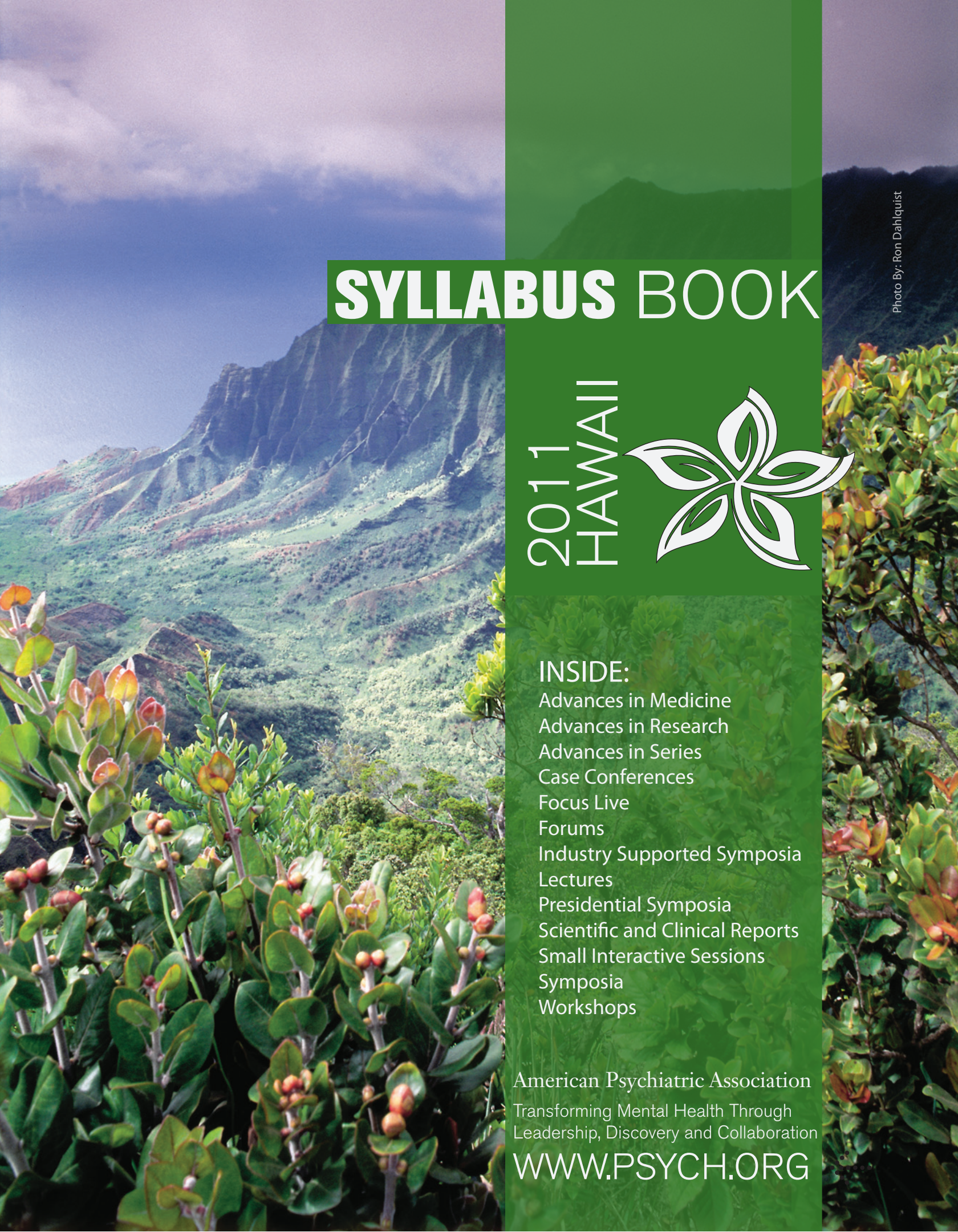

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2011 HAWAII

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IN SUMMARY FORM

THE ONE HUNDRED AND SIXTY FOURTH ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Honolulu, HI
May 14-18, 2011

Published by

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May 2011

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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.

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EMBARGO: News reports or summaries of APA 2010 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

2011 Annual Meeting • Honolulu, HI

Transforming Mental Health Through Leadership, Discovery and Collaboration

Carol A. Bernstein, M.D.
President, APA

Dear Colleagues and Guests:

Welcome to the 164th Annual Meeting of the American Psychiatric Association in Honolulu, an idyllic setting rich in cultural diversity and natural beauty. I think you will find the program thought-provoking and informative, reflecting a combination of new science, clinical advances and outstanding educational experiences. "Transforming Mental Health through Leadership, Discovery and Collaboration" is the meeting's theme. We have invited the best psychiatrists and scientists from across the country and around the world to teach us about their work in special lectures, scientific symposia and workshops. The official Opening Session will be on Sunday and the Convocation will be on Monday. We are honored to have world-renowned human rights activist and Nobel Peace Prize recipient Archbishop Desmond Tutu as the Convocation speaker. Also presenting a special lecture will be attorney Barry Scheck, co-founder of the Innocence Project, a non-profit legal clinic dedicated to exonerating wrongfully convicted people through DNA testing and to reforming the criminal justice system to prevent future similar injustices. We are delighted to once again partner with the National Institute on Mental Health (NIMH) to highlight how cutting-edge science on mental disorders is informing clinical practice. Lectures by NIMH director Thomas Insel, M.D., and David Lewis, M.D., director of the Translational Neuroscience Program at the University of Pittsburgh headline the NIMH track. Symposia will highlight the latest science, new developments in the treatment of neurodevelopmental and mood disorders, and progress on the revision of the DSM, including the status of field trials. FocusLive, the Advances In series, Advances in Medicine, and Advances in Research all return by popular demand. A new feature this year, the Annual Meeting Self-Assessment in Psychiatry, is designed to serve several purposes: identify areas needing improvement; fulfill the self-assessment component of Maintenance of Certification; help prioritize a learning program for the Annual Meeting; provide a score and peer comparison; and provide CME credit. After taking the 100-question assessment, physicians will receive feedback about areas of strength and weakness in medical knowledge. 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. Many thanks go out to the Scientific Program Committee for its outstanding work under the leadership of Tana Grady-Weliky, M.D., and Don Hilty, M.D., and to the APA staff members who have all worked so diligently to ensure the breadth and quality of the 2011 Annual Meeting program. The APA will be honoring the memory of Dr. Grady-Weliky, who passed away on January 17, 2011 after a long and valiant battle with cancer. The outstanding educational opportunities which await you at our 164th Annual APA meeting are a tribute to her leadership and vision.

I look forward to seeing you in Hawaii.

Sincerely,

Carol A. Bernstein, M.D.

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ADVANCES IN MEDICINE
SATURDAY MAY 14, 2011
8:00 AM SESSIONS

ADVANCES IN MEDICINE 1
MEDICAL MYSTERIES AND PRACTICAL MED PSYCH UPDATES: IS IT "MEDICAL", "PSYCHIATRIC" OR A LITTLE OF BOTH…?
Chair: Robert M McCarron, D.O., University of California, Davis, 2230 Stockton Blvd, Sacramento, CA 95817
Presenters: Glen L. Xiong, M.D. , Jane Gagliardi, M.D., Jaesu Han, M.D., Chris Kenedi, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify and 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.

MONDAY MAY 16, 2011
10:00 AM SESSION

ADVANCES IN MEDICINE 2
UPDATE ON EPILEPSY - THE DIAGNOSIS AND MANAGEMENT OF PATIENTS WITH "SPELLS"
Chair: Alan G. Stein, M.D., The Queen's Medical Center, 1301 Punchbowl St., Honolulu, HI 96813

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Define "seizures", "epilepsy", and "non-epileptic seizures"; 2) Recognize when seizures are medically intractable; 3) Assess the role of Video/EEG monitoring in the evaluation of medically intractable seizures; and 4) Recognize behaviors associated with psychogenic non-epileptic seizures.

SUMMARY:
Approximately 1 out of 10 people will have a seizure at one time in their life and approximately 1% of the population has epilepsy. This presentation will review the epidemiology and definition of seizures and epilepsy as well as the definition of medically intractable seizures. A review of various seizure types including psychogenic non-epileptic seizures will allow for discussion of appropriate evaluation of intractable seizures including the role of video/EEG monitoring. Viewing of a series of video presentations will reinforce recognition of behavioral findings associated with various common and uncommon seizure types including psychogenic non-epileptic seizures.

REFERENCES:
1. Neurol Clin. 2009 Nov;27(4):1003-13. Identification of pharmacoresistent epilepsy. Berg AT.
2. Neurology. 2006 Jun 13;66(11):1730-1. Ictal eye closure is a reliable indicator for psychogenic nonepileptic seizures. Chung SS, Gerber P, Kirlin KA.

TUESDAY MAY 17, 2011
8:00 AM SESSIONS

ADVANCES IN MEDICINE 3
THE TOP 10 MEDICAL ARTICLES OF 2010 - A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW
Chair: Monique V. Yohanan, M.D., M.P.H., Epocrates, 1100 Park Place, Suite 300, San Mateo, CA 94403

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify 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 co-morbid medical and psychiatric diagnoses; 3) Provide a critical appraisal of the evidence base and methodology of selected publications.

SUMMARY:
This session will provide a review of the medical literature and guidelines in Internal Medicine published in 2010. Areas covered will include those representing important findings likely to impact clinical medical practice, with a special focus on topics common to patients with co-morbid 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.

ADVANCES IN MEDICINE 4
CLINICAL CHALLENGES OF DIABETES MANAGEMENT IN PSYCHIATRIC DISORDERS

Chair: Richard F. Arakaki, M.D., John A. Burns School of Medicine, University of Hawaii-Manoa, 677 Ala Moana Blvd, Suite 1024, Honolulu, HI 96813

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Discuss the epidemiology and association of patients with diabetes and psychiatric illnesses; 2) Review the pathophysiologic approach to the treatment of hyperglycemia; and 3) Identify the challenges of diabetes management in the patient with psychiatric illness.

SUMMARY:
Patients with psychiatric illnesses have increased risk of CVD risk factors and mortality. There are greater rates of cigarette smoking, HTN, diabetes mellitus, and dyslipidemia among patients with severe mental illness. The use of anti-psychotic medications has been associated with increasing obesity and a 2-3 fold increased in type 2 diabetes with an overall prevalence rate estimated at 10-13% of adults. Additionally, patients with diabetes have an increased rate of psychiatric illnesses especially, depression which impacts long-term management. The current approach to the management of hyperglycemia in patients with diabetes targets the underlying pathophysiologic changes. Addressing beta-cell function with insulin and secretagogues as well as insulin resistance with weight loss and insulin sensitizers formulates the foundation of hyperglycemia intervention. More recently, incretin-based treatment with GLP-1 receptor agonist and DPP-4 inhibitors has offered new treatments that not only improve glycemia but also reduce weight. General guidelines for the diagnosis and management of diabetes mellitus in the patient is psychiatric illness is reviewer and elaborated.

REFERENCES:

1. Nathan, D. M., Buse, J. B., Davidson, M. B., et al. Medical management of hyperglycemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy. Diabetes Care 2009; 32:193-203.
2. American Diabetes Association, American Psychiatric Association, et al. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004;27:596-601.

10:00 AM-11:30AM

ADVANCES IN MEDICINE 5
ADVANCES IN BREAST CANCER AND THEIR IMPLICATIONS

Chair: William Audeh, M.D., Samuel Oschin Cancer Institute Cedars-Sinai Medical Center, 8700 Beverly Boulevard, Suite AC-1046, Los Angeles, CA 90048

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize advances and controversies in prevention and early detection of breast cancer; 2) Identify advances in genomic profiling and personalized medicine approaches in breast cancer; and 3) Review trends in clinical research in breast cancer and impact on patient management.

SUMMARY:
Breast Cancer remains the greatest health fear for women in the U.S., despite the many advances in the prevention, early detection, and treatment of breast cancer which have occurred in the past decade. Women concerned about their risk of breast cancer, and seeking means by which to reduce their risk or detect cancer at the earliest stages are met with confusing and often contradictory information from various sources, including physicians, particularly in regards to issues such as hormone use, genetic testing, and mammography. Controversies regarding prevention and early detection will be discussed. Women newly-diagnosed with breast cancer now have access to the latest genomic and molecular technology, such as tumor profiling, as well as an array of targeted therapies in both the early and late stages of disease, making for improved chance of cure and response to therapy. Genomic profiling allows for a "personalized medicine" approach to breast cancer, and has allowed many women to avoid chemotherapy. However, the complexity of information required for informed medical decision-

making can be overwhelming. The impact of these new technologies on women and their physicians will be discussed. For women with metastatic breast cancer, where cure is not considered possible, hundreds of new targeted therapies are currently in clinical trials, providing some hope for a change in the natural history of the disease, as well as promoting anxiety over concerns that "the cure" is out there somewhere, if the right physician or alternative healer could be found. Underlying these issues are the hormonal changes, fertility concerns, and issues of self-image and sexuality which accompany the diagnosis and treatment of breast cancer. The advances in breast cancer diagnosis and management and their impact on patients and physicians will be discussed, with the goal of understanding the complex issues involved in breast cancer management.

REFERENCES:

1. Crago, A., Azu, M., Tierney, S., Morrow, M., (Jan 2010) Randomized Clinical Trials in Breast Cancer. Surgical Oncology Clinics of North America, Vol. 19, Issue 1, Pages 33-58, DOI: 0.1016/j.soc.2009.09.003
2. Phuong Khanh H. Morrow and Gabriel N. Hortobagyi (Feb 2009) Management of Breast Cancer in the Genome Era Annual Review of Medicine, Vol. 60: p. 153 -165.

MONDAY MAY 16, 2011

8:00 AM SESSION

ADVANCES IN RESEARCH

Chair: Herbert Pardes, M.D., New York Presbyterian Hospital, 177 Fort Washington Avenue, Room 142, New York, NY 10032 U.S.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the various contributing factors influencing the aging process and neuro-psychiatric disorders of older populations. This includes the role of genetics, life style factors, wisdom and et.al.; 2) Describe the interaction between diabetes and depression both explicating the role of depression as a risk factor for the development of Type II diabetes and also the interaction between diabetes and depression as a co-morbid event with diabetes. Focusing particularly on the relationship of depression to complications of diabetes such as amputation and vascular events. Recognize the new interventions for patients with fully controlled diabetes, and behavioral and psychiatric aspects; 3) Review the best treatment and assessment approaches to disorders in children such as social phobia, generalized anxiety disorder, separation anxiety disorder, etc.; 4) Gain an understanding of the relationship between PTSD, depression and suicidal risk.

SUMMARY:

This group of outstanding academic and clinical psychiatric researchers will bring the audience up-to-date regarding key topics core to psychiatric care. These include updates on the child psychiatric conditions including obsessive compulsive disease, generalized anxiety disorders, phobias, etc. The panel will also cover the interaction between depression and non psychiatric illnesses such as diabetes with a focus both on the circumstances under which the one seems to be a contributor to the development of the other and other instances in which there are co-morbidities. The panel will also cover PTSD, dementia, and the universe of clinical approaches to both diagnosis and treatment.

ANXIETY DISORDER IN CHILDREN AND ADOLESCENTS: STATE OF THE ART ASSESSMENT AND TREATMENT

John T. Walkup, M.D., Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287-0005

Anxiety disorders are early in onset and among the most common conditions affecting children and adolescents. The best studied of the childhood anxiety disorders is obsessive compulsive disorder. Although less commonly studied, separation anxiety disorder, generalized anxiety disorder and social phobia are more prevalent and associated with persistent anxiety, depression and drug abuse in adulthood. Early recognition and intervention could prevent morbidity and even mortality due to these disorders. Initial treatment with pharmacological and psychotherapeutic interventions is effective but a substantial proportion of children are unresponsive. While combination treatment offers the best overall chance for response, high quality combination treatment is not readily available in many communities. This presentation will review the current state of the art in the assessment and treatment of childhood anxiety disorders and discuss approaches to the development of preemptive and personalized treatments for the childhood anxiety disorders.

POST TRAUMATIC STRESS DISORDER, MAJOR DEPRESSION AND THE RISK FOR SUICIDAL BEHAVIOR

Maria A. Oquendo, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032

Post-traumatic stress disorders (PTSD) and major depression are common, often co-morbid, and the presence of one diagnosis compounds risk for the development of the other. Indeed, between 14% and 25% of individuals exposed to catastrophic trauma develop PTSD, and about 26% have an additional diagnosis of major depressive episode. Moreover, within 8 months of a traumatic event, 23% of exposed adults develop major depressive episode with or without PTSD, often within days of the event. Community surveys suggest that lifetime prevalence of suicide attempts in major depressive episode is approximately 16% and 14.9 times more likely in patients with PTSD. Some, but not all studies of suicidal behavior in subjects with co-morbid PTSD and major depressive episode found have increased level of suicidal behavior. Although suicide rates are higher in Vietnam-era veterans than in the general population, there are conflicting results regarding suicide attempts and ideation in trauma victims. Studies of suicidal behavior among current military personnel and recent veterans are ongoing. Deeper understanding of the interaction between these two common diagnoses and the risk for suicidal behaviors may permit interventions to prevent morbidity and premature death in both civilian and military populations.

SUCCESSFUL COGNITIVE AGING AND WISDOM

Dilip V. Jeste, M.D., University of California at San Diego, 9500 Gilman Drive Room 0664, La Jolla, CA 92037

The next 20 years will witness the largest-ever increase in the numbers of older people, especially those living highly functional lives. Although it involves both mental and physical health, the critical component of successful aging requires a healthy brain and mind. This presentation will cover definition, prevalence, genetic markers, lifestyle factors, and other correlates of healthy aging as well as possible ways of enhancing the likelihood of successful aging. Our group has conducted studies of successful aging in > 3,000 community-dwelling seniors. Our results suggest that a majority of the respondents feel that they are aging well, often despite physical disability. Significant associations of successful aging include an absence of depression, high overall level of physical and psychosocial activities, resilience, and a positive attitude toward aging. We also have studied successful aging in people with schizophrenia. Nearly 10% of community-dwelling persons with schizophrenia have sustained remission. I will also discuss the concept of wisdom as described from the ancient to the modern times, and review the recent empirical research in this area, including its relation to successful aging. Wisdom is a uniquely human complex trait with several subcomponents including knowledge of life, emotional regulation, insight, pro-social behavior, value relativism, and acting in the face of uncertainty. I will present a putative neurobiological model of wisdom, and suggest ways of conducting further research.

DEPRESSION AND DIABETES: UNHEALTHY BEDFELLOWS

Wayne Katon, M.D., University of Washington Medical Center, Department of Psychiatry, P.O. Box 356560, Seattle, WA 98195-6560

This lecture will describe the bidirectional interaction between depression and diabetes. Depression is both a risk factor for development of type 2 diabetes and can also develop secondary to complications of diabetes such as amputation and vascular events. Comorbid depression in patients with diabetes is associated with increased symptom burden, functional impairment, higher medical costs, poor adherence to self-care regimens and an increased risk of macrovascular and microvascular complications and mortality. Three collaborative care trials have shown that, compared to usual primary care, depressive outcomes can be significantly improved and that the cost of enhanced depressive care was offset by greater savings in medical care. Finally, a new intervention approach, TEAMcare, will be described that has been shown in patients with poorly controlled diabetes and/or heart disease and co-morbid major depression to improve depression and medical disease control, including HbA1c, systolic blood pressure and LDL cholesterol compared to usual care.

REFERENCES:

1. Jeste, D.V., and Harris, J. C., Commentary: Wisdom - A neuroscience perspective. Journal of the American Medical Association 304:1602-1603, 2010.
2. Jeste, D. V., Depp, C. A., and Ipsit, V: Successful cognitive and emotional aging. World Psychiatry 9: 78-84, 2010
3. Katon W: Depression and diabetes: unhealthy bedfellows. Depression and Anxiety 27:323-328, 2010.
4. Katon W: The comorbidity of diabetes and depression. American Journal Medicine 121"S8-S15, 2008
5. Oquendo M, Brent DA, Birmaher B, Greenhill L, Kolko D, Stanley B, Zelazny J, Burke AK, Firinciogullari S, Ellis SP, Mann JJ. Am J Psychiatry. 2005. 162(3):560-6.

SUNDAY MAY 15, 2011
8:00 AM SESSION

ADVANCES IN 1 PSYCHOTHERAPY AND PHARMACOTHERAPY FOR SUBSTANCE USE DISORDERS

Chairperson.: Marc Galanter, M.D., New York University School of Medicine, 550 First Avenue, Room NBV-20N28, New York, NY 10016
Co-Chair: Herbert D. Kleber, M.D., Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Be better able to integrate pharmacotherapy into their psychotherapy with substance abusers; 2) Conduct more effective management of patients on buprenorphine maintenance; and 3) Work more effectively with state programs that monitor substance-abusing physicians.

OVERALL SUMMARY:
Over the course of recent years there have been marked advances in the variety of psychotherapeutic techniques available to the clinician in engaging and treating patients with substance use disorders. These techniques are particularly useful in office practice, but can also be applied in mental health or substance abuse treatment programs. Among these are intervention techniques which may be employed in order to initiate treatment, particularly with reluctant patients; motivation enhancement, which can be used to improve the willingness of patients to participate in treatment once they are contemplating dealing with their substance use disorder; cognitive behavioral therapy, a mainstay of treatment which can be employed in combination with a variety of other techniques, among them individual therapy, family therapy, and medication management. Additionally, with the advent of buprenorphine for management of opioid-dependent patients, the social and clinical context in which buprenorphine is applied is important in framing its use in the clinical setting. Finally, there have been marked advances in the management of physicians with substance use disorders, and options for both psychosocial and pharmacologic approaches are available in programs directed at physicians' health. This symposium will therefore deal with these important aspects of the treatment of addiction, with particular emphasis on how the psychotherapeutic context and the actions of pharmacologic agents interact, so that the attendees will be able to employ these in combination to achieve an optimal clinical outcome. The material presented here is therefore valuable, in that the psychotherapeutic and pharmacologic approaches are typically presented separately, without clarification of how they can be employed together.

No 1
INTERVENTION TECHNIQUES FOR INITIATING SOCIAL AND PHARMACOTHERAPEUTIC TREATMENT

Laurence Westreich, M.D., Langone Medical Center, 275 Central Park West, New York, NY 10024

SUMMARY:
Intervention is an attempt by those who care about the addicted person to change the addiction's course and promote treatment, using convincing techniques, group support, emotional pressure, and sometimes all three. Although many think of intervention only as the formal group intervention recently popularized by television shows like the A&E Network's weekly documentary Intervention, in fact true intervention with the addicted person resides along a broad spectrum of convincing and increasingly coercive tactics, from the quiet friendly word, to the group intervention, all the way up to court-mandated treatment. This presentation will consider the goals of intervention with the addicted person, some general techniques in confronting and then intervening, and some more specific intervention models such as Vernon Johnson's seminal "Intervention," the "Community Reinforcement and Family Training" (CRAFT) paradigm , and the "Pressures to Change" (PTC) protocol. Strategies involving dually diagnosed patients, medication, legal intervention, and professional interventionists will be addressed, as well as some suggestions for the therapeutic use of books and video in the intervention process. The focus throughout will be on practical suggestions on helping the addicted person engage with and benefit from addiction treatment. The goals of intervention with an addicted person are first, to preserve life and physical wellbeing, secondly, to get a full evaluation as soon as possible and thirdly, to encourage/bring

the addicted person to good treatment and support that treatment over time. Clinicians, family, and friends should focus on these three intervention goals if they want to change the trajectory of the addicted person's behavior. Although some specific intervention techniques will be described during the presentation, the presentation will also show the common modalities that the skilled and effective clinician uses, regardless of the actual protocol or set of protocols being deployed.

No 2

MOTIVATION ENHANCEMENT COMBINED WITH PHARMACOTHERAPY

Edward Nunes, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 51, New York, NY 10032

SUMMARY:
Several types of psychosocial-behavioral interventions have been studied for use either alone or in combination with medications for treatment of substance abuse. Such interventions have served as means of helping patients to achieve abstinence, encouraging lifestyle change, enhancing motivation, and promoting compliance with medications. An overview of models to enhance motivation, a brief review of findings in treatment outcome research, and a discussion of the implications for future research and treatment delivery will be provided.

No 3.

COGNITIVE BEHAVIORAL THERAPY COMBINED WITH PSYCHOPHARMACOTHERAPY

Kathleen Carroll Ph.D., Yale University School of Medicine, 950 Campbell Avenue, West Haven, CT 0 6516 and Bruce Rounsaville, M.D., Yale University School of Medicine, 333 Cedar Street, New Haven, CT 06510

SUMMARY:
CBT has strong empirical support across a range of different substance use disorders as well as psychiatric syndromes that frequently co-occur with substance use disorders (e.g., depression, anxiety). Key components of virtually all CBT approaches include functional analyses of substance use and individualized skill training with emphasis on cognitive and behavioral coping. Effects of CBT appear to be comparatively durable, with several studies reporting continuing improvement after patients leave treatment. Emphasis on skills training and practice may underlie this effect. Moreover, CBT is highly compatible with available pharmacotherapies for addiction, and recent evidence suggests it can be delivered in a range of formats and settings. Effective implementation of CBT in clinical practice is complex however. While a variety of manuals, videotapes and other training materials for CBT are available to clinicians; novel methods such as computer-assisted delivery may facilitate making this form of treatment available to a wide range of patients who may benefit from it.

No 4

THE THERAPEUTIC CONTEXT OF BUPRENORPHINE MAINTENANCE

Herbert D. Kleber, M.D., Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032

SUMMARY:
In 2002, the FDA approved buprenorphine as a schedule 3 drug that could be prescribed or dispensed from a physician's office for maintenance or detoxification of opioid dependence. Since then there has been a steady rise both in the number of patients receiving it and in the number of physicians who have the needed government waiver to prescribe or dispense it. Currently that number is in excess of 270,000 patients and 17,000 physicians. While the initial regulations limited the number of patients per physician to no more than 30, that has been modified to permit a physician to prescribe for 100 patients after 1 year at 30. While that has been good news in rural areas where certified physicians are few and distances great, it has opened the door to the possibility of prescription "mills" where the drug is given without any or the barest minimum of psychosocial intervention. This heights the risk of diversion to the street market, premature drop-out, poor performance and the risk that the patient achieves abstinence but not recovery. In alcoholism, this is known as being a "dry drunk." There are a number of roles for psychosocial interventions and for different types of such interventions and these will be discussed. Distinction will be made between interventions by addiction psychiatrists, general psychiatrists, and non-psychiatric physicians.

The need to modify the type and frequency of the intervention as the patient progresses will be stressed.

No 5.
TREATMENT OPTIONS AND OUTCOME FOR SUBSTANCE-ABUSING PHYSICIANS

Marc Galanter, M.D., New York University School of Medicine, 550 First Avenue, Room NBV-20N28, New York, NY 10016; and Robert Dupont, M.D., Institute for Behavior and Health, Inc., 6191 Executive Boulevard, Rockville, MD 20852

SUMMARY:
The problem of substance abuse and dependence among practicing physicians represents both a public health problem and a need for effective rehabilitation. In order to address this issue, most states now have programs for physicians' health that evaluate, monitor, and oversee treatment and recovery of substance-impaired physicians (as well as those with other impairments). Across the United States, there are currently thousands of such physicians enrolled in these programs. This presentation will clarify the nature of these programs and the modalities employed, as well as clarify implications for addiction treatment overall. A description of the case finding and monitoring functions of these programs will be provided, and the utility of differential modalities applied will be discussed. Among these are inpatient rehabilitation, psychotherapy, monitoring of urine toxicology, counseling, Twelve-Step recovery, and psychopharmacology. Each of these approaches has its own respective value in promoting recovery, and all are embedded to different degrees in different state programs. Although referral to Twelve-Step programs is typical of most physicians' health programs, other psychosocial modalities and psychopharmacology are applied as well. The outcome of full recovery among these programs and issues of return to practice will be described, based on empirical research recently conducted, also reflecting approaches employed in different settings. Because of the considerable success reported in the literature on these programs, and applications of similar interventions employed in quite different settings, implications for improvement in substance dependence treatment overall will be considered.

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NOON- SESSION

ADVANCES IN 2
ADVANCES IN THE TREATMENT OF BIPOLAR DISORDERS

Chair: Terence A Ketter, M.D., Stanford University School of Medicine, Department of Psychiatry, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723
Co-Chair: Po W. Wang, M.D., Stanford University School of Medicine, Department of Psychiatry, 401 Quarry Road, Stanford, CA 94304

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize how to quantify benefits, therapeutic effects and risks, adverse effects using number needed to treat (NNT) and number needed to harm (NNH); 2) Use evidence-based state-of-the-art pharmacotherapy for patients with bipolar disorders across all phases of the illness; and 3) Identify therapeutic implications of bipolar disorder occurring in children/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 agents. 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, there are 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.

No1.

ADVANCES IN TREATMENT OF ACUTE MANIA

Terence A. Ketter, M.D., Stanford University, Department of Psychiatry, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723

SUMMARY:
There are 3 mood stabilizers (lithium, valproate, and carbamazepine) and 7 antipsychotics (the first generation agent chlorpromazine, and the second generation agent olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, and asenapine) approved for the treatment of acute mania. Five of the latter (olanzapine, risperidone, quetiapine, aripiprazole, and asenapine) are also approved in combination with the mood stabilizers lithium or valproate. Although occasional outpatients with less severe symptoms may be managed with monotherapy, patients hospitalized for acute mania commonly require mood stabilizer plus second generation antipsychotic combination therapy. Sedation is a common effect of aggressively administered antimanic agents that might be considered advantageous during hospitalization, but becomes increasingly problematic after discharge when patients are trying to restore functioning. Also, some antimanic agents can yield clinically significant (at least 7%) weight gain during the 3-4 weeks of therapy necessary to treat acute mania. Thus, although the treatment of acute mania commonly requires aggressive pharmacotherapy that prioritizes efficacy over tolerability, decisions during that time need to integrate the need for efficacy with both the acute and longer- tolerability limitations of antimanic agents.

No 2

ADVANCES IN TREATMENT OF BIPOLAR DEPRESSION

Po W. Wang, M.D., Stanford University School of Medicine, Department of Psychiatry, 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 3

ADVANCES IN MAINTENANCE TREATMENT OF BIPOLAR DISORDER

Terence A. Ketter, M.D., Stanford University School of Medicine, Department of Psychiatry, 401 Quarry Road, Room 2124, Stanford, CA 94304

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-2010, the FDA approved longer-term treatments for bipolar disorders included five monotherapies (lithium, lamotrigine, olanzapine, aripiprazole, and risperidone), and three adjunctive (added to lithium or valproate) therapies (quetiapine, risperidone and ziprasidone). In addition, controlled data indicated that monotherapy with quetiapine and divalproex 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 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 recurrence. In general, mood stabilizers (lithium, lamotrigine, and divalproex) compared to second generation antipsychotics (olanzapine, aripiprazole, quetiapine, risperidone, and ziprasidone) 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 recurrence, as well as in profiles of specific adverse effects, with there being important unmet needs for treatments that prevent depressive recurrence, and well-tolerated treatments that prevent manic/mixed episode 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. 4

TREATMENT OF CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER

Kiki Chang, M.D., Stanford University, Department of Psychiatry, 401 Quarry Road, Stanford, CA 94305-5719

SUMMARY:
Bipolar disorder begins before age 18 years in over two-thirds of cases. Children and adolescents diagnosed with bipolar disorder 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 intervention. Early identification and treatment of pediatric bd is essential to prevent the chronicity of symptoms and associated complications. 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 for individuals with pediatric bipolar disorder.

No 5.

TREATMENT OF PREGNANT WOMEN WITH BIPOLAR DISORDER

Mytilee Vemuri, M.D., M.B.A., Stanford University, 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 6.

TREATMENT OF OLDER ADULTS WITH BIPOLAR DISORDER

John O. Brooks III, Ph.D., M.D., University of California – Los Angeles, Semel Institute, Psychiatry & Biobehavioral Sciences, 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, T. A., (Ed): Handbook of Diagnosis and Treatment of Bipolar Disorder. Washington, DC, American Psychiatric Publishing 2010.

MONDAY MAY 16, 2011
12:00 PM SESSION

ADVANCES IN 3
ADVANCES IN PSYCHOTHERAPY

Chair: Glen O. Gabbard, M.D., Baylor College of Medicine, 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 factors that determine psychotherapy strategies with suicidal patients, PTSD patients, substance abusers, and personality disorders.

SUMMARY:
This Advances in updates the audience with recent breakthroughs in research relevant to psychotherapy practice. Dr. Spiegel will present findings about the two subtypes of PTSD that lead to differential approaches to the therapeutic management of the patients. Dr. Gabbard will provide the latest findings regarding the relative roles of transference interpretation and the therapeutic alliance in producing change in psychotherapy. Dr. Stanley will offer empirical data to guide psychotherapists who are treating suicidal patients. Dr. O'Brien will provide an overview of findings on the value of combining medication and psychotherapy with substance abuse patients. Finally, Dr. Karlsson will share the findings of his research in Finland on the impact of psychotherapy on the brain.

No 1.
PSYCHOTHERAPIES FOR HYPERAROUSAL AND DISSOCIATIVE SUBTYPES OF PTSD: SIMILARITIES AND DIFFERENCES

David Spiegel, M.D., Stanford University, Department of Psychiatry & Behavioral Studies, 401 Quarry Road, Room 2325, Stanford, CA 94305-5718

SUMMARY
The working through involves the following "8 C's": 1) Confront Trauma. 2) Find a condensation of the traumatic experience. This makes the memories finite and manageable. 3) Allow for confession. Many trauma victims feel ashamed as a result of their experiences. 4) Provide consolation. Appropriate expressions of sympathy go a long way toward acknowledging the normality of an extreme reaction to an extreme experience. Detachment or disinterest conveys rejection. 5) Make conscious previously dissociated material in a graded and controlled manner. 6) Utilize focused concentration in the working through of traumatic memories. Techniques such as hypnosis can facilitate access to dissociated aspects of memory, and enhance control over their intrusive and arousing aspects. In particular, teaching dissociation of somatic from psychological arousal can enhance affective and cognitive modulation. 7) Enhance the patient's sense of control over the traumatic memories. The process of the therapy must reinforce the content by providing a greater sense of control over traumatic memories, and in the relationship with the therapist. Constant attention to the 'traumatic transference' implications of the psychotherapy is important, so that the therapeutic alliance is maintained and the therapist is not perceived as inflicting rather than helping with trauma. 8) Facilitate the development of congruence, the incorporation of traumatic memories into an integrated and acceptable view of the self. This counters dissociative fragmentation and stabilized treatment gains.

No 2.
PSYCHOTHERAPY WITH SUICIDAL PATIENTS

Barbara H. Stanley, Ph.D., New York State Psychiatric Institute, 1051 Riverside, Unit 42, New York, NY 10032

SUMMARY:
Managing and treating suicidal patients in outpatient settings is one of the most challenging and worrisome tasks that psychiatrists face. There is a delicate balance between maintaining the patient in outpatient treatment vs. insisting on a more restrictive or structured environment, e.g. inpatient hospitalization, day program. There is a danger if every declaration of suicidal thinking is met with alarm and possible hospitalization that the patient will withdraw and stop disclosing suicidal thoughts. In this presentation, we will discuss how suicidal behavior and thinking can be treated effectively in outpatient settings while using hospitalizations in a judicious manner. In particular, we will discuss how to create a climate of open disclosure, techniques that can be used (e.g. Safety Planning Intervention (Stanley & Brown, in press)) to mitigate suicide risk and additional monitoring and support that can be provided during times of acute suicidal crises. The importance of affirmatively assessing suicidality over time and developing plans collaboratively to cope with suicidal feelings. In addition, we will discuss how viewing suicidal threats as manipulative and attention-seeking is not generally helpful and, for most often, is not the primary reason for suicidal thinking. Many patients see suicide as a solution, as a way out of their intense emotional pain. We will discuss how therapists can effectively use validation by agreeing with the patient's wish to rid themselves of the emotional pain while offering options to suicide as ways to decrease pain. Finally, we will discuss the particular stresses on the therapist when working with suicidal patients and strategies for handling these stresses.

No 3.
TRANSFERENCE, INTERPRETATION,

THERAPEUTIC ALLIANCE, AND CHANGE

Glen O. Gabbard, M.D., Baylor College of Medicine, 6655 Travis St Suite 500, Houston, TX 77030-1316

One of the major controversies in the field of psychotherapy revolves around the relative contributions of transference interpretation and the therapeutic alliance to the process of change in psychotherapy. The two constructs are often artificially polarized as though they aren't mutually synergistic. Transference interpretation may strengthen the alliance, and the alliance may be necessary for effective transference interpretation. Recent research suggests that transference work may be necessary for successful therapy of patients with impaired object relations. New data supports this finding and also indicates that in patients who score high in object relations, transference interpretation may not be necessary for good outcomes. These findings will be discussed and the implications for psychotherapy will be elaborated.

No 4.

PSYCHOTHERAPY PLUS: MEDICATION FOR ADDICTIVE DISORDERS

Charles O'Brien, M.D., Ph.D., University of Pennsylvania School of Medicine, 3900 Chestnut Street, Philadelphia, PA 19104

SUMMARY:
The treatment of addictive disorders has advanced significantly over the past two decades. Manual guided psychotherapies have been developed and have shown efficacy in controlled trials. Efforts to develop new medications have benefited from the availability of animal models that predict results in the clinic; thus effective medications have been discovered that have passed FDA review in placebo controlled trials. The most effective clinicians combine medication and psychotherapy although there is still some resistance among those who are philosophically opposed to the use of medication in these disorders. The type of medication depends on the drug of abuse. Agonist medication activates receptors in a manner similar to the drug it replaces. Thus the agonist nicotine and the partial agonist varenicline reduce craving and withdrawal in smokers attempting to end their addiction. Bupropion reduces nicotine craving and all can be combined with well-described behavioral counseling. Three different types of medication are available for alcoholism. All can be combined with 12 step therapy. Naltrexone depends on the ability of alcohol to activate the endogenous opioid system. A variant of the gene for the μ opioid receptor predicts increased euphoria and endorphin response from alcohol. There is evidence that in the future, clinicians may be able to predict naltrexone responders by a genetic test. A long acting depot version of this medication is now available to be combined with psychotherapy in the treatment of this common disorder. In the treatment of opioid addiction, agonist medications have had a major impact because drug free treatment leads to relapse in most patients. Methadone and buprenorphine are both successful as long term maintenance medications making the patients able to be engaged in psychotherapy. Other patients respond best to antagonists that prevent relapse by blocking receptors.

No 5

PSYCHOTHERAPY INDUCES PROLIFERATION OF BRAIN SEROTONIN 5-HT1A RECEPTORS BUT DOES NOT INFLUENCE DOPAMINE D2/3 RECEPTORS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Hasse Karlsson M.D., University of Turku, Lehmustie 12-B, Turku, 20720 Finland

SUMMARY:
Background: The number of serotonin 5-HT1A receptors in the brain are decreased among patients with major depressive disorder (MDD) and it has been considered a trait marker of the illness. Also changes in the dopamine D2/3 receptors have been reported. Methods: In this study, which was a part of a larger randomized controlled trial (Salminen et al. 2008), we compared the effects of fluoxetine (FLX) medication and short-term psychodynamic psychotherapy (STPP) on the density of 5-HT1A and D2/3 receptors in the brain in MDD. In this part of the trial, 23 patients with non-comorbid MDD received either STPP or FLX medication for 16 weeks. 5-HT1A and D2/3 receptor densities were estimated before and after the treatments using positron emission tomography (PET), [carbonyl-11C] WAY-100635 and [carbonyl-11C] raclopride.

Results: While the clinical outcome was similar in both groups, psychotherapy increased the binding to 5-HT1A receptors, but antidepressant medication did not alter the 5-HT1A receptor density in these patients (Karlsson et al. 2010). Neither treatment affected the D2/3 system in striatum, but FLX increased the binding potential in lateral thalamus (Hirvonen et al. 2010). Conclusions: This is the first study to show that psychotherapy leads to changes in the molecular structure of the synapse in patients with MDD. Our findings also demonstrate that different antidepressant treatments are associated with different neurobiological molecular changes.

REFERENCES:

1) Gabbard GO: Long-Term Psychodynamic Psychotherapy: a Basic Text: 2nd edition, American Psychiatric Publishing, 2010
2) Lanius et al: Emotion modulation in PTSD. American Journal of Psychiatry 167:640-647, 2010
3) Stanley B and Seiver L: The interpersonal dimension of BPD. American Journal of Psychiatry 167:24-39, 20104)
4) Woody G et al: Psychotherapy in community methadone programs: a validation. American Journal of Psychiatry 152: 1302-1308, 1995.

TUESDAY MAY 17, 2011

NOON SESSIONS

ADVANCES IN 4
ADVANCES IN PERSONALITY DISORDERS

Chairperson: John M. Oldham, M.D., M.S., The Menninger Clinic, 2801 Gessner Drive, Houston, TX 77080
Co-Chair: Andrew E. Skodol, M.D., Sunbelt Collaborative, 6340 N. Campbell Avenue, Suite 130, Tucson, AZ 85718

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of new developments in research, treatment, and new directions relating to personality disorders (PDs).

SUMMARY:
Significant progress continues to be made in our advancing knowledge about personality styles, types, and disorders, and the ways that these fundamental components of human behavior contribute to overall health or illness. In the deliberations of the Task Force on *DSM-5*, the importance of understanding the individual personality profile of each patient has been emphasized, since co-morbidity complicates treatment response, and certain personality styles or disorders can dramatically undermine treatment adherence. In this symposium, an update will be presented of the proposed revisions for *DSM-5* in the realm of personality and personality disorders. New findings from neuroimaging research and from social neuroscience research on borderline personality disorder (BPD) will be described, and the way that new neurobiological findings inform treatment of patients with BPD will be considered. An update on our knowledge of antisocial personality disorder will be presented as well, of particular importance due to the cost and burden of this condition and the challenges involved in its treatment and prevention. Finally, a special look at the complex problems related to personality styles and disorders of soldiers on active duty will be provided.

No 1.
NEUROBIOLOGY, PSYCHOTHERAPY, AND BORDERLINE PERSONALITY DISORDER

Glen O. Gabbard, M.D., Baylor College of Medicine, 6655 Travis St Suite 500, Houston, TX 77030-1316

SUMMARY:
The neurobiological research related to borderline personality disorder is beginning to offer clues regarding possible modes of therapeutic action in the psychotherapy of the disorder. A striking finding in the psychotherapy research literature on bpd is that many approaches result in improvement. This finding suggests common neurobiological pathways in the psychotherapy of borderline personality disorder. This presentation will examine a subgroup of findings in the neurobiological research on bpd and show how these data may inform what we do with patients and how they may explain the apparent nonspecific factors at work in successful psychotherapy of borderline personality disorder.

No 2.
UPDATE ON NEUROIMAGING IN BORDERLINE PERSONALITY DISORDER

Christian Schmahl, M.D., Central Institute of Mental Health, J-5, Mannheim, D-68159 Germany

SUMMARY:
This presentation will give an overview of

neuroimaging findings in borderline personality disorder. Structural and functional imaging studies have revealed dysfunction in different brain regions which seem to contribute to borderline symptomatology. There are three domains of neuroimaging findings: (1) affective dysregulation, (2) the complex of dissociation, self-injurious behavior, and pain processing and, (3) social interaction. The amount of knowledge of the neural basis of borderline personality disorder has considerably grown over the last years. This presentation will also focus on the necessary next steps in neuroimaging research.

No 3.

THE SOCIAL NEUROSCIENCE OF BORDERLINE PERSONALITY DISORDER: EMPATHY AND ALEXITHYMIA

Antonia New, M.D., Mount Sinai School of Medicine, J. J. Peters Veterans Administration Medical Center, MIRECC, 130 West Kingsbridge Road, Bronx, New York 10468

SUMMARY:
Objective: borderline personality disorder (BPD) is characterized by interpersonal dysfunction, but little empirical research has focused on specific deficits in social cognition in BPD. We have shown that bpd patients hyper-respond physiologically to emotional probes, but show relatively attenuated subjective ratings of those responses. We hypothesized that this might reflect alexithymia in BPD. This study aimed to characterize components of social cognition in bpd including alexithymia and empathy in BPD. Method: 40 un-medicated BPD patients and 37 age- and sex-matched healthy controls we included. Alexithymia was measured with the Toronto Alexithymia scale and empathy with the interpersonal reactivity index (IRI); the influence of these measures on interpersonal functioning was also assessed. Finally, we measured responses to positive, negative and neutral emotional pictures with a computer task with subjects focusing both on the experience of the individual in the picture and also the subject's own experiences. Results: BPD subjects had dramatically higher alexithymia scores than controls ($p<0.00001$), poorer ability to take the perspective of others (iri-perspective taking: $p<0.01$), higher personal distress in response to others' distress (IRI-personal distress: $p<0.0001$), but intact compassion for pain in others (IRI-empathic concern). In bpd alexithymia was related to poor self-esteem and higher dissociation, whereas in controls, but not patients, it related to less tangible social support. Differences in task performance were clearest in response to positive valence pictures. Low-alexithymic controls rated positive experiences of self and others similarly, whereas high-alexithymic controls rated their own response to positive pictures less positively than others'. In BPD, low-alexithymic patients rated self-experiences less positively than others', but high-alexithymics rating self and others similarly. Conclusions: We show that some, but not all, aspects of social cognition are intact in BPD. Specifically, BPD patients are highly porous to the feelings of others, relating and hyper-responding to pain in others. However, they are impaired in identifying and describing feelings (alexithymic) and in taking the perspective of others. Alexithymia is associated with reduced availability of social contacts in controls but not BPD. Alexithymia also influenced responses to emotional probes differently in bpd than in controls. In controls, high levels of alexithymia made responses to positive images less positive when related to the self compared to others as might be expected. However, in bpd, low ratings of self-positive experiences were seen in the low not the high alexithymic group. This raises the possibility that alexithymia may even function in a protective mechanism in BPD.

No 4.

PROPOSED NEW MODEL FOR PERSONALITY AND PERSONALITY DISORDER ASSESSMENT AND DIAGNOSIS IN *DSM-5*: AN UPDATE

Andrew E. Skodol, M.D., Sunbelt Collaborative, 6340 N. Campbell Avenue, Suite 130, Tucson, AZ 85718

A new hybrid dimensional model for personality and personality disorder assessment and diagnosis is being proposed for DSM-5. Since its original posting on the APA's DSM-5 Website, the model has been simplified and streamlined in response to comments from the field. In its current iteration, ratings from three assessments combine to comprise the essential criteria for a personality disorder: a rating of mild impairment or greater on the Levels of Personality Functioning (criterion A), associated with a "good match" or "very good match" to a Personality Disorder Type or with a

rating of "extremely descriptive" on one or more Personality Trait Domains (criterion B). Criteria also require relative stability across time and consistency across situations and exclude culturally normative personality features and those due to the direct physiological effects of a substance or a general medical condition. The levels of personality functioning are based on disturbances in self and interpersonal functioning. Disturbances in thinking about the self are reflected in dimensions of identity and self-directedness. Interpersonal disturbances consist of impairments in empathy and intimacy. Disorder types (e.g., borderline, obsessive compulsive) are combinations of core personality pathology, personality traits, and behaviors. Broad personality trait domains (e.g., disinhibition and compulsivity) are defined, as well as component trait facets (e.g., impulsivity and perfectionism). Levels of personality functioning, the degree of correspondence between a patient's personality (disorder) and a type, and personality trait domains and facets are all dimensional ratings. The personality domain in DSM-5 is intended to describe the personality characteristics of all patients, whether they have a personality disorder or not. 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. In this presentation, the current model is described, rationales for the changes are summarized, and the model's practical application is illustrated with a brief clinical case.

No 5.
WHAT'S NEW WITH ANTISOCIAL PERSONALITY DISORDER?

Donald W. Black, M.D., University of Iowa, Department of Psychiatry, 200 Hawkins Drive, Psychiatry Research MEB, Iowa City, IA 52442

SUMMARY:
Antisocial personality disorder (ASP) is characterized by a pattern of socially irresponsible, exploitative, and guiltless behavior that begins in early childhood or early adolescence. The disorder is highly prevalent in the general population, and particularly among the homeless, substance abusers, and the incarcerated. The disorder is culturally universal. While chronic, ASPD tends to be worse early in its course, and patients improve with advancing age. Mortality studies show elevated rates of death. Mood disorders, anxiety disorders, attention deficit disorder, and impulse control disorders are common. ASP has long been known to run in families, and may be genetically transmitted to some extent. Etiologic theories suggest that chronic nervous system underarousal, disturbed neurotransmission, abnormal neurodevelopment/ brain injury may each play a role. A disturbed social and home environment may also contribute to the development of ASP. There are no standard treatments for ASP. Medication may reduce aggressive and impulsive tendencies in some antisocial persons. Motivated antisocial persons with mild disorders may benefit from cognitive-behavioral therapies. Advances in the neurobiology of and treatment for ASPD will be explored, as will the proposed diagnostic changes in DSM-5.

No 6
PERSONALITY DISORDERS IN COMBAT VETERANS: CHALLENGES FOR THE MILITARY CLINICIAN

Rick Malone, M.D., M.P.H., Walter Reed Army Medical Center, Forensic Psychiatry Service, 6900 Georgia Avenue Northwest, Washington, DC 20307-5001

SUMMARY:
Military regulations allow for the administrative separation of service members who are deemed unfit for duty due to personality disorders (1). Generally, service members who are administratively separated are not entitled to the same benefits as those who are medically retired as a result of injuries or illnesses (including Axis I Mental Disorders). Medical disability payment and access to lifelong medical treatment through the Veterans Administration health care system are among the potential benefits denied service members who are administratively separated. In times of high operational tempo and rapid deployment the "enduring maladaptive patterns of behavior and cognition that lead to clinically significant distress or impairment in social, occupational, or other important areas of functioning" that define personality disorders may not be readily apparent or may not come to clinical attention prior to a service member's deployment and exposure to the stressors of combat. Moreover, there may be considerable overlap in the clinical presentation of personality disorders and axis I conditions including Posttraumatic Stress Disorder.

The environmental factors that may predispose one to the development of a personality disorder may also increase vulnerability to PTSD, and irritability, aggression, and impulsivity may characterize persons with either personality disorder, PTSD, or both conditions (2). This presentation will outline the military regulations governing administrative separation for personality disorder as well as those pertaining to medical retirement. Diagnostic and management challenges--particularly as they relate to the determination of fitness for duty--will be described. Finally, current approaches to ensure appropriate and ongoing care for our nation's returning veterans with these potentially confusing and co-occurring conditions will be reviewed.

REFERENCES:

1) Mauchnik J, Schmahl C (2010): The latest neuroimaging findings in borderline personality disorder. Current Psychiatry Reports 12, 46-55.

2) Goodman M, Hazlett EA, New AS, Koenigsberg HW, Siever L: Quieting the affective storm of borderline personality disorder. Am J Psychiatry 2009; 166(5):522-8

3) Compton WM, Conway KP, Stinson FS, Colliver JD, Grant BF: Prevalence, correlates, and comorbidity of DSM-IV antisocial personality syndromes and specific drug use disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. 2005; J Clin Psychiatry 66:677-685.

4) Bollinger AR, Riggs DS, Blake DD, Ruzek JI. "Prevalence of personality disorders among combat veterans with posttraumatic stress disorder." Journal of Traumatic Stress. 13(2) (2000), pp. 255-271

SUNDAY MAY 15, 2011, 10:00 AM-11:30AM

CASE CONFERENCE 1

POST-PARTUM CATATONIA SUCCESSFULLY TREATED WITH ELECTROCONVULSIVE THERAPY: A CASE REPORT

Chair: Don M. Hilty, M.D. University of California – Davis, 2230 Stockton Boulevard, Sacramento, CA 95817
Presenter: Angela Strain, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify catatonia; 2) Understand different treatments for catatonia; and 3) Recognize and have a basic understanding of peripartum depression and psychosis.

SUMMARY:
Background: Catatonia is a relatively rare symptom that can occur in both mood and psychotic disorders. Post-partum depression affects roughly 10% of women within the first six months after delivery; it is sometimes complicated by psychotic features. Post-partum psychosis affects roughly 1% of women, and typically presents within the first few weeks after delivery. There is limited evidence available to guide treatment decisions. Case Presentation: We review a case in which post-partum depression with psychotic features presents with catatonia. Conclusion: Electroconvulsive therapy seems to be an effective treatment modality for post-partum depression with psychotic features and catatonia that was resistant to medications.

MONDAY, MAY 16, 2011
8:00 AM SESSION

CASE CONFERENCE 2
LINKING MEDICINE AND PSYCHIATRY: CLINICAL CASES IN PSYCHOSOMATIC MEDICINE

Chair: Michelle B. Riba, M.D., M.S., UH9C 9150, 1500 E. Medical Center Drive, SPC 5120, Ann Arbor, MI 48109
Presenters: Rachel Glick, M.D., David Belmonte, M.D. Sameh Dwaikat, M.D., Michael Casher, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Provide a differential diagnosis on some of the cases involved in acute mental status changes; 2) Discuss psycho-oncology topics that may impact on clinical care, such as the use of antidepressants and Chemotherapy; and 3) Review topics in geriatric psychosomatic medicine.

REFERENCES:
1. Bourgeios, J.A., Kahn D., Philbrick, K.L., Bostwick, J.M., (2009) Casebook of psychosomatic medicine, American Psychiatric Publishing, Inc.
2. Williams, D., Dale, J., (2006) The effectiveness of treatment for depression/depressive symptoms in adults with cancer: A systematic review. Br J Cancer, 94:372-390.
3. Daly, R., (2006) Untreated chronic illness blamed for high mortality. Psychiatric News, 43:10: August 15, 2006, p. 7, 24.
4. Polsky, D., Doshi, J.A., Marcus, S., Oslin, D., Rothbard, A., Thomas, N., Thompson, C.L., (2005) Long-term risk for depressive symptoms after a medical diagnosis. Arch Intern Med, 165 (11):1260-1266.

MONDAY, MAY 16, 2011, 12:00 PM- 1:30PM

CASE CONFERENCE 3
EVALUATING AND TREATING THE PSYCHOLOGICAL EFFECTS OF WAR

Chair(s): Elspeth C Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901; Marvin Oleshansky, M.D., Tripler Army Medical Center, 2418 Round Top Dr., Honolulu, HI, 96822-2069
Presenters: LTC Brett Schneider, M.D., COL John Bradley, M.D., MAJ Scott Moran, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize common reactions of soldiers to the long war; 2) Evaluate and treat PTSD and other reactions; 3) Identify available community resources to assist veterans.

SUMMARY:
Nearly 10 years have elapsed since 9/1/2001. In that time Service Members have fought in long protracted conflicts in Iraq and Afghanistan. They have also supported major natural disasters such as the tsunami in the Pacific and Hurricane Katrina in the Gulf. The reactions to the prolonged conflict include a range of reactions, such as PTSD and substance abuse, but also growth and resilience. Physical injuries, including traumatic brain injury, have added to the toll. This case conference will focus on: 1) recognizing the reactions of Soldiers and other service members; 2) treating common

disorders such as PTSD, depression, and substance abuse; and 3) working with local community resources to continue a safety net, even after the service member leaves the military.

REFERENCES:

1. Ritchie E, ed. Combat and Operational behavioral Health, Borden Institute, in press; Ritchie E, Owens M, Military Psychiatry, Psychiatric Clinics, 2006

TUESDAY, MAY 17, 2011, 8:00 AM- 9:30AM
MANAGING PROFESSIONAL BOUNDARIES IN PSYCHOTHERAPY

Moderator: Glen O Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 77030-1316
Presenter: Holly Crisp-Han, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify specific techniques for managing professional boundaries in the psychotherapeutic relationship.

SUMMARY:

In this case conference, the focus will be on professional boundaries in psychotherapy. The establishment of a therapeutic frame will be illustrated by a case presentation by Dr. Holly Crisp-Han. During the course of the presentation, Dr. Glen Gabbard will comment on therapeutic interventions that strengthen the frame and on the influence of specific gender constellations on boundary issues. He will emphasize that female therapists may need to exert more effort in managing the male patient's challenges to the frame than in the reveres gender constellation.

REFERENCES:

1. Gabbard GO, Crisp-Han H: Teaching professional boundaries to psychiatric residents. Academic Psychiatry in press.
2. Gabbard GO, Lester E: Boundaries and Boundary Violations in Psychoanalysis, Arlington, VA: American Psychiatric Publishing, 2003
3. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk management dimensions. American Journal of Psychiatry 150: 188-196, 1993
4. Gutheil TG, Gabbard GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. American Journal of Psychiatry 155: 409-414, 1998

TUESDAY, MAY 17, 2011

10:00 AM SESSION
CASE CONFERENCE 5
WHAT'S THE POINT? THE SIGNIFICANCE OF SUICIDAL IDEATION IN THE CRITICALLY AND TERMINALLY ILL PATIENT

Chairperson: Philip R Muskin, M.D., M.A., 1700 York Avenue, New York, NY 10128
Presenters: Rebecca Brendel, M.D., J.D., Linda Ganzini, M.D., M.P.H., Emily Gastelum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Form an opinion about how to assess a recently suicidal critically ill patient; 2) Recognize counter-transference reactions arising when treating terminally ill, suicidal patients; and 3) Identify different approaches to balancing their responsibility to deliver good end of life care and their obligation to respects patients' autonomous decisions with their duty to prevent impulsive, transitory or incompetent decisions that may result in death.

