternative treatments. For this reason, first-line psychotherapy or pharmacotherapy recommendations usually should be considered before neurostimulation or complementary therapies. These guidelines, if applied correctly, have the potential to add considerable value to the management of depression in primary and tertiary care.

No. 91-B

### CANMAT CLINICAL GUIDELINES FOR MANAGEMENT OF ADULTS WITH MAJOR DEPRESSIVE DISORDER

*Raymond Lam, M.D., 2255 Wesbrook Mall, Vancouver, V6T 2A1*

**SUMMARY:**

Objectives: Since 2001, when the first Canadian guidelines for depressive disorders was published, there has been significant progress in the management of major depressive disorder (MDD), including the advent of larger scale effectiveness trials to bridge the gap between pristine trials and daily clinical practice. This presentation will feature highlights from the 2009 major update of the CANMAT

depression guidelines, especially those that differ from other guidelines.Methods: A systematic literature search identified relevant studies with an emphasis on meta-analyses. Levels of Evidence were specified for recommendations, which were then graded according to Line of Treatment, where first-line treatment represents a balance of efficacy, tolerability and clinical support (referring to application of CANMAT expert opinion to ensure that interventions are realistic and applicable for clinical practice).Results: Of the 5 sections of the guidelines, the first deals with prevalence, burden and principles of management. The psychotherapy section focuses on "traditional" psychotherapies (e.g., CBT, IPT), emerging treatments (e.g., mindfulness-based approaches) and novel methods of delivery (e.g., internet-delivered CBT). The pharmacotherapy section focuses on comparative efficacy and tolerability among first-line antidepressants, add-on/adjunctive strategies to manage patients with incomplete response, and sequencing of pharmacotherapy. Two novel sections deal with neurostimulation therapies (ECT, VNS, rTMS and DBS) and the evidence and cautions for Complementary and Alternative Medicine treatments. Conclusions: There is good evidence to support efficacy of many treatments for MDD, but still limited information about the comparative efficacy of treatments and their optimal sequencing, especially in real-world clinical populations. Although the evidence base is the foundation for treatment selection, treatment choice must still be tailored for an individual patient.

No. 91-C

**CANMAT GUIDELINES FOR MANAGEMENT OF BIPOLAR DEPRESSION**

*Lakshmi Yatham, M.B.B.S, UBC Hospital, Vancouver, V6T 2A1*

**SUMMARY:**

Introduction: Although there is international consensus on guidelines for management of acute mania and prophylaxis of bipolar disorder, there continues to be wider disagrements about guidelines for managing bipolar depression. This presentation will outline the guidelines developed by the Canadian Network for Mood and Anxiety Treatments (CANMAT) group in collaboration with experts from the International Society for Bipolar Disorders (ISBD). Method: The strenght of evidence for each treatment was ranked in categories ranging from category 1 to 4 with category 1 being the best evidence as indicated by data from replicated double blind placebo controlled trials. The evidence was then translated by the group to clinical recommendations ranging from first line to not recommended categories and this took into account the evidence for efficacy, support for efficacy from clinical practice, and safety considerations.Results: The controversy was related mainly to use of antidepressants and lamotrigine. However, based on the above criteria, the group reached consensus that there is sufficient evidence to recommend Llithium, lamotrigine and quetiapine monotherapy, olanzapine plus SSRI, and lithium or divalproex plus SSRI/bupropion as first line options. New data support the use of adjunctive modafinil as a second line ption, and current evidence suggest that aripiprazole should not be used as monotherapy for bipolar depression. Conclusions: These recommendations are in contrast to other guidelines which do not recommend antidepressants and lamotrigine as first line treatments.

No. 91-D

**COMBINING EVIDENCE-BASED PSYCHIATRY WITH CLINICAL PRACTICE – CANMAT AND OTHER RECENT GUIDELINES**

*Sagar Parikh, M.D., Toronto*

**SUMMARY:**

Objectives: Treatment guidelines for psychiatric disorders have been created for many years, but uptake of these guidelines has often been disappointing. Methods: The Canadian Network for Mood and Anxiety Treatments (CANMAT) has issued multiple guidelines for Major Depressive Disorder and for Bipolar Disorder over the past 13 years. These guidelines were compiled and reviewed for development and format evaluation, as well as for dissemination strategies.Results: In order to make these guidelines useful in clinical practice, CANMAT guidelines have used a variety of strategies, starting from the way evidence is rated and including different ways of presenting guidelines in articles. In addition, multiple dissemination techniques have been employed, including mail-outs of standard guideline articles, adoption of formats from other areas of medicine, linking dissemination to government-led distribution of multiple therapeutic guidelines, live CME events, DVDs, newsletters, and on-line events. Qualitative feedback on various approaches was obtained. Conclusions: CANMAT used a variety of guideline designs to enhance clinical utility, and coupled these with a range of dissemination tactics, that resulted in improved uptake of these guidelines

**REFERENCES:**

1.Yatham LN, Kennedy SH, Schaffer A, et al. Canadian Network for Mood & Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: Update 2009. Bipolar Disorder 2009; 11:2225-255.

2.Kennedy SH, Lam RW, Parikh SV, Patten SB, Ravindran AV. Canadian Network for Mood & Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. J of Affect Dis 2009; 117:S1-S2.

**SYMPOSIUM 92**

## UPDATE ON CANNABIS USE DISORDERS

*Chairperson: David A Gorelick, M.D., Ph.D., NIDA IRP, Baltimore, MD 21224*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize patients at high risk for cannabis use disorders; 2) Identify effective, evidence-based psychosocial and pharmacological approaches for treatment of patients with cannabis use disorders; 3) Understand how cannabis acts in the brain to produce its behavioral effects and 4) Recognize common medical and psychiatric effects associated with cannabis use.

**OVERALL SUMMARY:**
This symposium provides the audience with the latest information on the epidemiology of cannabis use disorders in the US, how cannabis acts in the brain to produce its effects, evidence-based psychosocial and pharmacological treatments for cannabis use disorders, and the major medical and psychiatric comorbidities associated with cannabis use. Dr. Hasin will present results of a large epidemiological study (NESARC) that identified risks factors, symptom structure, and comorbidity for the prevalence and persistence of marijuana abuse and dependence in the general US population. Dr. Weinstein will review the neurobiology of cannabis effects in the brain, including the interaction of its primary psychoactive constituent, THC, with the cannabinoid CB1 receptor and results of fMRI and PET imaging studies in cannabis users. Dr. Budney will review evidence for effective psychosocial treatment of cannabis use disorders, including motivational enhancement therapy, cognitive-behavioral therapy, abstinence-based reinforcement, computer-assisted therapy, and multi-component treatment. Dr. Haney will review evidence for pharmacological treatment, including promising approaches such as agonist substitution. Dr. Gorelick will review the recognition and management of major medical and psychiatric effects associated with cannabis use, including pulmonary disorders and psychotic disorders such as schizophrenia. At the conclusion of this symposium, the audience should have up-to-date information to better diagnose and treat patients with cannabis use disorders.

No. 92-A
### MARIJUANA ABUSE AND DEPENDENCE IN THE GENERAL POPULATION: RISK FACTORS, SYMPTOM STRUCTURE, AND AXIS I AND AXIS II COMORBIDITY EFFECTS ON PERSISTENCE

*Deborah S. Hasin, Ph.D., 1051 Riverside Drive, Box 123, New York, NY 10032*

**SUMMARY:**
BACKGROUND. Until recently, little was known about the epidemiology of marijuana abuse and dependence. Waves 1 and 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) have provided a considerable amount of specific information, including demographic and psychiatric risk factors, information on the relationship of abuse to dependence criteria, the presence of a marijuana withdrawal syndrome, and Axis I and II predictors of persistent marijuana dependence between Wave 1 (2001-2002) and Wave 2 (2004-2005) three-year follow-up. METHOD. At Wave 1, 43,093 adult residents of households and group quarters were interviewed. Three years later, 34,654 of these participants were re-interviewed. Statistical procedures included logistic regression, factor and item response theory (IRT) analyses. RESULTS. Cannabis disorders were more likely among males, young adults and those living in the Western U.S. A cannabis withdrawal syndrome was demonstrated among frequent cannabis users. Factor and IRT analyses showed that DSM-IV cannabis abuse and dependence criteria form a unidimensional variable, with abuse and dependence criteria intermixed across the severity spectrum. Axis I disorders current at Wave 1 did not predict persistence of marijuana dependence at Wave 2. However, several personality disorders significantly predicted 3-year persistence of marijuana dependence, including antisocial, borderline, and schizotypal personality disorders, which all more than doubled the risk for persistence. CONCLUSIONS. A decision to combine abuse and dependence into a single category is supported by NESARC evidence, as is a decision to add marijuana withdrawal. Personality disorders should be considered in prevention efforts, and in addressing ways to reduce the persistence of marijuana dependence once it has occurred.

No. 92-B
### NEUROBIOLOGY AND BRAIN IMAGING OF CANNABIS DEPENDENCE

*Aviv Weinstein, B.S.C., Ph.D., Ein Kerem, Jerusalem, 91120*

**SUMMARY:**
The principal psychoactive compound of cannabis, delta-9-tetrahydrocannabinol (THC) acts on cannabinoid CB1 receptors in frontal, association, and limbic regions in the brain which mediate neurobehavioral and cognitive function. Regular use of cannabis is associated with deficits of learning, memory, and attention. Heavy cannabis use may damage short-term memory, visual scanning, and attention. Studies with functional magnetic resonance imaging (fMRI) have found no evidence for long-term deficits in working memory and attention in cannabis users, but have shown residual altered brain activity during working memory processing, which may indicate compensatory mechanisms. Acute use of marijuana is associated with impairment of motor skills and may affect driving safety. Brain imaging studies

using positron emission tomography (PET) have shown reduced metabolism in auditory, visual, and attention areas reflecting perceptual and cognitive alterations during acute cannabis intoxication. We studied the acute effects of THC on cognitive-motor tasks and associated brain metabolism in 12 regular cannabis users who underwent 2 PET scans using [18F] fluorodeoxyglucose (FDG) after smoking cigarettes with 17 mg THC or non-THC in a double blind placebo controlled study. A virtual reality maze task requiring attention and motor coordination was performed during each scan. Subjects hit the maze walls more often after THC than after non-THC. THC increased brain metabolism during task performance in areas mediating motor coordination and attention in the middle and medial frontal cortices and anterior cingulate and reduced metabolism in areas mediating visual integration of motion in the occipital and parietal lobes. These findings suggest that, in regular cannabis users, acute effects of marijuana may impair cognitive-motor skills and brain mechanisms that modulate coordinated movement and may affect driving safety. Funded by the Israeli Anti Drug Authority.

No. 92-C

**ADVANCES IN THE DEVELOPMENT OF BEHAVIORAL TREATMENTS FOR CANNABIS USE DISORDERS**

*Alan Budney, Ph.D., 4301 W. Markham, Slot 843, Little Rock, AR 72206*

**SUMMARY:**

Cannabis use disorders (CUD) pose a public health problem perhaps best recognized by the fact that the number of individuals enrolled in treatment for cannabis is comparable to the number seeking treatment for cocaine or heroin. Although the concept of dependence in relation to cannabis is questioned in some quarters, diagnostic, epidemiological, and laboratory studies clearly indicate the existence, importance, and potential for harm of CUD. Fortunately, well-specified behavioral treatments for CUD engender comparable outcomes to those achieved with treatments for other types of substance dependence. A succinct review of the seminal clinical trials will illustrate the growing evidence-based findings to support this statement. In particular, details and limitations of studies demonstrating the efficacy of the current "gold standard", i.e., a multi-component intervention comprising motivational enhancement therapy, cognitive-behavioral therapy, and abstinence-based reinforcement, will be discussed. In addition, preliminary findings from trials examining innovative clinical strategies for CUD, e.g., computer-assisted therapies and post-treatment check-up interventions, will provide a look at the most recent advances in the application of behavioral interventions to enhance the potency and cost effectiveness of treatments for CUD. In summary, this presentation will illustrate and critically appraise the continued systematic effort to develop and make available cost-effective behavioral treatment interventions for CUD. Although research-based interventions have been effective, three important limitations to translation must be addressed: (1) the availability of effective treatments; (2) cost of the most effective treatments; and (3) the continued need to reduce the substantial rate of treatment failures and relapse.

No. 92-D

**ADVANCES IN THE DEVELOPMENT OF PHARMACOLOGICAL TREATMENTS FOR CANNABIS USE DISORDERS**

*Margaret Haney, Ph.D., 1051 Riverside Drive, #120, New York, NY 10032*

**SUMMARY:**

Cannabis is the most frequently used illicit drug worldwide, and treatment admissions for cannabis use disorders have risen considerably. While psychosocial strategies have been shown to improve treatment outcome, relapse rates remain high. There is no FDA-approved medication for the treatment of cannabis dependence, and developing pharmacological interventions to improve treatment options is a priority. Double-blind, placebo-controlled, laboratory studies of potential pharmacotherapies in combination with active and placebo marijuana will be presented. One strategy for medications development is to block cannabis directly with the cannabinoid receptor antagonist, rimanobant. Another strategy is to reduce marijuana withdrawal. Abstinence from daily cannabis smoking can produce irritability, anxiety and disrupted sleep, and the resumption of cannabis smoking alleviates these symptoms. Bupropion and divalproex have been shown to worsen mood during abstinence, while nefazodone alleviates only a subset of withdrawal symptoms. The most effective medication to date to decrease symptoms of withdrawal has been substitution with the CB1 receptor agonist, dronabinol (synthetic THC). More recent studies testing medication effects on both withdrawal and relapse have shown that the anti-hypertensive, lofexidine, in combination with dronabinol, significantly decreased both cannabis withdrawal and relapse. The effects of baclofen, mirtazapine, and quetiapine on withdrawal and relapse will also be discussed. Thus, more treatment options for cannabis dependence are needed. Although cannabis has lower abuse liability than most other abused drugs, its prevalence results in a subset of individuals who are unable to achieve abstinence without treatment. Results from controlled laboratory studies indicate that dronabinol, lofexedine, and possibly rimonabant may have therapeutic benefit for those seeking treatment for cannabis-related problems.

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No. 92-E
**MEDICAL AND PSYCHIATRIC EFFECTS ASSOCIATED WITH CANNABIS USE**

*David Gorelick, M.D., Ph.D., NIDA IRP, Baltimore, MD 21224*

**SUMMARY:**
Cannabis is used by almost 165 million people around the world, putting users at risk for a variety of medical and psychiatric effects. Recent large-scale cross-sectional and prospective longitudinal studies, as well as growing knowledge about the mechanisms of cannabis effects on the body and the role of endogenous cannabinoid systems, have greatly improved our understanding of these effects. Risk of adverse effects depends on many factors related to both the cannabis agent (including frequency and intensity of use, potency of preparation, route of administration) and vulnerabilities of the user (including age of exposure, genotype). Prenatal cannabis exposure is associated with subtle impairment in working memory, attention, and abstract reasoning in childhood and young adulthood. Adolescent cannabis use is associated with impaired attention, even with extended abstinence. Early cannabis use (before age 17) is associated with increased risk of schizophrenia (greater in those with the high-activity allele of the COMT gene) and suicide attempt; the evidence is less clear-cut for depression and mania. In adults, acute cannabis smoking is associated with bronchodilation, while chronic use is dose-dependently associated with impaired large airway function: one joint has a similar effect to 2.5-5 tobacco cigarettes. Cannabis smoking has been associated with increased rates of lung cancer and increased risk of death after acute myocardial infarction. Patients with schizophrenia have higher rates of cannabis use (25-75%) than the general population. Such use is associated with greater positive symptoms and poorer treatment outcome. One study in patients with psychosis found cannabis use associated with weight gain and elevated blood glucose levels, suggesting an increased risk for metabolic problems. These findings indicate that cannabis use, especially at a young age or in people with psychiatric comorbidity, may cause specific adverse health consequences.

**REFERENCES:**
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2.Benyamina A, Lechacheux M, Blecha L, Reynaud M, Luka-ciewcz M: Pharmacotherapy and psychotherapy in cannabis withdrawal and dependence. Expert Rev Neurotherapeutics 2008; 8:479-491.

**SYMPOSIUM 93**

**CULTURAL ADAPTATION OF COGNITIVE BEHAVIOUR THERAPY FOR ETHNIC/MINORITY PATIENTS**

*Chairperson: Stephen M. Goldfinger, M.D., 450, Clarkson Avenue, Box 1203, Brooklyn, NY 1120,*
*Co-Chairperson: Shanaya Rathod, M.D.*
*Discussant: Toshiaki A. Furukawa, M.D., Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the need to culturally adapt Cognitive Behaviour Therapy to facilitate engagement and improve outcomes in patients from ethnic minority communities; 2) Recognize themes and adaptations of therapy that are specific to certain cultures and which impact on treatment when interacting with patients from these communities

**OVERALL SUMMARY:**
Engaging 'difficult to treat" severely ill patients can have many meanings, and foster many interventions. Difficulties in engagement, and poor treatment outcomes, have been reported for many racial, ethnic and other minority/underrepresented populations with severe mental illness. Cognitive behaviour therapy (CBT) is a widely used, effective and acceptable therapy for many psychiatric disorders, but explanations and techniques used in CBT are based on Western concepts and illness models. This modality, however, is now increasingly being recognized as viable, with robust outcomes, across a variety cultures if appropriately adapted. This Symposium, bringing together academics and clinicians with roots, and practices, in several continents will provide a cutting edge view of the application of CBT principles in diverse groups. The evidence to support cultural adaptation will be explored in the symposium as will problems associated with using therapy that is not culturally sensitive and appropriately adapted. Dissemination of cognitive therapy across widely diverse cultures is increasingly occurring. The evidence to support this is explored and updates on adaptations from different countries is discussed.The participants will discuss with the audience the need to develop therapies and manuals which are culturally appropriate and sensitive to the needs of ethnic minority populations leading to more balanced range of effective psychological treatments. The symposium will focus on current and completed research conducted in US, UK, Pakistan, China and Japan and invite contributions from the audience on their experiences elsewhere. As the literature on treatment outcomes with CBT continues to grow, the critical importance of adapting this technology to new populations becomes more critically important. We believe that benefits of this treatment approach can and will be realised at different levels: more effective and earlier engagement leading to early treatment response, leading to fewer admissions, improved adherence and enhanced satisfaction with services. Patients across the globe have come to accept, and been noted to respond, to CBT; our hopes are that the ideas and findings presented in

this symposium will enhance patient choice and clinician repertoire in this important treatment option.Background: Compared to their white counterparts, patients from minority ethnic groups with Schizophrenia are likely to be misunderstood and misdiagnosed and more likely to be treated with drugs and ECT rather than psychotherapy. There is a higher rate of involuntary admissions and dissatisfaction with the services among this group with psychosis. These problems would appear to principally stem from communication problems in relation to mental health. Studies in schizophrenia have shown cognitive behavioural therapy (CBT) to be of benefit in the treatment of positive symptoms and negative symptoms. However the outcome in African Caribbean patients has not been as good as white counterparts (Rathod 2005) Aim: The main aim of the study is to produce a culturally sensitive adaption of an existing CBT manual that is (a) well suited to the needs of clients with psychosis from three specified ethinic minority communities (Black Caribbean, Bangladeshi and Pakistani) and (b) is accompanied by guidance for health professionals to enable them to deliver CBT that is culturally sensitive and responsive for clients with psychosis from these communties.Methodology: The study has been conducted in 2 centres in the UK: Hampshire and London. It adopts an overarching qualitative methodology including face-to-face in-depth semi-structured interviews and focus groups.Results: A total of 114 participants were interviewed for the study. Interviews have been conducted until themes have been saturated. 20 Face to face interviews and 16 focus groups have been conducted. NVivo 8 (computer-assisted qualitative data analysis software) was used to manage and explore qualitative data in-depth. ConclusionThis study has important implications in the development of culturally sensitive and responsive therapies for psychiatric disorders. These will be discussed in detail.

No. 93-A

**COGNITIVE BEHAVIOUR THERAPY ACROSS CULTURES**

*David Kingdon, M.D., University of SouthamptonRoyal South Hants Hospital Brintons Terrace, Southampton, SO14 0YG*

**SUMMARY:**
Background: There is a literature demonstrating that people from non-white backgrounds are less likely to receive psychotherapy and more likely to be hospitalised involuntarily. Evidence merging from a multi-site multi-cultural study of CBT in psychosis in the UK raised our concerns that individuals from non-white groups were benefiting less from CBT than their white counter-parts. Aim: to discuss experiences of using and teaching CBT across different cultures. Methodology: Differences in presentation and use of CBT, particularly focussing on psychosis in US, UK, China & Japan will be discussed arising from experience in research studies in those countries. The program of research now specifically addressing these issues will be outlined. Conclusion: There are important adaptations that need to be made to CBT when applied in different cultural settings Although the individualised, collaborative approach inherent in CBT can facilitate this, knowledge of the individuals' background and models of illness can assist in engagement and mutual understanding and specific considerations (e.g. variability in family involvement) and techniques (e.g. using cultural texts, terminology and rituals) can improve outcomes.

No. 93-B

**DEVELOPING CULTURALLY SENSITIVE COGNITIVE BEHAVIOUR THERAPY FOR PSYCHOSIS: –A UNITED KINGDOM BASED STUDY**

*Shanaya Rathod, M.D., Hampshire Partnership NHS Trust, Melbury Lodge,, Winchester, SO22 5DG*

**SUMMARY:**
Background: Compared to their white counterparts, patients from minority ethnic groups with Schizophrenia are likely to be misunderstood and misdiagnosed and more likely to be treated with drugs and ECT rather than psychotherapy. There is a higher rate of involuntary admissions and dissatisfaction with the services among this group with psychosis. These problems would appear to principally stem from communication problems in relation to mental health. Studies in schizophrenia have shown cognitive behavioural therapy (CBT) to be of benefit in the treatment of positive symptoms and negative symptoms. However the outcome in African Caribbean patients has not been as good as white counterparts (Rathod 2005) Aim: The main aim of the study is to produce a culturally sensitive adaption of an existing CBT manual that is (a) well suited to the needs of clients with psychosis from three specified ethinic minority communities (Black Caribbean, Bangladeshi and Pakistani) and (b) is accompanied by guidance for health professionals to enable them to deliver CBT that is culturally sensitive and responsive for clients with psychosis from these communties. Methodology: The study has been conducted in 2 centres in the UK: Hampshire and London. It adopts an overarching qualitative methodology including face-to-face in-depth semi-structured interviews and focus groups. Results: A total of 114 participants were interviewed for the study. Interviews have been conducted until themes have been saturated. 20 Face to face interviews and 16 focus groups have been conducted. NVivo 8 (computer-assisted qualitative data analysis software) was used to manage and explore qualitative data in-depth. Conclusion This study has important implications in the development of culturally sensitive and responsive therapies for psychiatric disorders. These will be discussed in detail.

No. 93-C

**DEVELOPING CULTURALLY-SENSITIVE CBT PROJECT, SOUTHAMPTON: ADAPTATION OF CBT FOR DEPRESSION IN PAKISTAN**

*Farooq Naeem, M.R.C., Southampton University, Southampton, SO14 3ED*

**SUMMARY:**
While CBT has evolved over the past many years in the West and now has an established evidence base, it is hardly practised in non western cultures. This study was performed as part of "Developing Culturally-Sensitive CBT Project" at Southampton, in which we have developed methods to modify CBT for use in non-western cultures in the UK using Pakistan as an example. This was a two stage mixed method project whose aim was to establish whether cognitive behavioural therapy can be an acceptable, accessible and effective treatment for depression in a developing country. We also wanted to develop a method which could be followed to adapt CBT in any given culture. In the first stage interviews with psychologists, patients and university students were conducted. A frame work was developed on the basis of these studies as well as field observations by FN. The frame work was used to modify therapy manual which had already been developed using standard CBT. A pilot project has proved therapy to be effective and applicable in Pakistan. The second stage of the project will involve a randomised controlled trial to judge effectiveness of the CBT. The focus of this presentation will be framework which guided modification of therapy. While there are few frameworks available for adaptation of therapy for ethnic minorities in the west, we are not aware of any therapy adaptation framework which was developed in a non western culture, derived directly from systematic and focused on adaptation of CBT rather than psychotherapy in general. The framework consists of three major areas. Each major area is further subdivided into 7 minor areas. The major domains include; Culture and related issues(Culture, religion and spirituality, Family, Communication and Language, Rules of engagement, Expression of distress & symptoms, Focus of therapy, Traditional healing practices), Capacity and circumstances (Gender, Educational level, Coping strategies, Capacity of the health system, Mental health professionals, Pathways to care & help seeking behaviours) and Cognitions and beliefs(Beliefs about health and illness, causes of illness, treatment, health system, healing and the healer, about psychotherapy and Cognitive errors and dysfunctional beliefs).

No. 93-D

**IMPLEMENTING CBT FOR PSYCHOSIS IN THE TREATMENT OF ETHNIC MINORITIES IN THE UNITED STATES**

*Michael Garrett, M.D., 450 Clarkson Ave,Box 1203, Brooklyn, NY 11203*

**SUMMARY:**
Public clinics in the United States often differentiate between "medication patients" and "psychotherapy patients". Many of the "medication patients" suffer from chronic psychoses. Compared with "psychotherapy patients", these patients tend to be seen less frequently, for shorter visits, with treatment focused on psychopharmacology. If the treatment has any psychotherapeutic aim at all it is minimal. Such triaging can be particularly profound for those minority, impoverished or otherwise disaffiliated and disenfranchised patients that are often seen by trainees. This separation of psychotherapy and medication patients is a stigmatizing categorization which in effect assigns all patients with chronic psychosis to a disadvantaged, minority status. This approach can have a profoundly negative impact not only on the patients, but on trainees working in these sites. At SUNY Downstate, we are actively using a CBT for psychosis approach to overcome these obstacles and enhance our trainees' 'therapeutic toolbox".A number of obstacles arise in implementing a CBT for psychosis program in the public sector: A prejudice of hopelessness Clinicians may feel that little can be accomplished beyond using medication to keep them out of the hospital. A clinical case will be presented describing the dramatic gains achievable when 'medication patients' were allowed to engage in CBT for psychosis. Narrow case selection Clinicians who are open to CBT for psychosis may mistakenly believe that only a small subset of psychotic patients is suitable for psychotherapy, e.g. "I don't have a good case." Concerns of doing harm Clinicians who believe that delusions and hallucinations may play some role in self esteem regulation may believe that such psychotic symptoms are better left unexamined for fear of disturbing a fragile defensive balance. Lack of clinicians trained in CBT for psychosis who can teach it

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1.Rathod S, Naeem F, Phiri P, Kingdon D. Expansion of psychological therapies The British Journal of Psychiatry 2008; 193: 256.
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**SYMPOSIUM 94**

**CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE SYMPOSIUM**

*Chairperson: Herbert D Kleber, M.D., 1051 Riverside Drive, Unit 66. New York, NY 10032*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the pros and cons of various medications as well as behavioral interventions for the discussed abused

substances and; 2) They should also know the key issues in treating pain in the addicted patient.

**OVERALL SUMMARY:**

Substance Abuse/Dependence remains a major public health problem with important implications for health, financial costs, and the criminal justice system. Shifts continue to occur in cost, purity, and geographic spread of various agents. The fastest growing problem is prescription opioid and stimulant abuse while cocaine and heroin remain endemic, methamphetamine decreases, and marijuana has higher potency and lower age of onset. The symposium combines current scientific knowledge with the most efficacious treatments for all of these agents as well as a separate presentation on comorbid pain. Emphasis is on office-based approaches and includes both pharmacologic and psychologic treatment methods. The speakers are nationally recognized experts in the field and focus on practical and cutting edge treatments.

No. 94-A

**CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE**

*Adam Bisaga, M.D., Columbia University/NYSPI, 1051 Riverside Drive,, New York, NY 10032*

**SUMMARY:**

Cocaine abuse and dependence remain severe health problems, with treatment difficult, and no commonly accepted pharmacotherapies. A combination of pharmacological, possibly more than one medication, as well as behavioral interventions will likely be required for patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Trials of medications that decrease dopaminergic effects of cocaine, such as neuroleptics have not been successful. However medications that enhance dopaminergic tone and have stimulant properties such as disulfiram, d-amphetamine, modafinil and levodopa are promising as abstinence-inducing treatments. Medications that indirectly block effects of cocaine by enhancing GABA-ergic neurotransmission such as topiramate, tiagabine, and baclofen appear to have potential as abstinence-maintenance treatments. Strategies to prevent cocaine from entering the brain are also being developed and initial results with a "cocaine vaccine" are promising. A new approach in cocaine treatment trials involves using medications in combination with a specific form of behavioral therapy. For example, addition of dopamine enhancers have increased efficacy of contingency management treatment. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

No. 94-B

**CHOOSING TREATMENTS FOR CANNABIS DEPENDENCE: WHAT ARE THE OPTIONS?**

*Frances Levin, M.D., 1051 Riverside Drive, New York City, NY 07666*

**SUMMARY:**

Cannabis is the most commonly used illicit drug in the United States and the rates of abuse and dependence have increased, particularly among minority populations. A great deal of work has been completed concerning the basic mechaoisms of actions, pharmacology, aod neurophysiologic of cannabis. It has now been recognized that heavy chronic cannabis use can lead to a characteristic withdrawal syndrome upon discontinuation of use. Such withdrawal symptoms may hinder a patient's ability to reduce or cease hislher use. Although there have been several large clinical trials suggesting that various psychotherapeutic treatment approaches are efficacious, no one type of psychotherapy has been found to be superior. In addition, there has been a limited number of controlled laboratory aod treatment trials that have assessed the efficacy of pharmacologic interventions. At present, agonist and aotagonist therapies have shown promise, e.g., dronabinol (oral THC), aod combined pharmacotherapies (such as dronabinol aod lofexidine) may have clinical utility for treating cannabis dependence.

No. 94-C

**PRINCIPLES OF COMBINING MEDICATIONS AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE DEPENDENCE**

*Edward Nunes, M.D., 1051 Riverside Drive, Unit 51,, New York, NY 10032*

**SUMMARY:**

Several types of psychosocial-behavioral interventions, including cognitive behavioral skillbuilding approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation), have been studied for use either alone or in combination with medications for treatment of substance dependence. Such interventions have served as means of helping patients to achieve abstinence, encouraging lifestyle change, and promoting compliance with medications. An overview of these models and a brief review of findings in treatment outcome research will be provided. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts to date to generalize research findings to community settings will be addressed.

No. 94-D

**PAIN AND ADDICTION: SUBSTANCE USE DISORDERS IN THE CONTEXT OF OPIOID**

THERAPY

*Maria Sullivan, M.D., Ph.D., 1051 Riverside Drive, Unit 51,, New York, NY 10032*

**SUMMARY:**
In the past two decades the non-medical use and abuse of prescription opioids has risen dramatically in the United States, both among chronic pain patients and in the general U.S. population. 50 million people in the U.S. report significant current chronic pain. And among primary care patients with chronic lower back pain, lifetime and current prevalence of substance use disorders are 54% and 23% respectively. The treatment of chronic pain in substance abusers poses a significant clinical challenge. The rates at which all classes of opioids have been prescribed have also increased, and this rise has been most dramatic for oxycodone. Co-occurring increases in opioid abuse and prescribing in the last decade suggest that both emergency departments and office visits are channels for the supply of abused opioids (Mendelson et al. 2008). The clinical picture of addiction in pain patients is more subtle and difficult to identify than in illicit substance users. It is important to distinguish clinically between different causes of opioid misuse in pain treatment (Savage et al. 2008). As a set of universal precautions, care providers should obtain informed consent, carry out careful baseline and repeated pain assessments, evaluate psychological and substance use issues, and monitor adherence. Stratifying patients into risk categories for addiction liability will enable a clinician to determine individualized treatment strategies, including a specialty care setting when warranted, and increased monitoring with frequent visits and toxicology screens. For chronic pain patients with a history of opioid abuse, buprenorphine/naloxone can be an effective analgesic, which carries a low risk of abuse. By reviewing the various factors that contribute to the pain experience and assessing for the presence of aberrant behaviors surrounding medication use, chronic pain in substance users may be managed safely, and the risk of opioid misuse can be significantly reduced.

**REFERENCES:**

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2. American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Substance Use Disorders. 2nd Edition. HD. Kleber, Chair, Am J Psychiatrv, pp 75-84,April 2007 (supp).3. Nordstrom, B.R., Levin, F.R.: Treatment of Cannabis Use Disorders: A review of the Literature. Am J Addictions, 16:331-342,2007.

## SYMPOSIUM 95

## SHOULD 'RISK SYNDROME OF PSYCHOSIS' BE INCLUDED IN DSM 5 AS A DIAGNOSIS? A ROAD TOWARDS PREVENTIVE PSYCHIATRY

*Chairperson: Amresh Shrivastava, M.D., D.P.M., 467, Sunset Drive, Regional Mental Health Care, St.Thomas, Ontario, N5H 3V9 Canada*
*Discussant: William T Carpenter, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Have clarity of thought, decision-making, merits and demerits of Risk syndrome on following three parameter: Research advances and outcome, Impact on patients and families, Changes in the clinical practice.

**OVERALL SUMMARY:**
Psychiatric diagnosis has acquired a position of a quasi-legal document for mental health services and agencies working with mental health. Its utility has gone far beyond 'clinical diagnosis for treatment'. The concept of risk syndrome for schizophrenia has been thoroughly researched in last ten years or so. Significant advancement has been made in phenomenology, diagnostic criteria, classification, & neurobiology. The research of prodromal or at-risk or Ultra high-risk psychosis has significantly contributed to the body of knowledge of aetio-pathogenesis of schizophrenia. The science of risk syndrome has apparently matured and its proponents are ready for its inclusion in DSM V as a diagnosis. This may happen or may not happen. However it is a welcome agenda for working group of schizophrenia in DSM. All the stakeholders are curiously watching this exciting scientific discourse. We need to be mindful, in the process, not to do any thing in which interest of the 'patient' if left out. Schizophrenia affects about 1% people in the general population personal and social cost of schizophrenia is extremely high. The patients and the family members both suffer the burden of disability. Prevention of schizophrenia, therefore would offer substantial benefits to the patients, families and the community at large. Studies report that about 80-85% patients report experiencing subsyndomal symptoms for varying periods. Identification of individuals at prodromal stage would clinicians an opportunity to provide preventive intervention. The symposia will reflect, discuss and provide synthesis of data to frame an opinion based upon not only evidence but also on experience and expectations of consumers.

No. 95-A
### RISK SYNDROME OF PSYCHOSIS AS A DIAGNOSIS IN DSM 5: IS THE QUESTION LEGITIMATE?

*Amresh Shrivastava, M.D., 467,Sunset drive, St.Thomas, N5H3V9*

**SUMMARY:**
Schizophrenia frequently results in social and occupational

disability causes direct and indirect burden on families and costs exchequers dearly in economic terms. Prevention of schizophrenia would therefore would offer substantial benefit to the patient their family members and the community at large. Studies indicate that approximately 80-85% patients report experiencing subsyndromal symptoms for a period lasting several months to several years prior to the onset of the illness. Much of functional decline associated with schizophrenia occurs during this prodromal phase. Identification of individuals at prodromal stage of illness i.e. prior to onset of florid symptoms of schizophrenia would offer clinicians the opportunity to provide preventive interventions. Though the evidence for specific intervention is not very strong, frequently experience functional impairment. A number of them feel subjective distress as well as disability Morbidity of individuals who have at-risk or subthreshold symptoms, insufficient to qualify for a diagnosis of psychosis or schizophrenia, is significantly high. It is recognized that data available is insufficient and the field is full of 'non-specificities'. Concern of inappropriate prescribing and stigmatizing some one who does not have diagnosable mental illness is looming large. For prevention of schizophrenia there is no other route but to identify earliest, those who are vulnerable. The present debate presents an opportunity to examine value of a diagnosis. Is a diagnostic category necessary for prevention? May not be but without well-defined position in classification system it would be hard to make a move. It is felt by some experts that the opportunity need not be missed. Significant progress has been made in the research to contest dismissing the argument prematurely. As a clinician and consumer, research needs to reach clinics. In that sense the question appears legitimate.

No. 95-B

**INCLUSION OF THE PSYCHOSIS RISK SYNDROME IN DSM-V: AN ARGUMENT FOR PLACING IT IN THE APPENDIX**

*Cheryl Corcoran, M.D., NYSPI, Unit 61051 Riverside Drive, New York, NY 10032*

**SUMMARY:**

The appropriateness of inclusion of any new syndrome in the DSM depends on a careful analysis of both anticipated benefits and risks. Potential benefits of the psychosis risk syndrome include early recognition and case identification, and the hypothetical benefit of preventive intervention of psychotic disorders, for which there is as yet no evidence base. However, there is a potential for high rates of false positives – both at the expert and community level – given the difficulty in discriminating mild symptoms from normal variants and low base rates of the syndrome in the general population. High false positive rates in and of themselves are not necessarily problematic if the risk-benefit ratio is significantly favorable, as with screening for cardiovascular risk factors. For the psychosis risk syndrome, by contrast, there are substantial risks, for both stigma and discrimination, and for unnecessary exposure to antipsychotic medications, which arguably make the high false positive rate associated with the psychosis risk designation untenable. Improvement of the positive predictive value of the psychosis risk syndrome is necessary to enhance its candidacy for inclusion within the main text of future editions of the DSM. To encourage further research, a reasonable course would be to include the psychosis risk syndrome within the appendix of "criteria sets and axes provided for future study"; there is precedent for the wisdom of this compromise.

No. 95-C

**AN OVERVIEW OF THE CURRENT STATUS OF RISK SYNDROME FOR PSYCHOSIS**

*Ming Tsuang, M.D., Ph.D., University of California, San Diego 9500 Gilman Drive, MC 0603 Medical Teaching Facility, Room 453, La Jolla, CA 92093*

**SUMMARY:**

General principles and concepts of early identification and intervention towards the prevention of schizophrenia will be introduced (1). Various risks for schizophrenia will be briefly reviewed in relation to genetic and environmental factors. In order to prevent psychosis, the first step should be to identify characteristics of Risk Syndrome for Psychosis before its onset. We can then purposefully engage in early intervention aiming towards prevention. Currently there are relatively reliable and valid research criteria for identifying Risk Syndrome for Psychosis. By utilizing these criteria we can predict future occurrences of psychosis based on follow up studies (2). It is imperative that well designed field trials involving clinicians be undertaken utilizing clinical criteria for Risk Syndrome. These field trials should test reliability of the clinical criteria in order to identify Risk Syndrome for Psychosis among heath seeking subjects. In addition, comparison groups with other well established disorders should be selected to test the specificity of the clinical criteria. When the field trials are complete and have successfully demonstrated their reliability and specificity, DSM V should include Risk Syndrome for Psychosis for further refinement. This rigorous approach will prevent over-diagnosis and unnecessary treatment.

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No. 95-D

**RISK SYNDROME FOR PSYCHOSIS: A RELIABLE & VALID DIAGNOSIS**

*Scott Woods, M.D., 34 Park Street,, New Haven, CT 06519*

**SUMMARY:**
A risk syndrome for psychosis has been recognized for 100 years. Such persons suffer from current symptoms, distress, and functional and cognitive impairment, as well as risk of future decline. Recent years have witnessed substantial progress in our ability to diagnose the risk syndrome with reliability and validity in the research setting (Woods et al, Schizophrenia Bulletin 2009;35:894-908), and the issue of considering this earlier stage of psychotic illness for diagnostic inclusion in DSM-V has been raised. The major benefits of such inclusion are two: 1) widespread community education about who does and does not meet risk syndrome criteria, and 2) promotion of more rapid and larger-scale treatment research. The major risks of inclusion are also two: 1) stigma, and 2) overmedication of false positive patients. Stigma can be managed through provider education, similar to the way investigators minimize stigma associated with participation in risk syndrome research. Overmedication can also be managed by provider education, and if we have a *DSM-5* diagnosis we will be able to acquire far more information with which to educate. Lastly, the proportion of false positive identifications is partly a function of the criteria themselves. The criteria currently proposed for *DSM-5* are substantially more narrow than current research criteria. Characteristic attenuated positive symptoms are required to have been present in the past month, been accelerating within the past year, themselves led to help-seeking, and not been better explained by other *DSM-5* diagnoses. These restrictive criteria should help to ensure that persons receiving risk syndrome diagnoses are ill patients in need of care. It remains to be seen whether community psychiatrists can use the proposed *DSM-5* clinical criteria reliably. To this end, well-designed field trials should be conducted.

No. 95-E

**INCLUSION OF THE PSYCHOSIS AT-RISK CATEGORY IN *DSM-5*: IS IT PREMATURE?**

*Barbara Cornblatt , Ph.D., M.B.A., Zucker Hillside Hospital 75-59 263rd Street, Glen Oaks, NY 11004*

**SUMMARY:**
Over the past decade, there has been a dramatic increase in research concerned with the prevention of psychosis which parallels the considerably longer standing interest in the pre-emptive treatment of many chronic physical illnesses such as heart disease, diabetes and cancer. The emerging focus on providing early intervention for individuals thought to be at risk for severe mental illness has been received with a great deal of enthusiasm and the number of clinical trials and studies focusing on underlying mechanisms and risk factors have escalated over the past several years. This has supported the recent move to include risk for psychosis as a diagnostic class in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*). However, despite the promise of prodromal research, it may be premature to include a psychosis at-risk category in *DSM-5* This position is based on several concerns. One major issue is the considerable possibility that introducing the risk construct into the community will generate an unacceptably high rate of false positive cases (possibly in the 90% range). A second concern is the notable lack of evidence currently available to support type of treatment, when treatment should be started; or when it should be discontinued. Third, risk is currently defined by the presence of any one or more of 5 attenuated positive symptoms (suspiciousness, grandiosity, unusual thoughts, abnormal perceptions, disorganized communication). However, the rules for meeting criteria are complex and require considerable training. While reliability in academic settings is relatively well established, it is unclear how community ratings will compare when made without specialized training. Furthermore, validity of the prodromal concept, in any setting, is yet to be established. Thus, before the at-risk category is considered for inclusion in *DSM-5,* positive benefits must be shown to clearly outweigh potential negative consequences.

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**SYMPOSIUM 96**

**BASIC SCIENCE IN PSYCHIATRY: A MOVE TOWARD TRANSLATIONAL MEDICINE**

*Chairperson: Mark H Rapaport, M.D., 8730 Alden Drive, Thalians, C-301, Los Angeles, CA 90048*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand that rapid transitions in basic neurosciences are facilitating the develpment of novel new models for treatment; 2) Recognize it is now possible to develop comprehensive systems basedx on basic neuroscience principles for the development of new compounds for the treatment of major psychiatric disorders; and 3) Discern how advances both in clinical neurosciences and basic neurosciences are leading to bidirectional.

**OVERALL SUMMARY:**
The overall goal of the session is to introduce the participant to the exciting changes in information about psychiatric disorders that is being spurred on by rapid development of translational medicine techniques that crea1e a bidirectional synergy for the growth of new knowledge. In this symposium there will be presentations by three basic scientists, all of whom are engaged in collaborative translational research with clinical investigators. The fourth presentation will be made by a clinical scientist whose work in imaging and energy metabolism has led to his collaboration with pre-clinical scientists to investigate mitochondrial function. In this symposium, Professor Mark Rasenick will present some of his group's groundbreaking work investigating the cellular translocation and function of GSa and its impact on neuropsychiatric disorders. In particular, Professor Rasenick will share recent findings linking GSa protein location and its relationship to risk of suicide. He will also present exciting new data suggesting that translocation of GSa may be an indicator of antidepressant responsiveness. Dr. Carrolce Barlow will present work that she and her colleagues have done developing a comprehensive systematic approach 10 the assessment of neurogenesis and how it might be used potentially to prospective1y identify novel clinically-effective treatment combinations or new treatment approaches for neuropsychiatric disorders. Dr. Barlow will discuss how this systems approach to the concept of neurogenesis may facilitate the development of novel compound for the treatment of mood disorders. Professor Robert Pechnick will discuss the development of novel animal models that mimic either symptoms of or certain types of psychiatric syndromes. He will also present data demonstrating how one can use such models to begin exploring basic questions such as cell cycle turnover in the brain and how that may be linked to potential measures of treatment response. Dr. Dan Iosifescu will present data about how one can link clinical findings from imaging investigations back to the cellular level. He will use findings from his group todemonstrate how their work with FMRi led to the generation of hypothesis regarding the role of mitochondrial dysfunction in psychiatric disorders. By the end of these presentations, the participant should have a broader perspective about how basic research is blending with clinical neuroscience to facilitate the development of translational med

No. 96-A
**SYNAPTIC BIOLOGY OF DEPRESSION: G PROTEINS, LIPID RAFTS, AND THE SEARCH FOR A BIOMARKER**

*Mark Rasenick, Ph.D., 835 S Wolcott MC 901, Chicago, IL 60612-7342*

**SUMMARY:**
TheG protein, GSa conveys couples to a number of receptors to convey the signals of neurotransmitters like 5HT into the cellular interior. While receptors span the membrane bilayer, GSa occupies the inner face of the membrane and can be found in cholesterol-rich cytoskeleton-associated membrane structures (lipid rafts) or less “rigid” non-raft membrane regions. When GSa occupies Ihese non-raft membrane regions, it engages in a more facile stimulation of adenylyl cyclase in response to neurotransmitter activation. A number of antidepressants have been shown to increase stimulation of adenylyl cyclase by GSa. These studies subjected rats to chronic treatment with drugs or ECT.Control compounds or acute treatment with any of the antidepressants were ineffective. It was suggested that these effects might be post-synaptic and uptake independent, and studies with cultured cells, lacking transporters for biogenic amines revealed antidepressant-induced increases in adenylyl cyclase comparable to those seen in rat brain.Since movement of GSa out of lipid rafts increases stimulation of adenylyl cyclase, it was suggested that chronic antidepressant treatment might have this effect. This was seen in both rats and cultured cells, raising the possibility that chronic antidepressant treatment might target some membrane entity and counter membrane rearrangements evoked by depression. A post-mortem analysis revealed this to be the case. While the expression of GSa was not greatly altered in depression, the ratio of GSa in raft fractions was reduced. This is consistent with the long-term increases in cellular cAMP seen after antidepre:,sant treatment. It is suggested that increased lipid raft association of GSa might be a hallmark of depression and translocation of GSa to non-raft membrane fractions will accompany successful antidepressant treatment.

No. 96-B
**ANIMAL MODELS: CELL CYCLE REGULATORS AND NEUROBEHAVIORAL DISORDERS**

*Robert Pechnick, Ph.D., 8730 Alden Dr Ste E-123, Los Angeles, CA 90048*

**SUMMARY:**
In the hippocampus, neural stem cells and progenitors proliferate and differentiate into neurons throughout adulthood. The functional significance of adult neurogenesis is not known. The hippocampus is involved in a number of important functions, including memory formation and retrieval, learning, and neuroendocrine and mood regulation. Many studies have attempted to link changes in hippocamphal neurogenesis to alterations or deficits in these endpoints. The relationships among hippocamphal neurogenesis, depression and the mechanism of action of antidepressant drugs have generated a considerable amount of interest and controversy. Neurogenesis is under the control of cell cycle regulators. P21Cipl, a cyclin-dependent kinase inhibitor, restrains cell-cycle progression and proliferation throughout the body. It is found in neuroblasts and newly developing neurons in the sub granular zone of the hippocampus. Chronic treatment with the tricyclic antidepressant imipramine decreases p2lCipi transcript and protein levels, stimulates neurogenesis in this region and produces antidepressant-like behavior in animal models. Moreover, mice lacking p21Cipl have increased rates of hippocamphal neurogenesis. Thus, p21Cipl restrains neurogenesis in the hippocampus, and antidepressant-induced stimulation of neurogenesis might be due to decreased p21Cipl expression. Cell-cycle regulation occurs downstream from the primary site of action of antidepressants, suggesting that new therapeutic strategies might directly target cell-cycle proteins. Post-chemotherapy cognitive impairment, commonly called "chemobrain," has long been recognized in cancer survivors. After cancer chemotherapy, patients frequently suffer from memory lapses, have trouble concentrating, are unable to remember details, and have problems doing more than one thing at a time (i.e., multitasking) and trouble remembering common words and names. Some chemotherapeutic agents, such as methotrexate, disrupt hippocamphal neurogenesis and impair performance function in animal models of cognitive function. Therefore, post-chemotherapy-induced changes in neurogenesis might be a fundamental mechanism underlying the development. This information finding could lead to the development of treatment strategies to treat and-or prevent this frequent and troubling problem in cancer patients.

No. 96-C

**ALTERED BRAIN BIOENERGETICS: A REFLECTION OF MITOCHONDRIAL DYSFUNCTION DURING THE TREATMENT OF MAJOR DEPRESSIVE DISORDER**

*Dan Iosifescu, M.D., M.S., Massachusetts General Hospital 50 Staniford Street, Suite #401, Boston, MA 02114*

**SUMMARY:**
Purpose: Accumulating evidence suggests that oxidative stress, particularly mitochondrial dysfunction, plays a role in recurrent mood disorders. Mitochondrial dysfunction is related to neuroplasticity and to excessive inflammation. We will review studies using phosphorus magnetic resonance spectroscopy (31P-MRS) to investigate the brain bioenergetic metabolism, a reflection of mitochondrial function, in subjects wilh mood disorders. Methods: We will present results from several studies in major depressive disorder (MDD) subjects whose bioenergetic metabolism was assessed with 31P-MRS before and after antidepressant treatment (with thyroid hormones and with SSRls). Proton spectroscopy (1J-MRS) data was acquired at baseline and endpoint to assess levels of brain neurotransmitters (such as GABA and glutamine).Results: Beta-nucleoside triphosphate (beta-NTP) levels (primarily reflecting brain levels of adenosine triphosphate, ATP) are lower in MDD subjects compared to controls, suggesting a pattern of mitochondrial dysfunction in MDD. Such bioenergetic abnormalities appear to be partially corrected after successful antidepressant treatment. Changes in the levels of the main neurotransmitters (GABA, glutamine) are also associated with antidepressant response in MDD. Improvement in brain energy stores (beta-NTP) is associated with, and may be necessary for, increases in brain neurotransmitter levels. Importance: we propose a hypothesis of mitochondrial dysfunction in MDD and bipolar disorder that involves impaired oxidative phosphorylation and a decrease in total energy production. The resulting bioenergetic deficiencies might be associated with decreases in high-energy processes such as neurotransmitter synthesis. Correction of such bioenergetic abnormalities might be required for successful treatment of depression. Such a model justifies the search for novel antidepressant treatments with impact on mitochondrial function and brain bioenergetics.

No. 96-D

**NEUROGENESIS ASSAYS PROSPECTIVELY IDENTIFY A NOVEL CLINICALLY EFFICACIOUS COMBINATION FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER**

*Carrolee Barlow, M.D., Ph.D., 3565 General Atomics Ct Ste 200, San Diego, CA 92121*

**SUMMARY:**
That adult humans retain the ability to generate new neurons in the dentate gyrus of the hippocampus throughout life offers the potential for therapeutic interventions in various diseases. The preclinical finding that all classes of marketed antidepressants promote an increase in neurogenesis specific to the dentate gyrus is consistent with the concept that enhancing neurogenesis in humans may have clinical utility. Recently developed pre-clinical models, such as novelty suppressed feeding (NSF), assess the time-dependent behavioral effects of antidepressants. Chronic administration of antidepressants are required for efficacy in NSF and blocking neurogenesis renders

antidepressants ineffective, further strengthening the link between efficacy of antidepressants and neurogenesis. Since hippocamphal neurogenesis is suggested to contribute to the mechanism of action of antidepressants, we studied several agents in order to define a set of assays that could be used to identify agents with both a neurogenic and behavioral profile predictive of efficacy in treating depression. In these assays, neither buspirone nor melatonin ALONE showed an antidepressant-like signature in experiments utilizing human neural stem cells (NSCS). This lack of efficacy was confirmed in rodent ex vivo neurogenesis assays and in rodent in vivo behavioral assays.However, using systematic screening the combination of buspirone and melatonin displayed unexpected neurogenic and antidepressant-like activity in the human in vitro system, the rodent ex vivo neurogenesis assays and in rodent behavioral assays. Based on the neurogenic and the antidepressant-like profile of the combination of low dose buspirone and melatonin, we hypothesized that the combination could be efficacious in patients with Major Depressive Disorder (MDD). To test this hypothesis, we conducted a 6-week double-blind, placebo-controlled, randomized study (2:1:1) of 15 mg of buspirone with 3 mg melatonin (combination treatment) compared to placebo or 15 mg of buspirone alone nightly. Buspirone alone was included in the study because of reports that doses above 40 mg may be beneficial for MDD. Results and details of this study will be discussed during the session.

**SYMPOSIUM 97**

**THE SUPREME COURT AND PSYCHIATRY IN THE 21ST CENTURY**

*Chairperson: Paul S. Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032*
*Discussant: Richard Bonnie, J.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session the participant should be able to: Better appreciate the attitudes of the U.S. Supreme Court toward psychiatry, and the implications of the Court's decisions for future regulation of psychiatry.

**OVERALL SUMMARY:**
Since the turn of the millennium, the U.S. Supreme Court has taken on roughly one case of direct relevance to psychiatry each year. Although many of these cases focus on the application of psychiatric knowledge to criminal law, what they reveal of the Court's understanding and views of psychiatry has relevance to every aspect of the relationship between psychiatry and law. This symposium will review 4 of the most significant cases considered by the Court in the past 10 years, and suggest their implications for the years to come. As a group, the cases show the Court struggling with the extent to which psychiatry offers scientific evidence that can be of use in the adjudicatory process and in the resolution of difficult policy dilemmas. Atkins v. Virginia (2002), holding that the death penalty cannot be imposed on people with mental retardation, demonstrates the difficulty that the Court faces when it turns to the clinical disciplines for assistance in solving challenging moral problems. Reflecting the other side of the Court's ambivalence about psychiatry, Clark v. Arizona (2006) upheld the exclusion of psychiatric evidence from many criminal trials, displaying skepticism about the reliability and validity of psychiatric testimony. A more sophisticated view of psychiatry is evident in Panetti v. Quarterman (2007), a decision that recognized the pervasive impact of delusions on a death row prisoner's appreciation of his fate. Finally, in Edwards v. Indiana (2008), the Court once again acknowledged the subtle effects of mental illnesses on behavior, requiring more careful assessment of defendants' abilities to represent themselves in court. On balance, the Court appears to have a growing comprehension of the effects of mental disorders, and of the benefits and limits of psychiatric expertise. The discussant, an expert on mental health and law, will place these decisions in a broader legal and policy perspective.

No. 97-A
**ATKINS V. VIRGINIA: MENTAL RETARDATION AND THE DEATH PENALTY**

*Paul Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032*

**SUMMARY:**
In 2002 the U.S. Supreme Court declared execution of persons with mental retardation to constitute cruel and unusual punishment, and thus to be unconstitutional under the 8th Amendment. The case that triggered the decision, reversing an earlier Supreme Court precedent, involved Daryl Atkins, a man with 16 prior felony convictions, who was sentenced to death for the abduction, robbery, and murder of an airman from a local military base. Pointing to a developing consensus among the states that persons with mental retardation have a reduced level of culpability and should not be put to death, the majority held that evolving standards of decency precluded their execution. However, although the Court recognized that there might be serious disagreement about whether a particular defendant is mentally retarded, all considerations regarding how to implement the decision were explicitly left to the states. Since Atkins v. Virginia was decided, legislatures, courts, and mental health have struggled with its implementation. Among the issues that have been addressed and that will be reviewed in this presentation are: the definition of mental retardation, the means that should be used to assess mental retardation, and the procedures that should be followed for the legal determination of retardation, including the identity of the decision maker. The decision in Atkins can be seen as a reflection of our society's deep ambivalence about the death penalty; although reluctant

to surrender the option of imposing the ultimate penalty, we are nonetheless inclined to surround it with so many restrictions that it will only rarely be applied. Atkins offers a vivid example of just how poorly legal and clinical constructs mix, and how the failure of a court to grasp the complexity of clinical concepts—relying on them as the basis for legal rules—can create precedents that will be difficult for subsequent courts to apply.

No. 97-B

**CLARK V. ARIZONA: THE SUPREME COURT CONSIDERS THE INSANITY DEFENSE AND PSYCHIATRIC TESTIMONY**

*Steven Hoge, M.D., M.B.A., 420 Madison Avenue, Suite 801, New York, NY 10017*

**SUMMARY:**
Dr. Hoge will discuss Clark v. Arizona, decided by the U.S. Supreme Court in 2006. Eric Clark was convicted of intentionally killing a police officer. Evidence presented at trial indicated that Clark was psychotic at the time of the killing and believed that the police were aliens. In finding him guilty of first-degree murder, the trial judge rejected defense claims that Clark was insane or, alternatively, that delusional beliefs interfered with his ability to act intentionally (in legal terms, mens rea). The appeal to the Supreme Court challenged the constitutionality of two aspects of state law. First, Clark claimed that the Arizona insanity test was too narrow, as it turned entirely on whether the defendant knew that what he was doing was wrong. Clark argued that the insanity test must also include whether the defendant knew the nature and quality of his act. Second, Clark claimed that Arizona state law had impermissibly precluded introduction of his mental disorder in adjudicating his mens rea defense. In an opinion authored by Justice Souter, the U.S. Supreme Court rejected Clark's claims. In doing so, the majority opinion reflected distrust of psychiatric testimony, upholding Arizona's right to exclude expert testimony regarding mental disorders due, in part, to concerns about its potential to be confusing and unreliable. Dr. Hoge will discuss the troubling implications of the Clark v. Arizona decision, which leaves mentally disordered offenders facing potentially insurmountable hurdles in educating juries regarding the legitimacy and consequences of serious mental illness. Dr. Hoge will also discuss how Justice Souter's majority opinion may undermine lower courts' trust of expert psychiatric testimony, with implications beyond the criminal arena.

No. 97-C

**PANETTI V. QUARTERMAN (2007) COMPETENCE TO BE EXECUTED; AN ETHICAL CHALLENGE FOR PSYCHIATRISTS AND THE EVOLUTION OF THE LEGAL STANDARD**

*Howard Zonana, M.D., CMHC, 34 Park Street, New Haven, CT 06519*

**SUMMARY:**
Competency to stand Trial evaluations are the most frequent evaluations performed in the criminal justice system by psychiatrists and represents the recognition of a fundamental right of criminal defendants such that the legal proceedings are held in abeyance until the defendant is determined to be competent. In Ford v. Wainwright (1986), the U.S. Supreme Court, using a competence model, decided that executing a person who is "insane" violates the Eighth Amendment's proscription of cruel and unusual punishment. The justices did not define the standard by which to determine whether a death row prisoner could be executed. Prior to Panetti the courts used a standard suggested in a concurring opinion by Justice Powell, i.e. ... the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it" The court also ruled that a forensic professional must make that evaluation and, if the inmate is found incompetent, provide treatment to aid in the inmate gaining competency in order that the execution can take place. Providing treatment to an individual to enable that person to become competent to be executed placed mental health professionals in an ethical dilemma. The AMA with consultation from the APA passed a ethics guideline that defined the parameters for performiong the evaluation and the conditions under whch treatment could be provided. The National Medical Association took the position that ethically it is a physician's duty to provide treatment, regardless of the patient's legal situation. Others feel that it unethical to treat a person in order to execute them. Panetti, while not explicitly defining a standard broadened the concrete interpretation that courts gave to the "Powell" standard.

No. 97-D

**INDIANA V. EDWARDS: COMPETENCE TO REPRESENT ONESELF**

*Debra Pinals, M.D., 55 Lake Avenue North, Worcester, MA 01655*

**SUMMARY:**
The standard for a defendant's competence to stand trial was articulated by the United States Supreme Court in Dusky v. U.S. in 1960. That decision by the Court had a significant impact on forensic evaluations, as evaluations of competence to stand trial are the most common type of forensic mental health assessment in the criminal court system. Over the years, clinicians and courts have utilized the language of the Dusky standard and developed an increasingly sophisticated understanding of legal and clinical approaches to competence to stand trial. Legal challenges to the Dusky standard included propositions

that certain tasks during court proceedings (such as decisions to accept plea bargains and decisions to waive counsel) require greater degrees of competence, yet the Court continued to hold that the Dusky standard represents the standard to be utilized for competence to stand trial. In 2008, however, the U.S. Supreme Court issued its decision in the case of Indiana v. Edwards, in which a defendant who wished to represent himself in court was assigned an attorney. Mr. Edwards appealed, and the U.S. Supreme Court ultimately held that a defendant who is competent to stand trial may not be competent to represent himself. Additionally, the Court ruled that in those cases where a defendant lacks the mental capacity to conduct his trial defense unless represented, the Court may limit the defendant's right to self-representation and may assign criminal counsel. Given this ruling, forensic clinicians have begun to examine standards for evaluating competence for self-representation. This symposium will describe the U.S. Supreme Court finding and its subsequent implications for defendants and forensic mental health practice.

**REFERENCES:**

1.Appelbaum PS: Mental retardation and the death penalty: After Atkins. Psychiatric Services (in press, Oct. 2009

2.Bonnie RJ. Panetti v. Quarterman: Mental illness, the death penalty, and human dignity. Ohio State Journal of Criminal Law 2007; 5:257-283.

**SYMPOSIUM 98**

**NOVEL TOOLS FOR PREVENTING AND TREATING SUBSTANCE USE AND COMORBIDITIES IN THE MILITARY AND RETURNING VETERANS**

*The U.S. National Institute on Drug Abuse*

*Chairperson: Cecelia M Spitznas, Ph.D., 6001 Executive Blvd MSC 9593, Bethesda, MD 20982-9593, **Co**-Chairperson: Eve E Reider, Ph.D.*
*Discussant: Michael E Kilpatrick, B.A., M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize risk factors for substance abuse in deployed military and their family members; 2) Identify potential adjustment problems and treatment needs for veterans who may present in academic, community psychiatry and private health care settings and 3) Demonstrate familiarity of novel tools being researched for treating substance abuse and commorbidities in these groups.

**OVERALL SUMMARY:**

U.S. military personnel and their families have endured many challenges since September 11, 2001. In 2006, there were approximately 2.5 million non-civilian military personnel serving our country, of which 1.6 million are or have been deployed in support of the war efforts in Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom; OEF/OIF). These sustained combat operations have resulted in military personnel experiencing increased numbers and lengths of deployments and greater exposure to traumatic stressors. Recent epidemiological reports indicate that military personnel returning from OEF/OIF experience difficulties, including traumatic brain injury, post traumatic stress disorder, depression, anxiety, and alcohol abuse. The sustained combat operations have been difficult for families. Military operations have been described as particularly difficult for reserve and National Guard families who have less access to military support systems and fewer connections to other military families. New technology has been saving lives in an unprecedented manner; however, it is also resulting in a unique constellation of physical and psychological injuries in returning veterans that may predispose them to drug use disorders. NIDA researchers are in the process of developing novel tools to augment prevention and treatment care in these populations. These approaches may be helpful for reducing incidence of substance abuse in response to trauma and pain as well as for treating new cases of SUD and comorbidities. This symposium will discuss the available literature on substance use in deployed military and will feature presentations on novel tools ranging from Interactive Voice Response and Video approaches to prevention as well as treatment approaches such as Virtual Reality with d-Cycloserine for exposure therapy and computerized therapy to support relapse prevention.

No. 98-A

**UNDERSTANDING LONG-TERM TOBACCO AND ALCOHOL USE AND COMORBID MENTAL HEALTH SYMPTOMS IN MILITARY SERVICE MEMBERS AND VETERANS; THE MILLENNIUM COHORT STUDY**

*Tyler Smith, Ph.D., M.S., 3835 Centraloma Drive, San Diego, CA 92107*

**SUMMARY:**

Purpose: Deployments in support of operations in Iraq and Afghanistan have exposed US military service members to physical and psychological stressors that have short and long-term health effects. Content: To prospectively investigate new-onset and persistent PTSD and depression symptoms and alcohol and tobacco use in the Millennium Cohort Study, a large population-based US military cohort spanning all services and including active duty, Reserve and National Guard. Methods: The Millennium Cohort Study examines long-term health effects associated with military service. Baseline (2001- 2003) and follow-up (2004- 2006) data were used to assess changes in PTSD and depression symptoms along with cigarette smoking and alcohol misuse. Prior assault and functional health

at baseline were also investigated in relation to PTSD. Alcohol misuse included heavy weekly drinking, binge drinking and alcohol-related problems while smoking analyses investigated initiation and recidivism among nonsmokers, and quantity change among smokers. Results: 25% of Cohort members deployed between baseline and follow-up. New-onset PTSD symptoms or diagnosis were found in 8.7% of deployers reporting combat exposures, 2.1% of deployers reporting no combat exposures, and 3.0% of nondeployers. Male and female combat deployers reporting prior assault were twice as likely to report new-onset PTSD symptoms and those in the lowest 15th percentile of mental and physical functioning contributed over half of the new-onset PTSD. Combat deployment was associated with increased risk of new-onset depression, smoking initiation and recidivism, and new-onset of all alcohol outcomes examined among Reserve/Guard personnel. Conclusions: This presentation describes how symptoms of PTSD and depression and smoking and alcohol misuse emerge or persist in relation to combat deployment in support of the current conflicts within a large population-based military cohort. Findings emphasize combat exposure, prior stressful experiences, and pre-deployment functional health, rather than deployment itself, significantly affect the onset of these mental health symptoms and negative behaviors post deployment. Ongoing research aims to describe the co-occurrence of mental health symptoms and alcohol and cigarette misuse related to deployments.

No. 98-B

**AUTOMATED INTERACTIVE VOICE RESPONSE AS A THERAPEUTIC TOOL FOR CHRONIC PAIN REDUCTION AND OPIOID MEDICATION USE DECREASE**

*Magdalena Naylor, M.D., Ph.D., 1 S. Prospect Street, UHC, Burlington, VT 05401*

**SUMMARY:**

BACKGROUND: To test whether the Therapeutic Interactive Voice Response (TIVR) system can be used to decrease opioid medication use.

METHOD: Following 11 weeks of CBT fifty subjects with chronic pain were randomized to two groups. Twenty-five subjects participated in 4 months of TIVR, while control group of twenty-five subjects received standard care only. TIVR is an automated phone system designed to reinforce pain coping skills learned in group CBT. TIVR has four components: daily self-monitoring questionnaire, didactic review of coping skills, behavioral rehearsals of coping skills, and monthly therapist feedback. All four components can be accessed on demand via touch-tone phones.

RESULTS: Between-group analysis (ANCOVA) revealed significant differences at both 4 and 8 month follow-ups for most of the outcomes, notably MPQ Typical Pain ($p<0.001$), CSQ Control Pain ($p<0.0003$), TOPS Pain Experience ($p<0.0001$), and SF-36 Physical Composite ($p<0.001$). For all variables outcomes were superior for the TIVR group. There was no significant difference in opioid medication use from baseline at all follow-ups. Within subject repeated measures multiple regression analyses of the daily self-monitoring TIVR questionnaire revealed that daily practice of relaxation techniques was associated with improvement in coping ($p<0.001$), reductions in stress ($p<0.001$) and pain ($p<0.05$). An increase in coping skills used per day was associated with reductions in emotional distress ($p< 0.0001$), stress ($p<0.0001$) and improvement in coping ($p<0.0001$).Opioid analgesic use decreased in the experimental group in both follow-ups: 4- and 8-months post-CBT. In addition at 8-month follow up, 21% of the TIVR subjects had discontinued the use of opioid analgesics, 23% had discontinued NSAIDS, and 10% had discontinued antidepressant medications. In contrast, the control group showed increases in opioid and NSAIDS use. Analysis of covariance (ANCOVA) revealed significant between-group differences in opioid analgesic use at 8-month follow up ($p=0.004$).

CONCLUSION: Results demonstrate that the telephone-based TIVR maintenance enhancement program can be used not only to decrease pain, improve coping, and diminish likelihood of relapse into pain behavior but also, concurrently decrease opioid medication use.

No. 98-C

**VIRTUAL REALITY AND D-CYCLOSERINE FOR EXPOSURE BASED THERAPY**

*Barbara Rothbaum, Ph.D., Trauma and Anxiety Recovery Program, Emory University School of Medicine, 1256 Briarcliff Road, Atlanta, GA 30306*

**SUMMARY:**

PTSD has been estimated to affect up to18% of returning Operation Iraqi Freedom (OIF) veterans. Soldiers need to maintain constant vigilance to deal with unpredictable threats, and an unprecedented number of soldiers are now surviving serious wounds. These risk factors are significant for development of PTSD; therefore, early and efficient intervention options must be identified and presented in a form which is acceptable to military personnel. Empirical evidence has found exposure therapy to be a most effective treatment for PTSD. Virtual reality exposure therapy (virtual Iraq) to treat PTSD in veterans and active duty will be presented and discussed. Early results indicate preliminary promise for this treatment. D-Cycloserine (DCS), a cognitive enhancer that has been found to facilitate the extinction of fear in exposure therapy, will be discussed as a novel method to facilitate exposure therapy.
Disclosure Statement Dr. Rothbaum is a consultant to and owns equity in Virtually Better, Inc., which is developing products related to the virtual reality research described in this presentation, although Virtually Better did not create the Virtual Iraq to be presented. The terms of this

arrangement have been reviewed and approved by Emory University in accordance with its conflict of interest policies.

No. 98-D

**THE VIDEO DOCTOR APPROACH: POTENTIAL APPLICATIONS TO PSYCHIATRIC PRACTICES SERVING PATIENTS IMPACTED BY WAR**

*Barbara Gerbert, Ph.D., 707 Parnassus Avenue, San Francisco, CA 94143-0758*

**SUMMARY:**
The "Video Doctor" is an innovative approach that uses computer and video technology to support the work of clinicians by assessing and counseling patients, and cueing clinicians about ongoing patient risks and counseling needs. Participants use a laptop computer to complete a relevant risk assessment immediately prior to a regularly scheduled medical appointment in a health care setting. Upon completion of the risk assessment and prior to the medical appointment, the program seamlessly transitions to the Video Doctor for those participants randomized to receive an intervention which involves an actor-portrayed Video Doctor delivering interactive risk-reduction messages, designed to simulate an ideal discussion with a health care provider. Using a library of digital video clips, extensive branching logic, and participant input, the program tailors messages to the participant's gender, risk profile, and readiness to change. At the conclusion of each intervention session, the program automatically prints an "Educational Worksheet" for participants with questions for self-reflection, harm reduction tips, and local resources as well as a "Cueing Sheet" for providers use during the appointment. Identification of behavioral risks, including risky substance use, sexual behaviors and domestic violence using this technology holds promise for reducing demands on psychiatrists who treat members of the military, veterans, and their family members. To the extent that it facilitates patient disclosure so psychiatrists can make informed treatment decisions and referrals it may improve psychiatric care. In NIDA-funded randomized trials, the Video Doctor intervention has increased clinician-patient discussions of risks and reduced risky behaviors. Opportunities and needs for research on substance abuse and other risky behavior prevention in psychiatry settings with members of the military, veterans and their family members also will be discussed.

No. 98-E

**COMPUTER-BASED TRAINING IN COGNITIVE BEHAVIORAL THERAPY: NEW FINDINGS AND APPLICATIONS FOR MILITARY PERSONNEL**

*Kathleen Carroll, Ph.D., 950 Campbell Avenue, West Haven, CT 06516*

**SUMMARY:**
We have developed a computer assisted version of cognitive behavioral therapy (CBT) for substance dependence to make CBT more widely available. In our initial trial, 77 individuals seeking treatment for substance dependence in an outpatient community setting were randomized to standard treatment or standard treatment with biweekly access to the computer program over a period of 8 weeks. Several other trials are ongoing,including several in VA settings. Results. In our initial randomized clinical trial, treatment retention and availability of data were comparable across treatment conditions. Participants assigned to the computerized CBT condition (CBT4CBT) submitted significantly more urine specimens that were negative for all drugs and tended to have longer continuous periods of abstinence. The improved outcomes for the CBT4CBT conditions persisted through a 6-month follow-up. Conclusions. Computer-assisted delivery of CBT is an effective adjunct to standard treatment for substance dependence and may provide an important means of making CBT, an empirically validated treatment, more broadly available to a range of populations and settings.

**WEDNESDAY, MAY 26, 2010**
**2:00 PM- 5:00PM**

**SYMPOSIUM 99**

**HOT TOPICS IN AFROAMERICAN MENTAL HEALTH; IMPACT OF PAST AND CURRENT PREJUDICES; WOMENS' MENTAL HEALTH; HIV; UNIQUE PSYCHOPHARMACOLOGICAL FINDINGS**

*Chairperson: David W Smith, M.D., 1500 21st st, Sacramento, CA 95814*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the effect and impact of past and present mental health injustices perpetrated against Afroamericans and black Canadians; 2) Develop better mental health interventions with Afroamerican females; 3) Develop a system of thinking through effective interventions for treating Afroamericans with HIV/AIDS; and 4) Make more thoughtful psychopharmacological choices for Afroamerican patients.

**OVERALL SUMMARY:**
Talk 4- HIV mental health- There is a well documented disproportiate number of Afroamericans aflicted with HIV/AIDS. There is alarming growth of new patients amongst Afroamerican women and teens. AIDS is the leading cause of death among African American women ages 25-34. The co-occurence of Axis 1 diagnoses concomitant with HIV is close to 50%, magnifying the gap that already exists between

Afroamerican mental health and the rest of the population at large. This talk with graphically show the difficulty many gay black men have with being forthcoming about their sexual orientation, using media clips and interviews with patients. I will also discuss the importance in making thoughtful psychiatric diagnoses in the face of addiction as well as making careful choices of psychopharmacological agents given the high rate of kidney disease and diabetes in Afroamericans.talk 1- Harriett A Washington- I will trace specific historical trends events scholars and theories that provided the medical underpinning to racial categorization of persons that informed racial etiologies ant that drove the characterization of "black" Physical and mental disorders. I will present and critique racial theories of mental illness that spanned from antiquity through the 18th century proliferation of US slavery to present day . I will also illustrate how the work of individuals such as Louis Agassiz,Samuel Cartwright,Cesar Lombroso and scholarly entities such as the American School of
Ethnologh defined and provided the undergirding of black diseases many of which were psychological disorders with strong forensic component.Talk 2-Dr Zack Chernofsky has already submitted. Talk 3- Dr Janet Taylor has already submitted. Talk 5- Dr Wm Lawson has submitted

No. 99-A

**HISTORY OF RACISM IN MENTAL HEALTH; SEEDS OF DISTRUST**

*Harriet Washington, B.S., Rodchester, NY*

**SUMMARY:**
My presentation will trace and enable auditors to identify specific historical trends,events schlors and theories that provided the medical underpinning to racial categorization of persons that informed racial etiologies and that drove the characterization of "black" Physical and mental disorders. I will present and critique racial theories of mental illnes that spanned from antiquitiy through the 18th century proliferation of US slavery to the present day . I will also illustrate how the work of individuals such as Louis Agassiz,Samuel Cartwright,Cesar Lombroso and scholarly entities such as the American School of Ethnology defined and provided the undergirding of black diseases many of which were psychological disorders with strong forensic components. As well as historical events being traced I will also discuss present day " bad science" and its effect on stigmatizing afroamericans as well as hispanic children.

No. 99-B

**PSEUDOSCIENTIFIC LITERATURE PROMOTES RACIAL PREJUDICE AMONG PHYSICIANS**

*Zack Cernovsky, Ph.D., 98 Greenbrier Crescent, London, N6J 3X9*

**SUMMARY:**
Massive mail-outs to physicians by psychology professor J.P. Rushton included free-of-charge books describing his "scientific" theory that blacks are genetically inferior (low IQ, prone to mental illness and crime, oversexed, and multiplying at a fast rate). A scientific scrutiny shows that Rushton's inept methodology (e.g., measuring head circumference by tape as a substitute for IQ tests) and his grandiose generalizations from inadequate samples discredit his work. However, his books have probably misled at least some physicians. As there were no adequate measures by universities to warn all these physicians that Rushton's work does not meet scientific standards, these MDs may resort to discriminatory practices in their clinical decisions about black patients.

No. 99-C

**BLACK WOMEN & DEPRESSION: THE ROLE OF STIGMA AS A BARRIER TO TREATMENT**

*Janet Taylor, M.D., M.P.H., 103 Hardscrabble Lake, Chappaqua, NY 10514*

**SUMMARY:**
Almost 1 in 5 people will experience an episode of Major Depression over the course of their lifetime. Major Depressive Disorder is treatable, yet it is estimated that up to 75% of individuals with Major Depressive Disorder are either untreated or under-treated. The impact of genetics, environmental influences , adverse events in childhood, ongoing stressors and the role of stigma is a significant barrier to the understanding, acceptance , diagnosis and treatment of Major Depressive Disorder in Black women. Stigma is a psychological, social and community barrier that can influence help-seeking behavior in black women. Understanding the role of stigma as a barrier to mental health treatment can improve psychological well-being and physical health in Black women.

No. 99-D

**HIV AND AFROAMERICAN AMERICAN MENTAL HEALTH**

*David Smith, M.D., 1500 21st st, Sacramento, CA 95814*

**SUMMARY:**
There has been a disproportionate number of afroamericans with HIV/AIds and a staggering number of women amongst new cases. The phenomenon of " the down low " will be discussed including the stigma of homosexuality in the afroamerican religious community. Biologically all of the issues of misdiagnosis in this population become magnified. Medication choices for mental illness must take into account not ony obvious drug drug interactions but the high rates of kidney disease and diabetes in this population. The presentataion will include taped interviews and media film clips .

No. 99-E
**RESPONSE AND TOLERABILITY OF PSYCHOTROPICS IN AFRICAN AMERICANS**

*William Lawson, M.D., Ph.D., 2041 Georgia Avenue, Washington, DC 20060*

**SUMMARY:**
African Americans (AA) have less access to mental health services which may lead to poorer outcomes. Socioeconomic factors, racism, and inappropriate or missed diagnosis certainly are factors. Negative attitudes by patients of providers, psychotropics, and mental health in general are involved. Racial differences in tolerability and response to psychotropics may contribute to the unwillingness to accept psychotropics. AA are more likely to experience extrapyramidal side effects (EPS) with neuroleptics, and are less tolerant of tricyclic antidepressants, and lithium. Newer treatments reportedly showed fewer of these side effects. However while newer antipsychotics are less likely to cause EPS, they as well as newer antidepressants show a heightened risk for metabolic consequences. These metabolic effects are especially problematic for AA since they exacerbate known health disparities seen in AA. Recently approved antipsychotics seem to have a lessened risk for these metabolic consequences. Racial differences in response and outcome have been reported particular for antidepressants. Socioeconomic factors and substance abuse are clearly factors. Hepatic microsomal enzymes have been proposed as a factor. Ethnic differences in genetic polymorphisms for the serotonin receptor or transporter may also be important. Further research is needed in ethnopsychopharmacology. Adequate representation of African Americans in clinical trials is essential.

**REFERENCES:**
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**SYMPOSIUM 100**

**DYSFUNCTIONS IN MENTALIZATION OR METACOGNITION IN PERSONALITY DISORDERS: EMPIRICAL EVIDENCE AND IMPLICATIONS FOR PATHOLOGY, TREATMENT AND RESEARCH**

*Chairperson: Giuseppe Nicolo, M.D., Via ravenna 9 c, Rome, 00161 Italy*
*Discussant: Giuseppe, Giancarlo Dimaggio, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Have a broad and clear overview of the metacognitive or mentalistic impairment and to understand relevance for personality pathology; 2) Identify the different aspects of a metacognitive impairment; and 3) Learn how to assess it and how it may become a focus of treatment or an outcome variable.

**OVERALL SUMMARY:**
It is increasingly recognized that persons with personality disorders (PD) have difficulties in making sense of mental states and this impairment is a barrier to healing. For example patients with borderline PD example have problems forming an integrated image of the self and distinguishing mental representations from reality. Borderline PD also presents minor disturbances in decoding the facial expressions of the others. Many PD, such as avoidant, feature poor ability to recognize own's emotions and describe them in word, that is alexithymia. Therefore it appears more and more relevant correctly assessing the mentalistic or metacognitive impairment and tailor treatment accordingly. The speakers of this symposium will present evidence about the existence of a mentalizing or metacognitive impariments in PD and discuss how to best address them in therapy. Metacognitive or mentalizing impairments constitute one of the most significant difficulty in treating PD. In fact some therapy methods, such as mentalization-based treatment (1,2) or metacognitive interpersonal therapy (3,4) have been designed to improve the patient's ability to reason on mental states. Mentalization and metacognition could be considerd like outcome variable in psychotherapy treatment and also like moderator or mediator of change (5,6). One paper will describe how to assess the metacognitive disorder with clinical interview and explore its correlates with symptoms, social functioning and overall personality disorder severity.

No. 100-A

**IMPAIRED METACOGNITION AND CORRELATIONS WITH SYMPTOMS, SOCIAL FUNCTIONING AND OVERALL PERSONALITY DISORDER SEVERITY**

*Giuseppe Nicolo, M.D., Via ravenna 9 c, Rome 00161*

**SUMMARY:**
Evidence is accumulating that the capacity to understand mental states is a multifaceted phenomenon, and that different manifestations of psychiatric disorders involve different kinds of impairments in this human ability (1). Theory and evidence is mounting that personality disorders (PD) feature poor understanding of mental state or metacognition. Clinicians facing these problems are starting to search for solutions and results are promising. Evidence is emerging, for instance, that treatments may improve patients' capacities for understanding mental states by encouraging them to mentalize. Moreover, it has been noted that psychotherapy cases with good outcomes, can be conceptualized as promoting greater awareness of thoughts and feelings, better integration of representations of the self with others and an increase in the ability to adopt the perspective of other people. This involves the ability to identifying mental states and ascribing them to oneself and others and reflecting on and reasoning about mental states (2). We explored the hypotheses that: a) the more severe the PD - with severity measured as number of PD criteria met by a patient - the more impaired the metacognitive ability of the person; b) impaired metacognition correlates with symptoms; c) impaired metacognition correlates with social and interpersonal problems. In this paper around 200 patients have been assessed in an outpatient clinic in Italy, most of them suffering from PD as diagnosed with the SCID II. Measures: Metacognition Assessment Interview (MAI); Toronto Alexithymia Scale -20 ; Symptoms CheckList 90-Revised; Attachment Scale Questionnaire; Inventory of Interpersonal Problems-47; Global Assessment of Functioning (GAF). Correlations of the metacognitive impariment with symptoms and functioning, and implications for planning treatment in patients with PD will be discussed.

No. 100-B

**IMPROVING MENTALIZATION IN BORDERLINE PATIENTS IN TRANSFERENCE-FOCUSED PSYCHOTHERAPY (TFP)**

*John Clarkin, Ph.D., New York Presbyterian Hospital-Cornell Medical Center,21 Bloomingdale Road, White Plains, NY 10605*

**SUMMARY:**
In addition to impulsive and self-destructive behaviors, borderline patients have limited capacities to represent themselves and others, and represent their relations with others. This incapacity is seen as directly related to their disturbed relationships with others in friendships, intimate relations, and in work situation. Transference-Focused Psychotherapy (TFP) is focused on the nature and depth of the relationship between patient and therapist with the goal of clarifying and expanding the patients' ability to conceptualize self and others. TFP has been shown to not only significantly reduce symptoms, but also to significantly improve the patients' mentalization. The therapeutic process that leads to this change will be described in this presentation.

No. 100-C

**VERBAL ELABORATION OF DISTINCT AFFECT CATEGORIES IN BPD**

*Serge Lecours, Ph.D., C.P. 6128, succ. Centre-ville, MOntréal, H3C 3J7*

**SUMMARY:**
Verbal elaboration of affect (VEA) is an operational model of affect mentalization. It defines levels of verbal elaboration which can lead, in their most abstract and elaborate form, to a metacognitive approach to affective experience. Higher levels of VEA are conceptualized as leading to a "wiser" type of affect regulation, associated with increased integration of affect experience and better control over its expression. This type of affect regulation is known to elude most BPD patients. The present study explores the relationship between VEA and the severity of BPD symptoms in the verbal description of affective relationship episodes of 51 outpatients. Affect mentalization was assessed with the Grille de l'Élaboration Verbale de l'Affect (GEVA), an observer-rated measure of levels of elaboration of verbalized affect, and the Measure of Affect Content (MAC), which identifies the content of the verbalized affect (e.g. anger). Diagnostic criteria were obtained with the SCID-II interview. A "wise" regulation of affect is operationnalized as a combination of openness to affective experience, without excess (adequate frequency of affect categories), and of the achievement of cognitive articulation of subjective experience (higher levels of VEA). The severity of BPD symptoms was related to a higher frequency of disgust and contempt directed toward others, anger directed toward self, as well as to less frequent sadness. It was also associated with lower levels of VEA for sadness and hostility directed toward self. Patterns of VEA for BPD criteria directly related to affect dysregulation will also be discussed. These findings point to a selective deficit of affect regulation in BPD which suggests the need for interventions facilitating increased mentalization for distinct affect categories: more control over hostility and more openness to sadness. Thus, BPD is associated with a difficulty regulating hostility, directed toward others and self, and sadness.

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**SYMPOSIUM 102**

## TREATING BORDERLINE PERSONALITY DISORDER: CURRENT PSYCHODYNAMIC PERSPECTIVES

*Chairperson: Eve Caligor, M.D., 19 East 88th Street, New York, NY 10128*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the basic models of pathology of borderline personality disorder underlying MBT, TFP, SE and integrative approaches; 2) Demonstrate an understanding of the strategies and techniques employed by MBT, TFP and SE to treat borderline personality disorder; 3) Make use of the basic psychotherapeutic techniques employed by each of these treatments approaches; and 4) Demonstrate an understanding of the theoretical and technical elements common to these different treatment approache

**OVERALL SUMMARY:**

The clinical challenges presented by patients with borderline personality disorder are well known to clinicians, and long-term psychotherapy remains a cornerstone of successful treatment. Psychodynamically-oriented clinicians and researchers have worked extensively and in-depth with this patient population, and clinical experience and empirical findings have led to the development of a variety of psychodynamically-oriented treatment approaches designed to meet the clinical needs of for patients with borderline personality disorder. Transference-focused psychotherapy (TFP) and Mentalization-base Therapy (MBT) are both manualized, empirically tested psychodynamically-oriented psychotherapies, representing the most clearly described and extensively researched psychodynamic treatments for BPD. Supportive-Expressive (SE) and integrative psychodynamic psychodynamically-oriented psychotherapeutic approaches are also widely described in the literature and widely practiced in the community. This symposium will offer a systematic presentation of these four psychodynamic models of treatment and will address the following questions:1 – What are the essential elements of each treatment? 2 – To what degree do the models overlap? 3 – Might one model be more appropriate than another for particular sub-populations of patients with borderline personality disorder? 4 – To what degree are models that are manualized and researched practiced in "pure form" in clinical settings? Should this be a goal? The symposium will begin with overviews of MBT, TFP, SE psychotherapy, and an integrative dynamic approach. Each overview will cover the model of pathology within which the treatment is embedded, treatment goals and model of therapeutic change, followed by description of the treatment including treatment frame, therapeutic stance, and the specific strategies, tactics and techniques that define each treatment. The overviews will be followed by a case presentation. Each panelist will discuss the clinical material as a means of illustrating the application of his clinical approach, including how the presenter formulates the clinical problem and how the treatment discussed would address the identified clinical problem within that treatment framework. The symposium chair will direct discussion regarding similarities and differences among these treatments as well as the issue of the relationship between manualized, evidence-based models and clinical work in the commu

No. 102-A

## KEY CLINICAL INTERVENTIONS OF MENTALIZATION BASED TREATMENT

*Anthony Bateman, M.D., St Ann's Hospital, London, N15 3TH*

**SUMMARY:**

In this brief presentation an outline will be given of the key features of mentalization based treatment (MBT). The aim of MBT is to increase the mentalizating capacity of the individual particularly in interpersonal relationships and during states of high emotional intensity. The steps undertaken by the therapist will be outlined as if they are delivered in a step-wide manner only for clarity. First the therapist takes a specific not-knowing stance. Once this is underway he identifies any break in mentalizing, indicated

by psychic equivalence, pretend mode, or teleological understanding. The emergence of these modes of thinking indicates that mentalizing is vulnerable and marks a point at which the therapist needs to try to re-stimulate mentalizing. Next, the therapist asks the patient to rewind to the moment before the break in subjective continuity occurred. If necessary the therapist pinpoints the moment when he thought a change occurred. Third, the therapist explores the current emotional context contributing to the break in the session by identifying the momentary affective state between patient and therapist. Fourth, the therapist explicitly identifies and owns up to his own contribution to the break in mentalizing. It is only after this work has been done that the therapist seeks to help the patient understand the mental states implicit in the current state of the patient-therapist relationship which forms mentalizing the transference. The clinical case which forms the focus for this session will be used to illustrate the clinical interventions used in MBT. These will be contrasted with other psychodynamic treatments.

No. 102-B
**TRANSFERENCE-FOCUSED PSYCHOTHERAPY IN THEORY AND IN PRACTICE**

*Frank Yeomans, M.D., Ph.D., 286 Madison Avenue suite 1602, New York, NY 10017*

**SUMMARY:**
Transerence-Focused Psychotherapy (TFP), designed for patients with BPD and other serious personality disorders, is a twice weekly individual therapy based on psychodynamic concepts. It rests upon the idea that mental conflicts play a large role in specific symptom development. TFP places special emphasis on assessment and a treatment contract established with patient collaboration to anticipate likely threats to the patient's well-being and to the treatment. TFP explores the psychological structure that underlies specific symptoms of BPD by focusing on the fundamental split that divides in the patient's mind internal representations of self and others into extremes of bad (negative affects) and good (positive affects). This split determines how the patient perceives and experiences himself and the world around him, is the basis of the patient's chaotic and troubling way of experiencing self, others and the environment, and manifests itself in stormy interpersonal relations and impulsive self-destructive behaviors. TFP contains the behaviors of BPD pathology through the structure, limit setting, and the developing relation with the therapist. Elements of the split psychological structure are observed and analyzed as they unfold in the transference. As the patient better appreciates his internal world, he can begin to understand the anxieties underlying the internal split between positive and negative affects. The goal is to integrate these extreme affects into a more coherent and textured sense of self. The theory, principles, and techniques of TFP have been described in a treatment manual and are taught extensively. A theme for this symposium will be the cohesiveness of the model as a whole, the overlap with other models, and the usefulness of elements of the model for therapists who chose to integrate these elements into a broader overall approach.

No. 102-C
**OVERVIEW OF EXPRESSIVE SUPPORTIVE PSYCHOTHERAPY (ESP)**

*John Gunderson, M.D., 115 Mill Street, Belmont, MA 02478*

**SUMMARY:**
The general model of ESP combines encouraging patients to open up areas of pain or conflict with supportive interventions. While the "opening-up" interventions use general psychodynamic principles of identifying covert feelings and motives, but unlike traditional psychoanalytic therapies, the ESP model presented here makes active use of therapist self-disclosures, reassurances, and offering directives—including admonitions about what the therapist believes is good or bad for the patient's welfare. Indirect support for the efficacy of these interventions can be found in evidence-based treatments (i.e., the Menninger Psychotherapy Research Project (Wallerstein 1980), and in recent trials of Supportive Therapy vs. (Applebaum 2005), and of proactive Case Management (Links et al., 1998). The proposed model additionally (and enthusiastically) adapts interventions highlighted by DBT and MBT (Links et al., in press). This model of ESP includes specific interventions not found in prior EBT studies; these include the liberal use of psychoeducation (about BPD and it's therapies), the focus on work (more than love), the value of split treatment (especially group modalities), and the collaborative involvement of families.The model of supportive expressive psychotherapy which the preventor has evolved is eclectic, generalizable, and pragmatic. Still, it is not one which can be learned easily without significant experience in case management.

No. 102-D
**AN OVERVIEW OF INTEGRATED PSYCHOTHERAPY FOR BPD**

*Glen Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 77030-1316*

**SUMMARY:**
A basic principle of psychodynamic psychotherapy is that one adjusts the treatment to the patient, not the patient to the treatment. Nowhere is this more applicable than with borderline personality disorder. This diagnostic entity is, in reality, a spectrum with varying degrees of capacity for psychological mindedness. At least four studies, for example demonstrate greater neuropsychological impairments on psychological testing in BPD subjects compared to

controls. Hence patients with limited capacity for abstract thinking may require more ego-supportive approaches while others may do well with interpretive strategies. Moreover, some patients work well with transference while others do not. To complicate the situation further, depending on the patient's affective state, the capacity for psychological work may vary from session to session. The therapist must shift flexibly from one strategy to another to stay with the patient's needs at the moment. This flexible approach captures what most good therapists do when not required to adhere to a manualized approach as part of an RCT.

No. 102-E
**CASE PRESENTATION: TREATING BPD WITH MBT**

*Peter Fonagy, Ph.D., University College London, Gower Street, London WC1 6BT, London, WC1 6BT*

**SUMMARY:**
The paper will be a discussion of a clinical case highlighting (a) the formulation of the case form the point of view of MBT as a treatment approach, (b) suggesting an illustrative treatment plan based on the formulation and © illustrating the technique of working with BPD patients with MBT. Participants will acquire a concrete sense of how MBT therapists and supervisors think about and work with BPD patients.

**SYMPOSIUM 103**

**COMPREHENSIVE HIV PSYCHIATRY UPDATE**

*Chairperson: Karl Goodkin, M.D., Ph.D., 8730 Alden Dr., Suite E-101, Los Angeles, CA 90048*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand current medical and treatment approaches; 2) Understand the incidence of neuropsychiatric and psychiatric illness; 3) Understand diagnostic and treatment approaches to psychiatric symptoms; 4) Understand the pathophysiology of HIV-1-associated neurocognitive impairment and disorders; and 5) Recognize that there are drug interactions between HIV medications and psychiatric medications.

**OVERALL SUMMARY:**
After more than 25 years, AIDS has evolved from a rapidly progressive and often fatal severe illness into a chronic medical illness. With people living longer, there is an increasing HIV-positive population living with multiple psychiatric co-morbidities, requiring the special training of psychiatry. And the pandemic continues with 5,300,000 new AIDS cases reported annually throughout the world and 50,000 new AIDS cases reported annually in the United States. In this symposium, we will present current approaches to the care of persons with HIV and AIDS. We will provide a comprehensive overview of current practice with a biopsychosocial approach to sources of severe distress in persons with HIV. Prevention of HIV-associated neurocognitive disorders has remained elusive and loss of cognitive function remains a source of distress. Antiretroviral treatments have changed the face of AIDS but can result in severe distress from lipodystrophy and their impact on appearance and body image and we will present new approaches to this source of anguish. Psychiatric care including psychotherapeutic modalities and psychotropic medications can reduce transmission of HIV, improve adherence to care, alleviate pain and suffering, and help patients, families, and caregivers to face the illness with optimism and dignity.

No. 103-A
**HIV/AIDS MEDICAL UPDATE**

*David Mushatt, M.D., M.P.H., 1415 Tulane Avenue, New Orleans, LA 70112*

**SUMMARY:**
There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. While antiretroviral regimens have fewer side effects, adherence to treatment is as crucial as ever to maintain a non-detectable viral load and to maximize immune reconstitution and must be durable for many years. This session will provide the most up-to-date epidemiological information, guidelines for antiretroviral therapy, and considerations for patients with a history of drug use, hepatitis C virus co-infection, and mental illness. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.

No. 103-B
**NEUROPSYCHIATRIC OVERVIEW**

*Mordecai Potash, M.D., 1415 Tulane Avenue, New Orleans, LA 70112*

**SUMMARY:**
Since the beginning of the epidemic over 28 years ago, the role of the psychiatrist has been critical in the management of HIV/AIDS. The prevalence of HIV among people with severe mental illness is estimated to be approximately ten times that in the US general population, and even higher among people with co-morbid substance use disorders. Psychiatric conditions may reduce adherence to HIV treatments and increase the likelihood of high risk sexual

and drug use behaviors. Depressive disorders are nearly twice as common in HIV positive subjects compared to matched controls and may be associated with HIV disease progression. Psychiatrists must consider the potential direct effects of HIV on the central nervous system, the peripheral nervous system, and on other organ systems when assessing neuropsychiatric and psychiatric complaints. In addition, persons with HIV are often on multiple medications that may have psychiatric side effects or may induce complex drug-drug interactions. Approximately 12% of people with HIV have a concurrent diagnosis of drug dependence, further complicating assessment and treatment. This presentation will review (1) the epidemiology of mental health disorders in HIV; (2) the differential diagnosis and evaluation of neuropsychiatric and psychiatric symptoms in the context of HIV; (3) the general psychopharmacologic and psychotherapeutic treatment approaches to neurocognitive, mood, anxiety, and psychotic disorders in HIV; and (4) the potential role of the neuropsychiatrist and psychiatrist in HIV prevention and as a member of an integrated, multidisciplinary approach to HIV medical care.

No. 103-C
**NEUROCOGNITIVE DECLINE**

*Karl Goodkin, M.D., Ph.D., 8730 Alden Dr., Suite E-101, Los Angeles, CA 90048*

**SUMMARY:**
Although HIV-1-associated dementia and minor neurocognitive disorder have declined in incidence, HIV-1-associated neurocognitive impairment continues to be a frequent and clinically important focus in the highly active antiretroviral therapy (HAART) era. This change is consistent with neuropathological changes noted in which the encephalopathy has actually become more common, although less severe than in the pre-HAART era. The clinical manifestations of the HIV-1 associated neurocognitive disorders themselves have changed, with chronic inactive and fluctuating forms of the dementia, for example, becoming more common. Long-term toxicities of the antiretroviral themselves are now known to contribute to the etiology of these disorders, primarily through the addition of a vascular pathogenic factor. Thus, new criteria have been promulgated for HIV-associated dementia (HAD) and minor cognitive-motor disorder (MCMD) [now referred to as mild neurocognitive disorder (MND)], and asymptomatic neurocognitive impairment has been added as a condition to be diagnosed. The laboratory measures posing a risk for neurocognitive disorder, HIV progression, and lack of treatment response that were useful previously for these disorders are no longer highly predictive in the HAART era. The HIV-associated neurocognitive disorders (HAND) conditions remain diagnoses of exclusion. Documented, effective therapies for these treatment targets remain largely constrained to the CNS-penetrating antiretroviral regimens and the psycho stimulants. The recently FDA-approved antiretroviral drugs in the classes of CCR5 antagonists and integrate inhibitors deserve study for the treatment of HAND, along with antiretroviral adjuvant pharmacotherapy's specific to the CNS.

No. 103-D
**PSYCHOPHARMACOLOGY**

*Marshall Forstein, M.D., Jamaica Plain Massachusettes, 02130*

**SUMMARY:**
The current psychopharmacology for HIV/AIDS recognizes particular drug interactions between HIV medications and psychiatric drugs. Highly active antiretroviral therapy, known as HARRT, is the drug regimen which needs to be taken every day for viral suppression and control of the disease. HAART is broadly divided into three categories which follow predictable metabolic pathways in the liver known as the cytochrome p450 system. HAART can compete with psychiatric medications in the liver, block or slow down these pathway (inhibit) or increase the activity or enhance the pathway (induce). HARRT is metabolized by the cytochrome 3A4 and the 2D6 pathways which are the same ones used by many psychiatric drugs. An overview of the clinically significant interactions will be offered. Clinicians will be introduced to medication interaction tables that are free, reliable, easy to use and readily available by the internet. Clinicians will also appreciate the potential dangers of certain medications such as trazodone due to drug-drug interactions as well as other prescribed and over the counter medications. Recreational drugs (including "club" drugs) and their interactions will be discussed as well.Some HIV medications which are the backbone of treatment (such as efavarenz or Sustiva) can worsen symptoms for individuals with major depression or post-traumatic stress disorder. This can lead to non-adherence to the medications. Pharmacologic strategies will be discussed. Both individuals taking HAART as well as individuals with HIV who do not yet require HAART can have increased sensitivity to medications which are commonly used in psychiatry. These include lithium, valproate, antidepressants and antipsychotics. These will be discussed. Recognition of the stage of HIV/AIDS of the individual can be helpful in making medication determinations and this will be described as well.

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## SYMPOSIUM 104

## UNDERSTANDING COMORBIDITY OF HEART DISEASE WITH DEPRESSION AND ANXIETY DISORDERS

*Chairperson: Ruby C Castilla-Puentes, M.D., D.P.H., 530 South 2nd. St. Suite 743, Philadelphia, PA 19147,*
*Co-Chairperson: Maria A Oquendo, M.D.*
*Discussant: Carlos León-Andrade, M.D.*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the relationship between panic disorder, depression and coronary heart disease; 2) Review the pathophysiological alterations associated with depression, panic disorder and coronary heart disease; and 3) Evaluate the effective treatment options for both panic disorder and depression.

### OVERALL SUMMARY:

There has been increased interest in the role of psychological conditions and the risk for developing cardiovascular disease over the last two decades. Depression has been the most extensively studied psychological condition influencing the development and prognosis of coronary heart disease (CHD). Very little is known, however, about the risk of CHD conferred by both, depression and a history of panic disorder (PD). PD is characterized by unpredictable and devastating feelings of fear accompanied by a variety of symptoms of sympathetic nervous system arousal, such as sweating, tremor, palpitations, and diarrhea. Symptoms associated with PD are very similar to those of acute cardiovascular events, such as sweating, shortness of breath, palpitations, sensation of choking, and hot flashes. Recent evidence suggests that PD is prevalent among 7 to 53% of CHD patients and 3 to 8% of patients in the primary care setting. The large overlap between PD, depression and CHD suggests a potentially common mediated etiology between these 3 conditions.In this symposium we will addresses the epidemiology, diagnosis and clinical features of the relationship of a history of PD, a concurrent diagnosis of depression (a comorbid condition with PD), and the risk of CHD; the possible physiopatology (including genetic factors) and the treatment options.

No.104-A
### DEPRESSION-ANXIETY COMORBIDITY: CLINICAL ASPECTS

*Jose Luis Ayuso, M.D., Ph.D., Alcala 152,, Madrid, 28028*

### SUMMARY:

Physicians often attempt to separate depression from anxiety. Unfortunately, such distinctions are often challenging and artificial. Anxiety symptoms are common in patients with major depression: 72% worry, 62% present with psychic anxiety, 42% have somatic anxiety, and 29% have panic attacks. Factors that favor MDD include symptoms such as anergic hopelessness, feeling as if they “just can’t go on,” anhedonia, and early-morning awakenings, whereas problems such as initial insomnia, worry or fears, and specific behaviors such as avoidance or phobias point to anxiety. However, as the National Comorbidity Survey indicates, comorbid depression and anxiety is the rule rather than the exception in up to 60% of patients with MDD. Clinical practice suggest that many patients who attend primary care settings or psychiatric outpatient clinics show mixed anxious and depressive symptoms of different severity. The symptomatologic overlapping rises important questions for the clinician. The basic question we will respond in this presentation is: to which extent the predominance of anxious or depressive symptoms has an influence on diagnosis or treatment?

No. 104-B
### TREATMENT OF ANXIETY DISORDERS IS ASSOCIATED WITH A SIGNIFICANTLY LOWER PREVALENCE OF SECONDARY DEPRESSION

*Leo Russo, Ph.D., 725 Chesterbrook Blvd, Wayne, PA 19087*

### SUMMARY:

Comorbidity of anxiety and depression increases the level of impairment, disability and socio-economic impact of these disorders. Early recognition and treatment of anxiety disorders might therefore prevent development of secondary depression and improve long-term health outcomes. Using data from a large community based study investigating the prevalence and associated factors of mental disorders in the general population of 6 European countries, we will present data comparing the frequency of secondary depression and other health outcomes, in individuals with a lifetime occurrence of a primary anxiety disorder, according to whether treatment was sought. Treatment of primary anxiety disorders was associated with a significantly lower prevalence of secondary depression. Furthermore, treatment of certain anxiety disorders is associated with a lower frequency of suicidal ideation and healthcare utilisation. These data emphasise that early treatment intervention may improve long-term prognosis and reduce healthcare costs. Antidepressants with broad spectrum efficacy and good tolerability across the anxiety

disorders may provide a valid treatment option.

No. 104-C

**NEUROBIOLOGICAL MECHANISMS IN ANXIETY/ DEPRESSION AND THE IMPACT ON CORONARY HEART DISEASE**

*Jorge Tellez-Vargas, M.D., Carrera 18 79-40 of 301, Bogota 089*

**SUMMARY:**
Separating the independent effect of depression and anxiety is difficult given their common concurrence. Biologic pathways involving the sympathetic nervous system, the hypothalamic-pituitary axis, and the coagulation pathway are all implicated. A considerable body of preclinical and clinical evidence suggests that dysregulated activity of noradrenergic systems in the brain is involved in the development of mood disturbance, anxiety, and fear. Neuroanatomical and neurophysiological studies of the noradrenergic system provide a basis for relating increased activity of this system to the behavioral expression of fear and anxiety and the somatic symptoms and cardiovascular changes that accompany severe anxiety states. This presentation examine neuronal, hormonal, and immunologic responses in anxiety/depression and the possible impact on coronary heart disease (CHD).

No. 104-D

**UNDERSTANDING COMORBIDITY OF HEART DISEASE WITH DEPRESSIÓN AND ANXIETY DISORDERS**

*Ricardo Secin, M.D., Hospital Angeles Pedregal, Cmno. Sta Teresa 1055-602,, Mexico, 10700*

**SUMMARY:**
Despite the availability of efficacious treatments, panic is often undiagnosed and untreated. Delay in diagnosis and treatment of several chronic medical conditions is clearly associated with a greater risk of subsequent associated morbidity (e.g., untreated hypertension is associated with greater risk of coronary disease- CHD). Treatment of panic attack may be a roadblock or a detour on the pathway from panic symptoms to major depression. In this regard, it is interesting to note that panic and major depression share a recommended first-line psychopharmacological treatment, i.e., selective serotonin reuptake inhibitors. The purpose of this presentation is to review the alternatives of treatment of panic disorders, comorbid with major depression in patients with CHD.References: Narrow WE, Regier DA, Rae DS, Manderscheid RW, Locke BZ: Use of services by persons with mental and addictive disorders: findings from the National Institute of Mental Health Epidemiologic Catchment Area Program. Arch Gen Psychiatry 1993; 50:95-107

No. 104-E

**DEPRESSION AND PANIC DISORDERS SIGNIFICANTLY INCREASE THE RISK FOR HEART DISEASE: ONE MORE PIECE OF EVIDENCE**

*Ruby Castilla-Puentes, M.D., D.P.H., 530 South 2nd. St. Suite 743, Philadelphia, PA 19147*

**SUMMARY:**
The association between panic disorder (PD), depression and coronary heart disease (CHD) was examined in a large national (US) managed care database. A cohort study was designed with more than 30,000 PD patients and an equal number of patients without PD. The Cox proportional hazards regression models were used to assess the risk of CHD adjusted for age at entry into the cohort, tobacco use, obesity, depression, and use of medications including angiotensin converting enzyme inhibitors, beta blockers, and statins. Patients with PD were observed to have nearly a 2-fold increased risk for CHD after adjusting for these factors. There was some evidence of a possible trend toward increased risk in a subgroup of patients diagnosed with depression. After controlling for the aforementioned covariates and comparing these patients with those who did not have a diagnosis of depression, it was noted that patients with a comorbid diagnosis of depression were almost 3 times more likely to develop CHD. The risk of CHD associated with a diagnosis of PD suggests the need for cardiologists and internists to monitor panic disorder to ensure a reduction in the risk of CHD.

No. 104-F

**ASSOCIATION STUDY BETWEEN BLOOD PRESSURE AND PERSONALITY, ANXIETY AND DEPRESSION**

*Jorge Ospina, M.D., Calle 2 Sur # 46-55, Consultorio 335. Clínica Las Vegas, Medellin, 335*

**SUMMARY:**
Individuals with heart disease are twice as likely to suffer from depression as the general population, an association the medical community has largely been unable to explain. Several mechanisms have been suggested to account for the greater prevalence of depression/anxiety among cardiac patients, including the stress of a poor prognosis and systemic inflammation, although little attention has been paid to date about the possibility of a genetic cause. Following genotyping analyses, studies have discovered that genetic variations involving endothelial dysfunction and platelet aggregation appear to contribute to depressive symptoms. Genome-wide association studies, which involve the study of genetic variations across the entire human genome , are needed to further identify genes and pathways that may be associated with depression and heart disease. In this presentation we will review studies that

reveal there may be genetic variations that contribute to depression in heart disease patients

No. 104-G

**STRATEGIES FOR OPTIMIZING TREATMENT OF DEPRESSION AND PANIC DISORDER: WHAT TO DO WHEN SSRIS FAIL?**

*Carolina Remedi, M.D., Ambrosio Olmos 688 8o Nueva Cordoba, Cordoba, 5000*

**SUMMARY:**
Selective serotonin reuptake inhibitors (SSRIs) are the drug of choice for treatment of patients with comorbid depression and panic disorder. Most patients have a favorable response to SSRI therapy; however, almost 30 percent will have an unfavorable or incomplete response. Strategies to improve treatment of such patients include optimizing SSRI dosing (starting at a low dose and slowly increasing the dose to reach the optimal dose) and ensuring an adequate trial before switching to a different drug. Benzodiazepines, when necessary, may be used for a short duration or may be used long-term in patients for whom other treatments have failed. Slower-onset, longer-acting benzodiazepines are preferred. All patients should be encouraged to try cognitive behavior therapy. Augmentation therapy should be considered in patients who do not have a complete response. Drugs to consider for use in augmentation therapy include benzodiazepines, new antiepileptic medications, valproate sodium, buspirone, beta blockers and tricyclic antidepressants

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**SYMPOSIUM 105**

**THE ETHICS OF INNOVATIVE INTERVENTIONS IN PSYCHIATRY**

*Chairperson: Paul S. Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032,*
*Co-Chairperson: Laura B Dunn, M.D.*
*Discussant: Scott Y Kim, M.D., Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify major ethical issues associated with innovative treatments in psychiatry; and 2) Describe reasonable approaches to resolving them.

**OVERALL SUMMARY:**
Recent years have seen new treatment and diagnostic approaches in psychiatry, each of which has raised ethical issues. Some of the questions apply to innovative treatments in general: when are treatments ready to move from development into human trials and then into clinical use; how can meaningful consent be obtained from research subjects and patients when there is limited experience; what strategies should be used to manage expectations of recipients who may be desperate for help and unrealistically optimistic about the chances of success? But each new intervention also brings unique challenges of its own. This symposium will focus on the ethical issues associated with 4 new approaches in psychiatry. Deep brain stimulation (DBS), a technique used widely for Parkinson's disease, is now being applied to depression, OCD, and other psychiatric disorders. Concerns with DBS relate to the potential for serious risks, the uncertainties of benefit, and the abilities of those with severe mental illness to provide meaningful consent. Genetic screening for certain psychiatric disorders has become available, in some cases via the internet. Challenges exist in defining when such testing is appropriate—given relatively low predictive values and the risk of stigmatization—and in helping patients use such information appropriately. Transcranial magnetic stimulation (TMS) and vagal nerve stimulation (VNS) are being used for depression and other disorders. However, equivocal evidence regarding efficacy has raised issues regarding selection of patients and the consent process. Finally, enhancement therapies, such as stimulants to improve school or work performance, may not target disorders in the usual sense, but aim at improving normal function. Active controversies exist over the legitimacy of using medical approaches to address issues of performance. The discussant will highlight ethical similarities and differences across these techniques, and how they might be addressed.Many psychiatric disorders remain intractable and severely disabling, despite patients' and practitioners' best attempts to find effective treatments. For some people, desperate for help, new treatment modalities currently either approved (vagal nerve stimulation, transcranial magnetic stimulation), or under study (deep brain stimulation, or DBS) may seem appealing and "cutting edge." DBS, which involves chronic high frequency stimulation in pathologically active brain circuit, is already FDA-approved as a neurosurgical treatment for Parkinson's disease (PD), essential tremor and dystonia. Numerous research efforts are now underway to examine the efficacy and safety of DBS for psychiatric conditions, with preliminary efficacy shown in relatively small studies of DBS for treatment-resistant major depression (TRD), obsessive-compulsive disorder (OCD), and Tourette's syndrome. As DBS is evaluated in more broadly defined clinical populations—potential future targets could include bipolar disorder, schizophrenia, addictions, eating disorders, Alzheimer's Disease (AD), and childhood-onset disorders—ethical concerns are certain to intensify and gain increasing public awareness. This presentation will

analyze a set of ethical issues regarding DBS as a treatment for mental illness, placing them in the context of available empirical evidence. We discuss four overlapping types of ethical objections to DBS as treatment for mental illness. These include the novelty of the technology and the negative emotional reactions that may be elicited by this modality, the potential for serious risks, concerns about misuse based on historical precedent, and concerns about unique vulnerabilities of those with mental illness. This presentation will examine the ways in which these issues are or are not unique to psychiatric research.

No. 105-A

**ETHICAL ISSUES IN DBS RESEARCH FOR PSYCHIATRIC DISORDERS**

*Laura Dunn, M.D., 401 Parnassus Ave., Box 0984-F, San Francisco, CA 94143-0984*

**SUMMARY:**

Many psychiatric disorders remain intractable and severely disabling, despite patients' and practitioners' best attempts to find effective treatments. For some people, desperate for help, new treatment modalities currently either approved (vagal nerve stimulation, transcranial magnetic stimulation), or under study (deep brain stimulation, or DBS) may seem appealing and "cutting edge." DBS, which involves chronic high frequency stimulation in pathologically active brain circuit, is already FDA-approved as a neurosurgical treatment for Parkinson's disease (PD), essential tremor and dystonia. Numerous research efforts are now underway to examine the efficacy and safety of DBS for psychiatric conditions, with preliminary efficacy shown in relatively small studies of DBS for treatment-resistant major depression (TRD), obsessive-compulsive disorder (OCD), and Tourette's syndrome. As DBS is evaluated in more broadly defined clinical populations—potential future targets could include bipolar disorder, schizophrenia, addictions, eating disorders, Alzheimer's Disease (AD), and childhood-onset disorders—ethical concerns are certain to intensify and gain increasing public awareness. This presentation will analyze a set of ethical issues regarding DBS as a treatment for mental illness, placing them in the context of available empirical evidence. We discuss four overlapping types of ethical objections to DBS as treatment for mental illness. These include the novelty of the technology and the negative emotional reactions that may be elicited by this modality, the potential for serious risks, concerns about misuse based on historical precedent, and concerns about unique vulnerabilities of those with mental illness. This presentation will examine the ways in which these issues are or are not unique to psychiatric research.

No. 105-B

**THE ETHICS OF GENETIC SCREENING FOR PSYCHIATRIC DISORDERS**

*Paul Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032*

**SUMMARY:**

Current evidence suggests that the etiology of most psychiatric disorders rests on a combination of multiple genetic and environmental factors. Tests for the gene variants involved are becoming more easily available, with several already marketed directly to consumers on the internet, e.g., the serotonin transporter gene, which has been linked to risk of depression, and the promoter region of the monoamine oxidase A gene, which has been connected with antisocial behavior. Availability of genetic tests is likely to lead to pressures to use them for prenatal testing, screening of children and adults, selection of potential adoptees, and premarital screening. This will occur despite evidence that most alleles linked to psychiatric disorders have relatively limited predictive power, and in the absence of accepted interventions to prevent onset of the disorders. Common problems that will need to be addressed include popular misunderstanding of the consequences of possessing an affected allele, impact of knowledge of one's genetic make-up on one's sense of self, and the discriminatory use of genetic information to deny persons access to insurance and employment. Although most states and the federal government have legislation aimed at preventing discrimination, the laws' coverage is incomplete and enforcement will be difficult. Physicians may find that newly available genetic information creates new duties for them, including warning third parties who may share the patient's genetic endowment. And genetics research itself has raised questions about when to disclose information to subjects and their family members about the genes that are being studied, and how to define the subjects of the research when information is collected about family members other than the proband. Approaches to this range of issues are urgently needed in psychiatric practice, and should be based on a realistic understanding

of the limits of knowledge that can be gained from genetic tests.

No. 105-C

**ETHICAL ISSUES RELATED TO THE USE OF TRANSCRANIAL MAGNETIC STIMULATION AND VAGUS NERVE STIMULATION IN PSYCHIATRY**

*Paul Holtzheimer, M.D., 101 Woodruff Circle NE, Suite 4000, Atlanta, GA 30322*

**SUMMARY:**
Focal brain stimulation techniques are receiving increasing attention as potentially valuable therapies for a number of psychiatric disorders, especially treatment-resistant depression. Transcranial magnetic stimulation (TMS) involves non-invasive induction of an electrical current in the cortex under the electromagnetic coil and is approved by the U.S. Food and Drug Administration (FDA) for the treatment of depressed patients that have not responded to one antidepressant treatment. VNS requires relatively minor surgery to attach a stimulation electrode to the vagus nerve and a subcutaneous pulse generator that provides chronic, intermittent stimulation; VNS is FDA-approved for medication-refractory epilepsy and for the long-term treatment of depression that has not responded to at least four antidepressant medications. Despite FDA approval of these interventions, their use is somewhat controversial due to low reported response and remission rates, uncertain long-term benefits, no available predictors of which patients are most likely to benefit, and cost (with patients potentially responsible for the full cost of these therapies with no assistance from a third party payor). Therefore, the clinical use of TMS and VNS raises important ethical considerations related to which patients should be offered these interventions and how appropriate informed consent should be obtained. This presentation will briefly describe these treatments and their supporting clinical data, then discuss the ethical issues related to their clinical use in psychiatry.

No. 105-D

**ETHICAL ISSUES IN PHARMACOLOGIC ENHANCEMENT**

*Jinger Hoop, M.D., M.F.A., Department of Psychiatry and Behavioral Medicine Medical College of Wisconsin 8701 Watertown Plank Road, Milwaukee, WI 53226*

**SUMMARY:**
One of the more contentious ethical issues raised by recent psychiatric interventions is the use of psychopharmacology to improve normal human functioning. Selective serotonin reuptake inhibitors (SSRIs), for example, may have some usefulness as “personality enhancers” as well as psychiatric treatments. Beta blockers may have benefit as agents to prevent posttraumatic stress disorder by blocking emotion-laden aspects of memory. Psychostimulants and the wakefulness-enhancing drug modafinil are used by students and even scientific researchers to improve mental focus and intellectual ability. On a philosophical level, these types of enhancement raise profound questions about what it means to be authentically human: To continually strive to better oneself, using one’s creativity and innovation? Or to fully accept one’s shortcomings, suffer with them, and learn from them? Enhancement also raises questions about the potential impact upon society. On the one hand, it could help mitigate the problems of an increasingly troubled world--creating smarter leaders, kinder parents, less emotionally scarred veterans. On the other hand, enhancement might lead to a widening opportunity gap among students and workers who can afford to enhance and those who cannot, and a coercive pressure to use drugs to keep up with one’s peers. Clinical psychiatrists are on the front lines of prescribing medications that could be used for enhancement purposes and will benefit from an understanding of the philosophical complexities and ethical controversies surrounding this emerging practice.

**REFERENCES:**

1) Appelbaum PS: Ethical issues in psychiatric genetics. Journal of Psychiatric Practice 2004; 10:343-351.

**SATURDAY, MAY 22, 2010**
**9:00 AM-10:30 AM**

WORKSHOP 1
## MANAGEMENT OF THE SUICIDAL OUTPATIENT: BEYOND THE CONTRACT FOR SAFETY

*Chairperson: Jeanne Goodman, M.D., 1051 Riverside Drive, Box 106, New York, NY 10032*
*Presenters: Mark Petrini, M.D., Barbara H. Stanley, Ph.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, the participant should be able to: 1) Describe the purpose of a safety plan intervention; 2) Recognize clinical scenarios in which the use of such a plan is appropriate; 3) Develop the six major steps of the safety plan collaboratively with outpatients; and 4) Devise the written safety plan with outpatients in a readily accessible and easy-to-use manner.

**SUMMARY:**
Managing patients who become suicidal in outpatient treatment is one of the most challenging and anxiety-provoking aspects of clinical practice. Yet most practitioners face this challenge routinely. Clinicians often feel that their options for managing a suicidal crisis are limited: ask the patient to agree to seek help before acting on a suicidal impulse (known as a “contract for safety”), call 911, or go to the nearest emergency room.
In this workshop, participants will have the opportunity to practice a safety plan intervention which can be utilized on an outpatient basis to manage suicidal crises and promote recovery. The safety plan, developed by Stanley et al. (Stanley B., 2009) is a prioritized written list of coping strategies and resources for use during a suicidal crisis. Individual safety plans are created collaboratively by the patient and the therapist using cognitive and dialectical behavioral approaches. At the beginning of this workshop, emergency psychiatrist Dr. Mark Petrini will lead an interactive discussion about how to determine which suicidal patients are best sent to the emergency room for evaluation. For those who may be better managed as outpatients, Dr. Barbara Stanley will then present the six major steps of the safety plan, including recognizing warning signs, employing internal coping strategies, socializing for distraction, contacting family or friends for help with the suicidal crisis, contacting a mental health professional and, finally, reducing the potential for use of lethal means. The safety plan will be taught interactively, mainly through role-play. Upon completion of this workshop, participants will feel comfortable with the development and implementation of a safety plan. Given that existing active interventions have not been shown to be effective for many suicidal patients, particularly chronically suicidal outpatients, the ability to implement a safety plan is a critical skill necessary in the management of suicidal outpatients.

**REFERENCES:**
1. Stanley, B. Brown, G., Brent, DA, Wells, K. Poling, K., Kennard, B., Wagner, A., Curry, J., Cwik, M., Goldstein, T., Vitiello, B., Klomek Brunstein, A., Barnett, S., Daniel, S: Cognitive Behavior Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility and Acceptability. J Am Acad Child Adolesc Psychiatry Oct, 2009.
2. Stanley, B. & Brown, G: Safety Plan Treatment Manual to Reduce Suicide Risk. Veteran Version. Washington, D.C.: United States Department of Veterans Affairs, 2008
3. Simon R., Shuman DW. The standard of care in suicide risk assessment: An elusive concept. CNS Spectr. 2006, 6: 442-5.

WORKSHOP 2
## THE DEADLY YEARS: PREVENTING SUICIDE IN ASIAN-AMERICAN COLLEGE STUDENTS

***Caucus of Asian-American Psychiatrists***

*Chairperson: Russell Lim, M.D., 2230 Stockton, Blvd., Sacramento, CA 95817*
*Co-Chairperson: Velandy Mohandar, M.D., Presenters: Aradhana Sood, M.D., Kristine Girard, M.D., Dan Tzuang, M.D., Jack Yen, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe three stressors on Asian-American college students; 2) Describe three barriers to seeking mental health care at the university; and 3) Discuss strategies to reduce both stressors and barriers to care so as to prevent suicide in this group.

**SUMMARY:**
Suicide among Asian-American college students is a growing problem. According to the Department of Health and Human Services, Asian-American women aged 15-24 have the highest suicide rate of women in any race or ethnic group in that age group. In 2009, three Chinese-American male students at Cal Tech committed suicide within three months. The goal of the workshop is to bring attention to the mental health needs of Asian-American college students, who make up over 14% of some college’s attendance, yet under-utilize mental health services, and are over-represented in completed suicides, and to suggest improved ways of serving their unique needs by training in cultural competent assessment and treatment of their

mental disorders.

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The pressure to excel in college from parents who see a college degree as the only pathway to success, the myth of Asian Americans as the model minority with no mental health problems, as well as intergenerational conflicts between parents and children all contribute to the increased incidence of suicide in Asian-American college students.

Panel members will discuss the barriers that depressed Asian-American college students face in seeking care, such as a reluctance to reveal private matters to strangers, bringing shame on the family, or sometimes erroneous assumptions made by counselors based on racial stereotypes (such as they have "supportive families"). Panel members will also discuss strategies to engage Asian-American college students in therapy, such as training counselors to be aware of possible stereotyping and mis-interpretation of the Asian-American student's behavior and cultural values, as well as the role of intergenerational stress. Other strategies include hiring Asian-American counselors, cultural competence training, public service announcements, and flexible scheduling.

**REFERENCES:**

1. Choi JL, Rogers JR and Werth JL. Suicide Risk Assessment With Asian American College Students: A Culturally Informed Perspective. The Counseling Psychologist 2009; 37; 186

WORKSHOP 3

**A MEDICINAL CANNABIS UPDATE FOR 2010: USE, ABUSE, NEW RESEARCH, NEW FORENSIC AND NEW POLITICAL REALITIES**

**(For APA Members Only)**

*Chairperson: Lawrence Richards, M.D., 714 S. Lynn St., Champaign, IL 61820*
*Presenters: David Ostrow, M.D., Jahan Marcu, Ronald Abramson, M.D., John Halpern, M.D.,*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of the session, participants will be able to: 1) Demonstrate new knowledge on the current status of Molecular Biology and Medicinal Cannabis (MC); 2) Demonstrate knowledge of the many myths about medical marijuana; 3) Demonstrate knowledge of the states with laws legalizing such treatment; and 4) Demonstrate knowledge of some federal law, policies, and procedures regulating and blocking such treatment and the related legitimate clinical and basic scientific research.

**SUMMARY:**

Interactivity is fostered via multiple brief presentations, not lengthy sequential ones. The Chair will encourage sharing of memories and interactions with colleagues and patients throughout. This W/S provides information from molecular biology and in vivo, ex vivo, and in vitro research, plus a mutual updating on many specifics regarding medicinal cannabis (MC) usage and abuse concerns, the laws that impact that, the associated myths, and an understanding of the possibilities for clarifying research, the need for same, and the impediments thereto. Current basic science and clinical uses are contrasted with historical perspectives including those from a circa 1972 U.S. Army Substance Abuse Program. Review occurs of the states (13 in Aug., 2009 with 2 pending) which legalized MC and comparisons with Maryland's 2003 "Medical Cannabis Affirmative Defense Law" are made. Physician anxiety and "growing pains" with the 2009 implementation of Michigan's new "grow your own" MC law are described. The criticality of individual physicians is described, and a new dynamic theory about the role of "big pharma" and non-psychiatric physicians will be presented. The psychosocial epidemic dynamics of drug abuse are presented as insights via Edw. Brecher's review.

Additional details regarding research missed and problems encountered because of the positions taken by federal government employees are given. The new political realities following the last federal elections and the possible related impacts are raised.

References directly discussed will include [Brecher...Report] and the last marijuana treatment case to achieve major national importance. The latter began as the California case of Angel Raich v. Ashcroft, resulted in an injunction against the Federal Gov D.E.A. by the Ninth Circuit Court of Appeals, and eventually a counter appeal by the U.S. Dept. of Justice being heard by the U.S. Supreme Court as Gonzales versus Raich, 545 US 1, (2005). That vacated the injunction by Ninth Circuit Court of Appeals because the case mainly but not entirely involved the Commerce Clause, which appears in The 1787 Constitution of The United States and which accords to Congress the power to "regulate commerce" among "the several states", with the

Controlled Substances Act being seen to come under that clause at the time of the U.S. Supreme Court's decision. Issues of right to treatment, right to privacy, patients' rights, the pursuit of happiness, etc., played no role.

**REFERENCES:**

1. McAllister SD, Chan C., et al. Cannabinoids selectively inhibit proliferation and induce death of cultured human glioblastoma multiforme cells. Journal of Neuro-Oncology 2005; 74: 31–40
2. Brecher, EM. Licit and Illicit Drugs: Consumer Union Report, Little, Brown & Co, Boston, 1972.
3. Iversen, L. Cannabis and the Brain. Brain 2003; 126(6): 1252-1270
4. Zimmer L and Morgan JP. Marijuana Myths. Marijuana Facts. New York, Lindesmith Center and Gotham City Printing, 1997.

WORKSHOP 4

## UNCONSCIOUS PROJECTIONS: THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

*Chairperson: Steven Pflanz, M.D., 6244 Split Creek Ln., Alexandria, VA, 22312*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe how the portrayal of psychiatry in film impacts the public perception of mental illness and the profession of psychiatry.