SUMMARY:

This case conference will discuss how clinical context affects the significance of suicidal ideation in the critically or terminally ill patient when assessing capacity to remove life sustaining measures. Patients express the desire to die in the midst of a severe depression despite good medical prognosis, we prevent the patient from acts of self-harm and treat the depression. The wish to die may be expressed by a critically ill patient; comfort measures may have a welcomed effect of hastening death. When a patient wishes to stop life sustaining treatments, resulting in death, a careful assessment of capacity is necessary. Assessment of prognosis is essential, but evolves. Should we negotiate to continue life sustaining treatment in a patient with a poor prognosis? Protracted examination may be required to be confident that the decision to stop treatment is acceptable. Prolonged capacity assessments near the end of a patient's life may compound demoralization and erode the alliance. Emily Gastelum, M.D., will present a patient who had a treatable medical illness but expressed suicidal ideation with a highly lethal plan. Depression/suicidal ideation resolved; however, his health deteriorated in the hospital (from iatrogenic complications) with recurrence of his desire to die. The C-L team was asked to assess his

capacity when he requested to be disconnected from the ventilator. Linda Ganzini, M.D., M.P.H., will address the ethical issues in this case, with attention to determining capacity on a sliding scale; the effect of depression on life-sustaining decisions; the role of prognosis; balancing responsibility to deliver good end of life care and obligation to respects patients' autonomous decisions but prevent impulsive, transitory or incompetent decisions that result in death Rebecca Brendel, M.D., J.D., will address the legal framework in which clinical determinations of decisional capacity are made and the legal construct of individual autonomy and limitations on patient choice and the mechanisms by which decisions may be made for individuals lacking capacity. Philip Muskin MD will discuss countertransference with patients where iatrogenic complications have life-threatening consequences, how we explore the meaning of why a patient wishes to die and training issues for psychiatric residents asked to consult on this type of patient

REFERENCES:

1. Brendel RW, Schouten RA. Legal Concerns in Psychosomatic Medicine. Psychiatry Clin North Am 2007; 30(4): 663-676.

2. Ganzini L, Lee MA, Heintz RT, Bloom JD: Depression, suicide, and the right to refuse life-sustaining medical treatment. (editorial) Journal of Clinical Ethics 4:337-340, 1993

3. Ganzini L, Lee MA, Heintz RT, Bloom JD, Fenn DS: The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. American Journal of Psychiatry 151:1631-1636, 1994

4. Muskin PR: The request to die: role for a psychodynamic perspective on physician-assisted suicide. JAMA 1998; 279:323-328.

MONDAY MAY 16, 2011
8:00 AM-9:30 AM

FOCUS LIVE 1
PSYCHOPHARMACOLOGY: TREATMENT-RESISTANT DISORDERS

Chair: Charles B. Nemeroff, M.D., Ph.D., Chairman, Department of Psychiatry and Behavioral Sciences, Leonard M. Miller School of Medicine, University of Miami, Miami, Florida

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 treatment-resistant disorders, and have increased understanding of the efficacy of current treatments and their application to clinical practice.

SUMMARY:
As psychiatrists, we treat patients with mood and anxiety disorders that do not respond to monotherapy with commonly prescribed psychopharmacological agents such as selective serotonin reuptake inhibitors.
In this multiple choice question and answer session, information is provided about the management of treatment-refractory disorders as well as discussion of the emerging field of personalized medicine in psychiatry, which has the goal of reducing treatment failures in patients with these disorders by matching individual patients with the therapies most likely to successfully treat their symptoms. Current approaches to managing TRD include medication augmentation, psychotherapy, and ECT. Advances in understanding the neurobiology of mood regulation and depression have led to potential new approaches to managing TRD, including medications and focal brain stimulation techniques.
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 on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

REFERENCES:
1) Myers AJ, Nemeroff CB. New vistas in the management of treatment-refractory psychiatric disorders: genomics and personalized medicine. Focus 2010 8: 525-535
2) Holtzheimer PE. Advances in the management of treatment-resistant depression. Focus 2010 8: 488-500

10:00 AM-11:30 AM

FOCUS LIVE 2
ADDICTION: CURRENT AND FUTURE TREATMENTS

Chair: Marc Galanter, M.D., Professor of Psychiatry, and Director, Division of Alcoholism and Drug Abuse, NYU School of Medicine, New York, NY

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, test their knowledge of the clinical management of patients, and have increased understanding of approaches to the treatment of substance use disorders.

SUMMARY:
Substance use disorders have great impact and cost on society. In the United States 18% of people experience a substance use disorder at some point in their lives. Advances have been made in the underlying science of addiction medicine, in psychosocial treatments, and in the growth of psychopharmacotherapies. There are a wide variety of evidence-based psychotherapies and pharmacotherapies which demonstrate efficacy and effectiveness for the treatment of substance abuse disorders. However ones opportunity to heal substance abusers rests on the ability of the physician to relate to each patient. Defensiveness and denial can be overcome by engagement and willingness to help the patient. FOCUS LIVE presents multiple choice questions for the psychiatrist interested in

keeping up to date with clinical innovations in the treatment of addiction. Treatments include both evidence based pharmacotherapies and behavior interventions that can enhance medication efficacy. 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 on a clinical topic important to practicing general psychiatrists.

REFERENCES:

1) Galanter M, Kleber HD (eds). American Psychiatric Publishing Textbook of Substance Abuse Treatment. 4th ed. 2008 American Psychiatric Publishing Inc.
2) Work Group on Substance Use Disorders; Treatment of patients with substance use disorders, second edition. American Psychiatric Association. Am J Psychiatry. 2006 Aug;163(8 Suppl):5-82.
3) Koob GF. Neurobiology of Addiction. Focus 2011 9: 55-65

SUNDAY MAY 15, 2011, 10:00 AM-11:30AM

CASE CONFERENCE 1

POST-PARTUM CATATONIA SUCCESSFULLY TREATED WITH ELECTROCONVULSIVE THERAPY: A CASE REPORT

Chair: Don M. Hilty, M.D. University of California – Davis, 2230 Stockton Boulevard, Sacramento, CA 95817
Presenter: Angela Strain, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify catatonia; 2) Understand different treatments for catatonia; and 3) Recognize and have a basic understanding of peripartum depression and psychosis.

SUMMARY:
Background: Catatonia is a relatively rare symptom that can occur in both mood and psychotic disorders. Post-partum depression affects roughly 10% of women within the first six months after delivery; it is sometimes complicated by psychotic features. Post-partum psychosis affects roughly 1% of women, and typically presents within the first few weeks after delivery. There is limited evidence available to guide treatment decisions. Case Presentation: We review a case in which post-partum depression with psychotic features presents with catatonia. Conclusion: Electroconvulsive therapy seems to be an effective treatment modality for post-partum depression with psychotic features and catatonia that was resistant to medications.

MONDAY, MAY 16, 2011
8:00 AM SESSION

CASE CONFERENCE 2
LINKING MEDICINE AND PSYCHIATRY: CLINICAL CASES IN PSYCHOSOMATIC MEDICINE

Chair: Michelle B. Riba, M.D., M.S., UH9C 9150, 1500 E. Medical Center Drive, SPC 5120, Ann Arbor, MI 48109
Presenters: Rachel Glick, M.D., David Belmonte, M.D. Sameh Dwaikat, M.D., Michael Casher, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Provide a differential diagnosis on some of the cases involved in acute mental status changes; 2) Discuss psycho-oncology topics that may impact on clinical care, such as the use of antidepressants and Chemotherapy; and 3) Review topics in geriatric psychosomatic medicine.

REFERENCES:

1. Bourgeios, J.A., Kahn D., Philbrick, K.L., Bostwick, J.M., (2009) Casebook of psychosomatic medicine, American Psychiatric Publishing, Inc.
2. Williams, D., Dale, J., (2006) The effectiveness of treatment for depression/depressive symptoms in adults with cancer: A systematic review. Br J Cancer, 94:372-390.
3. Daly, R., (2006) Untreated chronic illness blamed for high mortality. Psychiatric News, 43:10: August 15, 2006, p. 7, 24.
4. Polsky, D., Doshi, J.A., Marcus, S., Oslin, D., Rothbard, A., Thomas, N., Thompson, C.L., (2005) Long-term risk for depressive symptoms after a medical diagnosis. Arch Intern Med, 165 (11):1260-1266.

MONDAY, MAY 16, 2011, 12:00 PM- 1:30PM

CASE CONFERENCE 3
EVALUATING AND TREATING THE PSYCHOLOGICAL EFFECTS OF WAR

Chair(s): Elspeth C Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901; Marvin Oleshansky, M.D., Tripler Army Medical Center, 2418 Round Top Dr., Honolulu, HI, 96822-2069
Presenters: LTC Brett Schneider, M.D., COL John Bradley, M.D., MAJ Scott Moran, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize common reactions of soldiers to the long war; 2) Evaluate and treat PTSD and other reactions; 3) Identify available community resources to assist veterans.

SUMMARY:
Nearly 10 years have elapsed since 9/1/2001. In that time Service Members have fought in long protracted conflicts in Iraq and Afghanistan. They have also supported major natural disasters such as the tsunami in the Pacific and Hurricane Katrina in the Gulf. The reactions to the prolonged conflict include a range of reactions, such as PTSD and substance abuse, but also growth and resilience. Physical injuries, including traumatic brain injury, have added to the toll. This case conference will focus on: 1) recognizing the reactions of Soldiers and other service members; 2) treating common

disorders such as PTSD, depression, and substance abuse; and 3) working with local community resources to continue a safety net, even after the service member leaves the military.

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TUESDAY, MAY 17, 2011, 8:00 AM- 9:30AM

MANAGING PROFESSIONAL BOUNDARIES IN PSYCHOTHERAPY

Moderator: Glen O Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 77030-1316
Presenter: Holly Crisp-Han, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify specific techniques for managing professional boundaries in the psychotherapeutic relationship.

SUMMARY:

In this case conference, the focus will be on professional boundaries in psychotherapy. The establishment of a therapeutic frame will be illustrated by a case presentation by Dr. Holly Crisp-Han. During the course of the presentation, Dr. Glen Gabbard will comment on therapeutic interventions that strengthen the frame and on the influence of specific gender constellations on boundary issues. He will emphasize that female therapists may need to exert more effort in managing the male patient's challenges to the frame than in the reveres gender constellation.

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1. Gabbard GO, Crisp-Han H: Teaching professional boundaries to psychiatric residents. Academic Psychiatry in press.
2. Gabbard GO, Lester E: Boundaries and Boundary Violations in Psychoanalysis, Arlington, VA: American Psychiatric Publishing, 2003
3. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk management dimensions. American Journal of Psychiatry 150: 188-196, 1993
4. Gutheil TG, Gabbard GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. American Journal of Psychiatry 155: 409-414, 1998

TUESDAY, MAY 17, 2011

10:00 AM SESSION

CASE CONFERENCE 5
WHAT'S THE POINT? THE SIGNIFICANCE OF SUICIDAL IDEATION IN THE CRITICALLY AND TERMINALLY ILL PATIENT

Chairperson: Philip R Muskin, M.D., M.A., 1700 York Avenue, New York, NY 10128
Presenters: Rebecca Brendel, M.D., J.D., Linda Ganzini, M.D., M.P.H., Emily Gastelum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Form an opinion about how to assess a recently suicidal critically ill patient; 2) Recognize counter-transference reactions arising when treating terminally ill, suicidal patients; and 3) Identify different approaches to balancing their responsibility to deliver good end of life care and their obligation to respects patients' autonomous decisions with their duty to prevent impulsive, transitory or incompetent decisions that may result in death.

SUMMARY:

This case conference will discuss how clinical context affects the significance of suicidal ideation in the critically or terminally ill patient when assessing capacity to remove life sustaining measures. Patients express the desire to die in the midst of a severe depression despite good medical prognosis, we prevent the patient from acts of self-harm and treat the depression. The wish to die may be expressed by a critically ill patient; comfort measures may have a welcomed effect of hastening death. When a patient wishes to stop life sustaining treatments, resulting in death, a careful assessment of capacity is necessary. Assessment of prognosis is essential, but evolves. Should we negotiate to continue life sustaining treatment in a patient with a poor prognosis? Protracted examination may be required to be confident that the decision to stop treatment is acceptable. Prolonged capacity assessments near the end of a patient's life may compound demoralization and erode the alliance. Emily Gastelum, M.D., will present a patient who had a treatable medical illness but expressed suicidal ideation with a highly lethal plan. Depression/suicidal ideation resolved; however,

his health deteriorated in the hospital (from iatrogenic complications) with recurrence of his desire to die. The C-L team was asked to assess his capacity when he requested to be disconnected from the ventilator. Linda Ganzini, M.D., M.P.H., will address the ethical issues in this case, with attention to determining capacity on a sliding scale; the effect of depression on life-sustaining decisions; the role of prognosis; balancing responsibility to deliver good end of life care and obligation to respects patients' autonomous decisions but prevent impulsive, transitory or incompetent decisions that result in death Rebecca Brendel, M.D., J.D., will address the legal framework in which clinical determinations of decisional capacity are made and the legal construct of individual autonomy and limitations on patient choice and the mechanisms by which decisions may be made for individuals lacking capacity. Philip Muskin MD will discuss countertransference with patients where iatrogenic complications have life-threatening consequences, how we explore the meaning of why a patient wishes to die and training issues for psychiatric residents asked to consult on this type of patient

REFERENCES:

1. Brendel RW, Schouten RA. Legal Concerns in Psychosomatic Medicine. Psychiatry Clin North Am 2007; 30(4): 663-676.

2. Ganzini L, Lee MA, Heintz RT, Bloom JD: Depression, suicide, and the right to refuse life-sustaining medical treatment. (editorial) Journal of Clinical Ethics 4:337-340, 1993

3. Ganzini L, Lee MA, Heintz RT, Bloom JD, Fenn DS: The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. American Journal of Psychiatry 151:1631-1636, 1994

4. Muskin PR: The request to die: role for a psychodynamic perspective on physician-assisted suicide. JAMA 1998; 279:323-328.

MONDAY, MAY 16, 2011:

6:00 P.M. SESSION
INDUSTRY-SUPPORTED
SYMPOSIUM

6:00 P.M.–8:00 P.M.

ENHANCING OUTCOMES
IN SCHIZOPHRENIA:
NEW TREATMENT APPROACHES
Supported by an Educational Grant from Sunovion
Chair: Stephen M. Stahl, M.D., 1930 Palomar Point Way Ste 103, Carlsbad, CA. 92008
Participants:Stephen M. Stahl, M.D., Rona Hu, M.D.., Joe McEvoy, M.D., Alice Medalia, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the role of receptor actions in therapeutic effects as well as side effects of current antipsychotic agents; 2) Evaluate what we have learned about the risks and benefits of specific agents in clinical practice, including how to select and switch from one agent to another; and 3) Have familiarity with how to leverage the actions of medications with cognitive remediation and related therapies for best outcomes in schizophrenia.

REFERENCE:
(All ISS must list at least a two literature references.)
1.Stahl SM, Stahls Essential Psychopharmacology, 3rd edition, Cambridge University Press, New York, 2008
2. Medalia, Choi. Neuropsychol Rev 2009;19:353-64;
3. Eack et al. Arch Gen Psychiatry 2010;67 (7):674-82.

OVERALL SUMMARY:
Although numerous new therapeutic agents have been introduced as approved treatments for schizophrenia, including several recent additions, numerous questions remain. Do any of the new drugs differ substantially from each other, or indeed do any of the newer antipsychotics differ substantially from older antipsychotics? Receptor pharmacology does show that no two of the new antipsychotics share the same profile, but is this meaningful from a clinical point of view? Furthermore, since patients constantly have changes in the antipsychotics drugs they receive, is this a good aspect of treatment of schizophrenia or not, and if one drug needs to be changed for another, how best should this be done in order not to disrupt treatment but to lead to better efficacy and tolerability? Comparing theoretical pharmacology with practical clinical use can be meaningful in determining whether any of the distinctions among the antipsychotics are clinically relevant, and also how to exploit such differences in a practical manner. Finally, since it is clear that no antipsychotic acting by any of the currently established pharmacologic mechanisms is capable of dramatically reversing the course of most patients with schizophrenia, nor can any often return patients to normal functioning, it is also obvious that the actions of the current antipsychotic drugs must be leveraged with additional therapeutic efforts, including combining them with therapies such as cognitive remediation. This symposium will review the various antipsychotic drugs, their pharmacologic properties, their differential clinical properties, how to use them, dose them and switch them, and finally how to leverage their efficacy with cognitive remediation and related therapies.

ISS1
MECHANISM OF ACTION OF ATYPICAL ANTIPSYCHOTICS: ARE THERE ANY MEANINGFUL DIFFERENCES?

Stephen Stahl, M.D., 1930 Palomar Point Way Ste 103, Carlsbad, CA. 92008

SUMMARY:
All antipsychotics block D2 dopamine receptors and all atypical (second generation) agents also block 5HT2A receptors. However, there are many other distinctions among the score of agents in this class, including some recently characterized receptors such as the 5HT6 and 5HT7 receptor. No two agents in this class share the same portfolio of receptor actions outside of D2/5HT2A antagonism, and this is the leading hypothesis to explain why some patients tolerate one agent in this class but not another, and why other patients respond to one agent in this class but not another. In order to tailor treatment selection to the individual patient a “bespoke” approach of matching receptor binding profile to clinical symptom/side effect profile is a strategy that the neurobiologically informed clinician is empowered to take.

ISS2
NEW ATYPICAL AGENTS FOR SCHIZOPHRENIA: WHAT HAVE WE LEARNED?

Rona Hu, M.D.

SUMMARY:
Do clinical trial data match clinical experience? The atypical antipsychotics are notorious for having doses established in clinical trials not being those that are optimum in clinical practice. This may be due in part to the differences between clinical trial patients and clinical practice patients as well as to other factors such as concomitant medications, compliance and concomitant substance abuse, among others. Are there differential clinical profiles among these agents? Although head to head experience suggests that one agent differs from another in this class mostly according to tolerability differences, many clinicians have observed one patient responding to one atypical antipsychotic better than to another in terms of efficacy. However, it has been difficult to predict which patients will respond to which agents other than by trial and error. Here the atypical antipsychotics as a class are discussed, including the three most recent agents for which there is yet less clinical experience, addressing how the newest agents stack up with the older agents. Also included is how the second generation agents in general compare with the first generation agents.

ISS3
SWITCH STRATEGIES IN PATIENTS WITH SCHIZOPHRENIA – WHAT WORKS BEST?

John Newcomer, M.D.

SUMMARY:
Switching antipsychotic medications is common in clinical practice. Switching most frequently reflects clinicians' efforts to gain additional therapeutic benefit in poorly responsive, unstable patients and success is usually limited. However, among treatment responsive individuals for whom a switch is undertaken to reduce the burden of adverse events (while maintaining therapeutic benefit), success is more likely. In addition, with proper switch procedures, the risks of exploring a switch are small. In an open-label, non-randomized study of discontinuing antipsychotic poly-pharmacy, of 44 individuals who were switched from antipsychotic poly-pharmacy to mono-therapy, over half (54%) remained stable, (23%) showed improvement, and 23% fared more poorly when switched to monotherapy (Suzuki et al 2004). The switch procedures that are most commonly associated with successful switching involve quickly bringing the newly initiated antipsychotic medication to a fully therapeutic (but not excessive) dose, while gradually reducing the dose of the original antipsychotic medication to the point of discontinuation over approximately 2 week. Starting too low with the new antipsychotic medication, or leaving the new antipsychotic medication at a sub-therapeutic dose, or abruptly discontinuing the original antipsychotic medication can lead to problems in switching. The switch period is a time of increased risk for de-stabilizing a patient. Clinicians should see patients more frequently over a switch period, and assure that they have up-dated contact information for both the patient and a care-giver who can be checked in with to report on the patient's well-being. Adjustments can be made in the patient's pharmaco-therapy as needed. For instance, if a sedating antipsychotic agent given at bedtime is being discontinued problems with sleep may arise that can be quickly corrected (e.g. by adding a benzodiazepine at bedtime) allowing the switch to proceed successfully. Both patients and clinicians usually give the highest priority to therapeutic antipsychotic benefit produced by an antipsychotic medication. Even if the patient and clinician decide as a switch is completed that a decline in therapeutic benefit has occurred and they want to return to the original antipsychotic medication, this rarely is associated with relapse or re-hospitalization. The patient is simply returned to a fully therapeutic dose of the original antipsychotic medication and the new antipsychotic medication is discontinued.

ISS4
ENHANCING LONG-TERM OUTCOMES IN SCHIZOPHRENIA: THE ROLE OF COGNITIVE REMEDIATION

Alice Medalia, M.D.

SUMMARY:
Cognitive remediation is a behavioral intervention consisting of training activities which aim to

target a range of cognitive impairments like attention, memory, and problem solving, with the ultimate intent of improving functional outcome. Several meta-analyses of cognitive remediation efficacy studies have found moderate effect sizes for improvement in cognitive and psychosocial functioning. Further, these programs are popular with patients and have been linked with increases in participant self-esteem and motivation to learn. More recently, research is evaluating whether the integration of effective pharmacotherapy with cognitive remediation can provide schizophrenia patients with the necessary cognitive enrichment and motivation to further boost treatment effect sizes. While many questions remain about dosing, the relative merits of instructional techniques, the value of booster sessions, and the profiles of patients who respond best, there is convincing evidence that cognitive remediation can offer substantial and lasting benefits for the cognitive deficits seen in schizophrenia.

SATURDAY, MAY 14, 2011
8:00 AM SESSIONS

LECTURE 01
THE DOCTOR I NEED FOR THE HEALTH CARE I WANT
Distinguished Psychiatrist Lecture
Darrell G. Kirch, M.D., 2450 N ST NW, Washington, DC 20037

EDUCATIONAL OBJECTIVES:
By the conclusion of the presentation, attendees will: 1) Understand the changes required to create a true continuum of medical education; 2) Be familiar with the elements of the current health care delivery system that must change in tandem with reforms in medical education; 3) Know the culture change required for physicians to be able to achieve these goals.

SUMMARY:
As academic medicine celebrates the 100th anniversary of the Flexner report, it has an opportunity to reexamine the system of medical education shaped by that landmark document. Calls for a new revolution in medical education have been growing, while at the same time, the passage of the Affordable Care Act has moved the nation in the direction of providing many more Americans with health care insurance. This, in turn, creates an opportunity to truly reform the health care system so that it emphasizes wellness and prevention and meets needs of all in an affordable manner. The presentation will discuss how medical education and health care delivery must change in tandem if we are to produce the kind of physicians we desire working in a sustainable health care system.

REFERENCES:
1. Kirch, D. G., The Flexnerian Legacy in the 21st Century. Academic Medicine: February 2010 - Volume 85, Issue 2 pp. 190-192.

LECTURE 02
RETHINKING MENTAL ILLNESS
Frontiers of Science Lecture
National Institute of Mental Health
Thomas R. Insel, M.D., National Institute of Mental Health, National Institute of Health, 6001 Executive Blvd Room 8235, Bethesda, MD 20892

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify disruptive innovations in psychiatry; and 2) Recognize the Strategic Goals of NIMH funding; and 3) Identify best opportunities for breakthroughs in research.

SUMMARY:
Mental disorders (depression, schizophrenia, bipolar disorder, etc.) are the leading source of medical disability in the developed world. (WHO, 2008) In addition to high disability, the major mental disorders are a source of early mortality. People with these disorders have a life expectancy of 56 years, with more than two decades lost to suicide and various medical illnesses, especially cardio-pulmonary diseases. After a century of focusing on the psychological causes of mental disorders, we can now begin to address these mysterious behavioral and cognitive syndromes as brain disorders. Genetics and neuroscience are leading us to reconceptualize these disorders in terms of developmental brain processes that go off track due to the combined influences of genomic risk and early experience. The next decade will likely see a revolution in our approach to mental disorders with a new understanding of their biology and new opportunities for
treatments.

REFERENCES:
1. Insel, T. (April 2009) Disruptive Insights in Psychiatry: Transforming a Clinical Discipline, article from The Journal of Clinical Investigation P. 700-705, Volume 119, Number 4

10:00 AM SESSIONS

LECTURE 03
AMERICAN EXCEPTIONALISM AND NATIONAL IDENTITY: CAN WE ALL JUST GROW UP?
Distinguished Psychiatrist Lecture
Loree K. Sutton, M.D., 4677 35th St N, Arlington, VA 22207-4436

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Define exceptionalism; 2) Describe two historical antecedents to the concept of exceptionalism; 3) Identify two indicators of contemporary exceptionalism; 4) Describe two neuroscience principles that can minimize the

negative effects of exceptionalism; and 5) Identify two ways that psychiatrists can contribute to developing our resiliency as a nation.

SUMMARY:
This presentation offers a creative exploration of our post-9/11 American identity – who are we as a country, who might we become, what's working (or not), and how developmental neuropsychiatry and biologically-based approaches to trauma might inform our national journey. . . In short, can we all just grow up? As American citizens, we have long identified ourselves as belonging to an "exceptional" or even "indispensable" nation. . . As early as 1630, Puritan John Winthrop's sermon "A Model of Christian Charity" admonished the future Massachusetts Bay colonists that their new community would be a "city upon a hill", watched by the world. This adage gave rise to the widespread belief in American folklore that the USA is God's country because metaphorically it is a Shining City Upon a Hill. Invoked by President Kennedy as well as President Reagan, this image remains embedded in our national consciousness. Emerging victorious from the decades-long Cold War, our national identity focused on our role as the world's sole "superpower" or even "hyperpower," in recognition of our apparent exceptionalism. And then, 9/11. . . The ensuing past 10 years, now dubbed by some as the "no name decade," are characterized by a fear-based obsession with security, exposure of the limits to military power, financial system collapse, partisan hyper-polarization and the emergence of a political protest movement challenging the status-quo across the ideological spectrum. As professionals engaged in the healing arts and sciences, what might we contribute to the growing crescendo of voices questioning whether our best days as a nation are now behind us? As responsible citizens, what duty is ours to engage in the political process? And, finally, how can our burgeoning knowledge of the brain and its relationship to resiliency, trauma and the nervous system serve as a model
and metaphor to orient, balance and guide our future actions as individuals and as a nation?

LECTURE 04
SPIES AND LIES: COLD WAR PSYCHIATRY AND THE CIA
Benjamin Rush Award Lecture
Andrea Tone, Ph.D., 3647 Peel St, Montreal QC, H3A 1X1Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Have a better understanding of the ways in which the post-WWII interests of military and intelligence agencies intersected wittingly and unwittingly with psychiatrists and their research in the United States and Canada.

SUMMARY:
This talk will explore the history and politics of CIA funded mental health research and psychiatric development in the 1950s and 1960s in the United States and Canada. Providing an in-depth analysis of one of the most notorious sub-projects of the CIA's infamous MK-ULTRA project (a classified, $25-million dollar government research program that funded over 75 mind control experiments at universities and hospitals throughout North America), it will look at how American efforts to win the Cold War, physician and policymakers' determination to pioneer faster and cheaper methods of psychiatric therapy, and the relentless drive of a key clinic director converged in curious and unexpected ways. The result was a three year research experiment that was deemed path breaking by many contemporaries and loathsome to politicians and journalists a decade later. Drawing on a broad array of sources, many of them newly available (archival manuscripts, CIA records, court cases, government investigations, military and state records, letters from patients and consumers, and oral histories), this presentation will show how the politics of a different age reframed "therapy" as an unacceptable, imperialist assault on vulnerable Canadians.

12:00 PM SESSIONS

Lecture 05
FORTY YEARS SINCE JOHN FRYER: THAT WAS THEN; THIS IS NOW
John Fryer Award Lecture
The Right Reverend V. Gene Robinson, D. Min., 63 Green St, Concord, NH 03301

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate and better understand the current social, political, religious and

psychological landscape facing LGBT people; 2) Recognize and develop a deeper understanding of the religious underpinnings of anti-gay sentiment, and the religious resources for a gay-positive faith; and 3) Identify practical help in better serving your LGBT clients for facing today's challenges.

REFERENCE:
Bishop Robinson's new book, God Believes in Love: Straight Talk about Gay Marriage, will be published by Alfred Knopf in the spring of 2012.

SUMMARY:
This lecture, in honor of the psychiatrist who donned a mask and came out as gay to the 1972 Convention of the APA, will examine how far we've come, and how far we have to go in society's acceptance of gay, lesbian, bisexual and transgender people, and more specifically, what role psychiatrists might play in that movement forward. Forty years after Dr. Fryer's testimony, it's a different and more welcoming world, but hardly a perfect one for LGBT people. Anti-gay bullying resulted in numerous teenage suicides in 2010, the Religious Right still labels homosexuality a sin, and gay couples are still denied marriage equality in most states. If the new generation is so free of homophobia, why are so many gay kids still killing themselves? Even if the protesters from Westboro (Kansas) Baptist Church are viewed as crazy, why does anti-gay rhetoric still work for political candidates? Why is geography still the best predictor of the level of acceptance of LGBT people? And what is next in the movement for equal rights and healthy self-understanding for LGBT people? This lecture will address the progress we've made in the mental health area since Dr. Fryer's time. The ways in which religion creates the self-loathing experienced by so many members of the sexual minority community. Why religion should matter to your LGBT clients, even if they are not religious! How to undo the unhealthy effects of conservative religion in your clients without destroying their faith. How righteous anger can be a tool for liberation. Why the dichotomous straight/gay continuum is unhelpful and more limiting for heterosexuals than for homosexuals. Why transgender people are a threat and challenge to both gay and straight people. Why today's work is less about homophobia and more about heterosexism, less about sexual orientation and more about gender identity/expression. Why gay rights are good (and threatening) for heterosexual people. Why mental health professionals have a social responsibility to weigh in on equal rights for LGBT people – and why one-on-one compassion isn't enough. Lastly, it will discuss what you can do to better support your LGBT clients in this changing landscape.

SUNDAY, MAY 15, 2011
8:00 AM SESSIONS

LECTURE 06
WHAT MAKES A GOOD CLINICAL TEACHER?
APA/NIMH Vestermark Award Lecture
Richard Balon, M.D., UPC Jefferson 2751 E Jefferson Ste 200, Detroit, MI 48207

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate the importance of clinical teaching; 2) Understand the characteristics and qualities of a good clinical teacher; and 3) Assess the qualities of good clinical teacher(s).

SUMMARY:
The most important societal role of medical schools is the preparation of a new generation of competent, compassionate and well clinically trained physicians. Thus, clinical teaching is central to the academic mission of medical schools and residency training programs. Clinical teachers, mainly physicians, play a cardinal role in clinical teaching. But what does it really mean to be a good clinical teacher/supervisor? What are the qualities and characteristics of a good and effective clinical teacher? This presentation will focus on these qualities, review the literature on characteristics of good clinical teachers, and provide some personal reflections on clinical teaching. Finally, assessment of clinical teachers and its use for further faculty development will be discussed.

LECTURE 07
GLIAL-NEURONAL MODELS OF DEPRESSIVE DISORDERS
Frontiers of Science Lecture
Ian B. Hickie, M.D., 94 Mallet Street, Sydney, 2050 Australia

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant

should be able to: 1) Recognize the brain circuitry that is disrupted in major depression; 2) Appreciate the extent to which recent changes in our understanding of the ways in which different cells in the CNS respond to specific stimuli may be relevant to the pathophysiology of major depression; and 3) Identify and consider the likely implications for diagnosis and treatment choices in specific clinical situations.

SUMMARY:

After working in the area of clinical research related to common mood disorders, and related public health and health service development, it has become increasingly evident to me that we are desperately in need of new approaches to our field. Those new approaches need to incorporate a fundamental emphasis on prevention or early intervention as well as a better utilization of recent developments in basic neuroscience. Consequently, this lecture will review the evidence now available about the ways in which different cellular elements in the brain (i.e. neurons and glial cells) respond to various external (i.e. infection or changed day/night cycles) or internal (i.e. increased anxiety or small vessel vascular disease). These examples will be used to illustrate the extent to which such cellular responses may be relevant to the onset and pathophysiology of common depressive disorders. The developments in neuroscience that are relevant include: 1) increased understanding of the ways in which various cellular elements communicate, with particular reference to the ways in which stimulated glial cells have direct effects on synaptic transmission; 2) increased awareness of the extent to which glial cells respond to a range of immunological and other signals, particularly in patients with depressive disorders who have been exposed to relevant environmental stimuli; 3) increasing use of new neuroimaging techniques to track changes in microglial activity in patients with neuropsychiatric disorders; and 4) the extent to which we can now describe more meaningful CNS circuits that underpin key phenomena related to depressive disorders (including, fronto-subcortical, fronto-temporal as well as those that regulate circadian function. The lecture will use four specific examples from clinical settings to highlight these perspectives - and the way in which this evolving perspective can be used to improve diagnosis and treatment selection. The four examples are early-onset major depression, depression related to circadian disturbance, post-infective depressive and fatigue states and late-life depression related to underlying vascular disease. Each example will consider not only the relevant genetic risk factors, but more importantly how various external and internal stimuli lead to critical cellular responses within critical circuitry and that such changes are likely to explain key clinical phenomena including symptoms, illness course and response to behavioral or pharmacological treatments. The lecture proposes that we will soon move to more etiologically-based sub-classifications of common mood disorders and that such a process will start to lead to a great emphasis on prevention and early intervention (at different points in the life cycle) as well as greater personalization of treatment selection. This movement needs to be communicated to a wider audience, indicating the extent to which our field has a sound scientific basis and a very bright future.

REFERENCES:

1. Bennett M. R., Synapse Regression in depression: the role of 5-HT receptors in modulating NMDA function and synaptic plasticity Australian and New Zealand Journal of Psychiatry, 44 (4):301-308

2.Bennett M. R., Synaptic P2X7 receptor regenerative-loop hypothesis of depression Australian and New Zealand Journal of Psychiatry, 41 (7): 563-571

10:00 AM SESSIONS

LECTURE 08
LIVING UP TO OUR COMMITMENTS: IMPERATIVES FOR PROFESSIONALISM AND LEADERSHIP IN PSYCHIATRY

Distinguished Psychiatrist Lecture

Laura W. Roberts, M.D., Stanford University School of Medicine, 401 Quarry Road, Stanford, CA 94305

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the major workforce and demographic issues that will shape the field of psychiatry in the coming decade; 2) Recognize and have knowledge about relevant scientific findings that influence the effectiveness of psychiatry as a profession in our society; 3) Develop a familiarity with critical policy issues emerging in the field of psychiatry; and 4) Identify major leadership and professionalism related issues in the field of psychiatry.

SUMMARY:
Neuropsychiatric diseases are prevalent and devastating for their impact, whether viewed in relation to individual suffering or broad onsequences for global health. The profession of psychiatry is the specialty of medicine entrusted by society with advancing the well-being of people living with these serious illnesses -- engaging in scientific inquiry, clinical innovation, educational advancement, community outreach, and policy endeavors to diminish the burden of neuropsychiatric disease and related conditions. Our success to date has been mixed. Although the past decade has brought extraordinary progress, with advances ranging from scientific discovery (e.g., biomarkers, genetics) to broad social policy (e.g., "parity" legislation), we struggle as a profession and our future is fragile. We struggle for definition as a field, we remain divided on many fundamental issues, we are undervalued in medicine, and we are stigmatized within society. Our integrity as a profession is scrutinized, questioned, and threatened. Moreover, the number of physicians and physician scientists entering psychiatry is small, less than those leaving the field, and insufficient to meet the needs of the public. The coming decade thus represents nothing less than a turning point in which either we will establish the value of our profession – or, sadly, we will not. Reaffirming the field of psychiatry entails that we live up to our commitments to people living with neuropsychiatric disease, certainly. Fulfilling the public trust and gaining support within society and medicine, it is argued, require more -- that we recognize and undertake critical imperatives for more explicit professionalism and leadership in psychiatry.

12:00 PM SESSIONS

LECTURE 09
EARLY INTERVENTION AND YOUTH MENTAL HEALTH MODELS OF CARE: 21ST CENTURY SOLUTIONS TO STRENGTHEN MENTAL HEALTH CARE AND MODERN SOCIETY

International Guest Lecture
Patrick D. McGorry, M.D., Ph.D., Orygen Youth Health Center for Youth Mental Health, Locked Bag 10, Parkville, VIC-3052Australia

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the pattern of onset of mental disorders across the lifespan and appreciate the crucial need to construct a novel system of care to provide early diagnosis, engagement and tenure of care for adolescents and young adults; 2) Recognize the growing evidence base in support of early intervention in psychiatry; and 3) Gain knowledge about international developments in mental health reform in relation to these new ways.

SUMMARY:
Mental and substance use disorders are among the most important health issues facing society. They are by far the key health issue for young people in the teenage years and early twenties, and if they persist, they constrain, distress and disable for decades. Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have an age of onset by 24 years of age, with the onset for most of these disorders – notably psychotic, mood, personality, eating and substance use disorders– mainly falling into a relatively discrete time band from the early teens up until the mid 20s, reaching a peak in the early twenties. While we have been preoccupied with health spending at the other end of the lifespan, young people have the greatest capacity to benefit from stepwise evidence based treatments and better health care delivery. In recent years, a worldwide focus on the early stages of schizophrenia and other psychotic disorders has improved the prospects for understanding these complex illnesses and improving their short term and longer term outcomes. This reform paradigm has also illustrated how a clinical staging model may assist in interpreting and utilizing biological data and refining diagnosis and treatment selection. There are crucial lessons for psychiatric research and treatment, particularly in the fields of mood and substance use disorders. Furthermore, the critical developmental needs of adolescents and emerging adults are poorly met by existing conceptual approaches and service models. The pediatric-adult structure of general health care, adopted with little reflection by psychiatry, turns out to be a poor fit for mental health care since the age pattern of morbidity of the latter is the inverse of the former. Youth culture demands that young people are offered a different style and content of service provision in order to engage with and benefit from interventions. The need for international structural reform and an

innovative research agenda represents one of our greatest opportunities and challenges in the field of psychiatry.

1:30 PM SESSIONS

LECTURE 10
PSYCHIATRIC DISABILITY: A MODEL FOR ASSESSMENT
Manfred S. Guttmacher Award Lecture
Liza H. Gold, M.D., 2501 N Glebe Rd Ste 204, Arlington, VA 22207

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate and provide a practical model for assessment of claims of psychiatric disability; 2) Recognize and understand how to utilize this model to develop case formulations; and 3) Indentify how to combine the model and case formulations to provide commonly sought opinions in disability evaluations.

SUMMARY:
Disability evaluations are functional assessments intended to provide administrative or legal systems with information it can translate into concrete actions such as awards of benefits or legal damages. Work disability is the result of a dynamic process between factors internal to the individual and external factors not limited to work impairment. A model for assessment of all factors relevant to disability evaluations will be discussed. This model can provide the basis for development of a case formulation. Case formulations can then be utilized to answer the questions most frequently asked in disability evaluations. These questions and the relevance of the model and associated case formulations will be reviewed utilizing case examples.

REFERENCES:
1. Gold LH, Shuman W: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. New York: Springer, 2009
2. Gold LH, Anfang, SA, Drukteinis AM, et al: Forensic Evaluation of Psychiatric Disability Practice Guideline. Journal of the American Academy of Psychiatry and the Law 36:S1-S50, 2008

MONDAY, MAY 16, 2011
8:00 AM SESSIONS

LECTURE 11
WRONGFUL CONVICTIONS: CHALLENGES FOR PSYCHIATRY AND FORENSIC SCIENCE
Outside Guest Lecture
Barry Scheck, J.D., 100 Fifth Avenue, New York, NY 10011

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the psychological factors that lead to false confessions; 2) Recognize the psychological challenges of the wrongly convicted; and 3) Evaluate lessons learned from post conviction exonerations.

SUMMARY:
Lessons that can be drawn from the 266 post-conviction DNA exonerations with respect to cognitive bias in forensic science and police investigations, the psychological factors that lead to false confessions and the psychological challenges encountered by the wrongly convicted.

LECTURE 12
PERSONALITY DISORDERS: WHERE BRAIN MEETS SELF
Judd Marmor Award Lecture
Larry J. Siever, M.D., The Mount Sinai Medical Center, One Gustave L. Levy Place, Box 1230, New York, NY 10029-6574

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the latest advances in neurobiology of personality disorders; 2) Evaluate the new paradigms to evaluate social cognition and interpersonal behavior; and 3) Recognize new directions in exploring pathophysiology and interventions for interpersonal dysfunction.

SUMMARY:
While our understanding of personality disorder was traditionally framed in psychodynamic terms, it has become increasingly clear that severe personality disorders like borderline and schizotypal personality disorder have underlying neurobiologic vulnerabilities grounded in the brain. Prefrontal-amygdala connectivity modulated by the serotonin system may be instrumental in the vulnerability to impulsive aggression, while limbic irritability is

associated with affective instability. Yet, the primary sphere where psychopathology is manifest for these disorders is the interpersonal sphere and patients with personality disorders may be exposed to adverse circumstances and are extremely sensitive to a range of interpersonal contexts. An increasing knowledge of how environmental milieus may affect the brain and interact with genetic expression and how brain systems and neuropeptide modulators are associated with interpersonal reactivity and social cognition may help us bridge the gap between neurobiology, interpersonal behavior/cognition, and self providing new targets for intervention. Furthermore, as this understanding is applied to the developmental context when personality disorders begin to emerge, possibilities of earlier preventive measures may be more readily realized. Implications for DSMV personality disorders will be discussed.

REFERENCES:

1. Stanley, B., Siever, L. J., The Interpersonal Dimension of Borderline Personality Disorder: Toward a Neuropeptide Model. Am J Psychiatry, 167:24-39, 2010.
2. Siever, L. J., Weinstein LN: Neurobiology of Personality Disorders: Implications for Psychoanalysis. J Am Psychoanal Assoc, 57:361-398, 2009.

10:00 AM SESSIONS

LECTURE 13
DISEASE BIOMARKERS FOR SCHIZOPHRENIA: FROM LABORATORY TO PATIENT BEDSIDE

Frontiers of Science Lecture

Sabine *Bahn*, *M.D.*, *Tennis Court Rd*, *Cambridge*, *CB1 2AN*, *United Kingdom*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify serum biomarkers in first onset schizophrenia; 2) Recognize systemic alterations associated with schizophrenia; and 3) Diagnosis metabolic dysfunction in schizophrenia.

SUMMARY:

Schizophrenia is a multifaceted neuropsychiatric disorder. It almost certainly presents a heterogeneous group of a etiologies which may not be reflected in the symptomatic/clinical presentation of patients. Therefore, a better molecular understanding of the disease onset and progression is urgently needed. Multi-omics profiling approaches can be employed to investigate large numbers of patient and control samples in a single experiment. These large scale experiments are required to identify disease intrinsic molecular signatures as well as patient subgroups with potentially distinct biochemical pathways underpinning their symptoms. I will present results from our biomarker discovery studies. We have identified a number of highly significant peptides and proteins that distinguish first onset paranoid schizophrenia patients from healthy controls. Our findings suggest alterations in glucoregulatory processes in CSF of drug naïve patients with first onset schizophrenia. Short term treatment with atypical antipsychotic medication resulted in a normalization of the CSF disease signature in half the patients well before a clinical improvement would be expected. Furthermore, our results suggest that the initiation of antipsychotic treatment during a first psychotic episode may influence treatment response and/or outcome. More recently, we have identified a candidate biomarker panel in patient serum, specifically up or down regulated in drug naive, first onset schizophrenia patients using high throughput proteomic profiling and multiplexed immunoassay profiling technology. A panel of 51 markers was found to yield an average sensitivity and specificity of >85% across five clinical centers. Abnormalities remained significant after adjustment for all recorded baseline characteristics. The panel has now been developed into a test which can help confirm the diagnosis of schizophrenia.

REFERENCES:

1. Biomark Insights. 2010 May 12;5:39-47. Validation of a blood-based laboratory test to aid in the confirmation of a diagnosis of schizophrenia. Schwarz, E., Izmailov, R., Spain, M., Barnes, A., Mapes, J.P., Guest, P.C., Rahmoune, H., Pietsch, S., Leweke, F.M., Rothermundt, M., Steiner, J., Koethe, D., Kranaster, L., Ohrmann, P., Suslow, T., Levin, Y., Bogerts, B., van Beveren, N. J., McAllister, G., Weber, N., Niebuhr, D., Cowan, D., Yolken, R.H., Bahn, S.

LECTURE 14
THE ALIENIST IN THE 21ST CENTURY

International Guest Lecture

Dinesh Bhugra, *M.B.B.S*, *Ph.D.*, *17 Belgrave Square*, *London*, *SW1X 8PGUnited Kingdom*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the changing role of

the psychiatrists in the 21st century; 2) Identify obstacles which may impede personal development.

SUMMARY:

For a considerable period of time individuals with mental illness were identified as aliens, as distinct from beggars and vagabonds, and those treating aliens were known as alienists. This started to change in the 19th century. The public gaze focused on the aliens where people paid money to go and see patients in the Bethlem Hospital and the creation of the 'other'. However with increasing medical and psychological knowledge, enlightened alienists liberated their patients from their chains. However, as drugs and other therapeutic interventions became available in the early part of the 20th century, not only did the public expectations change the role of the institutions but doctors also underwent a critical shift. As more therapeutic interventions became available there was a shift towards treating patients in the community, and although public attitudes were negative their expectations were high. As a result, treatment in psychiatric asylums was transferred to the community. With increasing equality in the doctor/patient relationship in the early part of the 21st century, and also with changing expectations with newer interventions available and politicians urging patients to become consumers, the profession is facing challenges of a different kind. Not only has an emphasis on quality of services become ever so important and patients are aware of what components of quality are, it is inevitable that the profession needs to look at professionalism and revisit the psychiatry's contract with society. Other factors that must be remembered include stigma and discrimination against mental illness and the mentally ill and the advent of psychopharmacogenomics, both of which will change the role of the psychiatrist. In this lecture, a history of alienism, challenges and development of psychiatry will be discussed in the context of cultural and social shifts and some ways forward will be addressed.

REFERENCES:

1. D Bhugra, A Malik and G Ikkos (eds) (2010): Psychiatry's Contract with Society: Concepts, Controversies and Consequences. Oxford: Oxford University Press.
2. D Bhugra (2008): Professionalism and psychiatry: the profession speaks. Acta Psychiatrica Scandinavica 118, 327-329.

LECTURE 15
30 YEARS EXPERIENCES IN PROVIDING MENTAL HEALTH CARE TO ASIAN REFUGEES AND IMMIGRANTS

Kun-Poo Soo Award Lecture
Paul Leung, M.D., 3181 SW Sam Jackson Park Rd, Portland, OR 97239-3011

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Indentify in general the challenges facing the refugee and immigrant communities in America; 2) Recognize the model of treatment that has been successfully used for 3 decades in providing mental health care to the refugee and immigrant communities; and 3) Evaluate the challenges facing clinicians in the community.

SUMMARY:

For more than 30 years the Department of Psychiatry of Oregon Health & Sciences University (OHSU) has operated the Intercultural Psychiatric Program (IPP) focusing on providing comprehensive mental health services to the immigrant and refugee communities. To date, IPP serves more than 1,300 patients of 23 language groups. It utilizes the proven model of pairing a psychiatrist with an ethnic mental health professional constituting the treatment team for a particular ethnic patient-group. Over the years we have provided high quality, culturally & linguistically competent services to our patients. Many of them were victims of trauma due to the political and economical instability of the regions where they came from. In this presentation the author will reflect on his experiences in providing mental health care, in particular, to the Asian communities in Oregon. He will also describe the model of treatment IPP has employed with rewarding outcomes. A significant portion of the presentation will be devoted to the discussion of the continuous challenges facing programs alike in providing cares to these communities.

LECTURE 16
TRANSFORMING CLINICAL OUTCOMES IN ADDICTION

Frontiers of Science Lecture
National Institute of Drug Addiction
Nora D. Volkow, M.D., 6001 Executive Boulevard Room 5274, MSC 9581, Bethesda, MD 20892

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate the complexity of molecular mechanisms underlying acute and long term effects of drug exposure; 2) Identify the major brain circuits that play a role in addiction; and 3) Recognize the implications of these scientific findings for targeted prevention and treatment development and some of the key questions on which future research will focus.

SUMMARY:
Recent scientific advances have dramatically increased our understanding of the complex biological, developmental and environmental factors involved in drug abuse and addiction. This presentation will discuss what we know about: molecular mechanisms underlying the effects of drugs of abuse; consequences of acute and chronic drug exposure on epigenetic modifications, gene expression and cell function; brain circuit disruption in addiction; and factors involved in genetic vulnerability and resilience for drug abuse. In the coming years research efforts will focus on answering such key questions as: what neurobiological processes mediate the effects of stressors on drug abuse vulnerability?; what genes play a role in brain development and how are they affected by drugs?; and how can Neuroimaging tools for biofeedback be most effectively employed to strengthen neural circuits disrupted by addiction? All of this knowledge will have a profound impact on the development of increasingly targeted prevention and treatment strategies and on improving clinical outcomes.

REFERENCES:
1. Koob, G.F., Volkow, N.D., Neurocircuitry of addiction Neuropsychopharmacology. 2010 Jan; 35(1):217-238.

12:00 PM SESSIONS

LECTURE 17
TRANSLATING NEURAL CIRCUITS INTO NOVEL THERAPEUTICS FOR SCHIZOPHRENIA
Distinguished Psychiatrist Lecture
National Institute of Mental Health
David Lewis, M.D., 3811 O'Hara St W1650 BST, Pittsburgh, PA 15213

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the importance of cognitive deficits for functional outcome in individuals with schizophrenia; 2) Understand the abnormalities in specific cortical circuits that contribute to these cognitive deficits; and 3) Understand how these circuitry abnormalities reveal molecular targets for novel therapeutic interventions.

SUMMARY:
The principal pharmacological treatment for schizophrenia, antipsychotic medications, reduces the severity of positive symptoms of the disorder, but has limited effectiveness in reducing the cognitive impairments that are the major determinants of long-term social and occupational outcome. This presentation will illustrate a strategy for the development of novel therapeutic approaches based on an understanding of the neural circuitry disturbances that result from the underlying disease process. Specifically, current data suggest that molecular alterations in specific populations of GABA neurons in the dorsolateral prefrontal cortex give rise to alterations in neural network oscillations that underlie the well-documented working memory dysfunction in schizophrenia. The potential contribution of cannabis use, a risk factor for schizophrenia, to disrupting this circuitry will also be discussed. The convergence of these findings led to the development of a new medication that improved both network oscillations and working memory function in patients with schizophrenia in an initial proof-of-concept clinical trial.

REFERENCES:
1.Lewis DA and Sweet RA: Schizophrenia from a neural circuitry perspective: Advancing toward rational pharmacological therapies. J Clin Invest 119: 706-716, 2009.

LECTURE 18
STRESS, CORTISOL AND PSYCHOSIS IN DEPRESSION
Distinguished Psychiatrist Lecture
Alan F. Schatzberg, M.D., Stanford University School of Medicine, 401 Quarry Road, Stanford, CA 94305-5717

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Differentiate characteristics of psychotic depression; 2) Identify the relationship of elevated cortisol to cognitive impairment; and 3)

Understand the importance of f-MRI in psychotic major depression during memory tasks.

SUMMARY:
In recent years there has been considerable attention paid to the hypothalamic pituitary adrenal (HPA) axis as playing key roles in the pathophysiology of several depressive subtypes. The axis is activated by stress and represents a feedback system that includes the hypothalamus and hippocampus, the pituitary, and the adrenal gland. Its functions are mediated through several peptides and hormones including the brain peptide - corticotropin releasing hormone (CRH)—and the hormone cortisol—produced in the adrenal but that crosses into the brain. Over-activity of both of these has been particularly emphasized. This presentation will review studies from our group and others on HPA axis over-activity in patients with major depression with psychotic features (PMD). We present recent data collected in over 140 subjects that point to significantly elevated cortisol activity between 6PM and 1AM in PMD subjects compared to those depressives without psychotic features and healthy controls. PMD patients demonstrate impaired verbal and working memory as well as in response inhibition. Memory deficits are significantly correlated with evening cortisol activity. Further, data are presented on alterations in both structural and functional brain imaging in PMD patients as compared to non-delusional depressives and healthy controls. f-MRI studies of verbal memory point to significant impairment in encoding in PMD patients. On both verbal and working memory tasks PMD patients—in contrast to nondelusional depressives and healthy controls-must activate parahippocampal regions to perform the tasks, suggesting that typical regional activation is insufficient to complete the tasks. Last, we will provide preliminary data from studies on studies on genetic risks for developing PMD and discuss the therapeutic implications of our studies to date.

REFERENCES:
1. Garrett A., Kelly R., Gomez R., Keller J., Schatzberg A., Reiss A., Aberrant brain activation during a working memory task in psychotic major depression. American Journal of Psychiatry in press.

TUESDAY, MAY 17, 2011
8:00 AM SESSIONS

LECTURE 20

THE OSKAR PFISTER DIALOGUES: A SEARCH FOR MEANINGS
Oskar Pfister Award Lecture
Clark S. Aist, Ph.D., 2700 Martin Luther King Jr Avenue Southeast Washington, DC 20032

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the background and early history of the Oskar Pfister Award; 2) Identify some of the major factors that have mediated the success of the Pfister project, and 3) Recognize how these factors may serve as bridges for further collaboration with the religious community and spiritual caregivers.

SUMMARY:
With the landmark transition from "psycho-dynamic perspectives" to a "neuro-biological orientation" that began in American psychiatry during the late 1960s and 1970s, there was a wide-spread assumption that psychiatry's already fragile interest in religion and spirituality would become even more tenuous or vanish altogether. Near the peak of the transition in 1980, the Oskar Pfister Award was formally established as a joint effort by the American Psychiatric Association and the Association of Mental Health clergy. Named for a Swiss Protestant minister and lay psychoanalyst who conducted an extended correspondence with Sigmund Freud on a range of topics, but notably their respective views on the place of religion in human experience, the award was intended as a forum to sustain and expand an informed dialogue about religion and psychiatry. To some the project seemed strangely out of joint with the times. With the publication in 1980 of the DSM-III featuring atheoretical categories and descriptive nomenclature, psychiatry had clearly embraced a medical model. In this environment there was even concern that the new venture for "exploring the interface between religion and psychiatry" might arrive still-born. To the surprise of many, however, the Pfister Award seemed to tap a growing awareness of the religious and spiritual dimensions of problems that people bring to psychiatrists, as well as a growing disposition among psychiatrists to deal with these dimensions with sensitivity and understanding. Over the years the award has not only grown in stature but has assumed a prominent role in charting a major reappraisal of the significance of religion and spirituality in

contemporary psychiatry. This address will explore the meanings that underlie this unpredictable development. It will propose that the Pfister Award and its associated lectures represent a robust phenomenon that invites analysis and understanding of the factors that have mediated its success. These factors arise not alone from the field of psychiatry but also include the broader cultural domains of philosophy, theology and other human sciences. These issues are especially important to the work of clergy and chaplains, particularly those who work with persons with mental and emotional disorders. They represent significant bridges of collaboration among psychiatrists and other behavioral health specialists in the process of holistic healing. By taking the Pfister lectures as a "text" that narrates a "story" about the exploration of a domain of human experience that has heretofore been under-regarded and often marginalized in psychiatry, I shall attempt to identify some of the undergirding influences that have shaped the Pfister "narrative" and the larger reassessment of spirituality as an object of therapeutic interest. These will include: 1) The significance of culture in human healing, 2) The creative power of ritualized dependence, 3) The psychic function of belief, 4) The triumph of "faith" over skepticism, 5) Neurobiological foundations for faith and spirituality, and 6) The relevance of recovery narratives. Suggestions will also be offered regarding future issues that may be addressed by the Pfister dialogue.

LECTURE 21
ELECTRIFYING PSYCHIATRY: WHAT WILDER PENFIELD, JAMES MAXWELL, AND UGO CERLETTI HAVE IN COMMON

Distinguished Psychiatrist Lecture

Sarah H. Lisanby, M.D., Duke University School of Medicine, Department of Psychiatry and Behavioral Sciences, 125 Science Drive, Durham, NC 27710

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the FDA approved brain stimulation devices available in psychiatry today; 2) Define the current role of brain stimulation devices in clinical care; and 3) List the mechanisms of action of the different brain stimulation technologies in use today.

SUMMARY:
Psychiatry has been electric for nearly a century. Neural activity generates electric fields that can be recorded from the scalp; likewise, electric fields applied to the brain alter neural activity. The appreciation that the brain both generates and responds to electric fields predates our modern day understanding of psychopharmacology. Brain stimulation represents both our oldest (e.g. electroconvulsive therapy) and newest (e.g. transcranial magnetic stimulation) somatic treatments in psychiatry. Beyond its therapeutic potential, brain stimulation has opened an entirely novel window onto brain function that has greatly advanced our understanding of brain/behavior relationships in health and disease. As such, brain stimulation technologies have propelled basic neuroscience investigation and pathophysiology studies yielding previously unprecedented discoveries. This work has ushered in a new era for our field when engineering has come to play a major role in the development and refinement of novel psychiatric devices. In addition to the new interdisciplinary perspective that brain stimulation has brought, it also has driven new inter-professional collaborations and novel care delivery models regarding the role for nursing and allied health professionals in the delivery of these interventions. This presentation will describe the paradigm shift brought about by the field of brain stimulation, and how these new developments impact clinical care. It will also describe the future challenges facing the field as together we determine the proper clinical role for these new tools in our clinical armamentarium.