**SUMMARY:**

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Like other art forms, movies can be seen as projections of the unconscious minds of their Hollywood creators and psychiatry is a recurring thematic device. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. In order to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the audience will discuss the portrayal of psychiatry in contemporary films from the past two decades, including such films as A Beautiful Mind, The Hours, Antwone Fisher, As Good As It Gets, Good Will Hunting, and Girl, Interrupted. Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. The audience will view short film clips from each of these movies, discussing each in turn. The majority of the session will be devoted to audience discussion of how we understand contemporary film to influence the image of psychiatry and mental illness in America.

**REFERENCES:**

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

WORKSHOP 5

## PSYCHIATRIC CARE AT THE END OF LIFE

*Chairperson: Jonathan Stewart, M.D., 1900 Follow Thru Rd., St. Petersburg, FL, 33710*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Explain the optimal role of the psychiatrist as a member of the hospice and palliative care team, and in the management of such patients; 2) Demonstrate facility in the aspects of communicating with patients and their families that are unique to end-of-life care; and 3) Discuss typical psychiatric syndromes and symptoms at the end of life, their typical manifestations and their management.

**SUMMARY:**

The most fundamental goal for end of life care, both for the patient and for the family, is the alleviation of suffering. Much of this suffering is well within our purview as psychiatrists, placing us in an ideal position to provide meaningful care. Unfortunately, those patients nearing the end of life are historically underserved by psychiatrists; at this time only about 30% of US hospice programs have access to a psychiatrist. This workshop will focus on opportunities for the psychiatrist who wishes to work with these patients and their families, to alleviate suffering and to optimize the quality of this last phase of life. We will focus on the unique aspects of communicating with these patients and their families, diagnosis and management of common end-of-life psychiatric symptoms (including depression, the wish to hasten death, anxiety and delirium), management of end stage dementia, management of the chronic psychiatric patient at the end of life and evaluation and management of bereavement. Group discussions during the workshop will focus on management of specific clinical scenarios and ethical dilemmas.

**REFERENCES:**


1. Breitbart W, Alici Y: Agitation and delirium at the end of life. JAMA 2008; 300:2898-2910.
2. Breitbart W, Chochinov HM, Passik SD: Psychiatric symptoms in palliative medicine, in Oxford Textbook of Palliative Medicine (3rd ed). Edited by Doyle D, Hanks G, Cherny NI, Calman K. Oxford, Oxford University Press, 2002, pp 746-771.
3. Breitbart W, Strout D: Delirium in the terminally ill. Clin Geriatr Med 2000; 16:357-372.
4. Irwin SA, Ferris FD: The opportunity for psychiatry in palliative care. Can J Psychiatry 2008; 53:713-724.
5. Kelly B, Burnett P, Pelusi D, Badger S, Varghese F, Robertson M: Terminally ill cancer patients' wish to hasten death. Palliat Med 2002; 16:339-345.
6. Kettl P: Helping families with end-of-life care in Alzheimer's disease. J Clin Psychiatry 2007; 68:445-450.
7. Lander M, Wilson K, Chochinov HM: Depression and the dying older patient. Clin Geriatr Med 2000; 16:335-356.
8. Rummans TA, Bostwick JM, Clark MM: Maintaining quality of life at the end of life. Mayo Clin Proc 2000; 75:1305-1310.
9. Schonwetter RS (ed): AAHPM Hospice and Palliative Medicine Core Curriculum and Review Syllabus. Dubuque, Kendall/Hunt Publishing Co, 1999.
10. Schuster JL: Palliative care for advanced dementia. Clin Geriatr Med 2000; 16:373-386.


WORKSHOP 6
## ENHANCING RISK-ASSESSMENT ACROSS SERVICES IN MENTAL HEALTH

*Chairperson: Amresh Shrivastava, M.D., 467 Sunset Drive, St. Thomas, Ontario NSH 3V9, Canada*
*Presenter: Megan Johnston, M.A.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize existing gaps in area of risk assessment; 2) Identify measures to overcome the barriers in local conditions; and 3) Be able to demonstrate substantial enhancement of skills of risk assessment.

**SUMMARY:**

Clinical practice of psychiatry has acquired role and responsibility which goes far beyond traditional expectations. Incident of suicide, particularly, is considered a high liability for then professionals, organizations and the consumer. It also remains a clinical issue which examines can we prevent suicide which in the system of care. Studies have shown about 1 in 6 psychologists or psychiatrist are likely to loose a patient due to suicide in a mean duration of 18-20 years practice. Repeatedly it has demonstrated that clinical skill training for risk assessment is the necessary for all professionals not only in mental health but also in general health and other high-risk settings. There is merit in the argument that enhancing risk assessment can minimize chances of suicide and provide better legal protection in event of litigation. The course contains literature review, concept of risk, tools for assessment, briefly describes anew tool, and usage video-based case vintage for hands on experience, floor discussion and evaluation of what has been learnt. The course contains pre-course and post-course exercise for evaluation and develops on documentation issue as well. Suicide prevention is a life-saving measure. Enhancing assessment quality is for professional excellence in clinical practice.

**REFERENCES:**


1. Mahal SK, Chee CB, Lee JC, Nguyen T, Woo BK.: Improving the quality of suicide risk assessments in the psychiatric emergency setting: physician documentation of process indicators, J Am Osteopath Assoc. 2009,109:354-358.
2. Hermes B, Deakin K, Lee K, Robinson S. Suicide risk assessment: 6 steps to a better instrument. J Psychosocial Nurs Ment Health Serv. 2009,47:44-49
3. Miret M, Nuevo R, Ayuso-Mateos JL. Documentation of suicide risk assessment in clinical records. Psychiatr Serv. 2009; 60:994
4. Shrivastava, Amresh and Nelson, Charles, "Coping up Challenges of Risk Assessment: Towards a New Scale: SIS-MAP" (2009). Psychiatry Presentations. Paper 5. http://ir.lib.uwo.ca/psychiatrypres/5
5. Shrivastava,A , Nelson, C, New scale may help docs manage suicide risk in clinical practice . Canadian Psychiatry Aujourd'hui. 2008, 4: .6


WORKSHOP 7
## THE "NEGATIVE OUTCOME" IN PSYCHOTHERAPY: WHO IS RESPONSIBLE AND HOW?

*Chairperson: Janet Lewis, M.D., 108 Kimball Ave., Ste. 1, Penn Yan, NY, 14527*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the multiple factors which can contribute to negative outcome in psychotherapy; 2) Recognize multiple possible meanings of the term "responsibility," as applied to the psychotherapy relationship; 3) Appreciate shame and guilt issues for therapists and patients in working with the concept of responsibility; and 4) Use the 4 quadrants of the Integral Theory model as a theoretical framework.

**SUMMARY:**

It is recognized from empirical studies and their meta-analyses that psychotherapy can be an effective treatment. Nevertheless it has always been known that there are

cases in which patients seem to have negative effects from psychotherapy. When a therapy ends badly, the patient, the therapist, and the patient's subsequent therapists may struggle with issues of responsibility. Who is responsible for what might have been a harmful therapy and how are they responsible? While some harmful therapies involve obvious ethical breaches by the therapist, others do not. Nevertheless in some cases the patient can be devastated and require a lengthy and painful period of recovery. Discussions about responsibility are often difficult because those involved are considering different domains of reality – the patient's or therapist's subjective experience, the intersubjective two person culture of the asymmetrical therapy relationship, the therapist's or patient's behavior, or the systems of psychotherapy training, administration, and professional discipline. In this workshop, we will explore various meanings of "responsibility," as applied to psychotherapy. The Integral Theory model will be introduced as a way of understanding both the multiple perspectives from which one can consider responsibility and ways in which a more comprehensive understanding of responsibility may assist therapists and patients to learn from "negative outcome" experiences. The literature on negative outcomes in psychotherapy will be briefly reviewed as will literature on responsibility, and on the psychodynamic topics of shame and guilt. This workshop will include experiential exercise, and small and large group discussion of case vignettes as well as lecture format. There will be an opportunity for participants to reflect on issues of responsibility in their own experiences with negative outcome. We will explore this important topic, which is at the interface of psychotherapy and ethics.

**REFERENCES:**

1. Baldwin SA, Wampold BE, Imel ZE: Untangling the Alliance-Outcome Correlation: Exploring the relative importance of therapist and patient variability in the alliance. Journal of Consulting and Clinical Psychology 2007;75:842-852.
2. Lambert M: Presidential Address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. Psychotherapy Research 2007; 17:1-14.
3. Langs R: Therapeutic Misalliance. International Journal of Psychoanalytic Psychotherapy 1975; 77-105

WORKSHOP 8

## COGNITIVE THERAPY FOR PERSONALITY DISORDERS

*Chairperson: Judith Beck, Ph.D., 1 Belmont Ave., Ste. 700, Philadelphia, PA 19004*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Conceptualize personality disorder patients according to the cognitive model; 2) Improve and use the therapeutic alliance in treatment; 3) Set goals and plan treatment for patients with characterological disturbance; 4) Enhance medication adherence; and 5) Describe and implement advanced cognitive and behavioral techniques.

SUMMARY:

A number of studies have demonstrated the efficacy of Cognitive Therapy in the treatment of Axis II patients. The conceptualization and treatment for these patients is far more complex than for patients with Axis I disorders. Therapists need to understand the cognitive formulation for each of the personality disorders. They need to be able to take the data patients present to develop individualized conceptualizations, including the role of adverse childhood experiences in the development and maintenance of patients' core beliefs and compensatory strategies. This conceptualization guides the clinician in planning treatment within and across sessions and in effectively dealing with problems in the therapeutic alliance. Experiential strategies are often required for patients to change their core beliefs of themselves, their worlds, and other people not only at the intellectual level but also at the emotional level.

**REFERENCES:**

1. Beck, J.S. (2005) Cognitive therapy for challenging problems: What to do when the basics don't work. New York: Guilford.
2. Beck, A. T., Freeman, A., & and Associates (2004). Cognitive therapy of personality disorders, second edition. New York: Guilford.

WORKSHOP 9

## THE IMG JOURNEY: SNAPSHOTS ACROSS THE PROFESSIONAL LIFESPAN

*Chairperson: Vishal Madaan, M.D., 3528 Dodge St., Omaha, NE 68131*
*Co-Chairperson: Durga Bestha, M.B.B.S*
*Presenters: Shamala Jeevarakshagan, M.D., Renato Alarcon, M.D.,*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Recognize the challenges faced by international medical graduates (IMGs) during both residency training and professional advancement in their practice of psychiatry; and 2) Identify successful strategies to overcome obstacles that may prevent IMGs from realizing their optimal potential in their careers in psychiatry.

**SUMMARY:**
International Medical Graduates (IMGs) constitute a significant proportion of both trainee residents and practicing faculty in Psychiatry across the United States. Recent National Residency Matching Program (NRMP) data suggests that up to 1 in 3 of the PGY-1 positions in Psychiatry have been filled by IMGs. Furthermore, IMGs also constitute a substantial percentage of the practicing psychiatrists' workforce in various practice settings, which range from the private sector to practicing in underserved areas, public sector and academic settings. IMGs thus constitute a significant critical mass in the delivery of psychiatric care to a population which also has become more culturally diverse.
Despite clearly being an indispensable aspect of the American healthcare system, IMGs commencing psychiatry residency training may struggle with overcoming cultural barriers, understanding aspects of the psychosocial framework, verbal and non-verbal communication skills and understanding psychotherapy from an American perspective. This is further complicated by their attempts at acculturation which may continue to hinder their academic progress even beyond the initial training years. The IMG Early Career Psychiatrists (ECPs) similarly face unique dilemmas in their career trajectory which range from a lack of federal research funding opportunities, to establishing a niche for themselves with the local population, if practicing in the community. As senior faculty, the IMG psychiatrist may similarly encounter challenges related to obtaining leadership positions.
In this unique workshop, we will explore the challenges that IMGs face at various stages of their professional careers, identify potential corrective measures, and discuss innovative measures to consolidate strengths and overcome weaknesses. The speakers will also emphasize successful strategies to help supervising and mentoring the IMG trainees and early career psychiatrists, developing better interview skills, approaching psychotherapy from an IMG perspective, and providing resources to access research and career opportunities. We will accomplish this by interacting with the audience, using real-life case scenarios and presentations by speakers ranging from a resident to a senior professor.
The career trajectory of an IMG has numerous challenges in addition to acculturation and professional stressors and it is important to address them to promote professional development.

**REFERENCES:**

1. NRMP. Results and data, 2009. Available at http://www.nrmp.org/data/resultsanddata2009.pdf
2. Searight HR, Gafford J. Behavioral Science Education and IMG. Acad Med. 2006;81:164-170.
3. Meyers GE. Addressing the effects of Culture on the Boundary-Keeping practices of Psychiatry residents educated outside of the United states.Academic psychiatry 2004; 28.
4. Blanco C, Carvalho C, Olfson M, Finnerty M, Pincus HA: Practice patterns of international and U.S. medical graduate psychiatrists. Am J Psychiatry 1999;156: 445-450.

WORKSHOP 10

**A DISCUSSION ABOUT WEIGHT GAIN DURING MEDICATION TREATMENT FOR SCHIZOPHRENIA: HOW MUCH AND WHAT TO DO ABOUT IT**

*Presenter: Peter Buckley, M.D., 1515 Pope Avenue, Augusta, GA 30912 U.S.A.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1. Understand amount of weight gain in patients who are being treated for schizophrenia, 2. Identify features that might predict what patients are at a greater risk for weight gain, 3. What medication strategies can be helpful, and
4. What non-pharmacologic strategies (if any) can be helpful

**SUMMARY:**
Weight gain has emerged as a major consideration in the treatment of patients with schizophrenia. Although one might reason that weight gain is more likely to occur with older patients that have an established illness and a long history of medication use, there is also evidence that supports younger patients are also prone to develop weight gain as a side effect of medications. These physical and metabolic consequences of weight gain in patients with schizophrenia can be potentially life threatening.

WORKSHOP 11

**A PROGRAM OF PSYCHOTHERAPY FOR COMBATANTS' DEPENDENTS - THE EFFECT ON RECALL RATES: "THEY ARE NOT GOING FOR THREE WEEKS AND THE FIGHTING HAS BEGUN!"**

*Chairperson: Michael Wise, M.B.B.S., M.S.C., 14 Devonshire Place, London, W1G 6HX*
*Presenter: Inge Wise*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to recognize the salient features of a therapeutic

program which can reduce morbidity in a military setting. Participants should be familiar with the unique characteristics of military institutions which may require adaption of usual practice, as well as some of the institutional features which may require navigation during the treatment program to maximize therapeutic efficiency

**SUMMARY:**
Deployment to conflict areas poses particular problems for service families:
Anxieties over their partner's absence
That in doing their duty their partner might sustain serious injury or die; even though they knew this to be a low risk statisticallyMarital stress
Mothers having to contain their own and their children's anxieties.
Becoming a 'single' parent
These stressors pose a high social cost due to the increased rates of marital and family break up and the resultant impact on operational effectiveness, through early recall from a combat zone. The project grew from concerns about the welfare of the families of army personnel deployed on operations in Iraq and Afghanistan. The project aimed to help them develop a greater capacity to manage, contain and function with these worries. This program was a preliminary examination of applying psychoanalytic processes to a previously neglected group that was not wholly army, but is essential to its well-being.
On the whole the men and women about to go on their mission look forward to it while their loved ones have more ambivalent feelings about it. This applies even though they understand and support their partners' commitment to the army. The time before deployment is hard on those who stay behind, who experience high levels of anxiety. Those about to be deployed feel guilty about leaving their families, and have to manage their own anxieties about what the mission will bring - hard work, excitement and some danger. Most do not talk about this to their partners, who in turn have to manage their own inner turmoil and worst case 'fantasies'.
In anticipation of separation each partner withdraws into their own shell. As one wife put it: "They are not going for 3 weeks, and the fighting has already begun ".
The program gave the families of soldiers a greater understanding of the emotional difficulties faced by their partnersbefore, during and after deployment and lessened the stress in their relationships; strengthening their own and their partners' sense of self, of resilience, and the marital bond.
Through the use of group and individual sessions, and close liaison with the welfare officers, the expected reduction in the welfare of the unit's dependents was not observed. Usually 3-5% of a unit would be recalled from combat operations, over the duration of a tour, for 'personal' reasons, this was reduced to 1%.

WORKSHOP 12
## NEW APA PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER

*Chairperson: Joel Yager, M.D.,*
*Co-Chairperson: Alan Gelenberg, M.D.,*
*Presenter: Laura Fochtmann, M.D.,*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand objectives and development process for APA practice guidelines; and 2) Learn key recommendations of a new APA practice guideline on major depressive disorder.

**SUMMARY:**
In a reformed U.S. health care system, evidence-based clinical practice guidelines are expected to play an important role in determining appropriate treatment, as noted by President Obama in his 2009 address to the American Medical Association. Depression is a prevalent illness and a leading cause of health care disability and cost. The first APA practice guideline on major depressive disorder was published in 1993, and a second edition was published in 2000. Following five years of development effort, a third edition of the guideline will be published in spring 2010 as a supplement to the American Journal of Psychiatry. In this workshop, presenters will describe the development process used for the guideline, including mechanisms intended to minimize the possibility of bias from conflicts of interest, and review the key recommendations of the guideline, highlighting changes from the 2000 edition. Clinical topics to be reviewed include the choice between psychotherapy and pharmacotherapy depending on illness severity and other patient factors, strategies for treatment-resistant illness, and the use of formal scales and measures to improve care. In two Q&A sessions, the audience will be invited to comment on the guideline, the development process, and implications for the field.

**REFERENCES:**
1. American Psychiatric Association. Practice Guideline for the Treatment of Major Depressive Disorder, Third Edition, Am J Psychiatry, publication expected Spring 2010

**11:00 AM - 12:30 PM**
**WORKSHOPS**

WORKSHOP 13
**CHALLENGES AND OPPORTUNITIES IN TEACHING NEUROLOGY TO PSYCHIATRY RESIDENTS**

*Chairperson: Claudia Reardon, M.D., 6001 Research Park Blvd., Madison, WI 53713*
*Co-Chairperson: Art Walaszek, M.D.,*
*Presenters: Michelle Riba, M.D., Stacey Burpee, D.O. Kayla Pope, M.D., M. Justin Coffey, M.D., Sheldon Benjamin, M.D.,*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe the types and extent of neurology education offered by U.S. psychiatry residency programs, thereby allowing training directors to compare their own programs to others; 2) Possess the knowledge and skills necessary to improve a psychiatry residency's neurology educational experiences; and 3) Develop an awareness of the importance of longitudinal, integrated neurology experiences in psychiatry residencies.

**SUMMARY:**
Psychiatry residency programs have had a requirement for 2 months of cross-training in neurology since 1978. Furthermore, psychiatry residents need to be knowledgeable in neurology for ABPN certification, and psychiatry residency programs are evaluated in part based on ABPN outcomes. Research has been conducted on the format and content of neurology training desired for psychiatry residents by training directors. However, there have been minimal published data on types of neurology experiences actually offered by residency programs. Moreover, strategies for implementing neurology curricula are rarely discussed.
Drs. Claudia Reardon and Art Walaszek of the University of Wisconsin conducted a 2009 survey of all U.S.
Psychiatry Residency Training Directors to determine the type and extent of neurology education that programs offer. Survey results will be shared, as will a general review of the state of knowledge of neurology education for psychiatry residents.
A panel of experts in psychiatry education will then discuss models of neurology/neuroscience curricula. Concomitant with their conducting the 2009 survey, the University of Wisconsin initiated a formal program of neurology didactics, and Dr. Walaszek will discuss challenges and opportunities associated with starting and maintaining such a program. Dr. Michelle Riba, Associate Chair for Integrated Medicine and Psychiatry Services at the University of Michigan and former President of AADPRT, APA, and AAP, will share her experiences and recommendations on teaching neurology to psychiatry residents as informed by her research in this area. Dr. Justin Coffey has worked with Dr. Riba in helping to develop and foster a model neurology curriculum for residents in their program, and he will share his suggestions on this topic. For many years the
University of Massachusetts has offered a cutting-edge neurology curriculum for its psychiatry residents, and Dr. Sheldon Benjamin will share this program's experiences and recommendations on this topic. Dr. Benjamin also helped to lead the American Neuropsychiatric Association Education Committee that developed a set of neuropsychiatric competencies recommended for achievement by general psychiatry residents, and he will review this document as well. Finally, Dr. Kayla Pope will discuss her ongoing experiences working with the NIH, NIMH, and AADPRT in developing a standardized neuroscience curriculum for psychiatry residents.

**REFERENCES:**
1. Selwa LM, Hales DJ, and Kanner AM. What should psychiatry residents be taught about neurology? A survey of psychiatry residency directors. Neurology 2006; 12 (5): 268-70.

WORKSHOP 14
**DEALING WITH THE DIFFICULT PROFESSIONAL EMPLOYEE: EFFECTIVE PERSONNEL MANAGEMENT STRATEGIES**

*Chairperson: Stephen Soltys, M.D., P.O. Box 19642, Springfield, IL 62794*
*Presenter: Kay Titchenal*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to construct effective plans of correction and have confidence in dealing with negative and disruptive employee behaviors in a clinical practice.

**SUMMARY:**
In order for a mental health organization to run effectively, employees from a range of disciplines must be recruited and motivated to work together as a team. However, some personnel may function in a disruptive manner. Clinicians in administrative positions quickly find that successfully motivating individuals to work with their co-workers requires personnel management skills which are

significantly different from the interpersonal clinical skills they have developed. In this workshop, a psychiatrist with twenty years of administrative experience and the executive director of a human resource department with extensive management experience will help participants develop skills to deal with difficult employees who are requiring effective intervention. Methods for effective supervision, discipline and termination will be described with attention toward decreasing the risk of legal actions. Approaches toward motivating both professional and nonprofessional employees will be explained.

The format will use case examples to facilitate discussion of didactic material with active participation by the audience in exploring potential solutions to the cases. During the question and answer period, participants will be encouraged to share situations they have encountered for extensive discussion with the workshop faculty and other workshop participants.

**REFERENCES:**

1. Latham G: (2009). Becoming the Evidence Based Manager. Mountain View, CA: Davies-Black Publishing.
2. Smith JD and Mazin R: (2004). HR Answer Book. New York, NY: AMACOM.
3. Guerin LD and DelPo A. (2009). The Essential Guide to Federal Employment Laws (2nd ed). Berkeley, CA: NOLO and Society for Human Resource Management.
4. DelPo A. (2007). Dealing with Problem Employees (4th ed). Berkeley, CA: NOLO.

WORKSHOP 15

## MÜNCHAUSEN REVISITED: FACTITIOUS DISORDER IN THE AGE OF THE INTERNET AND DSM-5

*Chairperson: Damir Huremovic, M.D., 2201 Hempstead Turnpike, East Meadow, NY 11554*
*Co-Chairperson: Shabneet Hira-Brar, M.D.,*
*Presenters: Jacob Sperber, M.D., Reena Trivedi, M.D., Sameh Dwaikat , M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to understand how online communications, resources, and virtual communities changed the clinical picture of many patients with factitious disorder. The participant will also learn how to use online resources to better suspect, diagnose, and treat patients with factitious disorder.

**SUMMARY:**

Group of factitious disorders, in which patients consciously feign and produce symptoms of physical or mental illnesses for the purpose of assuming a sick role and gaining attention, sympathy, and care on behalf of unsuspecting providers and laypersons, remains one of the least understood phenomena in modern psychiatry and medicine.

Although relatively recently recognized and defined, factitious disorders have been present throughout the history of medicine, reflecting affected individuals' maladaptive expression of universal human yearning for attention, respect, and care. As cultures and societies developed, clinical presentations of factitious disorder evolved, reflecting the progress in mass-media and telecommunications (e.g. 'factitious disorder by proxy').

The Internet has, unsurprisingly, introduced a new dimension to factitious disorder, for both patients and clinicians. For patients, being online means access to endless medical resources that can be used to more accurately produce their 'symptoms'. Moreover, individuals with factitious disorder can now not only perfect, but also perpetuate their pathology though bona fide online communities that exist to support individuals with serious illnesses ('factitious disorder by internet'). Clinicians, on the other side, can use the Internet to educate themselves about the disorder, verify individual patient's claims pertaining to identity and medical history, and to cross-check electronic medical records where possible. Can DSM-5 account for these changes or is a more fundamental rethinking of this entity in order?

This workshop will equip clinicians with practical advice on suspecting factitious disorder and using the online resources to establish diagnosis and to engage such patients without alienating them, a crucial first step on the arduous road to recovery of pathological liars. Cases from presenters' practice spanning continents and cultures will be used to illustrate critical points of this workshop.

**REFERENCES:**

1. Asher R. Munchausen syndrome, Lancet 1951:1:339.
2. Feldman, M.D., (2000): Munchausen by Internet: detecting factitious illness and crisis on the Internet. Southern Journal of Medicine, 93, 669-672

WORKSHOP 16

## TELEPSYCHIATRY FOR EDUCATION AND PSYCHOTHERAPY: TEACHING TO THE NEAR AND FAR ENDS

*Chairperson: John Teshima, M.D., 2075 Bayview Ave., Toronto M4N 3M5, Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the relevant content and methods

for teaching trainees about telepsychiatry; 2) Discuss the unique challenges of delivering education and supervision via telepsychiatry to distant sites; and 3) consider implementing or improving telepsychiatry education at their local practice sites.

**SUMMARY:**

Telepsychiatry has been used for a variety of educational purposes. At the near end, trainees from various professional backgrounds can be exposed to and gain experience in telepsychiatry as a model of service delivery to distant sites. Trainees can also be exposed to and gain experience with patient populations that are not as accessible at the near site. At the far end, continuing education and ongoing supervision can be provided to mental health professionals. While there have been a number of guidelines published about clinical practices in telepsychiatry, little has been written about educational practices.

This workshop will explore methods of telepsychiatry education at both the near and far ends. It will review the existing literature, including relevant studies from areas of telehealth education and videoconferenced teaching. It will also draw upon the ideas and experiences of the workshop participants. It will also draw from the experience of a large pediatric telepsychiatry program in Toronto, Canada. This program has been operating since 2000. Over 100 residents have participated in telepsychiatry training, with several completing longitudinal experiences lasting up to six months. The program has also delivered over 150 seminars to over 6000 participants at 15 different distant sites.

This workshop will explore the relevant content to teach trainees at the near end about telepsychiatry, as well as the methods used to expose trainees to telepsychiatry. This workshop will also explore methods to deliver continuing education and supervision via telepsychiatry, particularly focusing on the unique differences of telepsychiatry versus face-to-face teaching. This workshop will use a mix of large and small group exercises, with short didactic sections. In summary, this will be an interactive workshop that will engage participants in discussing and exploring issues in telepsychiatry education, both for trainees at the near end and for learners at the far end.

**REFERENCES:**

1. Hilty DM, Marks SL, Urness D, Yellowlees PM, Nesbitt TS: Clinical and educational telepsychiatry applications: a review. Canadian Journal of Psychiatry 2004;49:12-23

WORKSHOP 17

## PREPARING IMG (INTERNATIONAL MEDICAL GRADUATE) PSYCHIATRY RESIDENTS FOR A CAREER IN ACADEMIC PSYCHIATRY

***APA/GlaxoSmithKline Fellows***

*Chairperson: Sosunmolu Shoyinka M.B.B.S, 1298 Hartford Turnpike, #7i, New Haven, CT 06473*
*Co-Chairperson: Oladipo Kukoyi, M.D.,*
*Presenters: Milton Kramer, M.D., Richard Balon, M.D., Paulo Shiroma, M.D., Ezra Griffith, M.D., Nalini Juthani, M.D., Charles Dike, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of the presentation, participants should be able to: 1) Identify various specialty tracks in academia (e.g. researcher, clinician-educator, administrator); 2) Demonstrate a knowledge of how mentoring IMGs differs from mentoring USMGs and identify specific ways in which they can encourage and assist the IMG resident in developing their interest in academia; and 3) Learn how to identify/select a mentor, and develop ideas for research.

**SUMMARY:**

International Medical Graduates (IMGS) now comprise over a third of residents in US psychiatric residency programs, as well as over 25% of APA members (1, 2). IMGs have been shown to play an important role in the US health care delivery system as providers of clinical care to disadvantaged populations, including the poor, the psychotic, and the elderly (3), as well as inner city and rural populations. In general academia, IMGs now constitute nearly a fifth of full-time faculty at US medical schools and of principal investigators (PIs) on National Institutes of Health (NIH) research project grants (4). IMG faculty in basic science departments and IMG physician PIs outnumber their US graduate counterparts by a ratio of 2:1 (5) In psychiatry, little is known about IMGs' roles in academia or of their career paths in academia as distinct from those of their USMG (United States Medical Graduate) colleagues. There is some evidence from literature (6) that significant obstacles exist for IMGs seeking residency training but less is known about the challenges faced by IMGs desiring a career in academia, post-residency training. The workshop is aimed at all psychiatry residents and psychiatrists desiring an academic career, with special focus on IMGs, early career psychiatrists and training directors involved in the education of IMGs. The purpose of the workshop is to clarify what an academic career entails, different tracks in academia and to provide a forum to discuss issues specifically related to IMG psychiatry residents who wish to pursue a career in academia. The workshop also aims to provide faculty involved in training and mentoring IMGs with tools to aid

them in assisting their IMG trainees. Finally, it is hoped that the workshop will provide an avenue for mentoring relationships and collaborative networks to develop among IMGs and trainers interested in assisting them along their chosen career path.

**REFERENCES:**

1. Hales D: APA Census of Psychiatry Residents, 2003–2004. Arlington, VA, American Psychiatric Publishing, 2004.
2. Bondurant A: Department of Minority/National Affairs, American Psychiatric Association. Personal Communication, 2005.
3. Blanco C, Carvalho C, Olfson M, et al: Practice patterns of international and US Medical graduate psychiatrists. Am J Psychiatry 1999; 156:445–450.
4. AAMC Analysis in Brief: Trends Among Foreign-Graduate Faculty at U.S. Medical Schools. Washington, DC, Association of American Medical Colleges, 2003.
5. Contributions of International Medical Graduates to US Biomedical Research: The Experience of US Medical Schools, Journal of investigative medicine ISSN 1081-5589, Source / Source 2007, vol. 55, no 8, pp. 410-414 [5 page).
6. Balon R, Mufti R, Williams W, et al: Possible discrimination in recruitment of psychiatry residents? American Journal of Psychiatry 1997; 154:1608–1609

WORKSHOP 18

**IS THAT AN UNCONSCIOUS FANTASY OR A CORE BELIEF? A RESIDENT'S PERSPECTIVE ON LEARNING MULTIPLE THERAPIES SIMULTANEOUSLY**

*Chairperson: Emily Gastelum, M.D., 1051 Riverside Dr., Box 81, New York, NY 10032*
*Co-Chairperson: Aerin Hyun, M.D.*
*Presenters: Deborah Cabaniss, M.D., David Goldberg, M.D., Donna Sudak, M.D., Barbara Stanley, Ph.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Be familiar with the "Y model" and the way in which it helps to explain similarities among psychotherapies; 2) Have an understanding of the way in which learning multiple psychotherapeutic techniques simultaneously affects residents' assessments and treatment formulations; and 3) Be able to discuss the benefits and drawbacks of learning multiple psychotherapies simultaneously.

**SUMMARY:**

Purpose: To examine how the experience of learning multiple types of psychotherapy simultaneously affects the way psychiatric residents 1) formulate their cases and 2) treat their patients.
Content: According to the Psychiatry RRC guidelines, psychiatry residents in the U.S. must demonstrate competency in 5 types of psychotherapy. This creates an interesting situation in which trainees are trying to master several types of therapy simultaneously. We have noticed that this can enrich learning, by offering residents different types of therapeutic techniques, demonstrating to them in vivo that many of the psychotherapies share characteristics and by leading residents to ponder the most useful ways to employ these techniques in clinical care.
Methodology: A resident will discuss a case that could be conceptualized from several different perspectives. She will share her experience in formulating the case with an explanation of the challenges and opportunities this case posed as she learned multiple psychotherapies simultaneously. Presenters will lead small group discussions and encourage reflection upon: What core issues did participants hear in the case? How might different models of the mind benefit this patient? Would participants favor one treatment over another or combine different elements of each modality? Attendees will reconvene for a large group conversation with each small group sharing highlights of their discussion.
Results: Residents and educators will share ideas about psychotherapy education. Residents will have a forum to share their experience of becoming skilled in multiple psychotherapy modalities. Participants will meet trainees and educators from many programs, promoting collaborative relationships. An important part of psychiatry residency training is the simultaneous acquisition of multiple therapeutic modalities. This unique experience warrants discussion and appreciation for the impact it has upon resident case formulations and practice.

**REFERENCES:**

1. Beck, Judith S. "Cognitive Therapy: Basics and Beyond." New York: Guilford Press, 1995.
2. Gabbard, Glen O. "Psychodynamic Psychiatry in Clinical Practice." Washington DC: American Psychoanalytic Press, 2005.
3. Linehan, Marsha. "Cognitive-Behavioral Treatment of Borderline Personality Disorder." New York and London: Guilford Press, 1993.
4. Weissman Myrna M., Markowitz John C., Klerman Gerald L. "Comprehensive Guide to Interpersonal Psychotherapy." New York: Basic Books, 2000.

WORKSHOP 19

**TRANSPLANT PSYCHIATRY UPDATE**

*Chairperson: Paula Zimbrean, M.D., 184 Liberty St., Rm. LV125, New Haven, CT 06519*
*Co-Chairperson: Swapna Vaidya, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should

be able to: 1) Identify the main components and relevant clinical factors in the Psychiatric assessment of patients requiring a liver transplant for acute liver failure; and 2) Recognize the risk factors for substance abuse relapse in transplant recipients and their role in determining transplant eligibility.

**SUMMARY:**
As of end of September 2009 there were 103,947 candidates waiting on the UNOS list and only 14,191 transplants had been completed in the US for this calendar year. Considering this severe organ shortage, the role of the Psychiatrist in the selection of transplant candidates is increasing. We will present the data available on two of the most difficult and controversial situations in Transplantation Psychiatry: the Psychiatric evaluation of the patient with fulminant liver failure and the role of substance abuse and dependence in selection of liver transplant recipients.
Most of the patients presenting with fulminant liver failure in need of a liver transplant are comatose or delirious at presentation, therefore their assessment often lacks the most important component of a Psychiatric evaluation, the patient interview. Often the decision to proceed with the transplant must be taken with limited clinical and background information and in the presence of rapid clinical deterioration; delay could result in a patient becoming un-transplantable due to the development of clinical contra-indications. Details regarding the present illness, prior self-destructive behaviors, substance abuse, psychiatric disorders, stressors, and other risk factors for future suicide attempts must be obtained, usually from family members or treatment teams who feel pressured as well by the urgency of the situation. Subsequently all information is reviewed in a transplant team meeting. Often times, differences in opinion among transplant team members and other health care providers arise regarding a particular patient's candidacy for transplantation. Additional consultations with hospital ethics committee, risk management services or legal department may be necessary and instructive with complex cases. The second topic we will discuss is the role of substance abuse and dependence in determining eligibility for liver transplantation. Alcoholic Liver Disease is currently the second leading indication for liver transplantation in the US. 75% of patients transplanted for Alcoholic Liver Disease meet criteria for Alcohol Dependence. In addition, an increasing number of patients on methadone maintenance for opiate dependence are receiving liver transplantation for hepatitis C cirrhosis. In this context, identifying the risk factors for relapse becomes the Psychiatrist's main task. Topic will be discussed in greater detail during workshop.

**REFERENCES:**
1. M.W. Russo, J.A. Galanko and R. Shrestha et al., Liver transplantation for acute liver failure from drug induced liver injury in the United States, Liver Transpl 10 (2004), pp. 1018-1023
2. A.F. DiMartini, M.A. Dew and P.T. Trzepacz, Organ transplantation. In: J.L. Levenson, Editor, The American psychiatric publishing textbook of psychosomatic medicine, The American Psychiatric Press, Inc., Washington, DC (2005), pp. 675-700.
3. Predictors of psychological morbidity in liver transplant assessment candidates: is alcohol abuse or dependence a factor?. Day E. Best D. Sweeting R. Russell R. Webb K. Georgiou G. Neuberger J. Transplant International. 22(6):606-14, 2009 Jun.
4. Polysubstance abuse in liver transplant patients and its impact on survival outcome. Nickels M. Jain A. Sharma R. Orloff M. Tsoulfas G. Kashyap R. Bozorgzadeh A. Experimental & Clinical Transplantation: Official Journal of the Middle East Society for Organ Transplantation. 5(2):680-5, 2007 Dec.
5. Clusters of alcohol use disorders diagnostic criteria and predictors of alcohol use after liver transplantation for alcoholic liver disease. DiMartini A. Dew MA. Fitzgerald MG. Fontes P. Psychosomatics. 49(4):332-40, 2008 Jul-Aug.

WORKSHOP 20
## WHEN DISORDER HITS HOME: DEALING WITH SERIOUS PSYCHIATRIC DISORDERS IN OUR OWN FAMILIES

*American Group Psychotherapy Association*

*Chairperson: Julia Frank, M.D., 2150 Pennsylvania Ave. NW, Washington, DC 20037*
*Presenters: Mitchell Cohen, M.D., Kathryn McIntyre, M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Discuss the benefits and drawbacks of psychaitric training dealing with disorders in close family members; and 2) List helpful resources for family care of eating disorders, substance abuse and impulsive aggression.

**SUMMARY:**
In the era of impugning families as the cause of psychiatric disorders, psychiatrists as parents were supposedly responsible for neurotic and adjustment problems in their children. This view is both shaming and dismissive of the reality that serious psychiatric problems may arise in families of every kind, including ours. At the same time, it is clear than family members can contribute a great deal to the treatment of members with psychiatric disorders. Concerns about stigma, confidentialty and overdiagnosis may inhibit psychiatrists' efforts to help their own family members. In this workshop, three psychiatrists who have helped their adolescent and young adult children through severe behavioral disorders will reflect on the

experience, using a technique of round robin interviewing and discussion. The workshop will include dialog with participants on how their professional training might both help and hinder them in analogous situations. It will encourage reflection about how the experience of dealing with such problems may enhance our ability to address similar problems for patients and their families

**REFERENCES:**

1. Lock, J and Lagrange, D. Help Your Teenager Beat an Eating Disorder. NY: Guilford Press, 2005
2. Heru, A. Family Psychiatry from Research to Practice, AJP!63-962-8, 2006.

WORKSHOP 21

**LOST IN TRANSLATION: GENERATIONAL ISSUES AND MENTAL HEALTH**

*Association of Women Psychiatrists*

*Chairperson: Tana Grady-Weliky, M.D., 3181 SW Sam Jackson Pk. Rd., Portland, OR 97221*
*Presenters: Doris Iarovici, M.D., Leah Dickstein, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify two differences across generations in the school and/or workplace; 2) List common problems that present to psychiatrists in college mental health services; 3) Identify strategies to work with students and/or colleagues who are from different generations.

**SUMMARY:**

Generational differences or the so-called "generation gap," are not new phenomena. But a vastly accelerated pace of change in communication patterns and social networks, driven by changes in technology, has created interesting challenges for psychiatry, especially as Gen Y or the "Millennial Generation" enters the medical workplace. The influx of this particular generation into the workplace, e.g. psychiatry residents, or in medical schools, however, has created somewhat unique, multi-faceted challenges. The differences in core values across the generations contribute to the communication tensions that exist between the generations. Varying perspectives on medical professionalism is just one example of how generational differences have been described in the medical literature. This workshop will include an overview of the key differences across the generations (from veteran to boomer to generation X and millennial). Additionally, there will be a discussion of common mental health problems present in college age students and the generational influences of treatment choice associated with these problems. Finally, a current resident will provide perspectives from generation "Y." The presenters are comprised of diverse generations - veteran, boomer, generation X and generation Y. Case presentations will be utilized to engage the audience in discussion. The workshop is designed to facilitate audience reflection and participation.

**REFERENCES:**

1. Howell LP, Servis G, and Bonham A: Multigenerational Challenges in Academic Medicine - UC Davis's Response. Acad Med. 80: 527-532, 2005.

WORKSHOP 22

**DIAGNOSIS AND TREATMENT OF PSYCHOGENIC NONEPILEPTIC SEIZURES: WHAT DOES A PSYCHIATRIST DO ONCE THE DIAGNOSIS IS MADE?**

*Chairperson: W. Curt LaFrance, Jr., M.D., M.P.H., 593 Eddy St., Providence, RI 02903*
*Co-Chairperson: Andres Kanner, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize the most common signs, symptoms and history associated with the presentation and diagnosis of psychogenic nonepileptic seizures (PNES); differentiate epileptic and nonepileptic events; apply the proper approach to discuss the diagnosis of NES to ensure acceptance of treatment; recognize the treatment options available for patients with PNES.

**SUMMARY:**

Relatively few psychiatrists treat patients with psychogenic nonepileptic seizures (PNES), despite being a commonly presenting conversion/somatoform disorder. The disorder presents with a combination of neurologic signs, underlying psychological conflicts and comorbid psychiatric disorders. For more than a century, neurologists and psychiatrists have accumulated data and insights about the phenomenology, epidemiology, risks, comorbidities, and prognosis of PNES. The gold standard of video electroencephalography and adjunctive tests are used in establishing the diagnosis of PNES, which has also been instrumental in demonstrating the difference between epileptic seizures and PNES. Participants will view video EEGs of various seizures and vote on whether they are epileptic or nonepileptic. Patients with PNES share some commonalities in their histories, including a history of abuse, depression, post-traumatic stress symptoms, and dissociation. Once the diagnosis of PNES is made, patients often refuse to accept the diagnosis and to follow

recommendations for treatment. Other barriers arise with lack of communication or disagreement between the mental health professionals and the neurologist regarding assuredness of the diagnosis. The role of the neurologist and mental health providers in the diagnosis and management of these patients will be discussed. The common obstacles that preclude a proper treatment will be reviewed. The similarities and differences of these problems in the adult and pediatric patient with PNES will be discussed. The current treatment research and recommendations for PNES treatment will be described. Questions from the audience will be addressed on the topics of diagnosis, treatment, and participant's cases. Participants in the workshop will be better equipped to evaluate and treat patients with PNES.

**REFERENCES:**

1. Schachter SC, LaFrance Jr WC, editors. Nonepileptic Seizures. Cambridge: Cambridge University Press; 2009.
2. Kanner AM, LaFrance Jr WC, Betts T. Chapter 282. Psychogenic Nonepileptic Seizures. In: Engel Jr J, Pedley TA, editors. Epilepsy: A Comprehensive Textbook. 2nd ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins; 2008. p. 2795-2810.

WORKSHOP 23

## ORAL BOARDS BOOT CAMP 2010: FOCUS ON DIAGNOSTIC INTERVIEWING

*Chairperson: Elyse Weiner, M.D., 113 University Pl., Ste. 1010, New York, NY 10003*
*Co-Chairperson: Eric Peselow, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Greatly refine his or her technique for performing a boards style diagnostic interview and examination.

**SUMMARY:**

Oral Boards Boot Camp is a comprehensive, interactive approach to becoming an effective oral boards candidate that has been an APA Annual Meeting workshop since 2004. Oral Boards Boot Camp seeks to help candidates hone their interview and presentation skills through a long-term practice model. Integral to the development of the Oral Boards Boots Camp method has been the gathering of all types of information about the oral boards and the incorporation of this information into this in-depth approach to preparation. The board certification process is about to undergo radical changes. This is the final year that the traditional oral boards are being given by the ABPN to all candidates. The oral boards are being replaced by a certification process which, following the successful completion of the written examination, will be decided at the residency training level. To respond to these changes, we have retooled Oral Boards Boot Camp to focus on the diagnostic interview and presentation skills which are the most important part of becoming a successful boards candidate. These skills are critically important for a resident's success as a psychiatrist and can even benefit trainees across disciplines. The workshop will continue to start with a didactic portion. The chairpersons will present their opinion of the current oral boards certification process with updated information on the changes as available. However, the emphasis of the didactic portion will be practice methods for diagnostic interviewing and techniques for conducting an outstanding boards style interview and examination. As in the past, the second part of the workshop will consist of a lively discussion with ample time for audience questions. Oral Boards Boot Camp has always viewed studying for the boards as a long-term process. Given the procedural changes, all students and residents should find attending this session valuable. We believe that the early refining of diagnostic interview and presentation skills will help all trainees throughout their careers and is, of course, critical for those who will seek ABPN certification in psychiatry.

**REFERENCES:**

1. Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's New Guide to Part II of the APBN Examination, Third Edition. Washington DC, American Psychiatric Press, 2009
2. Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry, Second Edition. Washington DC, American Psychiatric Press, 2009

WORKSHOP 24

## THE BEHAVIORAL HEALTH ACTION NETWORK: REORGANIZING THE BEHAVIORAL HEALTH DELIVERY SYSTEM IN POST-KATRINA NEW ORLEANS

*Chairperson: Elmore Rigamer, M.D., 4201 N. Rampart St., New Orleans, LA 70117*
*Presenter: Sarah Hoffpauir L.C.S.W. Craig Coenson, M.D., Jose Calderon-Abbo, M.D., Candace Cutrone, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1. Understand how professionals can organize to promote improvements in behavioral health systems; 2. Understand how to engage elected officials to acknowledge and support community behavioral health needs; 3. Understand how to promote communication and collaboration among providers and agencies to improve patient outcomes; 4. Understand how to prioritize

responses in post disaster environments; and 5. Understand how systems can perform better after a crisis if they resist.

**SUMMARY:**

Following hurricane Katrina, the mental health professionals in New Orleans created the Behavioral Health Action Network (BHAN) to respond to the unmet mental health needs in the population and to government policy in addressing the city's health crisis. Behavioral health services in New Orleans were fragmented and poorly managed before Katrina. The disaster worsened the situation and highlighted the health system's inability to deal effectively with the serious mentally ill and previously well who were experiencing depression and PTSD. Overwhelmed emergency rooms and increases in homelessness and the incarcerated mentally ill were barometers of system failure. Loss of community clinics, hospital beds and displaced professionals partially explained the inadequate responses, but ineffective organization at critical junctures in the delivery system also contributed to the crisis.

Necessity stimulated resourcefulness and innovation in the ravaged mental health system of post-Katrina New Orleans. Recognizing that the system was reverting to the status quo, BHAN was founded in December 2006 as an organization where behavioral health professionals would meet regularly to evaluate services, identify gaps, advocate for resources and promote public awareness of mental health issues. BHAN members included representatives from the entire behavioral health continuum of care. In three years since its founding, BHAN has improved communication and collaboration among health care organizations, law enforcement agencies, and city and state health departments. The organization is an example of what professionals can accomplish when they organize around patient needs and offer solutions when advocating to public officials and funding agencies.

The panelists will present examples of how care was reorganized after Katrina at different stages of the continuum: community behavioral health clinics, in patient, assertive community treatment and transitional housing.

**REFERENCES:**

1. Berggren RE, Curiel TJ: After the Storm: Health Care Infrastructure in Post Katrina New Orleans. N Engl J Med 2006; 354: 1549-1552
2. Calderon-Abbo J: The Long Road Home: Rebuilding Public Inpatient Psychiatric Services in Post-Katrina New Orleans. Psychiatric Services 2008; 59: 304-309
3. Goldman H, Newman S: Putting Housing First, Making Housing Last: Housing Policy for Persons With Severe Mental Illness. Am J Psychiatry 2008; 165: 1242–1248
4. Louisiana Public Health Institute: Overview of the Current Status of the New Orleans Mental Health System. July 18, 2008
5. The Children's Health Fund and The Columbia University Mailman School of Public Health: Responding to an Emerging Humanitarian Crisis in Louisiana and Mississippi - Urgent Need for a Health Care Marshall Plan. April 17 2006

**1:30 PM - 3:00 PM**

**WORKSHOPS**

WORKSHOP 25

**ADULT PERVASIVE DEVELOPMENTAL DISORDER: FOR BETTER UNDERSTANDING AND TREATMENT**

*Chairperson: Soonjo Hwang, M.D., 95 Grasslands Rd., Box 495, Valhalla, NY 10595*
*Co-Chairperson: Mathew Brams, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate a better understanding of adult PDD; 2) Identify and describe different cases of adult PDD; 3) Identify the issues and challenges regarding diagnosis and treatment of PDD; 4) Demonstrate a knowledge of the difference between adult and child PDD; and 5) Demonstrate a better understanding of developmental issues through life stages of person with PDD.

**SUMMARY:**

Autism and pervasive developmental disorder (PDD) is neurodevelopmental condition characterized by impairment in social interaction, communication, and stereotype behavior. During last 20 years, pervasive developmental disorder has received increasing attention. (Tsakanikos, Costello, Holt, Sturmey, & Bouras, 2007) However, even though several researchers have tried to elicit developmental course and consequences of this condition into adulthood, little has established in agreement of phenomenology, characteristics, optimization of treatment, and possible application of social services for adults with PDD.

Many studies have been done for the adulthood outcome of PDD and demonstrated markedly different result depending on method, study population, and duration of study. (Larry Burd et al., 2002) Considering broad spectrum of manifestation of this disease category and different trajectory pattern of development being influenced by genetic composition and environmental situation of growing-up, it is not surprising that all of the individuals with adult PDD show their own unique make-up of disease and personality related to PDD.

Most of these studies are done by persons related to child psychiatry or psychology, and general psychiatrists have little knowledge and understanding regarding adulthood PDD even though they may have fair amount of chance to be faced with this, and even opportunity of treating them as their patients.

Hence this workshop is aimed for better understanding of adult with PDD for clinicians who have and will treat these patients psychologically and pharmacologically. Familial and social intervention for adult with PDD also requires extensive discussion for better outcome and social adjustment of these people.

Many different cases will be presented to the audience regarding adult with PDD, with various phenomenology and manifestation. Optimal treatment will be discussed as well, including pharmacological and non-pharmacological intervention. Different outcome and prognosis will be a focus of this workshop, too. The participants will have better understanding of adult PDD, their own different features from child PDD, and the challenge for diagnosis and treatment.

This is project of APA Shire Fellowship.

**REFERENCES:**

1. Larry Burd P, Jacob Kerbeshian M, Westerland A, et al.: Prospective long-term follow-up of patients with pervasive developmental disorders. J Child Neurol 17:681-688, 2002.

2. Tsakanikos E, Costello H, Holt G, et al.: Behaviour Management Problems as Predictors of Psychotrophic Medication and Use of Psychiatric Services in Adults with Autism. J Autism Dev Disord 37:1080-1085, 2007.

WORKSHOP 26

## BRIDGING THE CULTURAL DIVIDE: CHALLENGES OF FIRST GENERATION IMMIGRANTS WITH CHILDREN WITH MENTAL ILLNESS

*APA/SAMHSA Minority Fellows*

*Chairperson: Timothy Liu, M.D., 118 Gulf St., Ste. 18, Milford, CT 06460*
*Co-Chairperson: Steve Koh, M.D.,*
*Presenters: Kiet Truong, M.D., Ranjan Avasthi, M.D, Arshad Husain, M.D,. David Rue, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the specific challenges of immigrant parents who are coping with mental illnesses in their children; 2) Recognize the current lack of clinical attention and social support dedicated to immigrant parents in the conventional clinical setting; and 3) Demonstrate openness and receptiveness in learning about diverse cultural beliefs and attitudes of immigrant parents towards children's mental health.

**SUMMARY:**

Immigration populations in the United States over the last decade have seen larger proportions of families and children (1, 2). Recent census estimated that one in five U.S. children is an immigrant or the child of an immigrant (1). Despite increase in awareness of immigrant mental health, little attention is given to first-generation parents who are coping with psychiatric disorders in their children. Parents are often the first to notice emotional symptoms in their children. Existing research suggests that parental attributions for child behaviors differ across cultures (3). The manner in which parents explain children's behaviors has important implications for the parents' immediate responses, as well as the parent–child relationship in the long term (4). An even more pressing issue for the clinician is that parents' causal explanations may predict help-seeking behaviors, as well as the acceptability and implementation of recommended interventions (5, 6). On the other hand immigrant parents are themselves faced with the challenges of acculturation and disruption of social networks (7). It is crucial for psychiatrists to be mindful of their added stress of caring for children with mental health needs.

The purpose of this workshop is to bring the audience's attention to the immigrant parent, whose cultural background and needs are often overlooked in the clinical care of the child. Using case vignettes we will illustrate the diversity of parents' cultural beliefs, and their influences on the presentations of mental disorders in children. We will study a number of religious practices, and explore how they might affect treatment delivery. We will invite a discussion about culturally sensitive responses to these considerations, and ways to engage the family therapeutically. Our faculty panel will share their experiences in working with immigrant families. Current literature and community resources will also be reviewed.

**REFERENCES:**

1. U.S. Census Bureau: The foreign-born population in the United States. Current Population Survey March 2003; 20-539. Available at: http://www.census.gov/population/www/socdemo/foreign/cps2003.html (accessed September 20, 2009)

2. Logan JR, Zhang W, Alba RD: Immigrant enclaves and ethnic communities in New York and Los Angeles. Am Sociol Rev 2002; 67:299-322

3. Chiang T, Barrett KC, Nunez NN: Maternal attributions of Taiwanese and American toddlers' misdeeds and accomplishments. J Cross Cult Psychol 2000; 31:349–368

4. Bugental DB, Johnston C: Parental and child cognitions in the context of the family. Annu Rev Psychol 2000; 51:315–

345. Johnston C, Seipp C, Hommersen P, Hoza B, Fine S: Treatment choices and experiences in attention-deficit/hyperactivity disorder: relations to parents' beliefs and attributions. Child Care Health Dev 2005; 31:1–9
6. Yeh M, McCabe K, Hough RL, Lau A, Fakhry F, Garland A: Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. J Consult Clin Psychol 2005; 73:800–807
7. Rogler LH, Gurak DT, Cooney RS: The migration experience and mental health: Formulations relevant to Hispanics and other immigrants, in Health and behavior: Research agenda for Hispanics. Edited by Gaviria M, Arana JD. Chicago, University of Illinois Press, 1987, pp 72-84

## WORKSHOP 27
## EVALUATION AND MANAGEMENT OF PATIENTS WITH EXCESSIVE DAYTIME SLEEPINESS IN PSYCHIATRIC PRACTICE

*Chairperson: Dimitri Markov, M.D., 211 S. Ninth St., Fifth Fl., Philadelphia, PA 19107*
*Presenters: Nidhi Tewari, M.D., Karl Doghramji, M.D.*

### EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to list primary sleep disorders associated with excessive daytime sleepiness, understand the pathophysiology of narcolepsy, and understand how hypersomnias are diagnosed and treated.

### SUMMARY:
In recent years, there has been a great expansion of knowledge about sleep disorders. This knowledge, however, has not been fully implemented into clinical practice. Many psychiatrists can recognize common sleep disorders. However, more needs to be done to educate psychiatrists about diagnosing and treating sleep disorders that are associated with excessive daytime sleepiness. By addressing excessive daytime sleepiness of patients, psychiatrist can improve the physical and psychological health and quality of life of their patients.
Faculty will offer a practical framework to approach patients with excessive daytime sleepiness. We will discuss pathophysiology, clinical features, and management of primary sleep disorders associated with excessive daytime sleepiness. This highly interactive workshop will offer a practical framework to approach sleepy patients.

### REFERENCES:
1. Mignot E. Narcolepsy: Pharmacology, Pathophysiology, and Genetics. In: Kryger MH, Roth T, Dement WC, editors. Principles and practice of sleep medicine. Philadelphia: Saunders; 2005. p. 761-779

## WORKSHOP 28
## VULNERABILITY AND RESILIENCE: KATRINA'S WIDESPREAD IMPACT ON FIRST RESPONDERS, CLINICIANS, YOUTH AND RELOCATED SURVIVORS

*Chairperson: Phebe Tucker, M.D., PO Box 26901, Oklahoma City, OK 73190*
*Presenter: Joy Osofsky, Ph.D.*

### EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand secondary traumatic stress and implications in providing clinical care; 2)Understand children & adolescents' post disaster mental health symptoms and resilience building interventions; and 3) Understand how biological and emotional stress measures were affected in relocated Katrina survivors compared to matched Oklahoma controls

### SUMMARY:
This interactive workshop will explore Katrina's profound impact on many survivor groups over the years, focusing on factors associated with emotional vulnerability and resilience. Well meaning devoted responders and clinicians were more likely to demonstrate vicarious traumatization. Sick leave and heightened irritability were more common. A number of agencies and departments requested debriefing or supportive services. First Responders reported more home pressure, increased use of alcohol and recognition of the need for mental health support while gradually declining over time, elevated numbers of children and adolescents qualified for mental health services. At the same time, most appeared resilient, and youth leadership programs have been beneficial. We assessed emotional and biological stress measures for Katrina survivors relocated to Oklahoma, far from community support, and matched controls. Survivors had more symptoms and diagnoses of PTSD and depression, worse self-appraised health, and cardiovascular changes of decreased heart rate variability with flattened response to trauma reminders, greater autonomic reactivity in several measures, and higher pro-inflammatory interleukin-6 ($p<0.05$). High lifetime trauma rates in both groups may have attenuated some differences, pointing to sociodemographic factors contributing to pathology. A year-long support group for relocated survivors is described.

### REFERENCES:
1. Calderon-Abbo, Jose; Kronenberg, Mindy, Ph. D. ;Many, Michele LCSW; Osofsky, Howard J., M. D. Ph. D. Fostering Healthcare Providers' Post-traumatic Growth in Disaster Areas: Proposed Additional Core Competencies in Trauma-Impact

Management. American Journal of the Medical Sciences. 336(2):208-214, August 2008.

WORKSHOP 29

**WHEN ADULTS WITH PERVASIVE DEVELOPMENTAL DISORDERS PRESENT IN A COMMUNITY MENTAL HEALTH SETTING**

*American Association of Community Psychiatrists*

*Chairperson: Ann Hackman, M.D., 701 W. Pratt St., Baltimore, MD 21201*
*Presenters: Curtis Adams, Jr., M.D., Steven Hutchens, M.D., Theodora Balis, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize the symptoms of pervasive developmental disorder which may be seen in adults presenting to community mental health treatment and to identify areas of diagnostic overlap between overlap between pervasive developmental disorders and schizophrenia.

**SUMMARY:**

Studies indicate that there is significant overlap between the symptoms of pervasive developmental disorders (PDD) (such as autism and Aspergers)and schizophrenia spectrum illnesses. Yet in practice, in community mental health settings (including mental health clinics and assertive community treatment programs), consumers may present with diagnoses of schizophrenia when the primary diagnosis is actually a pervasive developmental disorder. PDD may be missed in adults when there is a lack of adequate available history for the consumer (particularly in instances where the person is not connected to family, has been homeless or has spent years lost to psychiatric follow-up). Additionally general psychiatrists have limited training in the identification of autism, Asperger's and other pervasive developmental disorders. Further adults with PDD may have psychotic symptoms or other co-occurring psychiatric illness. When such individuals are not acurately diagnosed they may have poor response to antipsychotic medications, may have behaviors which are problematic and do not respond to interventions and and may be thought to be refractory to treatment leading to frustration for consumers, care givers and treatment providers.

This workshop will consider the scope of this problem and the frequency with which PDD is seen in adults in a communitmental health system. Screening tools for identifying people will PDD will be reviewed. The stories of several consumers initially diagnosed with schizophrenia and later determined to have PDD will be described. Approaches to treatment of adults identified with PDD in a community mentla health setting, including education for consumers and care providers will be discussed. The panel will then with the audience further explore ways to improve diagnosis and treatment for such individuals.

**REFERENCES:**

1. Konstantareas MM & Hewitt T (2001) Autistic disorder and schizophrenia: diagnostic overlaps. Journal of Autism and Developmental Disorders 31:19-28

WORKSHOP 30

**FROM OUTREACH TO ASSERTIVE COMMUNITY TREATMENT: TRANSFERRING RESEARCH TO PRACTICE IN COMPREHENSIVE CARE FOR UNDERSERVED PEOPLE LIVING WITH HIV/AIDS**

*Chairperson: Gary Morse, Ph.D., 3738 Choteau Ave., St. Louis, MO, 63110*
*Presenters: John Winn, L.C.S.W., William Maurice Redden, M.D., Sheila Jackson*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify and describe 4 research-based interventions to assist in recovery for persons with HIV/AIDS and behavioral disorders; 2) Describe the outcomes of evidence-based interventions for persons living with HIV/AIDS and comorbid behavioral health conditions and 3) Analyze the feasibility, barriers, solutions and potential opportunities for providing comprehensive mental health services for persons living with HIV/AIDS.

**SUMMARY:**

Incidence data shows a disturbing increase in the incidence of HIV/AIDS among underserved minorities and hard-to-reach populations. In addition, many persons living with HIV/AIDS suffer from mental health disorders. Unfortunately, most service systems have been slow to respond to the special needs of persons with comorbid conditions of HIV/AIDS and mental heath disorders. Mental health service planning and delivery for this vulnerable group of persons is further complicated by both the lack of integration with medical care and by the diverse set of mental health disorders among persons living with HIV/AIDS. In this workshop, presenters will describe a multifaceted model of care that includes four promising and evidence-based practices: outreach, cognitive behavioral therapy, motivational interviewing, and Assertive Community Treatment (ACT). These interventions are designed to address the most common

behavioral health conditions among people living with HIV/AIDS (depression, anxiety, severe mental illness, and co-occurring substance abuse disorders). Presenters will share the experiences of clinicians working this area, the experiences of consumers receiving such mental health services, and report on promising preliminary pre- post-outcome findings. In a guided discussion, participants will identify the feasibility, barriers and solutions, and potential advantages of implementing similar comprehensive plans of care in their communities. This workshop will provide participants with evidence-based models and thoughtful discussion on ways to make a positive difference in the lives of underserved and high-need people living with HIV/AIDS and comorbid mental health disorders.

**REFERENCES:**

1. Calsyn, R.J., Klinkenberg, W.D., Morse, G.A., Miller, J., & Cruthis, R. (2004). Recruitment, engagement, and retention of people living with HIV and co-occurring mental health and substance use disorders. AIDS Care, 16(Supplement 1): S56-S70.

WORKSHOP 31

**SEXUAL MINORITY YOUTH: CLINICAL COMPETENCIES AND TRAINING NEEDS FOR THE 21ST CENTURY**

**American Academy of Child & Adolescent Psychiatry**

*Chairperson: Scott Leibowitz, M.D.,*
*Presenters: Edgardo Menvielle, M.D., Joel Stoddard, M.D.,*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the challenges and opportunities involved in training psychiatry trainees on GLBT issues; 2) Survey the evidence base, ethics, and practice standards for psychiatric practice with sexual minority youth; 3) Understand a model for curriculum development with actual examples from three varying institutions; and 4) Learn about resources that may facilitate teaching about these issues.

**SUMMARY:**

Background: In Massachusetts, the GLBT Health Access Project, a state-sponsored program, identified that GLBT patients' fear of discrimination and providers lack of competence in working with GLBT patients as the two major barriers to care. (Clark et al., 2001) Specifically, mental health professionals may be unaware of the empirical evidence of mental disorder risk of non-heterosexuals. Further, they may not be aware of the transition of the working model of mental illness morbidity to the chronic stress of the sexual minority status. Finally, they often lack adequate training. Compounding this, the GLBT community is highly diverse, and any discussion of health risks and behaviors risks of overgeneralization. The lack of standards of practice and training constitutes a major dilemma faced by clinicians exposed to patients with these issues.

Objectives: The goals of this workshop are to review key competencies for working with GLBT youth and provide resources for those involved in training, supervision, and clinical care. The content areas covered include issues related to sexual orientation and gender identity among children, adolescents and their parents. Presenters include child psychiatry fellows and faculty involved in such training.

Methods: The AACAP practice parameters on gay, lesbian, bisexual sexual orientation, gender-variant behavior and gender identity in children and adolescents, soon to be released, will offer a road map for child and adolescent psychiatrists and other mental health professionals. In our presentation we will include an in-depth discussion of the 11 practice principles included in the practice parameters, as well as a review of the current literature, clinical case vignettes, videos, and other teaching materials. The presenters will review models for setting up training on this topic and serve as consultants to the audience. Results and Conclusions: Developing clinical competence in matters relevant to treating gender variant/GLBT youth in both adult and child/adolescent psychiatrists is feasible. Doing so, results in better addressing clinical needs of GLBT youth, a prevalent population. Audience members will be exposed to the salient controversies and barriers in the treatment of sexual minority youth, as well as benefit from the specific educational models, newly synthesized content, and experiences of the presenters from their perspectives as clinicians, trainers, and trainees in three training programs.