10:00 AM SESSIONS

LECTURE 22
TRANSFORMING MENTAL HEALTH THROUGH LEADERSHIP, DISCOVERY, AND COLLABORATION – FROM CLINICAL EPIDEMIOLOGY TO CLINICAL TRIALS IN BIPOLAR DISORDER

Simon Bolivar Award Lecture

Mauricio Tohen, M.D., Ph.D., University of Texas Health Science Center San Antonio, 7703 Floyd Curl Drive, MC 7734, San Antonio, TX 78229-3901

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify how to learn the course and outcome after remission from a first episode of

mania; 2) Recognize the predictors of relapse into mania or depression in first episode bipolar disorder; and 3) Identify the use of clinical epidemiology in the design of clinical trials in bipolar disorder.

SUMMARY:
Bipolar disorder represents a major public health concern in all ethnic groups. Despite the introduction of new treatment the condition remains characterized by recurring episodes of mania, depression, or mixed states. Prevention of relapse and recurrence is a primary treatment objective in the management of the disorder. In order to develop new pharmacological treatments proper clinical trial designs are needed. To optimize the study of new drugs it is essential to first understand the clinical epidemiology of the condition, including its course and outcome Predictors of relapse are important to identify in order to determine its effects in response to treatment. The objective of the presentation will be for the author to describe how learning the clinical epidemiology of bipolar disorder enables the proper design of clinical trials.

LECTURE 23
SCIENCE AND HUMANISM IN CONTEMPORARY AMERICAN PSYCHIATRY: DIALOGUES TOWARD A DESIRABLE CONVERGENCE
George Tarjan Award Lecture
Renato D. Alarcon, M.D., Mayo Clinic, 200 First Street, SW, Rochester, MN 55905

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the main issues involved in the delineation of the identity of Psychiatry as a medical specialty, and the factors and controversies influencing such debates; 2) Examine and assess the historical evolvement of the Science-Humanism dichotomy, and perspectives on its current status in American psychiatry; and 3) Delineate the steps and work needed to continue developing a pathway towards the convergence of Science and Humanism through the work of diverse groups of professionals and institutions.

SUMMARY:
This presentation initially examines issues of Psychiatry's identity as a medical discipline, the subject of heated controversies throughout its history. This process has resulted in the elaboration of several dichotomies (being-doing, brain-mind, science-humanism, and others) materialized in the sometimes tense relationship between basic scientific research and clinical practice. The phenomena of globalization add to the complexity of a situation that affects all areas of psychiatric work and all kinds of psychiatric patients, their families, cultures and societies throughout the world. Discussions about the Science-Humanism dichotomy, clearly polemical at first, may have evolved (or be in the process of evolving) towards the conviction that only a high-leveled dialogue can assist in outlining a desirable itinerary of convergence, ending the problems generated by Cartesian and other types of dualism. To substantiate this possibility, a review of key aspects of the work of, and revealing quotations from several leading figures of contemporary psychiatry, neurosciences and other mental health disciplines in the U.S., are presented to characterize stations of such itinerary, and to document converging points of this conceptual, rhetoric and pragmatic journey. The contributions of these scientists, thinkers and practitioners are critically examined, and the increasingly stronger similarities and coincidences of their approaches and conclusions, are duly emphasized. The current debate between evidence-based and value-based approaches to psychopathological descriptions, diagnostic and treatment issues, also reflects a different angle of the dichotomy. This dialectical process will hopefully make it possible a comprehensive consideration of the suffering human being (patient) and a genuine explanatory pluralism. The achievement of a desirable convergence of Science and Humanism (similarity of purposes, objectives and actions by professionals from diverse cultural backgrounds and different fields of work) would require the formulation of a new humanism, the structuring of a new phenomenology, and the development of new diagnostic foci aimed at the solid systematization of an elusive psychopathology and its treatment. The role of professional and scientific institutions, and the contributions of groups such as the IMGs in American psychiatry, are crucial ingredients of these historical dialogues across the globe.

LECTURE 24
A JOURNEY INTO CHAOS: CREATIVITY AND THE UNCONSCIOUS
Distinguished Psychiatrist Lecture
Nancy C. Andreasen, M.D., Ph.D., University of Iowa

College of Medicine, 200 Hawkins, Iowa City, IA 52242

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Indentify ways that creativity can be defined; 2) Recognize the relationship between creativity and mental illness; 3) Identify brain regions that are active during the creative process.

SUMMARY:
The capacity to be creative—to produce new concepts, ideas, inventions, objects, or art—is perhaps the most important attribute of the human brain. We know very little, however, about the nature of creativity or its neural basis. Some important questions include: how should we define creativity? How is it related (or unrelated) to high intelligence? What psychological processes or environmental circumstance cause creative insights to occur? How is it related to conscious and unconscious processes? What is happening at the neural level during moments of creativity? How is it related to health or illness, and especially mental illness? This presentation will review introspective accounts from highly creative individuals. These accounts suggest that unconscious processes play an important role in achieving creative insights. Neuroimaging studies of the brain during "REST" (random episodic silent thought, also referred to as the default state) suggest that the association cortices are the primary areas that are active during this state and that the brain is spontaneously reorganizing and acting as a self-organizing system. Neuroimaging studies also suggest that highly creative individuals have more intense activity in association cortices when performing tasks that challenge them to "make associations." Studies of creative individuals also indicate that they have a higher rate of mental illness than a noncreative comparison group, as well as a higher rate of both creativity and mental illness in their first degree relatives. This raises interesting questions about the relationship between the nature of the unconscious, the unconscious, and the predisposition to both creativity and mental illness.

REFERENCES:
1. Andreasen, N. C., The Creating Brain: The Neuroscience of Genius, Dana Press, 2005

WEDNESDAY, MAY 18, 2011
10:00 AM SESSIONS

LECTURE 25
GENOMICS: UNPICKING THE GORDIAN KNOT OF PSYCHIATRY?
International Guest Lecture
Michael M. Owen, M.S.C., Ph.D., Henry Wellcome Building, Heath Park, Cardiff, CF64 4UF United Kingdom

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the audience should understand 1) Recognize the implications of recent advances in genomics for the classification and neurobiology of major psychiatric disorders; 2) Identify the likely trajectory of the field over the next 5 years; 3) Appreciate the major challenges faced by aetiological research in psychiatry.

SUMMARY:
The treatment of psychiatric disorders faces two major challenges: a lack of understanding of pathophysiology and a diagnostic process that is therefore largely descriptive and syndromic with disease categories that are consequently highly heterogeneous and overlapping. The complexity and relative inaccessibility of the human brain together with the difficulties inherent in developing valid model systems provide major obstacles to understanding disease biology. Given that many if not all psychiatric phenotypes display evidence for significant heritability, geneticists have long harboured the hope that identification of specific risk genes might allow crucial insights into disease pathogenesis to be obtained thus allowing the Gordian knot to be unpicked. Progress has until recently been disappointing but in the last 3 years the application of novel genomic approaches to disorders such as schizophrenia, bipolar disorder, autism and ADHD has yielded a number of important new insights and one can begin to see how these and future discoveries are likely to impact on psychiatry. Highlights include increasing evidence that common risk alleles are shared by schizophrenia and bipolar disorder and evidence that specific submicroscopic deletions and duplications of segments of DNA, known as copy number variants (CNVs), confer risk of schizophrenia and other neurodevelopmental disorders such as autism, ADHD, epilepsy and intellectual disability. These findings not only challenge the aetiological basis of current diagnostic categories but, together with evidence for frequent co-morbidity, suggest that we

should view the functional psychoses as members of a group of related and overlapping syndromes that result in part from a combination of genetic and environmental effects on brain development and which are associated with specific and general impairments of cognitive function. This has important implications for future research and for the configuration of psychiatric services. A model of the relationship between the major psychiatric syndromes will be presented and the implications for a meta-structure in DSMV and ICD11 will be discussed. The most important implications of genomic studies in psychiatry are likely to come from insights into disease pathogenesis.

REFERENCES:

1.Owen MJ, Craddock N, O'Donovan MC. Suggestion of roles for both common and rare risk variants in genome-wide studies of schizophrenia. Arch Gen Psychiatry. 2010; 67:667-73.

2. Craddock N, Owen MJ. The Kraepelinian dichotomy - going, going... but still not gone. Br J Psychiatry. 2010; 196:92-5.

SATURDAY, MAY 14, 2011
12:00 PM- 3:00PM

PRESIDENTIAL SYMPOSIUM 1 TEACHING PSYCHODYNAMIC PSYCHIATRY IN THE ERA OF NEUROSCIENCE

Chair: Carol C. Nadelson, M.D., 50 Longwood Ave Ste 1114, Brookline, MA 2446
Discussant: Carol A. Bernstein, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the importance of psychodynamic training for psychiatrists; 2) Understand the complex educational dilemmas that limit training; and 3) Analyze proposed educational solutions.

OVERALL SUMMARY:
Since psychiatric residencies must prepare residents to be competent in "applying supportive, psychodynamic, and cognitive behavior psychotherapies to both brief and long-term individual practice," according to ACGME (Accreditation Council for Graduate Medical Education), 2008 requirements, programs are challenged to comply. This symposium will focus on education in psychodynamic psychotherapy, addressing the reasons for its continuing importance for psychiatric training, how it can be taught given the realities of training, specific dilemmas for residents and programs, and how this requirement has been met by some programs, using specific examples.

PS1-1.
PSYCHOTHERAPY TEACHING STRATEGIES

Glen Gabbard, M.D., Baylor University, 6655 Travis Street, Suite 500, Houston, TX 77030-1316

SUMMARY:
In this presentation I will emphasize strategies for teaching psychotherapy in an era where we are at risk for neurobiological reductionism in psychiatry. It is important to avoid artificial dichotomies, such as mind vs. brain or genes vs. environment. Psychotherapy must be taught as a powerful intervention that affects the brain. One must also steer clear of the implication that psychotherapy only exists in a formal 50 minute hour designated as "psychotherapy" by an administrative form. Too much emphasis on theory runs the risk of polarizing different approaches and implying that we really understand the therapeutic action of psychotherapy. Teaching based on specific case material is far more convincing to residents than abstract discussions, so case based learning in supervision and in case conferences/seminars is likely to have the greatest lasting impact on residents who are learning psychotherapy.

PS1-2.
MANAGEMENT VERSUS INTERPRETATION: TEACHING PSYCHOTHERAPY TO RESIDENTS

Edward Shapiro, M.D., Austen Riggs Center, 19 Prospect Hill Road, P.O. Box 32, Stockbridge, MA 01262

SUMMARY:
The pressures of the health care system have pushed residents in training to manage their patients rather than listen to them. The contemporary emphasis on medication, safety, filling out forms and efficient use of short-term resources leaves little time for residents to reflect on their clinical experience or attend to what might be meaningful in the patient's symptoms and life. In addition, creating time for residents to have an extended encounter with the patient relatively free from the press of management demands is difficult to implement. In this presentation, the author will illustrate ways of introducing psychodynamic thinking into the management structures generally available to residents. Focusing on the psychodynamics of social systems can allow residents to grasp unconscious functioning, projective identification, counter transference and interpretation, opening a new way of thinking that illuminates and opens possibilities for learning psychodynamic psychotherapy.

PS1-3.
TEACHING PSYCHODYNAMIC PSYCHOTHERAPY: PROGRAMS IN BOSTON AND CLEVELAND

Malkah Notman, M.D., Cambridge Health Alliance, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139

SUMMARY:
There is a renewed interest in teaching psychotherapy in the context of the new ACGME standards for developing competency in psychotherapy. However many training programs

currently do not have the expertise or faculty to do so. The authors investigated the experience of psychiatry residency training programs in Boston and Cleveland as to their current practice in psychotherapy training and specifically psychodynamic psychotherapy. We asked about the extent and depth of the curriculum, length, number of hours of therapy and supervision, the composition of the faculty and the presence of psychoanalysts as teachers or supervisors. We shall describe these findings and the opportunities and challenges that are evident in the current environment of psychiatric training.

PS1-4
TEACHING PSYCHODYNAMIC PSYCHOTHERAPY: PROGRAMS IN BOSTON AND CLEVELAND

Norman Clemens, M.D., University Suburban Health Center, 1611 S Green Road Suite 301, Cleveland, OH 44121-4192

SUMMARY:
There is a renewed interest in teaching psychotherapy in the context of the new ACGME standards for developing competency in psychotherapy. However many training programs currently do not have the expertise or faculty to do so. The authors investigated the experience of psychiatry residency training programs in Boston and Cleveland as to their current practice in psychotherapy training and specifically psychodynamic psychotherapy. We asked about the extent and depth of the curriculum, length, number of hours of therapy and supervision, the composition of the faculty and the presence of psychoanalysts as teachers or supervisors. We shall describe these findings and the opportunities and challenges that are evident in the current environment of psychiatric training.

PS1-5
LEARNING PSYCHOTHERAPY: THE EXPERIENCE OF PSYCHIATRY RESIDENTS

Michael Ferri, M.D., Vanderbilt University, Department of Psychiatry, 1601 23rd Avenue South, Nashville, TN 37212

SUMMARY:
Current challenges in residency psychotherapy training appear to parallel the broader shift away from the provision of psychotherapy by psychiatrists in clinical practice. Nonetheless, proficiency in psychotherapy is considered an essential element of psychiatry training by the Accreditation Council for Graduate Medical Education (ACGME). In this presentation I will discuss a number of challenges in providing psychotherapy training to psychiatry residents, based on the nature of psychiatry residency as well as the perspectives of psychiatry residents themselves. Unlike skills in other medical specialties, psychotherapy is a skill set to which new psychiatry residents usually have had no prior exposure. The clinical portion of psychotherapy training often does not begin until late in residency, and can be perceived as an "add-on" to an already overloaded clinical work week. In a recent pilot study at Vanderbilt, residents reported, and clinic data confirmed, that recruitment and retention of patients for psychotherapy is difficult. They reported high levels of anxiety and poor self-confidence when treating patients in psychotherapy. They had difficulty engaging patients in therapy and saw very few patients on a regular and long-term basis. They found it difficult to integrate different approaches and techniques. A consideration of the experience of psychiatry trainees and the distinct nature of psychiatry training will be valuable in the overall effort to improve psychotherapy competence in psychiatry.

REFERENCES:
1) "The Chief Resident for Psychotherapy: A Novel Teaching Role for Senior Residents" Ferri, M. J., Stovall, J., Bartek, A., Cabiness, D: Academic Psychiatry 34:4 302-309 July-August 2010

SUNDAY, MAY 15, 2011
8:00 AM-11:00 AM

PRESIDENTIAL SYMPOSIUM 2
DSM-5: IMPLICATIONS FOR CHILD PSYCHIATRY

Chair: Laurence L. Greenhill, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032
Discussant: David Shaffer, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) List the proposed DSM- 5 diagnoses in child and adolescent psychiatry that are controversial; 2) Identify the clinical characteristics of disruptive Mood Dysregulation disorder in

children and adolescents when they present during an evaluation; and 3) Discuss the possible unintended consequences of the new proposed diagnoses for children and adolescents in DSM-5.

OVERALL SUMMARY:
Significant changes in child and adolescent diagnoses have been proposed for the upcoming DSM-5 which will be published in May, 2013. The lecturers at this symposium will address the changes and their possible unintended consequences, including the nature of changes in the ADHD diagnosis (Dr. Cuffe), the modifications to the diagnosis of Bipolar I and Bipolar NOS when it begins in youth (Dr. Galanter), as well as the legal implications that relate to juvenile justice, family law, criminal responsibility, personal injury cases, civil commitment, and/or mental competency (Dr. Bernet). Dr. David Shaffer will go over the process and challenges faced by the workgroups that deliberated and generated these proposed changes, and Dr. Greenhill will describe the processes of validation and testing user friendliness that are occurring during the DSM-5 field trials.

PS2-1
ISSUES IN CHILD PSYCHIATRY FOR THE DSM-5 WORKGROUPS

David Shaffer, M.D., New York State Psychiatric Institute (NYSPI) 1051 Riverside Drive, Unit 78, New York, NY 10032

SUMMARY:
At the start of the *DSM* revision process, the three child and adolescent work groups (Neurodevelopmental Disorders, Chair: Sue Swedo, M.D.; Childhood and Adolescent Disorders, Chair: Danny Pine, M.D.; and ADHD and Disruptive Behavior Disorders, Co-chairs: myself and Xavier Castellanos, M.D.) met to develop and review an innovation strategy that would take into account: 1) their perception of problems in diagnosis that were negatively affecting clinical practice; 2) elements in DSM-IV that had been shown by new research to require revision; 3) the frequency with which different diagnoses were being used clinically and/or were the subject of useful and well-designed peer-reviewed research; 4) the rates of use of different diagnoses in clinical-encounter and publication records that might suggest an existing problem (e.g., a very high NOS rate); and 5) topics that had been brought to the attention of the three different work groups by specialized professional groups. These included advocates for inclusion of Parent Alienation Syndrome whose arguments will be heard later in this symposium; and also of sensory-processing disorder. Among the topics that seemed to be leading to problematic practice the foremost was the a great increase in the number of children and adolescents who were being designated bipolar NOS, a less publicized problem is the frequent misattribution of certain forms of self-injurious behavior as suicide attempts and, with that, the use of inappropriate management procedures. Other concerns were the seeming underuse of PTSD among young children; the deletion of under-socialized conduct disorder from a previous edition of *DSM* that was seen as depriving the field of useful treatment indicators; evidence that the subtypes of ADHD introduced in *DSM-IV* were unstable across time; and that Aspergers syndrome and autism shared many basic characteristics, although they differed in the magnitude of their impact.

PS2-2
MODIFICATIONS OF THE ADHD DIAGNOSIS IN DSM-5 AND ITS IMPACT ON PRACTICE

Steven Cuffe, M.D., University of Florida Jacksonville, 580 West 8th Street 6th Floor Tower 2, Suite 6005, Jacksonville, FL 32209

SUMMARY:
The significant changes proposed for the diagnosis of ADHD in *DSM-5* will be outlined and compared to *DSM-IV.* Three major proposed changes will be explored in detail: 1. increasing the age at onset to 12 (and changing the wording); 2. reducing the number of symptoms required to meet the disorder as older adolescents or adults to four inattention or four hyperactive/impulsive symptoms, and; 3. adding four new impulsivity symptom criteria (without increasing the number of symptoms required to make the diagnosis). Implications for prevalence, diagnosis and treatment of ADHD will be discussed.

PS2-3
MODIFICATIONS OF THE BIPOLAR DISORDER DIAGNOSIS, DISRUPTIVE MOOD DYSREGULATION DISORDER AND IMPLICATIONS FOR THE PRACTICING CLINICIAN

Cathryn Galanter, M.D., Columbia University, Department of Child and Adolescent Psychiatry, 1051 RSD, #78, New York, NY 10032

SUMMARY:
Introduction: In the past decade there has been a 40-fold increase in diagnosis of pediatric bipolar disorder (BD) in children and adolescents, particularly the Not Otherwise Specified (NOS) type. It is unclear whether the increase in the diagnosis of BD and BD NOS represents an increase of previously unrecognized BD, over diagnosis, or both. DSM-IV-TR BD criteria were developed for adults. Making developmentally appropriate adaptations has been challenging for researchers and community clinicians. Investigators have operationalized phenotypes and definitions for BD and BD NOS for use in research. Clinicians still struggle with how to accurately diagnose BD in children, especially children and adolescents who do not have prototypical BD presentations, episodicity, elation, grandiosity, decreased need for sleep, but who present with extreme irritability and dysregulated mood. Methods/Results: The speaker will review bipolar phenotypes from different research groups. She will then describe proposed DSM V changes to BD, BD NOS and the proposed alternative to the NOS diagnosis, disruptive mood dysregulation disorder with dysphoria (previously named temper dysregulation disorder with dysphoria). She will then use case example of a child with attention deficit hyperactivity disorder (ADHD) and some manic symptoms to illustrate how proposed changes may impact on diagnostic clinical decision making. Discussion: The speaker will discuss diagnostic challenges faced by clinicians working with children with bipolar disorder and mood dysregulation, proposed changes to DSM-V, and possible implications for treatment.

PS2-4.
DSM-5 AND FORENSICS: THE CALLOUS AND UNEMOTIONAL SPECIFIER AND PARENTAL ALIENATION RELATIONAL PROBLEM

William Bernet, M.D., Vanderbilt Psychiatric Hospital, 1601 Twenty-Third Avenue South, Suite 3050, Nashville, TN 37212-3182

SUMMARY:
Some of the diagnoses in *DSM-5* have legal implications that relate to juvenile justice, family law, criminal responsibility, personal injury cases, civil commitment, and/or mental competency. The presenter will discuss the possible forensic repercussions – the pros and cons – of two diagnoses that have been proposed for DSM-5. (1) The "callous and unemotional specifier" has been proposed as a new feature to the current diagnosis of conduct disorder. The basis for that proposal is decades of research on classifying and subdividing the heterogeneous group that is diagnosed with conduct disorder. The advantage of that specifier: patients will be more accurately classified with regard to etiology and clinical course, which will improve both the treatment of these individuals and future research. A possible disadvantage of that specifier: delinquent children and adolescents thus labeled will be more likely to be transferred from juvenile court to criminal court. (2) "Parental alienation relational problem" has been proposed as a new diagnosis for DSM-5. The basis for that proposal is extensive qualitative and quantitative research from many countries that has established the validity of the concept of parental alienation. The advantage of that proposed diagnosis: thousands of children and adolescents with that mental condition will be identified sooner (when the condition is treatable) rather than later (when the condition may be intractable). A possible disadvantage of that proposed diagnosis: some divorcing parents may misuse the diagnosis of parental alienation relational problem to wrongly achieve a stronger position in court.

PS2-5.
EXPERIENCES PARTICIPATING AS CHILD PSYCHIATRIST CLINICIAN IN THE DSM-5 FIELD TRIALS

Laurence L. Greenhill, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032

SUMMARY:
Field trials have been used before during the assessment of new diagnostic constructs in *DSM* for reliability and utility. The proposed *DSM-5* changes in existing *DSM-IV* psychiatric diagnoses for children and adolescents will be subjected to field trials to test the user acceptability, reliability, and to some extent, the validity of the modified or new diagnoses. Dr. Greenhill now serves as a research clinician in the *DSM-5* field trial being conducted at Columbia University. Various strategies have been designed to determine if the diagnoses fit the patient's presenting complaints when interviewed by an experienced child and adolescent psychiatrist or clinician. Data entry procedures and phrasing of inquiries have been planned carefully, backed

by review of videotapes gathered during the interviews. Dr. Greenhill will present his experiences determining whether patients meet the more controversial proposed changes, such as ADHD, conduct disorder's callous and unemotional specifier, and depressive Mood Dysregulation Disorder.

MONDAY, MAY 16, 2011
8:00 AM-11:00 AM

PRESIDENTIAL SYMPOSIUM 3 PSYCHIATRY AND PRIMARY CARE COLLABORATION UNDER HEALTH CARE REFORM: SUSTAINABLE MODELS THAT IMPROVE ACCESS AND QUALITY

Chair: Henry Chung, M.D., CMO, Care Management Company of Montefiore Medical Center, 200 Corporate Boulevard South, Yonkers, NY 10701

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to:1) Identify opportunities to improve psychiatric and medical quality of care; 2) Describe 3 models that use formal collaborative methods between psychiatry and primary care to improve access and quality; and 3) Analyze the opportunities under healthcare reform such as "medical home", "mental health home" and "accountable care organization" to address sustainability concerns for psychiatry and primary care collaboration

OVERALL SUMMARY:
There is robust literature demonstrating the effectiveness of collaborative (Integrated) models of care, particularly for patients with depression presenting in primary care settings that involve structured clinical interactions between primary care clinicians and mental health specialists, including psychiatrists. These models take advantage of opportunities for screening, early engagement and intervention, patient centered education and care, opportunities for self management across a range of comorbid medical and mental health conditions, and improved communication between treating specialties. Despite the success of these interventions in controlled studies, widespread adoption of these collaborative approaches, especially for patients with mood and anxiety disorders, remains limited. In particular, sustainability of these models, even in experimental sites that have demonstrated success during the intervention period, has been challenging due to the financial, systems, and philosophical constraints. In addition, there is a growing realization that an opportunity for collaboration exists for the improved medical care of patients with chronic mental illness. The recently passed healthcare reform legislation may present several opportunities that help overcome these barriers to adoption of collaborative care models. For example, the promotion of Primary Care Medical Homes (PCMH), "mental health" homes, electronic health records (EHR) and meaningful use incentives, are key elements that support collaborative care between psychiatry and primary care. Presenters will describe real world collaborative care models that have intervened in the following settings: university health settings; urban, low income primary care settings; community based primary care settings, academic/training primary care settings; and community mental health settings. Aspects of healthcare reform that further support their efforts to sustain these models will be discussed.

PS3-1.
COLLABORATIVE CARE FOR COLLEGE STUDENTS: THE NATIONAL COLLEGE DEPRESSION PARTNERSHIP (NCDP)

Henry Chung, M.D., CMO, Care Management Company of Montefiore Medical Center, 200 Corporate Boulevard South, Yonkers, NY 10701

SUMMARY:
Objective: To implement a collaborative care model for primary care and counseling centers in college health for depression treatment and suicide prevention. Methods: Using the Collaborative (Chronic) Care Model and the IHI/Breakthrough Series Learning method, 20 diverse college and university campuses implemented depression screening in primary care, measurement informed care, enhanced engagement and care management approaches, and self management for a national quality improvement project. The PHQ9 was selected for clinical measurement as well as for the tracking of main outcome measures. Results: Over an 18 month period, over 100,000 students were screened for depression at least once during the academic year. 2134 students with clinical depression and functional impairment were entered into site specific project registries and followed for 12 week outcomes. 50% had a significant reduction in depression symptoms and improvement in function. A significant proportion was also able to develop self management goals. Pilot data on learning outcomes indicated disruption in function and learning at baseline which began to resolve with treatment. Conclusion: The Collaborative Care Model is an

effective model for improving care for depressed students, including those with symptoms of suicidality. Replication and sustainability efforts with this model should be undertaken in college health.

PS3-2.
HEALTH PLAN IMPLEMENTATION OF PRIMARY CARE BASED BEHAVIORAL HEALTH SERVICES

Hyong Un, M.D., Aetna Behavioral Health, 1100 First Avenue, F226, King of Prussia, PA 19406

SUMMARY:
Background and objective: Significant portion of behavioral health disorders present in primary care setting. The evidence base suggests that collaborative care models are effective in improving access and outcomes for these disorders. However, the adoption rate of collaborative care for behavioral health has been limited. Some of the major barriers to implementation and sustainability include health care financing, heterogeneous practice organization and delivery models, training as well as cultural differences between primary care and specialty behavioral health care delivery. This presentation will focus on a case study of health plan implementation of primary care based behavioral health services with a goal of delineating potential sustainable solutions to address these barriers. Method: Health plan partnership with primary care network providers to implement collaborative care program by providing a)reimbursement for screening b)telephonic based case and disease management support, c)technical support, and d) facilitating collaboration between primary care and behavioral health. Results: Preliminary program results indicate enhanced medication adherence and significant reduction in depressive symptoms as measured by the PHQ9 as well as reduction in medical and behavioral health inpatient bed days and increase in behavioral health outpatient visits. Screening and brief intervention for problematic alcohol use led to reduction in both medical and psychiatric inpatient bed days as well as emergency department visits and increased outpatient medical and behavioral health visits. Conclusion: Health plans may be able to partner with primary care to promote collaborative care to improve access and quality of behavioral health. Pilot program will need further study and analysis to determine generalizabilty and sustainability in the context of health care reform.

PS3-3.
IMPROVING MENTAL HEALTH CARE FOR MEDICAL OUTPATIENTS: A CO-LOCATION MODEL USING PSYCHIATRISTS IN URBAN PRIMARY CARE SETTINGS

Bruce Schwartz, M.D., Montefiore Medical Center and Albert Einstein College of Medicine, 111 East 210th Street, Bronx, NY 10467

SUMMARY:
Background: Considering the high rate of co-morbid psychiatric and substance abuse disorders among chronically medically ill urban patient populations and the difficulty accessing psychiatric care, especially among low-income populations, it is not surprising that primary care physicians are the main prescribers of psychotropic medications and that these patients consume a disproportionate share of healthcare resources. Even when psychiatric care is available it is rarely coordinated with medical care. Co-location of psychiatrists in primary care settings has the potential of being a cost-effective strategy for delivering higher quality care especially as primary care providers' transition to Primary Care Medical Homes and larger systems evolve into Accountable Care Organizations. Objective: To demonstrate the utility of co-locating psychiatrists in large, urban primary care clinics associated with an academic medical center and to discuss the advantages and disadvantages of the different models being implemented. Methods: Case studies and modeling of costs, revenues and utilization data for 3 psychiatrists in urban primary care clinics will be used to discuss the challenges and successes of divergent approaches. Results: Utilization, treatment, diagnostic and fiscal data will be presented. Cultural issues of introducing psychiatric services into a primary care clinic will be presented as well. Conclusion: Co-location models which meet patient, primary care provider and health plan needs have the potential to improve care for both medical and psychiatric disorders. Furthermore, there is an opportunity to reduce the total medical costs of caring for an urban, chronically medically ill population. Models of collaboration and logistical challenges of various models will be discussed.

PS3-4.
IMPROVING MEDICAL CARE OF PATIENTS RECEIVING BEHAVIORAL HEALTH CARE

Joseph Parks, M.D., University of Missouri St Louis , Missouri Institute of Mental Health, 5400 Arsenal Street, St Louis, MO 63139

SUMMARY:
Background/Objective: Persons with severe mental illness served by public mental health systems have rates of co-occurring chronic medical illnesses 2 to 3 times higher than the general population, with a corresponding life expectancy that is 25 years less (1,2). Treatment of these chronic medical conditions in those with serious mental illness (SMI) is often substandard, with large numbers of such individuals receiving no treatment at all, and much of the treatment that they do receive coming in the form of costly ER visits and inpatient stays rather than as routine screenings and preventive medicine (2). The presentation will describe a collaborative approach that improves quality medical care for patients with SMI. Methods: Missouri Dept of Mental Health is using a 3 pronged approach to integrating Primary Care and Behavioral Healthcare. This model uses a Community Mental Health Center (CMHC) as a HealthCare Home with elements of case management, Co-location of MH and PCP services at both CMHCs and FQHCs, and Disease management for pre-diabetic SMI persons. Missouri's CMHC system consists of 29 CMHCs and case management affiliates that have approximately 28,000 persons in actively in service at any given time. Results: In Missouri, use of mental health case management by Community Mental Health Centers to ensure access to preventive healthcare and ongoing integration and management of medical care for this population has had a positive impact on hospitalization, outpatient, and pharmacy costs, including services for medical as well as psychiatric illnesses (3, 4). Conclusion: Community Mental Health Center Health Care Home Model with case management is an effective disease management care coordination intervention for chronic medical illness in persons with severe mental illness. This session will give a brief overview of each approach.

PS3-5

ACHIEVING COMPREHENSIVE, SUSTAINABLE MODELS OF CARE IN THE PATIENT-CENTERED MEDICAL HOME UNDER HEALTH CARE REFORM

Frank Degruy, M.D., University of Colorado School of Medicine, Department of Family Medicine, 12631 East 17th Avenue, Room 3613, Aurora, CO 80045

SUMMARY:
Objective: This presentation will begin with a consideration of the elements of a patient centered medical home (PCMH), particularly the concepts of "comprehensive" and "coordinated," and will discuss how psychiatrists and primary care clinicians in the nine Colorado Family Medicine Residency Programs and elsewhere are collaborating to create together comprehensive PCMHs—both in the primary care and the mental healthcare settings. Examples will be given from experience with both public and commercial payers, with a particular focus on how recent health care reform measures could influence the sustainability of these innovations. Method: The presenter has participated or is participating in over a dozen collaborative projects that involve hundreds of primary care clinicians, scores of mental health professionals, and thousands of patient encounters. He will use this experience to draw conclusions about the prerequisites and barriers to collaborative care, the costs and effects on the quality of care and health outcomes, and will discuss the conditions necessary for sustainability of successful models. Results: Three principles of successful collaboration between primary care clinicians and psychiatrists will be discussed: cultural accommodation, communication, and shared leadership, will be discussed. Likewise, the principles that lead to sustainability—alignment of incentives, quality based compensation, and vertical communication—will be described. Conclusion: Psychiatrists and primary care clinicians can, under the right conditions collaborate to produce high quality, high value care in the context of a PCMH.

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1) Gilbody, S., Whitty, P., Grimshaw, J., Thomas, R., Educational and organizational interventions to improve management of depression in primary care: a systematic review. JAMA. 2003;289(23): 3145-51.
2) Lutterman, T; Ganju, V; Schacht, L; Monihan, K; et.al. Sixteen State Study on Mental Health Performance Measures. DHHS Publication No. (SMA)03-3835. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.
3) Parks J., Svendsen D., Singer P., and Foti, MJ. Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors – Thirteenth in a Series of Technical Reports – October 2006. Available at

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5)Druss BG, Bornemann TH. Improving health and healthcare for persons with serious mental illness: the window for US federal policy change. JAMA. 2010;303(19):1971-1973. 3a) Byrd, J., Parks, J., Oestreich, G., Surles, R., Docherty, J., & Simpson, K. (2005). The identification of schizophrenic consumers at risk for high future healthcare costs. Poster presented at the 57th Meeting of the American Psychiatric Association Institute on Psychiatric Services.
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MONDAY, MAY 16, 2011
NOON- 3:00PM

PRESIDENTIAL SYMPOSIUM 4 TRANSLATING NEUROSCIENCE FOR ADVANCING TREATMENT AND PREVENTION OF POST TRAUMATIC STRESS DISORDER

Chair: Charles Marmar, M.D., New York University Langone Medical Center, 550 1st Ave, OBV Bldg A, Room A654, New York, NY 10016

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Be familiar with a translational neuroscience model of PTSD based on fear conditioning, fear extinction, memory consolidation and memory reconsolidation; 2) Understand novel models of intergenerational transmission of PTSD including emotion dysregulation in mothers with PTSD and epigenetic changes in mothers with PTSD that are heritable; 3) Be familiar with peptide neurotransmitters with potential for translating novel pharmacological treatments for insomnia in PTSD; and 4) Be familiar with novel behavioral and pharmacological interventions for use in the first hours and days after traumatic exposure with potential to prevent PTSD.

OVERALL SUMMARY:
In this session advances in neuroscience informed models of traumatic stress will be discussed with implications for treating and preventing posttraumatic stress disorder. Risk and resilience for PTSD is broadly conceived as depending on the neural circuitry of emotion regulation of fear, with greater prefrontal cortical inhibitory inputs to amygdale favoring resilience. In those with greater life threat exposure and weaker emotion regulation capacity, greater levels of sustained peritraumatic terror horror and hopelessness leads to greater fear conditioning and memory consolidation for the traumatic event, factors which increase the risk for PTSD. Dr. Claude Chemtob will present data on intergenerational transmission of trauma. In mothers with PTSD with young children, the mothers own emotion regulation difficulties in combination with exposure to stress hormones in utero and epigenetic factors favor the development of PTSD in their children. Data will be presented showing that treating the mother's PTSD can reduce the risk for intergenerational transmission. Dr. Thomas Neylan will present new data on protein neurotransmission and the development of novel treatments for insomnia PTSD. Dr. Arieh Shalev will present findings on early intervention to mitigate fear conditioning, decrease memory consolidation, increase fear extinction learning and an alter memory reconsolidation in order to prevent chronic PTSD. Dr. Charles Marmar will present translational neuroscience informed behavioral and pharmacological interventions for use in the first hours after traumatic exposure to prevent acute stress disorders and PTSD.

PS4-1.
INTERRUPTING THE INTERGENERATIONAL TRANSMISSION OF TRAUMA BY TREATING MATERNAL PTSD AND OPTIMIZING MATERNAL CARE

Claude Chemtob, Ph.D., New York University Langone Medical Center, 550 First Avenue, Millhauser Labs-HN323, New York, NY 10016

SUMMARY:
Maternal variations in care are associated maternal early exposure to severe stressors and result

in intergenerational transmission of adverse developmental outcomes. Conversely, maternal patterns of optimal care for offspring can be protective. In humans, although this has been studied in the context of maternal depression, little is known about maternal PTSD and its impact on offspring developmental outcomes. Maternal PTSD in the context of terrorism exposure, is associated with poorer developmental outcomes, and co-morbid depression and PTSD in mothers is associated with substantially more adverse child outcomes. Currently exploring this in the context of pediatric primary care and of child welfare services, we intervene with mothers who are at risk of repeat child maltreatment, and who have maternal PTSD, to reduce the risk of repeat offspring maltreatment. Our treatment successfully reduces maternal PTSD, reduces parental stress, and optimizes positive parenting. Early data showing the efficacy of the treatment, and illustrating the challenges of integrating approaches to treatment grounded in a translational perspective into existing clinical service systems will be presented.

PS4-2.

TARGETING PEPTIDE NEUROTRANSMITTERS FOR NOVEL PHARMACOLOGICAL TREATMENTS OF POST TRAUMATIC STRESS DISORDER

Thomas Neylan, M.D., University of California San Francisco, Department of Psychiatry, Box 116P VAMC, San Francisco, CA 94143-116P

SUMMARY:
Pharmacologic agents, which target monoamine neurotransmitter systems, have had limited success in the treatment of Posttraumatic Stress Disorder. These agents often have protean effects on brain function because of the wide distribution of monoaminergic neurotransmitter systems at all levels of the brain. This pattern of distribution has both potential benefits for targeting multiple facets of PTSD, but also suffers from a high likelihood of non-therapeutic effects. Protein neurotransmission is an exciting area for the development of novel treatments because these systems usually have localized distribution networks in the brain. Thus, novel treatments which target peptide neurotransmitter signaling have the potential for greater specificity for discrete circuits which modulate domains implicated in PTSD such as fear, anxious arousal, and sleep. This presentation will describe the different pharmacodynamic and pharmokinetic issues related to targeting protein neurotransmitter systems and will contrast the challenges related to producing large molecule agonists versus small molecule antagonists. The presentation will then focus on a number of candidate systems that have substantial potential for novel treatment development in PTSD. Specifically, these include the family of Neurokinins, Corticotropin Releasing Factor, Hypocretin/orexin, oxytocin, and Neuropeptide Y.

PS4-3.

NEUROSCIENCE INFORMED STRATEGIES FOR EARLY INTERVENTION FOR POST TRAUMATIC STRESS DISORDER

Arieh Shalev, M.D., Hadassah University Hospital, Department of Psychiatry, Kiriat Hadassah Ein-Kerem Campus, Jerusalem, 91120

SUMMARY:
The neurobiology of post-traumatic stress disorder comprises several robust and replicable models, such as fear conditioning, extinction, consolidation, time-dependent sensitization and re-consolidation. The evidence-based prevention of PTSD, however, mainly consists of psychological interventions, whereas several pharmacological interventions had limited or negative outcomes. This should make us reconsider the implicit boundaries between 'biological' (often understood as bodily) and 'psychosocial' interventions and their implication for translational research. This presentation will discuss the early responses to traumatic stress, and their management, as occurring in a context of active, time–sensitive host–environment interaction, which either resolves or leads to chronic PTSD. It will identify several layers of psychobiological responses, discuss the construct of 'critical period' for each, and outline future directions for research and prevention.

PS4-4.

NEUROSCIENCE INFORMED STRATEGIES FOR EARLY INTERVENTION FOR PTSD: WHAT TO DO IN THE FIRST HOURS AFTER EXPOSURE

Charles Marmar, M.D., New York University, Langone Medical Center, 550 1st Avenue, OBV Building A, Room A654, New York, NY 10016

SUMMARY:
Risk and resilience for PTSD is broadly conceived as depending on the neural circuitry of emotion

regulation of fear, with greater prefrontal cortical inhibitory inputs to amygdale favoring resilience. In those with greater life threat exposure and weaker emotion regulation capacity, greater levels of sustained peritraumatic terror horror and hopelessness leads to greater fear conditioning and memory consolidation for the traumatic event, factors which increase the risk for PTSD. Immediate intervention in the first hours after exposure, which targets peritraumatic panic, has the potential to reduce fear conditioning and memory consolidation, which in turn may reduce the risk for PTSD. A review of current studies will be presented focusing on adrenergic blocking agents, glucocorticoids and opioid strategies for reducing peritraumatic emotional distress. Novel behavioral strategies will also be presented including a modification of cognitive behavioral treatment for panic disorder for use in the first hours after traumatic events. This novel treatment, Anxiety Reduction Treatment for Acute Trauma (ARTAT) is a single session 15 minute behavioral treatment consisting of psycho education, breathing control, deep muscle relaxation and worry control. ARTAT is currently being tested in civilians at a trauma center at Bellevue NYU Hospital and in theater in Afghanistan.

SATURDAY, MAY 14, 2011
7:00 AM - 8:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 1

ANXIETY DISORDERS

No.1
THE ABNORMALITIES OF MYELIN INTEGRITY IN OBSESSIVE-COMPULSIVE DISORDER: A MULTI-PARAMETER DIFFUSION TENSOR IMAGING STUDY

Qing Fan, M.D., Ph.D., Wan Ping Nan Road 600, Shanghai, 200030 China

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize changes in the fronto-striato-thalamo-cortical-circuit loop as suggested in the pathogenesis of obsessive-compulsive disorder (OCD).

SUMMARY:
Objectives: Changes in the fronto-striato-thalamo-cortical-circuit loop have been suggested in the pathogenesis of obsessive-compulsive disorder (OCD), and have been studied using diffusion tensor imaging (DTI) with interesting findings. However, the results of recent DTI studies are inconsistent, and most studies only used fractional anisotropy (FA) as marker of white matter abnormality. The purpose of this paper was to use multi-parameter maps of DTI to study myelin integrity alterations in fronto-striato-thalamo-cortical circuit among OCD patients. Methods: FA, radial and axial diffusivity maps were acquired from DTI data of 30 unmedicated OCD patients and 24 matched healthy controls. Then voxel-based analysis was performed to show regions with significant group difference. Results: Compared with controls, abnormal multi-parameters in OCD patients were observed in the white matter in the prefrontal lobe, rolandic operculum, olfactory lobe, middle and inferior temporal lobe, temporo-parietal lobe, temporto-occipital lobe, temporo-parieto-occipital lobe and in the white matter around the anterior cingulum and striatum. Additionally, there was lower FA and higher RD without the change of AD in the white matter in the left orbitofrontal lobe, left rolandic operculum, left temporo-parietal lobe and right striatum in patients. Conclusions:Our findings suggest that the disruptions of myelin integrity in fronto-striato-thalamo-cortical circuit are involved in the pathophysiology of OCD. Key words: axial diffusivity, diffusion tensor imaging, fractional anisotropy, myelin integrity, obsessive-compulsive disorder, radial diffusivity

No.2
A LONGITUDINAL INVESTIGATION OF THE ROLE OF SELF-MEDICATION IN THE DEVELOPMENT OF COMORBID ANXIETY AND SUBSTANCE USE DISORDERS

Jennifer Robinson, M.A., PZ430-771 Bannatyne Ave, Winnipeg, MD R3E 3N4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify specific subpopulations at risk for the development of substance use and anxiety disorders; 2) Understand the risks that self-medication confers on the development of future disorders; and 3) Understand the proportion of incident disorders attributable to self-medication behavior

SUMMARY:
Context: Self-medication of anxiety symptoms with alcohol and/or drugs has been a plausible mechanism for the co-occurrence of anxiety disorders and substance use disorders. However, due to the cross-sectional nature of the previous studies, it has remained unknown whether self-medication of anxiety symptoms is a risk factor for the development of incident substance use disorder or is a correlate of substance use. Objectives: To examine whether self-medication confers risk of comorbidity. Design: A longitudinal, nationally representative survey was conducted by the National Institute on Alcohol Abuse and Alcoholism. The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) assessed *DSM-IV* psychiatric disorders, self-medication and sociodemographic variables at two time points. Participants: 34,653 adult, U.S. participants completed both waves of the survey. Wave 1 was conducted between 2001-2002 and Wave 2 interviews took place 3 years later (2004-2005). Main Outcome Measure: Incident substance use disorders among those with baseline

anxiety disorders, and incident anxiety disorders among those with baseline substance use disorders. Results: Logistic regression analyses revealed that self-medication conferred a heightened risk of new-onset substance use disorders among those with baseline anxiety disorders (adjusted odds ratios ranged from 2.08 [p < .01] and 4.33 [p < .001]). Among those with baseline substance use disorders, self-medication with drugs, but not alcohol, was associated with an increased risk of social phobia (AOR among baseline alcohol use disorders: 2.92 [p < .001]; AOR among baseline drug use disorders: 2.70 [p < .01]). Conclusion: Self-medication within anxiety disorders confers substantial risk of developing incident substance use disorders. Conversely, self-medication within substance use disorders is associated with incident social phobia. These results not only clarify several pathways which may lead to the development of comorbidity, but indicate at-risk populations and suggest potential points of intervention in the treatment of comorbidity.

REFERENCES:

1) Merikangas KR, Zhang H, Avenevoli S, Acharyya S, Neuenschwander M, Angst J. Longitudinal trajectories of depression and anxiety in a prospective community study: the Zurich Cohort Study. Arch Gen Psychiatry. 2003;60:993-1000.

No.3

PREDICTORS OF TREATMENT RESPONSE IN CANADIAN COMBAT AND PEACEKEEPING VETERANS WITH MILITARY-RELATED PTSD

J Don Richardson, M.D., 801 Commissioners Rd East, London, Ontario, N6C 5J1 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Better understand the clinical presentation of combat veterans and deployed peacekeepers with posttraumatic stress disorder (PTSD); 2) Identify predictor of treatment outcome for veterans with posttraumatic stress disorder (PTSD); and 3) Appreciate the need to screen for objective measures of treatment response and the benefit of long term treatment.

SUMMARY:

Objective: This study examined the initial clinical presentation and monthly re-assessments for a group of combat and peacekeeper veterans with posttraumatic stress disorder. Method: Participants were 102 Canadian combat and peacekeeping Veterans attending specialized PTSD treatment clinic. We conducted latent growth curve modeling and assessed symptom trajectories over time from pre-treatment through 12-month follow-up. Results: Baseline scores averaged 64.98 (SD = 10.97) on the PCL, compared to 46.13 (SD = 14.52) after one-year follow-up. Based on a PCL cutoff score of 50 or greater to diagnose probable PTSD, 57.8% (52 out of 90) no longer met the criteria for probable PTSD after one year. The PCL's unconditional model was significant, Yuan-Bentler ?2 (86, N = 99) = 282.45, p < .001, indicating a significant decrease in PTSD severity over the one-year follow-up. There was a significant interaction between the intercept and slope (ß = -.23, SE = .11, p = .04), indicating that patients with higher baseline PCL scores improved most. The mean level of improvement was 1.04 standard deviations per month (SE = .13), p < .001. Only the baseline BAI significantly predicted the PCL's intercept (ß = .46, SE = .14, p = .001), and no covariates (baseline BDI and AUDIT scores and years with PTSD symptoms) predicted the slope decline. Conclusions: Chronicity, alcohol use, and anxiety or depression severity were not significant predictors for PTSD symptoms decline. Initial depression significantly predicted anxiety symptom declines and initial anxiety predicted depression symptom declines. The significant treatment gains including remission of PTSD observed in this study emphasizes the need to encourage patients to stay in treatment as symptom reduction continued up to one year of treatment.

REFERENCES:

1) Institute of Medicine (IOM). TREATMENT OF PTSD: AN ASSESSMENT OF THE EVIDENCE. Washington, DC: National Academies Press 2008.
2) Friedman MJ. Posttraumatic Stress Disorder Among Military Returnees From Afghanistan and Iraq. Am J Psychiatry 2006;163:586-93.

No.4

LONG TERM AND WITHDRAWAL PHASE OF TREATMENT OF PANIC DISORDER WITH CLONAZEPAM OR PAROXETINE: A RANDOMIZED NATURALISTIC STUDY

Antonio Nardi, M.D., Ph.D., R Visconde de Piraja 407-702, Rio de Janeiro, 22410003 Brazil

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Analyze the similarities and differences of long-term and withdrawal phase of a randomized naturalistic 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 of panic disorder (PD) patients to clonazepam (Cl) or paroxetine (Px) during 3-year long-term treatment and the 2-month withdrawal phase. Methods: A total of 120 PD (*DSM-IV*) outpatients were recruited for 3-year with Cl (1.9 ± 0.2 mg/ day) or Px (34 ± 9.8 mg/ day). AE and efficacy parameters (CGI-S and CGI-I, number of panic attacks (PA), and HAMA) were recorded at baseline, acute phase (8 weeks) and long term (1, 2 and 3 years). For the 2-month withdrawal process the Composite Benzodiazepine Discontinuation Symptom Scale (CBDSS) sum was used. Results: Baseline characteristics of Cl and Px were similar. Cl had a faster response with a significant difference in weeks 1 and 2 for CGI-I and for HAMA. After 2 weeks the CGI-I was for Cl 2.2 ± 1.0 and 2.7 ± 1.2 for Px (p=0.003); and the HAMA was for Cl 11.1 ± 3.4 and 12.7 ± 4.3 for Px (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 to 1.7 PA/month) than the Px group (5.3 to 2.8 PA/month). After two month of treatment both groups showed similar efficacy in the scale scores, and in the reduction in PA. More patients under Px had AE (95% vs 73%, p=0.001). After 8-weeks patients were invited to continue treatment over a 3-year total treatment. Long-term treatment with Cl led to significantly greater improvement in CGI than Px (mean difference: CGI-S: -3.48 vs. -3.24; p=0.02; CGI-I: 1.06 vs. 1.11; p=0.04). Both treatments similarly reduced the number of PA and the severity of anxiety. Patients treated with Cl had significantly fewer adverse events than with Px (28.9% vs. 70.6%; p<0.001). Drug free state within the foreseen 2 months was achieved by 80% Cl and 55% Px patients. During the withdrawal period there was in all groups only a slight worsening. Mild and transient AE were frequent during withdrawal - Cl less frequent than with Px (p<0.05). The withdrawal success as a whole was with Cl much better (71% vs 33% early or delayed complete success). Conclusion: Cl had a faster response than Px in PD, but after 8 weeks of treatment the two drugs gave equivalent response. Monotherapy of Cl and Px over 3-years 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 Px group. The withdrawal process was successful for both drugs.

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1) Nardi AE, Perna G: Clonazepam in the treatment of psychiatric disorders: an update. Int Clin Psychopharmacol 2006; 21:131-142.

2)Nardi AE, Freire RC, Valença AM, et al. Tapering clonazepam in panic disorder patients after at least 3 years of treatment. J Clin Psychopharmacol 2010; 30: 290-293.

SCIENTIFIC AND CLINICAL REPORT SESSION 2

BIOLOGICAL PSYCHIATRY AND NEUROSCIENCE

No.1

NEUROLOGICAL UNDERPINNINGS OF FOOD INTAKE, ENERGY BALANCE AND OBESITY: IMPLICATIONS FOR PSYCHIATRISTS TREATING PATIENTS WITH ATYPICAL ANTIPSYCHOTICS

Sandhya Narayanan, M.A., 6040 Blvd E #25G, West New York, NJ 07093

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify some causal mechanisms of weight gain associated with atypical antipsychotics; 2) Understand and take these mechanisms into consideration; and 3) ehance the quality of care and treatment of patients with atypical antipsychotic medication induced weight gain and metabolic syndrome.

SUMMARY:

Psychiatric patients generally gain weight at an alarming rate, increasing risk for weight related medical co morbidities. Clinical research as well as animal studies have shed light on the role of psychiatric medications in contributing significantly to the weight gain. Despite this extensive research based knowledge, practicing psychiatrists have paid less attention to the relationships between central and peripheral chemicals/cues (e.g. leptin, ghrelin, adiponectin) and other factors (such as thrifty genes) with eating behavior and obesity. This session will provide a broad overview of the complex

neuroendocrine network to enhance psychiatrists' understanding of the basic science behind food intake, energy balance and obesity. In particular, the role of leptin, and other chemicals from the metabolic periphery, in modulating the feedback and adaptive mechanisms in energy homeostasis will be reviewed and summarized. The review will briefly highlight the impact of atypical antipsychotic medication on leptin. Taking into consideration the underlying factors behind the fuel sensing and feedback pathways and their effect on food intake and obesity has direct implications for improvement in patient care and treatment. This scientific review of existing literature will shift the emphasis of psychiatrists treating patients on atypical antipsychotic medications to issues of energy intake and metabolism. Recommendations for incorporating diet and exercise into individualized patient treatment plans will be discussed based on the review of the research as outlined above. This session will further enhance psychiatric practice by carefully translating the implications of bench research to clinical work.

REFERENCES:

1) Potential mechanisms of atypical antipsychotic-induced metabolic derangement: Clues for understanding obesity and novel drug design Pharmacology & Therapeutics, Volume 127, Issue 3, September 2010, Pages 210-251 Roberto Coccurello and Anna Moles

No.2

POST MORTEM DOPAMINE ABNORMALITIES IN HUMAN COCAINE USERS: NEW TARGETS FOR IN VIVO IMAGING AND THERAPEUTIC INTERVENTIONS

Karley Little, M.D., 2003 Holcombe, Houston, TX 75030

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List a number of important alterations in dopamine neurons induced by chronic cocaine use; 2) Describe the functional implications of these changes; and 3) Identify potential clinical and therapeutic implications of these changes.

SUMMARY:

A number of pathological brain abnormalities have been discovered in dopamine neurons from human cocaine users. These alterations may explain significant clinical symptoms, such as cocaine-induced mood disorders and apathy, cocaine withdrawal symptoms, and dysregulated control of reward pursuit. Post mortem experiments performed by the presenter, and in vivo studies by others, have shown that chronic cocaine exposure leads to an eventual depletion of dopamine stores. In addition, a compensatory upregulation develops in dopamine transporter (DAT) trafficking to the neuronal surface (seen in post mortem and in vivo studies), which parallels increased dopamine uptake. These changes may lead to diminished cocaine reward, as well as an inability to experience fully normal reward. Further, over time these changes appear to lead to an eventual toxicity to the whole neuron. Among a recently examined post mortem sample of midbrains from cocaine users, there was a statistically significant loss of dopamine neurons (average loss of 18%). This midbrain loss was inversely correlated with the degree of striatal upregulation of DAT surface sites. A functional increase in DAT uptake sites is possible despite overall loss of neurons because most DAT (about 75%) is normally stored in perisynaptic locations. The presenter will review these pathological findings, discuss the correlative and therapeutic implications, and suggest specific follow up in vivo imaging and animal modeling experiments that need to be performed to further establish the significance of these findings.

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No.3

INTEGRATING NEUROSCIENCE ADVANCES INTO CLINICAL PSYCHIATRIC PRACTICE

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: 1) Describe key issues, opportunities, and potential pitfalls related to incorporating neuroscience concepts into clinical work with psychiatric patients.

SUMMARY:
Despite the major advances of neuroscience and the increased presence of neuroscientists in academic psychiatry over the past few decades, there is a lack of compelling models for applying neuroscience concepts into clinical psychiatric practice. Data from in vitro studies, animal models, genetics, anatomical and functional neuroimaging studies, and other basic neuroscience technologies have provided key insights into brain development, cognition, and psychopathology. However, because of the complexity of such research, it can be debated whether it is premature to incorporate such concepts into daily psychiatric work. In this paper, I will describe one potential model for incorporating key neuroscience concepts into clinical work with patients suffering from mood and anxiety disorders. In order to be clinically useful, models must be scientifically accurate yet simple enough to be understood by the general public, and must have sufficient potential benefit to justify the time spent elucidating them. Key concepts for such a model include: 1) brain plasticity, the ongoing remodeling of brain structure and function throughout life, which can be affected by biological agents, behavior, exercise, and thought patterns; 2) the damaging impact of clinical depression and anxiety disorders on brain structure and function; 3) the importance of achieving remission of disorders, and its potential effects on limiting or even reversing brain injury occurring as a result of psychiatric disorders; 4) the importance of behaviors such as learning, psychotherapy, and exercise on brain remodeling and on alleviating disorders; 5) the impact of physical health on the brain and the course of psychiatric disorders; and 6) enhancing resilience as a means of alleviating chronic stress and improving the longterm outcome of mood and anxiety disorders. This model will be presented and case vignettes will be used to illustrate its potential relevance during different phases of clinical treatment.

REFERENCES:
1) Hellerstein DJ: Healing Your Brain: How the New Neuropsychiatry Can Help You Go From Better to Well. Baltimore, MD, Johns Hopkins University Press, 2011.

SCIENTIFIC AND CLINICAL REPORT SESSION 3

CHILD AND ADOLESCENT PSYCHIATRY

No.1

CORTICAL THICKNESS CORRELATES OF ATTENTION PROBLEMS IN A LARGE SCALE REPRESENTATIVE COHORT OF 4 TO 18 YEAR-OLD HEALTHY CHILDREN WITHOUT ADHD

Simon Ducharme, M.D., 801 Sherbrooke East Apt 1104, Montreal, H2L 0B7 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the cortical thickness correlates of attention problems in healthy children of 4 to 18 year-old; 2) Identify the similarities between cortical thickness correlates of ADHD versus attention problems in healthy subjects without ADHD; and 3) Analyze the impact of cortical thickness correlates of attention in healthy children on the diagnostic conceptualization of ADHD.

SUMMARY:
OBJECTIVE: Children with attention deficit/hyperactivity disorder (ADHD) were recently found to have delayed cortical maturation in the prefrontal cortex (PFC) and anomalies in the right orbito-frontal cortex (OFC)(1-3). A caveat of most neuroimaging studies is that they compare ADHD to healthy controls in a categorical manner. However, it remains unclear if ADHD is a discrete disorder or the extreme phenotype of normally distributed attention capacities(4). The current study aimed to provide some answers to this question by identifying cortical thickness correlates of attention problems in healthy children. METHOD: The NIH MRI Study of Normal Brain Development includes 433 healthy children of 4 to 18 years of age, representative of the US population(5). Data from the first MRI of each subject were used. Cortical thickness was obtained with automated pipelines(6-8). Attention was measured with the Attention Problems scale (AP) of the Child Behavior Checklist (CBCL)(9). No subject met diagnostic criteria for ADHD. After a stringent

MRI quality control, 205 subjects were included for analysis. AP raw scores were regressed against local cortical thickness (40,962 points/hemisphere) using first and second-order linear models while controlling for age, gender, scanner and total brain volume. Corrections for multiple comparisons were implemented using random field theory. RESULTS: There was no association between AP and cortical thickness in a first-order model. In a second-order model, a negative association was found with the left dorsolateral prefrontal cortex (DLPFC). The 'age by AP' interaction analysis revealed an association with bilateral OFC, right inferior frontal gyrus (IFG) and left middle temporal gyrus. In children of 13 or less (n=127, first-order), the right OFC was negatively associated with AP and there were negative trends in the left OFC, bilateral anterior cingulate cortex and right IFG. On the opposite, children of more than 13 (n=78) had small areas of positive associations distributed in the frontal, temporal and parietal lobes. Results from longitudinal data, (N=535) will also be presented. CONCLUSIONS: The negative association with the left DLPFC suggests that this area gets proportionally thinner as AP get closer to the pathological threshold. The fact that younger subjects have negative associations while older subject have positive ones is compatible with delayed grey matter peak thickness in children with higher AP. This suggests a

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2) Shaw P, Eckstrand K, Sharp W, et al. Attention-deficit/hyperactivity disorder is characterized by a delay in cortical maturation. PNAS 2007;104:19649-54.
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10) Worsley K, Taylor J, Tomaiuolo F, Lerch J. Unified univariate and multivariate random field theory. Neuroimage 2004;23:189-95.

No.2

PSYCHODYNAMIC PROFILE OF DIABETIC ADOLESCENT PATIENTS

Hani Hamed Dessoki, M.D., 2 Jeddah St Mohandessin, Giza, 12311 Egypt

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the psychological aspects of diabetic adolescents.

SUMMARY:

Objective: To investigate the effect of psychosocial factors as self-esteem, body image, coping strategies and family factors on diabetes self-management behavior and subsequent glycemic control in diabetic adolescents. Also, to assess the effect of cognitive and emotional response to disease and treatment on diabetes self-management behavior. Method: cross-sectional study which includes 37 controlled and 30 uncontrolled diabetic adolescents recruited from Abou El-Rich Hospital, All participants were subjected to Semi structured interview, Personal Models of Diabetes Questionnaire, Summary of Diabetes Self-Care Activity, Strengths & Difficulties Questionnaire, Coopersmith Self Esteem Inventory, Body Image Scale, Taxonomy of Children's Coping Strategies and Assessment of Glycosylated Hemoglobin. Results: The group of uncontrolled diabetes shows statistically significant higher emotional problems (p=0.003), higher peer problems (p=0.012) and higher total difficulties scores (p=0.023) compared to the group of controlled diabetes. Higher self-esteem in the group of controlled diabetes (14.91 + 3.43) compared to the group of uncontrolled diabetes (10.33+ 4.74). There was highly statistical significant difference regarding Coopersmith Self- Esteem Inventory (p<0.001). Conclusion: Peer problems, lower self-esteem and pathological body image

were more prevalent among uncontrolled diabetic adolescents with earlier age of onset.

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Project Group. Diabetes Care 23(10): 1516-1526.
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No.3

GENETIC EVIDENCE IN AUTISM: A REVIEW OF THE LITERATURE

Felicia Iftene, M.D., Ph.D., 752 King St W, Kingston, K7L 4X3 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the possible implications of chromosomes 2, 7, 10, 15, 17, in autism etiology; 2) Identify the need to consider the presence of other known genetic syndromes when they evaluate a new case of autism; and 3) Understand that autism etiology is probably very complex and involves an interaction between the genetics and the environmental factors.

SUMMARY:

Objective: Autism is a major neuropsychiatric disorder of unknown etiology with high implications for patients and their families. Recent studies indicated the importance of genetic factors in autism's development. This Study aimed to review and synthesize research presented on genetics' role in autism. Methods: A systematic literature review was undertaken, with the time frame limited to research over the five-year period 2004-2010. 120 genetics and autism studies were retrieved and summarized. Results: Autism is a heterogenic disorder with plurifactorial etiology. It is associated in 10 % of cases with known genetic syndromes such as tuberous sclerosis, fragile X syndrome, phenylketonuria, and Smith-Lemli-Opitz syndrome. Cytogenetic anomalies represent approximately 6-7 % of Autism Spectrum Disorder. The genes implicated in autism include both duplications and deletions on a variety of different chromosomal regions. The transporter gene for serotonin (SLC6A4, solute carrier family 6, member 4) on the chromosome 17 was assessed in several studies. OXTR gene on chromosome 3p was recently connected to autism susceptibility. Despite sex differences in the prevalence of autism, the studies didn't find linkage evidence on the chromosome X. Conclusions: Even if sophisticated genetics methods were used, the causes for autism remained unidentified in a significant proportion of cases. The lack of significant results is probably a consequence of small sample sizes combined with the etiological and phenotypical complexity of this disorder. With the help of new technology, genetic studies may realize larger samples with a higher statistical power and more significant results.

No.4

COMPARISON OF FACE RECOGNITION IN NON-AFFECTED SIBLINGS OF AUTISTIC CHILDREN AND NORMAL GROUP

Zahra Shahrivar, M.D., South Kargar Avenue, Tehran, 1333715914 Iran

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be familiar with the psychopathology especially the endophenotypes of

autism.

SUMMARY:
Background: autism is characterized as having difficulty in social relationship which could be due to inability in face recognition. Face recognition can be considered as an endophenotype which could be found in first degree relatives of autistic children. The main aim of this study was to compare the ability of face recognition in non affected siblings of autistic patients compared to healthy children. Method: twenty non affected siblings of autistic patients were evaluated on Benton Facial Recognition Test compared to 20 normal children matched on their sexes, ages, and IQs. All participants were assessed using Childhood Autism Rating Scale (CAARS) and Kiddie – Schedule for Affective Disorders and Schizophrenia (K-SADS). Results: there was no significant difference between two groups on Benton Facial Recognition Test variables. Using the Pearson correlation there was no relationship between the CAARS scores of autistic patients and the correct responses on Benton Test. Conclusion: it was found in this study that face recognition ability was different between non affected siblings of autistic patients and normal children. Keywords: Autism, endophenotype, face recognition, siblings.

SATURDAY, MAY 14, 2011
9:00 AM - 10:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 04

COGNITIVE DISORDERS (DELIRIUM, DEMENTIA)

No.1
COMPARISON OF MONTREAL COGNITIVE ASSESSMENT (MOCA) AND MINI MENTAL STATUS EXAM (MMSE) IN IDENTIFYING COGNITIVE DEFICITS IN MOOD DISORDERS

Neha Jain, M.D., 5812 5th Ave M31, Pittsburgh, PA 15232

EDUCATIONAL OBJECTIVES:
At the end of this session, the participant should be able to: 1) Evaluate the difference in sensitivities of the Montreal Cognitive Assessment as compared to the Mini Mental Status Exam in patients with mood disorders; and 2) Be aware of predictors of cognitive impairment in patients in mood disorders.

SUMMARY:
Objectives: 1) To compare the sensitivity of Montreal Cognitive Assessment (MoCA) and Mini Mental Status Exam (MMSE) in identifying cognitive impairment in patients with mood disorders; 2) To correlate the scores of MoCA and MMSE and 3)To explore predictors of cognitive impairment in mood disorders. Method: The study was conducted at the outpatient psychiatry clinic at a teaching hospital in West Virginia. Patients between the ages of 18-65 with an established diagnosis of mood disorders were included in the study, while those with a medical or neurological illness that might affect their performance on the neurocognitive tests were excluded. Using a cross-sectional design, subjects were administered the MOCA, MMSE, and the Hamilton Depression Rating Scale (HAM-D). One hundred participants (72 females, 95 caucasians) were involved in the study. The mean age of this cohort was 47 (S.D.= 11.1), range 18-64. The mean years of education were 14.6 (S.D.=3.5). The primary outcome measure was the proportion of patients with a score of less than 26 on either MoCA or MMSE. A score of less than 26 on the MMSE has been used in other studies as a cutoff for cognitive impairment. A cutoff of 26 in the MoCA was found to have the best sensitivity and specificity for identifying mild cognitive impairment. Results: The mean MMSE score was 28.8 (S.D.=1.5), range 23-30. The mean MoCA score was 24.5 (S.D.=2.9), range 15-30. The mean HAM-D score was 12.2 (S.D.=8.2), range 0-31. The percentage of subjects scoring below the cutoff score was higher on the MoCA (58%) compared with the MMSE (4%) indicating that MoCA is a more sensitive tool to identify cognitive impairment in patients with mood disorder compared with MMSE. A significant correlation was found between MMSE and MoCA ($r=.50$, $p<.05$). A significant impairment on MoCA was identified for visuospatial abilities, attention, language, abstraction and recall. The main predictors of cognitive impairment on MoCA were a lower educational level and higher HAM-D scores. A significant correlation was found between scores on HAM-D and the MoCA ($r= -.27$, $p<0.05$). Conclusion: More than half of the subjects with normal MMSE had cognitive impairment based on the MoCA. In contrast to the MMSE, MoCA scores showed a significant correlation with HAM-D scores. Our results suggest that the MoCA is a

more sensitive instrument than the MMSE for early detection of cognitive impairment in patients with mood disorders.

REFERENCES:

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No.2

ADDRESSING PATIENTS NEEDS I: FEELINGS OF LONELINESS BUT NOT SOCIAL ISOLATION PREDICT INCIDENT DEMENTIA IN OLDER PERSONS

Tjalling Holwerda, M.D., Van der Boechorststraat 7, Amsterdam, 1015VD Netherlands

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify feelings of loneliness as a possible risk factor predicting dementia that deserves clinical attention. Background: Stroke, vascular risk factors, ageing, female gender, low educational level, a family history of dementia, genetic factors, a history of head injury, mild cognitive impairment and depression are the most important known associated risk factors with Alzheimer's disease and other dementias.

SUMMARY:

Background: Vascular risk factors, ageing, family history of dementia, mild cognitive impairment and depression are the most important known associated risk factors with Alzheimer's disease and other dementias. The risk for dementia of social and individual frailty factors such as social isolation and feelings of loneliness is less well understood and prospective data are scarce. Methods: We tested the possible association between social isolation, feelings of loneliness and incident dementia in a prospective cohort study (The Amsterdam Study of the Elderly, AMSTEL) among 2,173 non demented community living older persons aged 65-84 years. Social isolation and feelings of loneliness were assessed at baseline. All participants were followed for three years when clinical dementia was assessed (GMS AGECAT). Logistic regression analysis was used to assess the association between social isolation and feelings of loneliness and the risk of clinical dementia, controlling for sociodemographic factors, vascular risk factors, other medical conditions, depression, cognitive functioning and functional status (ADL and IADL disabilities). Results: Social isolation: at baseline 1,005 (46.2%) of participants were living alone, 1,100 (50.6%) were not / no longer married and 1,590 (73.2%) of participants were lacking social support. Feelings of loneliness were reported by 433 (19.9%) of older persons. During follow-up in 158 (7.3%) participants clinical dementia had developed. Logistic regression analysis showed that after adjustment for confounding factors older persons with feelings of loneliness were more likely to develop clinical dementia (OR 1.70 CI 1.11-2.62) than those without these feelings. In socially isolated participants no higher risk for dementia was found. Conclusions: Feelings of loneliness and not social isolation factors are associated with an increased risk of and progression to clinical dementia in later life and can be considered a major risk-factor that, independent of vascular disease, depression and other confounding factors, deserves clinical attention. Feelings of loneliness may, independent of depression, signal the prodromal stage of dementia. A better understanding of the backgrounds of loneliness feelings may help us to identify persons in a predementia stage and develop interventions to improve outcome in older persons at risk for dementia.

REFERENCES:

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No.3

EPIDEMIOLOGICAL SURVEY OF INFLUENCES OF LONG-TERM TREATMENT WITH A TRADITIONAL JAPANESE MEDICINE, YOKUKANSAN, ON BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS

Kazunori Okahara, M.D., 762 Iwatino Kunitomi-cho, Higahimorokata,Miyazaki, 880-1111 Japan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize Behavioral and Psychological Symptoms of Dementia marked influences on the care burden, and the treatment of BPSD exceeding 6 months.

SUMMARY:
[Objective] BPSD (Behavioral and Psychological Symptoms of Dementia) may give marked influences on the care burden, and the treatment of BPSD is equally important to the treatment of the core symptoms of dementia. In recent years, many researches including us reported the effect of yokukansan (YKS) on BPSD, but almost none of the reports referred to long-term treatment exceeding 6 months. Thus we conducted an epidemiological survey of the influences of long-term treatment with YKS (up to 78 weeks) on BPSD. [Method] Among the patients who visited this hospital and were diagnosed with dementia accompanied by BPSD in the period from April 2006 to March 2010, those who were being treated with YKS for over 6 months (26 weeks) were evaluated. Epidemiological evaluation was performed by extracting, from the medical records, the data related to serum potassium level, adverse reactions, for safety evaluation and the data related to NPI / MMSE / Zarit Burden Interview (ZBI) / CDR for efficacy evaluation. On conducting this survey, we complied with the "Ethical Guideline for Epidemiological Survey" issued by the Ministry of Health, Labour and Welfare in Japan. [Result] Among a total of 558 dementia patients in the period concerned, 163 patients to whom YKS was prescribed for more than 6 months were targeted. The diagnosis was AD, DLB, VD and mixed type in 124, 23, 5 and 3 patients, respectively. A serum potassium value lower than the lower limit of the standard range specified at this hospital was seen in about 5% of the patients at Week 26 (excluding the patients whose baseline value was lower than the lower limit of the standard range), but the adverse reactions noted were only edema and hypokalemia (both noted in one patient each). NPI was evaluated in 108 patients with baseline data (data at Week 0 of YKS treatment), and a significant decrease was seen at Week 26 and Week 52. The ZBI score decreased significantly at Week 26. A decrease in MMSE was noted at Week 52 and Week 78, but no changes were seen in CDR. [Discussion] No serious adverse reactions were recognized, and the safety of long-term treatment with YKS could be confirmed. However, since a decrease in serum potassium level was seen in some of the patients, periodic examinations are necessary. A significant decrease was seen in NPI and ZBI score, and it was confirmed that the improvement of NPI by long-term treatment would lead to reduction of caregiver's burden.

SCIENTIFIC AND CLINICAL REPORT SESSION 05

CROSS CULTURAL AND MINORITY ISSUES

No.1

A FOLLOW UP STUDY OF RISK AND PROTECTIVE FACTORS INFLUENCING POSTTRAUMATIC STRESS REACTIONS IN SIERRA LEONEAN FORMER CHILD SOLDIERS

Theresa Betancourt, Sc.D., M.A., 651 Huntington Avenue, Boston, MA 02115

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the stressors associated with posttraumatic stress reactions among former child soldiers in Sierra Leone; 2) Understand the naturally-occurring protective processes that are associated with natural remission of posttraumatic stress reactions in this population; and 3) Explain how protective and treatment resources can be better leveraged to assist these and other youth affected by war.

SUMMARY:
OBJECTIVES: Recent research has demonstrated a high prevalence of posttraumatic stress reactions among war-affected youth (1-3). With violent conflicts occurring globally, information on protective processes that promote resilient outcomes in this population is needed. This longitudinal study assessed a cohort of Sierra Leonean male and female former child soldiers to examine risk and protective factors associated with PTSD reactions over two time points (2004 and 2008). METHODS: N=273 former child soldiers (29% female, average age 16.6 years) were interviewed and assessed for PTSD reactions. Primary outcome measures were PTSD symptoms assessed using a reduced 9-item version of the Child PTSD Reaction Index (4). Family and community support were assessed with instruments adapted for use with child soldiers in Sierra Leone (5). We used linear growth models to investigate trends in outcomes related to war experiences and post-conflict risk and protective resources. RESULTS: In our sample, PTSD reactions tended to decrease in the absence of further adverse life events. However, youth who experienced especially toxic forms of

violence during the war (killing/injuring others, rape) demonstrated continued difficulties. We also found that PTSD reactions were exacerbated by post-conflict risk factors (stigma, daily hardships) and partially mitigated by protective resources in the family and community. CONCLUSIONS: While former child soldiers face formidable challenges to healthy adjustment, protective resources in their community and social networks reinforce their capacity to overcome adversity. Ongoing exposure to post-conflict stressors may serve to undermine tendencies for PTSD symptoms to attenuate with time. Findings suggest that intervention programs can leverage natural protective resources to address the post-conflict challenges that aggravate emotional distress. This conclusion is reinforced by research completed in other regions (6, 7).

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No.2

MOTIVES FOR KHAT USE AND ABSTINENCE IN YEMEN: A GENDER PERSPECTIVE

Felix Wedegaertner, M.D., M.P.H., Carl-Neuberg-Str. 1, Hannover, 30625 Germany

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discern male from female motives for khat use and abstinence; 2) Address these in primary psychiatric care contacts; und 3) use this knowledge in interventions for khat abuse prevention.

SUMMARY:

Background: Khat consumption is widespread in Yemeni society and causes problems both in economic development and public health. Preventive measures have been largely unsuccessful and the cultivation continues to proliferate. The gender-specific motives for khat use and abstinence were studied to create a toe-hold for more specific interventions. Methods: In a quota sample with equal numbers of males, females, abstainers and consumers, 320 subjects were interviewed on their specific opinions about khat and its impact on subjective and public health, and on social and community functioning. Strata were compared in their acceptance and denial of opinions. Notions that could predict abstinence status or gender were identified with multivariate logistic regression analysis. Results: Male khat users had a strong identification with khat use, while females were more ambivalent. The notion that khat consumption is a bad habit (odds ratio (OR) 3.4; $p<0.001$) and consumers are malnuorished (OR 2.2; $p=0.046$) were associated with female genderamong khat users. Among the females worries about health impact (OR 3.2; $p=0.040$) and loss of esteem in the family (OR 3.1; $p=0.048$) when using khat predicted abstinence. Male abstainers opposed khat users in the belief that khat is the cause of social problems (OR 5.1, $p<0.001$). Logistic regression reached an accuracy of 75 and 73% for the prediction of abstinence and 71% for gender among consumers. (All models $p<0.001$. Conclusions: Distinct beliefs allow a differentiation between males, females, khat users and abstainers when targeting preventive measures. In accordance to their specific values female khat users are most ambivalent towards their habit. Positive opinions scored lower than expected in the consumers. Public opinion towards khat may have become slightl more negative in recent years. This finding creates a strong toe-hold for gender-specific public health interventions.

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No.3
INVESTIGATING A DECADE OF PSYCHIATRIC RESEARCH IN THE ARAB GULF REGION

Ossama Osman, M.D., M.B.A., P.O. Box 17666, Al-Ain, 0 U. Arab Emirates

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) understand the quantitative and qualitative characteristics of published psychiatric literature from the Arab Gulf region; 2) identify strengths and weaknesses of research areas and topics from that region; and 3) identify future opportunities for collaborative research opportunities.

SUMMARY:
This study evaluates the mental health research published from 1989 to 2008 in PubMed indexed journals from the Arab Gulf Countries in order to detect gaps and make recommendations. A sensitive PubMed search for general and mental health publications in Gulf Cooperation Council (GCC) countries including the United Arab Emirates (UAE) revealed a total of 192 mental health studies published in GCC countries over the past 20 years, which constituted less than 1% of the GCC total biomedical research. Most of the studies were from the UAE University and were either epidemiologic (48.98%) or psychometric (24.49%) with no studies addressing mental health systems research. Underrepresented were studies on health promotion and interdisciplinary, cross-cultural, ethnic, and gender research. There is an urgent need for respectable international collaborations and for developing policies which link research with services provided. longitudinal studies will be important to test the long-term impact of early interventions.

REFERENCES:

1) Osman OT and Afifi M. Troubled Minds in The Gulf: Mental Health Research in the United Arab Emirates. Asia Pac J Public Health 2010 22: 48S-53S.

No.4
TRADITIONAL AND ALTERNATIVE HEALERS: PREVALENCE OF USE IN PSYCHIATRIC PATIENTS

Zukiswa Zingela, M.B.B.S, M.Med., Postnet Ste 274 Private Bag X1313 Humewood, Port Elizabeth, 6013 South Africa

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the demographics of patients who consult traditional healers; 2) What influences a patient's decision to consult such healers; 3) Concordance with traditional healing interventions compared to conventional psychiatric interventions; and 4) Suggested solutions to collaborative working between traditional healers and mental health practitioners such that patients are referred earlier to psychiatric services

SUMMARY:
Background: Studies show patients seen by doctors also consult traditional or alternative healers (70 to 84% - South Africa). Patients receive traditional potions, which may contain unknown ingredients. The South African Stress and Health study (SASH), reported that 5.7% of people with a mental disorder had received any conventional mental health care in the preceding 12 months. In comparison, 5.8% consulted Complementary or Alternative Medicine Practitioners (CAMPs) and Traditional Healers (THs), and 6.6% consulted religious, spiritual or social work practitioners in the preceding 12 months. Aims and Method: The study investigates the number of psychiatric patients who consulted THs, CAMPs or religion-aligned practitioners (RAHs) in the past 12 months. So far, 213 subjects have been recruited from 6 in- and outpatient sites. A questionnaire regarding the use of THs/RAHs/CAMPs in the previous 12 months was the research tool used. Results: Subjects: Black 152 (71%), 151 of them Xhosa speaking, Coloured 47 (22%), White 11 (5%), Indian 3 (1%); male 104 (49%), female 109 (51%). Education: primary 41, secondary 114, tertiary = 58. Consulters of TH/RAH/CAMP: 69 (32.4%); non-consulters: 144 (67.6%). Percentage consulters by race - Black: 57 of 152 (37.5%), Coloured: 8 of 47 (17%), White: 3 of 4 (27%) and Indian 1 of 3 (33.3%). Consulters of THs 62%; of RAH 41%; of CAMP 4%. Consulters of both THs and RAHs 9%. Non-consulters: 83% Black, 12% Coloured, 4% White, 1% Indian. Emotional/physical/sexual abuse by a TH/RAH: reported by 28%. Absolute or near-compliance with the TH/RAH's prescription: 88%. Definitely/

likely to re-consult a TH/RAH: 78%. Concerning conventional treatment: no advice was given by the healer in 60% of cases, 30% were told to continue treatment as usual, 6% to stop medication permanently and 1% to stop and restart later. Some could not recall the advice given (3%). Conclusions: Results show a much higher prevalence than the SASH study (32% vs. 5.8%). Black, Xhosa speakers were more likely to consult THs/RAHs than other ethnic groups. A high compliance rate with the THs/RAHs' treatment and having only a small percentage of healers advising patients to stop regular medication indicate potential for collaboration between healers and mental health practitioners. The high reported abuse by some of the patients is of concern.

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1) Robertson BA: Does the Evidence Support Collaboration between Psychiatry and Traditional Healers? Findings from Three South African Studies: Review article. Sabinet Online 2006; Vol 9, No 2: 87 – 90.
2) Koen L et al: Use of Traditional Treatment Methods in a Xhosa Schizophrenia Population. South African Medical Journal 2003; Vol 93, No 6: 443
3)Stein DJ, Williams DR, Kessler RC: The Epidemiology of Psychiatric Disorders in South Africa: The SASH Survey. South African Medical Journal 2009; Vol 99, No 5: 337 – 344
4) Colvin M et al: Integrating Traditional Healers into a Tuberculosis Control Programme in Hlabisa, South Africa. Medical Research Council Policy Brief December 2001; No 4
5) Kyeyune P et al: Improving Patient care Through Referral System between Traditional Healers and Bio-medical Workers in Rural Uganda. 13th International AIDS Conference 9 – 14 July 2000; Durban, South Africa. Abstract MoPeD2614
6) Nyumbu M. Member Voices: Traditional Health Healers and Health Workers Partner in Zambian Care. Global Health Council Publications: AIDSLink 2003; Issue 82
7) Farrand D: Is a Combined Western and Traditional Health Service for Black Patients Desirable? South African Medical Journal 1984; Vol 66, No 11: 779 – 780
8)Babb DA et al: Use of Traditional Medicine by HIV-infected Individuals in South Africa in the Era of Antiretroviral Therapy. Psychology Health & Medicine 2007; Vol 22, No 3: 314 – 320
9) Sloan DJ, Dedicoat MJ, Lalloo DG: Health-care Seeking Behaviour and Use of Traditional Healers after Snakebite in Hlabisa Subdistrict, KwaZulu Natal. Tropical Medicine & International Health 2007; Vol 12, No 11: 1386 – 1390
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11) Ahmed IM et al. Characteristics of Visitors to Traditional Healers in Central Sudan. Eastern Mediterranean Health Journal 1999; Vol 5, No 1: 79 – 85
12) Farooqi YN et al. Traditional Healing Practices Sought by Muslim Psychiatric Patients in Lahore, Pakistan. International Journal of Disability, Development & Education 2006; Vol 53, No 4: 401 – 415
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14)Gqaleni N, Moodley I, Kruger H, Ntuli A, McLeod H. Traditional and complementary medicine. S Afr Health Rev 2007; chapter 12: 175 – 85

SCIENTIFIC AND CLINICAL REPORT SESSION 06

EPIDEMIOLOGY

No.1

UNDER-RECOGNITION AND UNDER-TREATMENT OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Albert Yeung, M.D., Sc.D., One Bowdoin Square 6/F, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the public health challenges of under-recognition and under-treatment of depressed Chinese immigrants in primary care settings.

SUMMARY:
Objective: To examine the prevalence of depression among Chinese Americans in primary care and the proportion of depressed Chinese Americans who receive treatment. Method: Between September 15, 2004 and February 15, 2007, depressed Chinese American patients in a primary care clinic were screened using the Chinese Bilingual version of Patient Health Questionnaire (CB-PHQ-9). Patients who screened positive (CB-PHQ-9=10) were asked if they had received treatment for depression in the past month. Those who were not receiving treatment for depression were encouraged to consider treatment after they were confirmed as having major depressive disorder (MDD) based on a structured psychiatric interview. Results: 4,228 subjects completed depression screening and 296 (7%) screened positive for MDD; among them 19 (6.5%) had been receiving psychiatric treatment for

depression and 155 (52 %) declined a psychiatric interview. The remaining 122 (40%) positively screened subjects consented to a psychiatric assessment. Among them, 104(85%) patients were confirmed as having MDD, suggesting that the CB-PHQ-9 correctly identifies positive cases of depression at a rate of 85%. The adjusted rate of depressed Chinese patients being treated by their primary care physicians was calculated to be 7.5%, lower than the rate reported in health centers in Seattle, Washington (7.5% vs 28%, p<0.001) and in European countries (7.5% vs 21%, p<0.01). Conclusions: Depressed Chinese Americans in primary care settings are under-recognized and under-treated. Key Words: Depression, primary care, Chinese Americans, under-recognition, under-treatment. Target Audience(s): Psychiatrists, Psychologists, Social Workers, Primary Care Practitioners, Trainees

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2)Simon GE, VonKorff M. Recognition, Management, and Outcomes of Depression in Primary Care. Arch Fam Med. 1995; 4:99-105.

No.2

PSYCHIATRIC COMORBIDITY AND SUICIDAL IDEATION ASSOCIATED WITH PTSD IN THE BASELINE SAMPLE OF 2,616 SOLDIERS IN THE OHIO ARMY NATIONAL GUARD

Joseph Calabrese, M.D., 10524 Euclid Ave 12th Fl, Cleveland, OH 44106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the spectrum and prevalence of psychiatric comorbidity in soldiers with posttraumatic stress disorder.

SUMMARY:
Objective – To study psychiatric comorbidity and suicidal ideation in an ongoing study of soldiers in the Ohio Army National Guard. Method –Using a random sample of Ohio National Guard soldiers who participated in a telephone interview we obtained data on lifetime trauma exposure, posttraumatic stress disorder (PTSD Checklist), depression and suicidal ideation (Patient Health Questionnaire-9), generalized anxiety disorder (GAD-7), and alcohol disorders (the Mini International Neuropsychiatric). Results – Among the 2,616 soldiers who participated (43% participation rate), 64% had at least one past deployment. The prevalence of PTSD within the past year was 7.2%, depression 14.0%, GAD 2.0%, AA 5.3%, AD 7.0%, and none of the above 73.9%. In soldiers with PTSD, GAD was 22 times more likely to have occurred within the past year compared to those without (OR 21.63; 95% CI 12.11-38.65), depression 7 times (OR 7.39; 95% CI 5.59–10.45), AD 3 times (OR 3.12; 95% CI 2.06–4.72), and a very highly increased risk of having all 3 conditions (OR 64.64, 95% CI 18.41–227.05). In soldiers with current PTSD accompanied by at least 2 comorbidities, lifetime suicidal ideation (which was present in 62%) was 7 times more likely to occur (OR 7.46; 95% CI 3.05-18-26). 67% had previously sought help through a professional or a self help group. Conclusions - These findings suggest that soldiers with PTSD frequently have a co-occurring mental health condition and a history of suicidal ideation, which highlights the complexity of this patient population and the magnitude of associated human suffering.

No.3

ASSOCIATION AMONG TRAUMATIC EXPERIENCES WITH PHYSICAL HEALTH CONDITIONS IN A NATIONALLY REPRESENTATIVE SAMPLE

M Natalie Husarewycz, M.D., PZ412 PsycHealth Centre 771 Bannatyne Ave, Winnipeg, R3E 3N4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify traumatic experiences associated with physical health conditions.

SUMMARY:
Background: Recently, there has been a growing body of research exploring relationships between physical health conditions and mental disorders. Posttraumatic stress disorder (PTSD), in particular, has been associated with several pain conditions. Preliminary research examining specific types of trauma, such as physical and sexual abuse in

relation to medical conditions suggests that these types of trauma are significantly associated with multiple physical health conditions, including neurological, musculoskeletal and gastrointestinal disorders. However, there has been a dearth of population-based research examining whether the nature of trauma experienced may be related to physical health conditions. Methods: The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Wave II (N=34 653; response rate 70.2%, age 20 years and older) was used in the current study. Participants provided reports regarding lifetime trauma experiences as well as medical conditions experienced over the past year. Multiple logistic regression models were used to examine the association between type of trauma and physical health conditions. Results: After adjusting for sociodemographic variables, Axis I mental disorders and all other trauma groups, injurious trauma, psychological trauma and natural disaster/terrorism were significantly associated with cardiovascular disease, arteriosclerosis or hypertension, gastrointestinal disease, diabetes and arthritis (adjusted odds ratios ranging from 1.10 to 1.54). Witnessing a trauma was associated with arteriosclerosis/hypertension, gastrointestinal disease and arthritis only. In the most stringent model, combat related trauma was not associated with any physical health condition. Conclusion: The present study demonstrates that there is an association between several types of trauma and physical health conditions, even when PTSD and other Axis I disorders are controlled for. his data suggests that the impact of certain types of traumatic events on physical health may be independent of PTSD.

No.4

SEX DIFFERENCES IN WORK STRESS IN A REPRESENTATIVE SAMPLE OF THE CANADIAN FORCES

Natalie Mota, M.A., 5-119 Scott St, Winnipeg, MD R3E 3N4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand how military men and women differ across a range of different aspects of occupational stress; and 2) Identify possible reasons for such differences.

SUMMARY:
Objectives: Women represent an increasing proportion of personnel in several militaries, however, how they perceive their occupations relative to men remains understudied. The present investigation aimed to examine sex differences across six aspects of work stress in a large, representative military sample. Method: Data came from the Canadian Community Health Survey on Mental Health and Wellbeing: Canadian Forces Supplement, which was collected in 2002 and included 8,441 regular and reserve force personnel ages 16-64. Work stress in the past year was assessed using an abbreviated version of the Job Content Questionnaire. This self-report measure consisted of 12 items divided into six subscales, each representing a different aspect of potential work stress. Higher scores represented higher levels of stress. Multiple linear regression analyses adjusted for sociodemographic and military variables were used to examine sex differences across each work stress sub-scale. Results: Women reported significantly higher levels of stress than men related to job demand (adjusted mean [AM]=4.06, SE=0.04 vs. AM=3.88, SE=0.02), job control (AM=3.13, SE=0.04 vs. AM=3,01, SE=0.03), and social support from co-workers and supervisors (AM=4.02, SE=0.05 vs. AM=3.79, SE=0.03). Men, on the other hand, reported significantly higher levels of physical exertion than women (AM=2.23, SE=0.02 vs. AM=1.90, SE=0.02). No sex differences were found with regard to psychological demand or job insecurity. Conclusions: The findings of this study will assist clinicians working with military men and women experiencing operational stress by providing a better understanding of existing sex differences.
This research was supported by a Social Sciences and Humanities Canadian Graduate Scholarship – Doctoral Award (Mota) and a Canadian Institutes of Health Research New Investigator Award (#152348) (Sareen).

SATURDAY, MAY 14, 2011,
11:00 AM - 12:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 7

FORENSIC PSYCHIATRY

No.1

WOMEN, MALINGERING AND THE SIRS: GENDER DIFFERENCES IN THE STRUCTURED INTERVIEW OF

REPORTED SYMPTOMS

Jessica Ferranti, M.D., 2230 Stockton Blvd, Sacramento, CA 95817

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe psychosocial, historical and crime variable factors associated with malingering in female jail inmates; and 2) Identify possible gender differences in the presentation of malingering in incarcerated populations.

SUMMARY:
Until recently, there has been a lack of information regarding female criminality in general including the phenomenon of incarcerated women who feign psychiatric symptoms. The purpose of this study is to investigate gender differences in psychosocial background, criminal history and malingering strategies in individuals who are administered the Structured Interview of Reported Symptoms (SIRS). At the Sacramento County (CA) Jail, the SIRS is routinely administered when clinicians feel there is a possibility that an inmate receiving psychiatric services may be feigning or exaggerating his/her symptoms. During the evaluation of these inmates, demographic and historical information were also collected to determine those factors most associated with malingering in jail inmates. Previous evaluation of these data indicate that the prevalence of malingering in our sample was quite high: over 66% were found to be malingering based on the scoring criteria for the SIRS. This analysis examines differences in primary scale distribution, psychosocial and crime variable characteristics between men and women found to be malingering based on administration of the SIRS.

REFERENCES:
1) McDermott BE, Sokolov G, Malingering in a correctional setting: the use of the Structured Interview of Reported Symptoms in a jail sample, Behav Sci Law,2009;27(5):753-65.

No.2
ETHICAL AND CLINICAL ASPECTS OF PRE-TRIAL FORCED NASO-GASTRIC ADMINISTRATION OF MEDICATION

William Richie, M.D., 9601 Steilacoom Blvd SW Bldg 28, Lakewood, WA 98498

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the psychopharmacologic agents that are currently only deliverable by the oral route; 2) Then be able to cross reference those agents with the current case law controlling involuntary administration of medication for restoration of competency to stand trial; and 3) Finally, the oral/nasal-gastric route is thoroughly considered with reference to risk/benefit ratios, length of stay and judicial time limits.

SUMMARY:
In 2003 the US Supreme Court handed down a landmark decision which provided guidelines for the lower courts in the authorization of the forced administration of medication for pre-trial detainees. In 2008 the 9th Circuit Court of Appeals issued a ruling which further limited the forced administration of psychotropic medication. Recognizing that some medications are only available through the oral route, forced administration of these medications becomes problematic from a number of perspectives. The authors review some of the applicable case law for Washington State. Some clinical considerations regarding the forcible administration of medication are also reviewed with regard to the particular route of administration, as well as the general consideration of side effects and management of clinical entities emerging from both voluntary and forced administration of psychotropic medication. A review of the ethical considerations facing forensic psychiatrists (vis-a-vis involuntary administration of medication for pre-trial defendants) is conducted. The authors entertain the hope that the conferees will join in a fruitful discussion regarding this narrow clinical entity. In so doing, we anticipate that we will be providing all of our colleagues with an enhanced database and increased awareness of the nuances of the management of this unique clinical concern.

REFERENCES:
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No.3
AMA VI PSYCHIATRIC IMPAIRMENT ASSESSMENT: IS IT VALID?

Gordon Davies, M.B., D.P.M., 33 Smith Street,

Wollongong, 2500 Australia

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should: 1) Have a good understanding of the use of the AMA VI criteria for psychological impairment assessment and of the validity of the assessment process together with some of the issues regarding reliability.

SUMMARY:
The 6th Edition of the AMA Guides for the Assessment of Permanent Impairment introduces a new system for evaluation of Mental and Behavioural Disorders. In some ways this has parallels to the 1st Edition in which several different systems were given as alternatives but the new system involves the use of the median value of each of the mandated measures. Importantly the new system incorporates two measures, The General Assessment of Function (GAF) and the Brief Psychiatric Rating Scale (BPRS) which have established studies of reliability although there remains a significant margin of error in application to individual cases rather than groups. There is also evidence for the validity of all the measures in their ability to order the severity of psychiatric disturbance in different contexts.Objectives:The present study is directed toward investigating the use of the combined measures using the criteria set out in the AMA Guides and examining the correlations between each individual measure and the final outcome measure.Method:Patients presenting for medico-legal examination were assessed using the three measures GAF, BPRS and Psychiatric Impairment Rating Scale (PIRS) as set out in the AMA Guides. Also comparisons were made with the PIRS as originally scored, an impairment rating system based on the 2nd Edition of the AMA Guides and on two subjective rating scales, the General Health Questionnaire (GHQ) and the Depression, Anxiety and Stress Scale (DASS). Results:The distributions of each of the variables was reasonably symmetrical. There is a strong correlation between the component measures of the overall AMA assessment although the correlation of the GAF and BPRS was much higher than that of each of the measures with the PIRS. The correlation of each score with the final AMA score was significantly higher, accounting for half the variance. Correlations with the subjective measures were lower with the GHQ having a stronger relationship to the final level of assessed disability than the DASS. Conclusions:The present study establishes good concurrent validity for the AMA 5 system of estimating mental and behavioural impairment. This means that despite the problems involved in estimating the disability due to psychiatric symptoms there is better evidence for its use than is available in other body symptoms. However the relationship between the "percentage" levels of impairment as measured and actual disability remains questionable.

REFERENCES:
1) Rondinelli RD (Ed): Guides to the Evaluation of Permanent Impairment (6th Edition), Chicago, American Medical Association, 2008

SCIENTIFIC AND CLINICAL REPORT SESSION 8

HEALTH SERVICES RESEARCH

No.1
IMPACT OF A COMPREHENSIVE CRISIS RESPONSE TEAM ON UTILIZATION OF HOSPITAL AND EMERGENCY SERVICES

Deepika Sabnis, M.D., 1500 East Medical Center Drive, Ann Arbor, MI 48109

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Analyze the impact of a mobile crisis team on inpatient and emergency service utilization.

SUMMARY:
This purpose of this study was to examine the impact of a public sector mobile crisis team (MCT) on the utilization of inpatient beds and psychiatric emergency services for patients seeking emergent care at a large teaching hospital, including changes in service utilization, patient characteristics associated with hospitalization, and treatment retention in outpatient care after MCT services were delivered. Data was collected from the hospital electronic medical record for every visit made to the psychiatric emergency service (PES) for all patients who qualified for public mental health funding (e.g. Medicaid; Medicaid/Medicare dual eligibility; no insurance) over two time periods: 1) Jan-Dec 2008 (pre-MCT); and 2) Jan-Dec 2009 (post-MCT implementation) and included patient demographics, diagnoses, total number of initial PES visits, repeat

emergency visits (within 14 days), disposition at release from PES, in-county and out-of-county inpatient hospitalizations; re-hospitalizations within 30 days of discharge, and number and percentage of patients who were receiving treatment in the community mental health center prior to and after inpatient admission. The number of adults who were hospitalized decreased slightly from the year before the MCT was enacted and following year. There was also a modest decrease in the percentage of out-of-county hospitalizations over the 2 years (24% vs. 21%). There were no differences in age (mean=37; S.D.=13 years) between the in-county and out-of-county hospitalized consumers. Hospitalizations were distributed across mental health diagnoses. The percentage of males sent to in-county hospitals increased over from Year 1 to Year 2 of the study (48% to 55%). Readmission to psychiatric emergency care and re-hospitalizations are also examined in this study for changes over time. The results of this study demonstrate small but important changes that took place the first year the Mobile Crisis Team was in place, including the course of in- and out-of county hospitalizations and readmissions, indicative of the importance of targeted multidisciplinary interventions to improve consumer outcomes. These early gains need to be monitored over longer periods of time to tailor interventions and crisis management and signal the need for an expansion of public mental health services to better accommodate those with significant need yet maximize consumer outcomes and manage the costs of care.

No.2

CANCER TREATMENT FOR PEOPLE WITH MENTAL ILLNESS: A SYSTEMATIC REVIEW OF THE LITERATURE

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) Understand the current literature on variation in and challenges to cancer care for adults with mental illness; 2) Identify patient characteristics and psychiatric symptoms that may interfere with completion of cancer care; and 3) Interdisciplinary strategies to improve cancer care for people with mental illness.

SUMMARY:
People with mental illness have higher rates of many malignancies than the general population and may be at greater risk of receiving substandard cancer treatment. The challenges of providing cancer care to patients with pre-existing mental illness have been frequently voiced by both generalists and specialists; however, there exists no comprehensive review on this topic. We searched PubMed, PsycInfo and EMBASE for articles that addressed any aspect of cancer treatment for adults with pre-existing mental illness. We systematically reviewed the results and made the following observations and recommendations: 1) Persons with mental illness were less likely to receive standard, curative treatment for several cancers; 2) uncontrolled psychiatric symptoms interfered with adequate cancer treatment; 3) depression is associated with delayed reporting of cancer-related symptoms; 4) robust interdisciplinary care, including psychiatric care, and social support are integral to the completion of cancer treatment; 5) special vigilance and persistence are called for in screening for cancer among patients with mental illness, especially depressive symptoms.

REFERENCES:

1) Carney, C.P., et al., Occurrence of Cancer Among People With Mental Health Claims in an Insured Population. Psychosom Med, 2004. 66(5): p. 735-743.

No.3

TWO IMPLEMENTATION MODELS FOR INTEGRATION OF PHYSICAL HEALTH INTO A BEHAVIORAL HEALTH SETTING FOR PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Shula Minsky, Ed.D., 151 Centtenial Ave., Piscataway, NJ 08854

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the need for integration of physical health into behavioral care settings; 2) Discuss two implementation models of physical health integration; and 3) analyze the advantages and disadvantages of each model.

SUMMARY:
Background: Persons with severe mental illness (SMI) die on average 25 years earlier than the general population. Approximately two-thirds

of this excess mortality is due to natural causes rather than suicide or violence. People with SMI experience 1.5 to 2 times higher prevalence of diabetes, hypertension, dyslipidemia and obesity. Furthermore, they have limited access to primary care services, due to lack of insurance, poor financial resources and reluctance of medical providers to treat them. In addition, patients with SMI, have limited ability to navigate the complex health care system. To improve health care for persons with SMI, there is a clear need to integrate psychiatric and medical services. Methods and data: With an anonymous donation, University Behavioral HealthCare (UBHC) set up in 2008 an affiliation with a clinic in New Brunswick, NJ. Clinic staff provided physical health care to UBHC clients, and communicated regularly with UBHC nurses. In 2009, the same donor offered UBHC an opportunity to open a second primary care clinic at UBHC Newark. UBHC established a partnership with the UMDNJ-NJ Medical School's Department of Family Medicine to provide the primary care services in the behavioral health building itself. This presentation will provide service and outcome data from the two distinct models; the first involving the use of an affiliated clinic; the second a co-located primary care service.The data will include: Level of services provided; Severity of medical presentation, based on number of co-morbid chronic medical conditions; Number of Emergency Room (ER) visits; Outcome measures related to hypertension, diabetes and obesity; and Development of wellness initiatives. Key Findings: In New Brunswick, 296 consumers received 1,468 appointments. The Newark clinic served 401 consumers, providing 1,415 appointments. Data on severity, chronic conditions and longitudinal outcome measures will be presented. Clinical and Policy Implications: While the co-located clinic model proved to be more effective, the cost of co-locating may be prohibitive without special funding. However, if a co-located clinic model can affect a meaningful reduction in ER visits, the model may prove to be sufficiently cost-effective to generate public financing (e.g. Medicaid).

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1).Brown S. Excess mortality of schizophrenia. A meta-analysis. Brit j Psychiat 1997; 171:502-508.
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3) Newcomer, J. W. (2005). Second-generation (atypical) antipsychotics and metabolic effects: A comprehensive literature review. CNS Drugs, 19(Suppl. 1), 1-93.
4) McEvoy J, Meyer J, Goff DC, et al: Prevalence of the metabolic syndrome in patients with schizophrenia: baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophr Res 2005; 80(1):19-32.
5) Parks J, Svendsen D, Singer P, Foti ME eds: Morbidity and mortality in people with serious mental illness from the National Association of State Mental Health Program Directors (NASMHPS) Medical Directors Council. www.nasmhpd.org
6) Newcomer JW, Hennekens CH: Severe mental illness and risk of cardiovascular disease. JAMA 2007; 298:1794-1796.

No.4

PARTIAL HOSPITALIZATION PROGRAM (PHP)FOR ADULTS IN PSYCHIATRIC DISTRESS: PREDICTORS AND CHARACTERISTICS OF CLINICAL RESPONSE

Deshmukh Parikshit, M.D., 10524 Euclid Ave, 8th floor, Cleveland, OH 44106

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand characteristics of the population that gets referred to PHP; 2) Identify the type of patient population which shows higher clinical response to PHP treatment; 3) Understand the correlation between response among different types of psychiatric symptoms in PHP patient population and its clinical implication; and 4) Identify the area where future studies are needed.

SUMMARY:

Background: Evidence suggests that PHP for adult patients in psychiatric distress, are as effective as inpatient hospitalization. While PHPs are financially demanding to operate, they are associated with more treatment related satisfaction for patients and families. However, the clinical indications for choosing PHP over inpatient hospitalization are not well established and it is not clear whether results can be generalized to all demographic populations. In light of these differences among the PHP and inpatient hospitalization treatment modalities,

research is warranted to identify predictors and characteristics of clinical response which may guide clinicians in initiating the appropriate referral. Methods: Eighty-three adult community mental health center patients in acute psychiatric crisis, were administered serial clinical assessments using the BASIS-32 during the treatment course of PHP. Clinical response was recorded in 5 domains that included Daily Living and Role Functioning (DLRF), Relation to Self and Others (RSO), Depression and Anxiety (DAA), Psychosis, and Impulsive and Addictive Behavior (IAB). Multiple regression analysis (MRA) was performed to determine if a given response to treatment could be correlated with demographic factors that included; age, gender, race, marital status, level of education and living arrangement. The magnitude of change within each domain was also compared between domains by MRA to determine if only a certain subset of domains show change after PHP treatment, or if all show similar change. Results: Forty-three (51.8 %) patients showed a 30% or greater reduction of score in all 5 domains. Of those, 24 (28.9%) patients showed a 50% or greater reduction in total score. The highest reduction of scores was found in RSO and DAA domains whereas the least reduction of scores was found in IAB. The psychosis domain showed widest fluctuation in response. The response in each domain significantly ($p<0.0001$) predicted the response in other domains. RSO and DLRF showed highest positive correlation. No significant statistical correlation was found between the demographic factors and the clinical response in any domain. Conclusions: A positive clinical response to PHP does not have a positive correlation with any demographic factor recorded in this study. Therefore, demographic factors should not be emphasized when considering PHP treatment. Phase dependent illnesses such as DAA and Psychosis may show relatively greater response

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1) Horvitz-Lennon M, Normand SL, Gaccione P, Frank RG. Partial versus full hospitalization for adults in psychiatric distress: a systematic review of the published literature (1957-1997). Am J Psychiatry. 2001 May;158(5):676-85.

2)Priebe S, Jones G, McCabe R, Briscoe J, Wright D, Sleed M, Beecham J. Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care: randomised controlled trial. Br J Psychiatry. 2006 Mar;188:243-9.

SCIENTIFIC AND CLINICAL REPORT SESSION 9

SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS-1

No.1

CURRENT PRESCRIBING PRACTICES: ANTIDEPRESSANT USE IN SCHIZOPHRENIA

Megan Ehret, Pharm.D., 200 Retreat Ave, Hartford, CT 6106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Discuss the relevance of these findings to current prescribing guidelines and to the controversy about the distinction between schizophrenia and schizoaffective disorder.

SUMMARY:
Objective: Given recent reports about the importance of depressive symptoms in patients with schizophrenia (SZ) the authors examined a large sample of hospitalized patients with a diagnosis of SZ to determine (1) the proportion for whom antidepressants were prescribed and (2) if demographic and clinical variables distinguished these patients from others with SZ. Methods: The sample was consecutive inpatient admissions age 18-64 discharged 2/00-6/09 with this diagnosis (n=1519). Demographics, co-diagnoses, and psychotropics at discharge were recorded. "Depression" was defined as major depressive disorder, bipolar disorder depressed phase, depressive disorder NOS, or dysthymic disorder. "Antidepressant" (AD) was any marketed drug in this class except trazodone and the tricyclics, which preliminary analyses showed were prescribed as sedatives at dosages subtherapeutic for depression. AD use in SZ was compared to use in patients with schizoaffective disorder (SA). Variables associated with AD use were identified with stepwise logistic regression. Chi-square analysis and t-tests were used to compare patients treated with vs. without ADs. Results: Antidepressants were prescribed for 28.0% of patients with SZ versus 49% of those with SA ($p<.001$). Of SZ patients on ADs, 6.8% had a co-diagnosis of depression; an additional 4.9% had a co-diagnosis of anxiety disorder and another 8.5% a personality disorder (PD). There was no difference in AD use by SZ subtype. Compared to all other

SZ patients, those for whom ADs were prescribed were more likely to receive atypical antipsychotics (86.1% vs. 76.5%, p<.001) but less likely to receive valproate (13.9% vs. 20.0%, p=.005). Regression analyses revealed that the AD patients were more likely to have a diagnosis of depression (OR=7.87), anxiety disorder (OR=1.93), or PD (OR=1.60), to be Latino (OR=1.39), and to receive atypical antipsychotics (OR=1.81) or a benzodiazepine (OR=1.38). There was no association with age, gender, length of stay or readmission within 1 year. Conclusions: Approximately 25% of patients with SZ were discharged on ADs. The documented presence of depression, anxiety or PD increased the odds of treatment with AD, but these co-diagnoses were not common and do not appear to explain fully clinicians' decisions about use of ADs. These findings may be relevant to recent reports about AD use for negative symptoms and to upcoming decisions for *DSM-5* distinctions between SZ, SA and psychotic mood disorder.

REFERENCES:

1) Whitehead C, Moss S, Cardno A, Lewis G: Antidepressants for the treatment of depression in people with schizophrenia: a systematic review. Psychol Med 2003;33:589.599.

2) Conley RR: The burden of depressive symptoms in people with schizophrenia. Psychiatr Clin North Am 2009;32:853-861.

No.2

DOES SOCIAL SUPPORT PREVENT RELAPSE AND REHOSPITALIZATION IN EARLY ONSET SCHIZOPHRENIA? RESULTS FROM THE LAMBETH EARLY ONSET STUDY

Raymond Tempier, M.D., M.S.C., 103 Hospital Drive, Saskatoon, S7N 0W8 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the influence of the social support on the outcome of first episode schizophrenia; 2) Evaluate the importance of assessing the social network and patients perceived support; and 3) Ascertain the beneficial role of patients spending time with family.

SUMMARY:

There is a growing evidence that social support influences the course of schizophrenia;It is a protective factor as higher support correlates with symptom decrease. It plays a direct causal role in reducing the risk of psychological impairment. The goal of this study is to determine the relationship between support characteristics and symptoms and hospitalization rates among patients (n=99) with first episodes of schizophrenia during a 2-year follow-up period in London, England. Methods: We analyze data from the Lambeth Early Onset (LEO) data set. The social support was characterized by: 1. the size of the support network, 2. the perceived quality of the support measured by the Significant Other Scale (Power et al ,1988, 3. the weekly time spent with the family. Outcome measures were characterized by psychiatric hospitalization count, and by a recovery index derived from the PANSS and the GAF scale. Results: The sample was made out of males (63.6%), mean age 26.1 y. old, single (86.5%) with secondary (49%,) or post secondary (50%) education. Most(88.6%)lived in private homes, 85.6% being unemployed. Most were from African origin (66.4%) or Caucasian & other ethnicity(i.e. Chinese, Indian, Pakistani or Latin American)(33.6%). The majority had a 1st Episode (74.5%) and 25.5% a 2nd Episode. More than half (57.9%) were hospitalized at baseline study intake. Mean Total PANSS score at 6-month was 58.2 (SD 18.3) and at 18-month 54.6(SD 15.1). Mean GAF score at 6-month was 59.1 (SD 13.7) and at 18-month 60.2 (SD 15.9). Most (77.7%) have one (39.4%), two (25.2%) or three (13.1%) confidants. Confidants are either a parent (31.4%), a sibling (18.6%) or a friend (22.1%). They(69.8%)perceive having a good support. Fewer (30.2%) have a low to moderate support. The confidants number was associated with the number of hospital days (p<0.01) and with the recovery index (p<0.01). Females have more chances to recover at 6-month follow up (OR 0.13 CI 0.29-0.56). Non black patients have 6 times more chance to recover at 18-month follow up (OR6.05,CI1.7-21.5). More hours spent with family members is associated with less readmission. Conclusions: Social support has a major influence on the course of schizophrenia as demonstrated here. Study limitations include: a small sample size, a short follow-up period and patients from diverse ethnic origin.

REFERENCES:

1) Buchanan J 1995, Arch Psychiatric Nursing

No.3

AFFECTIVE DEFICITS IN

SCHIZOPHRENIA REVISITED: THE ROLE OF AMBIVALENCE AND ALEXITHYMIA

Fabien Tremeau, M.D., 6 massa lane, edgewater, NJ 07020

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the major affective impairments present in schizophrenia.

SUMMARY:
Background: Affective research in schizophrenia has repeatedly brought discrepant results: compared to healthy controls, schizophrenia subjects show lower positive temperament and higher negative temperament on trait questionnaires, whereas they report similar levels of positive and negative affective reactivity in laboratory evocative tasks. Those findings question the coherence between trait measures and online ratings. However, the role of early-stage ambivalence and alexithymia (impaired emotional clarity) has rarely been examined. Methods: Eighty individuals with schizophrenia and 36 non-patient control participants completed an evocative affective task consisting of pictures and sounds. Following each presentation, participants rated their induced levels of pleasantness and unpleasantness on two separate ratings, and three scores were obtained: on-line global pleasantness, on-line global unpleasantness and ambivalence. All participants completed two trait questionnaires: the General Temperament Survey to measure positive temperament and negative temperament, and the Toronto Alexithymia Scale. Results: In the evocative task, schizophrenia participants showed higher ambivalence but no impairment in positive and negative emotional reactivity. Schizophrenia participants self-reported higher negative temperament and higher alexithymia. In both groups, negative temperament moderately correlated with induced negative experiences, but positive temperament did not correlate with global pleasantness. Regression analyses were conducted to test whether trait measures predicted on-line ratings, and negative temperament predicted on-line global unpleasantness in the schizophrenia group only. More importantly, in the schizophrenia group, ambivalence and alexithymia predicted negative temperament, accounting for 40% of the variance, and groups did not differ on negative temperament after controlling for ambivalence and alexithymia (p=0.99). Discussion: The coherence between affective state and trait measures was limited within the negative affect system, and quite poor within the positive affect system. In schizophrenia, increased early-stage ambivalence was a central affective deficit. Increased ambivalence and alexithymia explained the higher negative temperament of individuals with schizophrenia, which is consistent with the view that emotional clarity helps to regulate negative emotions.

SATURDAY, MAY 14, 2011
1:00 PM - 2:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 10

MOOD DISORDERS -1

No.1
STUDY DESIGN FEATURES AFFECTING OUTCOME IN ANTIDEPRESSANT TRIALS

Florian Seemüller, M.D., Nussbaumstr.7, Munich, 80336 Germany

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the influence of relevant study design features of antidepressant treatment trials on treatment outcome.