**REFERENCES:**

1. AACAP. Practice Parameter on Gay, Lesbian or Bisexual Sexual Orientation, Gender-Variant Behavior, and Gender Identity in Children and Adolescents. still in development, AACAP, 2009. Permission obtained from Stuart Adelson, MD (primary author) to refer to Practice Parameters while they are still in development.
2. Clark M et al. 2001. The GLBT health access project: A state-funded effort to improve access to care. Am J Public Health. 91(6): 895-6.

**3:30 PM - 5:00 PM**

**WORKSHOPS**

WORKSHOP 33

**MAKING THE MOST OF YOUR TWENTY-MINUTE HOUR: MAXIMIZING THE THERAPEUTIC EXPERIENCE**

*Chairperson: Frederick Guggenheim, M.D., 690 Angell St., Providence, RI 02906*
*Co-Chairperson: Robert J. Boland, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand how to maximize the limited time inherent in the modern psychiatric encounter; 2) Recognize and avoid pitfalls; 3) Troubleshoot specific clinical dilemmas and resolve them within the constraints of the twenty minute hour; and 4) Be able to teach others in the efficient use of clinical time.

**SUMMARY:**

Although some residency training programs have just 50 minute outpatient sessions for their residents, certainly some general residency clinics now give their residents 30 minutes, and at times even less, to see an established patient, report to a supervisor and write up the patient. Not may programs, however, are educating their residents on how to thrive in such pressured situations.

This session focuses on the PRACTICAL ways to increase your comfort and productivity in the limited time you have with your patient for medication management and psychotherapy.

Two experienced clinicians will share their SHORTCUTS and PITFALLS in working with patients, starting with meeting the patient in the waiting room, and ending with assuring that the patient leaves the office, satisfied with the visit, at the end of the scheduled appointment, not lingering on to put you behind in your already overloaded schedule.

**REFERENCES:**

1. Guggenheim, F.G. "Prime Time: Maximizing the Therapeutic Experience a primer for psychiatric clinicians." New York, Routledge, 2009

WORKSHOP 34

**PATIENT SUICIDE DURING PSYCHIATRY RESIDENCY: A WORKSHOP DISCUSSION**

*Chairperson: Allison Baker, M.D.*
*Co-Chairperson: Christina Mangurian, M.D.*
*Presenters: Meredith Kelly, M.D., Andrew Booty, M.D., Emily Gastelum, M.D., Aerin Hyun, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) List the typical reactions of residents to a patient suicide; 2) Recognize that residents are a high-risk group for experiencing patient suicide; 3) Cite the evidence for creating a support system at the level of residency training at their home institution if this is not already in place; and 4) Share their thoughts about and experiences of patient suicide or attempts in a supportive environment.

**SUMMARY:**

The suicide of a patient is arguably the most traumatic event that can occur during a psychiatrist's professional life. It has been estimated that between 15-68% of psychiatrists in general practice will experience at least one patient suicide during their careers and approximately one-third of psychiatric residents experience a patient suicide during residency. A patient's suicide frequently leads the treating psychiatrist to experience considerable stress, guilt, shame, anxiety, and even PTSD-like symptoms. Residents, at the early stage of their career and professional identity development, are uniquely vulnerable to stress from this event. A patient suicide may cause the resident to doubt his or her clinical skills, the decision to enter psychiatry, and previous treatment decisions. However, in their positions as trainees, residents have a unique opportunity for personal and professional growth at the time of such an event. In this workshop, which has been held at the APA annually since 2007, we hope to educate residents and attending psychiatrists alike about the epidemiology of residents who experience a patient suicide, and of the common reactions to such an experience. Further, we intend to present different models of institutional support that are in existence to address the issue of residents who experience a patient suicide. Finally, we hope to provide an opportunity for attendants of the workshop to hear about other residents' experiences and share their own. In so doing, we aim to minimize the isolation of attendees and give them a place to share with others who have gone through the same experience.

**REFERENCES:**

1. Alexander DA, Klein S, Gray NM, et al: Suicide by patients: questionnaire study of its effect on consultant psychiatrists. BMJ 2000; 320:1571-1574.
2. Chemtob CM, Hamada RS, Bauer G, et al: Patients' suicides: frequency and impact on psychiatrists. Am J Psychiatry 1988; 145:224-228.
3. Ellis TE, Dickey DOI, Jones EC: Patient Suicide in Psychiatry Residency Programs: A National Survey of Training and Postvention Practices. Acad Psychiatry 1998; 22:181-189.
4. Fang F, Kemp J, Jawandha A, et al: Encountering Patient

Suicide: A Resident's Experience. Acad Psychiatry 2007; 31:340-344.
5. Gitlin, 2006. Psychiatrist Reactions to Patient Suicide. In "Textbook of Suicide Assessment and Management." 2006. Eds. Simon, RI and Hales RE.
6. Mangurian, C et al. Improving Support of Residents After a Patient Suicide: A Residency Case Study Acad Psychiatry 2009 33: 278-281.

## WORKSHOP 36
## MEDITATION AND PSYCHIATRY

*Chairperson: Michael McGee, M.D., 172 Kingsley St., Nashua, NH 03060*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define meditation and identify the therapeutic components of a meditative practice; 2) Discuss the potential therapeutic benefits of meditation in a psychiatric practice; and 3) Describe the application of meditation as an adjunctive treatment for a variety of psychiatric disorders.

### SUMMARY:

How might meditation promote wellness and healing from psychiatric illness? How might it contribute to the practice of psychiatry? This workshop addresses these two questions. Meditation is the consciously willed practice of two actions, attending and abstaining, that all people spontaneously perform to a greater or lesser degree. Psychological health may correlate in part with the degree to which we naturally perform these actions. This workshop analyzes the nature of meditation and its therapeutic benefits. It includes participant practice of various meditative and contemplative techniques, and concludes with a review of issues pertinent to the adjunctive prescription of meditation in psychiatric care, including a discussion of specific clinical applications.

### REFERENCES:

1. Doraiswamy, P. M. & Xiong, G. L. Does Meditation Enhance Cognition and Brain Longevity? Annals of the New York Acedemy of Sciences (2007).
2. Evans, S. et al. Mindfulness-based Cognitive Therapy for Generalized Anxiety Disorder. J Anxiety Disord (2007).
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14. Levenson, M. R., Jennings, P. A., Aldwin, C. M. & Shiraishi, R. W. Self-transcendence: conceptualization and measurement. Int J Aging Hum Dev 60, 127-43 (2005).
15. Marlatt, G. A. & Chawla, M. Meditation and Alcohol Use. South Med J 100, 451-453 (2007).
16. McGee, M.D., Meditation and Psychiatry. Psychiatry 5(1) January, 28-41 (2008)

## WORKSHOP 37
## PUBLISHING BOOKS FOR THE GENERAL PUBLIC

*Chairperson: Lewis Cohen, M.D., 51 Harrison Ave., Northampton, MA 01060*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and understand the process of producing formal book proposals, obtaining a literary agent, and securing a publisher.

### SUMMARY:

Many psychiatrists have a secret ambition to publish a book for a general audience, and this workshop will involve its participants in a free-wheeling discussion of the necessary steps in achieving this goal. The workshop's chair has just published a non-fiction book, entitled, No Good Deed: A Story of Medicine, Accusations of Murder, and the Debate over How We Die (HarperCollins). In the process of writing this book, he was awarded a Guggenheim Fellowship and a Rockefeller Bellagio Residency. Lessons learned from the experience will be discussed, including how to select a subject, compose a formal book proposal,

secure the services of a literary agent, sell the manuscript to a publisher, and enjoy the subsequent steps in bringing the book to the attention of the public. Each of these topics will be briefly delineated and then followed by a general discussion with the audience. It is considerably easier for a psychiatrist to publish an academic book than to engage the interest of a lay publisher, but this workshop will describe some of the tips that should make this task more feasible. These will include: foregoing all jargon, avoiding the impulse to punctuate the text with memoir-like anecdotes, and the role of the narrator in modern non-fiction. The workshop is uniquely designed to encourage psychiatrists in fulfilling their dreams of publishing for the general public.

**REFERENCES:**

1. Rabiner S., Fortunato A.: Thinking Like Your Editor: How to Write Great Serious Nonfiction and Get it Published. W.W. Norton & Company, New York, 2002

WORKSHOP 38

## ETHICAL, CLINICAL AND LEGAL CHALLENGES CREATED BY INFORMATION TECHNOLOGY

*Chairperson: Malkah Notman, M.D., 54 Clark Rd., Brookline, MA 02445*
*Co-Chairperson: Elissa Benedek, M.D.*
*Presenters: Wade Myers, M.D., Jeffrey King, J.D., Carl Malmquist, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize problems posed by the internet, assess risks when using it and be familiar with means to protect practitioners and patients.

**SUMMARY:**

Information technologies such as the internet have created many new possibilities and patterns for information use and communication, but also for new ethical, clinical and legal problems. The workshop will describe these and illustrate with cases and a video showing a resident who googled a patient for confidential material. Topic to be discussed include googling, use of e-mail between doctor and patient, and social networking sites eg Facebook. Problems include privacy of patient information, potential for e-mails to lead to increasing intensity and boundary violations, potential for e-mails to be printed and stored in paper or electronic forms, repercussions of patients finding out personal information or legal information (eg past boundary violations) about therapist or therapist discovering information about patients.Networking sites eg Facebook make oproivate information available to a wide range of people.

**REFERENCES:**

1. Gutheil, T and Brodsky, A. Preventing Boundary Violations 2008, Guilford Press
2. Jain,S. Practicing Medicine in the Age of Facebook. NEJM.2009,361:649-651

WORKSHOP 39

## WHERE SCIENCE AND SOCIAL JUSTICE MEET: THE EXAMPLE OF SMOKING IN PERSONS WITH BIPOLAR DISORDER

*Chairperson: Annette Matthews, M.D., 3710 SW US Veterans Hospital Rd., Portland, OR 97207*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should understand risk factors for smoking in bipolar disorder, including the interpersonal, community, and societal factors that may promote it; learn about the uneven application of common tobacco control policies and how taking a social justice stance can motivate them to intervene on their patients smoking behavior; feel confident in providing basic smoking cessation services to persons with bipolar disorder.

**SUMMARY:**

The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) found that persons with Bipolar I have a 44.4% lifetime prevalence of nicotine dependence and other studies have found even higher rates of smoking, ranging from 55-70% lifetime prevalence. However, it is very difficult to successfully help persons with bipolar disorder stop smoking.
We will review some of the bio-psycho risk factors for heavy smoking in this population. We will then examine the many social factors that make it more difficult for the chronically mentally ill to stop smoking. Interpersonal factors that reinforce smoking may include the fact that peers and intimate partners make also smoke at a high level. Families and treatment programs encourage smoking as a recreational outlet or use cigarettes as a form of reward. Community factors include the acceptance or promotion of smoking being integrated into settings where the chronically mentally ill get care. For instance, a designated smoking area may be placed near a day treatment program, or there may be limited enforcement of existing restrictions on smoking because the mentally ill congregate in a specific place. Unfortunately, smoking in the chronically mentally ill is largely accepted as a societal norm, and so policies that

are known to reduce smoking in the general population may not be even be enacted in areas where the mentally ill are found in high numbers. For example it is known that smoke free housing prevents smoking initiation, but there are limited efforts to develop smoke-free supported housing. Our society also specifically tailors tobacco marking to the mentally ill.

After a review of common tobacco control mechanisms, the group will be encouraged to brainstorm areas where smoking is reinforced by communities and society and how a social justice approach can be used to motivate a provider to address smoking in this population. We will review some of the unique challenges and risks of providing smoking cessation services to this population and discuss how our profession can better address smoking on and individual and community level.

**REFERENCES:**

1. Schroeder SA. A 51-year-old woman with bipolar disorder who wants to quit smoking. JAMA. 2009;301:522-31

WORKSHOP 40

**COGNITIVE-BEHAVIORAL THERAPY: TROUBLESHOOTING COMMON CHALLENGES**

*Chairperson: Donna Sudak, M.D., c/o Friends Hospital, PO Box 45358, Philadelphia, PA 19124*
*Presenters: Judith Beck, Ph.D. Jesse Wright, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Employ techniques to counter problems with homework non-completion; 2) Demonstrate an understanding of key methods to deal with difficulties eliciting and changing automatic thoughts; and 3) Demonstrate an understanding of methods to help patients who are stuck in maladaptive behavioral patterns.

**SUMMARY:**

Cognitive-behavior therapy has been demonstrated to be effective, both with and without medication, for a wide range of psychiatric disorders. Despite the "commonsense" framework of CBT, psychiatrists are often confronted with more complex patients who do not respond to standard CBT techniques. The purpose of this workshop is to present solutions for the common clinical situations that may derail the progress of CBT. We will conceptualize problems, illustrate solutions through role-play or videos, and encourage discussion about the practical application of these techniques in clinical practice. We will also present resources for participants to follow up this workshop to strengthen their skills in using CBT in challenging clinical situations.

**REFERENCES:**

1. Sudak, D.M., Cognitive Behavior Therapy for Clinicians Philadelphia: Lippincott Williams and Wilkins, 2006.
2. Beck, J., Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work, New York: Guilford, 2005.
3. Wright, J.H., Basco, M.R., and Thase, M.E. Learning Cognitive-Behavior Therapy: An Illustrated Guide, Washington DC:APPI Press, 2006.

**SUNDAY, MAY 23**

**9:00 AM - 10:30 AM**

**WORKSHOPS**

WORKSHOP 41

**AFTER A PARENT'S SUICIDE: CHILDREN'S GRIEF AND HEALING**

*Chairperson: Nancy Rappaport, M.D., 6 Wyman Rd., Cambridge, MA 02138*
*Presenters: Diana Sands, Ph.D. Joanne Harpel, J.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the perspective of a clinician who survives a family member's suicide and how to construct a healing narrative; 2) Understand the impact of suicide on children and families and the range of grief responses experienced following a suicide death; and 3) Recognize ways that clinicians can promote the healing process in child and adolescent survivors of suicide loss.

**SUMMARY:**

Although reliable statistics are difficult to come by, a conservative estimate reveals that at least 10,000 to 20,000 children and adolescents in the United States are bereaved by suicide of a loved one each year.

Dr. Nancy Rappaport is a child psychiatrist and also the survivor of her mother's suicide, which occurred when Dr. Rappaport was only four years old. Like most survivors, since her mother's suicide, Dr. Rappaport has struggled to come to terms with the reasons why her mother took her own life. Dr. Rappaport wrote her new book (In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother's Death) as a way to help her understand the loss of her mother. Dr. Rappaport's story highlights her understanding of family tragedy, her resiliency, and the power of narrative to heal. Drawing upon her unique

experience as both a clinician and a childhood survivor, she will discuss her journey with an overview of research and guidelines for how caregivers/clinicians can explain suicide and help bereaved children heal after a suicide in the family. She will focus on the themes of self-reflection, resilience, and recovery in child survivors, and the ways that caregivers can foster these necessary attributes.

Dr. Diana Sands will show a short film, The Red Chocolate Elephants, about the experience of children bereaved by suicide and will discuss the range of children's grief responses, ways to facilitate this construction of meaning following a death by suicide in ways that develop resilience and connection. She will offer methods of using artwork with children in this construction of meaning. She will present her Australian community-based program that offers a menu of options to assist children in making meaning through art, drama, ritual, narrative, and other strategies to create a safe space to hold the confusion and pain. She will outline group outcomes and the use of some specific strategies.

Ms. Harpel, the Director of Survivor Initiatives for the American Foundation for Suicide Prevention, will facilitate discussion on the impact of suicide on children and families and ways that clinicians and others can promote the healing process in child and adolescent survivors of suicide loss.

**REFERENCES:**

1. Brent D, Melhem N, Donohoe MB, et al.: The Incidence and Course of Depression in Bereaved Youth 21 Months After the Loss of a Parent to Suicide, Accident, or Sudden Natural Death. American Journal of Psychiatry 166:786-794, 2009.
2. Jordan JR: Is suicide bereavement different? A reassessment of the literature. Suicide & Life-Threatening Behavior 31:91-102, 2001.
3. Rappaport N: In Her Wake: A child psychiatrist explores the mystery of her mother's suicide. New York: Basic Books, 2009.
4. Requarth M: After a Parent's Suicide: Helping children heal. Sebastopol, CA: Healing Hearts Press, 2006

WORKSHOP 42

**FROM NARRATIVE AND THEORY TO EVIDENCE-BASED SUPPORT FOR PSYCHIATRISTS WORKING UNDER EXTREME STRESS**

*APA Lifers*

*Chairperson: Sheila Hafter Gray, M.D., Box 40612, Palisades Station, Washington, DC 20016*
*Presenters: Captane Thomson, M.D., Leah Dickstein, M.D., Jane Tillman, Ph.D. David Huang, M.D., Milton Kramer, M.D., John Bradley, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to 1) Evaluate the narrative and evidence bases of the effect of professional stressors on mental health clinicians; 2) Differentiate the stressors psychiatrists encounter in a war zone from those encountered at home; 3) Consciously monitor his or her responses to acute and continuous stress; and 4) Develop and implement evidence-based skills for coping with the trauma psychiatrists encounter in stressful practice situations.

**SUMMARY:**

Our pride in the progress Psychiatry made in the care of patients is balanced by the stress we experience in our efforts to provide optimal care in difficult circumstances. Psychiatrists are vulnerable to assaults on our sense of competence; but without evidence about the effect of work-related stress on clinicians we rely on personal coping skills, lore and theoretical notions to endure these difficulties. This Workshop will offer samples of what we know, and invite participants to think about developing evidence-based skills to use when we must work under extreme stress.

Thomson will recount his reaction to the death of a colleague, the effect it had on his practice, and how he healed. Huang will share his history of running a clinical service in a war zone. Is the stress military psychiatrists experience working under fire the same as or different from professional stressors we encounter in civilian life? Do ordinary coping skills work? Kramer will present research findings which indicate that the psychiatrists' dreams are reliable indicator of the stress they experience and how they process it. How may awareness of our dreams help us master trauma? Tillman will describe a recent study of clinicians' response to a patient's suicide, in which she and coworkers found that those who imagined this event reported more symptoms of stress than those who had an actual experience. Dickstein will reconsider our prior supportive interventions in such cases in light of these new findings.

The discussion among participants will focus on what we know and what we need to know to develop an evidence-based protocol for coping with professional trauma, helping ourselves and improving the care of our patients.

Disclaimer: The opinions or assertions contained in these presentations are the private views of the authors and are not to be construed as official or as reflecting the views or policies of the U.S. Department of Defense or any of its affiliated organizations.

**REFERENCES:**

1. Daneault S: The wounded healer. Can Fam Physician 2008; 54:1218-1219
2. Zwiebel R: Dynamics of the countertransference dream. Int Rev Psychoanal 1985; 12:87-100

WORKSHOP 43
**PHYSICIAN HEAL THYSELF: SCANDALS, SUICIDES, AND SUBSTANCE ABUSE AMONG US**

*Chairperson: Margaret Bishop-Baier, M.D., 1542 Tulane Ave., New Orleans, LA 70112*
*Co-Chairperson: Scott Embley L.C.S.W.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Define impaired physician; 2) Appreciate the prevalence of physician impairment by specialty; 3) Understand their ethical and legal responsibilities toward impaired physicians; 4) Identify signs and symptoms of physician impairment; and 5) Intervene and refer residents, colleagues, and supervisors for evaluation and treatment.

**SUMMARY:**
An impaired physician is one who is unable to provide safe, effective care for patients due to his or her own illnesses or life circumstance. It is estimated that 10-15% of the physician population has an alcohol or drug related disorder. Additionally, physicians may be impaired due to medical illness, especially those affecting cognitive function, and other psychiatric illnesses. Disruptive behaviors which may or may not be related to neuro cognitive disorders may impair physicians. Depending on how broadly one defines impairment, we estimate that less than half of impaired physicians are identified and engaged in appropriate treatment.
In our workshop we will review data from the Federation of State Physician Health Programs that are specialty specific. We will also discuss the data available on physicians in training. Case vignettes drawn from the presenters' experiences with the Campus Assistance Program at Louisiana State University Health Sciences Center will be used in a small group exercise which allows participants to practice identifying and referring impaired physicians. Each small group will then present their recommendations to the entire group. Ethical and legal responsibilities including the American Psychiatric Association's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry will be presented and then applied to these cases. An overview of intervention, treatment and monitoring models will familiarize participants with current practices in occupational psychiatry.
In conclusion, it is our expectation that participants will leave this workshop with pride tempered by humility. In this context, humility means awareness that each physician should not expect to heal him or herself. With this humility we can maintain pride in our ability as professionals and colleagues to heal and be healed by one another.

WORKSHOP 44
**MOOD DISORDERS IN WOMEN OF REPRODUCTIVE AGE**

*Chairperson: Natalie Rasgon, M.D., 401 Quarry Road Ste 2368, Stanford, CA 94305-5723*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize effects of estrogen on mood and cognition in women during menopausal transition; 2) Identify brain biomarkers which represent risk factors for AD; and 3) Identify clinical applications of estrogen therapy in postmenopausal women with major depression.

**SUMMARY:**
We assessed the effects of use of hormone therapy (HT) on brain function in women at risk for developing Alzheimer's Disease (AD). Specifically, we aimed to assess longitudinally changes in brain function, utilizing fluorodeoxyglucose positron emission tomography (FDG-PET), magnetic resonance imaging (MRI), neuropsychological performance, and clinical ratings in the _original cohort_ (N=70) of cognitively asymptomatic recently postmenopausal women enriched for likelihood of developing AD by one or more clinical or genetic risk factors. We report significant differences in selective regions of interest and cognitive domains between users of conjugated equine estrogens (CEE) and those receiving 17-? estradiol preparations, we all as effects of opposed vs. unopposed HT./ /Other findings at baseline include effects of age, educational attainment and duration of endogenous estrogen exposure on neuroimaging biomarkers./ /Our data to date also suggest that women randomized to discontinue E/HT exhibited significant metabolic decline in the inferior parietal lobule and decline in subjective memory. The significant decline in parietal metabolism was attenuated for women who were randomized to stay on E/HT, but who were otherwise at equally increased risk for developing AD. The apparent cerebral protection associated with continued estrogen use was influenced by the presence of the ApoE-?4 allele.

WORKSHOP 45
**COGNITIVE BEHAVIORAL STRATEGIES FOR WEIGHT LOSS**

*Chairperson: Sarah B Johnson, M.D., M.S.C., 501 E. Broadway Med Center One Suite 340, Louisville, KY 40202*
*Co-Chairperson: Joyce Spurgeon, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand factors contributing to the obesity epidemic; 2) Explain risks and benefits of commonly used weight loss strategies; and 3) Integrate cognitive behavioral techniques to promote adherence to weight loss regimens.

**SUMMARY:**

We live in a society obsessed with food and weight loss. Current FDA data suggest that 2/3 of adults in the United States are overweight and nearly 1/3 are obese. Psychiatric patients may be particularly vulnerable to the obesity epidemic for a variety of reasons. There are a multitude of methods used to lose weight, including pharmacotherapy, diet plans and bariatric surgery. Behavioral techniques can improve success rates in individuals trying to lose weight without harmful side and health risks imposed by other methods.

This epidemic is multi-factorial. A combination of more sedentary lifestyle, more readily available fast food and other lifestyle factors of modern society have likely contributed to the steady rise in obesity since the early 1980's. However, the fact the only way to lose weight is to utilize more energy than consumed has remained the same. As weight increases, so does prevalence of heart disease, stroke, hypertension, type 2 diabetes, sleep apnea and certain cancers. This presentation will highlight some of the most widely used methods of weight loss and illustrate how cognitive behavioral strategies can be utilized to promote adherence and improve success rates in individuals trying to lose weight.

Common weight loss strategies including support groups, such as Weight Watchers, pharmacotherapy and bariatric surgery procedures will be reviewed to provide the psychiatrist with background information needed to understand the language of weight loss. Cognitive behavior strategies can be easily integrated into clinical practice to help individuals adhere to their weight loss strategies. Recent evidence based data will be presented to aid the clinician in educating their patients how these techniques lead to success. Interactive case presentations throughout the workshop will solidify these concepts and provide the audience with a model that they can use in their daily practice.

**REFERENCES:**

1. Beck J. 2007. The Beck Diet Solution. Oxmoor House.
2. Centers for Disease Control and Prevention. Obesity Trends Among U.S. Adults between 1985 and 2007. Retrieved September 7, 2008, from http://www.cdc.gov/nccdphp/ dnpa/obesity/trend/maps.
3. National Institutes of Health, National Heart, Lung, and Blood Institute. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. September 1998. NIH Publication Workshop 98-4083
4. Norris L. Psychiatric Issues in Bariatric Surgery. Psychiatric Clinics of North America 2007: 30:717-738.

WORKSHOP 46

**CHANGING PARADIGMS OF PSYCHIATRIC PRACTICE IN AN ERA OF HEALTH CARE REFORM**

***APA Council on Advocacy & Government Relations***

*Chairperson: Javeed Sukhera, M.D., 171 Kenwick Drive, Rochester, NY 14623*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify lessons learned from health care reform for psychiatric practice; 2) Address unintended consequences of the health reform process on vulnerable populations; 3) Highlight successful collaborations between psychiatry and primary care; and 4) Discuss the role of successful prevention programs and their importance to health care reform.

**SUMMARY:**

The volatile and politically charged process of health care reform has captured the headlines for much of the past year. Missing from the debate are reflections on the implications of health care reform for psychiatric practice. With change comes challenge and an opportunity for the future. This component workshop hopes to examine health care reform from several perspectives which converge on the concept of successful versus inadequate implementation. Topics include lessons learned from jurisdictions such as North Carolina and Massachusetts where previous reform initiatives are in the process of implementation. Presenters will discuss unintended consequences of health reform on under served and vulnerable populations, as well as outline changing models of health service delivery including unique collaborations between psychiatry and primary care. Further discussion will focus on the concept of prevention and how it relates to the implementation of health care reform.

WORKSHOP 47

**AMBULATORY MEDICAL CLINICS AS TRAINING SITES FOR RESIDENTS AND**

**FELLOWS IN PSYCHOSOMATIC MEDICINE**

*Chairperson: Robert C. Joseph, M.D., M.S., 1493 Cambridge Street, Cambridge, MA 02139*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize learning opportunities in Psychosomatic Medicine available in primary care and oncology ambulatory clinics that are not available in traditional inpatient services; 2) Identify opportunities for residents/fellows to be able to provide formal and informal educational sessions to our medical colleagues; and 3) Recognize the career opportunities related to ambulatory psychosomatic clinics.

**SUMMARY:**
Clinical training in Psychosomatic Medicine has traditionally taken place within the general hospital on medical and surgical units. Inpatient medicine and surgery provide training opportunities for liaison psychiatry and for most conditions at the core of Psychosomatic Medicine. However, several factors have created opportunities for training and employment in ambulatory medical clinics that are not present in hospital settings. These include: the increased emphasis on ambulatory medicine; the awareness of the behavioral contribution to the course of medical illnesses; the increasingly recognized value of a consulting psychiatrist to ambulatory medical clinics; and the development of innovative models of integrated health care delivery. The need for psychiatric consultation and mental health services integrated into ambulatory medical care has been highlighted by the programs for the management of depression and anxiety in primary care which have become the focus of many ambulatory health care quality initiatives. With the current national interest in reforming healthcare delivery while containing costs innovations such as the "medical home" and other integrated care models of health care are likely to be more broadly implemented. Despite the growth of such programs little attention has been paid to formal training of Psychosomatic Medicine providers in ambulatory medical clinics.
We will present illustrations of a variety of training opportunities that are only available in ambulatory medical sites and discuss learning objectives of the training experience. Presentations will discuss cross-disciplinary training in psychosomatic medicine in general primary care clinics and a psycho-oncology clinic, the training of primary care providers to improve the care or the mental health care they provide. Perspectives of both trainees and educators will be represented.

**REFERENCES:**
1) James R. Rundell, M.D., Kierin Amundsen, Teresa L. Rummans, M.D., and Gayla Tennen, M.D. Toward Defining the Scope of Psychosomatic Medicine Practice: Psychosomatic Medicine in an Outpatient, Tertiary-Care Practice Setting Psychosomatics 49:487-493, November-December.

**11:00 AM-12:30 PM**

WORKSHOP 48
**STREET TO HOME: SHAME IN HOMELESSNESS**

*Chairperson: Prakash Chandra, M.D., 515 Ovington Avenue, Brooklyn, NY 11209*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Appreciate predominant dynamic issues influencing the interactions between clinicians and their patients who have been homeless; and 2) Acquire additional perspectives on evaluating and treating the unique needs of homeless patients.

**SUMMARY:**
Homeless people in our society constitute invisible, nameless faces who are generally considered reminders of "failed lives." These people are mostly ignored, isolated and forgotten by society. The street is a home of last resort, where many live alongside shame, abuse, isolation, and hopelessness.
New York City has recently adopted a "street to home" policy, in which homeless individuals are placed in permanent housing as soon as possible, regardless of their clinical state. Project for Psychiatric Outreach to the Homeless (PPOH), a program of the non-profit agency Center for Urban Community Services (CUCS) places psychiatrists and psychiatric residents at a new supportive residence specifically for "street to home" clients, known as "The Schermerhorn," in Downtown Brooklyn.
We have found that the burden of shame among these people is pervasive. Shame takes many shapes and forms and inevitably dictates the therapeutic process with the entire multi-disciplinary staff at the permanent residence. In this workshop, two residents and another member of the staff will give an overview on the extent of shame in homeless people, how it affects their rehabilitation process and narratives on the experience of working with these patients. The supervising PPOH attending will describe how shame has affected tranference-countertransference processes. One third of the workshop's time will be dedicated for audience interaction. Attendees are encouraged to share their own experience.

**REFERENCES:**

1) Hopper K, Hay T, Jost J, Welber S, Haugland G “Homelessness, severe mental illness and the institutional circuit” Psychiatric Services 48 659-665 1997 www.cucs.org

WORKSHOP 49

## “I’M VIOLENT, ADMIT ME IF YOU DARE:” HOW AND WHERE TO MANAGE POTENTIALLY VIOLENT INDIVIDUALS WITH UNCLEAR DIAGNOSES PRESENTING TO EMERGENCY SERVICES

*Chairperson: Kenneth M Certa, M.D., 833 Chestnut St., Suite 210, Philadelphia, PA 19107*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to 1) Identify risk factors for violence by patients admitted to inpatient psychiatric units, 2) List alternative treatment options for managing violent individuals, 3) Recognize liability implications of treatment alternatives, and 4) Develop guidelines to intervene appropriately with potentially violent patients to protect the individual, hospital staff, and society.

**SUMMARY:**

Violence on inpatient psychiatric units can have serious adverse effects on perpetrators, hospital staff called upon to intervene, and other patients. Often the perpetrator is easily recognized at the time of admission. Recognizing such potentially violent individuals is a necessary task of emergency room psychiatrists. Identifying at-risk potential admissions creates the dilemma of what to do: do we knowingly put our other patients and staff at risk by admitting those with violent histories or current-state warning signs, or do we try to find any other way of dealing with the clinical crisis in order to maintain hospital safety? Does the decision change if the roots of the violence are related to substance abuse, personality disorder, or psychosis? At what point is involvement of the criminal justice system justified or indicated? Hospital risk management, workplace safety officers, and the plaintiffs bar all are eager to give advice, much of it conflicting.
Each treatment system is faced with individuals such as this, who are difficult to talk about in the abstract. We will present our thoughts on how to come to such treatment determinations, and then present several scenarios drawn from our work. Workshop participants will be encouraged to share their personal and systems’ solution to the problem of known violent patients, their opinion about our management decisions, and present examples from their own experience.

**REFERENCES:**

1. Amore M, Menchetti M, Tonti C, Scarlatti F, Lundgren E, Esposito W, Berardi D. Predictors of violent behavior among acute psychiatric patients: clinical study. Psychiatry Clin Neurosci. 2008 Jun;62(3):247-55.

WORKSHOP 50

## PSYCHIATRIC CARE IN LATIN AMERICA: CURRENT CHALLENGES AND FUTURE PERSPECTIVES

*Chairperson: Pedro Ruiz M.D., Room 1458 Clinical Research Building 1120 NW 14th Street Miami, FL 33136*
*Co Chair: Rodrigo A. Munoz M.D.*
*Presenters: Edgard Belfort M.D. Enrique Camarena M.D. Alfredo Cía M.D. Silvia Gaviria M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Learn about the current status of access and parity of psychiatric care in Latin America. 2) Recognize the challenges in planning large systems of psychiatric care in Latin America; 3) Understand the education and research needs with respect to the care of psychiatric patients in Latin America.

**SUMMARY:**

Latin America is one of the largest and most populated continents across the world; however, it is also one of the most underserved continents insofar as mental health care and prevention of mental illness are concerned. Lack of psychiatrists and other mental health professionals, deficient psychiatric training programs, lack of adequate funding for psychiatric research purposes, inadequate prevention efforts vis-à-vis mental illness, large numbers of indigenous populations in certain countries, lack and/or deficient mental health plans at the governmental level, and the like, make this continent a major challenge from a mental health and mental illness point of view. In this panel, the leadership of the Latin American Psychiatric Association (APAL) and the two Hispanic past presidents of the American Psychiatric Association (APA) will address those challenges and will also propose suitable solutions to resolve them. In the United States there are currently about 55 million of Hispanic migrants that have settled in this country. Therefore, it behooves to all of us to positively address what is needed not only in Latin America, but also in the United States to improve the future lives of this unique population. It is worth to note that in Latin

America the rates of the population living under the poverty level are much higher among the indigenous population than in the general population. For instance, in Guatemala is 86.6% in the indigenous population and 65.6% in the general population. Likewise, in Mexico is 80.6% in the indigenous population and 22.6% in the general population. Similarly, the malnutrition rates in the indigenous population of Guatemala are 69.5% and 35.7% in the non-indigenous population. These figures denote extremely well the challenges that currently exist in Latin America. Hopefully, at the end of this presentation the participants will address the most appropriate ways of successfully dealing with these problems.

**REFERENCES:**

1. Ruiz P: Addressing Culture, Race and Ethnicity in Psychiatric Practice. Psychiatric Annals, 34(7): 527-532, 2004.
2. Ruiz P: Hispanic Access to Health/Mental Health Services. Psychiatric Quarterly, 73(2): 85-91, 2002.

WORKSHOP 51
**UPDATE ON PARASOMNIAS: A REVIEW FOR PSYCHIATRIC PRACTICE**

*Chairperson: Dimitri D Markov, M.D., Jefferson Sleep Disorders Center 211 S. Ninth Street, 5th Floor, Philadelphia, PA 19107*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Describe clinical features of various parasomnias; 2) Distinguish among the various parasomnias based on history and the sleep state during which they occur; 3) Recognize common comorbidities in patients with parasomnias; and 4) Understand the etiologic factors associated with parasomnias.

**SUMMARY:**
Parasomnias, defined as undesirable behavioral, physiological or experiential events that accompany sleep, are common in the general population. As a rule they occur more frequently in children than in adults with the exception of REM sleep behavior disorder (RBD), which is more common in men over 50. No longer considered to be invariably a sign of psychopathology, parasomnias are currently understood as clinical phenomena that arise as brain transitions between REM sleep, non-REM sleep, and wakefulness. This paper presents a clinical approach to diagnosing and treating parasomnias in the general population and in psychiatric patients.

**REFERENCES:**

1. Mahowald MW, Schneck CH. Non-Rapid Eye Movement Sleep Parasomnias. Neurologic Clinics 2005 ; 23 pages 1077 - 1106
2. Schneck CH, Mahowald MW. Rapid Eye Movement Sleep Parasomnias. Neurologic Clinics 2005 ; 23 pages 1107 – 1126
3. Schneck CH, Mahowald MW. REM Sleep Behavior Disorder: Clinical, Developmental, and Neuroscience Perspectives 16 Years After its Formal Identification in SLEEP. SLEEP, Vol 25, Workshop 2, 2002 pages 120 - 138
4. Catwright R. Sleepwalking violence: a sleep disorder, a legal dilemma, and a physiological challenge. American Journal of Psychiatry 2004; 161: pages 1149 – 1158

WORKSHOP 52
**CULTURAL DIVERSITIES: THE IMPACT ON MENTAL HEALTH TREATMENT AND EVALUATION IN JAILS AND PRISONS**

*APA Council on Psychiatry & Law*

*Chairperson: Henry C. Weinstein, M.D., 1111 Park Avenue, New York, NY 10128*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Define and delineate the demographics of the cultural diversities and disparities among the inmates and staff (security and mental health) in jails and prisons; 2) Describe the effects of cultural diversities and disparities on mental health treatment and evaluation in jails and prisons; and 3) Describe the training programs that are being proposed to ameliorate the effects of such cultural diversities in jails and prisons.

**SUMMARY:**
To properly treat and evaluate inmates in a correctional setting, it is imperative that clinicians and staff overcome the consequences of the often substantial cultural differences in race, background, ethnicity, socioeconomic class, education and other types of diversities. These cultural differences between the inmate population and the correctional staff (including the mental health staff) make the need for training in cultural sensitivity particularly important in jails and prisons in order to assure sensitivity to such cultural differences and support efforts to overcome the negative consequences of the cultural diversity especially those that adversely affect the delivery of mental health services.
This Workshop, a presentation of the Caucus of Psychiatrists Practicing in Correctional Settings, will describe and discuss the demographics of such diversities, the effects of these diversities on mental health treatment and evaluation and the training programs that are being suggested for use in correctional facilities Such training programs seek to assure positive attitudes and acceptance

of other cultures by means of didactic and experiential components that focus on the development of attitudes, as well as demographic information, epidemiology, the psychological aspects of immigration, the psychological aspects of minority status, religious and other beliefs as well as attitudes about psychiatric treatments and the sources of misdiagnosis and frequently misdiagnosed problems.

**REFERENCES:**

1. Ruiz, P. et al. Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives, Washington, DC: American Psychiatric Press, Inc. (2009)
2. Johnson RMA. Racial Bias in the Criminal Justice System and Why We Should Care. Criminal Justice 2007: Winter: 1.

WORKSHOP 53

## SCOPE OF PRACTICE CHALLENGES: EXPERIENCES, SUCCESSES, AND TRIBULATIONS FROM ACROSS THE COUNTRY

*Chairperson: Jerry L Halverson, M.D., 6001 Research Park Blvd, Madison, WI 53719*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the arguments for and against expansion of psychiatric prescribing privileges to psychologists; 2) Possess the knowledge and skills necessary to advocate for patient safety as related to scope of practice issues in psychiatry; and 3) Develop alternative programs to expand access to psychiatric prescribing services.

**SUMMARY:**

Psychologists are increasingly pushing for legislation to gain prescriptive authority, which has been granted in 2 states thus far and defeated in over 20 more. The American Psychiatric Association and American Medical Association have taken firm stances against this scope of practice expansion. We will address what the evidence to date suggests about the impact of psychologist prescribing on quality of care, cost of care, and access to care. Included will be discussion of the Department of Defense pilot program to train military psychologists to prescribe.
A panel of geographically diverse psychiatrists will join APA Government Relations Staff in sharing their unique experiences and recommendations in working on this scope of practice issue. Unique perspectives will be offered by psychiatrists from Wisconsin, Illinois, Florida, Oklahoma, Louisiana (where psychologist prescribing has been allowed)and California. Experiences shared will include that of a Psychiatrist/Psychologist from Oklahoma and her experiences with an innovative, multi-specialty/ patient scope of practice partnership, perspectives from multiple psychiatrists who have delivered legislative testimony on this issue, and discussion of helpful ways to present information on this topic to legislators in written and oral form. Creative methods that states have found to increase access to psychiatric care will also be described. Side effects of the system of psychologist prescribing in Louisiana will be discussed by a psychiatrist practicing in the state. APA Government Relations Staff will share their experiences in partnering with District Branches on this issue and will discuss available resources. We will conclude with plenty of time for audience group discussion of what has worked in various parts of the U.S. to maintain patient safety and enhance access to psychiatric care.

**REFERENCES:**

1. Oakley R, Alpert M, Angrist B, et al. American College of Neuropsychopharmacology Evaluation Report and Final Summary: The Department of Defense Psychopharmacology Demonstration Project. ACNP Bulletin 2000; 6 (3).

**1:30 PM- 3:00 PM**

WORKSHOP 54

## MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART I

*Chairperson: Rex W Huang, M.D., 401 Quarry Road, Room 2312, Stanford, CA 94305*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Define the chief resident role more clearly; 2) Identify effective strategies used in other programs to deal with the common difficult issues and logistical tasks faced by chief residents; 3) Share his/her own learning experiences with other participants at the workshop; and 4) Network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

**SUMMARY:**

This is Part I in a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most chief residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the chief resident's duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature dating back to 1980 discussed the several problems inherent in the role, including: poor definition of

the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these chief residency issues, and to improve the lack of information that often accompany this role, (most programs typically have only 1 or 2 chief residents who are doing the job for the first time). This will include presentations from panelists who are finishing their chief year at programs across the country. Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include:
(1) logistical issues (making schedules, providing call coverage when residents are sick or away, organizing retreats, improving resident morale), and (2) dealing with difficult resident issues (how to support a resident after a patient suicide, how to support a resident after violence, how to support a resident struggling academically) Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

**REFERENCES:**

1. Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280
2. Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276 Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280

WORKSHOP 55

## PROMOTING INTERNATIONAL MEDICAL GRADUATES PSYCHOSOCIAL SUPPORT DURING RESIDENCY TRAINING

*Chairperson: Anu A. Matorin, M.D., 1300 Moursund, Houston, TX 77030*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant will have an increased awareness of the unique stressors facing international medical graduates (IMGs) during residency training. This workshop focuses on the roles of social support & acculturation in the psychosocial health of IMG trainees. It will also provide a forum to identify and implement creative strategies that help training programs to develop resources for improving IMG trainees' social support during acculturation process.

**SUMMARY:**

The Educational Commission for Foreign Medical Graduates has defined an international medical graduate (IMG) as "A physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada". IMGs have made significant contributions to the United States physician work force across all specialties. IMGs serve the underserved, both as trainees and practitioners and disproportionately cater to the health needs of immigrant and minority cohorts. Residency is a time of great emotional and psychological distress and consequently contemporary research has looked into it. However, the effects of acculturative stress on IMGs have mostly been neglected. IMGs confront, to varying extents, the twin stressors of migration – acculturative stress and changes in social support. In addition to the pressures and anxieties inherent to residency training, IMGs especially from Non English speaking countries face some very unique psychosocial stressors. The striving for a balance between personal and academic demands and a subjective loss of social status that accompanies their cross cultural transition can be intense. Understanding migration & its antecedents are important to identify and address the psychological needs of IMGs. A strong association exists between both social support and acculturative stress and psychological well being. An improved psychological health can assist in the successful cultural adaptation and, eventually, an enhancement in the optimal integration of IMG residents into the physician workforce of United States. This presentation discusses the unique psychosocial stressors that IMGs face during residency training. It also purports to provide a forum for exchange of ideas to identify and implement creative strategies that may help training programs in developing resources for improving IMG trainees' social support during the acculturation process.

**REFERENCES:**

1. McMahon, GT: Coming to America International Medical Graduates in the United States. N Engl J Med 2004; 350:2435 2437
2. Haveliwala YA. Problems of foreign born psychiatrists. Psychiatr Q. 1979; 51:307 311

WORKSHOP 56

## MAINTENANCE TREATMENT FOR OPIATE DEPENDENCE: TERMINABLE OR INTERMINABLE?

***U.S. National Institute on Drug Abuse***

*Chairperson: Ivan D Montoya, M.D., M.P.H., 6001 Executive Blvd., Bethesda, MD 20892*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participants should be able to recognize the advantages and disadvantages of different lengths of maintenance treatments and the factors that clinicians may consider when deciding to continue or stop maintenance treatments for opiate dependence.

**SUMMARY:**
Medications, such as methadone and buprenorphine, as well as psychosocial interventions are widely used for the treatment of opiate dependence. Traditionally, opiate dependence interventions have been classified in detoxification and maintenance treatments. According to the duration of the treatment, detoxification has been labeled as ultra-rapid, very short-term, short term, 21-day, etc. The duration of maintenance, however, has not been clearly defined and little is known about the relative efficacy of different lengths of opiate maintenance interventions. As a result, the decision to continue or terminate an opiate maintenance treatment represents a major dilemma for the clinician. Recent studies are providing information about the relative benefit of different lengths of opiate maintenance treatment in various populations and their results may assist clinicians in determining the most adequate duration of opiate maintenance interventions. The purpose of this workshop is to review the current scientific information and clinical recommendations about the optimal duration of opiate maintenance and the factors that may help the clinician decide whether to continue or terminate an opiate maintenance treatment. The topics and speakers are listed below. At the end of the workshop, the participants will gain knowledge to recognize the advantages and disadvantages of different lengths of maintenance treatments and the factors that clinicians may consider when deciding to continue or stop maintenance treatments for opiate dependence.

**REFERENCES:**
1. Gruber VA, Delucchi KL, Kielstein A, Batki SL.: A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug Alcohol Depend. 2008 Apr 1;94(1-3):199-206.

**3:00 PM- 5:00 PM**

WORKSHOP 57
**MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART II**

*Chairperson: Rex W Huang, M.D., 401 Quarry Road, Room 2312, Stanford, CA 94305*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Define the chief resident role more clearly; 2) Identify strategies for maximizing administrative and professional growth, and for handling the dual role of resident and administrator; 3) Share his/her own learning experiences with other participants at the workshop; and 4) Network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

**SUMMARY:**
This is Part II in a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most chief residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the chief resident's duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature dating back to 1980 discussed the several problems inherent in the role, including: poor definition of the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these chief residency issues, and to improve the lack of information that often accompany this role, (most programs typically have only 1 or 2 chief residents who are doing the job for the first time). This will include presentations from panelists who are finishing their chief year at programs across the country. Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include:
(1) The "dual role" of interfacing between residents and administrators, and (2) ways to maximize administrative, professional, and personal growth in a year that is rich in opportunities for all the above. Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

**REFERENCES:**
1. Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280
2. Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276
3. Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280

WORKSHOP 58
## PHARMACOLOGICAL APPROACHES TO AUTISM SPECTRUM DISORDERS FOR CLINICIANS

*Chairperson: Christopher J. McDougle, M.D., 1111 W 10th St Rm A305, Indianapolis, IN 46202-4800*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the differential diagnosis of autism spectrum disorders; 2) Identify the target symptoms associated with autism spectrum disorders that may be responsive to pharmacological treatment; and 3) Recognize the potential side effects associated with medications used to treat target symptoms associated with autism spectrum disorders.

**SUMMARY:**
This workshop will review the differential diagnosis of autism spectrum disorders, including autistic disorder, Asperger's disorder, Rett's disorder, Childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. We will then review results from randomized controlled trials of medications directed toward the amelioration of target symptoms in 4 clusters to include: motor hyperactivity and inattention, interfering repetitive phenomena, irritability (aggression, self-injurious behavior, severe tantrums), and impaired social relatedness. Potential side effects of medications will be discussed, as well. Ideas for future studies of medication treatment approaches will be reviewed. Questions from workshop participants will be encouraged and addressed throughout the discussion. The workshop is meant to be highly interactive and to address practical aspects of the psychopharmacology of autism spectrum disorders from the clinicians' perspective.

**REFERENCES:**
1). McDougle, C.J., Posey, D.J., Stigler, K.A.: Pharmacological treatments (Chapter 18). In Understanding Autism: From Basic Neuroscience to Treatment, Moldin, S.O., Rubenstein, J.L.R. (eds), CRC Press, Boca Raton, pp. 417-442, 2006.

**MONDAY, MAY 24, 2010**

**9:00 AM-10:30 AM**

WORKSHOP 60
## INTERVIEWING PATIENTS WHO HATE OR FEAR PSYCHIATRISTS

*Chairperson: James L Griffith, M.D., 8th Floor, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*

**EDUCATIONAL OBJECTIVES:**
At the completion of this session participants will be able to: 1) Articulate findings from social psychology and social neuroscience research on stigma in their relevance to psychiatric practice; 2) Conduct a systematic clinical assessment of stigmatizing beliefs and practices; and 3) Utilize a sociobiological perspective on stigma to facilitate interviews with patients who perceive psychiatrists categorically with suspiciousness or contempt.

**SUMMARY:**
Psychiatrists regularly confront clinical consequences of stigma, prejudice, and discrimination, more so than other physicians. Psychiatrists face stigma in public policies that distribute healthcare resources, in colleagues' and the public's negative perceptions of psychiatry, and in patients' attitudes towards psychiatric diagnoses and treatment. Patients so disdainful of psychiatrists that they refuse clinical consultations are extreme examples of such stigma. Stigma, prejudice, and discrimination are largely explained by sociobiological group processes, rather than individual psychological factors. Most psychiatrists, however, receive little training about the social psychology of stigma and its pragmatic implications for clinical practice. This workshop will review major research findings about stigma from social psychology and social neuroscience research in their relevance for clinical practice. Participants will learn how to assess stigmatizing beliefs and behaviors in clinical settings so that specific causative processes can be identified. Interview methods for patients who stigmatize psychiatrists for religious or ideological reasons will be illustrated. Using clinical vignettes, participants will practice interview strategies from an "out-group position" with patients whose worldviews perceive psychiatrists and psychiatric treatment categorically with suspiciousness or contempt.

**REFERENCES:**
1. Griffith, J. L. (2010, In Press). Religion that heals, religion that harms: Helping patients make moral decisions in their religious lives. New York: Guilford Press.
2. Neuberg, L. S. L., Smith, D.M., & Asher, T. (2000). Why people stigmatize: Toward a biocultural framework. In T. F. Heatherton, R. E., Kleck, M. R. Hebl, & J. G. Hull (Eds.), The social psychology of stigma. New York: Guilford Press.

WORKSHOP 61
## PATIENTS AS PRACTICE PARTNERS: CATALYZING RECOVERY THROUGH COLLABORATION

*Chairperson: Peter F Buckley, M.D., Medical College of Georgia, 997 St. Sebastian Way, Augusta, GA 30912*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify obstacles to implementing the Recovery approach; 2) Empower patients in defining and directing the course of their own treatment; 3) Select patients and family members to become behavioral health advisors; 4) Improve psychiatric services and facilities through collaboration with advisors; and 5) Hire and supervise peer specialists.

**SUMMARY:**
As envisioned by the President's New Freedom Commission and SAMHSA, U.S. psychiatric services aspire to truly collaborative relationships among providers, consumers, and family members. Realization of this aspect of the Recovery approach has been confounded by systemic obstacles as well as a gradual convergence of attitudes among providers and consumers. To bridge the gap between vision and practice, the Medical College of Georgia has developed, implemented, and evaluated a curriculum for psychiatry residents and mental health providers entitled Project GREAT (Georgia Recovery-based Educational Approach to Treatment). The program addresses, in very practical terms, how providers can make a fundamental shift in addressing mental health care. Project GREAT delineates the components of a collaborative model of care in which consumers participate in the development of goals, engage in joint decision making regarding health care interventions, and pursue wellness activities in order to contribute to their own health and well-being. This workshop, jointly presented by a psychiatrist, a psychologist, and a certified peer specialist, enables participants to generate proficiency in collaborative care through clinical vignettes and role plays.

**REFERENCES:**
1. Buckley PF, Fenley G, Mabe PA, Peeples S: Recovery and schizophrenia. Clin Schizophrenia Related Psychoses 2007; 1:96-100
2. Peebles SA, Mabe PA, Davidson L, Fricks L, Buckley P, Fenley G: Recovery and systems transformation for schizophrenia. Psychiatr Clinics North Amer 2007; 30:567-583
3. Fenley G: Checking realities: Consumer perspectives; Compliance and recovery. Clin Schizophrenia Related Psychoses 2008; 2:262-263

WORKSHOP 62
## DISASTER PREPAREDNESS, EVACUATION AND REBUILDING: LESSONS LEARNED FROM KATRINA APPLIED TO GUSTAV AND IKE

*Chairperson: Erich J Conrad, M.D., 1542 Tulane Ave, 2nd Fl, New Orleans, LA 70112*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant will be able to: 1) Effectively manage and plan for anticipated disasters, including preparedness, evacuation, and recovery; 2) Participant will recognize importance of consultation psychiatry in the midst of disaster; and 3) Participant will identify key elements to management during disasters and be able to ensure continuance of residency training and medical student education missions.

**SUMMARY:**
Title: Disaster Preparedness, Evacuation and Rebuilding. Lessons Learned from Katrina Applied to Gustav and Ike.
Purpose:This workshop will explore effective methods for medical student education and residency training to prepare, evacuate and recover following a disaster such as a hurricane.
Content:Disasters threaten personal safety, overwhelm defense mechanisms, and disrupt community and family structures. They may also cause mass casualties, destruction of property, and collapse of social networks and daily routines. Residency training and medical student education during hurricane preparedness and evacuation will be explored, highlighting lessons learned from previous experience with Hurricane Katrina. Rebuilding education and training programs following Hurricane Ike will be discussed.
Methodology: Retrospective data on disaster preparedness and the role of psychiatry consultation services during Hurricane Gustav will be presented, along with descriptive evaluation of medical student disruption and learning opportunities during an evacuation and recovery. Educational rebuilding difficulties and strategies for success will be highlighted in the context of Hurricane Ike.
Results:There are many aspects to management of disaster preparedness that can be implemented prior to disasters in which there is time to prepare, such as a hurricane. Psychiatric consultation services are an important part of preparedness and evacuation. Medical student education and residency training are able to be reinstated quickly following a disaster and effective communication plays a key role in preparing for immediate and long term recovery.
Importance of Proposed Presentation:
Having a well thought out plan for disasters is an important aspect of preparedness for psychiatric medical student education and residency training, in addition to service to the community.
Summary: Hurricanes can devastate a community and

educational missions. Effective disaster preparedness can aid in evacuation and rebuilding processes.

**REFERENCES:**

1. Szauter K, Ainsworth M, Lieberman S, Rowen J, Frye A, Asimakis G, Beach P. When Disaster Strikes: Learning form the Past-Sharing for the Future. Southern Group on Educational Affairs Annual Meeting New Orleans, LA April 2009 (poster presentation)

WORKSHOP 63

**THE EXPLOSION OF SOCIAL MEDIA: WHY, WHERE, WHEN AND HOW CAN PSYCHIATRISTS CATCH UP WITH THE TREND?**

***APA Council on Communications***

*Chairperson: Gabriella Cora, M.D., M.B.A., 8101 Biscayne Boulevard, Suite 516, Miami, FL 33138*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Learn the pros and cons of establishing a social network account; 2) Discuss clinical situations that may arise from patient use of social media and ways to handle them; 3) Discuss how to build a platform and effectively use social media to communicate a powerful message to fight stigma and promote mental health awareness; and 4) Learn strategies to integrate social media and networking to launch mental health projects and campaigns.

**SUMMARY:**

The internet has exploded exponentially with millions of blogs, followers on Twitter and users of Facebook. Social media offers instant communication and sharing of information amongst cyber community networks around the globe. While internet users may find good articles posted in serious media venues, readers have little guidance as far as the quality of information they read. The potential harm of social media is that people are constantly inundated by irrelevant, misguided or wrong information. This poses both a risk as well as an opportunity for psychiatrists. Psychiatrists have traditionally shied away from direct communication with the public. Many physicians have been reluctant to participate in any social-media networks. However, it is possible to consider our ethical duties and responsibilities while creating a presence in the internet where we can provide relevant, compassionate and user-friendly information to the public at large.

While many psychiatrists may still decide to ignore social media altogether, social networking has become a regular part of our patients' relationships and daily experiences. Many people, including children, adolescents, and young adults, spend more time socializing and creating online personas in cyberspace than they do in person.

Some people feel social media use is superficial and irrelevant. Yet, social media has been successfully used for large-scale charity fundraisers and political campaigns. Having a strong platform enables the social media user to be heard in printed media, on radio and television and on the internet.

In summary, one of the most challenging aspects of social media and social networking is that it may be perceived as a waste of time. On the other hand, we may be able to fight stigma and promote mental health awareness by integrating strategies to effectively communicate our message while distributing to all interested readers directly (via social media) or indirectly (via social networks).

**REFERENCES:**

1. Risk Management for Physician Bloggers. Psychiatric News. September 18, 2009. http://pn.psychiatryonline.org/cgi/content/full/44/18/31

Comer, B. AMA hops on the social media bandwagon. Medical Marketing Media. September 10, 2009. http://www.mmm-online.com/AMA-hops-on-the-social-media-bandwagon/article/148553/

WORKSHOP 64

**TREATING THE AGGRESSIVE CHILD AND TEEN: INTEGRATED TECHNIQUES FOR MANAGEMENT AND INTERVENTION**

*Chairperson: Niranjan S Karnik, M.D., Ph.D., 5841 S. Maryland, MC 3077, Chicago, IL 60637 Co-Chairperson: Hans Steiner, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this workshop, the participant should be able to: 1) Understand aggression from neuroscientific, psychological and sociological perspectives; 2) Subtype aggression into clinically-relevant, evidence-based categories; 3) Demonstrate knowledge of the latest methods for the treatment of aggression; and 4) Demonstrate understanding of how to integrate various techniques in-line with current practice parameters.

**SUMMARY:**

This presentation will review the approach to diagnosis and treatment of aggressive children and teens from a developmental and integrated perspective. The presenters are co-authors of the forthcoming AACAP Practice Parameter for the Treatment of Conduct Disorder, and will review the findings of their comprehensive analysis of

the current state of knowledge, and present this material in a case-based approach. They will review the neuroscience of aggression along with understandings from psychology and sociology, and the present a treatment algorithm based on the subtyping of aggression. They will emphasize the need to use multiple types of interventions including evidence-based individual and family therapy models as well as medications where indicated for specific symptoms. Aggression is a common presenting complaint for children and adolescents, and this workshop will provide practitioners with the most up-to-date knowledge about the etiology and treatment and this spectrum of disorders.

**REFERENCES:**

1. Blair RJ, Karnik NS, Coccaro EF, et al.: Taxonomy and neurobiology of aggression, in Principles and Practices of Child and Adolescent Forensic Mental Health. Edited by Ash P, Benedek E, Scott C. Washington, DC, American Psychiatric Publishing, Inc., 2009.
2. Findling RL, Steiner H, Weller EB: Use of antipsychotics in children and adolescents. J Clin Psychiatry 66 Suppl 7:29-40, 2005.
3. Jensen PS, Youngstrom EA, Steiner H, et al.: Consensus report on impulsive aggression as a symptom across diagnostic categories in child psychiatry: implications for medication studies. J Am Acad Child Adolesc Psychiatry 46:309-322, 2007.
4. Karnik NS, McMullin MA, Steiner H: Disruptive behaviors: conduct and oppositional disorders in adolescents. Adolesc Med Clin 17:97-114, 2006.
5.Steiner H, Remsing L: Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 46:126-141, 2007.

## WORKSHOP 65
## GUIDED SELF-HELP: A NEW INTERVENTION TO OVERCOME ANXIETY COMPLAINTS

*Chairperson: Christine A Van Boeijen, M.D., Ph.D., Hoenderparkweg 150, Apeldoorn, 7334 CC Netherlands*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Diagnose patients with anxiety disorders; 2) Demonstrate knowledge about the feasibility and efficacy of guided self-help to overcome anxiety complaints; and 3) Demonstrate knowledge about guiding the patient with self-help.

**SUMMARY:**

For patients with anxiety disorders few treatments are feasible in primary care. A literature review of self-help shows sufficient effectiveness. The results improve when guidance is added to keep the patient in the self-help program. Subsequently a guided self-help is developed. A preliminary study found that application of the guided self-help was feasible and led to improvement in treated primary care patients. A RCT following these findings made a comparison of the effectiveness and feasibility of the guided self-help, the guidelines and cognitive behaviour therapy 'golden standard'. There was no difference in outcome between the three interventions in the treatment period of 12 weeks. This effect lasted during the follow up at 3 and 9 months. The feasibility of guided self-help was greater than the guidelines. Guided self-help is now implemented in preventive, primary and secondary care.
The self-help manual comprises an introduction, information about anxiety, cognitive techniques, relaxation exercises and exposure in vivo. The goal of the treatment to overcome anxiety problems in 12 weeks is described. Each chapter ends with self-control questions. The patient is advised not to carry out the treatment alone, but with the help of a friend or relative. In addition a cd with relaxation training, a registration addition, an exercise addition, a flyer for 'the helper' and answers to the self-control questions are available.
This self-help manual was discussed with the patient in 5 sessions in the course of 12 weeks. The guidance consists of explanation about the self-help, answering questions, discussing the compliance and motivation to take enough time to practice and do homework.
This workshop consists knowledge about anxiety disorders, an explanation of the guided self-help and exercise of the first session.

**REFERENCES:**

1. Van boeijen ca, van balkom ajlm, van oppen p, blankenstein n, cherpanath a & van dyck r (2005). Efficacy of self-help manuals for anxiety disorders in primary care, a systematic review. Family practice 22(2),192-196.
2. Van Boeijen Ca, Van Oppen P, Van Balkom Ajlm, Visser S, Kempe Pt, Blankenstein N & Van Dyck R (2005). Treatment of anxiety disorders in primary care practice, a randomised controlled trial. British journal of general practice, 55, 763-769.
3. www.anxietycomplaints.com

## WORKSHOP 66
## PREVENTING LATE LIFE SEQUELAE RESULTING FROM EARLY LIFE TRAUMA

*Chairperson: Erikka Dzirasa, M.D., M.P.H., 718 Rutherford St, Durham, NC 27705*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participant should be able to: 1) Recognize the signs and symptoms of trauma in early childhood; 2) Demonstrate an

understanding of developmental and neurobiological implications of exposure to trauma for young children; 3) Demonstrate an understanding of diagnostic challenges of PTSD and the revised PTSD criteria for young children; and 4) Understand examples of preventive interventions and evidenced based treatment strategies for preschool children.

**SUMMARY:**

APA/Shire Child and Adolescent Psychiatry Fellowship Program

Exposure to trauma in early childhood can result in a range of complications, including post traumatic stress disorder, anxiety disorders, depressive disorders, disruptive behavior disorders, and developmental delays. If not recognized and treated early, such exposure can lead to significant impairment across biological, behavioral, cognitive and psychological domains and long term sequelae. When evaluating infants and preschoolers, it is important to recognize early behaviors and emotions related to trauma exposure. The ability to identify how risk factors interact with trauma exposure to produce impairing behaviors and emotions is necessary. It is also critical to understand the developmental implications of such exposure to trauma. The purpose of workshop is to explore the latest developments in evaluation of preschoolers exposed to trauma. These developments will include early evaluation and treatment, identification of risk factors, and advances in evidence based treatments for trauma in young children. Top researchers in the field will give brief presentations followed by an interactive discussion about challenges in evaluation, limitations of *DSM-IV* criteria, and strategies for prevention and treatment of preschoolers exposed to trauma.

## WORKSHOP 67
## BEHAVIORAL COMPLICATIONS OF DEMENTIA: A COMPREHENSIVE MULTI-DISCIPLINARY TREATMENT APPROACH

*Chairperson: Sanjay Vaswani, M.D., 1601 Dove St, Suite 230, Newport Beach, CA 92660*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the difficulty of managing behavioral disturbances in dementia; 2) Identify the etiology of episodes of agitation or aggressive behaviors; 3) Recognize different phases/stages of the episode; 4) Formulate an individualized plan for each stage; 5) Learn newer approaches to managing acute agitation in long term care settings; and 6) Develop treatment algorithms to prevent behavioral disturbances in elderly with dementia.