SUMMARY:
Context: So far, only very few studies have investigated the impact of study design features of pivotal pre-approval phase III antidepressant randomised controlled trials (RCTs) on study outcome. However, increased knowledge about potential associations may be highly relevant for the correct evaluation of the results. Currently, the interpretation of study results is challenged by inconsistent patterns of outcome and by the significant amount of variability observed in medication response rates. Objective: To look for relevant design factors influencing responder rates in antidepressant trials that could explain at least partially the observed variability. Data Sources: We reviewed complete data packages submitted as new drug applications to the Swiss Agency for Therapeutic Products (Swissmedic) from 1995 to 2008 with a focus on pivotal short-term antidepressant trials. Study selection: Included studies used HAMD-17 or HAMD-21 as primary

measures, lasted six, eight or nine weeks and enrolled hospitalised patients or outpatients aged 18 - 65 years with a diagnosis of major depression of at least moderate severity without further co-morbidity. Data Extraction: The multiple regression analyses investigated the transformed responder rates in combination with seven explanatory factors. Results: The dataset included 35 study reports with a total of N= 10.835 patients. Four out of seven factors were highly significant with a p-value < 0.0001: The active compound, study arm (placebo versus verum), scale used as primary outcome measure, geographical region. Further interactions were found for: Sample size (p=0.0001), dosage schedule (p=0.0094) and treatment duration (p=0.0188). Conclusions: Responder rates in antidepressant trials are significantly affected by various factors. Thus, treatment interaction tests (including detailed pre-specification of these analyses) should be conducted carefully in antidepressant clinical programs. The conduction of multiple pivotal studies appears necessary to check if results were robust.

No.2

ADDRESSING PATIENTS NEEDS III: COMMUNITY MENTAL HEALTH CARE FOR NON-PSYCHOTIC CHRONIC PATIENTS

Tjalling Holwerda, M.D., Van der Boechorststraat 7, Amsterdam, 1015VD Netherlands

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify three different multidisciplinary intervention methods for non-psychotic chronic patients.

SUMMARY:
Backgrounds: many non-psychotic chronic patients (severe personality disorders, bipolar disorders) are not able or not willing to participate in structured psychotherapeutic programs.There a few intervention methods to support mental health care professionals in their efforts to provide accessible care to these patients. Methods: we developed three multidisciplinary intervention programs for these patients groups, with the psychiatric nurse in a central position of care manager. The intervention programs were developed on the basis of systematic literature review, problem and needs analysis, consultation of experts and pilot testing. The feasibility and effectiveness of intervention are currently being tested. Results: The preliminary findings of the interventions show promising results for improving clinical practice regarding treatment and care for patients with chronic non-psychotic disorders in community mental health care.

REFERENCES:

1) Koekkoek B, van Meijel B, Schene A, Hutschemaekers G. Problems in psychiatric care of 'difficult patients': a Delphi-study. Epidemiol Psichiatr Soc. 2009; 18(4):323-30.
2) Koekkoek B, van Meijel B, Schene A, Hutschemaekers G. A Delphi study ofproblems in providing community care to patients with nonpsychotic chronic mental illness. Psychiatr Serv. 2009; 60(5):693-7
3) Stringer B, van Meijel B, Koekkoek B, Kerkhof AJFM, Beekman ATF. A Collaborative Care program for patients with severe (cluster B or NOS) personality disorders. 2010 (Submitted)Van der Voort N, van Meijel B, Goossens P, Beekman ATF, Kupka R. Collaborative Care for Patients with a Bipolar Disorder. 2010 (Submitted).

No.3

LARGE-SCALE DEPRESSION SCREENING IN PRIMARY CARE - UNEXPECTED BENEFITS

Gabrielle Beaubrun, M.D., 2081 Palos Verdes Drive North, Lomita, CA 90717

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify specific benefits associated with the implementation of a Depression Screening program within a large group practice; and 2) Discuss methods to overcome barriers to implementation of depression screening and treatment in Primary Care.

SUMMARY:
Background:The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place. However this recommendation has met with mixed reactions from medical groups concerned with its cost-effectiveness and practicability for large scale implementation. In 2005 Kaiser Permanente in Southern California began systematic depression screening of adults with cardiovascular diseases using the PHQ9 questionnaire and implementing a collaborative care treatment model based upon the IMPACT research design. Most of the initial depression screening

was conducted by mailing the PHQ9 with an information letter to patients' homes and following up with a telephone interview.Within this network HMO with an all-electronic medical record system linking medical, psychiatric and pharmacy records, we conducted a retrospective analysis in the period 2007-2008 to examine the effects of the depression screening on overall healthcare utilization. Method:Data for a study cohort of 309,000 members with cardiovascular conditions or diabetes was examined, and the number of medical visits one year prior to depression screening compared with one year after screening, for the 41,000 screened for depression and 268,000 unscreened members. Results:A statistically significant reduction in the total number of medical encounters per patient was demonstrated in the year following depression screening when compared with data for the same patient one year earlier. This effect was actually most prominent among the group who screened negative for depression, which constituted more than 80% of the screens. We present this as yet unpublished data for the first time. Conclusions: Demonstration of a cost-benefit to screening non-depressed clients has not to our knowledge been proposed previously and if this finding is replicated (we are currently undertaking a similar examination of a second cohort, which will be completed in 2010) it will support the cost-effectiveness of increased widespread depression screening.We present a discussion of possible psychological empowerment mechanisms by which learning of a negative depression screen might positively impact health outcome. We will also discuss barriers to implementation of screening and treatment encountered across the 12 large medical centers where this collaborative care model was introduced and how we overcame them.

REFERENCES:

1) The PHQ-9: validity of a brief depression severity measure. Kroenke K, Spitzer RL, Williams JB. J Gen Intern Med. 2001 Sep;16(9):606-13

2)O'Connor EA, Whitlock EP, Beil TL, Gaynes BN. Screening for depression in adult patients in primary care settings: a systematic evidence review. Ann Intern Med 2009;151:793-803.

SUNDAY, MAY 15, 2011
7:00 AM - 8:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION -11

PERSONALITY DISORDERS-1

No.1

STRUCTURAL BRAIN ABNORMALITIES AND SUICIDAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER

Paul Soloff, M.D., 3811 O'Hara St., Pittsburgh, PA 15213

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify brain regions implicated in suicidal behavior in borderline personality disorder.

SUMMARY:
Objective: Structural abnormalities have been demonstrated in subjects with BPD in fronto-limbic brain regions involved in regulation of emotion and impulsive behavior; however, their relationship to suicidality has not been assessed. Because emotion dysregulation and impulsive-behavioral dyscontrol are endophenotypic traits which contribute a diathesis to suicidal behavior in BPD, we asked if suicidal behavior in BPD was associated with changes in brain morphology, especially in fronto-limbic cortex. Method: Structural MRI scans, acquired on a 1.5T GE Signa MR scanner, were obtained on 68 BPD subjects (16 male, 52 female), defined by IPDE and DIB/R criteria, and 52 healthy controls (HC: 28 male, 24 female). Groups were compared by diagnosis (BPD attempters, non-attempters vs. HC), attempt status within BPD, low vs. high lethality attempt history (defined by median split on the Lethality Rating Scale). ROIs included: anterior cingulate, amygdala, fusiform gyrus, hippocampus, insula, lingual gyrus, mid-inf. orbitofrontal cortex, mid-sup temporal cortex and parahippocampal gyrus. Data were analyzed using optimized voxel-based morphometry implemented with DARTEL in SPM5, covaried for age and gender, corrected for cluster extent ($p<.05$), with AlphaSim. Results: Compared to HC, BPD attempters had significantly diminished gray matter concentrations in 8 of 9 ROIs, non-attempters in 6 of 9 ROIs. Within the BPD sample, attempters had diminished gray matter in Lt. insula compared to non-attempters. High lethality attempters had significant decreases in Rt. mid-sup. temporal gyrus, Rt. mid-inf. orbito-frontal gyrus, Rt. insular cortex, Lt. fusiform gyrus, Lt. lingual gyrus and Rt. parahippocampal gyrus compared to low lethality

attempters. Conclusions: Specific structural abnormalities discriminate BPD attempters from non-attempters and, importantly, high from low lethality attempters.

REFERENCES:

1) Soloff PH, Nutche J, Goradia D, Diwadkar V.(2008) Structural brain abnormalities in borderline personality disorder: A voxel-based morphometry study. Psychiatry Research: Neuroimaging 164:223-236

No.2

THE COURSE OF DYSPHORIC AFFECTIVE AND COGNITIVE STATES IN BORDERLINE PERSONALITY DISORDER: A 10-YEAR FOLLOW-UP STUDY

Lawrence Reed, Ph.D., 115 Mill Street, Belmont, MA 02478

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the severity of specific affective and cognitive states in borderline patients over a 10-year course in comparison to non-borderline axis II participants.

SUMMARY:

Objective: To assess the severity of specific dysphoric affective and cognitive states among patients with borderline personality disorder (BPD) and non-borderline axis II diagnoses (OPD) over a 10-year course of prospective follow-up. Method: Participants were 275 borderline inpatients and 67 axis II comparison participants. The Dysphoric Affect Scale (DAS) – a 50-item self-report measure of affective and cognitive states thought to be common among borderline patients and specific to the disorder – was administered at five waves of prospective follow-up to all participants. Items on the DAS corresponding to specific affects (e.g. empty, full of shame, in terrible pain) and cognitions (e.g. the pain will never end, I have no identity, I'm damaged beyond repair) were separately analyzed, yielding respective subscores. These scores reflect the percentage of time that each inner state was experienced. Results: BPD patients reported more severe affective and cognitive subscores compared to OPD comparison participants at baseline (48% vs. 21% affective; 32% vs. 10% cognitive). Additionally, the severity of affective and cognitive subscores declined significantly for both groups taken together over the 10 years of follow-up (62% decline for affective states; 57% decline for cognitive states), while remaining significantly more severe for those in the borderline group. Further analyses were conducted regarding recovery (i.e., concurrent remission from BPD and good social and vocational functioning) within the BPD group. Results showed a significant decline in total DAS scores for those who did and did not recover, but at significantly different rates (73% decline in recovered patients; 47% decline in non-recovered patients). Conclusion: The severity of specific dysphoric affective and cognitive states is greater for BPD patients than non-borderline axis II comparison participants and declines for both groups over time. Among BPD patients, those who recover report significantly less severe dysphoric states than those who do not recover.

REFERENCES:

1) Zanarini MC, Frankenburg FR, DeLuca CJ, Hennen J, Khera GS, Gunderson, JG. The pain of being borderline: Dysphoric states specific to borderline personality disorder. Harvard Rev Psychiatry, 1998;6: 201-207.

No.3

AFFECTIVE LABILITY IN BORDERLINE PERSONALITY AND BIPOLAR DISORDERS

D. Bradford Reich, M.D., Mclean Hospital115 Mill Street, Belmont, MA 02478

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify overlapping and differing patterns of affective lability in borderline personality disorder and bipolar II/cyclothymic disorders.

SUMMARY:

Background: The boundaries between the affective instability in bipolar disorder and borderline personality disorder have not been clearly defined. Using self-report measures, previous research has suggested that the affective lability of patients with bipolar disorder and borderline personality disorder may havedifferent characteristics. Methods: We assessed the mood states of 29 subjects meeting DIB-R and *DSM-IV* criteria for BPD and 25 subjects meeting *DSM-IV* criteria for bipolar II disorder or cyclothymia using the Affective Lability Scale (ALS), the Affect Intensity Measure (AIM), and a newly developed clinician-administered

instrument, the Affective Lability Interview for Borderline Personality Disorder (ALI-BPD). The ALI-BPD measures frequency and intensity of shifts in 8 affective dimensions. Subjects in the borderline group could not meet criteria for bipolar disorder; subjects in the bipolar/cyclothymia group could not meet criteria for BPD. Results: Patients in the bipolar group had significantly higher scores on the euthymia-elation subscale of the ALS; patients in the BPD group had significantly higher scores on the anxiety-depression subscale of the ALS. Bipolar patients had significantly higher total AIM scores and significantly higher score on the AIM positive emotion subscale. In terms of frequency, patients in the borderline group reported: 1) significantly less frequent affective shifts between euthymia-elation and depression-elation on the ALI-BPD; and 2) significantly more frequent shifts between euthymia-anger, anxiety-depression, and depression-anxiety. In terms of intensity, borderline patients reported: 1) significantly less intense shifts between euthymia-elation and depression-elation on the ALI-BPD; and 2) significantly more intense shifts between euthymia-anxiety, euthymia-anger, anxiety-depression, and depression-anxiety. Conclusion: The affective lability of borderline and bipolar II/cyclothymic patients can be differentiated with respect to frequency and intensity using both self-report and clinician-administered measures.

REFERENCES:

1) Henry C., Mitropolou V., New A.S., Koenigsberg H.W., Silverman J., Siever L.J., 2001. Affective instability and impulsivity in borderline personality and bipolar II disorders: similarities and differences. Psychiatry Res 2001 35:307-312.

No.4

REASONS FOR SELF-MUTILATION REPORTED BY BORDERLINE PATIENTS OVER 16 YEARS OF PROSPECTIVE FOLLOW-UP

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 borderline patients with a more extensive history of self-mutilation report being more motivated by dysphoric inner states of both an affective and cognitive nature than interpersonal reasons.

SUMMARY:

Objective: The main objective of this study was to assess the reasons for episodes of self-mutilation engaged in by patients with borderline personality disorder (BPD) over 16 years of prospective follow-up. Method: 290 patients meeting both DIB-R and *DSM-III-R* criteria for BPD were interviewed concerning episodes of self-mutilation nine times over these 16 years of prospective follow-up. These blinded assessments were made every two years using a semi-structured interview of proven reliability. We divided the borderline patients into two groups: those with a more extensive and those with a less extensive lifetime history of self-mutilation at the time of study entry (median number of episodes=35). Results: Those in the more and less extensive groups were not significantly different than one another on either of the interpersonally-directed reasons for self-mutilation: to get attention or being angry with someone. However, those in the group with a more extensive history of self-mutilation were significantly more likely to report each of the five internally-directed reasons studied: feeling numb or dead (RRR=1.45), to punish self (RRR=1.28), to relieve anxiety (RRR= 1.16), to control emotional pain (RRR=1.15), and to prevent being hurt in a worse way (1.96). Conclusions: Taken together, the results of this study suggest that borderline patients with a more extensive history of self-mutilation are motivated more by dysphoric inner states than interpersonal reasons for mutilating themselves.They also suggest that these states are both affective and cognitive in nature.

REFERENCES:

1) Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G, Weinberg I, Gunderson JG: The 10-year course of physically self-destructive acts reported by borderline patients and axis II comparison subjects. Acta Psychiatr Scand 2008; 117:177-184

SCIENTIFIC AND CLINICAL REPORT SESSION 12- PSYCHOPHARMACOLOGY- 1

No.1

TOLERABILITY AND SENSITIVITY OF PATIENTS WITH BIPOLAR DEPRESSION, MAJOR DEPRSSION, AND GENERALIZED ANXIETY DISORDER TO ATYPICAL ANTIPSYCHOTICS

Keming Gao, M.D., Ph.D., 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the different tolerabilities and sensitivities of patients with bipolar depression, major depressive disorder, and generalized anxiety disorder to atypicla antipsychotics.

SUMMARY:
Objective: To compare the tolerability and sensitivity of atypical antipsychotics relative to placebo in bipolar depression (BDP), major depressive disorder (MDD), and generalized anxiety disorder (GAD). Methods: Literature cited in Medline was searched with terms, generic/brand name of atypical antipsychotics, safety, tolerability, and BDP, MDD, or GAD, and placebo- controlled trial. The NNTH for the discontinuation due to adverse events (DAEs) and somnolence relative to placebo were estimated. Results: Five studies in BDP, 10 in MDD, and 3 in GAD were identified. Aripiprazole and olanzapine have been studied in BDP and refractory MDD, but quetiapine-XR has been studied in 3 psychiatric conditions with fixed dosing. The NNTH for DAEs was 14 for aripiprazole in BDP, but not significantly different from placebo in MDD. The NNTH for DAEs was 24 for olanzapine in BDP and 9 in MDD. The risk for DAEs with quetiapine-XR appeared to be associated with dose. At quetiapine-XR-300 mg/d, the NTTH for DAEs was 9 for BDP, 8 for refractory MDD, 9 for MDD, and 5 for GAD. Significantly increased risk for somnolence of olanzapine, quetiapine-IR, and quetiapine-XR relative to placebo was found in BPD, MDD, and GAD studies. In BDP, the NNTH was 6 for olanzapine alone, 12 for olanzapine-fluoxetine combination (OFC), 6 for quetiapine-IR 300 mg/d, 7 for quetiapine-IR 600 mg/d, and 4 for quetiapine-XR 300 mg/d. In MDD, the NNTH for somnolence was 15 for olanzapine alone and 8 for OFC. In refractory MDD, the NNTH for somnolence was 6 for quetiapine-XR 150 mg/d and 5 for quetiapine-XR 300 mg/d. In non-refractory MDD, the NNTH was 11 for quetiapine-XR 50 mg/d, 8 for quetiapine-XR 150 mg/d, and 5 for quetiapine-XR 300 mg/d. In GAD, the NNTH was 7 for quetiapine-XR 50 mg/d, 5 quetiapine-XR 150 mg/d, 5 for quetiapine-XR 300 mg/d. Conclusion: At the same dose of quetiapine-XR, patients with GAD appeared to have a lower tolerability and higher sensitivity than those with BDP or MDD.

REFERENCES:
1. Gao K, Ganocy SJ, Gajwani P, et al. A review of sensitivity and tolerability of antipsychotics in patients with bipolar disorder or schizophrenia: focus on somnolence. J Clin Psychiatry 2008; 69:302-309.
2) Gao K, Kemp DE, Ganocy SJ, et al. Antipsychotic-induced extrapyramidal side effects in bipolar disorder and schizophrenia: a systematic review. J Clin Psychopharmacol 2008; 28:203-209.

No.2
CURRENT PRESCRIBING PRACTICES: ANTIPSYCHOTIC POLYPHARMACY IN PATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

John Bonetti, D.O., 200 Retreat Avenue, Hartford, CT 06106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Present the data about the gap between current prescribing practices and evidence–based guidelines of antipsychotic polypharmacy; and 2) Discuss the evidence for/against this practice.

SUMMARY:
Objective: To determine the prevalence of antipsychotic polypharmacy (APP) and the demographic and clinical variables associated with this practice in hospitalized patients with a diagnosis of schizophrenia (SZ) or schizoaffective disorder (SA). The investigators also examined the change in APP over time. Method: The sample was inpatients age 18-64 admitted between 1/2000 and 6/09 with a clinical diagnosis of SZ or SA who were treated with antipsychotics (AP) (n=2893). Demographics, diagnoses, psychotropics at discharge and AP dosages (only available for the last 2 years) were recorded. To examine changes in prescribing practices we compared data from the first (2000-02; n=969) to the last three years (7/06-6/09; n=1463). Data were analyzed with stepwise logistic regression, chi-square and t-tests. Results: 28.2% of the sample received APP, 65.9% of whom received both second (SGA) and first generation agents (FGA). The most common combinations were an FGA

with risperidone, quetiapine or olanzapine (52.7% of all APP). Among patients on clozapine (n=263) 51.3% received another AP. Patients on = 2 APs were more likely to be white (OR=1.2) and to have a longer LOS (OR=1.0) but less likely to have drug abuse/dependence (OR=0.8). A separate regression that added as independent variables low-dose and high-dose AP (based on product labeling) found that patients on APP were more likely to receive both high (OR=3.8) and low dosages (OR=2.7), to be male (OR=1.7), to have a diagnosis of SA (OR=1.5) and a longer LOS (OR=1.1) but less likely to receive an antidepressant (OR=0.7). APP increased over time from 19.9% to 30.1% (p<.001). Combined treatment with FGA + SGA increased from 13.4% to 20.4% (p<.001); [there was not a significant change in the use of = 2 SGAs]. Conclusions: APP is common and appears to have increased in the last decade. The association of APP with lower than usual doses may reflect a strategy for treating patients unable to tolerate usual doses of a single AP; the association with high doses may be an approach to treatment-refractory conditions. The addition of FGA to SGA may be an effort to increase D2 blockade in patients with persistent hallucinations/delusions. Some associations were not expected and require further investigation.

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No.3

CURRENT PRESCRIBING PRACTICES: ANTIPSYCHOTIC USE IN CHILDREN AND ADOLESCENTS

Michael Stevens, Ph.D., 200 Retreat Avenue, Hartford, CT 6106

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe current practices in antipsychotic use in hospitalized children and adolescents; and 2) Discuss issues relevant to this practice.

SUMMARY:

Objective: To determine among children and adolescents the prevalence of antipsychotic (AP) use and its associated demographic, diagnostic, and clinical characteristics. We also compared current pediatric AP use to prescribing practices in 2000-2003. Method: The sample was all 5-17 year old inpatients admitted between 1/2000-6/2010 (n=3851). Demographics, diagnoses, psychotropics at discharge and AP dosages (only available 2004-2010) were recorded. Diagnoses included: psychosis (PSY; bipolar and psychotic MDD), behavioral disorder (BEH), depression without psychosis (DEP), PTSD, anxiety (ANX), and other diagnoses (OTH). To examine changes in prescribing practices over time, we compared data from 2001-2003 (n=1422) to 2006-2010 (n=2120). Variables associated with AP use were identified with stepwise logistic regression. Chi-square and t-tests compared patients treated with versus without APs the 2 time frames. Results: Antipsychotics were prescribed for 44% (n=1707) of the sample. APs were prescribed for 76% of PSY, 45% of BEH, 24% of DEP, 46% of PTSD, 31% of ANX, and 20% of OTH. Patients receiving APs were more likely to be male (OR=1.76), to be age 5-12 (OR=1.20), have psychosis (OR=7.18), PTSD (OR=2.23) or behavioral disorder (OR=1.93), had a longer length of stay (LOS) (OR=2.31, $\bar{x}$ =18.2 vs. 8.0 days) and less likely to be white (OR=0.69). 94% received an atypical AP, most often risperidone (32%), aripiprazole (29%), or quetiapine (24%). The mean dose (mg/day) was 11.8 for aripiprazole, 205.8 for quetiapine, and 1.5 for risperidone. AP polypharmacy was prescribed for 5% of patients discharged on an AP. AP use decreased over time from 47% to 44% (p=.044). Among patients discharged on APs, there were significant changes in use of olanzapine, (14% to 3%), risperidone (from 45% to 25%), and aripiprazole which increased from 9% to 40% (all p<.001). Conclusions: AP use for inpatients ages 5-17 is common and APs are often prescribed for behavioral disorders, non-psychotic mood disorders, and anxiety. Males and non-whites were more likely to receive APs. There was a substantial decrease over time in use of olanzapine and risperidone, perhaps due to increased concerns about metabolic symptoms with olanzapine and prolactin elevations with risperidone. Aripiprazole has become the most widely prescribed AP.

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adolescents with antipsychotic drugs. Arch Gen Psychiatry 2006;63:679-685.
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No.4
PATTERNS OF ANTIPSYCHOTIC USE IN HOSPITALIZED PSYCHIATRIC PATIENTS

Bonnie Szarek, R.N., Institute Of Living 200 Retreat Avenuehartford, Hartford, CT 6106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Summarize the published data about the prevalence of off-label use of antipsychotics; and 2) Discuss the clinical and demographic variables associated with these prescribing practices.

SUMMARY:
Objective: Antipsychotics (AP) are frequently used for "off label" indications, at dosages outside the recommended range, and in combination with other APs, practices that are neither approved nor well supported by published studies. This study examined the (1) prevalence of off label AP use (and change over time), (2) use of = 2 APs concurrently, and (3) clinical and demographic variables associated with these prescribing practices. Methods: The sample was consecutive patients age 18-64 hospitalized 2000-2009 (n=13,864). Data recorded included demographics, diagnoses (dx) and discharge APs. To examine changes in prescribing practices over time, we compared data from the 1st to the last 3 years of the study. Statistical analyses included descriptives, chi-square, t-tests, and logistic regression. Results: An AP was prescribed for 59% (n= 8191). In the AP group the dx was schizophrenia/schizoaffective (SZ/SA) in 35%, bipolar disorder (BP) in 19%, psychotic MDD in 17%, and nonpsychotic MDD in 14%; 15% had another diagnosis. 14% of all AP-treated patients received AP polypharmacy; the prevalence of this practice was much greater in patients with SZ/SA (28% vs 6% in all others on APs, p<.001). Doses below the recommended minimum were most frequently prescribed for quetiapine (51% of those on quetiapine), aripiprazole (43%), and risperidone (42%). Doses above the recommended maximum were most often prescribed for olanzapine (27%) and ziprasidone (16%). AP use in the sample as a whole increased from 51% to 69%, p<.001; significant increases were also seen in each dx examined. Although it was not surprising that BP patients with psychosis were more likely to receive APs (OR=6.3), this practice was not expected in patients with a co-diagnosis of borderline personality disorder (OR=1.5). Black (OR=1.6) and Latino BP patients (OR=1.8) were also more likely to receive APs, even those without psychosis (black, OR=2.4; Latino, OR=2.8), as were patients with mania without psychosis.Conclusions: APs are widely used for off-label indications and at dosages outside the FDA recommended therapeutic range, and use of APs increased significantly over time for all dx examined. Additional studies are needed to develop evidence-based guidelines for this expanded use of APs.

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SCIENTIFIC AND CLINICAL REPORT SESSION 13- SOCIAL AND COMMUNITY PSYCHIATRY

No.1
SMALL TOWN AND GOWN: TELEPSYCHIATRY COLLABORATIONS BETWEEN RURAL COMMUNITY MENTAL HEALTH CENTERS AND AN ACADEMIC MEDICAL CENTER

Robert Caudill, M.D., 550 South Jackson Street, Louisville, KY 40202

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize those elements of a Telepsychiatry program that must be coordinated to maintain and sustain such a collaborative relationship between academia and rural community mental health centers.

SUMMARY:
Telepsychiatry has proven to be a valuable means by which to improve the geographic distribution of mental health providers. Kentucky has consistently been identified as a state with significant areas that medically underserved. The majority of psychiatrists train and practice in urban areas. Since 2008, the department of psychiatry at the University of Louisville has reached out to rural Community Mental Health Centers in the state to help meet the psychiatric needs of citizens living in such areas. The development of partnerships with community mental health centers has allowed the department to deliver psychiatric care to populations that would otherwise have limited access to mental health services. The presentation will cover the three main areas involved in the establishment of such programs: clinical, technical, and administrative. Leaders from each of these areas within both the University and he rural CMHC's will share insights and experiences gained in the course of this ongoing collaboration.

No.2

DOMESTIC VIOLENCE IN A SAMPLE OF EGYPTIAN FEMALE PSYCHIATRIC PATIENTS: A PILOT STUDY

Hani Hamed Dessoki, M.D., 2 Jeddah St Mohandessin, Giza, 12311 Egypt

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify different forms of violence among egyptian psychiatric patients; and 2) Know psychiatric disorders associated with violence.

SUMMARY:
Domestic violence is one of the most pervasive of all social problems, Domestic violence for women is violence perpetrated within relationships; this violence is much serious than violence perpetrated by a stranger. The hypothesis of this work is that domestic violence is a general health problem and not present particularly in psychiatric patients, the study aims at studying domestic violence in married female psychiatric patients. Sixty Egyptian married females were included, 20 of them had the I.C.D.-10 diagnosis of bipolar affective disorder, 20 neurotic disorders and 20 control group. All groups were clinically and psychometrically assessed using clinical psychiatric sheet of Kasr El-Aini hospital. Those who reported history of domestic violence were subjected to: Zung self rating depression scale, locus of control, Esyenck Personality Questionnaire (E.P.Q) and a specially designed questionnaire to assess intimacy/abuse, and wives' perception of husbands characters. The results reveal no statistically significant difference between the 3 groups concerning the domestic violence or the degree of abuse. A significant relation was found between domestic violence and history of child abuse. Battered women of patient group were more depressed than control group with no statistical significance, while neurotic patients were significantly more depressed (87%) than bipolar patients (50%) and control group (57.1%)($p<0.05$).. Significant higher scores were found in neurotic patients on EPQ neuroticism scale, in bipolar patients on the lie scale, and in the control group on psychoticism scale. No significant relation was found between domestic violence and intimacy among couples. Conclusion: Domestic violence occurring in female psychiatric patients is not higher than normal. In addition, despite abuse, Egyptian wives tend to see their husbands positively.

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No.3

UNEMPLOYMENT AND THE PSYCHIATRIC EMERGENCY SERVICE IN A COUNTY OF 800,000

Tracy Lo, M.A., 14445 Olive View Dr.,, Sylmar, CA 91342

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the epidemiology of a PES at time of economic downturn; and 2) Identify the sub-group of PES that may require extra resources.

SUMMARY:
Objective: Previous research has established some connections between the economy and mental health utilization. For example, researchers found an increased in incidence of involuntary admission to psychiatric emergency services (PES) in men during economic recession. The present study attempts to further explores the relationship between current economic downturn and PES admission, as these findings have important implications for patient care and policy making. Method: To evaluate the impact of economic recession, we compared admission data from the PES at the Ventura County Medical Center, California (VCMC; management information system) before and during a major increase in unemployment rate. The first quarter of 2008 and 2009 were chosen to present the two different time period, respectively. VCMC has the only psychiatric emergency room and inpatient facility in a county of 800,000 inhabitants. There were a total of 2145 psychiatric emergency evaluation during the first quarters of 2008 and 2009 (n = 1030 and n = 1115, respectively). The following demographic and clinical characteristics were obtained: gender, age, ethnicity, marital status, legal status, insurance status, number of previous admissions, and Axis I diagnoses. Results: The average unemployment rates during the first quarter of 2008 and 2009 were 5.7% and 9.3%, respectively. Results showed that admission figures were significantly different between the two periods in terms of past mental health utilization and clinical diagnosis. Patients who utilized the PES during the first quarter of 2009 were more likely to have no history of mental health utilization ($p = 0.049$; $df = 3.87$) than those who utilized in 2008. Furthermore, depression and other disorders (e.g., stress reaction, adjustment, cognitive, impulse control, anxiety, and abuse/dependence disorders) were more often diagnosed among those who presented at the PES in 2009 than 2008 ($p = 0.004$, $df = 8.21$). Conclusions: The findings showed the effects of unemployment on PES. Specifically, it revealed a population who have no past mental health utilization but utilized the PES for the first time during the period of economic stress. These findings have important implication on policy making and patient care e.g., how to provide mental health services and community support for these first timers during economic downturn.

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No.4

THE EFFECTIVENESS OF THE NAMI FAMILY TO FAMILY EDUCATION PROGRAM: A RANDOMIZED TRIAL

Lisa Dixon, M.D., 737 West Lombard St. 5th Floor, Baltimore, MD 21201

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the potential benefits of the NAMI Family to Family program for family members.

SUMMARY:

Aims: The purpose of the study was to evaluate the effectiveness of the National Alliance on Mental Illness Family to Family Education Program (FTF). This program is delivered by trained family-member teachers and is available free of charge throughout the country. We hypothesized that individuals randomized to take FTF immediately would show greater coping, less distress and subjective family burden, and better family functioning after FTF compared to individuals asked to delay taking the class but having access to all other NAMI or community supports over the same time period. Methods: Each family member expressing interest in FTF within the geographic area of five participating Maryland NAMI affiliates was directed to the state FTF coordinator. She evaluated each person's appropriateness for FTF, and then ascertained their interest in the study. If interested, they were referred to research staff and asked to provide informed consent. A total of 532 individuals were screened, of whom 1168 were eligible. Of these, 27% (N=318) consented to be in the study, were randomized, and completed the baseline assessment. Staff blinded to treatment condition performed assessments again three months later. Follow up rates exceeded 80% and did not vary by condition. To assess differences in coping, distress, burden and family functioning (measured with continuous variables) we used a General Linear Mixed Model (SAS Proc MIXED) to compare scores at the three month assessment controlling for baseline and FTF class. Participants had an average age of 51.9 (SD=10.9); 77% were women. A total of 61% were parents, 13% were siblings, 10% were spouse/partners, 8% were other, and 7% were adult children of the consumer. A total of 66% were Caucasian, 27% were African American, and 7% were of other races/ethnicities. Results: Individuals having received FTF showed significantly greater overall empowerment and empowerment within their family, the service system and their community. Individuals who received FTF also had greater knowledge of mental illness, higher ratings of constructive emotion focused coping, and lower ratings of anxiety than individuals in the control condition.

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SCIENTIFIC AND CLINICAL REPORT SESSION 14

STRESS

No.1

STRESS IS VISIBLE: OBJECTIVE ASSESSMENT OF STRESS BASED ON MULTIPLE CYTOKINES IN PLASMA

Sekiyama Atsuo , M.D., Ph.D., Tsukinowacho, Seta, Shiga, 564-0063 Japan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how closely related a profile of plasma cytokines levels and mental and/or physical stress; and 2) At the same time, the participant shall be impressed by the fact that stress can be objectively assessed by plasma cytokines.

SUMMARY:

Background; Stress is major causative factor for psychiatric diseases, though there have been no biological means for objective assessment. Responses of hormones and monoamines after stress have been investigated, however, responses of cytokines and chemokines to stress have not. Method; 25-40 years old, 80 men and 80 women which were physically and psychologically healthy were loaded with Kraepelin's test and Tread Mill for three hours. Blood were overtaken every hour, plasma levels of cytokines and chemokines were determined, and whether plasma cytokines levels reflect context and severity of stressor was examined by multiple logistic regression analysis. Results; Participants loaded with Kraepelin Test or Tread Mill were serologically segregated with accuracy of 100%. Accuracy (mean of sensitivity and specificity) for segregation between before and after load was elevated according to duration of loads and decreased by rest. 8 to 10 cytokines and chemokines selected, were enough to maximize the effect. Conclusion; Kraepelin test and Tread Mill induces distinct levels of cytokines in plasma. It is revealed that responses of plasma cytokines and chemokines after stress do not follow the paradigm of classical stress response, a general adaptation syndrome, thus stress responses may be segregated and, further, categorized serologically basing on cytokines. Determination of host defense mediators in plasma may serve objective means

for detection of high risk group for stress-related psychiatric disorders and indicators for stress coping.

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No.2

STRESS IS VISIBLE; OBJECTIVE ASSESSMENT OF STRESS BASED ON MULTIPLE CYTOKINES IN PLASMA

Sekiyama Atsuo , M.D., Ph.D., Tsukinowacho, Seta, Shiga, 564-0063 Japan

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand how closely related a profile of plasma cytokines levels and mental and/or physical stress; and 2) At the same time, the participant shall be impressed by the fact that stress can be objectively assessed by plasma cytokines.

SUMMARY:

Background; Stress is major causative factor for psychiatric diseases, though there have been no biological means for objective assessment. Responses of hormones and monoamines after stress have been investigated, however, responses of cytokines and chemokines to stress have not. Method; 25-40 years old, 80 men and 80 women which were physically and psychologically healthy were loaded with Kraepelin's test and Tread Mill for three hours. Blood were overtaken every hour, plasma levels of cytokines and chemokines were determined, and whether plasma cytokines levels reflect context and severity of stressor was examined by multiple logistic regression analysis. Results; Participants loaded with Kraepelin Test or Tread Mill were serologically segregated with accuracy of 100%. Accuracy (mean of sensitivity and specificity) for segregation between before and after load was elevated according to duration of loads and decreased by rest. 8 to 10 cytokines and chemokines selected, were enough to maximize the effect. Conclusion; Kraepelin test and Tread Mill induces distinct levels of cytokines in plasma. It is revealed that responses of plasma cytokines and chemokines after stress do not follow the paradigm of classical stress response, a general adaptation syndrome, thus stress responses may be segregated and, further, categorized serologically basing on cytokines. Determination of host defense mediators in plasma may serve objective means for detection of high risk group for stress-related psychiatric disorders and indicators for stress coping.

REFERENCES:

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No.3

SLEEP DISRUPTION AMONG RETURNING COMBAT VETERANS FROM IRAQ AND AFGHANISTAN

Vincent Capaldi, M.D., M.S., 7007 Oak Grove Way, Elkridge, MD 21075

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of sleep disorders in combat veterans; 2) Analyze the association between sleep disordered breathing and PTSD, TBI and other psychiatric conditions; and 3) Identify opportunities for additional research to

better elucidate the relationship between stress, sleep and psychiatric conditions.

SUMMARY:
Background: Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) are common injuries among returning combat veterans from the wars in Iraq and Afghanistan. While these combat injuries have been associated with increased sleep disruption, little is known about the nature and specificity of sleep problems within these common injury categories. Method: A retrospective chart review of 69 consecutive referrals to the Walter Reed Army Medical Center (WRAMC) sleep clinic was conducted. All cases were active duty soldiers who had recently returned from combat deployment in Iraq or Afghanistan. Data from polysomnographically (PSG) recorded sleep stages, sleepiness scales, and documented medical diagnoses were extracted from medical records. Sleep data were compared across diagnoses of PTSD, TBI, and other clinical conditions. Results: Although clinical sleep disturbances, including rates of OSA, excessive awakenings, daytime sleepiness, and hypoxia, were high for the sample as a whole, no differences across diagnostic groups were found. Differences were observed, however, on PSG measures of sleep quality, suggesting more frequent arousals from sleep among patients with PTSD and greater slow wave sleep among those with TBI. Except for REM latency, medication status had virtually no effect on sleep variables. Conclusions: Among recently redeployed combat veterans, clinically significant sleep disturbances and problems with sleep disordered breathing are common but non-specific findings across primary diagnoses of PTSD, TBI, major depression, and anxiety disorder, whereas more subtle differences in sleep architecture and arousals as measured by overnight PSG recordings were modestly but significantly effective at distinguishing among the diagnostic groups.

SUNDAY, MAY 15, 2011
9:00 AM - 10:30AM

SCIENTIFIC AND CLINICAL REPORT SESSION 15

TREATMENT TECHNIQUES & OUTCOME STUDIES

No.1
IMPROVING EMPATHY IN PSYCHOTHERAPY: A RANDOMIZED PROOF-OF-CONCEPT STUDY

Bhaskar Sripada, M.D., 1747 W. Roosevelt Rd., Room 155, Chicago, IL 60608

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate and be able to use patient and therapist ratings on the Global Assessment of Functioning to improve empathic understanding in individual psychotherapy.

SUMMARY:
Objectives. To develop and evaluate a feedback method for improving empathic accuracy of the therapist and reducing empathic bias in the psychotherapist and his or her patient. Design. Randomized controlled trial conducted in a university-affiliated out-patient psychiatric clinic. Methods. Sixteen non-psychotic patients being treated for Axis I disorders by 12 psychiatry residents were randomly assigned to intervention and control conditions. In both conditions, at the end of each session, patients rated their own functioning on the Global Assessment of Functioning scale, and therapists predicted patients' ratings. Patients predicted their therapist's accuracy and therapists rated their confidence in their own predictions. In the intervention condition, therapists and patients reviewed their respective ratings from the previous session together. In the control condition, ratings were given directly to the investigator without being reviewed by either patients or therapists. Results. Therapists in the intervention condition showed greater overall accuracy than controls. Compared to intervention patients, those in the control group were more likely to either over-estimate (i.e., over-idealize) or under-estimate (i.e., under-idealize) their therapists' empathic accuracy. Therapists in the control group were more likely than those in the intervention group to have a biased estimate of their own accuracy (i.e., overconfidence). The instrument was well-tolerated by both intervention and control patients and therapists. Conclusion. An intervention such as the one tested in this study may be a practical and useful method for improving accuracy of understanding in a variety of training andclinical settings.

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ing empathic accuracy in psychotherapy. Psychology and Psychotherapy: Theory, Research and Practice. DOI:10.1348/147608310X495110

No.2

SWITCHING TO ARIPIPRAZOLE AS A STRATEGY FOR WEIGHT REDUCTION: A META-ANALYSIS IN PATIENTS SUFFERING FROM SCHIZOPHRENIA

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: 1) Identify patients suffering from schizophrenia in need of weight reduction; 2) Analyze the available strategies to achieve weight reduction in patients; 3) To consider switching to an antipsychotic better suited for patients suffering from obesity; and 4) To evaluate the outcome of these clinical strategies for weight reduction.

SUMMARY:

Background: Weight gain is one of the major drawbacks associated with the pharmacological treatment of schizophrenia. Existing strategies for the prevention and treatment of obesity amongst these patients are disappointing. Switching current antipsychotic to another that may favorably affect weight is not yet fully established in the psychiatric literature. Aim: This meta-analysis focused on switching to aripiprazole as it has a pharmacological and clinical profile that may result in improved weight. Methods: Mean change from baseline was the primary efficacy outcome measure in the present analysis. Studies were included only if mean change in weight was reported as well as the following variables: a) design: industry support, sample size, previous antipsychotic treatment, aripiprazole dose and treatment duration. b) demographic: age, gender and diagnosis. Results: Literature search yielded 47 articles of which 9 manuscripts fulfilled the inclusion criteria for the present metaanalysis. These studies spanned the period 2003 to 2010. Taken alltogether the cumulative sample size included 784 schizophrenia and schizoaffective patients from seven countries worldwide. There were 473 (60%) men and 311 (40%) women, mean age 39.4 + 7.0 years. The major significant findings of the present analysis were: (i)mean weight reduction by -2.55 + 1.5 kgs 95%CI: -3.7 to -1.4 (range: -1.2 to -5.3) following switch to aripiprazole $p<0.001$; (ii) mean weight reduction was statistically greater for patients diagnosed as suffering from schizophrenia (- 2.67 kgs) when compared to mean reduction in patients suffering from schizoaffective disorder (- 2.18 kgs), $p< 0.022$; (iii) the most significant weight reduction was noted in patients who were exposed to olanzapine prior to switching treatment to aripiprazole, $p<0.001$. Duration of aripiprazole treatment was negatively correlated with weight change not reaching statistical significance ($R2 = - 0.48$, $p = 0.085$). Conclusions: Switching to an antipsychotic with a lower propensity to induce weight gain need be explored as a strategy. Our analysis suggests that aripiprazole is a candidate for such a treatment strategy.

REFERENCES:

1) Barak Y, Aizenberg D. "Switching to Aripiprazole as a strategy for weight reduction: a meta-analysis in patients suffering from schizophrenia." J Obesity, 2010; Nov, (In Press).

No.3

CBT FOR DEPRESSED INPATIENTS: THE RELATIONSHIP BETWEEN TREATMENT ALLIANCE AND GROUP PARTICIPATION

Katherine Lynch, Ph.D., 21 Bloomingdale Road, White Plains, NY 10605

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the potential benefits of group CBT programming for depressed inpatients as a complement to medication and the therapeutic milieu; 2) Understand the relationship between treatment alliance, motivation, and group psychotherapy participation to patient outcomes; and 3) Recognize the relative impact of early participation in inpatient treatment to outcome at discharge.

SUMMARY:

Objective: As a time-limited, present-focused, and structured treatment, Cognitive Behavior Therapy (CBT) is ideally suited for adaptation to the inpatient unit. However, the successful provision of group-oriented CBT with the varied patient population typically present in the hospital requires a sensitivity to and awareness of many factors, including motivation for treatment and alliance

with the treatment team. This research will attempt to determine the impact of motivation and alliance on patients' time to participation in treatment and intensity of use of treatment. This study will also examine whether intensity of use of treatment, both in the early phase of hospitalization and over the entire hospitalization, predicts depression outcomes. Method: Participants are women ages 18-65 hospitalized on an acute stabilization unit at a large, metropolitan hospital, diagnosed with depressive disorders. They will complete a battery of self-report measures at admission and discharge, as well as after attending their first two CBT groups. A clinician-rated measure of depression is also completed at admission and discharge. Results: Regression analyses will be used to examine the relation of time to participation, level of participation in CBT groups, and patient motivation to outcomes. Multivariate repeated measures analysis of variance will be used to assess change in patient alliance with the treatment team and relationship with outcomes. Conclusions: Given the collaborative nature of CBT and the frequency and intensity of interactions between patient and treatment team during hospitalization, further understanding of factors promoting efficient, effective programming are needed. This study will help inform inpatient psychiatrists about the impact of treatment alliance and patient motivation in an inpatient CBT program, serving to guide programs' investment in resources that maximize the hospitalization experience, promoting patient engagement and positive outcomes.

REFERENCES:

1) Martin DJ, Garske JP, Davis K: Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. J Consult Clin Psychol 2000; 68:438-450.2) Wright JH, Thase ME, Beck AT, Ludgate JW: Cognitive Therapy with Inpatients: Developing a Cognitive Milieu. New York, Guilford Press, 1993.

SCIENTIFIC AND CLINICAL REPORT SESSION 16

VIOLENCE, TRAUMA AND VICTIMIZATION

No.1

VICARIOUS TRAUMA IN MENTAL HEALTH PROFESSIONALS FOLLOWING 9/11: THE IMPACT OF WORKING WITH TRAUMA VICTIMS

Gertie Quitangon, M.D., 423 East 23rd St., New York, NY 10023

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the factors that predict vicarious trauma in mental health professionals; 2) Describe the impact of providing assistance to victims of the 9/11 terrorist attacks on mental health professionals; and 3) evaluate the existing literature on vicarious trauma in mental health professionals who provided assistance to 9/11 victims.

SUMMARY:
Introduction: Studies show that search and rescue personnel, firefighters, and other first responders are at increased risk for posttraumatic stress disorder (PTSD); however the impact of providing psychotherapy to victims of such large-scale events as the 9/11 terrorist attack on mental health professionals has been less widely studied. Objectives: This study sought to 1) evaluate the impact of treating victims of the 9/11 terrorist attacks on a group of mental health professionals; 2) identify factors that predict vicarious trauma in mental health professionals; and 3) provide recommendations for improving mental health outcomes of those providing therapy to victims of trauma. Methods: In 2002, 35 mental health professionals who provided services to a number of New York City residents affected by the 9/11 terrorist attacks were surveyed one year following 9/11. A literature review was conducted 8 years later to determine: 1) if similar studies had been conducted since the event; and 2) whether these studies reported similar results. The results of our initial study were compared and contrasted with the results of studies identified in the literature review. Results: In our initial study, previous trauma was significantly associated with symptoms of psychological distress following 9/11 (67% of those with past trauma reported experiencing symptoms following 9/11, compared to 35% of those with no previous trauma). Mental health professionals endorsing depressive symptoms prior to 9/11 were significantly more likely to have elevated intrusion scores on the IES-r following 9/11 than those who did not report pre 9/11 depressive symptoms (chi-square = 3.85; p=0.014). Similar results had been reported by a number of researchers, including

Boscarino et al (2009), Pulido (2007), and Perrin et al (2007). Conclusions: On the eve of the 10-year anniversary of the 9/11 attacks, results of this current study give ample support to vicarious trauma among health care providers, and based on the breadth of related studies, a meta-analysis would appear feasible. Vicarious trauma does occur in certain mental health providers who provide treatment to victims of mass traumatic events; in particular, past trauma was a strong predictor of psychological distress among mental health professionals who treated 9/11 trauma victims.

No.2

POSTTRAUMATIC STRESS DISORDER AMONG AMERICAN INDIAN VETERANS: IS IT MORE COMORBID WITH EXTERNALIZING OR INTERNALIZING DISORDER?

Joseph Westermeyer, M.D., Ph.D., 1 Veterans Dr, Minneapolis, MN 55417

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify common disorders that are comorbid with Posttraumatic Stress Disorders (PTSD) among American Indian veterans; 2) Analyze PTSD in regard to whether is more associated with internalizing or externalizing disorders; and 3) diagnose disorders comorbid with PTSD.

SUMMARY:
Goal was to assess the comorbidity associated with Posttraumatic Stress Disorder (PTSD) among American Indian veterans, including both internalizing disorders and externalizing disorders. Sample included 557 American Indian veterans in a community sample, with targeted sampling designed to provide a representative sample, structured to include equal numbers of rural and urban veterans and a two-fold over sample of women. Data collection involved lifetime diagnoses based on the Diagnostic Interview Schedule/Quick Version/ *DSM-III-R*, demographic characteristics, and combat exposure. Findings. Bivariate comparisons showed relationships of PTSD with Mood, Anxiety, and Substance Use Disorders, but not Antisocial Personality Disorder or Pathological Gambling. Regression analyses showed an independent association of PTSD with both internalizing disorders (Mood and Anxiety Disorders) but not with both externalizing disorders" (Substance Use Disorder and Pathological Gambling). Conclusion is that comorbid externalizing disorders can accompany PTSD, but do not predict lifetime PTSD when analyzed with other factors. On the contrary, comorbid internalizing disorders both accompany and predict lifetime PTSD.

REFERENCES:

1) Brinker M, Westermeyer J, Thuras P, Canive J. Severity of combat-related PTSD versus non-combat-related PTSD: A community-based study in American Indian and Hispanic veterans. Journal Nervous Mental Disease. 2007;185(8):655-61.

No.3

SUCCESSFUL REDUCTION OF SECLUSION USE AND VIOLENCE ON PSYCHIATRIC UNITS

Shane Konrad, M.D., 55 North 1st. St., Brooklyn, NY 11211

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify how their specific treatment setting may benefit from utilizing a brief screening interview to identify patients at increased risk for violence; and 2) Train staff to utilize graded sequential interventions, from least to most restrictive, to decrease violence and the overall need for seclusion use.

SUMMARY:
Objectives: Management of violent patients is a growing safety concern for inpatient psychiatric settings. Current literature emphasizes importance of early identification of violence risk factors, and increased staff-to-patient ratio to reduce violence and use of seclusion. However, there is a lack of information detailing an efficient and reliable method of identifying which patients may become violent, and detailing specific behavioral interventions that can be utilized to reach these goals. Our objectives were to make system changes to easily identify the potential for violence, and train staff to use interventions that were less restrictive than seclusion. Methods: Data was collected from 229 consecutive admissions in 2002, and 175 consecutive admissions in 2008. These were admissions to a community psychiatry unit that

cares for acutely ill patients. A nurse administered an 11-item questionnaire upon admission. A physician re-administered the same screening interview within 24-48 hours of admission. The screening interview alerted nurses to the need for early increased observation status for patients identified as potentially violent. Nurses were trained to use graded sequential interventions in an attempt to avoid violence on the unit and the use of seclusion. When seclusion was used, patient demographics, case- mix severity, and outcomes were recorded. Results: 22 patients were responsible for 68 acts of violence. All were identified by the screening interview. No gender or age differences were noted between aggressive and non-aggressive patients. There were significant differences between groups for illness complexity, length of stay, and cost of hospitalization. The use of seclusion, average length of stay, and overall cost of inpatient care decreased after one calendar year. Kappa scores demonstrated good inter-rater reliability between nursing staff and physicians. Conclusions: It is possible to utilize a brief screening interview to identify patients who are at increased risk for violence. There was good inter-rater reliability in this screening interview. Training staff to utilize graded sequential interventions, from least to most restrictive, decreases overall need for seclusion use. These strategies reduced length-of-stay and overall cost of inpatient psychiatric care, despite increased use of close observation as an alternative. Further work lies in identifying those questions with the greatest specificity for violence.

REFERENCES:

1) Fisher WA: Restraint and Seclusion: A Review of the Literature. Am J Psychiatry 151: 1584-91, 1994

2) Owen C, Tarantello C, Jones M: Repetitively Violent Patients in Psychiatric Units. Psychiatric Services 49: 1458-61, 1998

SUNDAY, MAY 15, 2011
NOON - 1:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 17-
NEUROPSYCHIATRY AND GENETICS

No.1
DYSLIPIDEMIA IN PSYCHTROPIC-TREATED PATIENTS CORRELATES WITH COMBINATORIAL CYP450 DRUG METABOLISM INDICES

Gualberto Ruano, M.D., Ph.D., Genomas, Inc., 67 Jefferson Street Hartford, CT 06106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the prevalence and significance of CYP450 drug metabolism deficiencies; 2) Assess the utility of CYP450 combinatorial drug metabolism indices in characterizing and individual's metabolic phenotype; and 3) utilize combinatorial index values to improve psychotropic management.

SUMMARY:
Objective: To examine the combinatorial effect of polymorphisms in the cytochrome P450 genes CYP2C9, CYP2C19, and CYP2D6 on HDL and LDL 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 with antidepressants and antipsychotics. Their DNA was genotyped to detect CYP2C9, CYP2C19, and CYP2D6 polymorphisms. We analyzed lipid values for a correlation with four quantitative drug metabolism indices measuring innate hepatic drug metabolism reserve and gene polymorphism: the drug metabolism reserve index, drug metabolism alteration index, allele alteration index and gene alteration index. An individual with low metabolic reserve carries multiple deficient or null alleles, whereas a high metabolic reserve denotes the presence of mainly reference and/or ultra-rapid alleles. Greater alteration index values signify greater presence of non-reference alleles. Results: After correcting for covariates, we found that individuals with lower metabolic reserve had higher LDL (p=0.02). Individuals with greater metabolic alteration, allele alteration and gene alteration also had higher LDL values (p=0.008, 0.046, 0.002, respectively). Patients with more gene alterations had significantly lower HDL (p=0.018). Finally, LDL/HDL values varied directly with alteration index values and inversely with metabolic reserve index values (p=0.012, 0.038, 0.099, 0.008 for metabolic reserve, metabolic alteration, allele alteration, and gene alteration, respectively). No individual gene alone was correlated with dyslipidemia. Conclusions: Psychiatric inpatients treated for MDD with low innate metabolic

capacity and a higher degree of allele and gene alterations have greater LDL and lower HDL values. Dyslipidemia is a side effect of psychotropic medications which may be exacerbated in patients with low metabolic reserve and therefore high drug plasma concentrations. The results suggest that benchmarking innate drug metabolism capacity through combinatorial CYP450 genotyping is relevant to psychotropic management and superior to single gene testing for predicting and avoiding adverse side effects.

REFERENCES:

1) Blank K, Szarek BL, Goethe JW. Metabolic abnormalities in adult and geriatric major depression with and without comorbid dementia. J Clin Hypertens (Greenwich). 2010 June; 12 (6): 456-61.

2) Goethe JW, Szarek BL, Caley CF, Woolley SB. Signs and symptoms associated with the metabolic syndrome in psychiatric inpatients receiving antipsychotics: a retrospective chart review. J Clin Psychiatry. 2007 Jan;68(1):22-8.

No.2

AGE AT ONSET OF PSYCHIATRIC DISORDERS IN FRAGILE X MENTAL RETARDATION (FMR1) ADULT PREMUTATION CARRIERS

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) Identify the most common neuropsychiatric disorders in FMR1 gene adult premutation carriers; 2) Understand differences in ages at onset of psychiatric disorders in FMR1 premutation carriers vs. general population; and 3) Analyze the burden of psychiatric illness in FMR1 premutation carriers.

SUMMARY:
Adult premutation carriers of the fragile X mental retardation (FMR1) gene are afflicted with several psychiatric disorders, including mood, anxiety, substance abuse, somatoform, and eating disorders. Both men and women may develop the neurodegenerative disorder, fragile X-associated tremor ataxia syndrome (FXTAS). In addition, older men (more often than women) may develop dementia. We will review lifetime prevalence and investigate ages at onset of psychiatric disorders in this population, based on the Structured Clinical Interview for *DSM-IV TR* performed on 175 premutation carriers. We have demonstrated that lifetime prevalence of mood and anxiety disorders is higher in the premutation carriers versus the general population (Bourgeois et al., 2010). We studied ages of onset of major depressive disorder and anxiety disorders in premutation carriers, compared to the general population.

REFERENCES:

1) Bourgeois J.A., Seritan A.L., Casillas E.M., Hessl D., Schneider A., Yang Y., Kaur I., Cogswell J., Nguyen D.V., Hagerman R.J. Lifetime prevalence of mood and anxiety disorders in fragile X premutation carriers. J Clin Psychiatry 2010; Aug 24 [Epub ahead of print]

No.3

USING PHARMACOGENOMIC TESTING IN CLINICAL PRACTICE

Amita Patel, M.D., 1435 Haven Hill Drive, Dayton, OH 45459

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Discuss the pharmacogenomic basis of the test; 2) discuss uses of pharmmacogenomic testing in clinical practice; and 3) Understand the results of the clinical trial done in her practice to look at its validity and reliability.