**SUMMARY:**

Approximately 5% to 7% of the U.S. population over the age of 65 years lives in a skilled nursing facility. Among these, more than 70% have a psychiatric illness or symptoms thereof. These challenging patients have complex medical and psychiatric co-morbidities often including dementia with its associated behaviors, suffering, disability, and poor quality of life. Among the most difficult behavioral symptoms of dementia to manage are those characterized by a patient's sudden aggression or agitation. An episode of aggressive or agitated behavior generally begins with some sort of antecedent event or trigger and develops in a series of identifiable phases. Establishing a set of procedures to follow as these phases build is a crucial part of successfully treating these episodes. Additionally, not only must treatment of such aggression be undertaken quickly, but caregivers must also assess the etiology of the episode so as to treat the symptoms and th=-=e underlying triggers. Some risk factors include environment, stage of dementia, psychiatric diagnosis, co-morbid medical conditions and psychosocial factors. As a clinician in long term care, one also has to understand barriers to organizational changes, staff training, using multidisciplinary care approaches and examining FTAG 329 regulations. With a combination of accurate evaluation of underlying triggers, pharmacotherapy, environmental strategies and developing an individualized treatment plan, a more successful treatment outcome of behavioral disturbances in elderly patients may be achieved which translates into improved quality of life. This workshop addresses the identification, evaluation, management and prevention techniques for episodic and chronic behavioral disturbances in dementia patients. Active participation and interaction with the audience will be achieved by utilizing clinical vignettes and real life examples.

**REFERENCES:**

1. Souder E, Heithoff K, O'Sullivan PS, Lancaster AE, Beck C. Identifying patterns of disruptive behavior in long-term care residents. JAGS 47:830-836, 1999.
2. Henry Brodaty, Brian M Draper and Lee-Fay Low. Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. MJA 2003; 178: 231-234.
3. Michelle Bourgeois and Ellen Hickey. "Dementia: From Diagnosis to Management - A functional Approach" Textbook, Psychology Press, 2009

## WORKSHOP 68
## CORE COMPETENCIES AND MAINTENANCE OF COMPETENCY IN EUROPE AND THE UNITED STATES OF AMERICA: AN

**EDUCATIONAL MODEL**

*Chairperson: Deborah Hales M.D. APA, 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209*
*Presenters: Wolfgang Gaebel M.D. Michael Musalek M.D. Cyril Hoschl M.D. Livia Vavrusova M.D.*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand the role of core competencies from an American and an European point of view; 2) Use core competencies more appropriately in the clinical care of patients; and 3) Integrate better core competencies in the training curriculum of medical students, psychiatric residents and psychiatric fellowships.

**SUMMARY:**
During the last decade, core competencies have become a major educational tool in the United States. Currently, core competencies are being introduced in the psychiatric curriculum across the European Union. Now-a-days, the globalization process encourages the movement of large amount of population all over the world, including mental patients. In order to improve the psychiatric education system across the world, it is imperative to secure experiences about what works and what does not work. In this panel presentation the participants will be able to hear different models of utilization of core competencies from different countries of the European Union; namely, Germany, Austria, Czech Republic, and Slovak Republic. Additionally, we will examine the educational differences and its outcome between Europe and the United States. Hopefully, this educational interchanges will help to improve the use of core competencies in both Europe and the United States. This exchange will also ultimately lead to better patient care in those two regions of the world.

**REFERENCES:**
1. SC Scheiber, TAM Kramer, SE Adamowski (eds.): Core Competencies for Psychiatric Practice.
Washington, D.C., American Psychiatric Press, Inc., 2003.
2. Ruiz P: Recent Advances in Graduate Psychiatric Training. World Psychiatry, 2(1): 57-59, 2003.

WORKSHOP 69
**WRITING FOR THE "BLUE JOURNAL": THE RESIDENTS' AND FELLOWS' EDITION OF THE AMERICAN JOURNAL OF PSYCHIATRY**

*Chairperson: Robert Freedman, M.D., 13001 East 17th Place, Mail Stop E3251, Aurora, CO 88945*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) To learn to be an author for medical publication; 2) Learn how the Residents' Journal can be a learning tool in medical education; and 3) Select topics, editors, and authors for future issues.

**SUMMARY:**
The residents' and fellows' edition of the American Journal of Psychiatry, the blue journal companion to the green journal, is a web-based publication that is edited and written by residents and fellows for residents and fellows. It appears each month by free email subscription and on the American Journal of Psychiatry website http://ajp.psychiatryonline.org. The cover page is also published in the American Journal of Psychiatry. The 2009 editor-in-chief, Sarah B. Johnson, is a PGY4 resident at the University of Louisville. Each issue has its own editor, selected by the editor-in-chief. Each year new editors are chosen by the residents and fellows and are trained by American Journal of Psychiatry staff editors. The purpose of this workshop is (1) to discuss the direction and content of the residents' journal, (2) to introduce residents and fellows who have not participated before to the various possible roles as editors and authors, and (3) to select new editors for the 2010 academic year.
The blue journal features articles of interest to residents and fellows. Issues have focused on pregnancy during training, the experiences of international medical graduates in residency, residents' relationships with pharmaceutical companies, and the use of supervision in training and patient care. Articles are generally short, less than 1000 words, but receive full editing from the resident editors and the journal staff. Authors submit their work—editorials, interview, case conferences, research reports, and book reviews—directly to the American Journal of Psychiatry reviewing website: http://mc.manuscriptcentral.com/appi-ajp.
Dr. Sarah Johnson will co-lead the discussion with Robert Freedman, M.D., the Editor of the American Journal of Psychiatry, which sponsors the blue journal.

WORKSHOP 70
**A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER FROM THE EXPERTS: PART I**
***(For Residents Only)***

*Chairperson: John G Gunderson, M.D., 115 Mill Street, Belmont, MA 02478*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be

able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

**SUMMARY:**

Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with participant discussions will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II presented over consecutive days). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, it examines core features of effective psychotherapy as well as features of treatments likely to make patients worse. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Principles of family involvement follows next, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Finally, objectives for residency education will help participants bring content from the workshop and integrate it with their current training. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

**REFERENCES:**

1. Gunderson JG, Links PS: Borderline Personality Disorder: A Clinical Guide, 2nd Ed. Washington, DC, American Psychiatric Publishing, Inc., 2008

WORKSHOP 71

**"IF A PATIENT GOOGLES ME, WHAT WILL THEY FIND?" – THE INFORMATION AGE AND ITS IMPACT ON RESIDENCY TRAINING**

*Chairperson: Donald M. Hilty, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Be more aware of the impact of access to personal information on the internet (e.g., Facebook) in terms of training psychiatry residents; 2) Be more aware of the pros and cons of communication options via technology (e.g.,Twitter, e-mail, texting) impact the ways in which we train psychiatry residents; and 3) Have methods and approaches for addressing these issues in didactics and supervision.

**SUMMARY:**

The astonishing array of information that we now have access to affects every aspect of our society, with information at our fingertips and current events communicated in an instant. This information affects the doctor/patient relationship in many ways, including new access to information about one another and new ways to "connect"—sometimes at odd hours and at lightening speed. This has prompted many questions, concerns, and guidelines (e.g., HIPAA in terms of confidentiality). Nowhere is this change having more of an impact than in psychiatry. What exactly is the impact of technology and how should psychiatrists and psychiatric educators respond? Furthermore, with clinical and training implications, how do we reflect, monitor, study, and discuss technology in our teaching and supervision of psychiatric residents.

The Medical Education Committee of the Group for the Advancement of Psychiatry has discussed this issue and proposes an interactive workshop based on 3 vignettes:

1. Ready access to information via search-engines and its impact on confidentiality and transference
2. "Facebook" style web sites and professionalism as a psychiatrist and psychiatric resident
3. When and what should patients and their psychiatrists communicate via e-mail vs. phone vs. in-person—and how do these options affect the "frame" of clinical care?

**REFERENCES:**

1. Briscoe GW, Fore Arcand LG, Lin T, et al: Students' and residents' perceptions regarding technology in medical training. Acad Psychiatry 30 (6):470-479, 2006
2. Hilty DM, Alverson D, Yellowlees P, et al: Innovations in education: virtual reality, simulation & other technologies. Acad Psychiatry 30(6): 528-533, 2006

**11:00 AM-12:30 PM**

WORKSHOP 72

**AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN SYCHIATRY AND ITS SUBSPECIALITIES**

*Chairperson: Larry R Faulkner, M.D., 2150 E Lake Cook Road, #900, Buffalo Grove, IL 60089*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe the American Board of Psychiatry and Neurology's policies and procedures for certification in psychiatry and its subspecialties.

**SUMMARY:**

The purpose of this workshop is to present information on the ABPN's requirements for certification in psychiatry and in the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as in the inter-disciplinary subspecialties of clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine. Application procedures, including training and licensure requirements, will be outlined, and the new requirements for the assessment of clinical skills during residency training in psychiatry and in child and adolescent psychiatry will be delineated. The schedule for phasing out the Part II (oral) examinations in general psychiatry and in child and adolescent psychiatry and the proposed changes in the computerized certification examinations will be presented. The content and format of the extant Part I (computer-administered multiple choice), Part II (oral), and subspecialty examinations will be reviewed, as will examination results. A substantial amount of time will be available for the panelists to respond to queries from the audience.

**REFERENCES:**

1. Shore JH, Scheiber SC (eds.): Certification, Recertification, and Lifetime Learning in Psychiatry.
Washington, DC, American Psychiatric Press, 1994

WORKSHOP 73

**TRANSCRANIAL MAGNETIC STIMULATION IN CLINICAL PRACTICE: A PRAGMATIC APPROACH TO A NEW PSYCHIATRIC PROCEDURE**

*Chairperson: Timothy H Derstine, M.D., 320 Rolling Ridge Drive, Suite 100, State College, PA 16801*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of the session, participants should be able to: 1) Understand the steps involved in the use of TMS as an outpatient procedure; 2) Understand the clinical personnel required to administer TMS; 3) Understand the basic clinical evaluation for and evidence to support the routine clinical use of TMS in patients with depression who have not benefited from prior antidepressants; and 4) Know how to present the potential risks and benefits of TMS to patients with depression, including clinically appropriate informed consent.

**SUMMARY:**

Transcranial Magnetic Stimulation (TMS) was cleared by the FDA last year for use in the US as an antidepressant treatment for patients with Major Depressive Disorder (MDD) who have failed to receive adequate clinical benefit from prior antidepressant therapy. TMS is distinct from any other antidepressant treatment modality, and is the first contemporary, office-based psychiatric therapeutic procedure. As such, a proper understanding of what TMS is and how it is administered is of interest to all psychiatrists who treat patients with MDD. This understanding should help practicing clinicians whether they are already performing TMS as a clinical therapeutic procedure, are planning to incorporate TMS into their clinical practice, or may have an interest in referring a treatment resistant patient with MDD for evaluation and potential treatment. This workshop will provide a highly interactive discussion of several important aspects of the clinical use of TMS in routine practice. A brief discussion of the logistical implications of the use of TMS in an office setting will be described, including the location and practical mechanical needs of the device, and a standard configuration of clinical personnel who should work with the attending psychiatrist. A review of the standard clinical workup, including contraindications for use, and methods of informed consent will be discussed. The panel will review how the existing scientific evidence for the efficacy and safety of TMS inform their discussions of the potential risks and benefits with their patients in clinical practice. Finally, each panel member will present an actual clinical case, including a review of clinical outcomes for audience discussion.

**REFERENCES:**

1. Demitrack, M.A., Thase, M.E. Clinical Significance of Transcranial Magnetic Stimulation (TMS) in the Treatment of Pharmacoresistant Depression: A Review and Synthesis of Recent Data. Psychopharmacology Bulletin, 42(2):5-38, 2009
2. Wassermann, EM. Risk and Safety of Repetitive Transcranial Magnetic Stimulation: Report and Suggested Guidelines from the International Workshop on the Safety of Repetitive Transcranial Magnetic Stimulation, June 5-7, 1996. Electron-

encephalog Clin Neurophysiol, 108:1-16, 1998

WORKSHOP 74
**TO FILE OR NOT TO FILE: GUARDIANSHIP FOR OLDER ADULTS WITH DEMENTIA**

*Chairperson: Asghar-Ali A Ali, M.D., 11828 Longwood Garden Way, Houston, TX 77047*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this workshop, participants should be able to: 1) Understand the concepts of geriatric assent and consent to treatment; 2) Recognize situations where problems in the social network will trigger the need to file for guardianship; and 3) Implement newly acquired skills in working with the family around complex medical, social, and ethical aspects of situations where guardianship is needed for elderly individuals with dementia.

**SUMMARY:**
Although guardianship focuses on the cognitive capacity of those who are incapacitated, most persons who are cognitively impaired do not require guardianship. Typically, those with severe dementia are cared for without this additional legal support. Elderly individuals with dementia often provide "geriatric assent" when a family member consents on their behalf. Such geriatric assent may not be possible if the individual is unwilling, or if there is no available family to make medical decisions. The need to decide whether or not to file for guardianship may be defined as a "situational" need, rather than just a strict question about capacity for medical and financial decision-making. Therefore, guardianship is necessary not just because an individual is cognitively impaired, but for those who, in addition, may lack or reject a supportive social network. In this workshop we will discuss the medical, social, and ethical aspects of situations where cognitively impaired patients require guardianship. Case vignettes will be used to highlight such situations.

**REFERENCES:**
1. Grisso, T. (1994). Clinical assessments for legal competence of older adults. In M. Storandt and G.R. VandenBos (Eds.), Neuropsychological assessment of dementia and depression in older adults: A clinician's guide (pp. 119-140). Washington, DC: American Psychological Association.
2. A J Rosin and Y van Dijin. Subtle ethical dilemmas in geriatric management and clinical practice. J Ethic Med 2005; 31:355-359

WORKSHOP 75
**THE VICISSITUDES OF THE DOCTOR-PATIENT RELATIONSHIP IN MODERN MEDICINE: ENDURANCE, EROSION OR TRANSFORMATION**

*Chairperson: Robert C. Joseph, M.D., M.S., 1493 Cambridge Street, Cambridge, MA 02139*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) List many of the factors in modern medicine that are affecting physician training and the quality of the doctor-physician relationship; 2) Recognize which of these factors are influencing your own practice of psychiatry; and 3) Recognize the affect of these factors on medical education.

**SUMMARY:**
When Szasz and Hollander categorized the doctor-patient relationship in 1956 as either "active-passive," "guidance-cooperative "or "mutual participation," they could not have anticipated the many changes that were to come in medical care. Since then the encounters between patients and their physicians have been tossed about like small boats on a rough sea by the managed care and post-managed care era; by bioethical considerations regarding medical technology; by quality initiatives; and by forensic complexities which have created an encounter tinged with "defensive medicine". While some may look upon these changes as progressive, others bemoan the loss of the "old-fashioned" doctor. Doctors and patients have become "providers" and "consumers" and medical services have become "products" like widgets in the marketplace. The holy grail of the dyadic doctor-patient relationship has been eroded by these forces to the point of being unrecognizable. In response some physicians seek early retirement while patients complain that they don't get to see their doctor and express distrust, financial distress and escalating confusion over health care policy, coverage, and "medical necessity." These forces have affected the training in, and practice of medicine, psychiatry and have even insinuated themselves into the practice of psychotherapy which, according to recent figures, is uncommonly practiced by psychiatrists. Our workshop will explore several current factors affecting the patient-physician relationship in both general medicine and psychiatry. We will examine the effects of technology (the electronic medical record), risk management (defensive medicine and documentation), quality programs (disease management programs and pay for performance) on medical training and the doctor-patient relationship for both the internist and the psychiatrist.

**REFERENCES:**

1. Sasz TS, Hollender MH: A Contribution to the Philosophy of Medicine: the Basic Models of the Doctor-Patient Relationship. Arch Intern Med 1956;97:585-592.
2. Mojtabai R, Olfson M: National Trends in Psychotherapy by Office-Based Psychiatrists. Arcj Gem Psychiatry 2008;65(8):962-970.

WORKSHOP 76

**WHEN IS PSYCHIATRIC ILLNESS TERMINAL?**

*Chairperson: Melinda S Henderson, M.D., 1718 Patterson, Nashville, TN 37064*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe hospice and palliative care; 2) List criteria for terminal psychiatric illness; 3) Identify clinical scenarios in which hospice or palliative care might be considered for psychiatric illness; and 4) Discuss barriers and benefits to hospice or palliative care in psychiatric illness.

**SUMMARY:**

Hospice care can be defined as the care of patients whose disease is unresponsive to curative treatment and who have a predicted life expectancy of less than six months. For most diseases, an absence of curative therapy, combined with a predictable terminal outcome, prompts a shift to hospice. Do the same norms apply when the illness is psychiatric in nature or when psychiatric conditions have lead to the fatal pathology? Similar to physical illness, there are descriptions of severe psychiatric diseases and predictable criteria for conditions with high mortality. Psychiatric illness, like depression, can be a barrier to good symptom management with physical illness and may lead to patient avoidance of treatable physical conditions. There are also conditions classified as primarily psychological, like anorexia nervosa, that have devastating physical consequences leading to death. Four categories of terminal psychological conditions are proposed: (1) Psychological components of physical illness (2) Physical complications of psychiatric illness (3) Chronic psychiatric illness and (4) Mixed cases.

This session will begin with a review of traditional hospice criteria and palliative care precepts. Participants will then be divided into small groups to review clinical cases where psychiatric features predominate, and asked to develop criteria or guidelines for terminal psychiatric illness. The small groups will also be asked to formulate appropriate hospice and palliative care responses in the setting of terminal psychiatric illness.

**REFERENCES:**

1. Academy of Psychosomatic Medicine: Position Statement: Psychiatric Aspects of Excellent End-of-Life Care. http://www.apm.org/papers/eol-care.shtml.
2. Biermann B: When depression becomes terminal: The impact of patient suicide during Residency. J Am Acad of Psychoanal and Dyna Psych. 2003; 31:443-457.
3. Breier-Mackie S: Percutaneous feeding tube placement and severe anorexia nervosa. Gastro Nurs. 2006; 29:484-6.
4. Cherny NI: Sedation in response to refractory existential distress: Walking the fine line. J Pain and Sym Manage. 1998; 16:404-6.
5. Dein S: Psychiatric liaison in palliative care. Adv Psych Treat. 2003; 9:241-248.
6. Deluty RH: Physical illness, psychiatric illness, and the acceptability of suicide. Omega. 1988; 19:79-91.
7. Draper H: Anorexia nervosa and respecting a refusal of life-prolonging therapy: A limited justification. Bioethics. 2000; 14:120-133.
8. Kissane DW: The contribution of demoralization to end of life decision making. Hast Ctr Rep. 2004; 34:21 31.
9. O'Neill J, Crowther T, Sampson G: Anorexia nervosa: Palliative care of terminal psychiatric disease. Am J Hosp & Pal Care. 1994; 11:36-8.
10. Perron V and Schonwetter R: Hospice and palliative care programs. Primary Care: Clinics in Office Practice 2001; 28(2): 427-40.
11. Reeves G: terminal mental illness: Resident experience of patient suicide. J Am Acad of Psychoanal and Dyna Psych. 2003; 31:429-441.
12. Reman IM: Terminal optimism, terminal hope. Am J Psychiatry. 2008; 165:1518-1519.
13. Rousseau P: Existential suffering and palliative sedation in terminal illness. Prog Pal Care. 2002; 10:222 4.

WORKSHOP 77

**NEONATICIDE: PHENOMENOLOGY AND PREVENTION**

*Chairperson: Renee M Sorrentino, M.D., 1233 Hancock St-Rear, Quincy, MA 02169*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe commonalities among perpetrators of neonaticide; 2) Define denial of pregnancy; and 3) Understand the intersection of denial of pregnancy/neonaticide and the law in arenas other than sanity, including Safe Haven laws and judicial bypass evaluations.

**SUMMARY:**

Neonaticide, murder of the infant in the first day of life, is distinct from other filicides. Neonaticide offenders often are poor, relatively young, single women free of major psychiatric disorders, who did not seek prenatal care. They often denied or concealed pregnancy. Also intricately

related to neonaticides are judicial bypass evaluations for abortion, Safe Haven laws, and insanity/ diminished capacity evaluations. Mandated parental notification laws, before a minor can obtain an abortion, exist in many states. Teenage girls who commit neonaticide because they cannot face their parents (due to shame) may not procure a lawful abortion. The panel will discuss "judicial bypass" psychiatric evaluations, also known as "Jane Doe evaluations", which are considered controversial by some. An American response to the problem, Safe Haven laws, will be discussed. Mothers depositing infants in Safe Havens often remain anonymous with reduced risk of prosecution. Neonaticide occurs before the usual onset of postpartum psychosis or postpartum depression. Maternal suicide attempts are quite uncommon in conjunction with neonaticides. However, in some cases, insanity or diminished capacity defenses may be raised. Illustrative cases will be presented. The motivations for such crimes will be discussed by the panel.

**REFERENCES:**

1. Hatters Friedman S, Horwitz S, Resnick P: Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. Am J Psychiatry 162: 1578-1587, 2005

WORKSHOP 78

## INTEGRATING COMPLEMENTARY ALTERNATIVE MEDICINE (CAM) IN PSYCHIATRIC CARE: NEW PARADIGMS AND PERSPECTIVES

*Chairperson: Simon Chiu, M.D., Ph.D., Regional Mental Health Care, ST. Thomas site St. Joseph Health Care (London), St. Thomas, N5P3V9 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant will be able to: 1) Understand better the emerging role of CAM in reconfiguring holistic recovery-focused psychiatric care; 2) Critically evaluate evidence in support of efficacy claims of herbal and dietary supplements in mental health; and 3) Implement strategies for monitoring adverse events.

**SUMMARY:**

Recent survey of prevalence of CAM indicates that 36 % of the US population utilizes CAM for diverse medical conditions. Mental health providers often adopt polarizing attitudes towards integrating CAM in traditional psychiatric practice. In our workshop, the Chairperson and the panel of presenters address the issue of integration from new vistas to be shared interactively with the audience through the use of clinical vignettes. evidence-based review and debate formats. We discuss global CAM patterns of use with the audience. We propose the definition of CAM to be expanded in scope and content. Science and critical pathways of analysis of evidence from randomized controlled trials forms the basis of Integration Medicine. Traditional mental health services can harmonize with CAM approach through adopting vigorous pursuit of neurobiological studies of CAM-based interventions, especially supplements. At the same time, both systems agree on a holistic recovery-focused theme of caring for patients with psychiatric diagnoses. We illustrate our position with discussion of Pub-Med search of reviews and meta-analysis of selected herbal and dietary supplements eg: Ginseng, omega-fatty acid, Curcumin, in depression, Alzheimer dementia and schizophrenia. We next identify how supplements take advantage of cutting edge biotechnology and bio-informatics to delineate the the brain signaling pathways related to psychiatric symptoms. For safety issues, we relate supplement-drug interaction to adverse events in the light of updated research findings and appraisal of relevant database in various clinical context. We will use the debate format to discuss the pros and cons of regulating CAM practice at multi-levels: research-development, and government regulations. We conclude by discussing NICAM training-educational initiatives to harmonize CAM practice and traditional mental health care providers.

**REFERENCES:**

1. Pilkington K, Rampes H, Richardson J Complementary medicine for depression.
Expert Rev Neurother. 2006 Nov; 6(11):1741-51.
2. Pearson NJ, Chesney MA. The CAM Education Program of the National Center for Complementary and Alternative Medicine: an overview. Acad Med. 2007 Oct; 82(10):921-6. Review.

WORKSHOP 79

## THE USE OF RESEARCH MEASURES IN CLINICAL PRACTICE

*Chairperson: Joan Busner, Ph.D., 575 E. Swedesford Rd, Suite 101, Wayne, PA 19087*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to administer and integrate common research tools into his or her own clinical work.

**SUMMARY:**

Objective: This is a repeat and expansion of our well-attended, highly successful workshop at the 2009 APA Annual Meeting in San Francisco. As was true last year, the objective of this workshop is to help psychiatric clinicians appreciate the potential utility of well-established research instruments in their own clinical

practices. We have received numerous requests to repeat last year's workshop with additional measures. Research instruments are often daunting to clinicians and many clinicians have not had the opportunity to learn how the measures can enhance their ability to establish diagnoses, measure symptom severity, and measure response to treatment. Using a highly interactive methodology, with patient videos, audience scoring and interactive feedback, we plan to familiarize the psychiatric clinician with common measures that can easily be incorporated into daily clinical practice. Method. The workshop will provide interactive, practical, hands-on training in the use of research instruments as tools for assisting in forming accurate diagnoses, rating illness severity, and measuring intervention outcomes. Instruments have been selected for their direct applicability to the clinical setting. The workshop will focus on diagnoses the practitioner typically encounters such as Adult ADHD, Generalized Anxiety Disorder, and Major Depressive Disorder, and will include structured diagnostic interviews, self-report measures, and brief clinician completed measures.

Participants will receive copywritten measures organized by diagnosis, and will view and score videotapes of actual patient interviews. Participants will have the opportunity to role-play scale administration with live expert feedback. Results. At the end of the workshop, participants will be able to administer and integrate common research tools into their own clinical work. Conclusions. The workshop will facilitate the integration of common research tools into clinical practice

## REFERENCES:

1. Conners CK, Erhardt D, Sparrow MA. Conners' Adult ADHD Rating Scales (CAARS). New York: Multihealth Systems, Inc., 1999.

## WORKSHOP 80
## "TAKING IT PERSONAL": INTEGRATING PHARMACOGENETICS INTO THE MANAGEMENT OF DEPRESSION

*Chairperson: Sheldon H. Preskorn, M.D., 201 S. Hillside, Wichita, KS 67211*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the session, participants should be able to: 1) Recognize the significance of genetic factors on disease pathology, drug disposition, and patient response in depression treatment; 2) Understand the interactions between drugs and physiological pathways that can result in phenoconversion – an exogenously-driven shift to a phenotype typically associated with a different genotypic variant; and 3) Consider pharmacogenetics and phenoconversion when prescribing therapy for depression management in patients with a suboptimal response to current therapies.

## SUMMARY:

Although our knowledge has expanded considerably in recent years, the complex interplay between genetics, disease pathology, and the pharmacological effect of medications has long been recognized. In the realm of mood disorders, it has become clear that a patient's genetic makeup can directly influence the likelihood and nature of depression experienced throughout the course of a lifetime. Similarly, genetic variation also impacts the disposition, activity, and effectiveness of pharmacological agents used to manage depression. Finally, a medication can affect not only physiological functioning, but also the disposition and effect of coadministered medications.

This workshop will center on key concepts in pharmacogenetics and its role in depression management. Drivers of variability in patient response, such as differential expression and activity of serotonin/norepinephrine receptors and drug transporters will be reviewed. There will be special focus on the polymorphic nature of the cytochrome P 450 gene loci and the consequent phenotypic variability in drug metabolism.

Several recent findings will be specifically discussed: a genetic polymorphism that accounts for a doubling of the remission rate achieved with a specific antidepressant; pharmacokinetic effects of altered metabolism, such as decreased clearance of medications and a skewing of exposure to administered drugs and their metabolites and the relationship to clinical sequelae; how the ratio of the serotonin-norepinephrine reuptake inhibitor venlafaxine and its active metabolite, desvenlafaxine, can be used to phenotype patients in terms of CYP 2D6 status; and the importance of considering metabolizer status and other pharmacogenetic information when treating depression.1,2 In summary, this session will provide a forum for a discussion of the current application and future potential of pharmacogenetics in the management of depression.

## REFERENCES:

1. Nichols AI, Lobello K, Guico-Pabia CJ, Paul J, Preskorn SH: Venlafaxine metabolism as a marker of cytochrome P450 enzyme 2D6 metabolizer status. J Clin Psychopharmacol 2009;29:383-386

2. Lobello KW, Preskorn SH, Guico-Pabia CJ, Jiang Q, Paul J, Nichols AI, Ninan PT: CYP2D6 phenotype predicts antidepressant efficacy of venlafaxine. J Clin Psychiatry. In press.

## WORKSHOP 82
## GUARDIANSHIP AND POWERS OF ATTORNEY:

**ISSUES IN GERIATRIC PSYCHIATRY**

*Chairperson: David A Casey, M.D., University of Louisville Department of Psychiatry and Behavioral Sciences, 401 E. Chestnut St., Suite 610, Louisville, KY 40202*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the applications of guardianships and powers of attorney in geriatric psychiatry; and 2) Identify the problems and controversies surrounding these concepts.

**SUMMARY:**

Guardianships and powers of attorney are commonly encountered in geriatric psychiatry and other fields of medicine, particularly in dementia. While useful for patients, families, and physicians, their applications may raise legal and ethical questions. In this workshop, we will explore these issues. The panel includes Professor Winsor Schmidt, a national legal authority. Guardianship empowers one adult person to act on another's behalf. Guardians' responsibilities include arranging a residence, any needed social or medical services, consenting for medical services, and finances. On occasion, the court may handle financial affairs separately, through a separate guardian known as a conservator. Guardianship generally requires a court order evaluation, with a finding of mental incapacity and an order naming the guardian and his/her authority. Guardianship is a significant step, as it declares an individual legally incapacitated. Guardianship is essentially permanent, unless the court reverses it. The incapacitated person can no longer independently enter into contracts such as buying and selling property. For these reasons, the process involves a formal court proceeding with due process, and a search for alternatives such as "representative payee" may be appropriate. In the absence of a willing private citizen, a state officer may be appointed as a "public" guardian. Issues with guardianship include finding a willing and capable guardian and protecting the rights of the disabled. Guardianship rules differ by state, and jurisdictional problems may arise. A guardian may have the legal power to supervise their ward, but lack the practical means to do so. In psychiatric care, the power of guardians may be at issue, including the ability to consent to hospitalization or treatments, especially electroconvulsive therapy. Powers of attorney (POA) also present issues. Unlike court ordered guardianships, which are involuntary, POA are private, voluntary, contractual relationships between two (or more) parties. POA for medical purposes are activated and remain in effect if the individual becomes incapacitated, functioning as an advance directive. Such POA are known as "durable". In a durable POA, one party designates another to manage their affairs, including medical decisions, if they become incapacitated. Conflict may arise if 3rd parties do not honor the POA, over whether the person is incapacitated, wishes to cancel the POA, or was competent to make the POA.

**REFERENCES:**

1. Schmidt WC(ed.): Guardianship: Court of Last Resort for the Elderly and Disabled. Carolina Academic Press, 1995.
2. Teaster PB, Schmidt WC, Lawrence SA, Mendionado, MS, Woof, EF: Public Guardianship: In the Best Interests of Incapacitated People? Praeger, 2010.

WORKSHOP 81

**TELEPSYCHIATRY AND THE CHANGING FACE OF ACCESS FOR RURAL AMERICA'S CHILDREN AND ADOLESCENTS**

***APA Council on Children, Adolescents & Their Families***

*Chairperson: L. Charolette Lippolis, D.O., M.P.H., 13001 E 17th Pl., Campus Box F546, Aurora, CO 80045*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of session, participants should be able to: 1) Describe ways child and adolescent psychiatrists can expand mental health services through local provider consultation and education; 2) Understand how telepsychiatry can improve mental health care of Native American youth; 3) Describe implementation of child and adolescent telepsychiatry services within an existing rural mental health system; and 4) Discuss telepsychiatric health service costs and reimbursement issues.

**SUMMARY:**

Research shows that nearly 20% of America's children and adolescents suffer with mental health issues, yet the Surgeon General has reported that only 1 in 5 of those in need of treatment, receive mental health care. If the need requires a child and adolescent psychiatrist, the numbers are smaller still. The situation is even worse for the 25% of the U.S. population living in rural settings, as rural departments of health report greater problems with access to specialists than their urban counterparts. Increasing access to psychiatric services is a challenge in many communities and technology has helped this problem through interactive videoconferencing, also referred to as telepsychiatry. Research has shown that telepsychiatry via videoconferencing approximates face to face psychiatric treatment service delivery on three key measures: patient satisfaction, provider satisfaction and treatment efficacy. Telepsychiatry provides the opportunity to improve service delivery through the expansion of services by allowing local providers to care for patients with the support of case consultation with a child and adolescent psychiatrist via interactive videoconferencing. In addition, the extension

of services in areas of shortage allows a specialist to see patients directly via telemedicine. This workshop will focus on the utilization of telepsychiatry in underserved, rural, child and adolescent populations. Three models will be described including increased access of rural youth to child and adolescent psychiatrists by providing local provider consultation and education; utilization of telepsychiatry to improve mental health care of Native American youth, and an approach to implementing child and adolescent telepsychiatry service within an existing rural mental health system. A discussion of telemental health service costs and reimbursement issues will also be explored. There will be ample time for interaction and exchange of ideas with workshop participants.

**REFERENCES:**

1. Hilty DM, Yellowlees PM, Sonik P, Derlet M, Hendren RL: Rural child and adolescent telepsychiatry: successes and struggles. Pediatr Ann. 2009 Apr; 38(4):228-32.

WORKSHOP 83

**PRACTICAL PHARMACOTHERAPY OF MOOD DISORDERS**

*Chairperson: Gary E Miller, M.D., 530 Wells Fargo Drive, Suite #110, Houston, TX 77090 Co-Chairperson: Richard Noel, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this workshop, participants will have acquired an improved understanding of means of distinguishing between unipolar and bipolar depression, the bipolar spectrum, and pharmacological management of mood disorders.

**SUMMARY:**

The workshop is directed toward clinicians engaged in pharmacological management of mood disorders. The presenters are psychiatrists who have treated over 10,000 patients with mood disorders over the last 17 years. They will present vignettes of actual patients, each illustrating a problematic diagnostic or treatment issue facing clinicians. Attendees will be encouraged to discuss the cases presented and to convey their own clinical experience and views. The focus of the presentations and discussion will be crucial issues in the diagnosis and treatment of mood disorders including the following: differentiating between unipolar and bipolar depression; the bipolar spectrum; the relative efficacy and safety of mood stabilizers; the role of antidepressants, atypical antipsychotics and thyroid hormones in management of mood disorders; and application of the STEP-BP and STAR*D studies to clinical practice.

**REFERENCES:**

1. Miller GE, Noel RL. Controversies in Bipolar Disorder: Trust Evidence or Experience? Current Psychiatry. 2009;8(2):27-39.

**1:30 PM- 3:00 PM**

WORKSHOP 84

**MALPRACTICE DEFENSE: STRATEGIES FOR SUCCESS**

*Chairperson: Abe M Rychik, J.D., 150 E. 77th St., New York, NY 10021*
*Co-Chairperson: Eugene Lowenkopf, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the process of a medical malpractice suit; 2) Participate more effectively within the legal system; 3) Know the relevant legal issues and standards and how to effectively respond to accusations in a Court of Law.

**SUMMARY:**

In every malpractice lawsuit there are a number of critical junctures at which time the physician and the attorney can positively or negatively affect the outcome of the suit, regardless of the merits of the case. This workshop presents one case from viewpoint of the defendant psychiatrist and defendant's attorney, with emphasis on the decisions and actions to be taken, which in this case contributed to a defense verdict. The workshop presents the general legal framework and discusses the issues that arise. It offers concrete recommendations for a successful litigation outcome. This workshop examines the following issues: a. What constitutes malpractice? b. The record as evidence. c. The pleadings. d. Venue (State or Federal) considerations. e. Reporting requirements and insurance policy concerns. f. Role of insurer via-à-vis the lawyer and defendant. g. Statute of limitations and continuous treatment doctrine. h. The discovery process (depositions, interrogatories, fact and expert documents). i. Plaintiff and defendant strategies. j. The Trial. k. Post-Trial activity and Appeal. l. Issues of licensure and the National Practitioner's Data bank. In summary, this workshop will provide the audience with basic knowledge and recommendations on how to most effectively proceed in a malpractice litigation.

REFERENCES:

1. Lowenkopf, EL: Memoirs of Malpractice Suit. Jnl of AM Acad. Psychoanalysis 1995; 23(4): 731-748
2. Cully C, Spisak L: So you're being sued: Do's and Don'ts for

the defendant. Cleve Clin J Med.2002; 69:752-760

WORKSHOP 85

**THE PSYCHIATRIST'S ROLE IN INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH CARE: FRIEND OR FOE?**

*Chairperson: Ruth S Shim, M.D., M.P.H., 720 Westview Drive, Atlanta, GA 30310*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the evidence basis for integrating primary care and behavioral health; 2) Determine the barriers to integration of primary care and behavioral health care; 3) Recognize the psychiatrist's role in integrated care; and 4) Develop strategies to implement integrated care models in local community settings.

**SUMMARY:**

Primary care settings are usually the first point of contact and the treatment site of choice for minority and low income consumers, with mental health problems constituting upwards of 40% of consumers' presenting complaints. Many consumers view mental health treatment in primary care settings as less stigmatizing than care received in specialty behavioral health settings. However, a great deal of evidence has demonstrated that primary care practitioners have difficulty recognizing and treating the mental health challenges of their patients. Unfortunately, fewer than half of the depression cases seen in primary care are correctly diagnosed, and only half of those diagnosed receive appropriate clinical care.

At the same time, persons with mental illness often have high levels of early mortality and a heavy burden of medical morbidity. Often, consumers seen by behavioral health practitioners do not receive needed primary care. Perhaps the most promising approach for improving rates of evidence-based treatment in primary care and behavioral health care settings has been with the use of multidisciplinary, team-based, integrated models of care. Such evidence-based treatment models have proven to be effective in clinical trials.

As the composition of the United States continues to become more racially and ethnically diverse, there is increasing demand for mental health interventions to be tailored to specific community needs. Poverty, lack of adequate access to quality health services, few culturally and linguistically competent providers and services, and lack of preventive health care are all factors that may be best addressed in integrative systems of care.

The role of the psychiatrist in integrated models of care is crucial to the effective implementation of these models. This workshop aims to review the evidence for adopting integrated care models, address the need create stronger collaborations with primary care providers, and to examine the barriers that prevent these collaborations.

**REFERENCES:**

1. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. 2006, Washington, DC: National Academy Press.

2. Chapa, T., Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations. Draft Issue Brief, September. Office of Minority Health, 2004.

**3:30 PM- 5:00 PM**

WORKSHOP 86

**TEACHING PSYCHIATRY IN NEW MEDICAL SCHOOLS**

*Chairperson: Zebulon Taintor, M.D., 19 EAst 93rd Street, New York, NY 10128*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to describe behavioral science and psychiatry teaching choices being made in five new medical schools, based on views of future physician practices, school mission, community needs, relationships with other departments, and available resources.

**SUMMARY:**

This workshop will describe the innovations and choices made by five new medical schools setting up psychiatry and behavioral science programs: Central Florida, Cleveland Clinic, Florida International, Texas Tech at El Paso (all allopathic), Touro (osteopathic). Each has different resources and mission statements vary, but all are attempting to respond to the national shortage of physicians, especially in primary care, and the need for physician researchers. Each is attempting to use modern technology, especially computers and the Internet, especially as they understand that one effect of technology is to move diagnosis and treatment closer to the onset of disease. Each is influenced by different resources and sources of funding, views of what physicians in the future will be doing, and service delivery issues, such as health care reform. Older issues, such as the mind-brain dichotomy and managed care, will be mentioned. Their communities vary from El Paso to Harlem. Relationships with neurology and neuroscience vary. Allotted curricular time and teaching in other courses

is evolving.

**REFERENCES:**

1. Langsley DG, McDermott JF, Enelow AJ (eds): Mental Health Education in the New Medical Schools. San Francisco, Jossey-Bass, 1973.
2. Luhrmann TM: Of Two Minds: The Growing Disorder in American Psychiatry. New York, Alfred A. Knopf, 2001.
3. Meyer RE, McLaughlin CJ (eds): Between Mind, Brain, and Managed care. Washington, D.C., American Psychiatric press, 1998.
4. Yager J (ed): The Future of Psychiatry as a Medical Specialty. Washington, D.C., American Psychiatric Press, 1989.

WORKSHOP 87

**DEAFNESS - DISABILITY OR DIFFERENCE? THE CULTURAL AND CLINICAL NEEDS OF DEAF PATIENTS**

*APA/SAMHSA Minority Fellows*

*Chairperson: Neil K Aggarwal, M.D., M.B.A., 623 Whitney Ave, New Haven, CT 06511*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant will understand the epidemiology of deafness and psychiatric disorders within the deaf population, recognize barriers to competent treatment, gain strategies to diagnose and treat deaf patients through mental status examination, and know how to access the wealth of resources available for clinical and social services.

**SUMMARY:**

PURPOSE: Communication with deaf patients is difficult for many clinicians, leading to misdiagnosis of patients and disparities in care. CONTENT: This workshop explores the cultural and clinical needs of the deaf. METHODOLOGY: A case presentation will be narrated throughout to illustrate key points involved in the care of deaf patients. Participants will present powerpoint slides in relation to points raised from the case presentation through thorough literature reviews. RESULTS: The epidemiology of deafness and psychiatric disorders among deaf populations will be introduced. Barriers to treatment will next be highlighted in order to sensitize clinicians to personal biases. Clinical features will then be discussed to distinguish language-related disability from psychiatric disturbances with attention to strategies around optimizing the mental status examination. The presentation will conclude with an outline of available clinical, social, residential services available for treatment. IMPORTANCE: The workshop can serve as a comprehensive initial step for clinicians interested in working with the deaf.

**TUESDAY, MAY 25, 2010**

**9:00 AM-10:30 AM**

WORKSHOP 88

**AGING HEROICALLY IN AN URBAN SETTING: THE DIARY OF JESSIE SYLVESTER "THE BEAUTIFUL HILLS OF BROOKLYN"**

*Chairperson: David w Preven, M.D., 110 Riverside Dr Apt 13E, New York, NY 10024*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, using the film as a case study, the participant should be able to: 1) Identify the advantages and disadvantages of aging in an urban setting; 2) Identify personal qualities that help or hinder successful aging; and 3) Identify features that make an A-V stimulus a useful teaching device.

**SUMMARY:**

"Beautiful Hills of Brooklyn" is moving film based on the diary of Jessie Singer Sylvester. The soundtrack is taken from her actual journal that was written over 3 years from age 77 and is interwoven with lines from Walt Whitman's poem Crossing to Brooklyn. The talented actress Joanna Merlin does an outstanding job in capturing the inner life of this remarkable woman. After 59 years working as a clerk, now living alone on a pension, Ms. Sylvester demonstrates the personal qualities that allow her to age successfully in spite of the inevitable losses she experiences. The film examines the advantages and disadvantages of aging in an urban setting.

It explores the ways she deals with a deteriorating neighborhood, the loss of her sister and early cognitive decline. Despite these experiences, Ms. Sylvester, remarkably upbeat, shares with us the role that her senior citizens' center plays as a support system. The film refutes many of the stereotypes our society has about how the aging copes with this penultimate rite of passage.

The film raises many questions for discussion. Is Ms. Sylvester's aging process really healthy? How could her primary care physician be helpful in supporting her needs? What role do community services play in her life? How can this film be used as a teaching stimulus? What ages and broad groups might benefit most from it? Finally, in his famous model for the stages of development, Erik Erickson asserts the last stage in old age-65 and above-is: Ego Development Outcome: Integrity vs. Despair.

Basic Strengths: Wisdom. Do you think Ms Sylvester was successful in achieving Integrity?

**REFERENCES:**

1. Erikson, E.H. (1975). Life History and the Historical Moment. New York: Norton.

WORKSHOP 89

**TRANSCRANIAL MAGNETIC STIMULATION (TMS) IN THE TREATMENT OF MAJOR DEPRESSION: A NEW THERAPEUTIC TOOL FOR PSYCHIATRY**

*Chairperson: John O'Reardon,, 8 Oakley Court, Cherry Hill, NJ 08003-2225*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the role of Transcranial Magnetic Stimulation (TMS) in the clinical treatment of major depression in light of its recent FDA clearance; 2) Understand the basics of TMS as an outpatient brain stimulation technique; 3) Understand the logistics of setting up a clinical TMS program and the role of nurses in the treatment team; and 4) Know the expected side effects of TMS and the process of advance patient screening.

**SUMMARY:**

Transcranial Magnetic Stimulation (TMS) is a novel, noninvasive, office-based device technology that delivers focused stimulation to the cortex of the brain by means of magnetic pulses. It was approved by the US FDA for the treatment of major depression in 2008 and is now being introduced into clinical practice. TMS sessions are conducted in the psychiatrist's office by a trained TMS clinician with the patient awake and alert throughout and able to resume normal activities immediately post treatment. A typical acute course of TMS for major depression lasts 20-30 sessions administered over a period of 4-6 weeks. TMS is generally a very safe intervention. This workshop will review the efficacy and safety profile of TMS and outline the logistics of running a TMS clinic in clinical practice.

**REFERENCES:**

1. Efficacy and safety of transcranial magnetic stimulation in the acute treatment of major depression: a multi-site randomized controlled trial. Biological psychiatry 2007;62:1208-16.O'Reardon JP, Solvason HB, Janicak PG, Sampson S, Isenberg KE, Nahas Z, McDonald WF, Avery D, Fitzgerald PB, Loo C, Demitrack MA, George MS, Sackeim HA.

2. Janicak PG, O'Reardon JP, Sampson SM, Husain MM, Lisanby SH, Rado JT, Demitrack MA. Transcranial Magnetic Stimulation (TMS) in the Treatment of Major Depression: A Comprehensive Summary of Safety Experience from Acute Exposure, Extended Exposure and During Reintroduction Treatment. J Clinical Psychiatry 2008;69:222-232.

WORKSHOP 90

**UNDERSTANDING CPT CODING AND HOW FEES ARE CALCULATED**

*APA Committee on RBRVS, Codes & Reimbursement*

*Chairperson: Ronald M Burd, M.D., P.O. Box MC, Fargo, ND 58122-0390*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should have a general understanding of: 1) The resource-based relative value system (the framework of the current Medicare system); 2) The range of CPT codes available for psychiatric services; and 3) Medicare reimbursement concerns.

**SUMMARY:**

Committee members will present an introduction to the CPT coding system and how Medicare fees for these codes are calculated using the resource based relative value system (RBRVS). The values that are used to calculate Medicare physician fees serve as the de facto reimbursement scheme for all medical services as most private payers use these values as a basis for their fees. The current range of CPT codes available to psychiatrists will be presented as will advice as to appropriate documentation for codes used frequently by psychiatrists. Current issues for discussion include the upcoming 5-year review of physician work as defined by the AMA RVS Update Committee. Time will be reserved for answering attendees questions about the coding issues they encounter in their own practices.

**REFERENCES:**

1. American Medication Association: Current Procedural Terminology, Fourth Edition (CPT), 2009, Chicago, IL, AMA Press, 2008.

2. American Medical Association: Medicare RBRVS: The Physicians Guide, 2009, Chicago, IL, AMA Press 2008

3. CMS online manuals (www.cms.hhs.gov)

WORKSHOP 91

**PRACTICAL CHALLENGES FOR PSYCHIATRISTS IMPLEMENTING THE RECOVERY MODEL**

*Chairperson: Mark Ragins, M.D., 456 Elm Avenue, Long Beach, CA 90802-2426*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify some common areas of challenge in implementing the recovery model; 2) Have shared challenges in implementing the recovery model with other psychiatrists working in the field; 3) To further understand the recovery model's approaches to several serious challenges to help guide their decision making and practice; and 4) To have some new ideas how to approach these challenges.

**SUMMARY:**

Many community psychiatrists are being pressured to adopt the recovery model in their practice and are often, fairly or unfairly, described as resistant or "not getting it" discounting serious practical challenges in implementing the recovery model. This workshop assumes a basic understanding of recovery and the practice transformations involved in working in a recovery based model. This workshop will be an guided discussion of some common areas of difficulty including: 1) How should we be collaborative and use "shared decision making" with patients with diminished competence. Whose really responsible for their bad decisions? Us as professionals or them because it's their life? What about malpractice risk? 2) How do you implement evidence based practices in a "client driven" program? Should "research" or "listening to our patients" determine effectiveness? 3) In a "person centered" approach, how central really are psychiatrists and medications? Will the recovery model affect the professional development, role satisfaction, and/or burnout of psychiatrists? 4) Psychiatrists are being asked to work alongside "consumer staff," sometimes including their own patients. How should we handle that? What about boundaries? Confidentiality? Our concerns about their competency to help other people? 5) We're often making lots of program cuts. Does recovery change the way we "partner" with our patients when we advocate for more services (or to face unpleasant realities together)? For each area I will briefly present the area of challenge including advantages and disadvantages of the recovery model over more traditional approaches, solicit colleagial discussion from the group, and attempt to clarify the recovery model's perspective for each challenge.

WORKSHOP 92

## COGNITIVE-BEHAVIORAL AND PSYCHODYNAMIC APPROACHES TO MEDICATION ADHERENCE IN SEVERE MENTAL ILLNESS

*Chairperson: Jesse H Wright, M.D., Ph.D., Suite 610, 401 East Chestnut, Street, Louisville, KY 40202*

*Co-Chairperson: Glen Gabbard, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Compare and contrast cognitive-behavioral and psychodynamic methods of enhancing medication adherence in patients with severe mental illness; 2) Identify methods for medication adherence that are common to each psychotherapeutic approach; 3) Identify specific differences between the two psychotherapeutic approaches in working with adherence problems; and 4) Recognize practical methods of improving medication adherence.

**SUMMARY:**

This workshop is intended for clinicians who are interested in exploring the usefulness of psychotherapeutic methods for enhancing medication adherence in patients with severe mental disorders. Experienced clinicians who employ cognitive-behavior therapy (Drs. Wright and Turkington) and psychodynamic therapy (Drs. Gabbard and Tasman) will first briefly describe the general methods used to address adherence problems with these two major forms of psychotherapy. Then a single case will be presented to allow detailing of specific methods from CBT and dynamic therapy that could be used to target adherence problems in this patient with a challenging psychiatric condition. Attendees will be asked to help identify similarities and differences in the two treatment approaches and to discuss opportunities and problems in using psychotherapy to promote medication adherence. Questions and open dialogue with the audience will be encouraged throughout the Workshop.

**REFERENCES:**

1. Julius RJ, Novitsky AM, Dubin WR: Medication adherence: A review of the literature and implications for clinical practice. J of Psychiatric Practice 15(1): 34-44, 2009
2. Drymalski WM, Campbell TC: A review of motivational interviewing to enhance adherence to antipsychotic medication in patients with schizophrenia: Evidence and recommendations. J of Mental Health 18(1): 6-15, 2009
3. Zeber JE, Copeland LA, Good CB et al: Therapeutic alliance perceptions and medication adherence in patients with bipolar disorder. J of Affective Disorders 107(1-3): 53-62, 2008

WORKSHOP 93

## BOUNDARY CROSSINGS AS BOUNDARY ACCOMMODATIONS: THE PHYSICIAN/ PATIENT RELATIONSHIP WITH MEDICALLY ILL PATIENTS

*Chairperson: James W Lomax, M.D., Menninger Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza,*

*BCM350, Houston, TX 77030*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify useful alterations from "usual practice" when providing psychotherapy to medically ill patients; 2) Use consultation so that boundary crossings do not become boundary violations; and 3) Utilize professionals from other settings to address boundary concerns in their practice.

**SUMMARY:**

Treating individuals in an outpatient setting has emphasized maintaining appropriate therapeutic boundaries between physician-patient and the dangers of ignoring boundaries. Managing physician-patient boundaries when caring for patients with serious medical illnesses has received little attention. As our population ages, this "comorbidity" will become an increasingly common challenge.This workshop is an opportunity for "practice-based" learning as a critically important type of continuing medical education. The workshop presenters will discuss a case involving individual psychotherapy provided in a variety of settings to a severely medically ill patient (a physician suffering from a terminal illness similar to ones that she once treated). The case will emphasize management of boundary crossings such as meeting with the patient in settings outside the office (house calls), managing gifts to the therapist in a non-exploitative way, and participation with a patient in contexts outside of the usual treatment settings (attendance at special events of/for the patient).

An additional feature of this "case" is that the patient wrote a paper about her treatment published in Psychiatric Times. The paper will be assigned as recommended "homework" for the workshop participants and distributed at the workshop.

The case presentation will be interrupted to provide audience discussion of a series of critical moments in treatment. Audience members will offer "consultation" to the presenter and/or examples of what they have done in analogous situations.

A third and critically important element of this workshop will involve audience members presenting to the workshop presenters illustrative examples of their own challenges with boundary crossings (or accommodations) which could potentially become boundary violations.

Workshop participants are encouraged to read the two literature references in advance of the meeting in order to make maximal use of the workshop.

**REFERENCES:**

1. Gutheil TG and Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. Am J Psychiatry 1993 150: 188-196.
2. A Physician's Personal Experience—The Gift of Depression by Jan Goddard-Finegold, M.D. in Psychiatric Times, May 26, 2009.

**11:00 AM-12:30 PM**

WORKSHOP 94

**ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE**

*Ethics Committee*

*Chairperson: Wade Myers, M.D., 64 Alumni Ave, Providence, RI 02906*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize common situations which signal professional risk.

**SUMMARY:**

To provide sufficient time to adequately address complex practice issues and dilemmas raised by audience members, this workshop will be entirely devoted to the APA Ethics Committee members taking questions from the audience on ethical dilemmas they have encountered, participated in, or read about. Audience participation and interaction will be encouraged, and ensuing discussions will be mutually driven by audience members and Ethics Committee members. All questions related to ethics in psychiatric practice will be welcomed. Possible topics might include boundary issues, conflicts of interest, confidentiality, child and adolescent issues, multiple roles (dual agency), gifts, emergency situations, trainee issues, impaired colleagues, and forensic matters.

**REFERENCES:**

1. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. United States of America, American Psychiatric Association, 2009.

WORKSHOP 95

**CAM OR SCAM FOR MOOD DISORDERS: HERBALS AND BEYOND!**

*Chairperson: Vishal Madaan, M.D., M.B.B.S, 3528, Dodge St, Omaha, NE 68131*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the current

evidence for use of herbal medications in mood disorders; and 2) Recognize the value of Indian complementary and alternative medicine techniques in mood disorders.

## SUMMARY:

Summary: Complementary and alternative medicine (CAM) treatment strategies are commonly utilized by patients with chronic mood disorders, often with a hope of embracing a more holistic model of care, reducing serious adverse effects from conventional psychotropic agents or decreasing the cost of their medications. Thus, greater knowledge and understanding of the indications, adverse effects and available evidence of efficacy with these agents is vital for the psychiatrist to inform patients regarding their appropriate use. While some herbal medications such as St John's wort (Hypericum perforatum) and S-adenosylmethionine (SAMe) have been shown to be effective as alternative treatments in mild to moderate cases of anxiety and depression, others such as L-Tryptophan have been implicated in causation of serious adverse effects. Additionally, CAM interventions such as omega-3-fatty acids, exercise and folate have also been well studied in the context of perinatal depression which is of critical importance since more women tend to be depressed and use CAM compared to men. Despite evidence indicating efficacy of certain CAM approaches for treatment of mood disorders, a lack of consensus exists regarding integrating such strategies into clinical practice. This is especially significant since current professional regulations may make it extremely difficult for psychiatrists to practice such forms of medicine.

This workshop will present an updated overview of research using CAM treatments and stimulate lively discussion on the evidence-based strategies for integrating these treatments into clinical practice. Beginning with interactive case vignettes, the workshop will include a presentation on the evolving knowledge base of CAM in the treatment of mood disorders, along with the challenges and clinical considerations associated with the integration of CAM techniques into practice. This will be followed by a brief discussion of the current evidence for the available CAM strategies for sleep disturbances associated with mood disorders. The workshop leaders will then explore the realm of CAM techniques from India, including ayurveda and yoga. The workshop will provide for an interactive discussion with audience participation while exploring widely used and easily accessible CAM.

## REFERENCES:

1. Sarris J, Kavanagh DJ. Kava and St. John's Wort: current evidence for use in mood and anxiety disorders. J Altern Complement Med. 2009 Aug;15(8):827-36.
2. Werneke U. Complementary medicines in mental health. Evid Based Ment Health. 2009 Feb;12(1):1-4
3. Freeman M. Complementary and alternative medicine for perinatal depression J Affect Disord. 2009 Jan;112(1-3):1-10.

## WORKSHOP 96
## A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART II)

*(For Residents Only)*

*Chairperson: John G Gunderson, M.D., 115 Mill Street, Belmont, MA 02478*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

## SUMMARY:

This is Part II of the workshop and is a continuation of Part I. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with participant discussions will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II presented over consecutive days). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, it examines core features of effective psychotherapy as well as features of treatments likely to make patients worse. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Principles of family

involvement follows next, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Finally, objectives for residency education will help participants bring content from the workshop and integrate it with their current training. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

**REFERENCES:**

1. Gunderson JG, Links PS: Borderline Personality Disorder: A Clinical Guide, 2nd Ed. Washington, DC, American Psychiatric Publishing, Inc., 2008

**WORKSHOP 97**
**PSYCHIATRIC PROFESSIONAL LIABILITY 2009: THE YEAR IN REVIEW**

*Chairperson: Donna Vanderpool, J.D., M.B.A., 1515 Wilson Blvd. #800, Arlington, VA 22209*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify the major high-risk psychiatric professional liability risks that lead to malpractice lawsuits; 2) recognize current psychiatric professional liability trends based on hundreds of initiated, but not yet resolved claims and lawsuits reported in 2009 to PRMS; and 3) Incorporate into practice at least three risk management strategies that decrease or prevent exposure to psychiatric professional liability risks.

**SUMMARY:**

Based on PRMS' more than 20 years of experience managing claims and lawsuits against psychiatrists, we are able to identify common sources of malpractice actions against psychiatrists and the outcomes of such lawsuits.

Malpractice lawsuits pose a significant problem for psychiatrists in all practice settings. From our experience, PRMS has seen a 6-8% overall risk for a psychiatrist to be involved in a claim or lawsuit. It is important for psychiatrists to understand the sources of malpractice lawsuits and the malpractice risks they face as clinicians, teachers, and administrators.

Participants will learn from the panel (composed of specialists with clinical, legal, insurance, and risk management experience/expertise) general information on PRMS malpractice cases that were resolved in 2009 as well as cases that were initiated, but not resolved in 2009. Special emphasis will be placed on what can be learned from analyzing these cases, particularly high-risk exposure liability cases such as patient suicide and adverse events related to prescribing psychotropic medication.

Additionally, participants will learn about future liability issues that are being reported as risk management concerns to PRMS' Risk Management Consultation Service Helpline. These topics include emerging technology issues such as participation in social networking sites (e.g., "Facebook"), blogging, and electronic health records. The workshop will conclude with a question and answer period with the audience.

Throughout the discussion, participants will learn not only what liability risks they face, but also risk management strategies that can reduce malpractice risk as well as support patient safety and quality patient care.

**REFERENCES:**

1. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo L, Brennan TA. Claims, errors, and compensation payments in medical malpractice litigation. New Eng Journal of Medicine. 2006. 354:2024-2033.

2. Melonas JM, Cash CD. Identifying and reducing professional liability when treating older adults. Psych Times 2009. Vol. XXVI, Issue 1.

WORKSHOP 98
**THE TRAIN HAS LEFT THE STATION: NATIONAL INCENTIVES AND DEVELOPMENTS IN ELECTRONIC HEALTH RECORDS**

*Chairperson: Laura J Fochtmann, M.D., HSC-T10, Stony Brook, NY 11794-8101*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Describe the current status and major initiatives of the national EHR movement; 2) Describe considerations in EHR selection, such as software certification; 3) Describe potential advantages and pitfalls of electronic prescribing; and 4) Describe potential advantages of EHR use, including facilitated communication with primary care.

**SUMMARY:**

The American Recovery and Reinvestment Act of 2009 included over $17 billion in incentives for physicians who demonstrate "meaningful use" of Electronic Health Records. Starting in 2015, Medicare reimbursement rates will be reduced for physicians who do not meet this requirement. While physician use of EHR has been limited to date, these initiatives are expected to accelerate adoption. In this workshop, presenters from the APA's Committee on Electronic Health Records will summarize some of the national activity in this area. Themes such as

privacy and security, considerations in software selection, electronic prescribing, and emerging software standards will be covered. After brief presentations, the session will provide an opportunity for attendees to engage in open dialog about national health information technology initiatives and on the potential benefits and pitfalls of EHR use in psychiatry.

**REFERENCES:**

1. Blumenthal D. Stimulating the Adoption of Health Information Technology. N Engl J Med. 2009 Apr 9;360(15):1477-9.
2. Lawlor T, Barrows E. Behavioral health electronic medical record. Psychiatr Clin North Am. 2008 Mar;31(1):95-103.

## WORKSHOP 99
## COGNITIVE THERAPY FOR PSYCHOSIS IN PRACTICE: BASIC TECHNIQUES FOR PSYCHIATRISTS

*Chairperson: Shanaya Rathod, M.D., Hampshire Partnership NHS Trust, Melbury Lodge,, Winchester, SO22 5DG United Kingdom*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Demonstrate understanding of which of their patients with schizophrenia may benefit from cognitive therapy; and 2) Be able to incorporate evidence-based elements of Cognitive Therapy into their work with patients with schizophrenia.

**SUMMARY:**

Cognitive Behaviour therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and twenty two published Randomised controlled trials. Unfortunately, few training schemes exist and consequently trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully (Turkington & Kingdon, 2000). They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community and inpatient settings. CBT compliments medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, video-interviews and allow plenty of opportunity for discussion.

**REFERENCES:**

1. Kingdon, D.G., Turkington, D (2002). A Casebook Guide to Cognitive Behaviour Therapy: practice, training and implementation. Chichester: Wiley Kingdon, D.G.,
2. Turkington, D (due out 2004). Treatment Manual for Cognitive Behaviour Therapy of Schizophrenia and Psychotic Symptoms. Series Editor: J. Persons. NY: Guilford.

**1:30 PM- 3:00 PM**

## WORKSHOP 100
## RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

*Chairperson: Eric M Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to 1) enumerate clinician responses to patient suicide; and 2) list practical recommendations for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives.

**SUMMARY:**

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric colleagues because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a study revealing 8 thematic clinician responses to suicide: Initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame and humiliation; crises of faith in treatment; fear of litigation, and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive

discussion with participants about their own experiences with patient suicide.

**REFERENCES:**

1. Plakun, EM, Tillman, JT. Responding to the impact of suicide on clinicians. Directions In Psychiatry, 2005; 25:301-309

**3:30 PM- 5:00 PM**

## WORKSHOP 101
## ETHICAL CHALLENGES IN END OF LIFE CARE IN THE HOSPITALIZED ELDERLY

*Chairperson: Maria I Lapid, M.D., 200 First St SW, Rochester, MN 55905*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Gain an understanding of common ethical dilemmas occurring in the care of the hospitalized geriatric patient. 2) Learn practical skills for identifying and managing ethical challenges arising from difficult decisions in hospitalized geriatric patients.

**SUMMARY:**
Ethical dilemmas are frequently encountered in caring for acutely medically ill elderly patients in the inpatient setting, and pose unique challenges in life threatening situations. In this session, we will present a case of an elderly married male who was admitted to the general hospital with an acute medical condition, but subsequently developed life threatening complications that required life saving measures. While he initially appeared to be capable of making his own medical decisions, his wife disagreed with his code status preference, and had unrealistic expectations of his care and condition. More ethical issues emerged as his medical condition worsened and he approached end of life. This case study will highlight the complexities involved in caring for very ill elderly patients and the complex interactions between medical, geropsychiatric, bioethical, medicolegal, palliative, and end of life issues. The various ethical dilemmas and bioethical principles will be explored and reviewed, and clinical and practical approaches in navigating these ethical dilemmas will be discussed. Dr. Maria Lapid will chair the workshop, Dr. M. Caroline Burton will describe the case and review the medical and geropsychiatric aspects of the case, and Dr. Jarrett Richardson will be the main discussant who will focus on the ethical, medicolegal, palliative, and end of life aspects of the case.  Approximately 45 minutes will be spent on the case study presentation, and the last 45 minutes will be an interactive discussion between the panel and the audience. The goal of the session is for clinicians to be familiar with ethical principles involved in caring for the hospitalized geriatric patients, to recognize potential ethical issues in a given clinical situation, and to discuss approaches to effectively manage challenging ethical dilemmas.

**REFERENCES:**

1. Lyness, Jeffrey M. End-of-Life Care: Issues Relevant to the Geriatric Psychiatrist. Focus 2007 5: 459-471.
2. Rajput V, Bekes CE. Ethical issues in hospital medicine. Med Clin North Am. 2002 Jul;86(4):869-86.

## WORKSHOP 102
## DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINES: AN ALLIANCE BASED INTERVENTION FOR SUICIDE

*Chairperson: Eric M Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand converging approaches to treating self-destructive patients from DBT and dynamic perspectives; 2) Enumerate principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients; 3) Implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients; and 4) List countertransference problems in work with these patients.

**SUMMARY:**
Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge.  Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practical clinical guidance is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from non-lethal self-destructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) non-punitively interpret the patient's aggression in

considering ending the therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (9) provision of an opportunity for repair. These principles are compared to Linehan's DBT and Kernberg's Transference Focused Psychotherapy (TFP). DBT and TFP arrive at a similar clinical approach to work with suicidal patients despite markedly different theoretical starting points. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

**REFERENCES:**

1. Plakun, EM, A View From Riggs: Treatment Resistance and Patient Authority, Paper XI: An alliance based intervention for suicide, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 2009, pp. 539-560.

## WORKSHOP 103
## MAKING YOUR PRESENTATION MORE INTERACTIVE: THE BETTER WAY!

*Chairperson: Jon JD Davine, M.D., 2757 King Street East,, Hamilton, L8K 2G4 Canada*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the superiority of interactive group teaching versus the traditional didactic model in changing physican behaviour; 2) Use and participate in different group activities that enhance interactive group teaching; 3) Maximize the use of "Hollywood" film clips and audiovisual patient encounters to enhance group teaching.

**SUMMARY:**

Educational literature has shown us that traditional presentations usually are not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we look at factors that can enhance interaction, including room arrangements, proper needs assessment, and methods to facilitate interactive discussions. The group will have an interactive component, which will involve participating in different group activities, such as "Buzz Groups", "Think-Pair-Share", and "Stand Up and Be Counted", which enhance small group interaction. The use of commercial films to enhance educational presentations has been coined "cinemeducation". We will discuss techniques to help use films as teaching tools, along with having an experiential component involving the direct viewing and discussion of a film clip. We will also comment on how to maximize the use of audiovisual tapes of patient encounters as a teaching tool. This will also involve direct viewing of an audiovisual tape to illustrate these principles.

**REFERENCES:**

1. Jacques D. ABC of Learning and Teaching in Medicine: Teaching small groups. BMJ, 2003, vol 326, 492-494.
2. Davis D, Thomson O'Brien M, et al. Impact of Formal Continuing Medical Education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behaviour or health care oucomes? JAMA, 1999, vol 282, Workshop 9, 867-874.

## WORKSHOP 104
## FIGHTING STIGMA: WHEN PSYCHIATRISTS WHO HAVE BEEN IN TREATMENT SPEAK OUT

*Chairperson: Michael F Myers, M.D., 450 Clarkson Avenue, Brooklyn, NY 11203*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Appreciate the kinds of illnesses that may befall physicians; 2) Understand how physicians grow through healing

**SUMMARY:**

Addressing the stigma attached to mental illness is a central imperative in the daily work of all psychiatrists. However, this effort is usually on behalf of our patients. What about the situation in which we are the ones suffering from a psychiatric condition? Should we self-disclose? When "we walk the walk" do we have more effect than if we merely "talk the talk"? What are the risks (and benefits) of "coming out" to our medical colleagues – especially our psychiatrist colleagues - or to the general public? In this workshop, our four speakers will address these questions and many more: how the journey from psychotic depression and PTSD to healing is a transformative one; how most psychiatrists who have suffered a major illness should not be viewed as "impaired" – they live with their conditions, take care of themselves and function very well; how psychotherapy is key in both restoration and maintenance of good health and frequently trumps medication; how the telephone and email support of psychiatrist colleagues who themselves know illness from "the inside out" is profoundly important; how being a patient affects one's perspective

on the recovery movement, especially various ideologies; how writing about one's life and experiences with illness is soothing and clarifying. This will be an interactive session as one half the workshop time is protected and preserved for discussion with the audience.

**REFERENCES:**

1. Cournos F. City of One: A Memoir. New York, NY. WW Norton & Co., 1999
2. Myers MF, Gabbard GO. The Physician As Patient. Washington, DC. American Psychiatric Publishing, Inc., 2008

## WORKSHOP 105
## THE AWKWARD PROCESS OF RECRUITING YOUR OWN

*Chairperson: Lewis Krain, M.D., 215 Crystal Court, Little Rock, AR 72205*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the complexities of internal faculty recruitment; 2) Engage in discussion of and role-playing exercises simulating faculty recruitment; and 3) Develop strategies for negotiation from the perspectives of the prospective faculty member, the chair, and the training director.

**SUMMARY:**
It is surprisingly complex to transition a recently graduated resident into a junior faculty position. Applicants are often inexperienced negotiators with limited understanding of how to structure an academic appointment or advocate for themselves. The chair must balance the applicant's career development with the needs of the department. Salary and benefits for an applicant's first "real" job can besensitive topics.
Although one might expect that familiarity between the recruiting institution and an applicant would facilitate this process, existing relationships between the resident, the chair, and other faculty can create new obstacles when the faculty applicant is a trainee within the department. Examples include awkward changes to mentorship relationships, in-depth knowledge of the other party, and interference from departmental gossip. Both the training director and the chair can experience divided loyalties as they try to guide the trainee into an appropriate academic position, but also fill the needs of their own department. Although this hiring process occurs frequently in departments across the country, there is little literature dealing with this special circumstance.
This workshop will explore the intradepartmental negotiation process from the perspectives of a department chair, residency director, recently hired faculty member, and senior resident through an interactive panel discussion and participant role-playing. Attendance by all levels of faculty and trainees is encouraged to foster discussion and to help participants build skills for handling this process more effectively.

## WORKSHOP 106
## ASSESSMENT OF CAPACITY: DEVELOPMENTS, DOCUMENTATION & DEFENDABILITY

*Chairperson: Michael Jan Wise, M.B.B.S, M.S.C., Wiser Minds Ltd, 14 Devonshire PLace, London, W1G 6HX United Kingdom*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Recognize the principles of capacity and informed consent, and their differences; 2) Demonstrate awareness of different resources used in the assessment of capacity, and new ideas for recording the information in more defendable formats.

**SUMMARY:**
Aim: The aim of the workshop is to help participants improve their ability to assess capacity and be aware of relevant tools for aiding decisions regarding capacity and consent.
The workshop is aimed at psychiatrists of all levels. Research has shown that there is room for improving the knowledge of the principles of capacity at all levels of experience from trainee to board registered practitioner.
The principles of capacity and the right to self-determination are broadly similar across a range of legal settings, whether the legal principles are embodied in the probate code, as in california, or in new legislation, the United Kingdom. Teaching will be a mix of interactive exercises, demonstrations, presentation, and discussions. Initially participants will view a clinical dilemma and discuss whether capacity is present. A presentation will then inform participants of legal principles. A second dilemma will allow participants to determine their understanding of the principles. The second case will be used to demonstrate an algorithm, which has been used in multiple jurisdictions for the assessment of capacity. A third dilemma will illustrate the boundaries of tools and involve a group decision. Prior versions of this workshop have improved assessment accuracy from 40% to 80%.
This session will improve awareness of the issues involved in assessing capacity, including relevant legal tests. It will also improve the assessment skills of participants. To learn about resources for assessing capacity and consent, both

US and International. Participants awareness of the subtle differences of the relative weights given to the underlying ethical principles in different legislative settings is often enhanced.

REFERENCES:
1.Restoration of Competency to Stand Trial. Journal of the American Academy of Psychiatry & Law. 31(2): 189-201, 2003.
2.Informed Consent: Information or Knowledge? Medicine & Law. 22(4): 743-50, 2003

**11:00 AM-12:30 PM**

**WORKSHOP 107**
**TAI CHI EXERCISE, A CONTROLLABLE PHYSICAL INTERVENTION TO ENHANCE MINDFULNESS AND BEHAVIORAL ACTIVATION IN CBT GROUP TREATMENT FOR DEPRESSED PATIENTS**

*Chairperson: Jun Yang, M.D., Ph.D., 8730 Alden Dr. Suite W101, Los Angeles, CA 90048*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this presentation, the participant should be able to demonstrate understanding of how Tai Chi (TC) will enhance mindfulness & behavioral activation - two components of CBT being particularly effective to treat depression.

**SUMMARY:**
TC is a form of traditional Chinese martial arts applied with internal power to focus the mind solely on the physical movement which helps to bring about a state of mental calm and clarity. TC involves meditation on relieving stress, maintaining optimum health, and yielding appropriate change in response to outside forces. TC brings significant psychosocial benefits relating to improvement in mental health, emotional well-being, stress reduction, and socialization.
Exercise has been shown to cause functional and morphologic changes in cortex. Skill training of complex moving sequences leads functional increases in neural activation. However, prolonged training results in a relative neural deactivation, suggesting that extensive training results in a more efficient way to control movements. Our previous animal study indicates that training increases the efficiency of neural processing and enhances influence of the cerebellar-thalamic-cortical circuit.
Exercise plus cognitive strategy is more effective than exercise lacking a structured cognitive component in promoting psychological benefits. Both mindful and non-mindful exercises have short-term effect in alleviating depression, but mindful exercise like TC has long-term effect. Different from randomly applied behavioral interventions in CBT, TC integrates all critical ingredients, such as muscle relaxation, breathing modification, mediation and mindfulness into a comprehensive training system which efficiently maintain body-mind harmony at a higher level.
Current study is designed to evaluate the effectiveness of a combination of cognitive therapy and TC (CTC) on improving the depressive mood of adult patients. Adults with depression will be randomly assigned to the CTC and CBT groups. 12 sessions will be conducted. In each 90 minute session, cognitive therapy and behavioral intervention are conducted evenly. 6 weekly sessions will be designed to train patients and followed with 6 sessions to consolidate performance skills. Treatment-related changes will be measured using the Beck Depression Inventory II and Montgomery-Asberg Depression Rating Scale at baseline, 5 and 10 weeks.

**REFERENCES:**
1. Brown DR, Wang Y, Ward A, Ebbeling CB, Fortlage L, Puleo E, Benson H, Rippe JM: Chronic psychological effects of exercise and exercise plus cognitive strategies. Med Sci Sports Exerc 1995; 27:765-775
2. Bertisch SM, Wee CC, Phillips RS, McCarthy EP: Alternative mind-body therapies used by adults with medical conditions. J Psychosom Res 2009; 66:511-519
3. Rogers CE, Larkey LK, Keller C: A review of clinical trials of tai chi and qigong in older adults. West J Nurs Res 2009 31:245-279
4. Cho KL: Effect of Tai Chi on depressive symptoms amongst Chinese older patients with major depression: the role of social support. Med Sport Sci 2008; 52:146-154
5. Sjösten N, Vaapio S, Kivelä SL: The effects of fall prevention trials on depressive symptoms and fear of falling among the aged: a systematic review. Aging Ment Health 2008; 12:30-46.
6. Tsang HW, Chan EP, Cheung WM: Effects of mindful and non-mindful exercises on people with depression: a systematic review. . Br J Clin Psychol 2008; 47:303-322
7. Chou KL, Lee PW, Yu EC, Macfarlane D, Cheng YH, Chan SS, Chi I: Effect of Tai Chi on depressive symptoms amongst Chinese older patients with depressive disorders: a randomized clinical trial. Int J Geriatr Psychiatry 2004; 19:1105-1107
8. Brown DR, Wang Y, Ward A, Ebbeling CB, Fortlage L, Puleo E, Benson H, Rippe JM: Chronic psychological effects of exercise and exercise plus cognitive strategies. Med Sci Sports Exerc 1995; 27:765-775
9. Ospina MB, Bond K, Karkhaneh M, Buscemi N, Dryden DM, Barnes V, Carlson LE, Dusek JA, Shannahoff-Khalsa D: Clinical trials of meditation practices in health care: characteristics and quality. J Altern Complement Med 2008; 14:1199-1213
10. Klein PJ: Tai Chi Chuan in the management of Parkinson's disease and Alzheimer's disease. Med Sport Sci 2008;

52:173-181
11. Siu AM, Chan CC, Poon PK, Chui DY, Chan SC: Evaluation of the chronic disease self-management program in a Chinese population. Patient Educ Couns 2007; 65:42-50
12. De Lange FP, Koers A, Kalkman JS, Bleijenberg G, Hagoort P, van der Meer JW, Toni I: Increase in prefrontal cortical volume following cognitive behavioural therapy in patients with chronic fatigue syndrome. Brain 2008; 131:2172-2180
13. Forrester LW, Wheaton LA, Luft AR.: Exercise-mediated locomotor recovery and lower-limb neuroplasticity after stroke. J Rehabil Res Dev 2008; 45:205-220
14. Draganski B, May A: Training-induced structural changes in the adult human brain. Behav Brain Res 2

## WORKSHOP 108
## USING THE DSM-IV-TR OUTLINE FOR CULTURAL FORMULATION FOR CULTURALLY APPROPRIATE ASSESSMENT: A SKILLS BASED APPROACH WITH DVD CASES

*Chairperson: Russell F Lim, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Elicit an explanatory model; 2) Understand how to assess a patient's cultural identity and health beliefs; 3) Recognize intercultural transference and countertransference; and 4) Negotiate a treatment plan.

### SUMMARY:

Culturally appropriate assessment is a required skill of graduating residents according to the RRC and the ACGME Core Competencies. Understanding how to use the DSM-IV-TR Outline for Cultural Formulation will assist psychiatrists in understanding their own culture and those of the patient. The session will include a self-assessment of the participant's cultural identity, as well as teaching practical methods of eliciting the patient's explanatory model, and developing rapport. The audience will also be shown excerpts of case material from videotaped cases to illustrate techniques that can be used in the assessment and treatment of culturally diverse individuals.

### REFERENCES:

1. Lim RF: The Clinical Manual of Cultural Psychiatry, APPI, Arlington, VA, 2006
2. Culturally Appropriate Assessment, 2008, a four disc set of videotapes

## WORKSHOP 109
## CHILDREN OF PSYCHIATRISTS

*Chairperson: Michelle B. Riba, M.D., M.S., 4250 Plymouth Road, Room 1533, Ann Arbor, MI 48109-2700*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and understand how as psychiatrist-parents, their children think and feel about their psychiarist-parents.

### SUMMARY:

This 13th annual workshop, which enables children of psychiatrists to share personal anecdotes and advance with the audience of psychiatrist-parents and parents-to-be, has been offered to standing room audiences annually. While stigma toward psychiatry in general has diminished, psychiatrists, because of training and professional work, in addition to their professional life, bear emotional fears and concerns of how they will and do function as parents. Each of the three presenters will speak about their personal experiences and also offer advice to attendees. There will be an introduction by Dr. Dickstein to set the tone for the audience, the presenters will speak; Dr. Riba will lead an interactive 30-minute question/answer discussion and brief wrap-up.

### REFERENCES:

1. Dickstein, LJ: an interview with Stella Chess, M.D., in Women Physicians in Leadership Roles, edited by Leah J. Dickstein, M.D. and Carol C. Nadelson, M.D., American Psychiatric Press, Inc., pp. 149-158
2. Mueller-Kueppers, Manfred: The Child Psychiatrist as Father, The Father as Child Psychiatrist (German), Praxis der Kinderpsychologie und Kinderpsychiatrie, Vol. 34j(8), Nov.–Dec., 1985, pp. 309-315

**1:30 PM- 3:00 PM**

## WORKSHOP 110
## GAMES PEOPLE PLAY: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT VIDEO GAMES

*Chairperson: Deidre E Williams, M.D., M.Ed., 401 Parnassus Ave, Box 0984, San Francisco, CA 94143*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of current popular video games, gamer characteristics, and motivation for play 2) Discuss what constitutes "problematic play" and whether the creation of a DSM-V diagnosis related to video gaming may be warranted; and 3) Talk to their

patients about video game play, and know what questions to ask when taking a video game history.

**SUMMARY:**

Video games are becoming an increasingly prevalent part of our culture. As terms such as "video game addiction," "pathologic play," and "problematic use" are entering psychiatric lexicon, psychiatrists may be asked to diagnose and treat these issues. Many psychiatrists, however, may know less about these games than their patients, as many psychiatrists have never played the games and have a poor understanding of their attraction. This problem may have further repercussions for psychiatrists involved in medical student and resident education, since they may be asked to teach a subject about which they have less practical awareness than their students. In order to effectively address this emerging area of clinical practice, psychiatrists (particularly those involved in education) need to develop an understanding of what video games are, who is playing them, and why they play. This workshop will present information about several of the most popular games, as well as some recent information about gamers and problematic play. Participants will be given the opportunity to play some of the games, and there will be an interactive discussion about the many facets of this controversial topic. Participants will also work together to generate questions to be included when taking a video game history.

## WORKSHOP 111
## HOW TO IMPLEMENT CARDIOMETABOLIC MONITORING ACROSS LARGE PUBLIC HEALTH SYSTEMS

*Chairperson: Laura K. Kent, M.D., 1051 Riverside Drive, PO Box 49, New York, NY 10032*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, the participant should be able to demonstrate understanding of how to implement a cardiometabolic health monitoring project across a wide system of mental health clinics (whether state-wide or county-wide), and specifically how to bring together administrative, information technology, data collection, outcomes research and operations aspects of the project to affect efficient implementation and improve health care monitoring of the clients they serve.

**SUMMARY:**

A recent study of adults with severe and persistent mental illness (SPMI) who receive care in the public mental health sector revealed that these consumers die 25 years earlier than the general population. They are subject to the diseases that affect all of us, including heart and vascular disease, diabetes and cancer. The key difference is that individuals with mental illness get sick earlier and die far sooner. Poor diet, sedentary life style, smoking and lack of preventative healthcare all appear to contribute to this increased risk of early death, as do some of the medications they take for their mental illnesses. Most consumers with SPMI are served in the public mental health system. Given the striking morbidity and mortality rates, medical directors throughout the country are trying to develop ways to implement increased medical screening of the consumers they serve in their public mental health systems. These systems are often financially strapped and lack primary care providers. How to implement increased screening systematically has been difficult for many public mental health administrators.

In this workshop, we will compare and contrast two cardiometabolic screening implementation strategies in the US: 1) New York State Office of Mental Health's Health Indicator Initiative and 2) San Francisco County Behavioral Health Service's Metabolic Monitoring Initiative. We will review how these two public mental health systems deal with provision of equipment, utilize information technology, track monitoring, and encourage screening throughout their facilities.

We will also provide time for audience members to share implementation strategies in their home systems. A goal of the workshop will be to collectively address common barriers encountered in these public mental health systems (e.g. time constraints, lack of equipment, training, etc.) and develop creative solutions to overcome these barriers. The hope is that each audience participant will be able to leave with tools to implement enhanced screening programs at their home facility to improve the medical health of the mentally ill consumers they serve.

**REFERENCES:**

1. Newcomer JW, Hennekens CH: Severe mental illness and risk of cardiovascular disease. JAMA 298:1794-1796, 2007.
2. Marder SR, Essock SM, Miller AL, et al.: Physical health monitoring of patients with schizophrenia. Am J Psychiatry 161:1334-1349, 2004.

**2:00 PM- 5:00 PM**

## MEDIA WORKSHOP 8-RACHEL IS GETTING MARRIED, KYM IS GETTING SOBER, EVERYONE IS LOSING IT

***American Academy of Addiction Psychiatry***

*Chairperson: Petros Levounis, M.D., M.A., 357 West 29th*

*Street, #3A, New York, NY 10001*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Discuss attachments from characterological and biological perspectives; 2) Identify dysfunctional dynamics among siblings in families who struggle with addiction; and 3) Recognize opportunities and limitations of psychiatric training when used in the therapist's own everyday life.

**SUMMARY:**
In "Rachel Getting Married" (2008, 113 minutes) director Jonathan Demme introduces us to a world of relentless interpersonal destruction and reconstitution in the context of a family reunion. Kym, the identified family problem, gets a pass from an inpatient addiction rehabilitation center to attend the wedding of her sister Rachel, the trained psychotherapist. The film won top honors at the National Institute on Drug Abuse (NIDA) 2009 Prism Awards. The NIDA Prism Awards honor films that accurately depict addiction in the popular culture.
The conflict scenes between the two sisters provide exquisite material for discussion of borderline insecure attachment types and chemical attachment, as coexisting ways characterizing the dually diagnosed patient. Furthermore, as Rachel and Kym keep loving and hating each other, the movie postulates that individual memories of historical events can operate as either foundations for construction or wrecking balls for demolition of interpersonal relationships—or both.
The workshop discussants will propose a psychodynamic formulation of the protagonist, Kym, based on the complex relationships depicted in the film. The discussants will also lead the workshop participants in an exploration of the role of the psychotherapist in addressing problems in her or his own life as reflected in Rachel's dilemmas. To what extend are we allowed to attempt to use our psychiatric training during a family dispute of the Kym-Rachel type? Even more fundamentally, how well does psychotherapy translate outside the office?
The workshop is open to all psychiatrists who would like to study the interface of addiction and personality disturbance but is particularly targeted towards members in training and early career psychiatrists.

**REFERENCES:**
1. Olsen P, Levounis P: Sober Siblings: How to Help Your Alcoholic Brother or Sister and Not Lose Yourself. Cambridge, MA, DaCapo Lifelong Books (Perseus), 2008
2. Ross S, Dermatis H, Levounis P, Galanter M: A comparison between dually diagnosed inpatients with and without Axis II co-morbidity and the relationship to treatment outcome. Am J Drug Alcohol Abuse 29:263-279, 2003

**3:30 PM- 5:00 PM**

## WORKSHOP 113
## MAINTENANCE OF CERTIFICATION FOR DIPLOMATES OF THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

*Chairperson: Larry R Faulkner, M.D., 2150 E Lake Cook Road, #900, Buffalo Grove, IL 60089*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to describe the four components of the maintenance of certification (MOC) program of the American Board of Psychiatry and Neruology as it applies to general psychiatry and to the subspecialties.

**SUMMARY:**
The components and requirements of the ABPN's maintenance of certification (MOC) program will be described. The four components are professional standing (licensure), self-assessment and lifelong learning, cognitive expertise (computerized multiple-choice examination), and assessment of performance-in-practice. The phase-in schedule for the components and the various options that are available for completing them will be presented. The computerized multiple-choice examinations will be described, as will examination results. Related issues such as maintenance of licensure will also be addressed.

**REFERENCES:**
1. Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, 1994

## WORKSHOP 114
## SUICIDE BOMBERS: PSYCHOLOGY, PSYCHOPATHOLOGY AND CULTURAL VIEWS

*Chairperson: Mostafa K Ismail, M.D., M.R.C., Institute of Psychiatry, Faculty of Medicine, Ain Shams University, Cairo, Deir Elmalak, Egypt*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Know how the bombers think and why; 2) Identify high-risk groups and their possible psychopathology; and 3) Recognize the role of mental health professionals to prevent such phenomenon.

**SUMMARY:**

The existence of suicide bombers dates back at least to World War II, when some Japanese soldiers tied bombs around their waists and jumped into the war ships-causing entire vessels to blow. Few years ago, the devastation brought by the Sept. 11 suicide bombers had been seared into the world's collective consciousness. Suicidal bombing is a phenomenon that challenges the minds and the forces of many countries. How can we understand it? Really are they suicidal? Why to do so? Are they accepted culturally? Suicide bombers want to attain the height of bliss through martyr's death. The height of bliss comes with the end of the countdown: ten, nine, eight, seven, six, five, four, three, two, one. They belief when reach 'one,' and then 'boom,' they sense themselves flying, because they know for certain that they are not dead, it is a transition to another more beautiful world, because they know very well that within seconds they will see the light of the Creator. These are their beliefs. Why would anyone submit to this type of thinking and behavior? Perhaps some sort of illness could distort the thought processes in such a way to allow a perpetrator to become involved in terrorism. But there are a lot of other possibilities as brain washing, frustration, revenge, extreme poverty, dictatorship, hopelessness, racial and religious discrimination etc. Weapons will not solve the problem but will add to it and synergize its essence as we all see in Iraq, Afghanistan, Indonesia and Somalia. Investment to explore and understand all possibilities is much cheaper than weapons. How much the expense of wars in the last years? To what extent there was a success? How many innocent civilians were killed during these wars? How many years the governments here and there can withstand these wars? We should bear in our minds that the only solution is to explore psychology and psychopathology of those people and to put a plan to bring them back to the common sense. That's why in this session we will discuss the subject from all its aspects and put suggestions for interventions.

**REFERENCES:**

1. Gadit AAM: Suicide bombers deconstructed. Clinical psychiatry news, April, 2009.

## WORKSHOP 115
## FEEDBACK ON CRITERIA AND TERMINOLOGY IN *DSM-5*

*Chairperson: David J Kupfer, M.D., 3811 O'Hara Street, Pittsburgh, PA 15213 Co-Chairperson: Darrel A. Regier, M.D.*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to identity major criteria changes under consideration as part of revisions to *DSM-5*. The participant should also be able to recognize diagnostic terminology being considered in light of potential negative impact on patients (e.g., stigma).

**SUMMARY:**

Development of *DSM-5* has been steadily progressing over the past 10 years, and the revision working groups are in the process of preparing for field trials of suggested changes. In addition to proposing novel disorders and suggesting the deletion of certain existing ones, potential revisions include refining diagnostic criteria to better reflect the clinical realities of disorder presentations and to mirror recent advances in clinical research, neuroscience, and psychiatric epidemiology. This workshop will provide the audience with an opportunity to evaluate, via an interactive electronic rating system, tentative recommendations for *DSM-5*, including proposals for new disorders and criteria changes among current disorders (e.g., schizoaffective disorder; mixed anxiety-depression). Videotaped simulations of portions of clinical interviews will be shown, and participants will have the opportunity to respond to questions about patient symptoms and possible diagnoses. In addition, some *DSM-5* revisions may involve changes in terminology among diagnostic criteria and disorder names. This workshop will also gather audience feedback about terminology, such as addiction and dependence, as well as names of diagnoses, such as schizophrenia and personality disorder, to assess for possible negative connotations, impact on patient care, and potential for stigmatization. This workshop will be used in part for pilot testing for future *DSM-5* field trials, and feedback from the audience will help inform decision-making on the part of the *DSM-5* Task Force and Work Groups in finalizing recommendations for changes.

**REFERENCES:**

1. Kupfer DJ, First MB, Regier DA (eds). A Research Agenda for the DSM-V. Washington, DC: American Psychiatric Association, 2002.
2. Regier DA, Narrow WE, Kuhl EA, Kupfer DJ. The Conceptual Development of *DSM-5*. American Journal of Psychiatry 2009; 166(6):645-650.

**SATURDAY MAY 22, 2010**
**7:00PM-10:00PM**

MEDIA WORKSHOP 1

## ISN'T ALL HORROR PSYCHOLOGICAL? HORROR FILM DIRECTOR GEORGE ROMERO AND STEVE SCHLOZMAN, M.D., DISCUSS POLANSKI'S CLASSIC FILM "REPULSION"

*Chair: Steven Schlozman, M.D., Harvard Medical School, 55 Fruit Street, Belmont, MA 02478*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1)Identify key psychological elements of classic horror cinema; 2) Discuss possible psychological etiologies for the the broad public appeal of horror films; and 3) Discuss the potential for stigma or advocacy when psychiatric illness plays a central role in horror films.

**SUMMARY:**
Horror genre cinema has long been the subject of intense creative psychological debate. What is the attraction of the sometimes gruesome tales that are viscerally depicted on the wide screen? Why do horror movies continually gross huge sums of money? Why do some directors choose horror as their venue through which important cultural and political messages can best be conveyed? And are there fundamental techniques that are central to the creation of horror cinema? These questions are the subject of entire books and syllabi studying the history and creativity of the "scary movie." in this presentation, film director and screen writer george romero, creator of "night of the living dead," "dawn of the dead," and "martin", will discuss roman polanski's classic film "repulsion." repulsion is polanski's first english language film and is classified a horror film, though the supernatural nature of its subject is in the mind of the protagonist, played by catherine deneuve as she slides into worsening psychosis. The objective of this presentation is to allow meeting participants to discuss with each other and with the presenters the nature of modern horror cinema, the relationship of horror to psychological distress, and the techniques that are central to creating classic horror films. Additionally, time will be spent discussing pitfalls as well as potential benefits to having psychiatric illness as a central theme in this particular film genre.

**REFERENCES:**
1. Akram, Adil; O'Brien, Aileen; O'Neill, Aidan; Latham, Richard, Crossing the line--Learning psychiatry at the movies. International Review of Psychiatry. Vol.21(3), Jun 2009, pp. 267-268
2. Connolly A. , Psychoanalytic theory in times of terror. Journal of Analytical Psychology. 48(4):407-31, 2003 Sep.

**SUNDAY MAY 23, 2010**
**7:00 PM-10:00 PM**

MEDIA WORKSHOP 2

## VOICING UNSPEAKABLE: REFLECTIONS ON, AND DISCUSSION ABOUT, OVERCOMING LOSS BY SUICIDE

*Chairperson: Sally Heckel, B.A., M.F.A., 52 E 1st St #4, New York, NY 10003 (Contact via www.unspeakablethefilm.com)*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, attendees should have gained a better understanding of the complex nature of the suicide grieving process, and be better able to recognize and empathize with the effects that shame, guilt, family loyalties, and social pressures have on a survivor's capacity to recover emotionally and psychologically from the suicide of a family member or loved one.

**SUMMARY:**
On a bright spring morning in May, Dr. George Heckel climbed the stairs to the attic of his home in Rochester, New York, and shot himself. He had a thriving medical practice, a wife and three children, and a beautiful home. Twenty years later, his daughter, filmmaker Sally Heckel, 17 at the time of her father's death, started making a non-fiction film exploring her father's despondent state of mind and her relationship to this tragic event. Over time, the film grew from an expression of anger and accusation toward her father to an in-depth perusal of the suicide and the years surrounding it.
In a storyline that bridges past and present, Heckel weaves home movies of what appears to be an idyllic post-war American childhood with dramatic silent recreations of a home life that reveal a darker side of the American family. Acting as the film's narrator and protagonist, Heckel coaxes her family and friends out of their silence and through their voice-over recollections and reflections, she delves deeply and with devastating honesty into the life, death, and legacy of her father and his decision to end his own life.
In Voicing Unspeakable, Heckel is joined by psychiatrist Dr. Michael Myers and writer Carla Fine to talk about the unique nature of overcoming the grief of the death of a loved one by suicide. They are the co-authors of "Touched By Suicide: Hope and Healing After Loss" (Gotham Penguin Books 2006). With their combined perspectives as a physician and survivor, they speak frequently to professional and lay audiences about the impact of suicide on those left behind. Ms Fine is also the author of "No Time to Say Goodbye: Surviving the

Suicide of a Loved One", her personal story of losing her physician husband to suicide.

**MONDAY, MAY 24, 2010**

**2:00 PM- 5:00 PM**

MEDIA WORKSHOP 3

**PATRIK, AGE 1,5: A SWEDISH FILM ABOUT UNEXPECTED AND GAY ADOPTION**

*American Academy of Child & Adolescent Psychiatry*

*Chairperson: Richard R Pleak, M.D., Long Island Jewish Medical Center, Zucker Hillside Hospital, ACP, Glen Oaks, NY 11004*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize barriers to adoption by same-sex couples and understand how expections for adoption can be challenged and resolved.

**SUMMARY:**

Patrik, Age 1,5 is a 2008 Swedish film that explores issues of child and adolescent adoption by a gay male couple, and of adoption expections by a couple being upended and how they are resolved. Husbands Sven and Goran step into a picture-perfect suburban life and long for a baby to call their own and they have been cleared for adoption by the Swedish authorities. The problem is that no country seems to be willing to give a child to a homosexual couple. After a string of disappointments at the adoption agency, good news appears to have manifested in the form of an infant named Patrik, aged 1.5. But one very small typo leads to the arrival of a homophobic and very troubled teenaged punk. Left to deal with the boy, the men are forced to reevaluate their notions of family, coupledom, and fatherhood in this inspiring, touching, and humorous film. The film has won multiple awards and has been selected for screenings at many film festivals such as New York's NewFest, the Traverse City Film Festival, the Seattle International Film Festival, and the Palm Springs International Film Festival. Following the screening, the presenters, all child and adolescent psychiatrists with expertise in LGBT issues, will engage in a discussion of the issues raised with the audience.

Patrik, Age 1,5 runs 98 minutes, in Swedish with English subtitles.

**REFERENCES:**

1. Telingator CJ, Paterson C. Children and adolescents of gay and lesbian parents. J Am Acad Child Adolesc Psychiatry 2008;43:1364-1368.

2. American Academy of Pediatrics Committee on Psychological Aspects of Child and Family Health. Coparent or second-parent adoption by same-sex parents. Pediatrics. 2002;109:339.

**7:00 PM-10:00 PM**

MEDIA WORKSHOP 4

**NATIONAL DISASTERS: DEVELOPING A ROAD MAP FOR PREPAREDNESS AND INTERVENTIONS**

*World Psychiatric Association*

*Chairperson: Arshad Husain, M.D., N 118 Umc Hlth Sci Ctr, Columbia, MO 65211*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of the workshop, participants should be able to: 1) Demonstrate familiarity with the evidence based principles that are essential in preparing individuals and communities in managing the aftermath of disasters; 2) Demonstrate familiarity with the benefits of utilizing the survivors' spiritual and faith-dependant believe systems in the recovery from trauma.

**SUMMARY:**

Man-made and natural disasters are endemic globally. For instance, any given time 50 armed conflicts rage around the world (UNICEF). Children, women and the elderly are the most common victims. Similarly, natural disasters, such as earthquake, hurricane and tsunamis, devastate communities and cause deaths and destruction that reach a catastrophic proportion. Although the humanitarian and rescue responses to these calamities are universal, abundant and varied, the evidence based consensus has been often lacking and a clear set of recommendations for interventions are scant. The presenters of this workshop, who have recognizable expertise in Trauma and Disaster Psychiatry, plan to share with the audience the information based on their vast personal experiences in the field of Disaster Psychiatry and the review of the scientific literature on the subject to encourage the participants to utilize evidence informed approach to preparedness and interventions in the aftermath of disaster. The presenters, drawing from their international experience, will introduce the evidence supporting the effectiveness of spirituality in the recovery from trauma.

**REFERENCES:**

1. Weisaeth, l., Grette, D. and Heir, T.: Disaster Medicine and Mental Health: Who, How, When for International and National Disasters. Psychiatry 70(4), Winter 2007

**TUESDAY, MAY 25, 2010**

**2:00PM-5:00PM**

MEDIA WORKSHOP 5
**NOVEL PROGRAMS TO PROMOTE MENTAL WELLNESS IN MEDICAL STUDENTS**

*American Foundation for Suicide Prevention*

*Chairperson: Julie A Chilton, M.D., Penn Behavioral Health, 3535 Market St, 2nd floor, Philadelphia, PA 19104*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participants should be able to: 1) Demonstrate awareness of the high incidence of depression in medical students and suicide in physicians; 2) Recognize signs of depression in themselves and others and understand the reasons many physicians do not get help until it is too late; and 3) Know the various programs medical schools have implemented to promote mental wellness and be given tools to implement them at their own institutions.

**SUMMARY:**
Physicians have a higher rate of suicide than members of any other profession. Specifically, female physicians complete suicide at a rate of 2.5 to 4 times that of women in the general population and male physicians complete suicide 70% more often than men in the general population. The reason for the high incidence of suicide in physicians is unknown. Studies of medical students have shown increased rates of depression 15 to 30 % higher than the general population, but a relatively small percentage actually seeks help. In fact, of the physicians who commit suicide relatively few are under the care of a psychiatrist. Surveys of depressed medical students have revealed the following barriers to care: cost, stigma, lack of time, lack of confidentiality, and perceived consequences. When physicians do access care, outcome measures such as emotional exhaustion decrease significantly. Several initiatives have been developed to combat the loss of 300 to 400 physicians to suicide each year. Among them are programs developed by the American Foundation for Suicide Prevention and the American Medical Student Association. Additionally, several medical schools have introduced novel ways of providing support to medical students. In this workshop, we will showcase the FREDDIE award-winning AFSP documentary titled Struggling in Silence: Physician Depression and Suicide, underwritten by the American College of Psychiatrists and Wyeth. Then we will present other programs initiated at the medical schools of the University of Louisville, the University of Pennsylvania, the University of California San Francisco, and the University of California San Diego. During the workshop, audience members should feel free to ask questions and comment on the various ideas presented. At the end of the presentation, resources will be available that participants can take home to help develop similar programs at their respective institutions.

**REFERENCES:**

1. www.afsp.org
2. www.doctorswithdepression.org
3. Center et al. Confronting depression and suicide in physicians: a consensus statement. JAMA. 2003;289(23):3161-6.
4. Zoccolillo M, Murphy GE, Wetzel RD. Depression among medical students. J Affect Discord. 1986;11:91-96.
5. Givens JL, Tjia J. Depressed medical students use of mental health services and barriers to use. Acad Med. 2002;77:918-921.
6. Hampton T. Experts Address Risk of Physician Suicide. JAMA. 2005;294(10):1189-91. Ro KE,
7. Gude T, Tyssen R, Aasland OG. Counselling for burnout in Norwegian doctors: one-year cohort study. BMJ. 2008;337:a2004.
8. Dyrbye LN, Thomas MR, Shanafelt TD. Medical Student Distress: Causes, Consequences, and Proposed Solutions. Mayo Clin Proc. 2005;80(12):1613-1622.
9. Chew-Graham CA, Rogers A, Yassin N. 'Wouldn't want it on my CV or their records': medical students' experience

**TUESDAY MAY 25, 2010**

**7:00 PM-10:00 PM**

MEDIA WORKSHOP 6
**BOY INTERRUPTED**

*Chairperson: Nancy Rappaport, M.D., 6 Wyman Rd., Cambridge, MA 02138*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Understand one family's journey to build a narrative after losing their young son to suicide; 2) Appreciate the complexity of treatment in the context of a boy that struggled with debilitating mental illness; and 3) Allow for discussion about how to manage the difficult decision of honoring the autonomy of a patient and negotiating the life saving decision to take medication.

**SUMMARY:**
Boy Interrupted is a film that raises questions. It asks how a young boy can end his life at the age of 15. The movie is a deep exploration by two parents who are documentary film makers seeking answers after their son's suicide. It is a naked display of the filmmakers' personal life, both revealing and disturbing. What defines this film as a remarkably unique and truth-telling achievement is the way it explores how filmmaking can create closure for its creators as well as its audience. Dana Perry has gathered home movies, photographs, and a variety of different documents to tell the story of her son, Evan: his bipolar illness, his life, and his death, and the impact on those who loved him the most. She interviews his siblings and friends, his doctors and his teachers, and in the process, she chronicles a harrowing and difficult journey. The camera provides insight and revelation. The film functions, in the final analysis, as therapy for both its viewers and its subjects at a most fundamental level. It is a profound human story about a parent's worst nightmare. Following the film, Dr. Rappaport, Ms. Harpel, and Ms. Perry will lead a discussion about how this movie can shape our practice with patients. They will explore the complexity of discussing medication with families and how to honor patients' autonomy while negotiating the potentially life-saving decision to take medication. Dr. Rappaport will speak about the fragile alliance between the teenager and the child psychiatrist. Her comments will help to place the personal story in greater context. Ms. Harpel will provide her perspective as the Director of Survivor Initiatives for the American Foundation of Suicide Prevention and will discuss her organization's support for this film. Ms. Perry will share how she made the decision to make this movie and how she created such a compelling story.

**WEDNESDAY, MAY 26, 2010**

**9:00 AM-12:00 PM**

MEDIA WORKSHOP 7

## BUILDING BRIDGES: THE INTERSECTION BETWEEN FAITH AND MENTAL HEALTH

*Chairperson: Asghar-Ali A Ali, M.D., 11828 Longwood Garden Way, Houston, TX 77047*

**EDUCATIONAL OBJECTIVES:**
At the conclusion of this session, the participant should be able to: 1) Identify the role of faith healers in treatment of mental health disorders; 2) Recognize the contribution of stigma in mental health disparities; 3) Describe affective community outreach programs involving psychiatric trainees and faith leaders; and 4) Delineate methods for the use of media in providing mental health advocacy and education to the community.

**SUMMARY:**
There are few reports of educational programs that address issues of religion and spirituality in mental health. However, there is a growing body of literature that stresses the importance of this topic (1, 2). The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults also now include a recommendation for a sensitive evaluation of the patient's religious/spiritual beliefs as well as any important religious influences in the patient's life (3). Reflecting this, many residency programs include some training in religion and spirituality. According to a recent survey by the George Washington Institute of Religion and Health, 102 of 144 medical and osteopathic schools have some sort of religion and spirituality training available, although not all of these are part of the mandatory curriculum (4). The content and format of this training is not described, and very little has been published about their effectiveness. Some literature does support the effectiveness of traditional classroom educational programs, in terms of self-reported increases in knowledge and skill base (5). However, it is not clear whether current educational programs translate into greater effectiveness. The APA's Office of Minority and National Affairs (OMNA) recommends several strategies to reduce mental health disparities in diverse ethnic groups. One strategy is to address stigma through workshops and symposia and foster collaborations between mental health professionals and faith and community leaders. One barrier to participating in community engaged scholarship such as this is the perceived absence of opportunities to collaborate with the community. Although media can serve as an effective means of increasing mental health awareness, many practicing mental health providers lack the technical expertise to develop multimedia outreach. This workshop will educate participants on means of utilizing media in addressing stigma.

**REFERENCES:**

1. Weaver et al. Trends in the scientific study of religion, spirituality, and health. J. Rel. and Health, 45, 208-214.
2. Worthington, et al. "Empirical research on religion and psychotherapeutic processes and outcomes." Psych.Bul., 119, 448-487.
3. American Psychiatric Association: Practice guidelines for the psychiatric evaluation of adults. Am J Psychiatry 1995; 152(11 suppl):64–80.
4. www.gwish.org
4. Grabovac et al. Pilot study and evaluation of postgraduate course on "the interface between spirituality, religion, and psychiatry". Academic Psychiatry 2008; 32:332-337.

# COURSE BROCHURE

## 2010 ANNUAL MEETING

# NEW ORLEANS, LA

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Kristen Moeller*, Director*

## Continuing Medical Education Courses

The American Psychiatric Association (APA) Scientific Program Committee for the Annual Meeting works in collaboration with the Division of Continuing Medical Education and the Annual Meetings Department to develop quality continuing medical education programs at the Annual Meeting. One aspect of this effort has been the development of short courses covering a single topic in depth and detail. Attendance is limited to allow participants greater opportunities for active participation.

Each of the courses described in this brochure was reviewed by the Scientific Program Committee and is judged to be of high educational quality. **Each course also meets the requirements for AMA PRA Category 1 Credits™.**

Courses provide an excellent opportunity for learning the essential skills of the psychiatric profession. They equip the participant with knowledge and practical skills to meet the challenges in his or her daily practice. Courses are designed for their educational content and accepted for the quality of their presentation, which provides for direct participant/faculty interaction in a small-group setting. All courses are designated for **AMA PRA Category 1 Credits™**.

Courses are one of the most popular formats at the Annual Meeting. All are encouraged to enroll early to avoid the potential disappointment of having first-choice selections filled.

### CME REQUIREMENTS

By referendum in 1974, the membership of the American Psychiatric Association endorsed participation in Continuing Medical Education (CME) activities as a condition of membership. The primary purpose of the requirement is to promote the highest quality psychiatric care and to encourage continuing professional growth of the individual psychiatrist.

Members must participate in 150 hours of CME activities during each three-year period. Of the 150 CME hours required, a minimum of 60 hours must be in category 1 activities. Category 1 activities are sponsored or jointly sponsored by organizations accredited for CME and meet specific standards of needs assessment, planning, professional participation and leadership, and evaluation.

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA designates these educational activities for **AMA PRA Category 1 Credits™** . Physicians should claim credit commensurate with the extent of their participation in the activity.

### EVALUATION

Category 1 activities require evaluation by the participants and faculty. Participants will be given the opportunity to evaluate their own learning through self-assessment of content and to provide feedback on the quality and value of their learning experience. Course directors and program planners for future activities will use this information.

## TAPE RECORDING POLICY

Audiotape recording is only permitted for personal use. Participants are welcome to use their own small, portable audiotape recorders to record any course **unless the course description states otherwise**. Larger professional tape recorders, however, are not permitted. Participants are **not permitted to videotape courses** because the intrusive nature of the process may disrupt the session.

## COURSES

Since most of the spaces in the courses fill quite early, you are encouraged to enroll in advance to ensure the availability of space in the course(s) of your choice.

The Subcommittee on Courses has endeavored to develop a balanced course program to cover all aspects of psychiatry, so that courses will be available to participants regardless of their specific interests. The courses have been scheduled throughout the week to minimize conflicts with other program offerings.

This year, 82 Continuing Medical Education Courses will be offered at the Annual Meeting in New Orleans, LA ; five (5) Master Courses; thirty-one (31) will be offered for the first time. Forty-six (46) courses that were evaluated most favorably last year will be updated and repeated. The courses are divided into half-day (four hours) and full-day (six hours or eight hours) sessions. All courses will be held at the Sheraton Hotel , New Orleans and the Morial Convention Center.

**Please be advised that children are not permitted to attend courses with their parent(s).**

## COURSE FEES

| | Early Bird |
|---|---|
| Half-day (4 hrs.) | $130 |
| Full-day (6 hrs.) | $190 |
| Full-day (8 hrs.) | $230 |
| Master Courses | $295 |

| | Advance | On-Site |
|---|---|---|
| Half-day (4 hrs.) | $150 | $170 |
| Full-day (6 hrs.) | $220 | $250 |
| Full-day (8 hrs.) | $270 | $310 |
| Master Courses | $320 | $350 |

**MASTER COURSE FEES – Include a Book**

Specific fees are listed with each course description. Please take time to ensure that the proper fees for both registration and your course selection(s) are enclosed when filling out the Advance Registration and Course Enrollment Form. **Although registration fees are waived in some cases (see the advance registration form for fee-exempt categories), all registrants who attend courses must pay the full course enrollment fee(s).**

## PRE-ENROLLMENT

Pre-enrollment for CME courses is open to **ALL** Annual Meeting registrants.
You are encouraged to enroll early during the pre-enrollment period to avoid the potential disappointment of having your chosen course(s) fully subscribed. Please note that requests will be processed on a first-come, first-served basis.

The maximum number of participants for each course is stated in the description, as well as the date, time, location, and fee.

Please use the Advance Registration and Course Enrollment form included in the Advance Registration Brochure or the on-site course enrollment form when making your selection(s). Please pay careful attention to the registration and enrollment procedures to ensure that the proper fees in U.S. dollars are sent.

Course spaces cannot be reserved; you must purchase a ticket.

All registration and pre-enrollment forms, faxed or mailed, must be **RECEIVED** at the APA on or before April 16, 2010. Registration for the annual meeting is required in order to purchase course tickets.

## ON-SITE ENROLLMENT

On-site course enrollment and registration will take place in the Morial Convention Center.

**Course enrollment hours are:**

| | | |
|---|---|---|
| Fri., | May 21: | 12:00 p.m.-5:00 p.m. |
| Sat., | May 22: | 7:00 a.m.-5:00 p.m. |
| Sun., | May 23: | 7:30 a.m.-5:00 p.m. |
| Mon., | May 24: | 7:30 a.m.-5:00 p.m. |
| Tue., | May 25: | 7:30 a.m.-5:00 p.m. |
| Wed., | May 26: | 7:30 a.m.-2:00 p.m. |

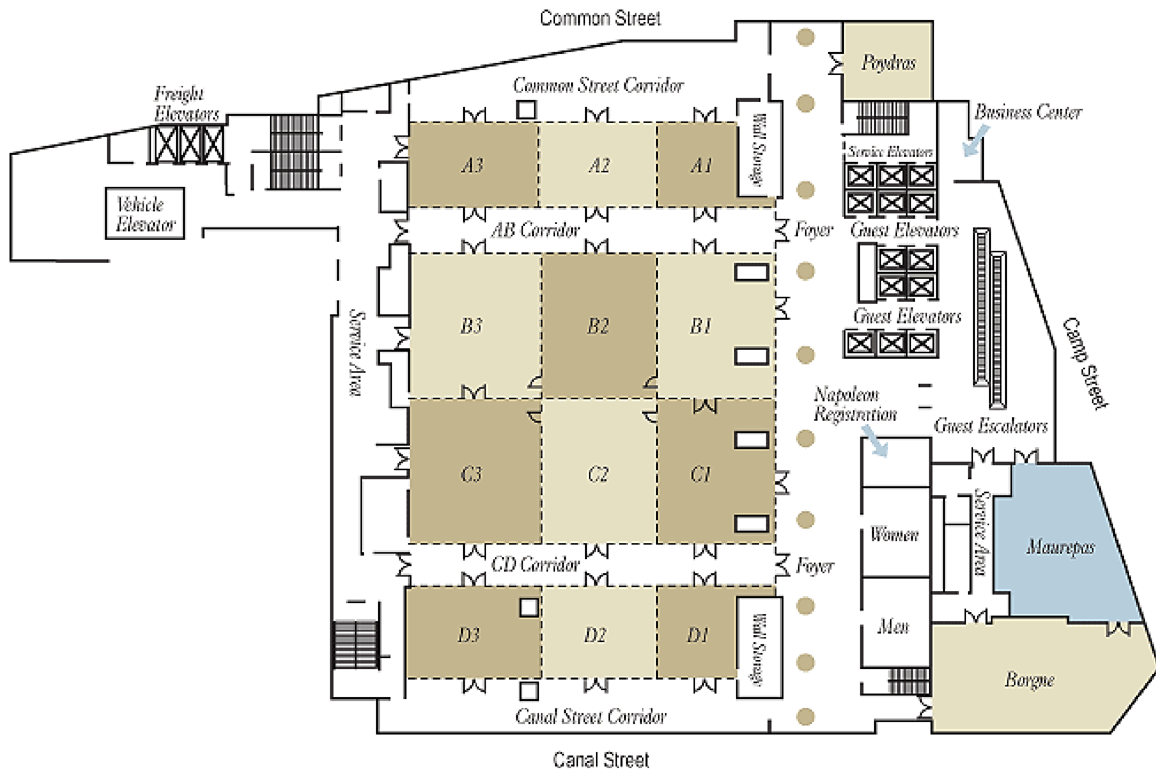
## REFUNDS

**After April 30, absolutely no refunds will be granted or changes in course selections permitted.**

Written notices of cancellations or changes **RECEIVED** postmarked by April 30 will be honored, less a $50 per course processing fee. There will be no exceptions to the refund policy. These written notifications should be addressed to:

Jolene McNeil
Association Director, Meetings & Conventions
American Psychiatric Association
1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209-3901
or fax to 703-907-1090 or email
registration@psych.org

**Sheraton New Orleans**
**HOTEL**




**Napoleon Exposition Hall and Ballroom**

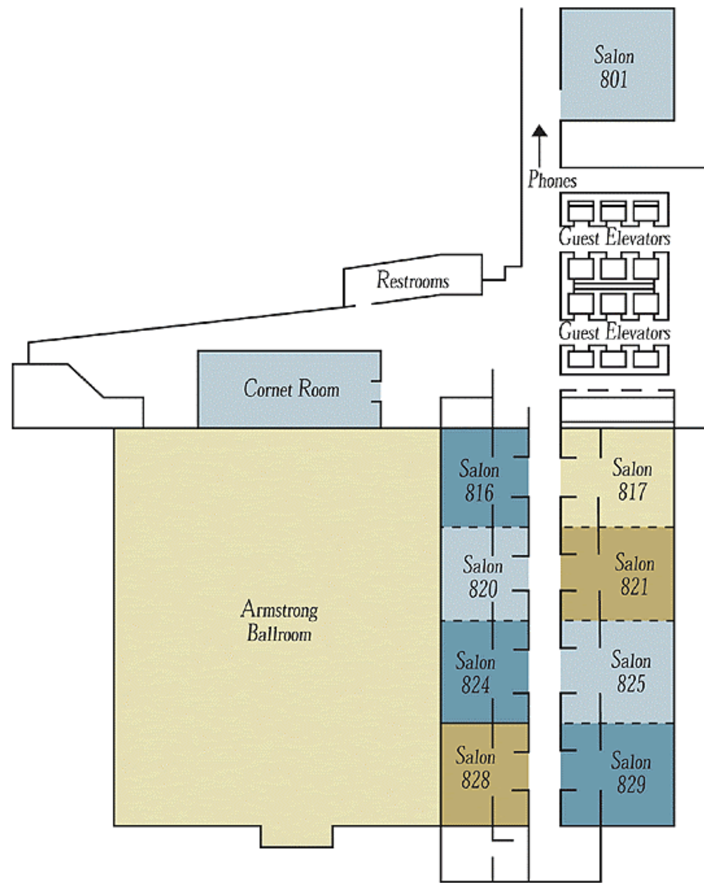
# Third Floor

Fourth Floor

Sheraton Hotel

Fifth Floor

Sheraton Hotel

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# MASTER COURSES

## Master Course 01 Update on Pediatric Psychopharmacology

**Topic: Child & Adolescent Psychiatry/Psychopharmacology**

**Director:** Christopher J. Kratochvil, M.D.
**Faculty:** Christopher McDougle, M.D., John Walkup , M.D.

**Educational Objectives:**At the conclusion of this session, the participant should be able to: 1) Current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders; 2) Practical clinical use of psychopharmacology and management of adverse effects; and 3) Recent research on pharmacotherapy in common psychiatric disorders of childhood.

**Description:** Objective: The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents in their practices. Methods: This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorders. The role of pharmacotherapy in the treatment of these disorders will be addressed, as will practical clinical aspects of using psychotropic medications in the treatment of children and adolescents. Management of adverse effects will be reviewed as well. Awareness of recent research data will help to facilitate an understanding of the basis for current clinical guidelines for the treatment of these psychiatric disorders. Clinically relevant research will be reviewed, within the context of clinical treatment. Conclusion: Awareness of recent research and practice parameters on the use of pediatric psychopharmacology, and the application of this information to clinical practice, can inform and positively impact patient care.

**Course Level:** Intermediate
**Format:** Lecture

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours;**

**Morial Convention Center; Spaces Available: 290**

**Early Bird $295; Advance $320; On Site $350**

## Master Course 02 - Staying on the Cutting Edge of Advances in Clinical Psychopharmacology

**Topic: Psychopharmacology/ Child & Adolescent**

**Director:** Alan Schatzberg, M.D.
**Co Director:** Ira D. Glick, M.D.
**Faculty:** Charles DeBattista, M.D., Kiki Chang, M.D., Terence Ketter, M.D., Natalie Rasgon, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to; Demonstrate knowledge of treatment for: Depressive Disorders, Bipolar Disorders and Schizophrenia and Child Psychopharmacology & Special Issues Associated With Disorders in Women.

**Description:** Rapid advances in neuroscience, drug development and clinical research have made it very difficult to keep up with advances applicable to clinical psychopharmacology, evidence based practice.This master's course, designed for psychiatric clinicians, will focus on the cutting edge issues every clinician needs to know to ensure quality of practice. Advances over the last year will be highlighted.The content focuses on five of the fields most commonly encountered in practice:

- depressive disorder
- bipolar disorders
- child/adolescent disorders
- women's health disorders and treatment
- schizophrenia

Course methodology will include not only carefully crafted overviews by experts in the field, but also immediate follow up of lecturers (with course participants) following the lecture. This follow up will be in a small group breakup session of 30 minutes.

**Course Level:** Intermediate
**Format:** Lectures and small-group discussion.

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours; Morial Convention Center; Spaces Available: 290**
**Early Bird $295; Advance $320; On Site $350**

## Master Course 03 Psychodynamic Psychotherapy

**Topic: Individual Psychotherapies, Psychoanalysis**

**Director:** Glen O. Gabbard, M.D.
**Faculty:** Robert Michels, M.D., John Gunderson, M.D., Gabrielle Hobday, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of contemporary strategies to approach resistance in psychodynamic psychotherapy; 2) Demonstrate knowledge of transference and countertransference issues involved in the treatment of VIP patients; and 3) Demonstrate knowledge of flexible approaches to the termination of dynamic psychotherapy.

**Description:** this course is designed to teach the fundamental principles and techniques in dynamic psychotherapy, including managing resistance, when and how to use therapeutic interventions, transference and countertransference, challenges with vip patients, and flexible strategies for termination in psychodynamic psychotherapy. Robert Michels will teach a conceptual model of thinking about the principle of resistance in psychodynamic psychotherapy and demonstrate how this understand-

ing of resistance informs therapeutic decision-making. Glen Gabbard will use dvd vignettes to stimulate discussion about the choice of therapeutic interventions, such as interpretation, clarification, observation, and confrontation, in the context of in-the-moment clinical decision-making. John Gunderson will present a case of a VIP patient he treated, and Glen Gabbard will comment on the particular challenges one faces when treating patients who are wealthy, famous, or infamous. Finally, the topic of termination of dynamic psychotherapy will end the course. Gabrielle Hobday will present clinical material involving complex termination issues, and Glen Gabbard will use that presentation to teach current thinking about flexible termination strategies rather than adhering to mythic constructs about the nature of termination

**Course Level:** Intermediate
**Format:** Lecture, DVD Vignette discussions, Case presentation with discussion

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 290**
**Early Bird $295; Advance $320; On Site $350**

## Master Course 04 Practical Cognitive-Behavior Therapy

**Topic: Cognitive Behavior Therapy**

**Director:** Jesse Wright, lll M.D.
**Faculty:** Robert Goisman, M.D., Donna Sudak, M.D.

Educational Objectives: At the conclusion of this session the participant should be able to: 1) Describe core CBT theories that offer practical guidance for psychiatric treatment; 2) Use basic cognitive and behavioral methods for depression: and 3) Use basic cognitive and behavioral methods for anxiety disorders.

Description: Cognitive-behavior therapy (CBT) is a highly pragmatic, problem-oriented treatment that is used widely in psychiatric practice. Clinicians who employ CBT work on modifying maladaptive cognitions and behaviors in an effort to reduce symptoms and improve coping skills. This course is designed to help clinicians learn the fundamentals of CBT, including the basic cognitive-behavioral model, the collaborative-empirical relationship, methods of structuring and educating, techniques for changing dysfunctional automatic thoughts and schemas, behavioral interventions for anxiety and depression, and strategies of improving medication adherence. Teaching methods include didactic presentations, video illustrations, role plays, and interactive learning exercises.

**Course Level**: Basic
**Format:** Lecture

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 290**
**Early Bird $295; Advance $320; On Site $350**

## Master Course 05 Neuropsychiatry for Verterans

**Topic: Neuropsychiatry**

**Director:** Stuart C.Yudofsky, M.D.
**Faculty:** Robin Hurley, M.D.
**Co Director:** Thomas Kosten, M.D.
**Faculty:** Thomas Kosten, M.D., Thomas Newton, M.D., Kimberly Arlinghaus, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) To demonstrate knowledge of the neurobiology of the neuropsychaitric disorders most commonly affecting veterans; and 2) To apply neurobiology to diagnosing and treating traumatic brain injury, addictive disorders and post traumatic stress disorder in veterans.

**Description:** U.S. Veterans returning from the wars in Iraq and Afghanistan suffer high prevalence of alcoholism and substance use disorders, post traumatic stress disorder, and traumatic brain injury. This course will review the neurobiology underlying these conditions and apply this understanding to the diagnosis and biopsychosocial treatment of the most prevalent and disabling neuropsychiatric conditions in veterans both in inpatient and outpatient settings.

**Course Level:** Basic
**Format:** Lecture and Videotapes

**Wednesday, May 26, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 300**
**Early Bird $295; Advance $320; On Site $350**

# SATURDAY
# MAY 22, 2010
## 8 AM- NOON

### Course 01 - Neuropsychiatric Masquerades: Medical and Neurological Disorders that Present with Psychiatric Symptoms

**Topic: Psychosomatic Medicine**

**Director:** Jose R. Maldonado, M.D.
**Co Director:** Paula Trzepacz, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand the pathophysiology of delirium and discuss research based, effective treatment options for delirium, including the use of atypical antipsychotic and other novel agents; 2) Understand the incidence, epidemiology and clinical features of the most common neuropsychiatric disorders masquerading as psychiatric illness; and 3) Understand the research based, effective treatment options for these conditions.

**Description:** Psychiatric masquerades are medical and/or neurological conditions which present primarily with psychiatric or behavioral symptoms. The conditions included in this category range from neurological disorders (e.g. seizure disorders and MS), to infectious diseases (e.g. syphilis, herpes and HIV), to connective tissue disorders (e.g. vasculitis and SLE), to malignancies (e.g., paraneoplastic syndromes and pancreatic cancer), to metabolic disorders (e.g. Wilson's disease and prophyria), to various toxins and substances our patients may be exposed to. In this lecture, we will discuss the presentation and symptoms of the most common masquerades, focusing on pearls for timely diagnosis, and discuss potential management and treatment strategies. A special attention will be paid to delirium and confusional states, presenting in both general medical and psychiatric setting.

**Course Level**: Intermediate
**Format: Lecture;** Q&A Sessions; Interactive Discussions

**Saturday, May 22, 2010, 8am Noon; Half Day 4 hours; Morial Convention Center; Spaces Available: 120**
**Early Bird $130; Advance $150; On Site $170**

### Course 02 Losing a Patient to Suicide

**Director:** Michael Myers, M.D.
**Faculty:** Carla Fine, M.S., Frank Campbell, Ph.D.

**Topic: Patient Safety & Suicide**

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Recognize how one might react to losing a patient to suicide; 2) Appreciate what family members and others close to the deceased might experience; 3) Know what to do to minimize the risk of malpractice litigation and cope with a lawsuit should this occur; 4) Learn how to reach out to grieving families and others; and 5) Take action to look after oneself.

**Description:** Suicides occur in clinical practice despite best efforts at risk assessment and treatment. It is estimated that fifty per cent of psychiatrists can expect to have at least one patient die by suicide, an experience that may be one of the most difficult professional times in their careers. Although many residents lose a patient to suicide during their training, some do not; further, scientific literature in academic psychiatry concludes that residents do not always receive adequate support and teaching on this matter. This course is designed to prepare psychiatrists for what is considered an occupational hazard of treating mentally ill patients. The faculty will cover the following issues: 1) psychological reactions to patient suicide, including the myriad variables that characterize the physician patient relationship; 2) malpractice litigation after suicide – minimizing and dealing with lawsuits; 3) reactions of family and friends to the loss of a loved one to suicide (the survivors' experience); 4) psychiatric morbidity in family members after death by suicide; 5) the clinician's roles and responsibilities after suicide, including outreach to survivors; 6) self care after losing a patient to suicide; 7) the role of psychological autopsy in the aftermath of suicide; 8) special circumstances: patient–suicide during residency; suicide death on an inpatient unit, while out on pass or immediately after discharge; suicide death of a child, adolescent or geriatric patient; murder suicide; physician suicide. Discussion with the faculty and other attendees is an essential feature of this course; registrants can expect to gain much new knowledge and become more comfortable with this very difficult dimension of professional life.

**Course Level:** Basic
**Format:** Brief lectures, powerpoint presentations, narratives, case examples, DVDs x 2, discussion and Q&A

**Saturday, May 22, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

### Course 03 Examining Professional Boundaries: Weighing Risks versus Opportunities

**Topic: Professional & Personal Issues**

**Director:** Gail Robinson, M.D.
**Faculty:** Gary Schoener, M.A., Linda Jorgenson, M.A., Gail Robinson, M.D., Howard Book, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Recognize the difference between a boundary violation and a boundary crossing, and 2) be

able to assess the risks and benefits to the patients of boundary crossings such as nonsexual touching, self disclosure, doing favours, and meeting outside of the office.

**Description:** This program will examine professional boundaries dilemmas from a variety of perspectives. Never in the history of psychiatry have there been more challenges in maintaining boundaries. Personal exposure via interactions on the internet have added greatly to the longstanding challenges of encounters with clients, their friends and relatives, in the social environment. On the other hand, there are now tempting tools to enable practitioners to "research" their clients. Although there are very clear rules about sexual misconduct with patients, many practitioners are less clear re issues such as non sexual touching, doing favours, time and place of meetings, socializing, self disclosure and managing dual relationships. While boundary violations are always harmful to the patient , the therapy and often the therapist, boundary crossings may offer the therapist an opportunity to gain access into his/her own unconscious inner world, as well as the unconscious inner landscape of his/her patient and develop insights which may facilitate the provision of therapy. Practitioners can benefit by learning ways of assessing potential boundary crossings in order to weigh the potential risks and benefits to the therapy. Through the use of vignettes from both presenters and audience we will examine a wide range of situations where boundaries are crossed, or may be crossed. We will also view some videotape examples of situations and discuss the pro's and con's of various actions. We will present a way of analyzing potential actions in order to avoid risk to the patient.