SUMMARY:
Pharmacogenomics (PGX) is the study of how a patient's individual DNA affects their response to medication. Individual variation in response to psychiatric medication is substantively influenced by genetic factors. Pharmacokinetic factors, particularly variants in the cytochrome P450 (CYP450) genes, have been examined in the context of psychotropic medications1. These and other genes code for the proteins responsible for the metabolism of antipsychotics and antidepressants. Variation in these genes may produce enzymes with increased activity, normal activity, reduced activity, or no activity. This variation likely affects medications that use these particular enzymes in their metabolic pathways. The variation in the P450 system has led to a classification system for medication metabolism: Ultra-Rapid, Extensive (normal), Intermediate,

or Poor. Application of pharmacogenomics into clinical practice provides clinicians with guidance for the personalization of medication choices for individual patients. Human CYP450 enzyme families most important in drug metabolism are CYP1, CYP2, and CYP3A4. Cyp3A4 is responsible for the metabolism of more than half of clinically useful drugs followed by CYP2D6 (20%), CYP2C9 (15%), and CYP2C19 (5%)1. Each psychiatric medication is metabolized by its own cadre of CYP enzymes. Overlaying individual patient CYP heterogeneity with the variation in metabolic pathways for each psychiatric medication is a vexing problem for practicing psychiatrists. For example, paroxetine is almost exclusively metabolized by CYP2D6, whereas CYP2D6 has very little influence on the metabolism of fluvoxamine (where CYP1A2 has a more prominent role)2. Translating the information from specific genetic markers to providing improvement in psychiatric care presents several challenges. Translating the information from specific genetic markers to providing improvement in psychiatric care presents several challenges. One of the greatest challenges is educating practicing physicians about utilizing pharmacogenomics in a rational and appropriate way. To this end, the Mayo Clinic's Genomic Expression and Neuropsychiatric Evaluation group has developed a PGx-based depression treatment algorithm that incorporates published PGx information related to antidepressant effectiveness and safety. This algorithm has been incorporated into a new genotype interpretative report and is now available through AssureRx.

REFERENCES:

1) Kirchheiner J, Nickchen K, Bauer M, Wong ML, Licinio J, Roots I, Brockmöller J. Pharmacogenetics of antidepressants and antipsychotics: the contribution of allelic variations to the phenotype of drug response. Mol Psychiatry. 2004 May;9(5):442-73

No.4

ENVIRONMENT AFFECTS GENES THROUGH MEMES

Hoyle Leigh, M.D., 155 N. Fresno St., Fresno, CA 93701

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the mechanisms of epigenesis; 2) explain the role of memes in epigenesis; and 3) Identify the means of enhancing salutary memes that may buffer the noxious effects of stress.

SUMMARY:

Objective: To answer the question, "How does social environment actually affect genes encoded in DNA?" Method: Genes are known to be modified, and thus, phenotype altered, by such experiences as abuse or nurturance especially in early development. For example, the phenotypic stress-responsiveness of the serotonin transporter promoter gene (5HTTLPR) short allele may be reversed by good nurturance in monkeys. Exactly how such early experience affects genes, however, has not been elucidated. Results: Genes are turned on or off through methylation, changes in histone code, and other mechanisms within the microenvironment of the cell nucleus. Such microenvironmental changes are brought about by hormonal and neurotransmitter secretion controlled by the central nervous system, which, in turn, is affected by memes. Memes are information encoded as reinforced neural connections of clusters of neurons. Memes are based on memory, but are also replicated and may be communicated to other brains. Memes also reside in cultural environment. Perception of external stimulus such as abuse and nurturance is processed in the light of existing memes in the brain, resulting in specific activation or non-activation of specific pathways such as fight/flight, relaxation, etc. The mechanism by which perception of the environment, be it traumatic or nurturing, affects the microenvironment of cells is through memes. Memes, being specific neural connections, affect specific neural activation resulting in specific hormonal and neurotransmitter secretion causing epigenesis. Conclusions: Environment does not affect genes directly but it may alter genes through the mediation of memes. Pathogenic memes in the social environment may infect brains and predispose them to illness. By boosting salutary memes, the noxious effects of environmental stress may be prevented.

REFERENCES:

1) Leigh, H: Genes, Memes, Culture, and Mental Illness:Toward an Integrative Model, Springer, New York, 2010

SCIENTIFIC AND CLINICAL REPORT SESSION 18

WOMEN AND GENDER ISSUES

No.1

THE PSYCHOLOGICAL IMPACT OF A CANCER DIAGNOSED DURING PREGNANCY: DETERMINANTS OF LONG-TERM DISTRESS

Melissa Henry, Ph.D., 3755 Cote-Ste-Catherine Rd, Pavilion E, room E-904, Montreal, H3T 1E2 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the impact of a cancer diagnosed during pregnancy; and 2) Identify early predictors of long-term psychological distress in these women.

SUMMARY:
Cancer occurs during one in 1,000 to 5,000 of the approximately 6 million yearly US pregnancies identified by the American Pregnancy Association. Although a newly diagnosed cancer is associated with substantial distress, little is known and no studies have been conducted concerning cancer's emotional impact on women when diagnosed during pregnancy. The Cancer and Pregnancy Registry was developed by Dr Cardonick to examine the consequences of maternal cancer diagnosis and treatment during pregnancy on maternal, foetal and neonatal outcomes, including after in-utero exposure to chemotherapy. Participants were asked to complete questionnaires, including measures to ascertain levels of psychological distress, with the goal of examining predictors of long-term psychological distress. Predictors of distress included information on: sociodemographics, disease, pregnancy, birth and cancer treatment. Multiple regression analyses revealed that women were at higher risk of long-term distress on the IES if they: did not receive fertility assistance,[b= 12.4,ß=.27,p=0.02], had been advised to terminate the pregnancy(trend),[b=7.7,ß=.20,p=0.08], did not produce sufficient milk to breastfeed,[b=9.0 ,ß=.25,p=0.03], experienced a recurrence(trend), [b=8.6,ß=.21,p=0.06], and underwent surgery po st-pregnancy,[b=11.4,ß=.34,p=0.003;r2adj=.24]. Women scored higher on the BSI-18 if they: had a caesarean delivery,[b=5.9,ß=.27,p=0.02], did not produce sufficient milk to breastfeed,[b=7.0,ß=. 28,p=0.02], currently experienced a recurrence, [b=7.1,ß=.35,p=0.004], and underwent surgery post-pregnancy(trend),[b=4.7,ß=.20,p=0.08; r2adj=.20]. In conclusion, some women may be at particular risk of experiencing high levels of distress when diagnosed with cancer during pregnancy. Physicians can pay particular attention to early markers of distress suggesting a need for referral to psychological supports, which may in turn help improve long-term quality of life for these women and their children.

REFERENCES:

1) Cancer and Pregnancy Registry. www.cancerandpregnancy.com
2) Cardonick E, Dougherty R, Grana G, Gilmandyar D, Ghaffar S, Usmani A. Breast cancer during pregnancy: maternal and fetal outcomes. Cancer Journal 2010; 16(1):76-82.
3) Cardonick E, Iacobucci A. Use of chemotherapy during human pregnancy. Lancet Oncology 2004; 5(5):283-291.
4) Cardonick E, Usmani A, Ghaffar S. Perinatal outcomes of a pregnancy complicated by cancer, including neonatal follow-up after in utero exposure to chemotherapy: results of an international registry. American Journal of Clinical Oncology 2010; 33(3):221-8.

No.2

ANTIDEPRESSANT THERAPY RELATED TO COMBINED HORMONAL AND PROGESTIN-ONLY CONTRACEPTIVES: A NATIONWIDE POPULATION-BASED STUDY

Malou Lindberg, Ph.D., R&D Unit in Local Health Care, Linköping, 58185 Sweden

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be: 1) Aware of that special attention should be given to young women's mental history when prescribing hormonal contraceptives and vice versa: the contraceptive history should be taken into account when prescribing antidepressants.

SUMMARY:
Objectives: To elucidate the association between the use of antidepressant therapy and hormonal contraceptives by stratifying combined hormonal contraceptives and progestin-only drugs into different hormonal formulations. Methods: In a nationwide cross-sectional study among all women in Sweden aged 16-31, three-year drug expenditure data on antidepressants and hormonal contraceptives (combined hormone contraceptives (CHCs) as well as progestin-only contraceptives) were obtained from the Swedish Prescribed Drug Register. Odds ratios (ORs) for being an antidepressant user were calculated by logistic regression for hormonal contraceptive users versus non-users. ORs were presented for each hormonal formulation in the

age groups 16-19, 20-23, 24-27 and 28-31 years. Results: The overall progestin-only group had higher OR than the overall CHC group. OR was consequently highest in the youngest age group compared to the older groups in all hormonal formulations, although in varying magnitude. Of seven hormonal formulations in the CHC grouping, OR for Norelgestronim, Lynestrenol and Drospirenone was above 1 in the ages 20 years and older. Among the six progestin-only formulations the corresponding results, i.e. OR above 1, were for Medroxiprogesteron, Etonogestrel and Levonorgetsrel. Conclusion: Our results show that some hormonal formulations have a stronger association to antidepressant therapy. To verify and strengthen these results, prospectively designed studies are needed.

No.3
GENDER, IMPULSIVITY AND SEROTONIN

Donatella Marazziti, M.D., Dipartimento di psichiatria, Neurobiologia, Farmacologia e Biotecnologie, Univerrsity of Pisa, Pisa, 56100 Italy

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Analyze better the impulsivity traits; 2) Have a deeper knowledge on how the serotonin system may modulate it; and 3) Identify promptly the impact of gender on both.

SUMMARY:
The present study explored the possible relationships between impulsivity, gender and a peripheral serotonergic marker, the platelet serotonin (5-HT) transporter (SERT), in a group of 32 healthy subjects. The impulsivity was measured by means of the Barratt Impulsivity Scale, version 11 (BIS-11), a widely used self-report questionnaire, and the platelet SERT was evaluated by means of the specific binding of 3H-paroxetine (3H-Par) to platelet membranes, according to standardized protocols. The results showed that women had a higher BIS-11 total score than men, and also higher scores of two factors of the same scale: the motor impulsivity and the cognitive complexity. The analysis of the correlations revealed that the density of the SERT proteins, as measured by the maximum binding capacity (Bmax) of 3H-Par, was significantly and positively related to the cognitive complexity factor, but only in men. Men showed also a significant and negative correlation with the dissociation constant, Kd, of (3H-Par) binding, and the motor impulsivity factor. These findings suggest that women are generally more impulsive than men, but that the 5-HT system is more involved in the impulsivity of men than in that of women.

REFERENCES:
1) Arango V, Underwood MD, Boldrini M, et al. Serotonin 1A receptors, serotonin transporter binding and serotonin transporter mRNA expression in the brainstem of depressed suicide victims. Neuropsychopharmacology. 2001;25(6):892-903.

MONDAY, MAY 16, 2011
7:00 AM - 8:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 19-
HISTORICAL AND RESEARCH ISSUES

No.1
THE PARTICIPATION OF GERMAN PHYSICIANS IN THE SO CALLED "EUTHANASIA PROGRAM" DURING THE THIRD REICH: MOTIVATIONS, VERDICTS, AND SENTENCES

Robert McKelvey, M.D., 4306 SE Elsewhere Lane, Milwaukie, OR 97222

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify factors contributing to the participation of German physicians in the "Euthanasia Program"; 2) Understand how the program was organized, carried out, and modified over time; 3) Recognize the variability of the judicial verdicts and sentences given to participants depending on how long after the war and in what social and political context the trials were held; and 4) Analyze the present-day relevance of the trials.

SUMMARY:
During the Third Reich, Hitler issued a secret decree ordering that the "incurably mentally ill" should be killed. This decree authorized the appointment of a group of physicians, some prominent psychiatrists, to select physicians to participate in the identification of mentally-ill persons whose lives were "no longer worth living" so that they could be put to death by "mercy killing." In reality, this so-called "Euthanasia Program" was an outgrowth of the Nazis' philosophy of racial purification that sought to eliminate those

individuals who consumed resources that might be better allocated to productive members of society. Prominent among the over 200,000 German victims of this policy were disabled children and mentally-ill adults who were gathered together in designated mental hospitals and put to death by starvation, gassing, and overdoses of medication. After the war, as part of the "de-Nazification process," German courts in both East and West Germany were given the responsibility to try and sentence the participants in these mass murders. The trials began in 1946 and continued until 1988. As time passed, the verdicts and punishments meted out by the courts became increasingly mild as German society, recovering from and wishing to distance itself from the war, began to see in the trials a form of "victors' justice." The objective of this report is to review the verdicts and sentences handed down by German courts to German physician-participants in the "Euthanasia Program." Specifically, I would like to: identify the backgrounds and motivations of the physician participants; their postwar medical careers; their attempts at trial to justify their actions; and the evolution of the courts' decisions over both time and the differential political contexts of East and West Germany. This review will shed light on the cultural, historical, institutional, political, psychological, and social factors that influenced German physicians to deviate so grotesquely from the ancient tradition of their field to "do no harm." Such a review is timely given the present-day participation of US physicians and psychologists in the interrogation of suspected terrorists, and in recent allegations of physician endangerment of patients in research studies that employed tainted compounds.

REFERENCES:

1) DeMildt, D (ed.): Tatkomplexe: NS-Euthanasie: Die ost- und westdeutschen Strafurteile seit 1945. Amsterdam University Press, Amsterdam, 2009.

No.2

DREAMING WITH JUNG: CARL JUNG'S RED BOOK, AND CRITICAL IMPLICATIONS FOR PSYCHIATRIC PRACTICE 90 YEARS LATER

Scott Simpson, M.D., M.P.H., 1959 NE Pacific St, Box 356560, Seattle, WA 98121

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the narrative and illustrative content of Carl Jung's Red book in its historical context; 2) Understand basic principles of Jungian psychology and their relevance to modern psychiatric practice; and 3) Interpret the origins of Jungian theory through the stories of the Red Book.

SUMMARY:

The recent publication of Swiss psychiatrist Carl Jung's (1875-1961) Red Book has renewed interest in his psychological theories and their role in modern psychiatry. The richly narrated and illustrated Red Book -- whose production Jung called the "most important time of my life" founding all his later "scientific elaboration" -- records Jung's dreams and visions while recalling cultural and scientific movements of the 1910s and 20s. Several authors have described the Red Book's content (Shamdasani 2009, Harris 2010) but have not interpreted the stories themselves as origins of ultimate, formed clinical psychological theories -- in essence, re-tracing the process Jung himself undertook. Introducing Carl Jung and his writings in their cultural context, I aim here to explicitly connect the inchoate visions in the Red Book to the crucial theories extrapolated from them and their subsequent impact on clinical psychiatry. For instance, where Jung describes (and draws) visions of fantastic conversations with the Greek deities Cabriri who harbor the history of mankind, we see the seeds of Jung's theory of the collective unconscious whereby all humans share innate behavioral patterns. Where Jung dreams that he finds a princess locked in a castle only to be disappointed by her predictable stereotype, modern readers realize alongside Jung his conception of the archetype and the importance of recognizing common patterns to understanding the psychological world. Where Jung imagines himself to be an asylum patient and adopts the perspective of his own patients, one envisages today's less didactic clinical practice in which doctors and patients partner for care. Indeed, the Red Book reminds us how Jung's synthesis of biological and psychological science in his own career, from testing cognitive deficits in schizophrenia to considering projection as a mechanism of paranoia, embodies the interplay of neuroscience, neurochemistry, and psychology so prominent today.

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No.3

RISKS OF READMISSION IN PATIENTS DIAGNOSED WITH BIPOLAR, MAJOR DEPRESSIVE, OR SCHIZOAFFECTIVE DISORDERS: A LONGITUDINAL STUDY

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) List variables associated with readmission; and 2) Compare and contrast the risks associated with a diagnosis of bipolar versus schizoaffective versus major depression disorders.

SUMMARY:
Objective: To measure risk of readmission (RoR) at different time points in each of 3 diagnostic groups (bipolar [BP], major depression [MDD], schizoaffective disorder [SA]) after controlling for demographic and clinical characteristics. Method: For all adult inpatients (n=10,494) admitted 1/2002-6/2008 (index episodes) previous and subsequent admissions were recorded for the 2-year periods pre/post index hospitalization. Index episodes were categorized by diagnosis: BP, MDD, SA, or other. The associations between index diagnosis and RoR (within 90 days [90d] or 2 years [2y]) were examined controlling for demographics, change in diagnosis, previous inpatient treatment, psychiatric and other medications, and co-morbidities. Psychotic conditions were defined as schizophrenia, SA, and any other *DSM-IV* diagnosis specifying psychotic features. Result: The diagnosis was BP in 16%, MDD in 39%, and SA in 11.5%. 24.3% (n=2,554) were readmitted within 2y, approximately half of whom returned within 90d (11.5%). RoR was not associated with BP or MDD, but was increased in SA, both at 90d (odds ratio=1.83 and 95% confidence interval=[1.53, 2.19]) and 2y (2.11, [1.83, 2.42]). For BP and MDD RoR was not significantly different for patients with versus without psychotic features; for BP patients depressed but not manic or mixed had elevated RoR (90d 1.51 [1.19, 1.93]: 2y 1.35 [1.11, 1.64]). As expected, previous treatment was a strong predictor of readmission within 90d and 2y (6.14 [5.43, 6.95] and 7.80 [7.05, 8.63] respectively), but it did not explain the associations with index diagnoses. Among those without prior hospitalization BP was associated with readmission at 90d (1.32 [1.01, 1.73]) as was SA, at both 90d (1.81 [1.35, 2.44]) and 2y (1.70 [1.38, 2.09]). For patients not previously admitted the increase in RoR ranged from more than 2-fold to 20-fold, depending on the combination of diagnoses at the previous and index episodes. RoR for patients with SA during either or both episodes was elevated by more than 20%; patients with SA at both episodes had a 13-fold (90d) and 20-fold (2y) increase, compared to patients not previously admitted. However, RoR was not generally associated with stability of diagnosis. Other factors associated with RoR included: middle age, number and types of psychiatric diagnoses (schizophrenia, PTSD, drug abuse, personality disorders), pharmacotherapy (antipsychotics, anticonvulsants, psychotropic polypharmacy, antidiabetics, anticholiner

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No.4

DEVELOPMENT OF A COMORBIDITY INDEX FOR MENTAL HEALTH

Dianne Groll, Ph.D., 752 King St W, Kingston, K7L 4X3 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the importance of controlling for comorbid illness when studying the effectiveness of treatments and interventions

SUMMARY:
The use of psychiatric services has been correlated with several demographic and clinical variables, including comorbid illnesses. Without the ability to take into consideration the effect of these comorbid illnesses it is difficult, if not impossible, to determine the effectiveness of an intervention or treatment. However, while there is evidence that the type and number of comorbid health conditions influences mental health outcomes, there are no validated comorbidity indices listing the diagnoses most important to control for in studies of mental health. In many types of research, particularly where mortality is the outcome of interest, it is routine to adjust for the effect of comorbid diseases. However, diagnoses predictive of mortality have been shown to not always be relevant to outcomes such as quality of life or physical function, and similarly, these diseases may be expected to not be good predictors of mental health outcomes. Thus, the purpose of this study was to develop and validate an index of comorbid diseases with the SF-36 mental health subscale, and the Mental Component Subscale as the outcome of interest. This study will provide the first validated index of diagnoses needed to control for the effect for chronic comorbid conditions on mental health outcomes. This will improve our ability to know if a change in a person's mental health is due to the treatment or due to other factors such as other diseases they may have.

MONDAY, MAY 16, 2011
9:00 AM - 10:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 20

MICELLANEOUS TOPICS

No.1
DIAGNOSTIC STABILITY IN MAJOR DEPRESSIVE DISORDER WITH VERSUS WITHOUT PSYCHOTIC FEATURES

John Goethe, M.D., 200 Retreat Avenue Hartford, Hartford, CT 06106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Compare patterns of change in clinical diagnosis over time in MDD patients with versus without psychotic features; and 2) Discuss variables associated with change in diagnosis over time.

SUMMARY:
Objective: To determine, in a sample of inpatients with a clinical diagnosis of major depressive disorder (MDD), the proportion given this diagnosis at a subsequent hospitalization for the (1) sample as a whole and the (2) subsamples with vs without psychotic features (MDD-P vs MDD-NP). Also examined were the demographic and clinical variables associated with a change in diagnosis. Method: The sample was consecutive inpatient admissions age =18 with >1 hospitalization between 1/2000-12/2007 who at first admission had a *DSM-IV* diagnosis of MDD (n=1672, 74.6% of all MDD patients with >1admission). "Stability" was defined as having the same diagnosis at first and last admission. Demographic and treatment variables associated with a change in diagnosis were identified with stepwise logistic regressions. Results: Stability for the sample as a whole (i.e., all patients with MDD) was 69.7% ; an additional 13.9% of patients (n=232) had a diagnosis at last admission of mood disorder other than MDD and another 7% a diagnosis of schizoaffective disorder (SA). Thus, the presence of some disturbance in mood was identified by the clinician in 90.6% (n=1514) of the sample at both first and last admission. Change in diagnosis was more likely in males (OR=1.46) and in patients with a co-diagnosis of drug abuse/dependence (OR=1.72), but there was no association with age, LOS or treatment with antidepressants, antipsychotics, or ECT. Patients with MDD-P (38% of the sample, n=636) were less likely than those with MDD-NP (57.7%, n=958) to have MDD at last admission (59% vs 68%, p<.001) but more likely at last admission to have MDD-P (46% vs 19%, p<.001) or some other *DSM* diagnosis associated with psychosis (66% vs 25%, p<.001). For example, change to SZ was much more common in MDD-P than NP (12.9% vs 3.1%, p<.001). A change in diagnosis to bipolar was infrequent in both groups (7.5% vs 9.6%, p=.15). Conclusion: These data suggest that clinically applied *DSM-IV* criteria for MDD define a condition that is at least moderately stable. Mood disturbance was consistently identified in > 80% of the sample, more so in patients without psychotic features. While psychotic features were stable over time, patients with psychosis were less likely to continue to have a diagnosis of MDD. These findings are relevant to planning for *DSM-5* and contribute to the recent literature about the co-occurrence of symptoms of psychosis and mood

disorder.

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No.2

CONVERSION DISORDER PRESENTING AS HEMIPLEGIA IN A PATIENT WITH FAMILIAL HEMIPLEGIC MIGRAINE

George Paris, M.D., 35 Severance Circle Ap 508, East Cleveland, OH 44118

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Differentiate Conversion Disorder Manifesting as Hemiplegia in patients with Familial Hemiplegic Migraine.

SUMMARY:

INTRODUCTION: Familial hemiplegic migraine (FHM) is a rare genetically heterogeneous autosomal dominant subtype of migraine with aura. The headache attacks are associated with hemiparesis or hemiplegia, and may last from few hours to several days. We present the first case, to our knowledge, of a patient with known FHM presenting subsequently with hemiplegia as a manifestation of a conversion disorder. CASE REPORT: The patient is a 32 year old African American female with multiple episodes of hemiplegia due to FHM diagnosed by genetic testing (CACNA1A mutation). The patient presented with left-side hemiplegia that started a few minutes after having a fight at home with her mother. She did not complain of headache. Physical exam revealed: 1. A positive Hoover sign (involuntary extension of a pseudo-paralysed leg when the 'good leg' is flexing against resistance). 2. The patient reported decreased vibratory sensitivity only on the left side of the frontal area (frontal bone is a solid bone and vibratory sensitivity should be the same in both sides). 3. She could not move her left upper and lower extremities when asked to do so, but was able to tonically contract them. 4. She actively directed her left upper extremity towards her side after the arm was passively elevated above the face and then released. 5. She reported seeing blurry with the left eye, but visual acuity tested with Snellen chart was equal in both sides. The above clinical signs supported the diagnosis of a conversion disorder manifesting as hemiplegia. The patient was started on Lorazepam p.o. and after the second dose all symptoms disappeared. She was discharged in stable condition with the diagnosis of Conversion Disorder Manifesting as Hemiplegia and she was reffered to the Outpatient Psychiatric Service. CONCLUSION: Conversion disorders can present with a variety of neurologic complaints and should be considered when the symptoms do not correlate with the physical
findings. The association between FHM and conversion disorder manifesting as hemiplegia was not described before. These are two distinct entities with common features not related to each other. The distinction between the two can be made based on physical examination and it has therapeutical implications.

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6) Krem MM. Motor conversion disorders reviewed from a neuropsychiatric perspective. J Clin Psychiatry. Jun 2004;65(6):783-90Visualizing Mental Diseases: Distinct Plasma Levels of Cytokines and Chamokines in

No.3

SCHIZOPHRENIA AND MAJOR DEPRESSIVE DISORDER

Sekiyama Atsuo , M.D., Ph.D., Tsukinowacho, Seta, Shiga 564-0063 Japan

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Realize that plasma levels of cytokines in schizophrenia and MDD are so distinct that cytokines are useful biomarker for a screening

of mental diseases.

SUMMARY:
Background: Neural, immune, and endocrine systems interacts each other, consisting a network for host defenses, suggesting that disruption of one of those systems may cause an alteration of other systems. We have reported a stress-induced secretion of cytokines into plasma, which is one of the pathways by which neural, immune, and endocrine systems interact. Method: To reveal biochemical features of mental diseases, levels of signaling proteins in plasma were determined in healthy Mongoloid (Japanese) adults (N = 100), age and gender matched Mongoloid (Japanese) subjects of schizophrenia (N = 200) and major depression (N = 200). Results: Levels of signaling proteins in plasma were found to form a characteristic pattern in each group. Multiple logistic regression analysis showed that those patterns were associated with psychiatric diagnosis. Serological segregation in other groups of subjects showed that a classification based on those molecules in plasma achieved over 95 % of match with clinical diagnosis. Conclusions: It is suggested that signaling molecules in plasma are involved in the mental disorders. Mediators for Host defense network are capable to classify psychiatric disorders. Plasma signaling molecules may provide important information for psychiatric pathology and diagnosis.

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MONDAY, MAY 16, 2011
NOON - 1:30PM

SCIENTIFIC AND CLINICAL REPORT

SESSION 21-
PSYCHOPHARMACOLOGY-2

No.1
BRUXISM AND ANTIDEPRESSANTS

Harvinder Singh, M.D., 7675 Phoenix Dr, #624, Houston, TX 77030

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognise and treat bruxism as a side effect of antidepressants; and 2) Identify why prescribers and dentists should inquire specifically about these symptoms and antidepressants use in order to elicit a history of underlying bruxism.

SUMMARY:
Background: Bruxism is characterized by clenching or grinding of the dentition. Not only is bruxism more commonly a problem in individuals with depression and anxiety disorders, but also the medicines used to treat anxiety and depression can themselves often create a new iatrogenic or worsen a preexisting bruxism even when they successfully treat the target psychiatric problem. The authors describe a case of bruxism likely induced by the antidepressant Bupropion.Case Description: A case of Bruxism is reported in a female with major depressive disorder that developed a few days after initiating Bupropion. One week later, the patient reported mild improvement in her drpressive symptoms. She reported clenching and grinding of the teeth's and Buspirone (5mg BID) was started after a month of initiation of bupropion. Six weeks later her bruxism was so worse that she couldn't even open her mouth well, and bupropion was discontinued. The patient was advised to consult with a dentist if the bruxism continued.Clinical Implications: On the basis of this case and the available literature, the authors conclude that bruxism secondary to antidepressant therapy may be common. Bruxism symptoms may begin within hours of starting or changing antidepressant drug dosage; however, 90% of symptoms are observed during the first 3-5 days of starting or increasing dosage. Since antidepressants are frequently prescribed medications dentists should be aware of these drugs side effects when assessing patients with bruxism.

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acute dystonia. Ann Pharmacother. 2002 Feb;36(2):251-4.

No.2
RAPID RESPONSE OF DISABLING TARDIVE DYSKINESIA TO A SHORT COURSE OF AMANTADINE

Gaurav Jain, M.D., 901 West Jefferson, Springfield, IL 62794

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate a potential usefullness of a short course of amantadine in the treatment of Tardive Dyskinesia.

SUMMARY:
Introduction: About 20% of patients treated with standard neuroleptic drugs are affected with tardive dyskinesia (TD), and approximately 5% are expected to develop TD with each year of neuroleptic treatment (1). The majority of TD patients have a mild disorder but about 5-10% suffers impairment from the dyskinesia (2). The evidence in relation to the atypical antipsychotics suggests that these drugs present a significantly lower risk for TD in comparison to first generation antipsychotics (3). Reports suggest that the risk of TD is lowest with clozapine followed by quetiapine (4). The severity of TD and the absolute need for neuroleptic therapy often dictate the treatment approach. Although there is no currently effective treatment for TD, but amantadine has been reported to be beneficial, possibly because of its glutaminergic effects (4,5). I report a case of fifty-seven year female patient with disabling tardive dyskinesia (TD) due to quetiapine which responded rapidly to amantadine. To my knowledge, this report is the first description of rapid improvement of Quetiapine induced TD by Amantadine.Discussion: Tardive Dyskinesia (TD) is the most serious consequence of long-term neuroleptic administration, and all known approaches to its treatment are relatively unsuccessful (5). Amantadine is a commonly used drug in neurology but psychiatrists are generally less experienced with its usage. There has been very little work done on the use of amantadine in TD, and the patient population studied was on typical antipsychotics only (8-14). An 18-week, double-blind, crossover study by Angus et al, demonstrated that amantadine is significantly better than placebo in the management of TD, and there is little risk of exacerbating psychosis (14). Using amantadine to treat TD has produced a rapid improvement in the dyskinesia without emergence of psychosis even with prolonged administration. Conclusions: More studies are needed to prove the utility of amantadine in typical antipsychotic induced TD. Meanwhile, a trial of amantadine for a short period (1-2 week) in a patient with debilitating tardive dyskinesia may be useful.

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No.3
PRESCRIPTION RATES OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) AFTER INTRODUCTION OF GENERIC EQUIVALENTS: A

POPULATION-BASED STUDY

James Bolton, 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) Recognize that incident SSRI prescriptions continue to increase in rate over the years when the drug is under patent; 2) Appreciate that there is a significant decrease in the rate of new antidepressant prescriptions after that drug becomes generic; and 3) Understand that although generic antidepressants are less expensive, physicians prescribe them significantly less compared to the brand-name products

SUMMARY:
Objective: This study sought to examine how the prescription rates of SSRIs changed after the introduction of generic equivalents. This is of interest considering the cost reduction of generic drugs and the decrease in pharmaceutical company promotion. Methods: Data came from the Manitoba Centre for Health Policy data repository, which contains de-identified linked administrative health and census data for nearly all residents of the province of Manitoba in Canada (population 1.2 million). The study period was from 1996-2009. All medication dispensations in the population are recorded, providing detailed information on the dose, quantity, and date dispensed. During the study period sertraline, citalopram, and paroxetine had generics introduced. Generalized estimating equations determined the rate of incident prescriptions for all SSRIs and their change over the study period, adjusting for age group, sex, income, and region of residence. Results: In adjusted models, all branded SSRIs had increasing rates of prescription per yearly quarter while under patent. After generic citalopram became available the rate of increase of incident prescriptions dropped from 13.2% to 1.3% ($p<0.0001$). The rate of new prescriptions of sertraline and paroxetine not only significantly decreased after the introduction of generic equivalents, but continued to decrease for the remainder of the study period (1.5% and 1.9% quarterly decreasing rates, respectively, $p<0.0001$). The rate of incident fluoxetine and fluvoxamine prescriptions continued to decrease during the entire study period. New escitalopram prescriptions increased at a quarterly rate of 8.9% after its introduction. Conclusions: Despite the reduction in cost, generic SSRIs are prescribed less often than when they were under patent. These findings suggest that prescribing practices by physicians are perhaps more influenced by pharmaceutical company promotion than by the availability of more inexpensive medication alternatives.

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No.4
CURRENT PRESCRIBING PRACTICES: ANTIPSYCHOTIC POLYPHARMACY IN PATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

John Bonetti, D.O., 200 Retreat Avenue, Hartford, CT 06106

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Present the data about the gap between current prescribing practices and evidence–based guidelines of antipsychotic polypharmacy; and 2) Discuss the evidence for/against this practice.

SUMMARY:
Objective: To determine the prevalence of antipsychotic polypharmacy (APP) and the demographic and clinical variables associated with this practice in hospitalized patients with a diagnosis of schizophrenia (SZ) or schizoaffective disorder (SA). The investigators also examined the change in APP over time. Method: The sample was inpatients age 18-64 admitted between 1/2000 and 6/09 with a clinical diagnosis of SZ or SA who were treated with antipsychotics (AP) (n=2893). Demographics, diagnoses, psychotropics at discharge and AP dosages (only available for the last 2 years) were recorded. To examine changes in prescribing practices we compared data from the first (2000-02; n=969) to the last three years (7/06-6/09; n=1463). Data were analyzed with stepwise logistic regression, chi-square and t-tests. Results: 28.2% of the sample received APP, 65.9% of whom received both second (SGA) and first generation agents (FGA). The most common combinations were an FGA with risperidone, quetiapine or olanzapine (52.7% of all APP). Among patients on clozapine (n=263) 51.3% received another AP. Patients on = 2 APs were more likely to be white (OR=1.2) and to have

a longer LOS (OR=1.0) but less likely to have drug abuse/dependence (OR=0.8). A separate regression that added as independent variables low-dose and high-dose AP (based on product labeling) found that patients on APP were more likely to receive both high (OR=3.8) and low dosages (OR=2.7), to be male (OR=1.7), to have a diagnosis of SA (OR=1.5) and a longer LOS (OR=1.1) but less likely to receive an antidepressant (OR=0.7). APP increased over time from 19.9% to 30.1% (p<.001). Combined treatment with FGA + SGA increased from 13.4% to 20.4% (p<.001); [there was not a significant change in the use of = 2 SGAs]. Conclusions: APP is common and appears to have increased in the last decade. The association of APP with lower than usual doses may reflect a strategy for treating patients unable to tolerate usual doses of a single AP; the association with high doses may be an approach to treatment-refractory conditions. The addition of FGA to SGA may be an effort to increase D2 blockade in patients with persistent hallucinations/delusions. Some associations were not expected and require further investigation.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22

SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS

No.1

META-ANALYSIS OF PHASE III TRIALS OF ILOPERIDONE IN THE SHORT-TERM TREATMENT OF SCHIZOPHRENIA: EFFICACY OUTCOMES BASED ON PRETREATMENT STATUS

Stephen Stahl, M.D., Ph.D., 1930 Palomar Point Way Ste 103, Carlsbad, CA 92008

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess the efficacy of iloperidone therapy after short-term treatment on BPRS and PANSS scores among patients with and without prior treatment for schizophrenia.

SUMMARY:

Objective: An individual-patient-based meta-analysis of 4 phase III studies was conducted to examine the short-term efficacy of iloperidone (ILO), a mixed D2/5-HT2A antagonist for the treatment of schizophrenia, based on whether patients had previously received antipsychotics or were treatment-naïve. Methods: Data were derived from 4 double-blind, placebo (PBO)-controlled trials (4 or 6 weeks' duration) that enrolled adult patients with schizophrenia. Active controls were included to confirm trial validity. Brief Psychiatric Rating Scale-derived (BPRSd), Positive and Negative Syndrome Scale Total (PANSS-T), and Positive (PANSS-P) and Negative (PANSS-N) subscale scores were analyzed. Patient-level data for ILO 4–8, 10–16, and 20–24 mg/d, PBO, and active-control groups for each assessment were pooled. An LOCF approach was applied to the ITT population (all randomized patients who had at least 1 study medication dose and 1 on-treatment efficacy measurement). The last observation before Week 4 (1 study) or Week 6 (3 studies) was carried forward until Week 4 or 6, respectively. To compare reductions between treatments, least squared mean (LSM) change ± standard error (SE) was derived from an ANCOVA model with treatment, study, pretreated, and treatment by pretreated as factors and baseline as a covariate. Results: 1941 Patients were included: 1697 previously treated, 244 treatment-naïve. At Week 4/Week 6, LSM±SE changes in PANSS-T scores among previously treated patients were: -6.8±1.4/-7.2±1.4, ILO 4–8 mg/d; -10.4±1.1/-10.6±1.1, ILO 10–16 mg/d; -10.5±1.3/-12.4±2.3, ILO 20–24 mg/d; -5.5±1.0/-5.4±1.3, PBO (p<0.05, ILO 10–16 and 20–24 mg/d vs. PBO). Statistical separation vs. placebo for ILO 10–16 and 20–24 mg/d also was observed for BPRSd, PANSS-P, and PANSS-N among previously treated patients. Corresponding changes in PANSS-T among treatment-naïve patients were: -13.1±3.3/-15.1±3.6, -11.9±3.5/-13.5±3.9, and -11.9±2.7/-19.2±7.0 for ILO 4–8, 10–16, and 20–24 mg/d, respectively, vs. -6.7±2.4/-7.9±3.7 for PBO. Conclusions: A significant improvement in BPRSd and PANSS scores over 4 to 6 weeks was seen with ILO 10–16 mg/d or 20–24 mg/d in pretreated schizophrenia. Improvement among treatment-naïve patients was numerically better than for previously treated

patients but was not statistically significantly better vs. PBO due to small sample size. Research support: Novartis Pharmaceuticals Corporation.

No.2

MOOD SYMPTOMS IN PATIENTS PRESENTING WITH PRIMARY PSYCHOSIS AFTER AGE 40: A PROSPECTIVE COHORT STUDY

Rebecca Anglin, M.D., #403, 10 Morrison St, Toronto, M5V 2T8 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the nature and prevalence of mood symptoms in late-onset psychosis; 2) Appreciate the characteristics of patients with depression and late-onset psychosis and the course of illness in these patients; and 3) Understand that mood symptoms in patients with late-onset psychosis can respond robustly to treatment with neuroleptic medications alone.

SUMMARY:
Objectives: Depressive symptoms can be prominent in patients who present with psychosis later in life, but have received little research attention. The objectives of this study were to determine the prevalence, associated clinical features and treatment-response of depressive symptoms in a prospective cohort of patients with late-onset psychosis. Methods: We prospectively assessed consecutive patients age > 40 who were admitted to our service with first-episode psychosis. Patients with cognitive impairment, dementia, or a history of mood disorder were excluded. Assessments were carried out prior to treatment and weekly thereafter using the BPRS, HAM-D, HAM-A, GAF, YMRS and CGI. All patients were treated with low-dose antipsychotic medications and none received treatment with an antidepressant medication. Results: To date, we have diagnosed 103 patients (63 female, 40 male; mean age 66.6) with late-onset psychosis. The mean admission BPRS score +/-SD was 48.5 +/-8.75 and mean discharge BPRS score was 25.27 +/-5.6. Sixty-one patients (59%) had a HAM-D score of >17 at admission with a mean score of 23.8 +/-4.5. Compared to those with HAM-D scores <17, patients with HAM-D scores > 17 (i) were significantly younger (p 0.0006), (ii) had higher BPRS scores at the time of presentation (p 0.02) and (iii) were more likely to be suicidal: 21 (34%) vs 4 (9%). With anti-psychotic drug treatment alone (mean dose = 144 +/-8.9 CPZE), 55/61 patients (90%) had complete resolution of depressive symptoms (HAM-D < 7). The original diagnosis was maintained in all patients during the follow-up period (mean 5 years). Conclusions: [1] Patients presenting with primary psychosis later in life have a high prevalence of depressive symptoms [2] Those with depressive symptoms are significantly younger and more severely unwell than those without [3] Both psychotic and depressive symptoms respond robustly to antipsychotic treatment alone, without the addition of anti-depressant medication.

REFERENCES:

1) Howard R, Rabins PV, Castle DJ. Late Onset Schizophrenia. Petersfield, UK, Wrightson Biomedical Publishing,1999.

No.3

A RANDOMIZED TRIAL EXAMINING THE EFFECTIVENESS OF SWITCHING FROM OLANZAPINE, QUETIAPINE, OR RISPERIDONE TO ARIPIPRAZOLE TO REDUCE METABOLIC RISK

Thomas Stroup, M.D., M.P.H., 1051 Riverside Dr., New York, NY 10025

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Analyze the risks and benefits of switching medications to address metabolic side effects; and 2) Evaluate the impact of interventions to address metabolic problems associated with antipsychotic medications.

SUMMARY:
Objective: We conducted a randomized controlled trial examining the strategy of switching from olanzapine, quetiapine, or risperidone to aripiprazole to ameliorate metabolic problems that are risk factors for cardiovascular disease. Method: 215 patients with schizophrenia or schizoaffective disorder with BMI = 27 and non-HDL cholesterol = 130 mg/dl who were taking a stable dosage of olanzapine, quetiapine, or risperidone were randomly assigned to stay on the current medication (n=106) or switch to aripiprazole (n=109) for 24 weeks. Raters were blinded to treatment assignment. The primary and key secondary outcomes were

non-HDL change and efficacy failure, respectively. Results: The primary analysis included 89 persons who switched to aripiprazole and 98 who stayed on the current treatment. The least squares mean estimates of non-HDL cholesterol decreased more for the switch than the stay groups (-20.2 vs. -10.8 mg/dl), with a difference of 9.4 mg/dl (CI 2.2-16.5, p = 0.01). Switching was associated with larger reductions in weight (2.9 kg) and serum triglycerides (32.7 mg/dl). Twenty-two (20.6%) of those who switched to aripiprazole compared to 18 (17%) of those assigned to current medication experienced protocol-defined efficacy failure. Twenty (18.4%) switchers and 8 (7.6%) stayers discontinued the assigned treatment during the first month. Forty-seven (43.9%) switchers and 26 (24.5%) stayers stopped the assigned antipsychotic before 24 weeks. Fifty-one (47.7%) switchers and 29 (27.4%) stayers stopped the protocol-specified treatment before 24 weeks. Conclusion: Switching to aripiprazole led to improvement of metabolic parameters. Rates of efficacy failure, representing significantly worsening of clinical status, were similar between groups but switching to aripiprazole was associated with a higher rate of stopping the assigned treatment.

No.4

PARSING THE HETEROGENEITY OF SCHIZOPHRENIA: THE UTILITY OF FOUR EARLY-COURSE FEATURES IN SUBTYPING FIRST-EPISODE NONAFFECTIVE PSYCHOSIS

Michael Compton, M.D., M.P.H., 49 Jesse Hill Jr. Drive, S.E., Room #333, Atlanta, GA 30303

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) identify several key early-course features that may be useful in prognostic and subtyping considerations for psychotic disorders; 2) recognize that latent profile analysis is useful in identifying subgroups; and 3) consider key domains of outcomes in psychotic disorders.

SUMMARY:
Heterogeneity of symptoms, course, and outcomes among the primary psychotic disorders makes prognostication and treatment planning difficult, and complicates research on etiology and pathophysiology. This study aimed to identify interpretable subtypes of first-episode nonaffective psychosis based on four early-course features occurring even before the initial evaluation and treatment (premorbid academic functioning, premorbid social functioning, duration of the prodrome, and age at onset of psychosis). Data from 200 well-characterized patients hospitalized three public-sector inpatient units for first-episode nonaffective psychosis were used in latent profile analyses. Derived subtypes were then compared using post-hoc analyses of variance. Using the four early-course features, three classes were derived: (1) a good premorbid functioning/short duration of prodrome subtype was characterized by lesser severity of positive and dysphoric symptoms, fewer psychosocial problems, greater global and social/occupational functioning at the time of initial hospitalization, as well as a shorter duration of untreated psychosis; (2) a poor premorbid functioning/early onset of psychosis subtype evidenced greater severity of negative and autistic-like symptoms and more psychosocial problems; and (3) a long duration of prodrome/late onset of psychosis subtype resembled the second subtype except for having lesser negative symptoms. Findings suggest that early features that can be assessed at the initial evaluation may be useful in subtyping the disorder in terms of diverse symptom and psychosocial variables. This and related research, especially longitudinal studies of first-episode patients, could help to reduce the heterogeneity that is so characteristic of psychotic disorders, thereby advancing nosology, clinical practice, and etiologic research.

TUESDAY, MAY 17, 2011
7:00 AM - 8:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 23

PSYCHOSOMATIC MEDICINE

No.1

AN ANALYSIS OF SMOKING PATTERNS AND CESSATION EFFORTS AMONG CANADIAN FORCES MEMBERS AND VETERANS: AN EXPLORATION OF THE TRANSTHEORETICAL MODEL

Charles Nelson, Ph.D., 801 Commissioners Rd. E., London, N6C 5J1 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify factors that influence smoking maintenance and cessation in military populations; 2) Describe how the TM can be applied to smoking cessation in military populations; and 3) Compare differences between smoking patterns in military and civilian populations and explain how TM predicts these patterns.

SUMMARY:
Introduction: Canadian Forces (CF) members face significant challenges upon returning home from deployment, and the stress associated with adapting to their civilian roles and responsibilities often leads to increased tobacco use. Research shows the prevalence of smoking among military veterans is 1) higher than the prevalence in civilian populations; and 2) among those seeking care within the Veterans Affairs system than for other veterans. Objectives: This study seeks to: 1) determine the factors that affect smoking patterns among CF members and veterans; 2) establish the factors that contribute to successful smoking cessation within this group; and 3) determine if and how the Transtheoretical Model (TM) accounts for smoking maintenance and cessation among a sample of treatment-seeking Canadian military members and veterans. Methods: Approximately 200 CF and Royal Canadian Mounted Police (RCMP) members and veterans attending the Operational Stress Injury (OSI) Clinic at Parkwood Hospital in London, Ontario completed two standardized questionnaires (Pros and Cons of Smoking scale from the Decisional Balance measure, and the Self-Efficacy/Temptation scale), in addition to a brief survey soliciting information including current smoking levels, age of smoking initiation, and number of previous quit attempts. Demographic information, primary mental health diagnosis, and comorbid psychopathologies were obtained from the OSI clinic database. A series of t-tests and chi-square analyses will be used to examine bivariate relationships between sociodemographic variables, smoking status variables, and Stage of Change/ Decisional Balance subscale scores. Pearson's correlations will assess relationships between sociodemographic and smoking history variables. Stepwise linear regression models will investigate multivariate relationships between aggregate Decisional Balance and Self-Efficacy scores, sex, and other smoking characteristics. The findings will be compared to known patterns of smoking cessation among civilians in the Stage of Change model predicted by the TM. Results: Data analysis is currently ongoing. Conclusions: We expect to gain a basic epidemiological understanding of how OSIs influence smoking maintenance and cessation in military populations. We also expect the TM will provide a useful construct for informing clinical efforts to target smoking behaviour in a military population.

No.2

PREVALENCE AND PREDICTORS OF POST TRAUMATIC STRESS DISORDER AMONG THOSE IN METHADONE MAINTENANCE TREATMENT

Seth Himelhoch, M.D., M.P.H., 737 West Lombard Street, Suite 560, Baltimore, MD 21201

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the prevalence of PTSD among those in methadone maintenance; 2) Identify the predictors of PTSD among those in methadone maintenance; and 3) Appreciate the opportunity to improve screening, diagnosis and treatment of PTSD in methadone maintenance programs.

SUMMARY:
Background: Opiate use may be associated with an increased exposure to trauma, yet few studies have evaluated the prevalence and predictors of Post Traumatic Stress Disorder (PTSD) among those in methadone maintenance. Methods: This single site, cross sectional study assessed the prevalence and predictors of PTSD among people receiving methadone maintenance at an urban methadone treatment program. All patients who received methadone maintenance for at least 3 months, but not longer than approximately 12 months, were eligible to participate in the study. The Post Traumatic Diagnostic Scale was used to determine the prevalence of PTSD. The Life Stressor Checklist Revised was use to evaluate trauma history. Bivariate analysis evaluated associations between the outcome of interest--diagnosis of PTSD with the following variables: 1) demographic characteristics, 2) results of the toxicology screen and the 3) trauma history. Logistic regression analyses were used to examine associations between demographic and trauma related variables and the outcome of interest-- diagnosis of PTSD. All reported p-values

are 2-tailed. Results: Of the 115 eligible people, 89 (77%) participated in the study.The average participant age was 43.6 (SD=8.4).The majority of participants were male (66.3%), non-white (70.8%), non Hispanic (96.5%), unemployed (77.6%) and unmarried (81.2%). Most of the participants had at least a high school education (65.5%). Toxicity screenings revealed that 51.1% of the participants screened positive for one or more illicit substances. The mean number of reported lifetime trauma events was 8.0 (SD=3.7). PTSD was diagnosed in 27% of the participants.Being female (AOR [95% CI]; 3.89 [1.07-14.01]), experiencing a greater number of traumatic events (AOR [95% CI];1.34 [1.13-1.61]) and having less than a high school education (AOR [95% CI];4.13 [1.14-14.98]) were significantly associated with PTSD. Women with PTSD were significantly more likely to report being raped compared to men with PTSD. Conclusions: PTSD is highly prevalent among those in this urban methadone maintenance treatment program. Future efforts may need to be directed toward improving screening for traumatic events as well as PTSD among those in methadone maintenance treatment. This may be particularly true for women and those with lower educational status who may be at a particularly high risk for developing PTSD.

No.3

WORKERS' RISKS OF PERMANENT DISABILITY AND PREMATURE DEATH UNDER THE CONDITIONS OF ALCOHOL ABUSE AND ADDICTION

Felix Wedegaertner, M.D., M.P.H., Carl-Neuberg-Str. 1, Hannover, 30625 Germany

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appraise the impact of alcohol abuse on all-cause mortality and occupational disability if it surfaces by absenteeism from work, psychiatric inpatient treatment or during hospital treatment.

SUMMARY:

Aims: It was the aim of this study to estimate effects of alcohol abuse on early retirement and premature death in the working population with special emphasis on alcohol related absenteeism from work and inpatient treatment. Methods: Sample consisted of 125.019 resp. 128.001 health insurance clients up to age 58 resp. 74 were used. Mean follow-up period was 6.4 years. Excess risks were calculated with Cox regression models adjusted for age, gender, education and job classification. Results: Both alcohol-related absenteeism from work (without inpatient treatment) and detoxification treatment were associated with higher risks of early retirement (RR 2.59, CI 2.21-3.04, p<0.001; RR 2.29, CI 1.99-2.62, p<0.001) and premature death (RR 3.26 CI 2.74-3.88, p<0.001; RR 4.41, CI 3.90-4.98, p<0.001). Further analysis showed higher risks of early retirement for males. Females who sought inpatient treatment for alcohol abuse/addiction had the highest risk of premature death (RR 7.75, CI 5.61-10.68, p<0.001). Marked increases of the risks for permanent disablity and death during the follow-up period could also be oberserved after all-cause inpatient treatment in patients with a comorbid alcohol problem. Conclusions: The detrimental effect of alcoholism on life expectancy and capacity to work is considerable after absenteeism from work, psychiatric treatment and all-cause inpatient treatment. While female patients in detoxification wards are a minority, they may be more strongly affected by the somatic complications of alcohol abuse. Nevertheless, strong selection biases in this subsample need to be considered and the data interpreted with caution.

REFERENCES:

1) Hannerz H, Borgs P, Borritz M. Life expectancies for individuals with psychiatric diagnoses. Public Health 2001; 115 (5): 328-37.

SCIENTIFIC AND CLINICAL REPORT SESSION 24- PSYCHOSOMATIC MEDICINE

No.1

EFFECTIVENESS OF MOTIVATION-BASED INTERVENTIONS TO REDUCE CARDIOMETABOLIC RISK IN LOW-RESOURCE PSYCHIATRIC SETTINGS

Jeanie Tse, M.D., 40 Rector St, 8th Floor, New York, NY 10006

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify factors contributing to increased cardiometabolic mortality and morbidity for people with serious mental illness (schizophrenia, bipolar disorder, major depression); 2) Consider

evidence-based /best practices, such as motivational interviewing, that may be implemented in low resource community psychiatry settings to enhance health literacy, improve health outcomes and potentially reduce costs.

SUMMARY:
Objective: People with serious mental illness (schizophrenia, bipolar disorder, major depression) have increased morbidity and mortality related to higher rates of cardiometabolic disorders, including diabetes. An intervention designed to address barriers to accessing health care was evaluated in low-resource community psychiatric settings. Method: A Diabetes Self-Management Toolkit and a Healthy Living Toolkit were piloted in 81 New York City housing, case management and clinic programs. Both Toolkits were structured around workbooks enabling paraprofessionals to use motivational enhancement techniques to promote health literacy and treatment adherence for patients with serious mental illness. The effectiveness of these interventions was investigated using objective measures of health risk, self-report measures of health knowledge and behaviors, and utilization of inpatient and emergency services, assessed on a quarterly basis. Results: Significant pre- to post-intervention improvements in HbA1c levels, access to recommended diabetes monitoring interventions, self-reported diabetes self-management behaviors, and inpatient and emergency utilization were found for participants using the Diabetes Self-Management Toolkit (n=204). Significant improvements on the SF-8 Health Outcomes Questionnaire and in self-reported health knowledge and behaviors were found for participants using the Healthy Living Toolkit (n=1351). Conclusions: These findings suggest that a psychoeducational intervention based on motivational enhancement techniques may reduce cardiometabolic risk, and possibly health care costs, for people with serious mental illness in low-resource communities.

REFERENCES:

1) Miller WR, Rollnick S: Motivational interviewing: Preparing people to change addictivebehavior. New York: Guilford Press, 1991.
2)National Association of State Mental Health Program Directors Medical Directors Council:
Morbidity and mortality in people with serious mental illness. Http://www.nashmpd.org,
2006.

DEPRESSIVE SYMPTOM CLUSTERS ARE DIFFERENTIALLY ASSOCIATED WITH ATHEROSCLEROTIC DISEASE

Boudewijn Bus, M.D., Sint Jacobslaan 466, Nijmegen, 6533VZ Netherlands

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be: 1) Informed about the latest developments in research on the relation between cardiovascular disease and affective disorders.

SUMMARY:
Background - Depression increases the risk of subsequent vascular events in both cardiac and non-cardiac patients. Atherosclerosis, the underlying process leading to vascular events, has been associated with depression. This association, however, may be confounded by the somatic-affective symptoms being a consequence of cardiovascular disease. While taking into account the differentiation between somatic-affective and cognitive-affective symptoms of depression, we examined the association between depression and atherosclerosis in a community based sample. Methods – In 1261 participants of the Nijmegen Biomedical Study (NBS), aged 50 through 70 and free of stroke and dementia, we measured the intima-media thickness (IMT) of the carotid artery as a measure for atherosclerosis and we assessed depressive symptoms using the Beck Depression Inventory (BDI). Principal components analysis of the BDI-items yielded two factors, representing a cognitive-affective and a somatic-affective symptom cluster. While correcting for confounders, we used separate multiple regression analyses to test the BDI sum score and both depression symptom clusters. Results – We found a significant correlation between the BDI sum score and the IMT. However, whereas cognitive-affective symptoms were not associated, somatic-affective symptoms were associated with the IMT. When we stratified for coronary artery disease, the somatic-affective symptom cluster significantly correlated with depression both in patients with and patients without coronary artery disease. Conclusions – The association between depressive symptoms and atherosclerosis is explained by the somatic-affective symptom cluster of depression. Subclinical vascular disease thus may inflate depressive symptom scores and may explain why treatment of depression in cardiac patients hardly affects vascular outcome.

No.3
DIFFERENTIAL COMORBIDITY OF MIGRAINE WITH MOOD EPISODES

Tuong-Vi Nguyen, M.D., 760 Stravinski, Brossard, J4X 1S9 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the differential comorbidity of migraine with mood episodes; 2) List putative mechanisms of association between migraine and mood episodes; and 3) Identify unipolar mania as a separate bipolar syndrome as defined by different clinical and demographic correlates.

SUMMARY:
Objectives: Migraine has been found to be comorbid with bipolar disorder and major depressive disorder in clinical and population-based samples. However, variability in findings across studies suggests that examining mood episodes separately, as (1) manic episodes alone (2) depressive episodes alone and (3) manic and depressive episodes, may be fruitful in determining which of these mood episodes are specifically associated with migraine. Methods: Using a population-based sample (n=36984), the Canadian Community Health Survey 1.2, this study examined lifetime prevalence of migraine in subjects with lifetime history of manic episodes alone, depressive episodes alone and both manic and depressive episodes. Frequencies of migraine, demographic and treatment variables were conducted between the three subtypes of mood disorders and bivariate testing was conducted using chi-square tests, T-tests and ANOVAs. Logistic regression analyses were conducted, controlling for age, sex and education, (1) comparing rates of migraine between each of the three subtypes of mood disorders versus controls, and then (2) comparing rates of migraine directly between the three subtypes of mood disorders. Results: Subjects with both manic and depressive episodes were found to have different demographic and treatment characteristics when compared to the unipolar subtypes of mood disorders. Compared to controls, the adjusted odds ratio of having migraine was 2.0 (95%CI 1.4-2.8) for subjects with manic episodes alone, 1.9 (95%CI 1.6-2.1) for subjects with depressive episodes alone, and 3.0 (95%CI 2.3-3.9) for subjects with both manic and depressive episodes. Compared to the unipolar subtypes of mood disorders, the odds of having migraine were significantly increased when subjects had both manic and depressive episodes. Conclusions: Differential comorbidity of migraine with the manic-depressive subtype of bipolar disorder, when compared to unipolar mania and unipolar depression, supports the examination of mood disorders by specific type of mood episode. Differences in demographic and clinical correlates between unipolar mania and the manic-depressive subtype further support the existence of specific bipolar syndromes. These findings strengthen the argument that different phenomenology underlie migraine comorbidity with mood disorders.

TUESDAY, MAY 17, 2011
9:00 AM - 10:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 25

SCHIZOPHRENIA &OTHER PSYCHOTIC DISORDERS

No.1
GLYCINE TRANSPORTER TYPE 1 INHIBITOR RG1678: PHASE II STUDY SUPPORTS CONCEPT OF GLYT1 INHIBITION FOR TREATMENT OF NEGATIVE SYMPTOMS OF SCHIZOPHREINA

Daniel Umbricht, M.D., Grenzacherstrasse 124, Basel, CH-4070 Switzerland

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the concept of glycine reuptake inhibition as a therapeutic principle for negative symptoms of schizophrenia; and 2) Explain the efficacy of RG1678, a potent inhibitor of glycine transporter type 1 in patients with predominantly negative symptoms.

SUMMARY:
Background: A Phase IIb proof-of-concept study investigated the effects of RG1678, a potent, noncompetitive inhibitor of glycine transporter type 1 (GlyT1), on negative symptoms of schizophrenia. Methods: Clinically stable patients with predominant negative symptoms were randomized to 8 wk of treatment with 3 doses of RG1678 (10 mg, 30 mg, 60 mg) or placebo once

daily as adjunct to 2nd-generation antipsychotics. Efficacy parameters included: change from baseline in Positive and Negative Syndrome Scale (PANSS) negative symptom factor score (NSFS); proportion of responders (defined as =20% improvement in NSFS); Clinical Global Impression-Improvement (CGI-I) in Negative Symptoms; Personal and Social Performance (PSP) scale. Populations analyzed included intent-to-treat (ITT) and per protocol (PP; patients who completed 8 wk of treatment without any major protocol violations). Results: 323 patients were randomized (mean age, 39.9 ± 10.1 [SD] years; PANSS total, 79.2 ± 9.3; PANSS NSFS, 26.1 ± 3.9). The NSFS showed a significantly greater decrease from baseline (?=25%) in the 10 mg and 30 mg groups vs. placebo (?=19%) in the PP population (10 mg, p=0.049; 30 mg, p=0.034). The percentage of responders in the PP population was significantly higher in the 10 mg group vs. placebo (65% vs. 43%, p=0.013). Differences in CGI-I in Negative Symptoms were significant for the 10 mg group vs. placebo in both populations (ITT, p=0.021; PP, p=0.025). Compared with placebo, there was a trend towards functional improvement as assessed by increase in PSP scale from baseline to week 8 in the 10 mg group in the PP population. RG1678 was well tolerated. Discussion: RG1678 is the 1st compound in clinical development to demonstrate a consistent and clinically meaningful reduction in negative symptoms associated with a positive effect on functionality. These results provide clinical proof of concept of glycine reuptake inhibition as a therapeutic principle for negative symptoms of schizophrenia.

No.2

CHARACTERISTICS OF EYE-GAZE DISTRIBUTIONS OF SCHIZOPHRENIA PATIENTS MEASURED WITH SCANPATHS DURING EMOTION-PROVOKING CONVERSATION

Jae-Jin Kim, M.D., Ph.D., 712 Eonjuro, Gangnam-gu, Seoul, 135-720 Korea

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand a defect in eye gaze distribution during the conversation with two people as one of disabilities of social cognition in schizophrenia patients.

SUMMARY:
Impairment of social cognition affects social functioning of schizophrenia patients. It has been shown that patients with schizophrenia have abnormal eye-gaze patterns, specially reduced eye contacts during a one-on-one conversation. This study was designed to investigate characteristics of eye-gaze distributions of patients with schizophrenia while talking with two persons. Groups of schizophrenia patients (n=17, 8 males, mean age 29.2) and healthy participants (n=18, 8 males, mean age 28.2) performed the virtual reality conversation tasks in which two avatars were talking with participants. Participants were asked to answer the question of the main avatar at the end of the conversation with positive or negative emotion. During listening phase and expressing phase, the characteristics of eye-gaze toward main avatar and assistant avatar were measured with scanpaths. During both listening phase and expressing phase, schizophrenia patients showed shorter duration of gaze toward the avatars than healthy participants. Specially, during expressing phase of the scene with positive emotion, both groups showed same patterns of gaze distribution toward main and assistant avatars. But during expressing phase of the scene with negative emotion, schizophrenia patients showed higher proportion of gaze toward the assistant avatar than healthy participants. During the negative scenes, the proportions of gaze toward the assistant avatar had correlation with ER40 scores. It suggests a defect in social cognition that schizophrenia patients don't distribute their gaze appropriately during the conversation with two people.

REFERENCES:

1) Streit, M., Wlwer, W., & Gaebel, W. (1997). Facial-affect recognition and visual scanning behaviour in the course of schizophrenia. Schizophrenia research, 24, 311-317.

No.3

CHILDHOOD AND ADOLESCENCE SYMPTOMS PREDICTING FIRST EPISODE PSYCHOSIS IN GENERAL POPULATION: THE NORTHERN FINLAND 1986 BIRTH COHORT

Pirjo H. Maki, M.D., Ph.D., P O Box 5000, Oulu, 90014 Finland

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant

should be able to: 1) Understand that both positive and negative features are common in adolescence, especially in subjects developing first episode psychosis.

SUMMARY:

Objective: 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 in youth. The aim was to describe which kind of symptoms in childhood and adolescence precede onset of real hospital-treated psychosis in young subjects in a general population sample when taking account specificity. Method: 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 2008 for Rutter B2 scale analysis and from 2002 to 2008 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 (65%) compared to group of subjects who developed non-psychotic disorder (36%, $p<0.001$), and to group of subjects without any disorder (27%, $p<0.001$). Respective figures for negative symptoms were 55% in the group of psychotic subjects, 30% in the group of subjects with non-psychotic disorder ($p=0.01$) and 24% in the 'healthy', without psychiatric hospital treatment ($p<0.001$). 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 were common in adolescents who later developed psychosis. Acknowledgements: This study has been funded by the Academy of Finland, the Signe and Ane Gyllenberg Foundation, Finland and the Sigrid Juselius Foundation, Finland.

REFERENCES:

1) Heinimaa M et al. Int J Methods Psychiatric Res 2003; 12(2): 92-104 Järvelin M-R et al. Br J Obstet Gynaecol 1993; 100: 310-315

2) Miettunen J et al. Association of cannabis use with prodromal symptoms of psychosis in adolescence. Br J Psychiatry 2008; 192(6): 470-471 Weinberger DR. Lancet 1995; 346: 552-57

No.4

IMPACT OF SECOND-GENERATION ANTIPSYCHOTICS AND PERPHENAZINE ON DEPRESSIVE SYMPTOMS IN A RANDOMIZED TRIAL OF TREATMENT FOR CHRONIC SCHIZOPHRENIA

Donald Addington, M.D., Department of Psychiatry, Foothills Hospital, 1403 29th Street NW, Calgary, Alb, T2N 2T9 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize symptoms of depression in schizophrenia; and 2) Select appropriate antipsychotics for the treatment of depression in schizophrenia.

SUMMARY:

Objective: According to the American Psychiatric Association Clinical Practice Guidelines for schizophrenia, second-generation antipsychotics may be specifically indicated for the treatment of depression in schizophrenia. We examined the impact of these medications on symptoms of depression using the data from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), conducted between January 2001 and December 2004. Method: Patients with *DSM-IV*–defined schizophrenia (N = 1,460) were assigned to treatment with a first-generation antipsychotic (perphenazine) or one of 4 second-generation drugs (olanzapine, quetiapine, risperidone, or ziprasidone) and followed for up to 18 months (phase 1). Patients with tardive dyskinesia were excluded from the randomization that included perphenazine. Depression was assessed with the Calgary Depression Scale for Schizophrenia (CDSS). Mixed models were used to evaluate group differences during treatment with the initially assigned drug. An interaction analysis evaluated differences in drug response by whether patients had a baseline score on the CDSS of = 6, indicative of a current major depressive episode (MDE). Results: There were no

significant differences between treatment groups on phase 1 analysis, although there was a significant improvement in depression across all treatments. A significant interaction was found between treatment and experiencing an MDE at baseline (P = .05), and further paired comparisons suggested that quetiapine was superior to risperidone among patients who were in an MDE at baseline (P = .0056). Conclusions: We found no differences between any second-generation antipsychotic and the first generation antipsychotic perphenazine and no support for clinical practice recommendations suggesting the use of second generation antipsychotics over first generation antipsychotics for the treatment of depression in schizophrenia. We did detect a signal indicating a small potential difference favoring quetiapine over risperidone only in patients with an MDE at baseline.

REFERENCES:

1) Addington D, Addington J, Maticka-Tyndale E, et al. Reliability andvalidity of a depression rating scale for schizophrenics. Schizophr Res.1992;6(3):201–208.
2) Lieberman JA, Stroup TS, McEvoy JP, et al. Clinical Antipsychotic Trialsof Intervention Effectiveness (CAT-IE) Investigators. Effectivenessof antipsychotic drugs in patients with chronic schizophrenia.N Engl J Med. 2005;353(12):1209–1223.

SCIENTIFIC AND CLINICAL REPORT SESSION 26

ADDICTION PSYCHIATRY/SUBSTANCE USE DISORDERS

No.1

PROBLEM AND PATHOLOGICAL GAMBLING AMONG VETERANS IN CLINICAL CARE: PREVALENCE AND DEMOGRAPHIC RISK FACTORS

Joseph Westermeyer, M.D., Ph.D., 1 Veterans Dr, Minneapolis, MN 55417

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify demographic and clinical characteristics of veterans at high risk to problem and pathological gambling; 2) Know how to screen patients for gambling problems; 3) Diagnose problem and pathological gambling; and 4) prevent the development of gambling problems in veterans with demographic and clinical risk factors.

SUMMARY:
Purpose was to determine prevalence rates of Pathological Gambling and problem gambling, along with possible demographic risk factors, among veterans receiving VA care. Sample was randomly selected from veterans receiving care in 2006 and 2007 at the Albuquerque and Minneapolis VAMCs. Women and younger veterans were oversampled. Findings revealed that the lifetime prevalence rate of Pathological Gambling weighted for current VA patients was 2.0%, twice the general adult population rate. Current weighted prevalence of Pathological Gambling was 0.9%, with an additional 0.2% continuing problem gambling and 0.9% recovered. Lifetime weighted problem gambling rate was 8.8%. Altogether, 10.7% had lifetime Pathological Gambling or problem gambling. Women had higher rates of Pathological Gambling, but similar rates of problem gambling compared to men. The greater prevalence of Pathological Gambling for younger veterans aged 20-29 (1.3%) compared to veterans aged 30-39 (0.8%) was unusual and warrants further investigation. Conclusions: Veterans have high rates of gambling problems than the general population. Female and young veterans are at particular risk – an ominous finding for the future VA patient population.

REFERENCES:

1) Westermeyer J, Canive J, Garrard J, Thuras P, Thompson J. Lifetime prevalence of Pathological Gambling among American Indian and Hispanic Veterans. American Journal Public Health 2005;95(5):860-866.

No.2

DIFFERENT DIETS AND FOOD GROUPS COMPARED IN TERMS OF THEIR ROLES IN THE INCREASING RATES OF OBESITY IN THE UNITED STATES

Marc Lindberg, Ph.D., 1 Marshall Drive, Huntington, WV 25755

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the elements in food that lead to increases in consumption and weight gain, and therefore better treat obesity.

SUMMARY:
Background: Between 1970 and 2005, the average Body Mass Index (BMI) in the Unites States increased by roughly 10%. BMI levels at the high

end have been linked to increases in diabetes, heart disease, some types of cancer, depression, and a host of other related problems. Thus, one of the most important questions for researchers, practitioners, and the general public is, "Why has the BMI gone up so drastically in the last 35 years?" Methods: Several different hypotheses were tested with data for per capita food production available for consumption after spoilage for different kinds of foods and additives from the US Department of Agriculture. These food groups were used as independent variables to predict BMI increases. The following hypotheses were tested. Hypothesis 1: High-fat foods are most responsible for weight gain. Hypothesis 2; Sugar and sweetener consumption is most responsible for increases in BMI. Hypothesis 3: Foods high in palatability, most notably foods high in fat and sugar, are most responsible for the increases in BMI. Results: The additives of fat and sugars in combination, not separately, best predicted increases in BMI accounting for 97% of the variance in the linear regression analyses. When all food groups were entered into regressions to predict increases in BMI, fats and sugars in combination accounted for 96% of the variance for females and 97% for males, with the other food groups adding very little. Path analyses showed that fat and sweeteners had direct effects on BMI and were also the mediators of increased caloric consumption. Popular diet hypotheses emphasizing only fats, sugars, or carbohydrates were not strongly supported. Conclusions: In line with the major physiological theories emphasizing palatability as the trigger stimulus in models of incentives and addiction, palatability rather than particular foods or food groups accounted for increases in BMI. These physiological addiction based theories and data along with these data suggest that one should focus on palatability (the addictive aspect of food) in dealing with the increasing problem of obesity in the United States. Thus, the present data add to the physiologically based theories of Volkow, Gold, Koob, Kessler and others creating a theory with a robust nomological net that extends to population based data.

REFERENCES:

1) Kessler DA. The end of overeating. Taking Control of the Insatiable American Appetite. New York, New York: Rodale, 2009.

2) Volkow ND, Fowler JS, Wang G. The addicted human brain: insights from imaging studies. J Clin Invest 2003; 111: 1444-1451.

No.3

ASSOCIATION BETWEEN IMPULSIVITY AND DEPRESSION IN CURRENT AND ABSTINENT METHAMPHETAMINE USERS

Helenna Nakama, M.D., 1356 Lusitana Street, 4th floor, Honolulu, HI 96813

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify certain aspects depression, impulsivity, and suicidal behavior in methamphetamine (METH) users; 2) Analyze the differences and associations between depression, impulsivity, and suicidal behaviors in METH users; and 3) Treat METH users with the knowledge that depression and impulsivity may contribute to suicidal behaviors in METH users.

SUMMARY:

Impulsivity may lead to substance use and suicidal behavior. One of the risk factors associated with suicide attempts in methamphetamine (METH) users is depression. The direct relationship between METH use, depression, and suicidal behavior is unclear and may be related to impulsivity. Objective: Assess whether impulsivity, depression, and suicidal behaviors differed between current METH users, abstinent METH users and controls; Assess whether impulsivity was associated with depression or suicidal behavior. Method: Cross-sectional study in a university affiliated medical center; 86 subjects (28 controls, 30 abstinent, and 28 current meth-users). Current users (used METH within last 30 days) and abstinent METH users (last used between 1-24 months) were METH-dependent according to *DSM IV* and; controls never used any METH. All subjects were healthy, HIV negative, & had no significant medical or psychiatric illness or history of other illicit drug dependence. Subjects were assessed for estimated verbal IQ, completed the Center for Epidemiologic Study-Depression Scale (CES-D), Barrat Impulsivity Scale (BIS), Adult Suicide Index Questionnaire (ASIQ). Results: The 3 groups were well-matched by sex and age (mean 34; 18-55 yrs). Compared to controls, current users had the lowest education (12.6 vs abstinent 12.7 vs current 11.7 years, p= 0.01), lowest estimated verbal IQ (110 vs 102 vs 100, p=0.005), highest CES-D scores (10.1 vs 12.6 vs 17.5, p= 0.01) and highest ASIQ scores (9.7 vs 11.4 vs 18.4, p=0.04). Current users scored the highest in each of the 7 BIS subscales. Current and abstinent users were more

impulsive than the controls (59.1 vs 68.7 vs 72.1, p-values = 0.001), even after adjusting for CES-D and age. Age was negatively associated with BIS, p=0.07. CES-D also correlated with BIS (r=0.36, p= 0.001) and with ASIQ (r=0.35, p=0.003), but BIS and ASIQ were not correlated (p=0.44). There was no interaction between the groups. Covarying IQ and education did not alter the results. For METH-users, BIS was negatively correlated with length of abstinence (r=-0.30, p=0.03), but not duration or lifetime grams METH used. Conclusions: Depression and impulsivity need to be addressed in METH treatment due to the greater risk for suicide in those who are depressed, and who in turn might have greater impulsivity. Longitudinal studies are needed to assess if symptoms will diminish with abstinence.

TUESDAY, MAY 17, 2011
12:00 PM - 1:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 27

SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS

No.1
IS VITAMIN D IMPORTANT IN THE SEVERELY MENTALLY ILL?

Nigel Bark, M.D., Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Know that vitamin D is very low in schizophrenia and the severely mentally ill; 2) Should be able to identify the known effects of vitamin D or the lack of it: prenatally and in infancy as a risk factor and in adults on general health, diabetes, life expectancy etc; and 3) Wonder at the apparent absence of effects on psychopathology or outcome.

SUMMARY:
BACKGROUND: Low Vitamin D levels are associated with increased mortality, diabetes, BMI, Parkinson's disease, falls, smoking, incontinence, perhaps depression and cognitive functioning, and nonwhite race, all of which are features of patients in the authors' hospital. Deficient vitamin D perinatally is a risk factor for schizophrenia and in adult rats it increases dopamine in the cortex and hypothalamus. Low vitamin D has been reported in severely mentally ill patients but there is no evidence yet of whether it affects their symptoms or outcome. METHODS: All patients in a State hospital are having their Vitamin D level measured. This is being correlated with demographics, medical and psychiatric measures and movement disorders. An open label 3 month intervention study of those with low vitamin D has started. RESULTS: As of September 2010 143 subjects have been included, 104 with vitamin D levels. 33 had normal levels (30-100ng/ml), 20 insufficient levels (20-29.9ng/mL), 43 deficient levels (<20ng/ml) and 8 below 7ng/ml. There were significant correlations of vitamin D level with prescription of vitamin D, age and years of illness (because the elderly were prescribed vitamin D), BPRS activation, CGI, tardive dyskinesia and negative correlations with GAF and HBA1C. There was a trend towards a correlation with BPRS total and negatively with diabetes. There was no correlation with skin color, race, age of onset, sex, BPRS positive, negative or depression/anxiety, BMI, cholesterol, triglycerides, calcium, phosphorous, uric acid, blood pressure, smoking status, Parkinsonism, Akathisia, falls, psychiatric diagnosis or months in hospital. 12 subjects have entered the intervention study, with a slight improvement in the PANSS but this may be a time effect. DISCUSSION: The survey and the study are half way through. Updated results will be presented and whether Vitamin D is important in the severely mentally ill will be discussed.

REFERENCES:

1) Holick MF. Vitamin D Deficiency. N Engl J Med 2007; 357:266-81
2) McGrath JJ, Eyles DW, Pedersen CB etal Neonatal Vitamin D Status and Risk of Schizophrenia. Arch Gen Psychiatry 2010;67:889-894.

No.2
EXAMINING THE RESHAPING OF AN ENDURING SENSE OF SELF: THE PROCESS OF RECOVERY FROM A FIRST EPISODE OF SCHIZOPHRENIA

Donna Romano, M.S.C., Ph.D., 600 University Ave, Toronto, M5G 1X5 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of the session participants should

be able to: 1) Understand the evolution of the theoretical model which accounts for the process of recovery from first episode of schizophrenia (FES); 2) Examine the concept of reshaping an enduring sense of self in the context of FES and its clinical implications; 3)Discuss interventions that promote recovery for individuals experiencing FES; and 4) Describe the implications of integrating recovery for this FES clinical population.

SUMMARY:

Although many advances in the treatment of schizophrenia have been made over the past decade, little is known about the process of recovery from a first episode of schizophrenia (FES). To date, the study of recovery in the field of mental health has focused on long-term mental illness. This in depth qualitative study drew upon Charmaz's constructivist grounded theory methodology to address the following questions: How do individuals who have experienced a FES describe their process of recovery? How does an identified individual (e.g. friend, family member, teacher, or clinician) describe their role during the participant's process of recovery, and their perception of the recovery process? Ten primary participants (who self-identified as recovering from a FES) had two interviews; in addition, there was a one-time interview with a secondary participant, for a total of 30 interviews. Data collection sources included participant semi-structured interviews, participant selected personal objects that symbolized their recovery, and clinical records. The results provide a substantive theory of the process of recovery from a FES. The emergent process of recovery model for these participants is comprised of the following phases: 'Lives prior to the illness', 'Lives interrupted: Encountering the illness', 'Engaging in services and supports', 'Re-engaging in life', 'Envisioning the future'; and the core category, 'Re-shaping an enduring sense of self,' that occurred through all phases. A prominent distinctive feature of this model is that participants' enduring sense of self were reshaped versus reconstructed throughout their recovery. The emergent model of recovery from a FES is unique, and as such, provides implications for clinical care, future research, and policy development specifically for these young people and their families.

REFERENCES:

1) Romano, D., McCay, E., Goering, P., Boydell, K., & Zipursky. (2010). Reshaping an enduring sense of self: The process of recovery from a first episode of schizophrenia. Early Interventionin Psychiatry, 4(3), 243-250.
2) Charmaz, K. (1990). Discovering chronic illness: Using grounded theory. Social Science in Medicine, 30, 1161-1172

No.3

AHEAD OF HIS TIME: A CENTENNIAL REVISIT OF BLEULER'S GROUP OF SCHIZOPHRENIAS AND IMPLICATIONS ON PATIENT CARE AND TREATMENT

Roger Peele, M.D., P O Box 1040, Rockville, MD 20849-1040

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Identify the prominent symptoms of schizophrenia; 2) Analyze diagnostc procedures; 3) Diagnose schizophrenia and its variations; and 4) Treat schizophrenia

SUMMARY:

In Dementia Praecox or the Group of Schizophrenias published in 1911, Bleuler "called dementia praecox 'schizophrenia' because the 'splitting' of the different psychic functions is one of its most important characteristics." Using this terminology, he was able to encompass disorders with similar presentation. He proceeded to explain the concept of splitting by describing the alterations in psychic functions, which he'd been observing in patients. He proposed that certain symptoms were present and characteristic of schizophrenia at every period of the illness and identified them as "the fundamental symptoms." The fundamental symptoms included alterations in simple functions such as association, affectivity and ambivalence and in compound functions such as autism, attention, and will. Hallucinations, delusions along with somatic and catatonic functions were defined as "the accessory symptoms." His concept has come to be known as 4 As of schizophrenia. Over the last 100 years, the defining symptomatology of schizophrenia has been modified multiple times with the emergence of new theories and ongoing research. The presenting symptoms of schizophrenia were classified as positive and negative symptoms. Bleuler's fundamental symptoms started to be referred to as negative symptoms. As a consequence of positive effect of typical antipsychotics on visible symptoms and change in nomenclature, the positive symptoms became the cardinal and diagnostic symptoms of schizophrenia. The less rich and positive symptom oriented definition of

schizophrenia in *DSM-III* influenced the concept of schizophrenia and had significant implications on patient care and treatment and on the focus of clinical research. The efficacy of clozapine on negative symptoms of schizophrenia and resulting improvement in the functioning and quality of life of the patients with schizophrenia drew the attention back to the negative symptoms. The advances in neuroimaging and neuroscience disclosed the significance of impaired neurocircuits involved in cognitive processes in the pathophysiology of schizophrenia. We will discuss the results of current research that indicate the impairment in differential cognitive functions in schizophrenia, its correlation with Bleuler's description and its implications on patient care and treatment.

SCIENTIFIC AND CLINICAL REPORT SESSION 28- PATIENT SAFETY & SUICIDE

No.1

THE PSYCHIATRIC PAUSE: REDUCING NEGATIVE OUTCOMES BY REQUIRING SERIAL EVALUATIONS BEFORE DISCHARGE

Stephen Cummings, M.D., 222 W 39th Ave, San Mateo, CA 94019

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify potential clinical and medical-legal benefits of required serial evaluations of potentially dangerous patients in psychiatric emergency rooms; 2) Perform, or describe how to perform, such serial evaluations; and 3) List typical problems in implementing a requirement for serial evaluations and describe potential solutions

SUMMARY:
Objective: To report experience with required serial evaluations before discharge (the "psychiatric pause") over a four year period at a public hospital psychiatric emergency room. Method: A discussion of the rationale for the psychiatric pause, a description of its implementation at one hospital, and a preliminary report on experience with its use there over a 4 year period. Results: There have been few suicide attempts shortly after discharge among patients evaluated with a psychiatric pause. Use of the psychiatric pause has not led to serious workflow problems, the procedure has been accepted by patients and emergency psychiatrists, and reaction on the part of JCAHO site visitors has been favorable. Conclusions: The psychiatric pause is a potentially useful method for reducing negative outcomes following psychiatric emergency room visits and deserves further discussion and study.

No.2

USING THE JEOPARDY GAME FORMAT TO TEACH RESIDENTS ABOUT REDUCING MEDICATION ERRORS

Geetha Jayaram, M.D., M.B.A., Meyer 4-101, Johns Hopkins Hospital,, Baltimore, MD 21287

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the need to be knowledgeable about medication errors; 2) Work with pharmacists to avoid common pitfalls in prescribing; and 3) Use electronic systems to avoid adverse events.

SUMMARY:
Background:The focus on errors in psychiatry began with the IOM report in 2001. Since then, efforts have been made to identify systems problems, errors in processes of prescribing, transcribing, and dispensing medications to patients primarily on psychiatric inpatient units. Method:We studied medication error reduction by the use of an electronic Physician Order Entry System (POE), electronic error reporting system (Patient Safety Net PSN),nurse and resident training, and a systematic data collection system that monitored changes in numbers and types of errors. Among education formats that were highly popular with residents was the Jeopardy game format for teaching. Results: Over 5 years,we accomplished significant error reductions. Reported errors (confirmed by independent audit of charts chosen by random numbers)of prescribing and transcribing per 1,000 billed doses decreased over time from 1.47 to .25 to .14 in 2003, 2005 and 2007, respectively, with electronic entries. Reported errors of preparation and administration per 1,000 billed doses also decreased from 1.17 to .46 to .29 in 2003, 2005 and 2007 respectively(All results with p values <.002 to .000001 levels. Kappa scores of inter-rater reliability of audits was 0.60 or greater. Conclusions: The Jeopardy game format is a useful tool for teaching

about avoiding med errors. A game will be played during the workshop with 2 teams of residents or junior faculty to illustrate.

REFERENCES:

1) 1.Jayaram G. Medication Errors in Psychiatric Treatment: Where Do We Go From Here? Psychiatry. 2007;(4):63-64.
2)Jayaram G, Herzog A. Handbook on Patient Safety: SAFEMD: Practical Applications and Approaches to safe Psychiatric Practice. APPI Press 2009. ISBN: 978-0-89042-345-5.
3) K. Purcell. MD, PharmD. Teaching clinical pharmacology and toxicology to pediatric residents: use of a Jeopardy Game Format. Clinical Pharmacology and therapeutics, Vol 65, No. 2,Pg 173.

No.3
ETHNIC DIFFERENCES IN SUICIDE ATTEMPTS IN THE UNITED STATES

Shay-Lee Bolton, M.S., PZ430-771 Bannatyne Avenue, Winnipeg, R3E 3N4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Discuss the relevant literature on race/ethnic differences on suicidal behavior; and 2) Identify common and race/ethnic specific correlates of suicide attempts.

SUMMARY:
Controversy exists around the relationship between ethnicity and suicidal behavior. Some studies indicate higher risk among Whites compared with other ethnic groups, such as Blacks or Hispanics, yet others have suggested the converse. There is also some question as to whether risk and protective factors for suicide attempts measured in general population samples may not apply to specific ethnic groups. A recent review in this area noted that there is a need for large studies in general population samples, allowing exploration of differences in the prevalence and correlates of suicide attempts among a range of ethnic groups. The aim of the current study is to examine the prevalence and correlates (risk and protective) of suicide attempts in a large, representative, and ethnically diverse sample of the American general population. Data were from the National Epidemiologic Survey of Alcoholism and Related Conditions (NESARC; N=34,653), the largest nationally-representative mental health survey ever conducted. Race/ethnic categories were based on self-identified race/ethnicity. Descriptive and logistic regression analyses were utilized to examine differences in prevalence and correlates of lifetime suicide attempts among Whites, Blacks, American Indians/Alaska Natives, Asians/Native Hawaiians/Other Pacific Islanders, and Hispanics (any race). All analyses were stratified by sex. The highest prevalence of SA was consistently noted among male and female American Indians/Alaskan Natives, with 3.1% and 9.2%, respectively. American Indian/Alaska Native females were twice as likely as White females to report a lifetime history of suicide attempt (Unadjusted odds ratio [OR] = 2.18, 95% Confidence Interval [CI]: 1.47-3.22). In contrast, Asian/Native Hawaiian/Other Pacific Islander females were less than half as likely as White females to endorse a lifetime suicide attempt (OR=0.42, 95% CI: 0.22-0.78). No significant differences were noted in prevalence of suicide attempts among males. A range of differences in correlates of suicide attempts will be described. In conclusion, this study is the first to explore the relationship between suicide attempts and ethnicity in a large ethnically diverse general population sample. As ethnic diversity in the US continues to increase, the identification of common and specific risk and protective factors for suicide attempts is critical. This study hopes to shed some light on this controversial area.

REFERENCES:

1) Perez-Rodriguez MM, Baca-Garcia E, Oquendo MA, Blanco C. Ethnic differences in suicidal ideation and attempts. Prim Psychiatry 2008, 15: 44-53.
2) 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 Psychiatr Scan 2004, 110: 446-451.

WEDNESDAY, MAY 18, 2011
7:00 AM - 8:30 AM

SCIENTIFIC AND CLINICAL REPORT SESSION 29-
MOOD DISORDERS -2

No.1
EFFICACY OF VALPROIC ACID, LITHIUM CARBONATE AND CARBAMAZEPINE IN MAINTENANCE PHASE OF BIPOLAR

DISORDER- A NATURALISTIC STUDY

Eric Peselow, M.D., 308 Seaview Ave., Staten Island, NY 10305

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate the efficacy of lithium, depakote and tegretol in the prophylaxis of recurrent bipolar illness in order to ensure optimum treatment.

SUMMARY:
Background -Bipolar disorder is a lifelong illness for 90% of patients who experience a manic episode. Maintenance treatment is usually recommended. Our goal was to look at the efficacy of lithium, depakote and tegretol as maintenance treatment of bipolar disorder in a naturalistic setting. Method- 225 outpatients with bipolar disorder were followed for up to 124 months, or until they had a manic or depressive episode, or dropped out of the study well 98 patients (43.6%) were taking lithium, 77 (34.2%) depakote, and 50 (22.2%) tegretol. Results- A total of 103 patients (45.8%) had either a manic or depressive episode during the study period. Across the medication groups, 36.7% of the patients taking lithium (N = 36), 54.5% of the patients taking depakote (N = 42), and 50% of the patients taking tegretol (N = 25) had either a manic or depressive episode at some point during the 124 month study period. The median survival time was 45.76 months for the entire sample, 36 months the depakote group, 42 months tegretol, and 81 months for lithium. 52 patients dropped out of the study well and 70 remained in the study well. A cox regression model evaluating the probability of having a manic or depressive episode among the three medications after controlling for several covariates showed that patients taking depakote had a significantly higher risk of having a manic or depressive episode than patients taking lithium. For patients taking depakote the hazard of having a manic or depressive episode was 1.63 (CI 1.01 - 2.63) times higher vs. patients taking lithium. Thus, the hazard of becoming unstable was 38.5% lower in patients taking lithium compared to those taking depakote. There was a non-significant trend for greater maintenance efficacy of lithium vs tegretol and tegretol vs depakote. Conclusion- Lithium patients had statistically better maintenance than the depakote group and a trend toward better maintenance vs.the tegretol group in this naturalistic setting.

REFERENCES:

1) Graham J, Munro A, Slaney C et al. Prophylactic treatment response in bipolar disorder: Results of a naturalistic observation study. Journal of Affective Disorders 104 (2007)
pp185-190

No.2
L-METHYLFOLATE AUGMENTATION OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS FOR MAJOR DEPRESSIVE DISORDER: RESULTS OF TWO RANDOMIZED, DOUBLE-BLIND TRIALS

George Papakostas, M.D., One Bowdoin Square, 6th floor, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate and discuss the results of two randomized, double-blind trials of L-methylfolate augmentation of SSRIs in SSRI-resistant depression.

SUMMARY:
Objective: To evaluate the efficacy of L-methylfolate as augmentation for major depressive disorder (MDD). Methods: Two randomized, placebo-controlled trials of L-methylfolate (Deplin) augmentation of SSRIs were conducted. To enhance signal detection, a novel study design (sequential parallel comparison design-SPCD) was employed. In study one (TRD-1), 148 outpatients with SSRI-resistant MDD were enrolled in a 60-day, SPCD study, divided into two 30-day periods (phases 1 and 2). Patients were randomized in a 2:3:3 sequence to receive L-methylfolate (7.5mg/d in phase 1, 15mg/d in phase 2), placebo in phase 1 followed by L-methylfolate 7.5mg/d in phase 2, or placebo for both phases. Study two (TRD-2) involved 75 outpatients with SSRI-resistant MDD, and was identical in design to TRD-1 with the exception of the target dose of L-methylfolate (15mg). Results: In the TRD-1 Study, L-methylfolate 7.5 mg/d was not found to be more effective than placebo (weighted difference in response rates, approximately 3% in favor of placebo). However, the response rate for L-methylfolate (7.5mg/d) non-responders during phase 1 who underwent an increase in L-methylfolate dose (15mg/d) during phase 2 was 24.0% compared to 9.0% for

placebo (p=0.1). In phase 1 of the TRD-2 Study, 37% of the patients on L-methylfolate (15mg/d) responded and 18% placebo patients responded, while in phase 2 among placebo non-responders, the response rates were 28% on L-methylfolate (15mg/d) and 9.5% on placebo. When phases 1 and 2 were analyzed according to the SPCD model, the pooled difference in response rates was statistically significant in favor of L-methylfolate (p=0.0399). In terms of tolerability, the rates of spontaneously reported AEs appear to be rather comparable between L-methylfolate and placebo in both studies. In the same population, the rates of study discontinuation were also rather comparable (11.3% in TRD-1 and 10.8% in TRD-2 for L-methylfolate and 12.0% in TRD-1 and 10.4% in TRD-2 for placebo). Conclusion: These studies suggest that 15 mg/d of L-methylfolate may be a safe and effective augmentation strategy for patients with inadequate response to SSRI treatment. These studies were funded by Pamlab, LLC.

No.3

ASSESSMENT OF A BIOMARKER PANEL FOR MAJOR DEPRESSIVE DISORDER IN A COMMUNITY BASED STUDY

Perry Renshaw, M.D., Ph.D., 383 Colorow Drive, #309, Salt Lake City, UT 84108

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the clinical value of the application of a multianalyte biomarker panel to MDD diagnosis and patient management.

SUMMARY:
Objective: The objective of this study was to begin to assess the clinical validity and utility of a multianalyte panel of biomarkers for depression. Method: The MDDScore™ test was developed by evaluation of a group of serum-based biomarkers known to have a role in key physiological processes that play a role in depression, including representative markers of the neurotrophic, metabolic, inflammatory, and HPA axis processes. To evaluate the diagnostic application and clinical value of the test, a Clinical Experience Program (CEP) was conducted with a group of medical professionals in psychiatry who see and/or treat patients with psychiatric disorders including MDD. Following IRB approval, each participating physician was asked to enroll patients (~10) previously diagnosed with or suspected to have MDD based on clinical signs and symptoms. All participating patients had a clinical diagnosis of or clinical symptoms consistent with depression and were either untreated or undergoing antidepressant therapy at the time of the study. A total of 95 patients with a range of psychiatric diagnoses, albeit predominantly MDD, were enrolled over a period from December 2009 to March 2010, and 80 of these completed the study. The mean age of the study population was 48.5 ± 12.6 with a range from 21-80 years. Fifty-six (70%) were female and 24 (30%) were male. On each patient sample, the MDDScore™ was determined by quantitative immunoassay and a group optimized and weighted algorithm. Results: The MDDScore™ results for the CEP patients encompassed the reportable range of the test, ranging from <1 to >9, with 1 a low risk of MDD and 9 a high risk. The CEP group had a with mean score of 8.1 ± 2.3. In this clinical population, the test score was highly predictive of the previously established clinical diagnosis for individual patients, with a percent concordance of >89%. Nine of eighty patients had low (<4) or indeterminate (~5) MDDScores™. When MDDScores from male and female CEP patients, 21-50 years, were compared to an age and sex matched population of healthy normal subjects, the mean MDDScore for Patients (n=28) was 7.9 ± 2.3 while normal subjects (n=28) had a mean score of 2.8 ± 2.1. Conclusion: The p value for segregating MDD patients from healthy normal subjects was highly significant ($p < 0.0001$) over a broad range of male and female patients within a community based population. Case studies supporting the clinical utility of the test will also be presented.

No.4

DECREASE IN DEPRESSION PREDICTS LONGER SURVIVAL WITH METASTATIC BREAST CANCER

David Spiegel, M.D., Room 2325 401 Quarry Road, Palo Alto, CA 94305-5718

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the relationship between depression and cancer progression.

SUMMARY:
Purpose: Numerous studies have examined the co-morbidity of depression with cancer, and some

have indicated that depression may be associated with cancer progression or survival. However, few have assessed whether changes in depression symptoms are associated with survival. Methods: In a secondary analysis of a randomized trial of supportive-expressive group therapy, 125 women with metastatic breast cancer completed a depression symptom measure (CES-D) at baseline and were randomized to receive treatment or to a control group that received educational materials. At baseline and 3 follow-ups, 101 of these women completed a depression symptom measure. We used these data in a Cox Proportional Hazards analysis to examine whether decreasing depression symptoms over the first year of the study (the length of the intervention) would be associated with longer survival. Results: Median survival time was 53.6 months for those decreasing on CES-D scores over one year and 25.1 months for those increasing. There was a significant effect of change in CES-D over the first year on survival out to 14 years ($p = 0.007$), but no significant interaction between treatment condition and CES-D change on survival. Neither demographic nor medical variables associated with survival time such as age at diagnosis, disease-free interval, or hormone receptor status accounted for explained this association. Conclusions: Decreasing depression symptoms over the initial year were associated with longer subsequent survival for women with metastatic breast cancer in this sample. Further research would be necessary to confirm this hypothesis in other samples, and causation cannot be assumed based on this analysis.

REFERENCES:

1) Decrease in Depression Symptoms is Associated with Longer Survival inMetastatic Breast Cancer Patients: A Secondary AnalysisJanine Giese-Davis1, Kate Collie, Kate M. S. Rancourt, Eric Neri, Helena C. Kraemer, David Spiegel. Journal of Clinical Oncology, in press.

SCIENTIFIC AND CLINICAL REPORT SESSION 30

PERSONALITY DISORDERS

No.1

SCHEMA THERAPY: A COMPREHENSIVE TREATMENT FOR BORDERLINE PERSONALITY DISORDER

Heather Fretwell, M.D., 2919 S Post Rd, Indianapolis, IN 46239

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the treatment model of schema therapy for borderline personality disorder; 2)Identify its comparative effectiveness to treatment as usual; 3) Identify appropriate clients for referral; and 4) Describe the implementation of this model in group therapy format at a community mental health center.

SUMMARY:

Objective: This clinical report is designed to describe recent research for the treatment of Borderline Personality Disorder with Schema Therapy. Schema Therapy (ST) is a relatively new and highly effective treatment for BPD patients. Based on an integrative model, borrowing techniques and insights from CBT, attachment theory and other developmental theories, experiential therapies, psychodynamic theories, and interpersonal therapies, it offers a treatment model of BPD that is highly valued by many patients and therapists. Method: So far, 3 RCT's and one case series study have tested effectiveness and cost-effectiveness, and demonstrated favorable results of ST. This report will focus on two RTC's, one for individual ST and one for group ST, as well as give an update on the adaptation of the ST group therapy model in an community mental health center program consisting of 100+ patients with BPD. Outcome measures include the BPDSI, GAF, patient retention, and cost of care. Results: Notably, these studies demonstrated that ST can lead to full recovery of BPD and a quality of life in the normal range of the general population, and demonstrate cost effectiveness in clinical settings. Conclusion: ST can be successfully implemented in regular health care. An important new development is the use of group-ST which is not only potentially less costly than individual ST, but also seems to accelerate recovery from BPD by the use of specific group factors.

REFERENCES:

1) Giesen-Bloo, Josephine, et al. "Outpatient Psychotherapy for Borderline Personality Disorder: A Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy." Arch Gen Psychiatry. 2006;63:649-658.

2) Farrell, Joan, et al. "A schema-focused approach to group psychotherapy for outpatients with borderline

personality disorder: A randomized controlled trial." Journal of Behavior Therapy and Experimental Psychiatry Volume 40, Issue 2, June 2009, Pages 317-328

No.2

SMOKING IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Frances Frankenburg, M.D., 200 Springs Road, Bedford, MA 01730

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize that almost half of borderline patients smoke on a regular basis; and 2) Recognize that smoking is a significant risk factor for serious respiratory disease in patients with BPD.

SUMMARY:
This study has two main objectives. The first is to determine the prevalence of smoking among patients with borderline personality disorder (BPD) and axis II comparison subjects. The second is to assess the relationship between smoking and serious respiratory disease in these patient groups. Method: 290 patients meeting both DIB-R and *DSM-III-R* criteria for BPD and 72 axis II comparison subjects were interviewed concerning their smoking habits and physical health six times over 10 years of prospective follow-up. These blinded assessments were made every two years using a semi-structured interview of proven reliability. Results: Borderline patients were significantly more likely than axis II comparison subjects to be regular smokers (steady rates over time of about 45% vs. 30%). In addition, smoking in borderline patients was a significant risk factor for chronic bronchitis (RRR=1.9), emphysema (RRR=12.9), and the overarching category of COPD (RRR=2.2) but not in axis II comparison subjects. Conclusions: Taken together, the results of this study suggest that smoking is a common and persistent problem in patients with BPD. They also suggest that smoking is a significant risk factor for serious respiratory disease in borderline patients.

REFERENCES:
1) Frankenburg FR, Zanarini MC: The association between borderline personality disorder and chronic medical illnesses, poor health-related life style choices, and costly forms of health care utilization. J Clin Psychiatry 2004; 65:1660-1665.

No.3

DUAL CHALLENGE IN THE FIELD: HOW TO IDENTIFY AND TREAT PATIENTS WITH CO-MORBID DIAGNOSES OF BIPOLAR AND BORDERLINE PERSONALITY DISORDERS

Bernadette Grosjean, M.D., Harbor UCLA 1000 West Carson streetbox 497, Torrance, CA 90509

EDUCATIONAL OBJECTIVES:
At the end of this report, the participant should able to: 1) Identify the symptoms necessary to make a differential diagnosis between borderline personality disorder and bipolar disorder as either isolated or co-occurring disorders; and 2) Participants will be able to identify the therapeutic approaches needed to address these different problems and will have a better understanding of the specific challenges the provider faces when dealing with such dual pathology within a therapeutic team.

SUMMARY:
In 2004, California's voters passed Proposition 63 (Mental Health Services Act)to improve the delivery of mental health services . As a result, Full Service Partnership (FSP) programs were implemented. Patients referred to FSP are adults diagnosed with a severe mental illness who require intensive delivery of services in the community. The majority are homeless and high utilizer of state and county services: emergency room, inpatient units and jail. The FSP team task is to do "whatever it takes" to outreach, engage and treat in the field patients who present multiple and severe psychopathology. After three years, our team realized that many of our patients were presenting a borderline personality disorder beside the severe axis I diagnosis required to enter the program. This clinical observation confirmed indirectly previous researches showing that patients with bipolar disorder and personality disorder had significantly more lifetime day hospitalized and more severe symptomatology than those without PD (Barbato and Hafner(1998), were less likely to show symptoms recovery and less functional recovery (Duynarich et al 1996, 2000) and had worse outcome, lower rate of employment, more complex medication regimen and greater likelihood of substance abuse(Kay et al 2002; Bieling et al 2003). In this presentation the author will examine the data from the literature and from Harbor UCLA FSP program related to this dual pathology. She will then review the clinical diagnosis

and therapeutic challenges presented by that population. Finally she will offer general guidelines to work with patients presenting these complex and intricate psychopathology.

REFERENCES:

1) Descriptive and Longitudinal Observations on the Relationship of Borderline Personality Disorder and Bipolar Disorder. Gunderson et al. American Journal of Psychiatry 163 (7): 1173. (2006)

No.4
IMPLEMENTING STEPPS IN IOWA PRISONS

Donald W. Black, M.D., Psychiatry Research MEB, Iowa City, IA 52442

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand borderline personality disorder as an emotional intensity disorder; 2) Describe the STEPPS approach to treatment; and 3) identify its role in the treatment armamentarium in correctional settings.

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, programs to treat BPD in prisons. The Iowa Department of Corrections recognized that offenders with BPD have special needs that were not being addressed, and have been instrumental in implementing the STEPPS program in Iowa prisons to fill this gap. We describe the use of STEPPS in men's and women's units in Iowa prisons. The program has also been used in community corrections. 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 show 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. STEPPS has been disseminated widely throughout the US and is now being used in prisons in several states.

REFERENCES:

1) Black DW, Blum N, 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.

WEDNESDAY, MAY 18, 2011
9:00 AM - 10:30AM

SCIENTIFIC AND CLINICAL REPORT SESSION 31

ATTENTION SPECTRUM DISORDERS

No.1
ASSESSMENT OF COGNITIVE CHANGE IN ADULTS AND CHILDREN WITH ATTENTION DEFICIT DISORDER DURING MEDICATION TREATMENT

Kathleen Decker, M.D., 100 Emancipation Dr, Hampton, VA 23607

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize cognitive measures that change during treatment of ADD with medication; 2) Approach treatment of patients with ADD in a more quantitative manner; 3) Apply known cognitive tests to their treatment of patients with ADD to; and 4) Evaluate medication response in routine office clinical settings.

SUMMARY:
Objective: The goal of this study was to examine cognitive functioning in the course of routine community psychiatric treatment for Attention Deficit Disorder (ADD) in adults and children during routine clinical office practice using an abbreviated (1-hour) cognitive test. Method: Adult (n=12) and pediatric (n=11) patients from a solo clinical psychiatric practice who met *DSM-IV*

criteria for ADD underwent abbreviated cognitive testing. The Slosson Full-Range Intelligence Test (SFRIT) was administered prior to treatment and after 3-6 months of medication treatment for ADD with stimulants and/or certain antidepressants. Paired student's t-test was applied to each patient's age-adjusted cognitive performance on the SFRIT overall (Full-Range Intelligence Quotient or FRIQ) and its subscales-Verbal, Performance, Memory, Abstract and Quantitative. Results: Adults treated for ADD showed significant improvement on memory and abstract scales of the SFRIT after treatment with psychotropic medications (p=.01, .03 respectively). Pediatric patients demonstrated improvement on the SFRIT overall and all subscales of the SFRIT after treatment with p<.05 on FRIQ, Verbal, Performance, Memory, Abstract and Quantitative scales. Conclusions: Significant improvement was noted in memory, performance and abstract subscales in patients treated with psychotropic medications for Attention Deficit Disorder in both adults and children. Improvement in verbal scores was variable in adults and did not achieve statistical significance, although pediatric patients improved on all subscales. Therefore, this measure may be clinically useful as one of several methods of monitoring improvement in both adults and children during medication treatment of ADD. Limitations of the study include the fact that the sample size was small and that although this is a highly structured test, the psychiatrist was not blind to treatment status while administering the SFRIT. Clinicians in private practice can administer a rapid, quantitative cognitive test (SFRIT) to monitor progress in treatment of ADD in adults and children during routine office practice. None of the research presented in this abstract was funded by any industry or institution.

REFERENCES:

1) Biederman J, Seidman LJ, Petty CR, Fried R, Doyle AE, Cohen DR, Kenealy DC, Faraone SV. Effects of stimulant medication on neuropsychological functioning inyoung adults with attention-deficit/hyperactivity disorder. J Clin Psychiatry. 2008 Jul;69(7):1150-6.

2) Conners, CK Casat, C D Gualtieri, CT, Weller, E, Reader, M, Reiss, A, Weller, RA, Khayrallah, M, Ascher, J: Bupropion hydrochloride in attention deficit disorder with hyperactivity. J Am Acad Child & Adol Psychiatry 1996; 35(10):1314-1321.

3) Scheffler RM, Brown TT, Fulton BD, Hinshaw SP, Levine P, Stone S. Positive association between attention deficit/hyperactivity disorder medication use and academic achievement during elementary school. Pediatrics. 2009; May. 123(5): 1273-1279.

No.2

FAMILY RISK FOR DEFICIENT EMOTIONAL SELF REGULATION AND ADULT ATTENTION DEFICIT HYPERACTIVITY DISORDER

Craig Surman, M.D., 185 Alewife Brook Pkwy Ste 2000, Cambridge, MA 02138

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify that adults with ADHD are at risk for deficient emotional self regulation (desr); 2) Recognize that DESR contributes to morbidity in adults with ADHD; 3) Identify DESR symptoms in clinical practice; 4) Evaluate evidence that adults with ADHD and DESR demonstrate a phenotypic variant of ADHD rather than a comorbid condition; and 5) Consider the clinical and scientific utility of DESR as a dimensional Psychiatric construct.

SUMMARY:

Objective: A growing body of research suggests that deficient emotional self regulation (DESR) is prevalent and morbid in subjects with ADHD. Although family studies can provide a method of clarifying the co-occurrence of clinical features, no family studies have yet addressed ADHD and DESR. Method: Subjects were 83 probands with and without ADHD and 128 of their first degree relatives. All subjects were comprehensively assessed with structured diagnostic interviews. We defined DESR in adult probands and their relatives using items from the Barkley Current Behavior Scale. Analyses tested specific hypothesis about the familial relationship between ADHD and DESR. Results: Relatives of ADHD probands were at elevated risk of having ADHD irrespective of the presence or absence of DESR. Risk for DESR was elevated in relatives of ADHD+DESR probands, but not in relatives of ADHD probands. ADHD and DESR cosegregated in relatives. The risk for other psychiatric disorders was similar in relatives of ADHD proband groups. Conclusions:The pattern of inheritance of ADHD with DESR suggests that DESR may be a familial subtype of ADHD. Our data suggest that DESR is not an expression of other disorders, of non-familial environmental factors, or of effects secondary to ADHD. Further

investigation of DESR and its correlates and treatment both in and outside the context of ADHD is warranted.

REFERENCES:

1) Surman C, Biederman J, Spencer T, Miller C, Faraone SV: Understanding Deficient Emotional Self Regulation in Adults with Attention Deficit Hyperactivity Disorder: A Controlled Study. The Journal of ADHD and Related Disorders In press;
2) Barkley RA, Murphy KR: Deficient Emotional Self-Regulation in Adults with Attention-Deficit/Hyperactivity Disorders (ADHD): The Relative Contributions of Emotional Impulsivenes and ADHD Symptoms to Adaptive Impairments in Major Life Activities. Journal of ADHD and Related Disorders 2010; 1:5-28
3) Barkley RA, Fischer M: The unique contribution of emotional impulsiveness to impairment in major life activities in hyperactive children as adults. Journal of the American Academy of Child & Adolescent Psychiatry 2010; 49:503-13

No.3

GUANFACINE EXTENDED-RELEASE COADMINISTERED WITH PSYCHOSTIMULANTS: OVERALL, MORNING, AND EVENING ATTENTION-DEFICIT/HYPERACTIVITY DISORDER ASSESSMENTS

Timothy Wilens, M.D., 55 Fruit Street YAW 6A, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session participants should be able to: 1) Better understand efficacy of guanfacine extended release (GXR; dosed either upon awakening or at bedtime) coadministered with a long-acting psychostimulants for the treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents aged 6-17 years; 2) Efficacy of GXR as assessed overall and at morning and evening time points; and 3)Safety of GXR coadministered with psychostimulants for the treatment of ADHD

SUMMARY:
Objective: To examine the efficacy and safety of guanfacine extended release (GXR) coadministered with psychostimulants for the treatment of ADHD. Methods: This was a 9-week, multicenter, double-blind, placebo-controlled, dose-optimized study of GXR in subjects aged 6-17 with ADHD and suboptimal response to a psychostimulant in the opinion of the investigator. Subjects continued stable psychostimulant dose with addition of morning (AM) or evening (PM) GXR (<=4 mg/d) or placebo. Efficacy measures included the ADHD Rating Scale IV (ADHD-RS-IV), Conners' Global Index – Parent (CGI-P) morning (before school) and evening (before bedtime) assessment, and Before-School Functioning Questionnaire (BSFQ). Results: Of 461 randomized subjects, 386 (83.7%) completed the study. At endpoint, ADHD-RS-IV total scores were significantly reduced with either AM or PM administration of GXR vs placebo (both P<=0.002). The GXR + psychostimulant groups showed greater improvement vs placebo + psychostimulant on the CGI-P at morning (both P<=0.019) and evening assessments (both P<=0.002) and on the BSFQ (both P<=0.002). A greater proportion of GXR-treated subjects met symptomatic remission criteria (ADHD-RS-IV<=18) vs placebo (both P<=0.002). At endpoint, small mean (SD) decreases in supine pulse (-5.6 [12.02] bpm), and systolic (-2.2 [9.75] mm Hg) and diastolic BP (-1.2 [8.00] mm Hg) were observed in subjects receiving GXR + psychostimulant compared with subjects receiving placebo + psychostimulant (2.1 [10.65] bpm, -0.6 [8.38] mm Hg, and -0.0 [7.61] mm Hg, respectively). No unique TEAEs were reported compared with the effects reported historically for either treatment alone. Conclusions: In suboptimal responders to a psychostimulant, coadministration of GXR (AM or PM dosing) resulted in significant improvement in ADHD symptoms overall and at morning and evening time points. A greater proportion of subjects achieved remission compared with placebo + psychostimulant. No new safety findings occurred.

REFERENCES:

1) Spencer TJ, Greenbaum M, Ginsberg LD, Murphy WR. Safety and effectiveness of coadministration of guanfacine extended release and psychostimulants in children and adolescents with attention-deficit/hyperactivity disorder. J Child Adolesc Psychopharmacol. 2009;19:501-510.
2) Biederman J, Melmed RD, Patel A, McBurnett K, Donahue J, Lyne A. Long-term, open-label extension study of guanfacine extended release in children and adolescents with ADHD. CNS Spectr. 2008;13:1047-1055.

No.4

EFFICACY OF REBOXETINE IN ADULTS WITH ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER: A RANDOMIZED, PLACEBO-CONTROLLED CLINICAL TRIAL

Mehdi Tehranidoost, M.D., South Kargar Avenue, Tehran, 13337-15914 Iran

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the role of "reboxetine" in treating adult ADHD.

SUMMARY:
Background: Attention-deficit-hyperactivity disorder is a common disorder in adults. Stimulants are used as the first line treatment in this disorder. Because of some concerns of using stimulants, the non-stimulant drugs have been considered in adult ADHD. The main aim of this study is to evaluate the efficacy of reboxetine, which is a specific noradrenergic reuptake inhibitor (SNRI), in adults with ADHD. Methods: In a double blind placeb-controled clinical trial, the efficacy of 8 mg per day of reboxetine (twice daily) was compared with placebo in 40 adult patients diagnosed with ADHD. The measures were Conner's Adult ADHD Rating Scale (Self-report, Screening version) - (CAARS-S), Hamilton Anxiety and Depression Rating Scales, Clinical Global Impression – Severity Scale CGI-S, and Global Assessment of Functioning Scale GAF. Results: There was a main effect of time and significant time X type of treatment (reboxetine vs placebo) interaction on CAARS subscales and CGI scores which decreased along the study ($P<0.01$). There was also a main effect of time and time X treatment interaction on GAF score which increased at the end point of the study ($P<0.01$). In terms of Hamilton Anxiety and Depression Inventonies there was just a main effect of time on Hamilton Depression Scale ($P<0.01$). Irritability, anxiety, sleep disturbance and dry mouth were the common side effects of reboxetine. Conclusion: Reboxetine could be used and tolerated as an effective treatment for adult patients with ADHD.
Keywords: Adult ADHD, Reboxetine, SNRI.

SMALL INTERACTIVE SESSIONS
SUNDAY, MAY 15, 2011
7:00 AM SESSION

SMALL INTERACTIVE SESSION 01
UNDERSTANDING THE PERSON BEHIND THE ILLNESS: AN APPROACH TO PSYCHODYNAMIC FORMULATION

Residents Only
William H. Campbell, M.D., M.B.A., 1660 South Columbian Way, Seattle, WA 98108-1532 U.S.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Develop a psychodynamic formulation based on historical information obtained during a psychiatric interview.

SUMMARY:
This session 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 sample psychodynamic formulation based on information obtained from a patient interview to illustrate the approach. Group discussion will be encouraged to facilitate learning.

REFERENCES:
1. Kassaw K, Gabbard GO: Clinical case conference: Creating a psychodynamic formulation from a clinical evaluation. Am J Psychiatry 2002; 159:721-726.
2. Perry S, Cooper AM, Michels R: The psychodynamic formulation: Its purpose, structure, and clinical application. Am J Psychiatry 1987; 144:543-550.

9:00 AM SESSIONS
SMALL INTERACTIVE SESSION 02
HOW TO START AND MANAGE YOUR ACADEMIC CAREER

Julio Licinio, M.D., John Curtin School of Medical Research, Australian National University, Building 131 Garron Road, Canberra, ACT 2601 Australia

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify academic opportunities for early career psychiatrists; 2) Recognize and address professional challenges in academic psychiatry; and 3) Attain and to manage professional growth.