**Course Level:** Basic
**Format:** Lecture, videotapes, case vignettes, group discussion, sharing of participants' experiences

**Saturday, May 22, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $ 170**

# SATURDAY
# MAY 22, 2010
## 9 AM- 4 PM

## Course 04 An Overview of Sleep Medicine for the Mental Health Provider

**Topic: Sleep Disorders**

**Director:** R. Robert Auger, M.D.
**Co Director:** Thomas Hurwitz, M.D.
**Faculty:** Elliott Lee, M.D., Max Hirshkowitz, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Describe the basic features of the Sleep Disorders delineated in the *DSM IV TR;* 2) Recognize the manifold assessment strategies used in diagnosis; 3) Describe basic aspects of treatments, and develop thoughtful referral questions to the consulting sleep specialist; 4) Develop an appreciation for the multidisciplinary nature of the field; and 5) Become familiar with basic sleep/wake physiology.

**Description:** An understanding of the basic tenets of Sleep Medicine is essential for the mental health provider. The ubiquitous nature of sleep complaints among patients requires the knowledge to initiate treatment when necessary and/or refer thoughtfully to a sleep specialist when ambiguities arise. Many sleep disorders, including obstructive sleep apnea, insomnia, and restless legs syndrome, exhibit bidirectional influences with various psychiatric illnesses, creating an opportunity for enhanced treatment outcomes in the instance of proper diagnosis. In addition, many psychotropic agents can exacerbate or induce sleep complaints either directly or indirectly. This course will describe the basic features of the Sleep Disorders delineated in the *DSM IV TR,* highlight the manifold assessment strategies used in diagnosis, describe basic aspects of treatments, and enable the participant to develop thoughtful referral questions to the consulting sleep specialist. Participants will also develop an appreciation for the multidisciplinary nature of the field, and become familiar with basic sleep/wake physiology.

**Course Level:** Basic
**Format:** Lecture and Q & A sessions.

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 105**
**Early Bird $190; Advance $220; On Site $250**

## Course 05 A Practical Approach to Risk Assessment

**Topic: Forensic Psychiatry**

**Director:** William Campbell, M.D., M.B.A.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Identify risk factors for suicide and violence; 2) Formulate risk assessments for suicide and violence; and 3) Develop risk reduction plans for suicide and violence.

**Description:** This course shows participants how to employ a systematic approach to risk assessment in psychiatric patients. Risk and protective factors for suicide and violence will be reviewed and a paradigm will be presented with which to organize historical data. Videotaped interviews of patients with suicidal and homicidal ideation will be shown. Following each of these videotapes, participants will develop a risk reduction plan under faculty supervision. Psychiatric negligence and malpractice reduction in regard to risk assessment will also be reviewed.

**Course Level:** Basic
**Format:** PowerPoint presentation, videotaped interviews, work-

shop with presentation exercises and group discussion.

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $190; Advance $220; On Site $250**

## Course 06 Child and Adolescent Psychiatry for the General Psychiatrist

**Topic: Child & Adolescent Psychiatry**

**Director:** Robert Hendren, D.O.
**Co Director:** Malia McCarthy , M.D.

Educational Objectives: At the conclusion of this presentation, the participant should be able to: 1) Identify realistic expectations for situations in which a general psychiatrist might evaluate or treat a child or adolescent; 2) Utilize techniques for adapting the interview and assessment to the age and developmental level of the youth; 3) Identify key etiologic and diagnostic factors associated with disorders commonly presenting in youth describe age appropriate pharmacologic and non pharmacologic interventions. Description: General psychiatrists are often asked to evaluate and treat children and adolescents, especially in rural and underserved areas. While a portion of general psychiatry training is spent evaluating and treating children, it is often difficult to stay up to date on child and adolescent psychiatry and general psychiatrists may be uncomfortable working with youth. This course is designed as a review and update of current child and adolescent psychiatry geared to the general psychiatrist with an interest or need to evaluate and possibly treat children.

**Course Level**: Intermediate
**Format:** Lecture, case vignettes and Q & A

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 145**
**Early Bird $190; Advance $220; On Site $250**

## Course 07 Complementary and Integrative Treatments for Stress, Depression, Anxiety, PTSD, Mass Trauma, Cognitive Function, ADD, and Schizophrenia

**Topic: Other Somatic Therapies**

**Director:** Patricia Gerbarg, M.D.
**Co Director:** Richard Brown, M.D.
**Faculty:** Monica Vermani, M.A., Patricia Gerbarg, M.D., Richard Brown, M.D., Martin Katzman, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Identify complementary treatments, including herbs, nutrients, and mind body practices for which there is sufficient evidence of safety and efficacy for use in clinical practice; 2) Understand the mechanisms of action, risks, and benefits of those complementary treatments; and 3) Have the tools to pursue further information and updates on treatments he or she will consider using in practice.

**Description:** Participants will learn how to integrate complementary treatments with standard treatments in psychiatry practice to optimize patient outcomes. The course focuses on research and clinical applications of complementary treatments for which there is sufficient evidence of safety and efficacy. The authors have selected those treatments that are the most useful for clinicians to integrate into their practices from the following categories: herbs, adaptogens, nutrients, nootropics, hormones, mind body practices, cranial electrotherapy stimulation, and neurotherapy. Evidence for efficacy and clinical practice guidelines for integrative approaches will include the following diagnostic categories: Anxiety Disorders, PTSD, Depression, Bipolar Disorder, Fatigue, Cognitive Enhancement, Brain Injury, ADD,and Schizophrenia.Participants will be given an introductory experience of breath techniques that rapidly relieve stress and anxiety. Those interested in learning more about how to use mind body practices for their own well being as well as how to teach breath practices to their patients may also sign up for our full day course: Yoga of the East and West: Integrating Breath Work and Meditation into Clinical Practice.While this course is a repeat of last year's course, it will contain new sections and updated information on topics previously covered.

**Course Level:** Basic
**Format:** Lecture, Q & A, experiential

**Saturday, May 22, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 125**
**Early Bird $190; Advance $220; On Site $250**

# SATURDAY MAY 22, 2010

## 1PM- 5PM

## Course 08 Brain Stimulation Therapies in Psychiatry

**Topic: Other Somatic Therapies**

**Director:** Ziad H. Nahas, M.D.
**Faculty:** Linda Carpenter, M.D., Darin Dougherty, M.D., Husain Mustafa, M.D.

**Educational Objectives:** At the conclusion of this course, the participant should be able to: 1)Recognize the different brain stimulation modalities like ECT, TMS, VNS, DBS, tDC and other; and 2)Their role in treating neuropsychiatric conditions.

**Description:** This 4 hour course describes the various brain stimulation techniques and how they are playing in role in the therapeutic arsenal. It addresses a growing interest in therapeutic use of somatic intervention in neuropsychiatric conditions.

Originally limited to electroconvulsive therapy (ECT), now many new modalities have shown potential benefit for treatment resistant conditions like depression, hallucinations and OCD. These modalities can be generally grouped by their property of rely on an induced seizure or not to affect a therapeutic change. Of course ECT has been available for decades but more recently the US FDA approved Vagus Nerve Stimulation (VNS) Therapy for depression and a number of other therapies are in various stages in their pivotal studies and regulatory approvals (like Transcranial Magnetic Stimulation (TMS) and Deep Brain Stimulation (DBS)). The course describes the backdrop of functional neuroanatomy of major neuropsychiatric conditions and principals of electrical neuromodulations.(1 hour) The faculty will then details Convulsive Therapies (ECT [briefly since well covered in other symposia and workshops], Magnetic Seizure Therapy (MST) and Focal Electrically Administered Seizure Therapy (FEAST).(1 hour)The faculty will then details Sub Convulsive Therapies (TMS [briefly since well covered in other CME course], VNS, DBS, Cortical Electrical Stimulation (CES), Focal Electrically Administered Therapy (FEAT), transcranial Direct Electrical Current (tDEC) and Responsive NeuroStimulation (RNS) by focusing on data form clinical studies in mood disorders, as well as anxiety disorders, schizophrenia, obesity, Alzheimer disease and migraine headaches). Each modality will also be described in terms of its postulated mechanisms of actions and clinical set up.(2 hours)

**Course Level:** Basic
**Format:** Lectures, video and discussions

**Saturday, May 22, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 120**
**Early Bird $130; Advance $150; On Site $170**

## Course 09 Neuroanatomy of Behavior: An Introduction

**Topic: Biological Psychiatry & Neuroscience**

**Director:** David Clark, M.D.
**Co Director:** Nash Boutros, M.D.
**Faculty:** Mario Mendez, M.D.

**Educational Objectives:** At the conclusion of this course, the participant should be able to: 1) Recognize and describe the major behaviorally significant subdivisions of the brain; 2) Describe the functions of the cortical lobes with special emphasis on the frontal lobe as they relate to behavior; 3) Identify and describe the behaviorally significant components of the basal ganglia; and 4) Identify and describe the behavior controlled by the structures that make up the limbic system.

**Description:** Literature in print and on line available to the professional and general public describing brain structure as it relates to mental illness is becoming more and more sophisticated. The goal of our course is to present the attendee with a review of anatomy coupled with current views of behaviorally important brain function in a simplified, easy to remember format. The course begins with a review of basic brain anatomy with emphasis on the brain subdivisions that are recognized as important in behavior. Coverage will continue with an in depth look at the anatomy and function of the frontal and temporal lobes. The occipital and parietal lobes will also be examined. The basal ganglia and their role in movement disorders and related behavior including obsessive compulsive disorder will be discussed. The limbic system will be defined. The function of each component will be described. Interactions with other brain systems will be presented and related to clinically important behavior. The living brain is a complex structure especially as seen through imaging studies that reflect behavior and mental disease. Our goal is to provide the attendee with a simplified view of the workings of those portions of the brain that are of particular importance to the psychiatrist.

**Course Level:** Basic
**Format:** lecture / discussion

**Saturday, May 22, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

## Course 10 Time Limited Dynamic Psychotherapy: An Attachment based/Relational/Experiential Approach

**Topic: Individual Psychotherapies**

**Director:** Hanna Levenson, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Outline the basic principles and techniques of TLDP; 2) Use the procedures for obtaining a dynamic focus and for keeping the therapy attuned to specific goals; 3) Identify relational opportunities for shifting life long personality patterns, including transference countertransference reenactments; and 4) Tailor interventions to undermine the client's cyclical maladaptive pattern.

**Description:** Time limited, dynamic psychotherapy (TLDP) offers an empirically supported model that integrates current developments in relational psychodynamic approaches, an attachment based frame, emotionally focused experiential work, and interpersonal neurobiology. The purpose of this course is to be of practical and pragmatic help to therapists in making "every session count." TLDP emphasizes identifying the dysfunctional maladaptive patterns currently co created in the patient's life and often evidenced within the therapeutic relationship. By privileging experiential learning over insight through interpretation, TLDP significantly broadens the use of short term dynamic therapy to include individuals with chronic interpersonal problems (e.g., those with personality disorders). The course content will include a description of the basic principles and techniques of TLDP. Videotaped examples of actual therapy sessions will be used to illustrate. Video segments will demonstrate how the therapist can use information about the patient's in-

terpersonal difficulties combined with the problematic aspects of the client therapist relationship (transference countertransference reenactments) to discern the client's cyclical, maladaptive pattern. There will be material (with video) on how to use specific strategies with resistant or well defended clients. Discussion involving participants' anticipating what the therapist will say using stop frame video technique will make the learning "come alive." Throughout the course, the focus will be on how to achieve empathic attunement to core affects. The TLDP approach is built on the premise that one can do therapy that is both clinically rich, deep, and time efficient. Real clinical material provides a "how to do it" focus, and creates a bridge from theory to actual practice.

**Course Level:** Intermediate
**Format:** Lecture, Q & A, and video recorded clinical sessions.

**Saturday, May 22, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

# SUNDAY
# MAY 23, 2010
## 8 AM - 12 NOON

### Course 11 How to Give a More Effective Lecture: Punch, Passion and Polish

**Topic: Psychiatric Education**

**Director:** Phillip Resnick, M.D.

**Educational Objectives**: At the conclusion of this session, the participant should be able: to improve techniques for holding audience attention, involving the audience and using slides effectively.

**Description:** This course will provide practical advice on how to make a psychiatric presentation with punch, passion, and polish. Instruction will be given on planning a scientific paper presentation, a lecture, and a half day course. The course leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge. Participants will be told that they should never (1) read while lecturing; (2) display their esoteric vocabulary; or (3) rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Pitfalls of PowerPoint will be illustrated. Advice will be given on the effective use of videotape vignettes. A videotape will be used to illustrate common errors made by lecturers. The course will also cover preparation of handouts. Finally, participants will be strongly encouraged to make a three minute presentation with or without slides and receive feedback from workshop participants. Participants should plan to bring PowerPoint slides on CD or memory stick.

**Course Level:** Basic
**Format:** Lecture, videotapes and practice exercises.

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 110**
**Early Bird $130; Advance $150; On Site $170**

### Course 12 Emergency Psychiatry Course: Theory to Practice

**Topic: Patient Safety & Suicide**

**Director**: Anthony Ng, M.D.
**Faculty**: Seth Powsner, M.D., Anthony Ng, M.D., Jon Berlin, M.D., Rachel Glick, M.D.

**Educational Objectives**: At the conclusion of this session, the participant should be able to:
1) Identify clinical & system issues in psychiatric emergencies; 2) Highlight clinical skills in the assessment of psychiatric emergencies, including suicidal & homicidal risk assessments, using pragmatic skills; 3)Assess for acute precipitants of psychiatric emergencies; 4) Identify strategies & some practical clinical management; and 5) Identify challenges encountered in emergency psychiatry and strategies to deal with them.

**Description:** One of the most important aspects of clinical psychiatry is the assessment and management of psychiatric crises and emergencies. The notion of emergency psychiatry has gained greater prominence with the deinstitutionalization of the chronically mentally ill several dedcades ago. However, over time, as community resources for mental health dwindled, though with an apparent increase demand and need for mental health services, psychiatric emergencies have become more critical in the continuum of care for those with mental illness. Such emergencies may occur in office settings, inpatient settings as well as emergencies rooms, as well as in the communities and other non traditional settings. When psychiatric emergencies occur, psychiatric clinicians are often unprepared to deal with the clinical and system issues surrounding the assessment and management of such emergencies. There are often numerous parties involved in this process. Clinicians are challenged in differentiating true clinical emergencies from social emergencies, which while demand intervention strategies, yet with different paradigms. There is also an intricate spectrum of medico legal and cultural issues that must be appreciated. Psychiatrists can have extremely important clinical and leadership roles in such scenarios. Recognition and classification of these diverse relationships is critical to help those affected with appropriate interventions. This entry level course will increase awareness of the role of emergency and crisis psychiatry. The

course faculty will provide their expertise from extensive clinical and research experience in emergency psychiatry. The participants will learn about the evaluation and risk assessment of patients in crisis. The participants will also learn about the management of psychiatric emergencies including complication from substance abuse and medical issues. Lastly, special issues in emergency psychiatry such as commitments, medico legal and cultural issues will be discussed. Lecture and discussion formats will impart fundamental and pragmatic skills to identify, assess, triage, and manage the range of psychiatric emergencies.

**Course Level:** Basic
**Format:** Lecture, role play, audience interactions, questions and answers, video.

**Sunday, May 23, 2010, 8am-Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 150**
**Early Bird $130; Advance $150; On Site $170**

## Course 13 Psychiatric Disorders in Pregnant and Postpartum Women: Infant Morbidity and Mortality

**Topic: Women's Health Issues**

**Director:** Margaret Spinelli, M.D.
**Co Director:** Katherine Wisner, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Provide an overview of the phenomenology and presentation of childbirth associated psychiatric disorders; 2) Provide pharmacological, behavioral or alternative treatments for pregnant and postpartum women; 3) Perform risk/benefit analysis of psychopharmacology during pregnancy and lactation; 4) Perform a thorough clinical and forensic psychiatric interview of women with postpartum psychosis; and 5) Understand legislation and psychiatric perspectives on infanticide.

**Description:** Purpose: Childbirth is unique in psychiatry as a major provoker of mental illness that comes with 9 months warning. As psychiatrists, a significant number of our patients are women of childbearing age. It is, therefore essential to understand the biopsychosocial model of psychiatry as it relates to childbirth and presented in this symposium. Assessing the risk of medication vs. the risk of mental illness on the mother and fetus will be discussed. A body of evidence is presented for the association between maternal mental illness, infant morbidity and infanticide.Content: The course is an extensive review of the identification, treatment and prevention of mood and psychotic disorders associated with childbirth. Attendees are provided with instruction on perinatal assessment and management. In addition, the faculty describes the association of maternal mental illness with suicide and infanticide.Method: Using slide presentation, four lectures will cover major areas of maternal mental illness: Management of the Pregnant and Lactating Patient with Psychiatric Illness; Identification and Treatment of Postpartum Psychiatric Disorders; Postpartum Psychosis: Rapid onset, Fluctuating course and "lucid" intervals; Infanticide and Neonaticide associated with mental illness. Infanticide cases to include the case of Andrea Yates are reviewed using slide and audiovisual presentations. Result: Attendees will be knowledgeable about the association between perinatal psychiatric disorders and short and long term adverse outcomes for the mother and family, particularly as it affects children including emotional, cognitive, physical health and development. Conclusion: Perinatal psychiatric mental illness is a major public problem and the most significant adverse event of childbirth. Importance. Psychiatrists are challenged to be knowledgeable about diagnosis and treatment decisions for women in all phases of childbearing to include pregnancy, postpartum and lactation.

**Course Level:** Basic
**Format:** Lecture and Videotape

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 140**
**Early Bird $130; Advance $150; On Site $170**

## Course 14 Motivational Interviewing for Routine Psychiatric Practice

**Topic: Behavior & Cognitive Therapies**

**Director:** Steven Cole, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Describe the 4 core elements of Motivational Interviewing (MI); 2) Describe the 3 core questions of UB PAP("ultra brief personal action planning"); 3) Explain how to use 4 basic and 3 advanced MI interventions to enhance UB PAP; 4) Use UB PAP and 7 MI skills in routine practice; and 5) Teach UB PAP to trainees, team members or colleagues.

**Description:** Motivational Interviewing (MI) is, most recently, defined as a "collaborative, patient centered form of guiding to elicit and strengthen motivation for change." There are 11 books on MI, over 800 publications and 180 clinical trials, 1200 trainers in 27 languages, and dozens of international, federal, state, and foundation research and dissemination grants. Four meta analyses demonstrate effectiveness across multiple areas of patient behavior including substance abuse, smoking, obesity, and medication non adherence. New data confirms the relevance of MI for psychiatrists: the life expectancy of patients with severe mental illness is 32 years less than age and sex matched controls and the risk of death from CV disease is 2 3x higher than controls. Despite this evidence and the compelling relevance of MI for general psychiatric practice, most psychiatrists still have little appreciation of the principles and practice of MI.Using interactive lectures, demonstrations, and role play techniques, this course offers psychiatrists the opportunity to learn the core concepts of MI, as well as 4 basic and 3 advanced MI techniques. The course will also introduce participants to the use of an innovative motivational tool, "UB PAP (ultra brief personal action planning)," developed by the course director (who is a mem-

ber of MINT: Motivational Interviewing Network of Trainers). Research on UB PAP was presented at the First International Conference on MI (Interlaken, Switzerland 2008), as well at the Institute of Psychiatric Services (2009), the CDC (2009), and the HRSA Office of Rural Health Policy (2009). UB PAP was published by the AMA in its 2008 "Tipsheet for Physician Self Management Support." Participants will learn how to utilize the 3 core questions of UB PAP in a manner consistent with the 'spirit of motivational interviewing.' For patients more refractory or resistant to change, attendees will practice 7 evidence based MI skills. The 3 core questions of UB PAP supplemented by 7 focused MI interventions represent an integrated set of "comprehensive motivational interventions (CMI)" which are relevant for patients across the full spectrum of readiness to change. Though designed as a basic course, the program will also be useful to practitioners with intermediate or advanced experience in MI (or other behavior change skills) because they will learn how to integrate UB PAP and MI for brief clinical interventions and/or training programs.

**Course Level:** Basic
**Format:** Lectures, Video Demonstrations, Role Play Demonstrations, Role Play Practice, Interactive Discussions, and Small Group Discussions

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 80**
**Early Bird $130; Advance $150; On Site $170**

## Course 15 Cognitive Behavioral Therapy for Insomnia Co morbid With Depressive and Anxiety Disorders

**Topic: Sleep Disorders**

**Director:** Rachel Manber, Ph.D.
**Faculty:** Anne Germain, Ph.D., Jack Edinger, Ph.D., Colleen Carney, Ph.D., Rachel Manber, Ph.D., Jason Ong, Ph.D.

**Educational Objectives:** At the conclusion of this course, the participant should be able to: 1) Diagnose and conceptualize insomnia in patients with co morbid depressive and anxiety disorders; and 2) Have the tools to provide cognitive behavioral therapy for insomnia and recognize when a referral to a sleep specialist is indicated.

**Description:** Purpose: This course will provide mental health professionals the skills needed to assess, conceptualize, and use cognitive behavioral therapy (CBT) to treat insomnia in their patients. Importance: It is now increasingly recognized that even when insomnia initially emerges as a symptom of depression or anxiety disorder, it can develop into a comorbid condition that merits focused treatment. Untreated, insomnia may aggravate, complicate recovery, and persist even after the comorbid condition is successfully treated. CBT for insomnia is a brief focused therapy that is grounded in the principles of cognitive behavioral therapy and rooted in the most current scientific knowledge about the regulation of sleep. There is strong empirical support for the short and log term efficacy of CBT for primary insomnia and mounting evidence that it is also effective for comorbid insomnia. Content: This course will include five presentations by experts in the field of CBT for insomnia. The first presentation (Rachel Manber) will provide a rationale for using CBT for the treatment of insomnia in psychiatric disorders, discuss the pathophysiology of insomnia (including the regulation of sleep), case conceptualization and the assessment of insomnia. The second presentation ((Jack Edinger) will present the components of CBT for insomnia and review the outcome literature. The third presentation (Jason Ong) will discuss the application of mindfulness based stress reduction techniques in the context of treating insomnia. The fourth and fifth presentation will highlight considerations for adapting CBT to patients with depressive disorders (Colleen Carney) and anxiety disorders (Anne Germaine). These two presentations will also discuss the available evidence that CBT for insomnia is effective for improving insomnia comorbid with these psychiatric conditions and for improving psychiatric endpoints. For example, a recent controlled pilot study of patients with comorbid MDD and insomnia found that adding CBT for insomnia to the antidepressant escitalopram was associated with a significant increase in the rate of full remission of MDD relative to escitalopram plus a control insomnia therapy.Methodology: The course will include didactic presentations and will provide opportunity for role play and small group practice exercises.

**Course Level:** Basic
**Format:** Lecture, demonstrations, small group practice

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $130; Advance $150; On Site $170**

## Course 16 Mood Disorders in Later Life

**Topic: Geriatric Psychiatry**

**Director:** James Ellison, M.D., M.P.H.
**Co Director:** Yusuf Sivrioglu, M.D.
**Faculty:** Brent Forester, M.D., James Ellison, M.D., Donald Davidoff, Ph.D., Patricia Arean, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Implement a systematic approach for evaluating patients with late life mood disorders; 2) Guide treatment planning by drawing upon a range of evidence based somatic and psychotherapeutic approaches; and 3) Understand more fully the interrelationships between mood disorders and cerebrovascular disease in older adults.

**Description:** Clinicians who work with older adults must be able to detect, accurately diagnose, and effectively treat late life mood disorders. These disorders are widespread and disabling, and clinicians are more frequently faced with affected patients as a result of increasing longevity, greater acceptance of mental health care seeking by older adults, and advances in diagnostic

and treatment resources. This course provides an interdisciplinary overview of late life unipolar and bipolar mood disorders. The attendee should acquire an organized approach to assessment, a systematic and evidence based approach to treatment planning and choice among various modalities, an updated understanding of the relationship between cerebrovascular disease or other medical factors and geriatric mood disorders, and a greater awareness of the interactions between mood and cognitive symptoms. The discussion of psychotherapy for older adults with mood disorders will review evidence based approaches with particular emphasis on cognitive behavior therapy. The faculty will lecture, using slides, with time for interactive discussions between attendees and faculty members. This course is designed primarily for general psychiatrists seeking greater understanding and expertise in treating older patients. For psychiatric residents, this will be an advanced introduction. For geriatric psychiatrists, we will provide a review and update. This course will be of greatest practical value to attendees who treat older adults and already possess a basic familiarity with principles of pharmacotherapy and psychotherapy.

**Course Level:** Intermediate
**Format:** Lecture format.

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $130; Advance $150; On Site $170**

## Course 17 Mental Health Care of University Student Populations: A Practical Overview for Psychiatrists

**Topic: Psychiatric Administration & Services: Public, Private & University**

**Director:** Doris Iarovici, M.D.
**Co Director:** Ayesha Chaudhary, M.D.
**Faculty:** Hollister Rogers, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to 1) Identify major trends in diagnosis and treatment for university student populations; 2) Understand psychiatric symptom presentation within the context of the emerging adult developmental stage with a consideration for relevant cultural factors; 3) Learn strategies for interfacing with university administration and staff and 4) Learn strategies for building a referral base within the university student community.

**Description:** In the past decade, mental health problems among university students have increased in both incidence and severity , yet research and education about this population's needs remains scarce. Historically psychiatrists had minimal roles in college counseling centers, but as the public becomes more educated about the neurobiology of mental health, and due to high profile tragedies such as the massacre at Virginia Tech, there's more demand for specialized expertise. The use of psychiatric medications among college aged students has tripled—from 9% in 1994 to 26% in 2008. By reviewing the unique challenges and opportunities inherent in this population, this course will prepare psychiatrists both within university centers and in private practice to more effectively treat students. Faculty will review the epidemiology and changing demographics of university students in the US and introduce practical clinical and administrative skills for treating students. Because many affective, anxiety and psychotic disorders first present in this age group, we will examine how to differentiate first episodes of emerging psychopathology from developmentally normal crises. Other topics covered will include: 1)multicultural and international student concerns; 2)violence and suicide on campus, 3) ethics of psychotropic medications for enhancement versus treatment, including challenges of stimulants on campus; 4)identity formation, sexual orientation, academic pressure and the ambient campus climate (including the hook up culture, binge drinking, new drug use patterns); 5) new conceptualizations including "emerging adulthood" and "helicopter parents"; 6) how technologies impact students, from social networking to internet pornography, online gambling, and ready access to medications and drugs online. We will introduce a treatment framework for engaging students in care, including ways to weave complementary practices such as mindfulness meditation into treatment and how to collaborate effectively with faculty, deans and parents. We will also review techniques for building a "student friendly" practice.

**Course Level:** Basic
**Format**: Lecture, slides, case vignettes, discussion group, possibly video clips

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

## Course 18 Research and Publishing on a Shoe String Budget

**Topic: Research Issues**

**Director:** Mantosh Dewan, M.D.
**Faculty:** Michele Pato, M.D., Mantosh Dewan, M.D., Edward Silberman, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Recognize the key elements involved to generate testable hypotheses, formulate a research plan; 2) Analyse the data (sometimes with minimal help from a statistician); and 3) Publish the results in a refereed journal.

**Description:** This course would benefit junior faculty and clinicians (including the private practice setting) interested in doing research and in publishing despite minimal funding. It begins with a systematic explication of strategies for successful research, including a discussion of the need for research funds, sources for small amounts of money, and the advantages of collaboration. Examples of these strategies will be presented. A presentation on how to turn a notion into a testable hypothesis follows. Issues

of experimental design such as the null hypothesis, operationalising terms, defining the sample, dependent and independent variables, rating instruments and measures of change, analysis of data, and conclusions that can be drawn from your results, will be addressed. Ethical issues and Institutional Review Board requirements for the conduct of research will be detailed. An overview of statistics is presented. Then, faculty facilitated small groups will work on generating ideas and developing them into researchable projects (preferably requiring minimal funding). Finally, a presentation on getting your work published addresses how to choose the appropriate journal, the structure of research reports, difficulties in starting to write, pre submission reviews, and dealing with critiques and rejections. Discussion and interaction is encouraged throughout.

**Course Level:** Basic
**Format:** This course uses multiple, interactive formats: lectures to promote discussion; a problem solving group activity; small group work with individual participants.

**Sunday, May 23, 2010, 8am Noon; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

# SUNDAY
# MAY 23, 2010
## 9 AM- 4 PM

## Course 19 Essentials of Assessing & Treating Attention Deficit Hyperactivity Disorder in Adults and Children

**Topic: Attention Spectrum Disorders**

**Director:** Thomas E. Brown, Ph.D.
**Faculty:** Jefferson Prince, M.D., Anthony Rostain, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to 1) Recognize impairments caused by attention deficit disorders in adults or children; 2) Assess and diagnose adults or children for ADHD using appropriate instruments and methods; 3) Select appropriate medications for treatment of ADHD and comorbid disorders; and 4) Design multi modal treatment programs for adults or children with ADHD.

**Description:** Once understood as a disruptive behavior of childhood, ADHD is now recognized as developmental impairment of the brain's executive functions. Although initial diagnosis of ADHD is usually in childhood or adolescents, many individuals do not recognize their ADHD impairments until they encounter the challenges of adulthood. Yet many of these adults are not correctly diagnosed or effectively treated, especially if they are bright and their ADHD does not include hyperactivity. This comprehensive basic course for clinicians interested in treatment of adults and/or children and adolescents, will offer research and clinical data to provide: 1) an overview of the ways ADDs are manifest at various points across the lifespan with and without comorbid disorders; 2) descriptions of how ADDs impact upon education, employment, social relationships, and family life of adults; 3) a model that utilizes updated clinical and standardized psychological measures to assess ADDs; 4) research based selection criteria of medications for treatment of ADDs and various comorbid disorders; and 5) guidelines for integration of pharmacological, educational, behavioral and family interventions into a multimodal treatment plan tailored for specific individuals with ADHD.

**Course Level:** Basic
**Format:** Lectures, slides, case materials and discussion

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 115**
**Early Bird $190; Advance $220; On Site $250**

## Course 20 How to Blog, Tweet, Friend, Wiki, and Not Get Addicted: 21st Century Internet Technologies for Beginners

**Topic: Computers, Technology, Internet & Related**

**Director:** Robert Hsiung, M.D.
**Faculty:** Jerald Block, M.D., Steven Daviss, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Define social networking technologies; 2) Describe blogs, social networks, wikis, and virtual worlds; 3) Start a blog and find popular blogs and podcasts on psychiatric topics; 4) Create Twitter and Facebook profiles and "follow" and "friend" other Twitter and Facebook users; 5) Edit Wikipedia; 6) Discuss virtual worlds with their patients; 7) Describe factors that lead people to computer gaming; and 8) Identify pathological computer use.

**Description:** There's more to the Internet than Google. This course covers five types of 21st Century Internet technologies: blogs, Twitter, Facebook, wikis, and virtual worlds. We discuss the use of blogs, podcasts, and Twitter as methods of professional communication and education. We cover both the pros and the cons. We explore popular psychiatry blogs and podcasts. We review the technical aspects of creating a blogs and podcasts, including showing participants how to start a blog, to submit podcasts to iTunes, and to tweet. Social networking is in the news, practiced by psychiatrists, and the subject of research. We define it, review its evolution, and visit MySpace, LinkedIn, and Facebook. We show participants how to join Facebook, create a profile, choose security settings, "friend" others, upload photos, join groups, and install applications. Ways in which social networking can be detrimental are also reviewed. E professionalism is discussed, and a friending policy and procedure is recommended.We discuss wikis and demonstrate how to contribute

to Wikipedia.Nine computer games are sold every second in the United States. That's astounding! What are we to think? There has been a dearth of research exploring this new subject, one which is critically important but unfamiliar to many physicians. We introduce participants to the motivations and drives that attract people to computer gaming and virtual reality. We discuss normal and pathological computer use (PCU) and online sexuality. Using video clips and slides, we demonstrate various virtual worlds and what makes them so alluring.Wireless Internet access will be available, so participants who bring a laptop will have a hands on experience. All participants will benefit by learning more about what Generation Y is doing online, the potential benefits and risks of these technologies, and the safeguards that both psychiatrists and patients can take.

**Course Level:** Basic
**Format:** Lecture, demonstration, hands on following along **(participants who bring laptops)**, discussion.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 50**
**Early Bird $190; Advance $220; On Site $250**

## Course 21 EEG Feedback in Psychiatry: Clinical Applications

**Topic: Other Somatic Therapies**

**Director:** Thomas M. Brod, M.D.
**Co Director:** Michael Cohen, B.S.
**Faculty:** Ed Hamlin, Ph.D., Anne Stevens, Ph.D., Stephen Buie, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: Understand how EEG neurofeedback is applied in clinical psychiatric practice and the scientific and theoretical underpinnings of neurofeedback.

**Description:** EEG biofeedback (Neurofeedback) uses computer based technology to affect brain plasticity and accelerate positive clinical outcomes. How do you "train the brain" with EEG biofeedback to improve affect, attention and behavior? How do you train neuroregulation and neuromodulation by altering electroencephalographic patterns  and what are the clinical implications? How can neurofeedback (EEG biofeedback) be integrated into the practice of a reasonably tech savvy psychiatrist? Neurofeedback demonstrates the impact of information on the brain, creating functional (and, most likely, structural) changes that impact clinical syndromes. Beyond well known effects on arousal and attention mechanisms and its role in the treatment of ADHD, growing research publications and clinical experience have led to the application of neurofeedback in a wide range of disorders. With applications as disparate as mood and anxiety disorders, Tourette's syndrome, epilepsy, post traumatic brain injuries, attachment disorders, PTSD, substance abuse, and adolescent acting out, neurofeedback mirrors the scope of many general psychiatric practices. Neurofeedback is complementary to both psychopharmacology and dynamic psychotherapy. This course will focus on a few of those applications and offer resources for further study. Current research will be critically reviewed, and some of the fascinating theoretical issues of brain self regulation and plasticity will be noted, but essentially this six hour course will be directed with an eye on practical issues. Attendees also get to watch (or participate) in live demonstrations of several different available neurofeedback systems. Faculty are practitioners from several centers invited because of their exceptional teaching ability.

**Course Level:** Basic
**Format:** Lecture and demonstration.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 85**
**Early Bird $190; Advance $220; On Site $250**

## Course 22 Basic Concepts in Administrative Psychiatry I

**Topic: Psychiatric Administration & Services: Public, Private & University**

**Director:** Barry Herman, M.D.
**Co Director:** Douglas Brandt, M.D.
**Faculty:** L. Mark Russakoff, M.D., Shivkumar Hatti, M.D., David Nace, M.D., Sy Saeed, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Demonstrate a working knowledge of basic concepts in theoretical, human resources, fiscal, and information technological aspects of administrative psychiatry; and 2) Apply these concepts to psychiatric service systems.

**Description:** This is the first course of a two course series providing an overview of the theories, principles, concepts and developments relevant to administrative psychiatry. The first course covers broad areas of (1) Administrative Theory and Human Resources, (2) Fiscal Management, and (3) Advances in Information Technology. The first area includes the contributions of major management theorists; basic principles of delegating authority; management methodologies; program evaluation and computer utilization; organizational behavior; problem solving; decision making and implementation; principles and practices of human resources (including recruitment and selection, staff development and continuing education, performance evaluation, and labor management relations); and an overview of health technology as it applies to psychiatric administration.
Fiscal management includes the role and function of the financial manager within the mental health organization; the corporate structure and tax status of mental health facilities; methods and mechanisms for financing mental health care, including Medicare and Medicaid; accounting concepts; budgeting policies; program budgeting; zero base budgeting; cost effectiveness; fiscal controls; and automated financial systems. Health technology includes clinical support technologies; safety and privacy; connectivity strategies, population health, and personalized medicine. This course is intended to inform and assist psychia-

trists developing administrative aspects of their careers. Part II of the course addresses psychiatric care management, marketing tools and principles, legal and ethical aspects of administrative practice, and professional and career issues relevant to psychiatric administrators.

**Course Level:** Intermediate
**Format:** Lecture, PowerPoint presentation, case discussion, interactive discussion, and questions and answer sessions.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $190; Advance $220; On Site $250**

## Course 23 What is Psychiatry? Philosophies and Practices

**Topic: Psychiatric Education**

**Director:** S. Nassir Ghaemi, M.D., M.P.H.
**Co Director:** David H. Brendel, M.D.

**Educational Objectives:** At the end of this course, the participant should be able to: Understand the conceptual and philosophical aspects of psychiatric practice and research, including new recent work on the philosophies of pragmatism and pluralism as applied to psychiatry.

**Description:** In this course, we will review conceptual and philosophical aspects of psychiatry. These aspects of the field include philosophy of mind and philosophy of science. Applications of recent work in this field will be made by the co directors, both of whom have published books on this topic. Dr Brendel will present his material on the use of the philosophy of pragmatism to heal modern psychiatry. Dr. Ghaemi will present his research on the biopsychosocial model, its history, and his critique of its limits. He will also describe alternative models, including a model based on the philosophy of pluralism. Drs Ghaemi and Brendel will debate their alternative approaches, which share features but also differ, and the audience will be encouraged to engage actively in the discussion. The purpose of the course is to make psychiatrists more aware of, and thus able to constantly reflect on, the conceptual basis of their practice.

**Course Level:** Basic
**Format:** Lecture, small group discussion.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $190; Advance $ 220; On Site $250**

## Course 24 Treatment of Schizophrenia

**Topic: Psychopharmacology**

**Director:** Philip Janicak, M.D.
**Faculty:** Stephen Marder, M.D., Rajiv Tandon, M.D., Philip Janicak, M.D., Morris Goldman, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Describe the clinically relevant pharmacological aspect of first and second generation antipsychotic; 2) Understand their use for acute and chronic schizophrenia; 3) Describe recent approaches to integrating antipsychotics with psychosocial and rehabilitation programs.

**Description:** Treatment of schizophrenia and related psychotic disorders has rapidly evolved since the re introduction of clozapine in 1990. Six additional second generation antipsychotics in various formulations (i.e., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole and paliperidone ER) may soon be joined by others (e.g., asenapine, augmentation strategies). The relative efficacy of these drugs when compared with each other (e.g., CAFÉ trial in first episode psychosis) as well as with first generation antipsychotics (e.g., the CATIE and CUtLASS trials) continues to be clarified. Increasingly, safety and tolerability issues are the focus of attention, as well as strategies to improve cognition, mood and negative symptoms. The integration of psychosocial and rehabilitation programs with medication is also critical to improving long term outcomes. Our increased understanding of the psychopathology of schizophrenia will guide the development of yet another generation of agents and more effective use of maintenance strategies.

**Course Level:** Basic
**Format:** Lecture format with Q & A sessions

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 145**
**Early Bird $190; Advance $220; On Site $250**

## Course 25 Spirituality in Psychiatry

**Topic: Religion, Spirituality, & Psychiatry**

**Director:** Michael McGee, M.D.
**Faculty:** James Griffith, M.D., Christina Puchalski, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Discuss the relevance of spirituality to psychiatry; 2) Provide a working clinical definition of spirituality; 3) Describe how spiritual issues can be addressed clinically; 4) Communicate with patients and families about spirituality; and 5) Describe the role of compassionate presence in the treatment of patients.

**Description:** Spirituality is a universal, yet uniquely human, concern that the vast majority of patients that we treat hold to be important in their daily lives. The current body of research on spirituality and health suggests that spiritual health has a positive impact on both mental and physical health and well being, though the detailed natures of any causal relationships need to be better elucidated. The current biopsychosocial paradigm of psychiatry explicitly excludes attention to the spiritual concerns of our patients, necessitating the need for a new, "biopsychosocialspiritual" paradigm that incorporates the integrative and transcendent aspects of spirituality into a more "wholistic" mod-

el of psychiatry. This mixed didactic/experiential course discusses the relevance of spirituality to psychiatry, explores the integration of "spiritually attuned" clinical approaches into the daily practice of psychiatry and provides practical experiential exercises that address compassion and presence in the practice of psychiatry. At the end of the day, participants should be better equipped to begin practicing "biopsychosocialspiritual psychiatry."

**Course Level:** Basic
**Format:** Lecture and small group discussion.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $190; Advance $220; On Site $250**

## Course 26 Understanding the Person Behind the Illness: An Approach to Psychodynamic Formulation

**Topic: Diagnostic Issues**

**Director:** William Campbell, M.D., M.B.A.

**Educational Objectives:** At the conclusion of this session, the participant should be able to develop a psychodynamic formulation based on historical information obtained during a psychiatric interview.

**Description:** This course provides a systematic approach to the development of a psychodynamic formulation. Historical data obtained during a psychiatric interview will be organized into eight categories and then synthesized into a psychodynamic formulation. The faculty will present a psychodynamic formulation based on the information provided in a videotaped interview of a patient. Two additional videotapes of clinical interviews will be shown. Following each of these videotapes, participants will develop psychodynamic formulations under faculty supervision.

**Course Level:** Intermediate
**Format:** PowerPoint lecture, videotaped interviews, psychodynamic formulation model demonstration, workshop with formulation exercises, and group discussions.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $190; Advance $220; On Site $250**

## Course 27 Mindfulness: Practical Applications for Psychiatry

**Topic: Stress**

**Director:** Susan Abbey, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Define "mindfulness"; 2) Describe indications & contraindications for referral to mindfulness based therapeutic programs (MBTP) [e.g. MBSR,MBCT & MB Eat]or use with individuals; 3) List common characteristics of MBTPs; 4) explain how mindfulness approaches may be tailored to specific psychiatric disorders; 5) Answer patient's questions about how meditation impacts on brain function; and 6) Choose mindfulness practices that may reduce their own professional & personal stress.

**Description:** Mindfulness based therapeutic approaches are receiving increasing attention. They are used in both individual and group formats for a wide variety of common psychiatric problems. Most psychiatrists have received no training with respect to mindfulness and have little understanding of its value or of the clinical indications and contraindications for its use. This course will provide clinicians with a basic understanding of mindfulness and how it can be applied in the therapeutic context. The course will provide participants with both didactic material and the opportunity for experiential learning and small group discussion of common mindfulness practices. The course will provide an overview of the two most common mindfulness based therapeutic group interventions (MBSR & MBCT)and the empirical evidence for their use. Indications and contraindications will be reviewed. Participants will learn what to look for in programs prior to referring patients. The course will review how a mindfulness perspective can inform work with bodily sensations (e.g. pain) as well as distressing cognitions and affects. Recent neurobiological data on the impact of mindfulness interventions on brain biology will be summarized. Participants will learn about resources to allow them to develop their knowledge base and skills in this area. They will learn simple mindfulness practices that can reduce their own professional and personal stress and are easy to teach to patients.

**Course Level:** Basic
**Format:** Interactive format with didactic content delivered through lecture, videotapes of groups, experiential learning and small group discussion.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $190; Advance $220; On Site $250**

## Course 28 Yoga of the East and West: Integrating Breath Work and Meditation into Clinical Practice

**Topic: Stress**

**Director:** Patricia Gerbarg, M.D.
**Co Director:** Richard Brown, M.D.
**Faculty:** Monica Vermani, M.A., Patricia Gerbarg, M.D., Richard Brown, M.D., Martin Katzman, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Understand how Heart Rate Variability, sympatho vagal balance, and cardiopulmonary resonance contribute to stress resilience; 2) Experience Coherent Breathing for stress reduction and learn how to use it for patients; and 3) Experience Open Focus meditation for stress reduction, improved attention, relief of physical and psychological distress.

**Description:** Participants will learn the theoretical background and applications of two powerful self regulation strategies to improve their own well being and the mental health of their patients. A program of non religious practices will enable participants to experience "Coherent Breathing," Victorious Breath, Bellows Breath, and "Open Focus" meditation. Through a sequence of repeated rounds of breathing and meditation with gentle movements and interactive processes, participants will discover the benefits of mind/body practices. How to build upon this knowledge and use it in clinical practice will be discussed. An in depth case of a patient with posttraumatic stress disorder who benefited from the addition of yoga breathing to her ongoing therapy will be explored from the perspective of neuro psychoanalytic theory. This will also highlight clinical issues to consider when introducing mind/body practices in treatment. This course is suitable for novices as well as experienced practitioners.This course builds upon introductory material presented in the Course #7 "Yoga, Herbs and Nutrients in the Treatment of Anxiety, Post traumatic Stress Disorder, Depression, Bipolar, Cognitive Enhancement, Brain Injury, Attention Deficit Disorder, Schizophrenia, and Sexual Enhancement."

**Course Level:** Basic
**Format:** Lecture, Experiential teaching, Coaching in mind/body practices, Small group discussion

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 125**
**Early Bird $190; Advance $220; On Site $250**

## Course 29 Transference Focused Psychotherapy for Borderline Personality

**Topic: Personality Disorders**

**Director:** Frank Yeomans, M.D., Ph.D.
**Co Director:** Otto Kernberg, M.D.
**Faculty:** Eve Caligor, M.D., John Clarkin, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to understand: 1) The range of borderline personality pathology; 2) The split psychological structure that underlies borderline personality and ways of achieving an integrated psychological structure; 3) The strategies, tactics and techniques of effective psychodynamic psychotherapy for borderline personality; and 4) The role of research in advancing the psychotherapy of personality disorders.

**Description:** The treatment of patients with borderline personality disorder is one of the most challenging areas in psychiatry. Many clinicians are intimidated by the prospect, are pessimistic about the outcome, and consider stabilization of symptoms, without deep change in the personality, the best possible outcome. However, an increasing body of clinical experience and research shows that Transference Focused Psychotherapy (TFP) can help these patients achieve character change. TFP is a form of psychodynamic psychotherapy modified to address the borderline condition. It has been developed and is being researched at the Personality Disorders Institute of the Weill College of Medicine at Cornell University. This course will teach the participant the theory and techniques of TFP which, in practice, help the therapist provide effective treatment of this disorder with less chaos and stress than is usually associated with the treatment of borderline patients. The course will include an overview of object relations theory, which provides a way to understand the psychological structure of the borderline patient. The course will go on to describe the strategies, tactics, and techniques of the therapy, and will end with an overview of the research on TFP.

**Course Level:** Basic
**Format:** Lecture, clinical vignettes, and Q & A.

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours;**
**Morial Convention Center; Spaces Available: 80**
**Early Bird $190; Advance $220; On Site $250**

## Course 30 Advanced Interviewing Techniques

**Topic: Individual Psychotherapies**

**Director:** Shawn Shea, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Utilize 5 techniques for increasing validity: the behavioral incident, shame, attenuation, gentle assumption, symptom amplification, & denial of the specific; 2) Utilize interview strategy for eliciting suicidal ideation Chronological Assessment of Suicide Events(CASE Approach); 3) Utilize flexible strategy for rapidly arriving at differential diagnosis on Axis II of the *DSM IV TR*: and 4) Utilize practical strategies for responding to awkward personal inquiries and transforming patient anger.

Description: This course is designed to help front line clinicians handle some of the most difficult clinical situations that frequently arise in the initial assessment. Concrete validity techniques for uncovering sensitive and taboo topics, from domestic violence to antisocial behavior, will be presented including the behavioral incident, shame attenuation, gentle assumption, symptom amplification, and denial of the specific. An innovative interview strategy for eliciting suicidal ideation the Chronological Assessment of Suicide Events (CASE Approach) will be described, and demonstrated by videotape. A systematic strategy for rapidly, yet sensitively, performing an Axis II differential diagnosis using the *DSM IV TR* system is discussed and also demonstrated by videotape with a patient presenting with complex Axis II psychopathology. Finally, practical methods for transforming patient anger and for non defensively responding to awkward personal inquires and other statements that put the clinician "on the spot" are explored in detail. The course is designed for any front line clinician, from psychiatric resident to experienced interviewer, who routinely faces the clinical gremlins so common to the hectic practice of today.

**Course Level:** Intermediate
**Format:** Lectures, workshop interaction, videotapes, and role playing.

**Sunday, May 23, 2010, 9am 4pm; Spaces Available: 80 Full Day 6 hours; Morial Convention Center; Early Bird $190; Advance $220; On Site $250**

## Course 31 Autism Spectrum Disorders: Diagnostic Classification, Neurobiology, Biopsychosocial Interventions & Pharmacologic Management

**Topic: Child & Adolescent Psychiatry**

**Director:** Kimberly Stigler, M.D.
**Co Director:** Alice Mao, M.D.
**Faculty:** James Sutcliffe, Ph.D., Mathew Brams, M.D., Eric Courchesne, Ph.D., Nora Friedman, M.D., Stephanie Hamarman, M.D., Julie Chilton, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: (1) Understand how to more accurately diagnose autism spectrum disorders (ASDs); 2) Assist parents with the development of an integrated biopsychosocial treatment plan; 3) Discuss emerging research findings on the genetics of autism; 4) Review new neurobiological findings in autism; and 5) Review the psychopharmacology of ASDs; and (6) Describeeducational and behavioral interventions for ASDs over the lifespan.

**Description:** Autism spectrum disorders (ASDs) are lifelong neuropsychiatric disorders characterized by impairments in social skills and communication, as well as repetitive interests and activities. Children and adolescents presenting with symptoms suggestive of an ASD require careful clinical assessment and diagnostic clarification. After diagnosis, parents often experience uncertainty regarding the selection of appropriate biopsychosocial interventions. Furthermore, the lack of a clear understanding of the etiology of autism and related disorders often is a source of parental distress. Although the cause of autism is unknown, investigators are actively researching the neurobiology of autism, via modalities such as genetics and neuroimaging, to enhance our understanding of this complex disorder. In addition to the core impairments of ASDs, youth and adults also frequently exhibit interfering behavioral symptoms, including hyperactivity and inattention, repetitive behavior, and irritability, that require pharmacologic and behavioral interventions. This course will provide the practicing psychiatrist with an essential knowledge base important to making accurate diagnoses, understanding key neurobiological findings, developing comprehensive biopsychosocial treatment plans, and treating maladaptive behaviors in children, adolescents and adults with ASDs.

**Course Level:** Basic
**Format:** Lecture, discussion

**Sunday, May 23, 2010, 9am 4pm; Full Day 6 hours; Morial Convention Center; Spaces Available: 175 Early Bird $190; Advance $220; On Site $250**

# SUNDAY MAY 23, 2010
## 1 PM - 5 PM

## Course 32 Multidisciplinary Treatment of Chronic Pain

**Topic: Pain Management**

**Director:** Vladimir Bokarius, M.D., Ph.D.
**Co Director:** Steven Richeimer, M.D.
**Faculty:** Yogi Matharu, D.P.M., Ali Nemat, M.D., Karen McNulty, OTD, OTR/L, Faye Weinstein, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Recognize the complexity of the chronic pain syndrome; 2) Demonstrate understanding of the role of different healthcare professionals in the treatment of chronic pain; 3) Identify specific methods of treatment of chronic pain; and 4) Recognize advantages of multidisciplinary approach in treatment of chronic pain.

**Description:** Chronic pain is estimated to affect 15% to 33% of the U.S. population. Pharmacological or other types of treatments help most people control their pain. However, for many patients currently available methods of pain treatment are either not effective or can cause serious side effects. Besides, comorbid mental disorders may significantly complicate the course of treatment. Our center utilizes the most advanced technology for patient's physical improvement, as well as treatment to strengthen the patients' emotional ability to cope with debilitating effects of pain, and to promote the patients' return to a fully productive life. The goal of this presentation is to show the role of the combined effort of different healthcare professionals in the treatment of chronic pain.
**Course Level:** Basic
**Format:** Lecture, video, case discussions.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours; Morial Convention Center; Spaces Available: 110 Early Bird $130; Advance $150; On Site $170**

## Course 33 Neuroanatomy of Emotions

**Topic: Biological Psychiatry & Neuroscience**

**Director:** Ricardo Vela, M.D.

**Educational Objectives:** At the conclusion of this presentation, the participants should be able to: 1) Describe the functional neuroanatomical interrelationships of the hypothalamus, amygdala, septal nuclei, hippocampus, and anterior cingulate gyrus; 2) Identify the major limbic fiber pathways, their trajectories, and their specific targets; 3) Describe how each limbic structure contributes to the specific expression of emotions and attach-

ment behavior; 4) Discuss neuroanatomical–emotional correlates in autism.

**Description:** The rapid development of new brain imaging techniques has revolutionized psychiatric research. The human brain, the organ of psychiatry, had been largely neglected, in the face of intensive basic science research at the neurochemical/synaptic level. Practitioners find themselves poorly equipped with knowledge about neuroanatomy and neurocircuitry to feel competent understanding this new level of analysis. Psychiatrists need to access new knowledge to allow them to understand emerging data from functional imaging research studies. This requires a fundamental background of underlying brain mechanisms involved in emotions, cognition and mental illness. This course will describe the structure of limbic nuclei and their interconnections as they relate to the basic mechanisms of emotions. Neuroanatomical illustrations of limbic nuclei, associated prefrontal structures and principal fiber systems will be presented. Drawing from classic neurobiological research studies and clinical case data, this course will show how each limbic structure, interacting with one another contributes, to the expression of emotions and attachment behavior. Three dimensional relationships of limbic structures will be demonstrated through the use of a digital interactive brain atlas with animated illustrations. The relevance of neuroanatomical abnormalities in autism and schizophrenia will be discussed.

**Course Level:** Intermediate
**Format:** Lecture with PowerPoint slides supplemented by anatomical 3 dimensional movies and question and
answer sessions.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 150**
**Early Bird $130; Advance $150; On Site $170**

## Course 34 Management of Psychiatric Disorders in Pregnant and Postpartum Women

**Topic: Women's Health Issues**

**Director:** Shaila Misri, M.D.
**Co Director:** Diana Carter, M.D.
**Faculty:** Shari Lusskin, M.D., Deirdre Ryan, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to have an increased awareness and improved ability to identify and treat psychiatric disorders that occur in pregnancy and postpartum.

**Description:** This course provides comprehensive current clinical guidelines and research updates in major depression, anxiety disorders (GAD, PD, OCD and PTSD) and eating disorders in pregnancy and the postpartum. This course will also focus on mother baby attachment issues; controversy and reality in perinatal pharmacotherapy; management of women with bipolar disorder and schizophrenia during pregnancy and the postpartum, with updates on pharmacotherapy; and non pharmacological treatments including light therapy, psychotherapies, infant massage and alternative therapies in pregnancy/postpartum. This course is interactive. The audience is encouraged to bring forward their complex patients with management problems or case vignettes for discussion. Videoclips will be used to facilitate discussion and encourage audience participation. The course is presented in depth and the handouts are specifically designed to update the audience on cutting edge knowledge in this sub specialty.

**Course Level:** Intermediate
**Format:** Lecture, videotapes/case vignettes and discussion.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 140**
**Early Bird $130; Advance $150; On Site $170**

## Course 35 Mentalization Based Treatment (MBT) for Borderline Personality Disorder (BPD): Introduction to Clinical Practice

**Topic: Personality Disorders**

**Director:** Anthony Bateman, M.R.C.
**Co Director:** Peter Fonagy, Ph.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the mentalizing problems of borderline personality disorder; 2) Recognise mentalizing and non mentalizing interventions; 3) Develop and maintain a mentalizing therapeutic stance; and 4) Use some basic mentalizing techniques in their everyday clinical work.

**Description:** Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as their own) leading to self awareness and other awareness. We have to be able to continue to do this in the midst of emotional states but borderline personality disorder (BPD) is characterized by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity in order to ensure the development of better regulation of affective states and to increase interpersonal and social function. In this course we will consider and practice interventions which promote mentalizing contrasting them with those that are likely to reduce mentalizing. Participants will become aware of which of their current therapeutic interventions promote mentalizing. The most important aspect of MBT is the therapeutic stance. Video and role plays will be used to ensure participants recognize the stance and can use it in their everyday practice. Small group work will be used to practice basic mentalizing interventions described in the manual. In research trials MBT has been shown to be more effective than treatment as usual in the context of a partial hospital program both at the end of treatment and at 8 year follow up. A trial of MBT in an out patient setting shows

effectiveness when applied by non specialist practitioners. The course will therefore provide practitioners with information about an evidence based treatment for BPD, present them with an understanding of mentalizing problems as a core component of BPD, equip them with clinical skills that promote mentalizing and help them recognize non mentalizing interventions.

**Course Level:** Basic
**Format:** Lecture, role plays, video tapes and large group discussion.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 80**
**Early Bird $130; Advance $150; On Site $170**

## Course 36 Fostering Adherence to Psychotropic

**Topic: Psychopharmacology**

**Director:** Luis Ramirez, M.D.
**Co Director:** Richard McCormick, Ph.D.
**Faculty:** David Robinson, M.D.

**Educational Objectives:** At the conclusion of this presentation, the participant should be able to:1) Recognize the role of the prescriber of psychtropic medication in fostering adherence; 2) Recognize the interventions that have been demonstrated to improve adherence; and 3) Better foster adherence to medication among the seriously mentally ill by developing a collaborative relationship, improving patient motivation, increasing patient expectations of positive outcomes and creating a relapse prevention plan

**Description:** Less than 60% of patients with serious mental illnesses are adherent to medications. While strides have been made in developing biological interventions, the efficacy reported for these approaches is based on an assumption of adherence. There is a pressing need to foster the implementation of practical approaches for improving adherence. Lack of adherence is a failure of treatment, and a failure of the collaborative effort between the patient, clinicians and significant others to foster long term recovery.This course is based on the best research existing today and will provide a set of practical tools that can be artfully tailored to the needs of an individual patient, at a particular point in his recovery, to facilitate adherence to medication. The reasons for non adherence to medications are better understood today. It has been demonstrated that adherence can be significantly improved with reasonable, achievable effort, and this effort pays for itself many times over. Multifaceted approaches work best. Non adherence is a complex phenomenon which can be attacked from multiple directions simultaneously. The literature supports practical interventions to achieve the following: establish a collaborative partnership with the patient; increase the patient's motivation; provide knowledge about their disease to facilitate insight and informed decisions; reinforce patients' positive expectations that medications will improve the things they value; enhance patients' self efficacy; build social supports that reinforce adherence; teach practical coping skills that enhance adherence; address the misuse of alcohol or other substances; develop an individualized relapse prevention plan focused on ongoing adherence; and assist the patient with problem solving through the practical barriers to adherence. Four areas will be covered in greater detail; collaboration, motivation, positive expectations, and relapse prevention, including practical assessments and interventions.

**Course Level:** Basic
**Format:** Lecture, Videotapes, Role playing
**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $130; Advance $150; On Site $170**

## Course 37 Interpersonal Psychotherapy (IPT)

**Topic: Individual Psychotherapies**

Director: John Markowitz, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to understand the basic rationale and techniques of interpersonal psychotherapy for depression, key research supporting its use, and some of its adaptations for other diagnoses and formats.

**Description:** Interpersonal psychotherapy (IPT), a manualized, time limited psychotherapy, was developed by the late Gerald L. Klerman, M.D., Myrna M. Weissman, Ph.D., and colleagues in the 1970's to treat outpatients with major depression. Its strategies help patients understand links between environmental stressors and the onset of their mood disorder, and to explore practical options to achieve desired goals. IPT has had impressive research success in controlled clinical trials for acute depression, prophylaxis of recurrent depression, and other Axis I disorders such as bulimia. This course, now in its 17th consecutive year at the APA Annual Meeting, presents the theory, structure, and clinical techniques of IPT along with some of the research that supports its use. It is intended for therapists experienced in psychotherapy and treatment of depression who have not had previous exposure to IPT. Please note: the course will not provide certification in IPT, a process which requires ongoing training and supervision.Participants should read the IPT manual: Weissman MM, Markowitz JC, Klerman GL: Comprehensive Guide to Interpersonal Psychotherapy. New York: Basic Books, 2000; or Weissman MM, Markowitz JC, Klerman GL: A Clinician's Quick Guide to Interpersonal Psychotherapy. New York: Oxford University Press, 2007.

**Course Level:** Intermediate
**Format:** Lecture with clinical vignettes. Role play of a therapeutic encounter and group discussion as time permits.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 75**
**Early Bird $130; Advance $150; On Site $170**

## Course 38 Internal Medicine Update: What Psychiatrists Need to Know

**Topic: Other Somatic Therapies**

**Director:** Monique Yohanan, M.D.
**Co Director:** Michele Pato, M.D.
**Faculty:** Robert Cobb, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Recognize disparities in medical outcomes of people with mental health conditions; 2) Be aware of current diagnostic and treatment options for cardiovascular disease risk factors, including hypertension, diabetes; 3) Be able to apply prevention strategies for common behavioral problems, such as smoking and lack of exercise; and 4) Be able to apply principles of evidence based medicine to the medical care of psychiatric patients.

**Description:** The past 30 years have been marked by significant gains in the prevention, diagnosis and treatment of cardiovascular disease and other medical conditions. Unfortunately, people with mental health conditions have not consistently shared in these gains. Their mortality rates are up to 50% higher than patients without psychiatric diagnoses, and these disparities are even higher among members of ethnic and racial minority groups. There are patient specific factors, such as high smoking rates, that likely account for some of these differences. People with schizophrenia have rates of smoking of 60% or higher. Other risk factors, including obesity, are similarly common, while health promoting behaviors, such as regular aerobic exercise, are less so.But in addition to behavioral contributions, the medical care that patients with psychiatric disease receive often differs from their counterparts without such illnesses. Patients with psychiatric disease commonly receive prescription medications, notably atypical antipsychotics, which increase their risk of cardiovascular morbidity and mortality as well as inducing other metabolic syndromes. Despite this known iatrogenic risk, these patients are unlikely to receive screening and follow up to prevent and manage likely complications. Further, there are marked differences in hospital based care. Patients with mental health conditions are treated for acute myocardial infarction often do not receive standard of care treatments as basic as even aspirin therapy. When interventional therapies, such as cardiac catheterization and coronary artery bypass grafting are indicated, a history of psychiatric disease decreases the likelihood that patients will receive necessary treatments by as much as 65%. This course will focus on both sharing existing data and providing you with some evidence base practices you might use to get your patients the best medical care in addition to their psychiatric care.

**Course Level:** Basic
**Format:** Lecture

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 120**
**Early Bird $ 130; Advance $ 150; On Site $170**

## Course 39 Melatonin and Light Treatment of SAD, Sleep and Other Body Clock Disorders

**Topic: Mood Disorders**

**Director:** Alfred Lewy, M.D., Ph.D

**Educational Objectives:** At the conclusion of this session, the participant should be able to: Use the salivary dim light melatonin onset and sleep time to phase type circadian sleep and mood disorders as to whether they are phase advanced or phase delayed and then treat them with appropriately timed bright light exposure (evening or morning, respectively) and/or low dose melatonin administration (morning or afternoon, respectively), monitoring treatment response using the DLMO/mid sleep interval, targeting 6 hours.

**Description:** This course will enable practitioners to advise patients on how to use melatonin and bright light to treat circadian sleep and mood disorders. There are two categories for these disorders: phase advanced and phase delayed. The prototypical patient with SAD (seasonal affective disorder, or winter depression) is phase delayed; however, some are phase advanced (Lewy et al., PNAS, March 9, 2006). Shift work maladaptation, non seasonal major depressive disorder (Emens, Lewy et al., Psychiatry Res., Aug. 15, 2009) and ADHD can also be individually phase typed and then treated with a phase resetting agent at the appropriate time. Phase advanced disorders are treated with evening bright light exposure and/or low dose (= 0.5 mg) morning melatonin administration. Phase delayed disorders are treated with morning bright light and/or low dose afternoon/evening melatonin administration. High doses of melatonin can be given at bedtime to help some people sleep. The best phase marker is the circadian rhythm of melatonin production, specifically, the time of rise in levels during the evening. In sighted people, samples are collected under dim light conditions. This can be done at home using saliva. Within a year or two, this test should become available to clinicians. The dim light melatonin onset (DLMO) occurs on average at about 8 or 9 p.m.; earlier DLMOs indicate a phase advance, later DLMOs indicate a phase delay. The circadian alignment between DLMO and the sleep/wake cycle is also important. Use of the DLMO for phase typing and guiding clinically appropriate phase resetting will be discussed in detail, focusing on SAD. A jet lag treatment algorithm will be presented that takes into account the direction and number of time zones crossed, for when to avoid and when to obtain sunlight exposure at destination and when to take low dose melatonin before and after travel. Books instructing the use oflight treatment will also be reviewed, as well as the most recent research findings.

**Course Level:** Basic
**Format:** Lecture

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $ 170**

## Course 40 Counter Intuitives in Medical Ethics

**Topic: Ethics & Human Rights**

**Director:** Edmund Howe, M.D., J.D.

**Educational Objectives:** At the conclusion of this session, the

participant should be able to: 1) To consider arguments that are valid in ethical analysis, and, thus, should be "on the table" but which may be counter intuitive, such that participants might be less likely to come up with them on their own; 2) To appreciate the limitations of ethical analysis in resolving value conflicts; and3) To know such core differences between deontological and consequential values and between private and public morality.

**Description:** This is a course presenting counter intuitive but valid and important arguments currently used in ethical analyses. Initially, traditional and adjunctive approaches to resolving ethical conflicts will be presented. The course will then present twenty six brief paradigmatic cases for discussion and analysis. Each will raise different counter intuitive points in ethical theory. This will be followed by general discussion. Topics will include theoretical principles, medicine, psychiatry, pediatrics, obstetrics, genetics, law, allocation of resources, and research. While the concepts are advanced, this course should be understandable and beneficial to all regardless of their prior knowledge.

**Course Level:** Basic
**Format:** Lecture and discussion.

**Sunday, May 23, 2010, 1pm 5pm; Half Day 4 hours;**
**Morial Convention Center; Spaces Available: 55**
**Early Bird $130; Advance $150; On Site $170**

# MONDAY
# MAY 24, 2010
## 8 AM - NOON

### Course 41 Short term Psychodynamic Supportive Psychotherapy for Depression

**Topic: Individual Psychotherapies**

**Director:** Henricus Van, M.D.
**Co Director:** Frans De Jonghe, M.D.
**Faculty:** Simone Kool, Ph.D., Annemieke Noteboom, M.S.C., Mariëlle Hendriksen, M.A., Jack Dekker, M.S.C.

**Educational Objectives:** At the conclusion of this course, the participant should be able to: 1) Be aware of the core ingredients of short term psychodynamic supportive psychotherapy (SPSP); 2) Apply some key elements of SPSP in their psychotherapeutic approach in depression, in particular improve the therapeutic process by making use of the hierarchical arranged discourse levels; and 3) Understand the importance of adequate psychoanalytic support in all treatments of stress related axis I disorders such as depression.

**Description:** Short term psychodynamic supportive psychotherapy (SPSP) is based on a relational view on the psychodynamic approach. SPSP is originally developed for the treatment of depression but could be applied to other stress related psychiatric diseases as well. In several trials the efficacy of SPSP in depression has been demonstrated, in particularly in the case of co morbid personality pathology. The SPSP protocol consists of 16 sessions. SPSP emphasizes the interpersonal and intrapersonal etiology and significance of depression in an individual patient. The therapist focuses on the affective, behavioral and cognitive aspects of relationships. This can be discussed from several 'discourse levels', such as the level of symptoms, relational patterns or intrapersonal aspects. Depending on the focus of therapy and the capacities of the patient, the interventions of the therapist are primarily directed at the relief of depressive symptoms (e.g. by encouraging adaptive coping, reducing feelings of guilt) or at personality change in the sense that we aim at a minimal changes in the object relational templates. Manifestations of defense mechanisms and transference are recognized and adapted if necessary to improve the therapeutic process, but they will not be not interpreted in depth. In the course special attention will be given to determine the 'discourse level' of therapy, to establish an optimal therapeutic alliance and to provide adequate psychoanalytic support that fosters developmental progression. Videotapes of actual therapies will be used for demonstration.

**Course Level:** Basic
**Format:** Lectures, Video illustration, Role Play and Group discussion

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 40**
**Early Bird $130; Advance $150; On Site $170**

### Course 42 Exploring Technologies in Psychiatry

**Topic: Computers, Technology, Internet & Related**

**Director:** Robert Kennedy, M.D.
**Co Director:** John Luo, M.D.
**Faculty:** Carlyle Chan, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to 1) Understand the various current technologies and connections that are possible in medicine and psychiatry; 2) Review the emerging technologies and how they will impact the practice of medicine in the near future; and 3) Recognize the pros and cons of electronic physician patient communication.

**Description:** Managing information and technology has become a critical component of the practice of psychiatry and medicine. Finding ways to make technology work both as a means of communication and as a way of keeping up to date on current changes in the field is an important goal. The process of being connected means developing a new understanding about what technology can best facilitate the various levels of communication that are important. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system to visit a remote patient, participating in a social network about a career resource, using a personal digital assistant/telephone to

connect with email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in healthcare management, there are many ways and reasons to connect. This course will explore all of the ways that clinicians can connect to colleagues and to needed information and even to patients. Keeping up with the technology requires a basic review of the hardware aswell as the software that drives the connections. The goal of this course is to explore the most current technologies and how they can assist the busy clinician in managing the rapidly changing world of communication and information. It will explore the changing role of personal digital assistants, wired versus wireless, the Internet including Web 2.0, weblogs, wiki, rss feeds, remote access, teleconferencing, educational technologies, electronic medical records and much more. This course is not intended for novices. It will get the experienced computer user up to speed on cutting edge technologies and trends that will impact the profession over the next decade. It will also explore ways to participate in the creation of content to become part of the future. We encourage participants to bring their laptops to the course to connect wirelessly to the Internet and participate in the interactivity.

**Course Level:** Intermediate
**Format:** Lecture, interactive demos, and group participation.

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 85**
**Early Bird $130; Advance $150; On Site $170**

## Course 43 Psychiatric Consultation in Long term Care: Advanced Course

**Topic: Geriatric Psychiatry**

**Director:** Abhilash Desai, M.D.
**Co Director**: George Grossberg, M.D.

**Educational Objectives:** At the conclusion of this course, participants will be able to; 1) Evaluate and treat challenging and complex psychiatric disorders using an array of interventions (pharmacological, nonpharmacological, electroconvulsive therapy); 2) Understand end of life care issues including management of agitation; and 3) Learn about innovative strategies to overcome barriers to successful clinical management of psychiatric disorders in long term care residents.

**Description:** This course is designed for psychiatrists and physician extenders who would like to develop and enhance capabilities of becoming a clinical leader and educator in managing psychiatric disorders in individuals living in long term care (LTC) settings. LTC settings include home care, daycare, assisted living, sub acute care (skilled nursing unit), and nursing homes. The course will discuss evidence based and state of the art interventions (pharmacological and nonpharmacological) to manage complex and challenging psychiatric disorders and psychiatric aspects of end of life care. The course will have four sections. Part I discusses management of challenging behaviors and psychiatric disorders such as suicide attempt/suicidal ideas, life threatening depression and physical aggression using clinical vignettes. Part II will discuss evaluation and management of psychiatric symptoms and disorders in individuals with terminal dementia and other terminal conditions and discuss psychiatric aspects of end of life care. Using clinical vignettes on challenging cases (severe sexual aggression, refractory severe aggression, severe and persistent mental illness), Part III will discuss evaluation of various etiologies of psychiatric symptoms and complex psychopharmacological, nonpharmacological interventions to successfully manage such cases. Part IV will discuss educational, innovative and administrative strategies to overcome barriers to successful clinical management of psychiatric disorders inindividuals in long term care settings. Discussion and interaction will be encouraged throughout, and especially at the end of each part. Target audiences include psychiatrists and physician extenders who want to enhance their expertise in management of challenging and complex psychiatric disorders in long term care residents and assume
a leadership role.

**Course Level:** Advanced
**Format:** Lectures, including the use of clinical vignettes, and Q & A sessions.

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 70**
**Early Bird $130; Advance $150; On Site $170**

## Course 44 Street Drugs and Mental Disorders: Overview and Treatment of Dual Diagnosis PatientsTopic: Addiction Psychiatry/Substance Use Disorders

**Director:** John Tsuang, M.D.
**Faculty**: Stephen Ross, M.D.

**Educational Objectives**: At the conclusion of this session, the participant should be able to understand the issues relating to the treatment of dual diagnosis patients. Popular street drugs and club drugs will be discussed. The available pharmacological agents for treatment of dual diagnosis patients will be covered. Additionally, participants will learn the harm-reduction versus the abstinence model for dual diagnosis patients.

**Description**: According to the ECA, 50-percent of general psychiatric patients suffer from a substance abuse disorder. These patients, so-called dual diagnosis patients, are extremely difficult to treat and they are big utilizers of public health services. This course is designed to familiarize participants with diagnosis and state-of-the-art treatment for dual diagnosis patients. We will first review the different substance of abuse, including club drugs, and their psychiatric manifestations. The epidemiological data from the ECA study for dual diagnosis patients will be presented. Issues and difficulties relating to the treatment of dual diagnosis patients will be stressed. The available pharmacological agents for treatment of dual diagnosis patients and medication treatment for substance dependence will be covered. Additionally, participants will learn the harm reduction versus the abstinence model for dual diagnosis patients.

**Course Level:** Basic
**Format:** Lecture and PowerPoint demonstration

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours; Sheraton Hotel; Spaces Available: 205**
**Early Bird $130; Advance $150; On Site $170**

## Course 45 The Detection of Malingered Mental Illness

**Topic: Forensic Psychiatry**

**Director:** Phillip Resnick, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: skillfully detect deception and malingering, especially in persons faking psychosis and litigants who allege posttraumatic stress disorder.

**Description:** This course is designed to give psychiatrists practical advice about the detection of malingering and lying. Faculty will summarize recent research and describe approaches to suspected malingering in criminal defendants. Characteristics of true hallucinations will be contrasted with simulated hallucinations. Dr. Resnick will discuss faked amnesia, mental retardation, depression, and the reluctance of psychiatrists to diagnose malingering. The limitations of the clinical interview, psychological testing, hypnosis, and sodium amytal interview in detecting malingering will be covered. The course will delineate 12 clues to malingered psychosis and five signs of malingered insanity defenses. Videotapes of three defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned mental disease. Participants will also have a written exercise to assess a plaintiff alleging PTSD. Handouts will cover the so called "compensation neurosis," malingered mutism, and feigned posttraumatic stress disorder in combat veterans.

**Course Level:** Basic
**Format:** Lecture and videotapes

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours; Sheraton Hotel; Spaces Available: 100**
**Early Bird $130; Advance $150; On Site $170**

## Course 46 Advances in Neuropsychiatry The Neuropsychiatry of Emotion and Its Disorder

**Topic: Neuropsychiatry/Mood Disorders**

**Director:** C. Edward Coffey, M.D.
**Co Director:** Randolph Schiffer, M.D.
**Faculty:** Robert G. Robinson, M.D., Matthew Menza, M.D., Randolph Schiffer, M.D., Michael Trimble, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to; ; 1) Demonstrate knowledge of he neurobiology of emotion; 2) Demonstrate knowledge of the pathophysiology of mood disorders; and 3) Demonstrate knowledge of the management of mood disorders in patients with stroke, Parkinson's Disease, epilepsy, and Alzheimer's disease.

**Description:** Disturbances in emotional behavior are common in patients with certain neurological illnesses. These mood disturbances may have important implications for the clinical presentation, management, and prognosis of the neurological illness. On the other hand, the recognition and treatment of these mood disturbances may themselves be impacted by the underlying neurological illness.This course will discuss the evidenced based management of mood disorders in patients with common neurologic illnesses such as stroke, Parkinson's disease, epilepsy, and Alzheimer's disease. We will also review the implications of these co morbid conditions for our understanding of brain behavior relations in general, with particular reference to the neurobiology of emotional behavior.

**Course Level:** Basic
**Format:** Lecture

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours; Sheraton Hotel; Spaces Available: 215**
**Early Bird $130; Advance $150; On Site $170**

## Course 47 Treating Medical Students and Physicians

**Topic: Professional & Personal Issues**

**Director**: Michael Myers, M.D.
**Co Director:** Leah Dickstein, M.D.
**Faculty:** Penelope Ziegler, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand the role of stigma and other obstacles to care when treating medical students and physicians; 2) Feel comfortable treating physicians with addictions; 3) Appreciate the challenges when treating physicians with depression; and 4) Identify transference and countertransference dynamics.

**Description:** It is well known that medical students and physicians can pose unique challenges when they become ill. With liberal use of case examples, this course will cover the following issues: 1) engaging the medical student or physician in a treatment alliance and overcoming stigma; 2) advocacy issues when negotiating with deans of medical schools, training directors, licensing boards, and insurance carriers; 3) unique issues for gay and lesbian medical students, despite their long standing recognition; 4) treating substance abusing medical students and physicians and working with physician health committees; 5) addressing privacy and confidentiality of medical records; 6) avoiding conflict of interest matters; 7) treating physicians who have been sued or reported to their licensing board; 8) treating medical students and physicians who are members of racial, ethnic or religious minority groups or physicians who are international medical graduates (IMGs); 9) complexities when treating physicians with mood disorders, including the suicidal physician; 10) treating relationship strain in medical students and physicians; 11) reaching out to family members and significant others of symptomatic medical students and physicians; 12)

understanding the many transference and countertransference issues when psychiatrists treat medical students, residents, and colleagues. Participants are encouraged to bring disguised cases from their own practices for small group discussion.

**Course Level:** Intermediate
**Format:** Lectures by each faculty followed by Q&A. Three 35 minute discussion groups with each of the faculty.

**Monday, May 24, 2010, 8am-Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 60**
**Early Bird $130; Advance $150; On Site $170**

## Course 48 Culturally Appropriate Assessment Made Incredibly Clear A Skills based Course with Hands On Experiences

**Topic: Cross Cultural & Minority Issues**
**Director:** Russell Lim, M.D.
**Faculty:** Russell Lim, M.D., Francis Lu, M.D., Anita Ramanathan, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Elicit a cultural identity, using a sociodevelopmental history, and the Addressing outline, Part A OCF;2) Use Kleinman's questions to elicit an explanatory model, Part B OCF; 3)elicit stressors and supports, sociodevelopmental history, Part C OCF; 4) Identify ethnocultural transference and countertransference, Part D OCF; and 5) Develop a culturally informed differential diagnosis and treatment plan, using "LEARN", Part E OCF.

**Description:** Being able to perform a culturally competent assessment is a skill required by current RRC requirements and ACGME core competencies for all graduating psychiatric residents, and will be taught in a skills based course that allows for attendee participation with a standardized patient. In addition, the US Census Bureau has predicted that by 2025, Latinos will represent the majority population in California, Arizona, New Mexico and Texas and 33% of all U.S. children. The DSM IV TR Outline for Cultural Formulation (OCF) is an excellent tool for the assessment of culturally diverse individuals, broadly defined to include ethnicity, culture, race, gender, sexual orientation, religion and spirituality, and age, and has been include in the *DSM IV* since 1994, and in addition, was included in the 2006 APA Practice Guidelines on the Psychiatric Evaluation of Adults, Second edition. The course will also present Hay's ADDRESSING framework, as well as demonstrate Kleinman's eight questions to elicit an explanatory model, and the LEARN model to negotiate treatment with patients.Clinicians require culturally informed skills to accurately evaluate culturally diverse individuals to treat them both appropriately and effectively. The course will teach clinicians specific skills for the assessment of culturally diverse patients, and give four participants an opportunity to practice these skills on a standardized patient, while the others will watch, assist, and critique their colleagues' skills. Participants will have a small group exercise on their own cultural identities, and then mini lectures on the five parts of the *DSM IV TR* Outline for Cultural Formulation, as well as instruction on interview skills, supplemented by the viewing of taped case examples, in addition to the practical application of those skills with the standardized patient described above. Clinicians completing this course will have learned interviewing skills useful in the culturally appropriate assessment and treatment planning of culturally and ethnically diverse patients.

**Course Level:** Basic
**Format:** Role playing, lecture, videotaped interviews.

**Monday, May 24, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 40**
**Early Bird $130; Advance $150; On Site $170**

# MONDAY
# MAY 24, 2010
## 9 AM- 4 PM

## Course 49 Cognitive Behavior Therapy for Severe Mental Illness

**Topic: Behavior & Cognitive Therapies**
**Director:** Jesse Wright, M.D., Ph.D.
**Faculty:** Douglas Turkington, M.D., Michael Thase, M.D., David Kingdon, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: understand cognitive behavior.
Description: In recent years, cognitive behavior therapy (CBT) methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptomatology. This course presents these newer CBT applications for the treatment of persons with chronic or treatment resistant depression, schizophrenia, and bipolar disorder. Cognitive behavioral conceptualizations and specific treatment procedures are described for these patient groups.Several modifications of standard CBT techniques are suggested for the treatment of severe or persistent mental illnesses. Participants in this course will learn how to adapt CBT for patients with problems such as psychomotor retardation, hopelessness and suicidality, hallucinations, delusions, hypomania, and nonadherence to pharmacotherapy recommendations.CBT procedures are illustrated through case discussion, role plays, demonstration, and video examples. Worksheets that can facilitate application of CBT techniques are provided. Participants will have the opportunity to discuss application of CBT for their own patients.

**Course Level:** Intermediate
**Format:** Lecture, role play, video illustrations.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**

**Sheraton Hotel; Spaces Available: 100**
**Early Bird $190; Advance $220; On Site $250**

### Course 50 Basic Concepts in Administrative Psychiatry II

**Topic: Psychiatric Administration & Services: Public, Private & University**

**Director:** Douglas Brandt, M.D.
**Co Director:** Barry Herman, M.D.
**Faculty:** Alan Axelson, M.D., Arthur Lazarus, M.D., Jeri Davis, M.B.A., William Reid, M.D., Robert Atkins, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Demonstrate a working knowledge of basic concepts in psychiatric care management, marketing tools and principles, legal and ethical aspects of administrative practice, and professional and career issues relevant to psychiatric administrators; and 2) Apply these concepts to psychiatric service systems.

**Description:** This is the second course in a two course series providing an overview of the theories, principles, concepts and developments relevant to administrative psychiatry. This course covers the broad areas of 1) psychiatric care management; 2) law and ethics; 3) marketing; and 4) professional and career issues relevant to psychiatric administrators. The first area includes: clinical program issues; multidisciplinary service delivery; programs for special populations (e.g., substance abusers, older adults, and children and adolescents); medical and psychiatric care coordination; principles of disease management; accreditation readiness (e.g., NCQA and The Joint Commission); utilization management, performance improvement, and provider credentialing. Law and ethics includes: commitment procedures and patient's rights; confidentiality and privilege; competency and guardianship, civil versus criminal proceedings; record keeping; disclosure and duty to warn; and case law affecting administrative practice. The marketing portion of the course focuses on techniques for creating an organizational culture that represents quality values; ways to translate quality services into external perceptions and initiatives that build a strong positive organizational reputation; identification, from a psychiatric administrator's perspective, of "stakeholders" and their needs; and implementation of ideas and tools to help market the organization. The last part of the course will discuss professional issues relevant to psychiatric administrators, such as career development; skills and competencies required to manage psychiatric systems; alignment of personal and organizational goals; the realities of managing versus practicing; and ways to acquire business acumen. Parts I and II of "Basic Concepts in Administrative Psychiatry" provide an overview of areas considered prerequisite for managing the medical industrial complex.

**Course Level:** Intermediate
**Format:** Lecture, PowerPoint slides and small group discussion.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 70**
**Early Bird $190; Advance $220; On Site $250**

### Course 51 Seeing the Forest and the Trees: An Approach to Biopsychosocial Formulation

**Topic: Diagnostic Issues**

**Director:** William Campbell, M.D., M.B.A.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: develop a comprehensive biopsychosocial formulation based on historical information obtained during a psychiatric interview.

**Description:** This course provides a systematic approach to the development of a comprehensive biopsychosocial formulation. Biological, psychological, and social perspectives will be reviewed and a paradigm will be presented with which to organize historical data. The faculty will present a comprehensive biopsychosocial formulation based on the information provided in a videotaped interview of a patient. Two additional videotapes of clinical interviews will be shown. Following each of these videotapes, participants will develop comprehensive biopsychosocial formulations under faculty supervision.

**Course Level:** Basic
**Format**: PowerPoint lecture, videotaped interviews, biopsychosocial formulation model demonstration, workshop with formulation exercises, and group discussions.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 25**
**Early Bird $190; Advance $220; On Site $250**

### Course 52 Traumatic Brain Injury: Neuropsychiatric Assessment

**Topic: Neuropsychiatry**

**Director:** Robert Granacher, M.D., M.B.A.

**Educational Objectives:** At the conclusion of this course, the participant should be able to: 1) Perform a traumatic brain injury assessment for clinical or forensic purposes; 2) Understand the biomechanics and pathophysiology from blunt force, skull penetration, explosion and sports injuries; 3) Understand the various psychiatric and neuropsychiatric syndromes following TBI in adults and children; and 4) Understand pharmacologic psychosocial remedies and neurocognitive testing.

**Description:** This course teaches psychiatrists and others the methodology for neuropsychiatrically examining persons who have sustained traumatic brain injury. These methods include examination of medical records, history taking, mental and neurological examination, neuropsychological and psychological testing, establishing a pre injury cognitive baseline, measuring response bias and potential malingering, neuroimaging, genetic testing and clinical and forensic case analysis.

**Course Level:** Basic
**Format:** Lecture, slides, neuroimajing and case studies.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 100**
**Early Bird $190; Advance $220; On Site $250**

## COURSE 53 HAS MOVED TO TUESDAY, MAY 25, 9AM - 4PM

## Course 54 A Psychodynamic Approach to Treatment Resistant Mood Disorders: Breaking Through Complex Comorbid Treatment Resistance by Focusing on Axis I

**Topic: Individual Psychotherapies**

**Director:** Eric Plakun, M.D.
**Faculty:** Edward Shapiro, M.A., David Mintz, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Enumerate and utilize psychodynamic principles to improve outcomes in work with patients with treatment refractory mood disorders comorbid with other disorders, including prominent Axis II pathology; and 2)Training directors will be better able to teach psychodynamic therapy to residents.

**Description:** Although algorithms help psychiatrists select biological treatments for patients with treatment refractory mood disorders, the subset with prominent Axis II pathology often fails to respond to medications alone. These treatments frequently become chronic crisis management, with risk of suicide. Residencies have begun to re emphasize mastery of psychodynamic concepts that may be useful in integrating a treatment approach to these patients. This course offers a comprehensive overview of the approach to this subset of treatment refractory patients derived from a longitudinal study of patients in extended treatment at the Austen Riggs Center. Ten psychodynamic principles extracted from study of successful treatments are presented. These include listening beneath symptoms for repeating themes, putting unavailable affects into words, attending to transference countertransference paradigms contributing to treatment refractoriness, and attending to the meaning of medications. This psychodynamic approach guides interpretation in psychotherapy, but also guides adjunctive family work, helps integrate the psychopharmacologic approach and maximizes medication compliance. Ample opportunity will be offered for course participants to discuss their own cases as well as case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients, and to help training directors improve their grasp of and ability to teach psychodynamics to residents.

**Course Level:** Basic
**Format:** PowerPoint based lectures with interactive discussion.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 60**
**Early Bird $190; Advance $220; On Site $250**

## Course 55 Improving Psychotherapy Effectiveness: Making Therapeutic Use of Counter transference and Mentalizing

**Topic: Individual Psychotherapies**

**Director:** Paula Ravitz, M.D.
**Faculty:** Jon Hunter, M.D., Clare Pain, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand critical factors related to the effective establishment and maintenance of the therapeutic alliance; 2) Understand clinical approaches that reduce the risk of therapeutic impasses and negative outcomes in psychotherapy; and 3) Appreciate how attachment based formulation, mentalization, countertransference and meta communication can be effectively used in psychotherapy.

**Description:** This interactive course will help psychotherapists expand their clinical repertoire in order to better manage commonly encountered clinical challenges in contemporary psychotherapy. The course will facilitate improved therapeutic outcomes in difficult treatment situations through application of an integrative model and common therapeutic factors. Particular foci of emphasis include the therapeutic alliance, effective use of countertransference and therapeutic meta communication. The course format features a combination of didactic presentation and group learning with demonstration and direct application utilizing standardized patients.

**Course Level:** Intermediate
**Format**: Lecture, role play with standardized patient, group discussion.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 40**
**Early Bird $190; Advance $220; On Site $290**

## Course 56 Davanloo's Intensive Short Term Dynamic Psychotherapy in Clinical Practice

**Topic: Individual Psychotherapies**

**Director:** James Schubmehl, M.D.

**Educational Objectives:** At the conclusion of this session, the participants should be able to: 1) Understand the forces underlying human psychopathology, including the crucial elements of the healing process; and 2) Describe the main elements of Davanloo's technique, and apply them in their own clinical practices.

**Description:** Highly resistant, poorly motivated patients are a major challenge to every clinician, especially when the clinical picture includes a complex mixture of character pathology and

symptom disturbances. Davanloo's Intensive Short Term Dynamic Psychotherapy has shown rapid effectiveness with difficult to treat conditions, including functional disorders, depression, panic and other anxiety disorders. This course, for those who practice or make referrals to psychotherapy, will demonstrate the range of applications of this technique, with specific technical interventions for particular conditions. There will be extensive use of video recordings of patient interviews to demonstrate the innovative techniques and metapsychology underlying the activation of the therapeutic alliance, even with hard to engage patients. The "unlocking of the unconscious" will be demonstrated. Davanloo's revolutionary discovery of removing the resistance in a single interview will be shown, along with how this enables the patient to have full neurobiological experience of the impulses and feelings that have fueled the unconscious guilt that drives their suffering. This frees the patient from these destructive forces, starting in the in the first session, leading to symptomatic relief and characterologic change. The course will provide participants with an overview of this uniquely powerful way of understanding human psychic functioning and the related techniques which empower the therapist to help patients change.

**Course Level:** Basic
**Format:** Lectures, PowerPoint slides, video recorded clinical interviews and discussion with participants.

**Monday, May 24, 2010, 9am-4pm; Full Day 6 hours; Sheraton Hotel; Spaces Available: 60 Early Bird $190; Advance $220; On Site $250**

# MONDAY
# MAY 24,2010
## 1 PM - 5 PM

### Course 57 Pain and Palliative Care in Psychogeriatrics

**Topic: Geriatric Psychiatry**

**Director**: Abhilash Desai
**Faculty:** George Grossberg, M.D., Jothika Manepalli, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to; 1) Discuss rational approaches to manage pain using medications and behavioral strategies; 2) Learn about surrogate decision making, pain management and use of hospice in older adults with dementia; and 3) Learn about psychogocial concepts of authenticity, blessings, connectedness and dignity in all aspects of palliative care in older adults.

**Description:** This course is designed for psychiatrists and physician extenders who would like to expand their knowledge about psychiatric aspects of relieving pain and providing palliative care to older adults. This course will have four sections. Part 1 reviews pain mechanisms, understanding myths about pain in the older adults and rational treatment approaches using medications and behavioral strategies. Part II will discuss surrogate decision making, pain management in patients with dementia and use of hospice in older adults with dementia. Part III will discuss basic psychosocial concepts of authenticity, blessings, connectedness and dignity in all aspects of palliative care to relieve suffering of older adults receiving palliative care and their family caregivers. In part IV, attendees will be encouraged to share their experiences and clinical vignettes. Presenters (if necessary) will also share clinical vignettes to shed light on the importance of going beyond the treatment of depression and delirium to relieve suffering in older adults with terminal illness. Discussion and interaction will be encouraged throughout, especially at the end of each part.

**Course Level:** Advanced
**Format:** Lectures, slides, case examples, Q & A sessions.

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;
Sheraton Hotel; Spaces Available: 40
Early Bird $130; Advance $150; On Site $170**

### Course 58 Reel Psychiatry

**Topic: Psychiatric Education**

**Director:** Luis Ramirez, M.D.
**Co Director:** David Robinson, M.D.

**Educational Objectives:** At the conclusion of this course the participants will be familiar with: 1) The concept of movies as an art genre; 2) The utilization of movies to teach different aspects of psychiatry with emphasis on diagnosis, psychopathology and psychosocial issues; 3) How to select movies for the teaching of psychiatry; and 4) How to use movies for the teaching of psychiatry.

**Description:** The faculty will explain how movies are considered an art genre and how they are utilized to teach different aspects of psychiatry including diagnosis, psychopathology, treatment and psychosocial issues. The course will utilize didactic conferences plus an intensive interactive participation with a detailed discussions of clips from a recent movie (e.g., Shine) selected to illustrate the educational objectives of the course. The participants will be notified about the movie via e mail and the will be advised to watch the movie prior to taking the course (This is not a requirement for taking the course.)

**Course Level:** Basic
**Format:** Lecture, videotapes, and group discussion.

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;
Sheraton Hotel; Spaces Available: 85
Early Bird $130; Advance $150; On Site $170**

## Course 59 Psychiatric Pharmacogenomics

**Topic: Genetics**

**Director:** David Mrazek, M.D.,
**Faculty:** Dan Hall-Flavin, M.D., Renato Alarcon, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Review basic medical genomics including the identification of key genes associated with disease management; 2) Learn about improved therapeutic interventions through pharmacogenomics; 3) Interpret genetic test results and communicate the findings to patients and families; and 4) Understand the relevance and utility of genetic testing to optimizing outcomes in clinical psychiatric practice.

**Description:** This course is designed to provide a succinct overview of the rapidly developing area of psychiatric pharmacogenomics. It will begin with a basic review of recent advances in molecular genetics that have led to the successful mapping of the genome and the development of new technologies for diagnostic assessment. This presentation will specifically review important genes that are involved in the response of patients to psychotropic medication. These genes have all been reviewed in detail in a newly completed text entitled, "Psychiatric Pharmacogenomics", which has been published by Oxford University Press. In this course, clinicians will be able to review how specific polymorphisms have been linked to treatment response. Genes of particular interest are those in the cytochrome P450 family, dopamine family and serotonin family. Both drug metabolizing enzyme genes and drug target genes are discussed. The introduction of genotyping into clinical practice will be a strong emphasis of the course. This is a rapidly evolving area of clinical development which is now increasingly a part of medication management. Clinical issues related to outpatient testing will be reviewed and specific cases discussed. This will be followed by a discussion of incorporating pharmacogenomic testing into the inpatient treatment plan. Specific examples of care provided in the inpatient Mood Disorder Unit will be reviewed. This presentation is designed to provide participants with basic information during the review of molecular genetics which will prepare them for the discussion of their patient's clinical pharmacogenomic testing results.

**Course Level:** Intermediate
**Format:** Lecture and questions and answers

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours; Sheraton Hotel; Spaces Available: 70 Early Bird $130; Advance $150; On Site $170**

## Course 60 Psychopharmacologic, ECT and Psychotherapeutic Treatment of Psychotic (Delusional) Depression

**Topic: Mood Disorders**

**Director:** Anthony Rothschild, M.D.
**Faculty:** Brandon Gaudiano, Ph.D., Anthony Rothschild, M.D.,

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Accurately diagnose and assess patients with psychotic depression; 2) Identify the difficult differential diagnoses between psychotic depression and other psychiatric disorders; 3) Understand the use of adjunctive psychotherapy in patients with psychotic depression; and 4) Treat patients with psychotic depression with somatic therapies including medications or referral to electroconvulsive therapy.

**Description:** Psychotic depression is a serious illness during which a person suffers from the dangerous combination of depressed mood and psychosis, with the psychosis commonly manifesting itself as nihilistic, "bad things are about to happen" type delusions. Examples of this are unfortunately seen in every part of the world: the mother who inexplicably kills her children before killing herself or the retired, mild mannered college professor who sets himself and his home on fire; these are all real life examples of psychotic depression – a serious, life threatening illness. Although psychotic depression is treatable and people can make a full recovery, unfortunately, as will be discussed in this course, the diagnosis is frequently missed, leading to the prescription of ineffective treatments, and unfortunate outcomes. The course faculty has devoted their careers to the study of psychotic depression and have received NIMH funding to study the treatment of this disorder. Dr. Rothschild is the author of the recently published Clinical Manual for the Diagnosis and Treatment of Psychotic Depression (American Psychiatric Publishing , Inc., 2009). The course will consist of 3 lectures (each with a Q & A session and extensive interaction with the faculty) and a panel discussion with the speakers at the end of the half day. The course will focus on state of the art and clinically practical knowledge regarding the treatment of these seriously ill patients. The first lecture (Anthony Rothschild, M.D.) will focus on the challenges in assessing and accurately diagnosing patients with psychotic depression with particular attention to differential diagnosis. The second lecture (Brandon Gaudiano, Ph.D.) will discuss the use of adjunctive psychotherapy for the treatment of psychotic depression. The third lecture (Anthony Rothschild, M.D.) will focus on the use of medications and ECT for the treatment of psychotic depression. A panel discussion will conclude the course.

**Course Level:** Intermediate
**Format:** Lecture, Panel discussion with audience participation, audience questions and answers.

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours; Sheraton Hotel; Spaces Available: 205 Early Bird $130; Advance $150; On Site $170**

## Course 61 The Psychiatrist As Expert Witness

**Topic: Forensic Psychiatry**

**Director:** Phillip Resnick, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to give more effective

witness in civil and criminal trials.

**Description:** Trial procedure and rules of evidence governing fact and expert witnesses will be reviewed briefly. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre trial conferences and depositions. Participants will learn to cope with cross examiners who attack credentials, witness bias, adequacy of examination, and the validity of the expert's reasoning. Issues of power and control in the witness cross examiner relationship will be explored. Participants will learn how to answer questions about fees, pretrial conferences, questions from textbooks, and hypothetical questions. The use of jargon, humor, and sarcasm will be covered. Different styles of testimony and cross examination techniques will be illustrated by 8 videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of 60 suggestions for witnesses in depositions, 15 trick questions by attorneys, and 58 suggestions for attorneys cross examining psychiatrists.

**Course Level:** Basic
**Format:** Lecture and videotapes.

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 100**
**Early Bird $130; Advance $150; On Site $170**

### Course 62 Advanced Assessment and Treatment of Attention Deficit Hyperactivity Disorder

**Topic: Attention Spectrum Disorders**

**Director:** Thomas E. Brown, Ph.D.
**Faculty:** Jefferson Prince, M.D., Anthony Rostain, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand emerging new models of comorbidity of ADHD with other psychiatric disorders; 2) Adequately assess more complicated cases of ADHD; 3) Understand how medication treatments should be modified to deal with psychiatric or medical complications; and 4) Develop treatment plans to effectively address complicated ADHD across the lifespan.

**Description:** This advanced course provides an update on research based understandings of ADHD across the life cycle. It highlights the role of impairment in executive functions and the importance of modifying medications and other treatment strategies to deal with comorbid psychiatric and medical disorders that often complicate ADHD. Case examples of adults, adolescents and children are discussed to demonstrate the variety of ways in which ADHD can be complicated not only on initial presentation, but also over the course of treatment.

**Course Level:** Advanced
**Format:** lectures, slides, discussion

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 215**
**Early Bird $130; Advance $150; On Site $170**

### Course 63 Current Procedural Terminology Coding and Documentation

**Topic:** Practice Management
**Director:** Chester Schmidt, M.D.
**Co Director:** Tracy Gordy, M.D.
**Faculty:** Ronald Burd, M.D., David Nace, M.D., Jeremy Musher, M.D., Allan Anderson, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand the use of psychiatric evaluation codes, therapeutic procedure codes, and evaluation and management codes; and 2) Document the provision of services denoted by the above sets of codes.

**Description:** This course is for both clinicians (psychiatrists, psychologists, social workers) and office personnel who either provide mental health services or bill patients for such services using "Current Procedural Terminology (CPT) codes, copyrighted by the American Medical Association. Course attendees are encouraged to obtain the most recent published CPT Manual and read the following sections: 1) the Guideline Section for Evaluation and Management codes, 2) the Evaluation and Management codes themselves, and 3) the section on "Psychiatric Evaluation and Therapeutic Procedures." The objectives of the course are twofold: first, to familiarize the attendees with all the CPT codes used by mental health clinicians and review issues and problems associated with payer imposed barriers to payment for services denoted by the codes; second, the attendees will review the most up to date AMA/CMS guidelines for documenting the services/procedures provided to their patients. Templates for recording evaluation and management services, initial evaluations and psychotherapy services will be used to instruct the attendees in efficient methods of recording data to support their choice of CPT codes, and the level of service provided.

**Course Level:** Basic
**Format:** Lecture, handouts, Q & A.

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 60**
**Early Bird $130; Advance $150; On Site $170**

### Course 64 A Primer on Acceptance and Commitment Therapy

**Topic: Behavior & Cognitive Therapies**

**Director:** Kenneth Fung, M.D
**Co Director:** Mateusz Zurowski, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Distinguish the underlying philosophical and theoretical assumptions behind traditional types of psychotherapies versus "third wave" psychotherapies; 2) Describe the six core therapeutic components of Acceptance and Commitment Therapy (ACT); and 3) Formulate an understanding and plan treatment strategies for patients from an ACT perspective.

**Description:** Acceptance and Commitment Therapy (ACT) is one of the "third wave" psychological interventions that is garnering empirical support in research as well as growing interest among clinicians and the lay public. Like other "third wave" interventions such as Mindfulness Based Cognitive Therapy and Dialectical Behavioral Therapy, ACT includes elements of acceptance and mindfulness, and targets functional and contextual changes rather than changes in the content, form, or frequency of mental phenomena. This stands in contrast with the mainstream "second wave" interventions, such as cognitive behavioral therapy (CBT), that attempt to directly challenge and manipulate mental processes, such as automatic thoughts. ACT may be especially powerful for "stuck" patients who fail to respond to such direct first order change attempts. This introductory course will familiarize attendees with the basic philosophy and theory of ACT, namely Functional Contextualism and Relation Frame Theory. The six core components of ACT will be presented, these are: Acceptance, Cognitive Defusion, Contact with the Present Moment, Self as context, Values, and Committed Action. These concepts will be explicated both didactically and through self reflection, experiential exercises, and role plays so as to enhance comprehension and clinical utility. Greatest emphasis will be placed on Defusion, Contact with the Present Moment, and Values. The course will be of direct clinical relevance for therapists who find current models of psychotherapy limiting or ineffective. Exposure to the concepts presented will give attendees new ways to conceptualize and approach common clinical challenges.

**Course Level:** Basic
**Format:** lecture, DVD clip, experiential exercises, role play

**Monday, May 24, 2010, 1pm 5pm; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available 40**
**Early Bird $130; Advance $150; Onsite $170**

# TUESDAY
# MAY 25, 2010
## 8 AM - NOON

## Course 65 How to Practice Evidence Based Psychiatry: Principles and Case Studies

**TOPIC: Treatment Techniques & Outcome/Practice Management**

**Director:** C. Barr Taylor, M.D.

**Edutcational Objectives:** At the conclusion of this session, the participant should be able to: demonstrate knowledge of : 1) How to implement 3 or more evidence-based procedures into his/her practice;2) How to fine and use guidelines and algorithms; and 3.How to ask and answer evidence-based questions related to clinical practice.

**Description:** This course will focus on how to incorporate principles and practices of evidence based medicine into one's psychiatric practice. The skills discussed and practiced will include (1) how to consider treatment algorithms, guidelines and best practices when planning and providing treatment (2) how to use measures to determine progress of an individual patient (3) how to review patient's progress against personal and published standards (4) how to consider "evidence and experts" in clinical decisions, particularly with complex, co-morbid problems (5) how to ask and answer evidence based questions and (6) how to review ones overall practice. Three cases will be presented in detail including: (1) anorexia, obsessive-compulsive disorder, depression and emergent psychosis (2) major depression with psychotic features (3) panic disorder with work stress and social isolation.

**Course Level:** Basic
**Format:** Lecture Worksheet

**Tuesday, May 25, 2010, 8am Noon; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 70**
**Early Bird $130; Advance $150; On Site $170**

## Course 66 Risk Assessment for Violence

**Topic: Violence, Trauma & Victimization**

**Director:** Phillip Resnick, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Identify risk factors for violence; 2) Improve interview techniques in the assessment of dangerousness; and 3) Classify different types of stalkers.

**Description:** This course is designed to provide a practical map through the marshy minefield of uncertainty in risk assessment for violence. Recent research on the validity of psychiatric predictions of violence will be presented. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be reviewed. Dangerousness will be discussed in persons with psychosis, mania, depression, and substance abuse. Special attention will be given to persons with specific delusions, command hallucinations, premenstrual syndrome, and homosexual panic. Personality traits associated with violence will be discussed. Childhood antecedents of adult violence will be covered. Advice will be given on taking a history from

potentially dangerous patients and countertransference feelings. Instruction will be given in the elucidation of violent threats and "perceived intentionality." A classification of five types of stalkers will be discussed with implications for risk assessment. Finally, a videotape will be shown to allow participants to identify risk factors and develop a violence prevention plan for a man who attempted to kill his boss.

**Course Level:** Basic
**Format:** lecture and videotapes.

**Tuesday, May 25, 2010, 8am Noon; Half Day 4 hours; Sheraton Hotel; Spaces Available: 100**
**Early Bird $130; Advance $150; On Site $170**

## Course 67 ECT Practice Update for the General Psychiatrist

### Topic: Other Somatic Therapies

**Director:** Jerry Lewis, M.D., M.S.
**Faculty:** Laurie McCormick, M.D., Peter Rosenquist, M.D., Andrew Krystal, M.D., Charles Kellner, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Make an appropriate referral for Electroconvulsive Therapy; 2) Understand the indications for ECT; 3) Understand what special patient populations may need accomadation during ECT; 4) discuss the recent data concerning ultra brief pulse versus brief pulse ECT; 5) Discuss factors that may impact cognition; and 6) Discuss the impact of different anesthetic agents on ECT.

Description: Target Audience: General psychiatrists and other health care providers who are involved in providing ECT or referring patients for ECT. This course is intended for those who wish to update their knowledge of ECT, but is not intended as a "hands on" course to learn the technique of ECT. Many subjects will be covered including the history of ECT, indications for treatment, use of ECT in special patient populations, anesthesia options, potential side effects from ECT and concurrent use of psychotropic and non psychotropic medications. Emphasis will be placed on newer ideas such as ultra brief pulse right unilateral ECT, different forms of electrode placement and other techniques which may impact cognition.neuroimaging and basic science studies that point to possible explanations for the mechanism underlying ECT's therapeutic action. A video of an actual ECT procedure will be shown and a presentation on how to perform an ECT consult will be given. The five faculty of this course are intimately involved with both research and the administration of ECT on a regular basis. Any practitioner who has involvement with ECT, either in administration of the procedure or in the referral of patients for ECT, should consider attending this course.

**Course Level:** Basic
**Format:** Lecture, videotapes, and Q & A sessions.

**Tuesday, May 25, 2010, 8am Noon; Half Day 4 hours; Sheraton Hotel; Spaces Available: 100**
**Early Bird $130; Advance $150; On Site $170**

# TUESDAY MAY 25, 2010
## 8 AM - 5 PM

### Course 68 Office based Buprenorphine Treatment of Opioid Dependent Patients

**Topic: Addiction Psychiatry/Substance Use Disorders**

**Director:** Petros Levounis, M.D.
**Faculty:** Andrew Saxon, M.D., Laura McNicholas, M.D., John Renner, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to; 1) Identify the clinically relevant pharmacological characteristics of buprenorphine; 2) Describe the resources needed to set up office based treatment with buprenorphine for patients with opioid dependence; and 3) List at least five factors to consider in determining if the patient is an appropriate candidate for office based treatment with buprenorphine.

**Description:** The purpose of the course is to provide information and training to participants interested in learning about the treatment of opioid dependence, and in particular physicians who wish to provide office based prescribing of the medication buprenorphine for the treatment of opioid dependence. Federal legislative changes allow office based treatment for opioid dependence with certain approved medications, and Food and Drug Administration (FDA) approved buprenorphine for this indication. The legislation requires a minimum of eight hours training such as the proposed course. After successfully completing the course, participants will have fulfilled the necessary training requirement and can qualify for application to utilize buprenorphine in office based treatment of opioid dependence. Content of this course will include general aspects of opioid pharmacology, and specific aspects of the pharmacological characteristics of buprenorphine and its use for opioid dependence treatment. In addition, other areas pertinent to office based treatment of opioid dependence will be included in the course (e.g., non pharmacological treatments for substance abuse disorders, different levels of treatment services, confidentiality). Finally, the course will utilize case based, small group discussions to illustrate and elaborate upon points brought up in didactic presentations.

**Course Level:** Advanced
**Format:** Lecture and small group discussions.

**Tuesday, May 25, 2010, 8am 5pm; Full Day 8 hours;**
**Sheraton Hotel; Spaces Available: 205**
**Early Bird $230; Advance $270; On Site $310**

# TUESDAY MAY 25, 2010
## 9 AM - 4 PM

### Course 53 Adult Sexual Love and Infidelity

**Topic: Couple & Family Therapies**

**Director:** Stephen Levine, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Recognize and articulate the meanings and processes of love; 2) Define and use the power of psychological intimacy to promote the lives of couples; 3) Recognize the private mental and behavioral experiences with infidelity; and 4) Calmly think about extradyadic sex without reflexive moral censure.

**Description:** The course will begin with a detailed description of nine interlocking meanings of sexual love. The means of attaining psychological intimacy will be illuminated. Its aphrodisiac properties will be explained and it use as a therapy tool will be presented. The next presentation will stress love as an evolving process through three stages falling in love, being in love, and staying in love. The recent findings on the biology of love will be reviewed. After each topic segment there will be short periods of discussion. Participants will be asked to read case histories during the lunch break. The diverse forms of and motivations for extradyadic sex will be conceptualized followed by a long audience discussion of situations of infidelity using provided case materials. The emphasis will be on remaining calm and clear in the face of the affective storms of patients. The course will stress the role of therapist as an informed, lifelong student of the varied ways individuals seek to attain of love's ideals and how they deal with their disappointments.

**Course Level:** Intermediate
**Format:** Lecture, case histories and discussion.

**Monday, May 24, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 110**
**Early Bird $190; Advance $220; On Site $250**

### Course 69 Psychodynamic Psychopharmacology: Applying Practical Psychodynamics to Improve Pharmacologic Outcomes with Treatment Resistant Patients

**Topic: Combined Pharmacotherapy & Psychotherapy**

**Director:** David Mintz, M.D.
Faculty: Barri Belnap, M.D., Samar Habl, M.D., Anne Carter, M.D., David Flynn, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Describe the evidence base linking meaning factors and medication response; construct an integrated biopsychosocial treatment frame; recognize common psychodynamics of pharmacologic treatment resistance; 2) Use psychodynamic interventions to address psychodynamic sources of resistance to medications; and 3) Recognize and contain countertransference contributions to pharmacologic treatment resistance.

**Description:** Though psychiatry has benefited from an increasingly evidence based perspective and a proliferation of safer and more tolerable treatments, outcomes are not substantially better than they were a quarter of a century ago. Treatment resistance remains a serious problem across psychiatric diagnoses. One likely reason is that, as the pendulum has swung from a psychodynamic framework to a biological one, the impact of meaning has been relatively neglected, and psychiatrists have lost some of our potent tools for working with the most troubled patients. Psychodynamic psychopharmacology is an approach to psychiatric patients that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacologic treatment. While traditional objective descriptive psychopharmacology provides guidance about what to prescribe, psychodynamic psychopharmacology informs prescribers how to prescribe to maximize outcomes.The course will review the evidence base connecting meaning and medications, and will review psychodynamic concepts relevant to the practice of psychopharmacology. Then, reviewing faculty and participant cases, and with a more specific focus on treatment resistance, common psychodynamic sources of pharmacologic treatment resistance will be elucidated. This is intended to help participants better to be able to recognize those situations where psychodynamic interventions are likely to be necessary to enhance pharmacologic outcomes. Faculty will outline technical principles of psychodynamic psychopharmacology, providing participants with tools for working with psychodynamic resistances to and from psychiatric medications or who provide therapy to patients on medications to be able to recognize and treat psychodynamic impediments to healthy and effective use of medications.

**Course Level:** Intermediate
**Format:** The course is designed as a lecture format intended to be highly interactive with the audience. There will be spaces for discussion of faculty and participant cases.

**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours; Sheraton Hotel; Spaces Available: 100 Early Bird $190; Advance $220; On Site $250**

## Course 70 Kundalini Yoga Meditation Techniques for Schizophrenia, the Personality Disorders, and Autism

**Topic: Other Somatic Therapies**

**Director:** David Shannahoff Khalsa, B.A.

Educational Objectives: At the conclusion of this session, the participant should: 1) Have skills with techniques for treating schizophrenia, the 10 APA defined personality disorders, and autism; 2) Familiarity with case histories of schizophrenics, personality disorder patients, autism and 3) Be familiar with background studies published showing the efficacy of Kundalini yoga meditation for OCD and OC spectrum disorders; and
4) Be familiar with novel yogic perspectives for treating personality and autism disorders.

**Description:** A short review of two clinical trials will be presented that used Kundalini yoga meditation techniques for treating OCD. The first is an open trial with a 55% mean group improvement on the Y BOCS (International Journal of Neuroscience 1996) and the second is a randomized controlled trial (CNS Spectrums 1999) with a 71% mean group improvement on the Y BOCS. Whole head 148 channel magnetoencephalography brain imaging of 2 yogic breathing techniques (one for treating OCD and its inactive control rrelate) will be presented along with other novel studies in mind body medicine that were based on yogic concepts and techniques. These studies will be presented to help build greater confidence in yogic medicine. Participants will practice and learn to implement select disorder and condition specific meditation techniques for the following three disorders (1) the 9 variants of the psychoses, (2) the 10 APA defined personality disorders, and (3) autism. For the psychoses, the techniques will include one for inducing a meditative state, "A Protocol for Treating the Variants of Schizophrenia" that includes a 10 part yogic exercise set, a meditation technique to help eliminate negativity, a meditation to help combat delusions and to help stabilize a healthy sense of self identity, and a 4 part mini protocol for helping to terminate hallucinations. The techniques for the personality disorders will include 3 protocols that are specific for the respective 3 APA defined Clusters of A, B, and C, and each of the 3 primary cluster specific protocols will also include a meditation that can then be substituted for the respective 10 personality disorders. There will also be a unique Kundalini yoga meditation approach for treating autism that can also be applied to Aspergers' Syndrome patients. This autism specific approach is called The Dance of the Heart. There will also be simple and more advanced techniques taught that can be utilized in this "dance" depending on the severity of the patient. There are also an array of more advanced meditation techniques that can be used as substitutes for the variants of the psychoses, the personality disorders, and for the more improved autistic patient. Case histories of each disorder will be presented. Ampletime will be given to answer questions and to discuss the participant's personal experiences of the techniques during the course.

**Course Level:** Basic
**Format:** Format: In this course participants will be sitting in chairs, and the content will involve both lecture on the scientific publications of clinical OCD trials and MEG brain imaging of yogic techniques, and interactive participation where the participants learn and practice a wide range of meditation techniques.

The Powerpoint presentation and Course handouts will include all of the details on how the techniques are to be practiced, so note taking is not necessary.

**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 85**
**Early Bird $190; Advance $220; On Site $250**

## Course 71 Cognitive Behavioural Analysis Systems of Psychotherapy (CBASP): Hope for Chronic Depression

**Topic: Individual Psychotherapies**

**Director:** Sian Rawkins, M.D.
**Co Director:**:Molyn Leszcz, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to:1) Recognize maladaptive interpersonal behaviours and clinical challenges of chronically depressed patients; 2) Know principles/techniques of CBASP that include communicating transference hypotheses and 'Disciplined Personal Involvement'; and 3) Learn how to reduce the risk of therapeutic impasses and negative outcomes.

**Description:** CBASP is an integrative psychotherapy modality originated by Dr. Jim McCullough and designed specifically for the treatment of chronic depression. It is recognized in Treatment Guidelines and has robust empirical support (N Engl J Med 2000; 342:1462 70). This course will include interactive teaching and demonstration of techniques with a standardized patient. This continuing education course is intended to provide psychotherapists with an expanded clinical repertoire to facilitate improved outcomes and manage the complex psychotherapeutic challenges encountered in treating chronically depressed patients.

**Course Level:** Basic
**Format:** Lecture, role play with standardized patient, group discussion, case studies
**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 30**
**Early Bird $190; Advance $220; On Site $250**

## Course 72 Narrative Hypnosis for Psychiatry: Emphasis on Pain Management

**Topic: Individual Psychotherapies**

**Director:** Lewis Mehl Madrona, M.D., Ph.D.
**Faculty:** Ann Marie Chiasson, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to; 1) Identify five elements of hypnotic technique from listening to a session; 2) Describe three metaphors that can be used for reducing the sensation of pain; 3) Discuss how hypnosis can be used to augment patient motivation and willingness to respond to treatment; and 4) Practice basic hypnosis techniques, useful for reducing anxiety, panic, fear, and pain.

**Description:** What we call hypnosis today has been used for thousands of years as part of the persuasive arts and has been used by traditional healers from time immemorial. Hypnosis has been defined more recently as a state of heightened attention and complete absorption in one situation so as to enhance learning. Hypnosis is augmented through the power of story, for story is what grabs our attention. Story has been used for thousands of years to teach and instruct and to change people's behavior. In this course, we will learn some techniques of hypnosis (embedded commands, use of voice tonality and phrasing, implied causatives, linkages, truisms, interspersal technique) so that psychiatrists attending will be able to do basic hypnosis. We will practice these techniques. Then we will proceed to explore the power of metaphor and story and its use in hypnosis and the use of the power of words to enrich metaphor and story. We will practice constructing metaphors for use with people in chronic pain for increased hypnotic effectiveness. We will review some stories of chronic pain patients and will brainstorm about how pain can be reduced along with medication consumption. We will conclude by reviewing the literature on hypnosis and chronic pain, but primarily the course will be about learning how to do some basic hypnosis effectively.

**Course Level:** Basic
**Format:** Lecture, demonstrations, short videotape segments, small group discussion, role playing, practicing

**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 70**
**Early Bird $190; Advance $220; On Site $250**

## Course 73 Trauma Informed Care: Principles and Implementation

**Topic: Violence, Trauma & Victimization**

**Director:** S. Atdjian, M.D.
**Faculty:** Tonier Cain, Other, Joan Gillece, Ph.D.
**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) List trauma spectrum disorders; 2) Understand the prevalence and impact of trauma in symptom formation and behavioral presentations in individuals with psychiatric illness; 3) Recognize the importance of creating environments that facilitate self soothing in the healing of trauma survivors; and 4) Identify practical strategies to implement trauma informed care in all settings that treat individuals with mental illness.

**Description:** Interpersonal trauma is very prevalent in individuals with psychiatric illness. Trauma may lead to many psychiatric disorders that often go undetected or misdiagnosed. Adaptations to trauma are often at the center of symptom formation and behavioral responses. Treatments that do not address the impact of trauma may be ineffective and may even re traumatize survivors of trauma. Trauma Informed Care places trauma at the center of understanding symptoms and behaviors and looks to facilitate healing without the use of coercion,violence,seclusion or restraints.The course will review the principles of trauma informed care including trauma spectrum disorders, symptoms as

adaptations, the neurobiology of trauma and the facilitation of self soothing. A trauma survivor will recount her experiences in mental health treatment before, during and after her admission to a trauma informed treatment program. A videotape of four women treated at that program will be shown to discuss the impact of trauma informed care on treatment outcome. Finally the course will describe the creation of that trauma informed treatment center for women in Maryland.

**Course Level:** Basic
**Format:** Lecture, videotape and discussion.

**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 60**
**Early Bird $190; Advance $220; On Site $250**

## Course 74 Therapeutic Interventions in Eating Disorders: Basic Principles

**Topic: Eating Disorders**

**Director:** David Jimerson, M.D.
**Faculty:** Joel Yager, M.D., Katherine Halmi, M.D., Michael Devlin, M.D., James Mitchell, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Perform a comprehensive clinical assessment of patients with eating disorders; and 2) Plan initial treatment, considering short term psychotherapy and pharmacotherapy.

**Description:** The assessment and treatment of patients with eating disorders often present unique clinical challenges. Bulimia nervosa and anorexia nervosa are among the most common major psychiatric disorders in adolescents and young adults, particularly among young women. Treatment for patients with eating disorders is often complicated by the co occurrence of major depression, anxiety disorders, and substance use disorders.
Recent clinical investigations have demonstrated the efficacy of short term psychotherapies such as cognitive behavioral treatment for eating disorder symptoms. Significant benefits of pharmacotherapy have been demonstrated, particularly in bulimia nervosa. As clinicians are well aware, however, a significant number of patients show incomplete response to initial treatment, and relapse is not uncommon, prompting development of hierarchical strategies for more intensive clinical interventions. The course will open with an overview of current approaches for initial psychiatric evaluation, medical assessment, and treatment of eating disorders, including a review of the American Psychiatric Association Practice Guideline. Subsequent presentations will provide details for short term psychotherapy and pharmacotherapy for bulimia nervosa, anorexia nervosa and binge eating disorder; and approaches for working with treatment refractory patients.

**Course Level:** Basic
**Format:** Lectures with questions and discussion.

**Tuesday, May 25, 2010, 9am 4pm; Full Day 6 hours;**
**Sheraton Hotel; Spaces Available: 60**
**Early Bird $190; Advance $220; On Site $250**

# TUESDAY MAY 25, 2010
## 1 PM - 5 PM

## Course 75 The Standard EEG in Psychiatric Practice

**Topic: Neuropsychiatry**

**Director:** Nash Boutros, M.D.
**Co Director:** Silvana Riggio, M.D.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Understand the limitations of the standard EEG and broad categories of pathophysiology that produce EEG abnormalities; 2) Recognize general indications for EEG study and its specific diagnostic uses (aggression and violence, Panic Disorder, nonconvulsive status and Frontal Lobe Seizures); and 3) Know how to interpret the EEG report and how to incorporate the findings in the formulation of the diagnosis and management.

**Description:** EEG remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this course the clinical psychiatrist will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns.
Specific clinical indicators ("red flags") for EEG assessment will be stressed. More detailed coverage of selected areas will include (1) The role of EEG in the psychiatric assessment in the emergency department (2) The role of EEG in the assessment of the aggressive and violent patient (3) The role of EEG in clinical presentations where diagnostic blurring occurs (i.e. differential diagnosis of dementia, differential diagnosis of the agitated and psychotic patient, psychiatric manifestations of seizure disorders).Specific FLOW CHARTS for the EEG evaluation in patients with neuropsychiatric disorders will be provided.
Illustrated clinical vignettes will be provided. This course is intended for the practicing clinician.

**Course Level:** Basic
**Format:** The course will include didactic lectures supported by detailed slides, video presentations, and case discussion.

**Tuesday, May 25, 2010, 1pm 5pm; Half Day 4 hours;**
**Sheraton Hotel; Spaces Available: 70**

**Early Bird $130; Advance $150; On Site $170**

### Course 76 Evidence Based Psychodynamic Therapy

**Topic: Individual Psychotherapy**

**Director:** Richard Summers, M.D.
**Co Director:** Jacques Barber, Ph.D.

**Educational Objectives:** At the conclusion of this presentation, the participant should be able to: 1)Demonstrate understanding of the evidence base supporting psychodynamic psychotherapy; 2) Diagnose core psychodynamic problems and develop a formulation for appropriate patients; 3) Develop an effective therapeutic alliance, define a focus of therapy, and employ techniques for facilitating change; and 5)Recognize the important role of positive emotion and character strengths in the phases of dynamic treatment.

**Description:** This course focuses on the development of psychodynamic psychotherapy skills. We will distill from the tradition of psychoanalysis and psychoanalytic psychotherapy the features of this model that have stood the test of time and have greater empirical support, and show how some newer psychotherapy approaches add to its efficacy. We present Pragmatic Psychodynamic Psychotherapy, a model that emphasizes accurate diagnosis, formulation, goal setting, pragmatic approaches to change, strength building and positive emotions, and allows for effective integration with other modes of treatment. We begin with an overview of the process of learning psychotherapy, and the limitations of the traditional model of psychodynamic therapy. We review the outcome data on psychodynamic therapy, and then discuss in detail the following components of psychodynamic treatment which have supporting evidence – the therapeutic alliance, focus of therapy including diagnosis of core psychodynamic problems and psychodynamic formulation, active engagement, strategies for facilitating change, and attention to positive emotions. The presentation includes didactic presentation, actual patient video clips, a small group exercise in diagnosing core psychodynamic problems from clinical case vignettes, and large group exercise in developing a psychodynamic formulation. The course is based on Psychodynamic Therapy: A Guide to Evidence Based Practice by Drs. Summers and Barber, released in October, 2009 by Guilford Press. Evidence Based Psychodynamic Therapy uses a variety of modes of presentation, including video clips of actual patients, to present a concise and clear model of psychodynamic therapy based on current scientific evidence which is easier to learn and easier to apply than the traditional model and technique.

**Course Level:** Basic
**Format:** lecture, video clips, small group exercises, large group

**Tuesday, May 25, 2010, 1pm 5pm; Half Day 4 hours; Sheraton Hotel; Spaces Available: 70**
**Early Bird $130; Advance $150; On Site $170**

**Tuesday, May 25, 2010, 1pm 5pm; Half Day 4 hours; Sheraton Hotel; Spaces Available: 100**
**Early Bird $130; Advance $150; On Site $170**

## WEDNESDAY MAY 25, 2010
## 9 AM - 4 PM

### Course 77 Kundalini Yoga Meditation for Anxiety Disorders Including OCD, Depression, Attention Deficit Hyperactivity Disorder, and Posttraumatic Stress Disorder

**Topic: Other Somatic Therapies**

**Director:** David Shannahoff Khalsa, B.A.

**Educational Objectives:** At the conclusion of this session, the participant should be able to: 1) Have skills with specific meditation techniques for treating OCD, anxiety disorders, depression, grief, fear, anger, addictions, PTSD, and ADHD; 2) Be familiar with published results showing efficacy for new and treatment refractory OCD and OC spectrum disorders and comorbid patients; and 3) Be familiar with novel yogic concepts and techniques in mind body medicine now published in peer reviewed scientific journals.

**Description:** A short review of two clinical trials will be presented that used Kundalini yoga meditation techniques for treating OCD. The first is an open trial with a 55% improvement on the Y BOCS (International Journal of Neuroscience 1996) and the second is a randomized controlled trial (CNS Spectrums 1999) with a 71% mean group improvement on the Y BOCS. Whole head 148 channel magnetoencephalography brain imaging of 2 yogic breathing techniques (one for treating OCD and its inactive control rrelate) will be presented along with other novel studies in mind body medicine based on yogic concepts and techniques. Participants will practice and learn to implement select disorder and condition specific meditation techniques for inducing a meditative state, "energizing," facing mental challenges, one specific for OCD, several breathing techniques for generalized anxiety disorders, a 3 minute technique to help manage fears, an 11 minute technique for anger, a 3 minute technique to help focus the mind, 2 different meditation techniques specific for depression (one for 11 minutes and the other for 15 minutes), an 11 31 minute technique for addictions, a 11 minute technique for ADD/ADHD, one for releasing childhood anger, and one useful for PTSD and other traumatic events. The participants will also be taught how to formulate short protocols for patients that want to include these techniques in their treatment protocol as either a complement to medication, medication resistance, or electing to forgo medication. Complete protocols will be taught for OCD, ADHD, PTSD, and major depressive disorder. Ample time will be given to answer questions and to discuss the participant's personal experiences of the techniques
during the course.

**Course Level:** Basic
**Format:** In this course participants will be sitting in chairs, and the content will involve both lecture on scientific publications including clinical trials, and interactive participation where the participants learn and practice a wide range of meditation techniques. The Powerpoint presentation and Course handouts will include all of the details on how the techniques are to be practiced, so note taking is not necessary.

**Wednesday, May 26, 2010, 9am 4pm; Full Day 6 hours; Sheraton Hotel; Spaces Available: 110**
**Early Bird $190; Advance $220; On Site $250**

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