SUMMARY:
Academic psychiatry is a career path that requires considerable personal and professional investment. Many individuals start on this path without a clear plan and vision and after years of effort they leave academia. That is due to insufficient planning and lack of a career management strategy. There are abundant opportunities upon graduation from residency. Academia may be at first one of the most challenging. Such a pathway requires additional research training, typically in the form of a research fellowship or a second degree such as a Masters or PhD in translational investigation. Salaries during the post-residency research-training period are low and not competitive with private practice. Subsequently, one enters a highly competitive job market that may easily require a geographical move. Entry-level academic positions are relatively easy to obtain; however, after an initial period of support, the junior faculty member must raise funds for her/his own salary and for the cost of his research activities, including salaries for research team members. Competition for such funds is fierce and requires excellence, persistence and strategic thinking. In this session, we will discuss in an interactive manner the opportunities and challenges of pursuing an academic career in psychiatry. Topics to be approached include: choice of subspecialty, mentorship, research training pathways, pros and cons of a second degree, geographical moves, choice of institution, funding strategies, juggling career, family and personal needs, long-term opportunities, developing, building and nurturing one's own research team and program, and achieving and maintaining positions of leadership in the field. Despite its challenges, academic psychiatry is a viable and immensely rewarding career choice that is not adequately pursued by some of our most talented graduates. Better planning and career management may increase recruitment and retention of early-career academic psychiatrists.

SMALL INTERACTIVE SESSION 03
THE CURRENT STATE OF SCHIZOPHRENIA TREATMENT

Donald C. Goff, M.D., The Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the relative

benefits and disadvantages of currently available antipsychotic medications; 2) Be familiar with the evidence supporting and against antipsychotic polypharmacy; 3) Be familiar with interventions to improve adherence; and 4) Be familiar with new psychosocial treatment approaches, including cognitive remediation.

SUMMARY:
Currently available antipsychotic agents differ considerably in side effect profile and may differ in effectiveness. The art of treating individuals with schizophrenia involves medication selection and dosing to maximize efficacy and tolerability while minimizing medical morbidity. Equally important, clinicians must work collaboratively with the patient and other caregivers to improve adherence and psychosocial functioning. Controversies regarding polypharmacy and approaches to refractory psychosis will be discussed, in addition to new treatment modalities, including cognitive remediation.

REFERENCES:

1. Velligan DI, Weiden PI, Sajatovic M. Adherence problems in patients with serious and persistent mental illness. J Clin Psychiatry 2009; 70 (suppl 40: 1-46.
2. Freudenreich O, Goff DC. Antipsychotic combination therapy in schizophrenia. Acta Psychiatr Scand 2002; 106: 323-330.

MONDAY, MAY 16, 2011
8:00 AM SESSION

SMALL INTERACTIVE SESSION 04 OPPORTUNITIES IN THE ADDICTION FIELD: WHAT YOU SHOULD KNOW ABOUT TREATMENT, TRAINING AND RESEARCH

For Residents Only

Marc Galanter, M.D., New York University School of Medicine, 550 First Avenue, Room NBV20N28, New York, NY 10016

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants will be able to: 1) make use of a greater understanding of (1) effective management of substance abusing patients; (2) education and training opportunities in the addiction field (including fellowships); and (3) future dimensions of research in the field.

SUMMARY:
Every physician completing a psychiatry residency in our current era of evidence-based medicine should have a firm grounding in specific techniques which have been found effective in treating the substance-abusing patient. This session will provide an overview of these techniques and the opportunities to apply them in practice. It will also provide a grounding in options for addiction research and fellowship training for those who are interested. The topics covered by the Director of the Division of Alcoholism and Drug Abuse and Fellowship Director at NYU will include psychotherapeutic modalities, such as cognitive behavioral therapy, contingency management, family and network therapy, and motivational interviewing, which have been shown to be valuable in engaging patients in treatment and helping them sustain abstinence; and pharmacologic approaches, including longstanding modalities such as disulfiram and methadone maintenance, and more recently, buprenorphine. Alcoholics Anonymous is a longstanding approach available to physicians, and the technique of Twelve-Step facilitation offers clinicians the opportunity to help their patients become involved in a recovery regimen. Another important aspect of the field is that of physician recovery from substance abuse problems, as implemented through respective state programs. There are many research opportunities as well, as illustrated by techniques in development of vaccines for nicotine and cocaine; diverse pharmacologic opportunities for new treatments; and psychosocial modalities. All these provide a perspective on dimensions emerging in the field. Some residents may be considering further training in the form of a PGY 5 fellowship, and this session will also give indication of the options available in that regard, and the different academic settings where they are established.

REFERENCES:

1. Galanter M, Kleber HK (eds): Textbook of Substance Abuse Treatment, Fourth Edition. Washington DC: American Psychiatric Publishing, 2008.
2. Galanter M: Network Therapy for Alcohol and Drug Abuse, Expanded Edition. New York: Guilford Press, 1999.

SMALL INTERACTIVE SESSION 05 PATIENTS WITH PERSONALITY DISORDERS

For Residents Only

John M. Oldham, M.D., M.S., The Menninger Clinic, 2801 Gessner Drive, Houston, TX 77080

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the framework to diagnose personality disorders proposed for DSM-5; 2) Recognize the use of dimensional personality traits to evaluate personality; 3) Identify the use of this new diagnostic system to evaluate a sample patient.

SUMMARY:

Personality disorders are prevalent and disabling conditions that are often under-recognized in clinical populations. The DSM-5 Task Force has emphasized the importance of evaluating the personality profile of all patients in treatment settings, since personality and temperament can dramatically influence treatment adherence and outcome. In this session, the draft system currently proposed for DSM-5 to clarify and diagnose personality disorders will be reviewed. A brief recorded interview of a patient will be shown, and participants will practice using the proposed DSM-5 personality disorder system to evaluate this patient. Input from participants will provide valuable feedback to the DSM-5 Workgroup on Personality and Personality Disorders.

REFERENCES:

1. Skodol AE, Bender DS, Morey LC, et al.: Dimensional Representations of Personality Disorders for DSM-5: Proposed personality disorder types (in press)

10:00 AM SESSIONS

SMALL INTERACTIVE SESSION 06
CHILD PSYCHOPHARMACOLOGY: CURRENT CONTROVERSIES

BARBARA J. COFFEY, M.D., M.S., NEW YORK
University School of Medicine, Child and Adolescent Psychiatry, 63 Westminster Road, Lake Success, NY 11020

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Identify current controversies around use of antipsychotic medications in children and adolescents (growing preschool use and metabolic issues); 2) Recognize current controversies around use of the of antidepressants and anti- epileptics in children and adolescents (suicidality and behavioral activation); and 3) Evaluate current controversies around use of the stimulants in children and adolescents (cardiac issues.)

SUMMARY:

The use of psychopharmacological agents in child and adolescent psychiatry has grown exponentially in the past decade, but data is accumulating to suggest that youth may be at increased risk for adverse effects from these medications. In a study of privately insured children, the annualized rate of antipsychotic use in preschool children increased from 0.78 to 1.59 adjusted rate ratio. The most common diagnoses were pervasive developmental disorder (28%), attention deficit hyperactivity disorder (24%), and disruptive behavior disorders (13%). Unfortunately, children and adolescents appear to be at increased risk for a variety of adverse effects of the antipsychotics, especially weight gain and metabolic problems with the atypical agents. Additionally, since 2004 with the FDA's black box warning for increased risk of suicidality in children and adolescents treated with antidepressants, there has been a controversy regarding these agents. Although meta analysis of studies of antidepressants in youth suggest a 2% increased relative risk in suicidality with antidepressants, other investigators have noted that the highest period of risk in youth is actually in the one month prior to initiation of treatment. Finally, in the past several years, there has been controversial evidence regarding cardiac adverse effects of stimulants, long regarded as both effective and safe agents. In 2008 the American Heart Association published new recommendations suggesting EKGs prior to initiation of stimulant treatment in children. The American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry published rebuttal, stating a lack of supportive evidence. However, Gould et al 2009 published a case control study of mortality data in youth, providing support for an association between stimulants and sudden death, though a rare occurrence. This workshop will provide a review, update and recommendations on these and other current controversies.

REFERENCES:

1. Barbui, C. Esposito, E. and Cipriani, A. Selective Serotonin Reuptake Inhibitors and Risk of Suicide: A Systematic Review

of Observational Studies. Canadian Medical Journal; 2009; 180 (3) 291-7.
2. Bridge, J. Iyengar, S. Salary, C. et al. Clinical Response and Risk for Reported Suicidal Ideation and Suicide Attempts in Pediatric Antidepressant Treatment. A Meta-Analysis of Randomized Controlled Trials. JAMA 2007; 297; 1683-1696.
3. Brent, D. Greenhill, L Compton, S. The Treatment of Adolescent Suicide Attempters (TASA): Predictor of Suicidal Events in an Open Treatment Trial. JAACAP 2009; 48 (101); 987-996.
4. Correll, C. et al. Antipsychotic Use in Children and Adolescents: Minimizing Adverse Effects to Maximize Outcomes. Journal of the American Academy of Child and Adolescent Psychiatry; 2008; 47 (1); 9-20.

SMALL INTERACTIVE SESSION 07
TOP 10 GERIATRIC PSYCHIATRY ISSUES FOR THE GENERAL PSYCHIATRISTS

Josepha A. Cheong, M.D., University of Florida College of Medicine, Veterans Administration Medical Center, 1601 S. W. Archer Road, Room 11-A, Gainesville, FL 32608-1135

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the key issues in the geriatric patient presenting in a general clinic setting; 2) Initiate appropriate treatment and medication of cognitive disorders; and 3) Manage behavioral disturbances in an elderly patient with cognitive disorders.

SUMMARY:
With the ever increasing population of older adults over the age of 65, the population of elderly patients in a general psychiatry practice is growing exponentially also. Within this patient population, diagnoses and clinical presentations are unique from those seen in the general adult population. In particular, the general psychiatrist is likely to encounter a growing number of patients with cognitive disorders and behavioral disorders secondary to chronic medical illnesses. Given the usual multiple medical comorbidities as well as age-related metabolic changes, the geriatric patient with psychiatric illness may present unique challenges for the general psychiatrists. This interactive session will focus on the most common presentations of geriatric patients in a general setting. In addition to discussion of diagnostic elements, pharmacology and general management strategies will also be presented. This small interactive session will use pertinent clinical cases to stimulate the active participation of the learners.

REFERENCES:
1. Cheong JA. Ask the Expert: Geriatric Psychiatry – Atypical Antipsychotics in Dementia Patients. FOCUS. J of Lifelong Learning in Psychiatry. Winter 2009 Vol. VII No 1, pp 36-37.
2. Cheong, JA. An evidence-based approach to the management of agitation in dementia. Focus,J of Lifelong Learning in Psychiatry. Pp. 197-205, May 2004

12:00 PM SESSIONS

SMALL INTERACTIVE SESSION 08
SUCCESSFUL COGNITIVE AND EMOTIONAL AGING: HOW CAN WE GET THERE

Dilip V. Jeste, M.D., University of California at San Diego, Department of Psychiatry, 9500 Gilman Drive, Room 0664, La Jolla, CA 92093

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand definitions of successful aging; 2) Identify genetic, neurobiological, and psychosocial behavioral contributors to successful cognitive and emotional aging; and 3) Learn 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. I 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, I will focus on the influences of genes, mental attitudes, health, and

health-related behaviors on aging of brain and mind. Next, I will address the question of what people can do to increase their likelihood of successful cognitive and emotional aging. I 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. I will conclude with suggestions for the role of psychiatrists and other clinicians in promoting cognitive and emotional health among our patients.

REFERENCES:

1. Meeks T. & Jeste, D.V. The neurobiology of wisdom. Archives of General Psychiatry, 66:355-365, 2009.
2. Depp CA and Jeste DV (eds): Successful Cognitive and Emotional Aging. Washington, DC: American Psychiatric Press, Inc., 2009.

SMALL INTERACTIVE SESSION 09
MANAGEMENT OF ANXIETY AND DEPRESSION IN THE MEDICALLY ILL

Catherine C. Crone, M.D., Fairfax Hospital, Department of Psychiatry, 3300 Gallows Road, Falls Church, VA 22042

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify and more effectively assess and manage anxiety and depressive disorders in medically ill patients.

SUMMARY:
As the general population ages, psychiatrists will increasingly encounter patients with co-morbid medical illnesses. The presence of these medical illnesses will often need to be factored into the care of these patients due the overlap between physical and mental symptoms, sensitivity to drug side effects, altered drug metabolism, and multiple drug regimens. The aim of this small interactive session is to provide an opportunity for participants to learn more about diagnostic and treatment considerations in the care of anxiety and depressive disorders in the medically ill. The audience is encouraged to bring their own cases for discussion to enhance the clinical utility of this session.

REFERENCES:

1. Ferrando SJ, Levenson JL, Owen JA (eds), Clinical Manual of Psychopharmacology in the Medically Ill, American Psychiatric Publishing, Washington DC 2010
2. Levenson JL (ed). The American Psychiatric Publishing Textbook of Psychosomatic Medicine, American Psychiatric Publishing, Washington DC 2005

TUESDAY, MAY 17, 2011

7:00 AM SESSIONS

SMALL INTERACTIVE SESSION 10
DIAGNOSIS AND EVIDENCE-BASED TREATMENT OF BIPOLAR DISORDER

Terence A. Ketter, M.D., Stanford University School of Medicine, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Will demonstrate increased knowledge of diagnosis of bipolar disorder; 2) Recognize sources of 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 T.A.: Handbook of Diagnosis and Treatment of Bipolar Disorder. Washington, DC, American Psychiatric Publishing, Inc., 2010

8:00 AM SESSION

SMALL INTERACTIVE SESSION 11
NEUROPSYCHIATRY AND THE FUTURE OF PSYCHIATRY

Stuart C. Yudofsky, M.D., Baylor College of Medicine, Psychiatry and Behavioral Sciences, One Baylor Plaza, MS350, Houston, TX 77030

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the historical origins of Neuropsychiaty; 2) Identify how the concept of neuropsychiatry reduces stigma and improves care; and 3) Evaluate a new residency education curriculum for psychiatry and neurology.

SUMMARY:

The origins of the concepts of neuropsychiatry will be traced from the ancient Greeks to the present time. The origins of the separation of mind and brain in modern psychiatry will be reviewed and the destructive results presented. A new conceptual approach to re-combine neurology and psychiatry will be introduced and presented. Discussion will follow regarding the current status of psychiatry, neurology and their futures.

9:00 AM SESSION

SMALL INTERACTIVE SESSION 12
CLINICAL MANUAL FOR THE MANAGEMENT OF PTSD: AN OPPORTUNITY TO MEET WITH THE SENIOR EDITORS FOR AN OPEN-FORUM INTERACTIVE DISCUSSION

Gary Wynn, M.D., Walter Reed Army Institute of Research, Center for Military Psychiatry and Neuroscience, 4215 Lorcom Lane, Arlington, VA 22207

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Evaluate the typical practice patterns of other providers in terms of additional modalities available for treating PTSD; 2) Identify aspects of available psychiatric treatments for PTSD that have relevance for improving the general care of individuals suffering from PTSD; and 3) Recognize and provide a broader range of therapeutic options to individuals with PTSD.

SUMMARY:

This small group interactive session will provide participants the opportunity to interact with the editors of the Clinical Manual for Management of PTSD and other session attendees on a wide variety of topics. The topics covered in the manual and likely to be discussed at the session include the neurobiology of PTSD as well as psychotherapy, psychopharmacology and various other somatic therapies for PTSD. Additional discussion topics from the manual that may be covered encompass areas such as emerging therapies (e.g. virtual reality therapy), disorders comorbid with PTSD, functional impairment, sociocultural considerations and topics relevant to specific populations (e.g. military populations, sexual assault victims, children and adolescents). This session will start with a brief introduction by the senior editors with the remaining time dedicated to questions and discussion. The interests and inquiries of participants will guide the topic and tenor of this forum rather than a structured lecture or presentation.

REFERENCES:

1. Benedek D.M., Wynn G.H., Clinical Manual for Management of PTSD. Washington, DC, American Psychiatric Press, 2011

10:00 AM SESSIONS

SMALL INTERACTIVE SESSION 13
CAREER DEVELOPMENT FOR WOMEN PSYCHIATRY: RESIDENTS - CHALLENGES AND SOLUTIONS

For Residents Only

Carol C. Nadelson, M.D., Brigham and Women's Hospital, Office for Women's Career, 50 Longwood Avenue, Suite 1114, Brookline, MA 2446

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; 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 14
TREATMENT-RESISTANT DEPRESSION: A ROADMAP FOR EFFECTIVE CARE
Michelle B. Riba, M.D., M.S., University of Michigan, Department of Psychiatry, 4250 Plymouth Road, Room 1533 Rachel Upjohn Building, Ann Arbor, MI 48109-2700

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the characteristics of treatment resistant depression; 2) Develop strategies to diagnose, screen and treat treatment resistant depression; 3) Apply guidelines to identify patients who may need indefinite antidepressant treatment to prevent reoccurrences; and 4) Develop strategies to prevent the development of treatment resistant depression.

SUMMARY:
Meet the Authors: this small interactive session will focus discussion on the newly released book, Treatment Resistant Depression: A Roadmap for Effective Care. Treatment Resistant Depression (TRD) develops among 30% of the millions that suffer from Major Depressive Disorder (MDD) and is responsible for a huge percentage of the burden of depression. This proposed "Roadmap" provides sequential steps to diagnose, screen, prevent, and treat TRD; summarizes clinical barriers to achieving remission among patients; recommends screening and severity rating scales to use on a routine basis, clinical warning signs of TRD; step-wise, evidence-based treatment strategies; how to integrate pharmacotherapy and psychotherapy; guidelines for identifying patients who need indefinite antidepressant treatment to prevent recurrences; when to use the newly approved neuromodulation treatments such as rTMS and VNS; and strategies for preventing the development of TRD.

REFERENCES:
1. Insel, T.R., Wang, P.S. (2009) The STAR*D trial: revealing the need for better treatments. Psychiatric Serv 60:1466-7. DOI: 60/11/1466. PMID: 19880463
2. Riba MB, Balon, R., (2008) Combining Psychotherapy and pharmacotherapy. in eds.
3. Hales, R.E., Yudofsky, S. C., Gabbard, G.O., The American Psychiatric Publishing Textbook of Psychiatry, Fifth Edition,APPI, Inc., Arlington, VA, 1279-1301

12:00 PM

SMALL INTERACTIVE SESSION 15
THE PSYCHOLOGICAL EFFECTS OF THE LONG WAR ON SOLDIERS AND FAMILIES
Elspeth C. Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize signs and symptoms of the psychological effects of war; and 2) Identify and treat Post Traumatic Stress Disorder and Traumatic Brain Injury.

SUMMARY:
In the early years of the wars in Afghanistan and Iraq, unanticipated and extended deployments were extremely taxing for military families. The murders and murder/suicides at Ft Bragg in 1992 highlighted the perils of rapid return from the battlefields in Afghanistan to civilian life. The investigation at Ft Bragg and other installations

revealed continuing problems with access to care, as well as the reluctance of career minded Soldiers to seek treatment. In response to those and other events, training and systems were put into place to prepare Soldiers for re-deployment. One of the earlier trainings, Battlemind, was designed to help re-integrate service members and families. It recently evolved into the Comprehensive Soldier Fitness program, which is focused on enhancing resiliency. Many Soldiers are reluctant to engage in care for numerous reasons, including worry about effects on their career. Often their families are the ones who try to get them to seek treatment. To try to reach all service members, behavioral health has added many new systems of evaluation and care. The Post Deployment Health Assessment (PDHA), which screens Soldiers on return from theater, was implemented after the first Gulf War. However Soldiers often did not admit to symptoms as they were returning home, since they just wanted to get there, as fast as possible. Beginning in 2005 the PDHA was joined by the Post-Deployment Health Re-Assessment, done at three to six months after return. It was designed to connect with service members after "the honeymoon was over". In order to improve access to care, the Army and other Services have dramatically increased their number of mental health providers, up about 70% between 2007 and 2010. Stigma, however, is a persistent problem, despite numerous efforts to reduce it. A tremendous amount of money has been poured into Family programs. There are specialized programs at Walter Reed and other facilities for the families of the wounded. They seek to prepare children for seeing their father or mother missing a limb, or disfigured from a blast. Another tough area has been support to families of the deceased. In the past, spouses and children had to leave their base housing and support systems relatively soon after their loved one's death. Again this has improved over time, with longer access to housing and health care. Organizations such as TAPS have been invaluable in providing support. The rising suicide rate has been a major concern for all in the Army. The combination of unit and individual risk factors include: the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. There are consistent and high profile attempts to reduce suicide with numerous trainings for service members, focusing on buddy aid and gatekeepers however, so far the efforts have only been partially successful. The prolonged effects of exposure to violence and death are not easy to change. There continue to be new efforts to try and assist. The Defense Center of Excellence stood up in November of 2007, with a focus on best practices and reducing stigma. Others are the Comprehensive Behavioral Health Campaign Plan, the DoD-VA Integrated Mental Health Plan and the National Intrepid Center of Excellence. An ongoing concern is the long term effects of the Long War, for the next twenty, thirty or fifty years.

SATURDAY, MAY 14, 2011
8:00 AM-11:00 AM

SYMPOSIUM 1
SCOPE, CURRENT EVIDENCE, AND INNOVATIVE APPROACHES IN MANAGING PTSD IN THE MILITARY

American Psychiatric Institute for Research & Education

Chair: Darrel A. Regier, M.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209
Discussant: Matthew J. Friedman, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the scope of mental health problems in military populations, with specific focus on PTSD; 2) Discuss current evidencebased approaches and challenges in the management of PTSD and related conditions in military as well as civilian populations; and 3) Become familiar with innovative national approaches for improving care for service members with PTSD.

OVERALL SUMMARY:
The scope of service members' mental health and cognitive problems associated with the wars in Iraq and Afghanistan is well documented. In a recent study of Army soldiers, rates of PTSD rose from 5% before deployment to 13% after deployment to Iraq, while depression rose from 5% to 8%(Hoge et al, 2004).This session will provide uptodate information on the extent of mental health problems in military populations; review evidencebased treatment recommendations; and discuss availability and access to care, and challenges in 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 RESPECTMIL and the PTSD Care Dissemination Project, will be presented.

S1-1
EPIDEMIOLOGY AND TREATMENT OF PTSD ASSOCIATED WITH COMBAT: A CRITICAL LOOK AT THE EVIDENCE

Charles Hoge, M.D., 503 Robert Grant Dr, Silver Spring, MD, 20910

SUMMARY:
Numerous studies have assessed the prevalence of PTSD in service members and veterans of the wars in Iraq and Afghanistan. Although there is considerable variability in sampling methods and case definitions, consistency in results have been obtained when studies have been grouped according to the population sample (combat infantry units versus general population samples). Overall, the prevalence of PTSD has been 36% predeployment and 620% postdeployment, depending largely on the frequency and intensity of combat experiences. Given the high prevalence of PTSD, there is considerable need for effective treatment, and two therapeutic modalities, prolonged exposure and cognitive processing therapy, have become the treatments of choices for PTSD in most Veterans Health Administration (VA) and Department of Defense (DoD) clinics. However, the evidence is mixed as to what components of treatment are most effective and why a large percentage of individuals do not recover from PTSD, either because they drop out of therapy or because these techniques are not as effective as we would like. This talk will review the state of the knowledge on PTSD treatment, what we think we know, what we believe the evidence indicates, what the evidence actually tells us, and where the key opportunities are for improving treatment of combatrelated PTSD. The talk will disentangle assumptions/beliefs from facts identified in randomized clinical trials, dismantling studies, and the clinical practice guidelines mental health professionals depend on.

S1-2
PHARMACOTHERAPY FOR PTSD

David Benedek, M.D., 12294 Wake Forest Road, Clarksville, M.D. 21029

SUMMARY:
The APA's Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder was published in October 2004 As with most published practice guidelines, it supported the use of pharmacologic agents—particularly SSRIs—for the treatment of PTSD (1). In response to increased attention on U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine also reviewed and summarized the evidence supporting

treatment for PTSD. Their 2007 report concluded that existing evidence was sufficient only to establish the efficacy of exposurebased psychotherapies in the treatment of PTSD. However, the report included a dissenting opinion by one author about the strength of the evidence for pharmacotherapy. Recent studies bolster support for pharmacological intervention in many circumstances, but randomized controlled trials have called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans (2). Emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (dcycloserine). Other recent studies suggest that in certain patient populations new pharmacological options, such as prazosin, may be more effective than other widely prescribed medications (e.g., selective serotonin reuptake inhibitors) indicated for PTSD. Increased understanding of the neuromolecular basis for the stress response points to the possibility that new agents with other mechanisms of action may also be helpful, but efficacy has been established in clinical trials.

S1-3

UNDERSTANDING THE EVIDENCE ON EVIDENCEBASED PSYCHOTHERAPY FOR PTSD

Paula Schnurr, Ph.D., 1000 Wilson Blvd, Suite 1825, Arlington, VA 22209

SUMMARY:
This presentation will provide a review of the latest findings the psychotherapeutic treatment of PTSD in military and civilian populations. There are a number of practice guidelines around the world, with similar, but not identical recommendations. How does a clinician decide what to believe? Understanding psychotherapy research poses unique challenges due to issues such as the difficulty of administering "placebo" therapy (and the need to use of different kinds of control groups) and of blinding patients and providers. Participants will gain skills in reading the psychotherapy treatment literature, understanding what makes a study better or worse, and confidence in applying this knowledge when determining which treatments to use with their trauma patients. Participants also will gain increased knowledge about the latest findings on psychotherapy for PTSD and on relevant guidelines, including 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 Institute of Medicine (IOM) report, Posttraumatic Stress Disorder: Diagnosis and Assessment.

S1-4.

MENTAL HEALTH SERVICES DELIVERY IN PRIMARY CARE

Edward Post, M.D., 1000 Wilson Blvd, Suite 1825, Arlington, VA 22209

SUMMARY:
Primary care often is the de facto venue for PTSD management, even if the traditional evidence base for treatment is in specialty mental health. Emerging evidence suggests an important role within primary care for management of posttraumatic stress disorder (PTSD). This presentation will outline structural components and processes of Department of Veterans Affairs (VA) programs, and collaboration with the Department of Defense (DoD), in the area of primary caremental health integration. Both Departments have embarked on largescale implementation of integrated care programs that blend colocated collaborative and care management components. These two components provide collaborative mental health services to primary care patients that are highly complementary to one another. Populationbased screening for common mental health conditions such as depression, PTSD and alcohol misuse form one important starting point for these services. Subsequently, colocated collaborative providers assist primary care providers with ondemand diagnostic confirmation, assessment and triage, and expertise in both pharmacologic and nonpharmacologic therapies. Care management systems provide additional expertise in structured assessment, and most importantly a robust mechanism for longitudinal followup, patient education, monitoring and adjustment of treatments when needed, and referral management when indicated. Over 100 VA programs provide integrated mental health care, with an active focus of national program development in the areas of care management, and coordination with DoD on continuity of care, common outcome measures, and active incorporation of the evolving evidence

base. Specific attention will focus on reviewing the experience of programs around PTSD management including TIDES, RESPECTMil, and Behavioral Health Laboratory (BHL) care management programs. Incorporation of systemsbased approaches to managing PTSD, building on populationbased care within primary care, presents significant challenges to effective implementation but also unique opportunities to improve the process and outcomes of care for our nation's service people and Veterans.

S1-5

REENGINEERING SYSTEMS OF PRIMARY CARE TREATMENT FOR PTSD AND DEPRESSION IN THE US MILITARY: PROGRAM DESCRIPTION AND IMPLEMENTATION

Charles Engel, M.D., M.P.H., 6900 Georgia Avenue NW, Washington, DC 20307

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 systemslevel improvements in US Army primary care recognition and management of PTSD and depression ("ReEngineering Systems of Primary Care for PTSD and Depression in the Military", RESPECTMil) and assess its implementation. Methods: RESPECTMil 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: RESPECTMil 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.

S1-6

DOD/APIRE PTSD CARE DISSEMINATION PROJECT UPDATE

Farifteh Duffy, Ph.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209

SUMMARY:
The American Psychiatric Institute for Research and Education (APIRE) was awarded the Department of Defense PTSD Research Program Concept Award in order to convene a team of experts in PTSD to identify
and distribute key evidencebased recommendations from four major treatment guidelines for PTSD, and to
develop a continuing medical education course based on these evidencebased recommendations. Traditional continuing medical education approaches have not shown to be particularly effective in changing clinicians' practices. Practice collaboratives, however, have been successful in enhancing the ability of clinicians to plan, test and implement practicebased improvements. Using the Institute for Healthcare Improvement Breakthrough Series as a model, and building on its successful track record with practice collaborative methodology, APIRE plans to engage mental healthspecialty clinicians in two military treatment facilities (MTFs) in testing the best methods of implementing evidencebased approaches in the management of PTSD. This presentation will provide an uptodate report of activities related to this initiative and provide a preliminary report of its findings.

REFERENCES:

1) Thomas JL, Wilk JE, Riviere LA, McGurk D, Castro CA, Hoge CW.
Prevalence of mental health problems and functional impairment among active component and national guard soldiers 3 and 12 months following combat in Iraq. Arch Gen Psychiatry 2010; 67:614623.

2) Benedek DM, Friedman MJ, Zatzick D, and Ursano RJ. Guideline Watch: Practice Guideline for the
treatment of patients with acute stress disorder and posttraumatic stress disorder, Focus, 2009 Vol. VII, No.
2, 20413.
3) Wilk JE, Hoge CW. Military and veteran populations. In: Benedek D, Wynn GH (eds.). Clinical manual for
management of PTSD (pp 349369).
American Psychiatric Publishing, Arlington VA, 2010.
4) Duffy F.F.; Craig T.; Moscicki E.K., West J.C.; Fochtmann L.J.; Performance in Practice: Clinical Tools for
the Care of Patients with Posttraumatic Stress disorder; Focus; 2009; 7(2):186191.

SYMPOSIUM 2
THERAPEUTIC AND RESEARCH IMPLICATIONS OF DISSOCIATION IN PTSD; A GAP IN OUR AWARENESS?

Chair: Eric Vermetten, M.D., Ph.D., Heidelberglaan 1, Utrecht, 3584 CX Netherlands, Co-Chair: Lanius A Ruth, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the empirical, conceptual, and clinical reasons for including and clearly defining dissociative posttraumatic symptoms in the DSM-V diagnostic criteria; 2). Evaluate the contribution of dissociation in patients with PTSD; and 3). Treat patients in a phaseoriented approach when dissociative symptoms are highly prevalent.

OVERALL SUMMARY:
This panel will question the importance of dissociative responses in PTSD and other post trauma disorders for both neuroscientific research and clinical practice. There appears to be no consistency in *DSM-IV* in the conceptualization of dissociative symptoms relative to ASD, PTSD. Reexperiencing trauma is not described as a dissociative symptom, but flashback episodes are unquestionably dissociative. Research has shown heterogeneity of the reexperiencing networks. Inability to recall an important aspect of the trauma is not listed as a (negative) dissociative symptom under PTSD, but is listed as a dissociative symptom under acute stress disorder. Similar confusion exists regarding numbing and detachment, which are identified as dissociative symptoms under ASD, but not under PTSD. A dissociative subtype can be characterized by overmodulation of affect, while the more common undermodulated type involves the predominance of reexperiencing and hyperarousal symptoms. If these symptoms were acknowledged in the *DSM-5* as a dissociative subtype what would this mean for clinical practice? Clinicians already acknowledge the importance of recognizing this dissociative subtype in the tailoring of CBT and other exposure based therapies by introducing emotion regulation skills prior to engaging in trauma focused treatment. Moreover, it has long been acknowledged that numbing and other dissociative symptoms interfere with trauma processing. Clarification of the ways in which dissociation fits into the PTSD framework of modulation of traumarelated affect will help in our understanding and treatment traumabased disorders like ASD and PTSD. In this symposium, we will present evidence for 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 neural manifestations of the dissociative subtype in PTSD will be discussed and compared to the reexperiencing/hyperaroused subtype. A model that includes these two types of emotion dysregulation in PTSD will be described. In this model, reexperiencing/hyperarousal reactivity is considered to be a form of emotion dysregulation that involves emotional undermodulation, mediated by failure of prefrontal inhibition of limbic regions, including the amygdala. In contrast, the dissociative subtype of PTSD is regarded as a form of emotion dysregulation that involves emotional overmodulation mediated by midline prefrontal inhibition of the same limbic regions. These findings have important implications for the assessment and treatment of PTSD. The need to assess patients with PTSD for dissociative symptomatology and the importance of incorporating the treatment of dissociative symptoms into a stageoriented trauma treatment model will be discussed.

S2-1

HISTORICAL OVERVIEW OF TRAUMATIC DISSOCIATION IN PSYCHOTRAUMATOLOGY

Eric Vermetten, M.D., Ph.D., Heidelberglaan 1, Utrecht, 3584 CX

SUMMARY:
Traumatic dissociation has a long tradition that has seen a come and go in psychiatry. The psychiatric approach to dissociation for long time failed to acknowledge any relationship to psychological trauma. Before DSMIII dissociation was grouped with the old remnant of hysteria, conversion disorder, and called "dissociative hysteria." Due to this the dissociative disorders had difficulty shaking the suspicion that they were not true disorders, or that they were a disguise for secondary gain, malingering, or criminality. In 1980 dissociation in the dissociative disorders was separated from hysterical neurosis and gained independent status. Since then PTSD and the dissociative disorders have developed in a somewhat parallel fashion. Its link with trauma has given dissociation an opportunity to be examined in relation with PTSD studies. Contemporary psychological and psychiatric sciences have used the term dissociation to denote alterations in conscious experience, a breakdown in integrated information processing and psychological functioning and the operation of multiple independent streams of consciousness. Yet, the concept is fading in psychiatric textbooks. This despite recent studies that have shown their neural systems which play an key role in emotion and autonomic nervous system regulation, sensory processing, attention and memory that exhibit altered levels of brain activation during dissociation, and are different from responses of 'simple' intrusions and hyperarousal each representing unique pathways to chronic stressrelated psychopathology. This may open new vistas for awareness of an almost forgotten concept.

S2-2

THE DIAGNOSTIC DOMAIN OF DISSOCIATIVE SYMPTOMS: ASSESSMENT IN THE CONTEXT OF A DISSOCIATIVE SUBTYPE OF PTSD

Richard Loewenstein, M.D., 6501 N. Charles Street, Baltimore, MD 212046819

SUMMARY:
In order to understand the diagnostic domain of a dissociative PTSD subtype, it is important to be able to comprehensively assess dissociative symptoms in the clinical interview and in the research context. Dissociative disorders are common in the general population, about 910 percent in community surveys. Yet, dissociative symptoms are frequently unfamiliar to clinicians and researchers, as is the way they manifest in both the clinical and research contexts. Dissociative symptoms are usually subtle and are often "explained" by more familiar diagnostic constructs: affective, psychotic, personality disorders, among others. There are several wellvalidated screening and diagnostic inventories for assessment of dissociation and dissociative disorders. These include the Dissociative Experiences Scale (DES), Somatoform Dissociative Questionnaire (SDQ), the Clinician Administered Dissociative States Scale (CADSS), the Multiaxial Inventory of Dissociation (MID), Multiscale Dissociation Inventory (MDI), the Dissociative Disorders Interview Schedule (DDIS), and the Structured Clinical Interview for DSM IV Dissociative Disorders (SCIDD). In addition, there is a widely used comprehensive clinical assessment tool, the Office Mental Status Exam for Dissociative Symptoms/Disorders (OMSEDSD). This review will give an overview of dissociative symptoms, their clinical domain, and the ways they can be related to the emerging neurobiology of dissociative reactions to trauma.

S2-3

THE THEORETICAL AND STATISTICAL DIFFERENTIATION OF FANTASY AND TRAUMA MODELS OF DISSOCIATION

Constance Dalenberg, Ph.D., 4350 Executive Drive Ste 255, San Diego, CA 92121

SUMMARY:
Clear evidence has been presented in multiple research reports showing that dissociation strongly relates to dissociation. Various theoretical models of this relationship have been put forward, broadly divided into Fantasy Models and Trauma Models of dissociation. Statistical methods of differentiating models of dissociation as a variant of malingering or fantasy proneness, or as a precursor, comorbid feature and subtype of PTSD are presented.

Following presentation of the models, data are presented supporting the dissociative subtype alternative for PTSD.

S2-4

EMOTION DYSREGULATION IN PTSD: EVIDENCE FOR A DISSOCIATIVE SUBTYPE

Lanius Ruth, M.D., Ph.D., LHSCUH, 339 Windermere Rd, London, NC N6A 5A5

SUMMARY:
In this symposium, we will present evidence for 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 neural manifestations of the dissociative subtype in PTSD will be discussed and compared to the reexperiencing/hyperaroused subtype. A model that includes these two types of emotion dysregulation in PTSD will be described. In this model, reexperiencing/hyperarousal reactivity is considered to be a form of emotion dysregulation that involves emotional undermodulation, mediated by failure of prefrontal inhibition of limbic regions, including the amygdala. In contrast, the dissociative subtype of PTSD is regarded as a form of emotion dysregulation that involves emotional overmodulation mediated by midline prefrontal inhibition of the same limbic regions. These findings have important implications for the assessment and treatment of PTSD. The need to assess patients with PTSD for dissociative symptomatology and the importance of incorporating the treatment of dissociative symptoms into a stageoriented trauma treatment model will be discussed.

S2-5

DISSOCIATION IN *DSM-5* ASD AND PTSD

David Spiegel, M.D., Room 2325 401 Quarry Road, Palo Alto, CA 943055718

SUMMARY:
PTSD can be conceptualized as a defect in modulation of overwhelming affect related to traumatic stress, either undermodulation, with intrusive thoughts, flashbacks, and nightmares; or overmodulation, with numbing, avoidance, and amnesia. While all of these and other symptoms are part of the overall diagnosis of PTSD, there is growing evidence of a dissociative subtype of PTSD involving about 30% of those with the disorder. Functional neuroimaging indicates different brain activity – frontal hyperactivity and limbic suppression, rather than the frontal hypoactivity and amygdala/locus ceruleus activation seen in the hyperarousal subtypes. The DSM 5 planning process is as yet undecided about a dissociative subtype of PTSD, but is including dissociative symptoms in both Acute Stress Disorder and PTSD. ASD has a dissociative symptoms category that includes 1) numbing or detachment from others, 2) depersonalization/ derealization, and 3) amnesia. However, dissociative reactions such as flashbacks are listed among the intrusion symptoms. This is also the case in the PTSD criteria, and the first three are listed among "negative alterations in cognitions or mood." Thus while dissociative symptoms of over-modulation of affect are included, they are also spread among symptom categories. Flashbacks are the most conceptually problematic, since they represent dissociation of orientation to the present, rather than dissociation of traumarelated memories, often with under rather than over-modulation of affect. Thus a similar mental process occurs but with reverse content and affective control. Dissociation implies a kind of mental rigidity in which affect and memories are controlled in an allornone rather than a continuum basis – flooding or numbing. Further clarification of the ways in which dissociation fits into the PTSD framework of over and under-modulation of traumarelated affect will help in our understanding and treatment of ASD and PTSD.

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SYMPOSIUM 3

UNDERSTANDING THE RISK OF SUICIDE ASSOCIATED WITH RECENT DISCHARGE

Chair: Paul S Links, M.D., 30 Bond St., Rm 2010d Shuter St., Toronto, M5B 1W8 Canada
Discussant: Donald W. Black, M.D.

EDUCATIONAL OBJECTIVES:
Following this session the participant should be able to: 1) Describe risk factors for increased suicide ideation and behavior in recently discharged patients; 2) Understand the patients' experience of discharge including feeling ill/unprepared to return to their home in the community; and 3) Evaluate the merits of a proposed service intervention to reduce the risk of suicide ideation, suicide behavior and suicide in recently discharged patients.

OVERALL SUMMARY:
Objective: The aim of this symposium is to develop in the participants an understanding of the observed increased risk for suicide following discharge from an inpatient psychiatric service. Method: A concurrent mixed methods design was utilized in this research. The quantitative study was a prospective cohort study of all patients admitted to an acute urban innercity inpatient service with a lifetime history of suicidal behavior and current suicidal ideation and examined predictors of suicide ideation at 1, 3 and 6 months following discharge. The qualitative study used a holistic perspective and phenomenological inquiry to study the experience as 'lived' of being discharged from hospital for a subset of participants from the quantitative study. Results: 120 participants consented to participate in the study; 8 withdrew and 9 were lost to follow up. Suicide and suicide behavior were common outcomes amongst this cohort of patients with 4 of 103 (3.9%) participants dying by suicide and 33 of 97 (37.1%) reporting suicide behaviors in the six months after discharge from hospital. Overall, the results indicated that established risk factors such as a history of more than 1 attempt, a recent attempt; and high levels of depression, impulsivity and hopelessness were predictors of suicide ideation and suicide behavior in the 6 months following discharge from hospital. Twenty qualitative interviews were completed and the following themes were illustrated; patients feeling "Existential angst at the prospect of discharge" and "Trying to survive while living under the proverbial 'Sword of Damocles'. Conclusions and implications for practice: This research demonstrated that recently discharged patients are an identifiable high risk group for suicide and the transition from hospital to the community is a major transition. A proposed intervention to address this risk is highlighted.

S3-1

PROSPECTIVE RISK FACTORS FOR SUICIDE IDEATION AND BEHAVIOR IN RECENTLY DISCharged Patients

Paul Links, M.D., 30 Bond St., Rm 2010d Shuter St., Toronto, M5B 1W8

SUMMARY:
Objective: This prospective cohort study examined risk factors identified from a systematic literature review to determine their ability to predict suicide ideation and suicide behavior in the 6 months following discharge. Methods: A prospective cohort study was completed of all patients admitted to an acute urban innercity inpatient service with a lifetime history of suicidal behavior and current suicidal ideation. The study examined predictors of suicide ideation at 1, 3 and 6 months following discharge and of suicide behavior over the 6 months following discharge. Results: 120 participants consented to participate in the study; 8 withdrew and 9 were lost to follow up. Suicide and suicide behavior were common outcomes amongst this cohort of patients with 4 of 103 (3.9%) participants dying by suicide and 33 of 97 (37.1%) reporting suicide behaviors in the six months after discharge from hospital. The presence of suicide ideation over 1, 3 and 6 months follow up was predicted by the baseline variables including having a history of more than 1 suicide attempt, being admitted for a current suicide attempt, being female and the level of depression. The magnitude of suicide ideation at 1 month postdischarge was positively related to the baseline level of suicide ideation, having a history of more than 1 suicide attempt and the baseline level of hopelessness. The occurrence of suicide behavior over the 6 months postdischarge was significantly related to being admitted for a current suicide attempt and the baseline level of impulsivity. Conclusions and implications for practice: This research demonstrated that recently discharged patients are an identifiable high risk group for suicide and the findings stress the importance of

known risk factors – more than 1 attempt, recent attempt; depression; impulsivity; hopelessness in defining a target group for interventions.

S3-2
UNDERSTANDING THE RISKS OF RECENT DISCHARGE: THE PHENOMENOLOGICAL LIVEDEXPERIENCES

John Cutcliffe, Ph.D., B.S.C., 81 Papermill road, Hampden, ME 04444

SUMMARY:
People whose mental health problems lead them to require psychiatric hospitalization are at a significantly increased risk of suicide, particularly immediately following discharge. This paper reports on phenomenological findings from a federally funded, mixedmethods study which sought to better understand the observed increased risk for suicide following discharge from an inpatient psychiatric service. A purposive sample of twenty (20) of recently discharged former suicidal inpatients was obtained. Data were collected from the participants as a result of 'hermeneutic interviews, lasting between 1 and 2 hours and analysed according to van Manen's (1997) interpretation of hermeneutic phenomenology. Two key themes, "Existential angst at the prospect of discharge" and "Trying to survive while living under the proverbial 'Sword of Damocles'" were induced. Each of these was comprised of five themes: the first encompasses the following: 'Feeling scared, anxious, fearful and/or stressed', 'Preparedness', 'Leaving the place of safety', 'Duality and ambivalence', and 'Feel like a burden'. The second key theme encompasses the following: 'Needing postdischarge support', 'Feeling lost, uncertain and disorientated', 'Feeling alone and isolated', 'Suicide remains an option' and 'Engaging in soothing, comforting behaviours'.

S3-3
IS RESEARCH WITH SUICIDAL PARTICIPANTS RISKY BUSINESS?

Jesmin Antony, M.S., 30 Bond Street, Toronto, M5B1W8

SUMMARY:
Few studies have examined the effects of research assessments on study participants' suicidality. The purpose of this study was to examine the postassessment changes in suicidality of study participants with a lifetime history of suicidal behaviour. Study participants (N=120) were recruited from patients admitted with current suicidal ideation or suicide attempt plus a lifetime history of suicidal behavior to an inpatient psychiatric service and/or a crisis stabilization unit. Participants were assessed for suicidal ideation with the Suicide Ideation Scale at 1, 3, and 6 months following their discharge from hospital. The risk assessment protocol was administered at the start and at the end of each of the study followup assessments. The risk assessment protocol consisted of three selfrating questions: two of the questions asked participants to rate, on a scale of 0 (none) to 7 (severe), their urges to selfharm and their urges to suicide. A third question asked the participant to assess, on a scale of 0 (out of control) to 7 (in control), their sense of control over their suicidal urges. Changes in suicidality following study assessments were small, infrequent and were most likely to reflect a decrease in suicidality. By the end of the 6 month followup period, increases in suicidality postassessment were not seen. Similarly, participants rarely reported worsening selfcontrol over suicidal urges, and when they did, the effect was minimal. These findings are consistent with Reynolds et al. (2006) findings that a small proportion of suicidal participants will require intervention following an assessment.

S3-4
SUICIDE RISK ASSOCIATED WITH RECENT DISCHARGE: MOVING FROM MODELS TO INTERVENTION

Ken Balderson, M.D., B.S.C., 17033 Cardinal Carter Wing, 30 Bond Street, Toronto, M6G 2L6

SUMMARY:
Objective: This part of the symposium will review the literature on previous interventions and describe the process of developing and details of an intervention plan to reduce suicide risk in recently discharged patients. Method: Results of the initial study were used to develop potential interventions which were then presented at 5 hospitals for feedback which was integrated in developing a comprehensive planned intervention. Results: Based

on the initial study, a proposed intervention plan was developed and presented at rounds and in workshops at 5 hospitals, with a total of 170 participants attending rounds and 65 workshop participants. Consensus was reached on an intervention with 4 elements: targeting highrisk patients, preparing the patient for discharge, acknowledging the continued risk, and providing transitional support. The intervention includes 26 specific actions. Conclusions and implications for practice: A group of targeted interventions designed to reduce suicide risk after discharge is proposed.

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SYMPOSIUM 4
BRAIN MECHANISMS AND NEUROPSYCHIATRY IN SMOKING CESSATION

Chair: Geetha Subramaniam, M.D., 6001 Executive Blvd, Rm 3174 MSC 9583, Bethesda, MD 20892,
Co-Chair: Steven Grant, Ph.D.
Discussant: Tony P George, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Identify the underlying neurobiological mechanisms of smoking cessation and/or relapse, especially among those who present with impulsivity and depression; and 2) Understand and apply the new evidence for pharmacological and behavioral interventions that may further improve the smoking cessation outcomes of their patients.

OVERALL SUMMARY:

Smoking is a leading preventable cause of death in the US. While the evidence is compelling for the health benefits and costeffectiveness of treatments for smoking cessation, currently available medication and behavioral treatments are only modestly effective, and the abstinence is shortlived. It is imperative that new targets for and underlying mechanisms of smoking cessation be explored. Of particular interest is the interface between mechanisms underlying smoking behaviors and psychiatric conditions and manifestations. In this symposium, National Institute on Drug Abuse (NIDA) funded researchers will present preliminary cuttingedge evidence for brainbased mechanisms associated with smoking cessation/relapse and interrelated areas of weight gain, depressive symptoms and impulsivity; and to create new avenues for the development of more effective and novel pharmacological and behavioral interventions. Dr. Amy Janes will present emerging fMRI findings on cue reactivity and attentional bias in tobacco abstinence, which has potential to inform tailoring treatments addressing the influence of smoking cues on relapse. Dr. Richard Yi will discuss the role of impulsivity and delay discounting in smoking cigarettes that may suggest ways to improve smoking cessation success for those with vulnerabilities in the externalizing spectrum of behaviors. Drs. Benjamin Toll and Laura MacPherson will review two different means to further improve smoking outcomes in patients receiving standard nicotine replacement therapy (NRT) in smokers using a) a pharmacological agent, naltrexone (an opioid antagonist) and b) behavioral activation, a brief behavioral treatment (to enhance reward system). These strategies have the potential to provide information on tailoring smoking cessation efforts. Dr. Tony George, will serve as the formal discussant. He will provide both a commentary on the presentations and stimulate an interactive discussion with the panelists and the audience outlining potential future research directions aimed at improving smoking cessation treatments. The four presentations and ensuing discussions are also likely to provide practicing psychiatrists with potentially useful tools to augment and personalize smoking cessation interventions for some of the patients, they encounter in their practices.

S4-1
BRAIN FUNCTIONAL MAGNETIC RESONANCE IMAGING (FMRI)

REACTIVITY AND ATTENTIONAL BIAS IN TOBACCO ABSTINENCE

Amy Janes, Ph.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:
Smoking relapse rates remain high despite the existence of effective cessation therapies. Developing means to identify relapsevulnerable smokers before they try to quit may enable personalized treatment, which could reduce relapse. Smoking cue exposure precipitates relapse episodes, suggesting that cue reactivity may be associated with relapse vulnerability. We hypothesized that functional MRI (fMRI) of brain reactivity to smoking cues and attentional bias (AB) for smoking words can be used to identify relapsevulnerable smokers. Before a quit attempt, 21 nicotinedependent women underwent fMRI while viewing smoking and neutral images. AB for smokingrelated words was measured using a smoking emotional Stroop (SES) task. Smokers then attempted to quit with the aid of nicotine replacement therapy. Relapse vulnerability was identified based on shortterm cessation outcomes (abstinence vs. slip: smoking = 1 cigarette after attaining abstinence). Prequit fMRI and SES assessments in these groups were compared. While demographics did not differ between groups, smokers who slipped had greater fMRI reactivity to smoking images in brain regions involved in interoceptive awareness, emotion, and motor planning and execution, and greater smoking word AB. Smoking image fMRI reactivity in insula and dorsal anterior cingulate cortex (dACC) was correlated with increased smoking word AB. Together, fMRI and AB data predicted outcomes with 79% accuracy. Relapsevulnerable smokers also had reduced functional connectivity between an insulacontaining network and cognitive control brain regions, suggesting decreased topdown control of cueinduced reactivity. We conclude that smokers with enhanced fMRI reactivity and AB for smoking stimuli may be highly relapsevulnerable, that fMRI and AB measures may be good outcome predictors and useful for personalizing cessation treatment, and that topdown control of cuereactivity may be disrupted in relapse vulnerable smokers.

S4-2
IMPULSIVITY IN SMOKING CESSATION

Richard Yi, Ph.D., 2103 Cole FIeld House, College Park, MD 20742

SUMMARY:
Delay discounting refers to the reduction in the subjective value of an outcome as a function of the delay to that outcome. For instance, receiving some amount of money following a 1month delay is subjectively worth less than receiving that same amount immediately. Thought to be a measure of impulsivity, delay discounting is associated with various forms of substance use and abuse, including cigarette smoking. For instance, active cigarette smokers delay discount money outcomes more than nonsmokers, indicating that smokers are generally more presentfocused in their decisionmaking. Additionally, rate of delay discounting appears to predict ability to maintain abstinence efforts. This presentation will review the body of research that implicates delay discounting as an important factor in the development and maintenance of cigarette smoking. Recent advances in the conceptualization of delay discounting as it applies to cigarette smoking may suggest intervention approaches that directly target this presentoriented decisionmaking with possible attendant changes in smoking.

S4-3
NALTREXONE IN SUPPLEMENTING NICOTINE REPLACEMENT THERAPY FOR SMOKERS

Benjamin Toll, Ph.D., 1 Long Wharf Drive, New Haven, CT 06511

SUMMARY:
Naltrexone hydrochloride is a medication that has shown promise in reducing postsmoking cessation weight gain and may therefore address smokers' weight concerns. Several randomized studies have shown that naltrexone significantly minimizes postquit weight gain. In these studies, participants in the naltrexone group gained approximately 1.5 pounds on average, whereas those in the placebo group gained an average of 2.4 to 4.2 pounds (King et al, 2006; KrishnanSarin et al, 2003; O'Malley et al, 2006; Toll et al, 2008). Although naltrexone appears to reduce weight gain after quitting, effects on smoking cessation have been inconclusive, with some negative (King et al, 2006; Toll et al, 2008; Wong

et al, 1999) and some positive (Covey et al, 1999; KrishnanSarin et al, 2003; O'Malley et al, 2006) findings. In addition to discussing these studies, we will present data from a clinical trial in which smokers (N=172) who reported weight concerns were randomized to receive either 25mg naltrexone or placebo for 27 weeks. All participants received open label nicotine patch therapy for 8 weeks and counseling for 27 weeks. Although there was a small numerical difference in weight at 26 weeks postquit that favored the naltrexone group, this difference was not statistically significant (naltrexone: 6.8 lbs + 8.94 vs placebo: 9.7 lbs + 9.19, p=.47). Smoking abstinence rates were not significantly different but numerically favored the placebo group at 26 weeks postquit (naltrexone: 22% vs placebo: 27%, p=.43). We will also briefly present preliminary unpublished data from a pilot study that compared 25mg naltrexone to placebo for minimizing weight gain in combination with open label varenicline for smoking cessation. Data from these studies and the literature suggest that naltrexone may support smoking cessation at higher doses and for specific subpopulations and appears to minimize postquit weight gain when paired with specific pharmacotherapies (nicotine patch, bupropion).

S4-4

BEHAVIORAL ACTIVATION IN DEPRESSED SMOKERS RECEIVING NICOTINE REPLACEMENT THERAPY

Laura MacPherson, Ph.D., 2103 Cole Field House, College Park, MD 20742

SUMMARY:
Moderately elevated levels of pretreatment, current depressive symptoms are associated with poor smoking cessation outcomes (e.g., Cinciripini et al., 2003; Niaura et al., 2001). Antidepressant medications and/or moodspecific cognitive–behavioral treatments largely have not impacted depressive symptoms during quit attempts, and treatment effects appear unrelated to depressive symptom change (e.g., Piper et al., 2008). Beyond the putative role of depressive symptoms in cessation failure, emerging research indicates a critical role of low positive affect in poor cessation outcomes and in deprivationinduced withdrawal and craving. Although extant research typically has focused on the role of negative affectivity/mood on cessation failure, it remains crucial to consider low positive affect/anhedonia as these dimensions have also predicted smoking cessationrelated changes in withdrawal symptoms and relapse beyond depression history (Leventhal et al., 2008). Behavioral activation (BA; Lejuez, Hopko, & Hopko, 2001) is a promising adjunct to standard cessation strategies for smokers with elevated depressive symptoms, as this is a brief approach that targets greater contact with more valued environments through systematic efforts to increase rewarding experiences/enjoyment of daily activities, which may simultaneously reduce negative affect and improve positive affect through overt behavior change (Lejuez et al., 2001). Data from a Stage I trial indicate that a BA enhanced smoking intervention (BATS) produced improved abstinence rates and reduced depressive symptom among adult smokers with elevated depressive symptoms (MacPherson et al., 2010). The current study will present preliminary data from an ongoing Stage II trial of BATS, with a focus on putative treatment mechanisms including improvements in low positive affect and increases in reward sensitivity targeted with novel assessment strategies.

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SATURDAY, MAY 14, 2011
NOON -3:00 PM

SYMPOSIUM 5
CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

Chair: 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) List the advantages and disadvantages of various medications and behavioral interventions for the drugs discussed; and 2) Understand the key issues in treating pain in substancedependent patients.

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 officebased 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.

S5-1
CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE

Adam Bisaga, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 120, 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, damphetamine, modafinil and levodopa are promising as abstinenceinducing treatments. Medications that indirectly block effects of cocaine by enhancing GABAergic neurotransmission such as topiramate, tiagabine, and baclofen appear to have potential as abstinencemaintenance 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. As the cognitive impairments interfere with response to behavioral treatment, using cognitive enhancers may be a useful strategy in some patients. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

S5-2
CHOOSING TREATMENT FOR CANNABIS DEPENDENCE

Frances Levin, M.D., 1051 Riverside Drive, New York, NY 10032

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 mechanisms

of actions, pharmacology, and 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 his/her 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 have been a limited number of controlled laboratory and treatment trials that have assessed the efficacy of pharmacologic interventions. At present, agonist and antagonist therapies have shown promise, e.g., dronabinol (oral THC), and combined pharmacotherapies (such as dronabinol and lofexidine) may have clinical utility for treating cannabis dependence.

S5-3

COMBINING MEDICATIONS AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE ABUSE

Edward Nunes, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 51, New York, NY 10032

SUMMARY:
Several types of psychosocialbehavioral interventions, including cognitive behavioral skillbuilding approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12Step facilitation), have been studied for use either alone or in combination with medications for treatment of substance abuse. 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 generalize research findings to community settings will be addressed.

S5-4

OPIOID DEPENDENCE: AGONIST AND ANTAGONIST TREATMENT OPTIONS FOR ADDICTION

Maria Sullivan, M.D., Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 120, New York, NY 10032

SUMMARY:
Opioid dependence may be treated with either detoxification followed by antagonist therapy (naltrexone) or by agonist maintenance in methadone programs or officebased settings (buprenorphine). We review strategies for detoxification and naltrexone induction and compare retention rates between agonist and antagonist therapy. We present recent outcome data on the efficacy of the depot naltrexone formulation in combination with behavioral therapy. Depot naltrexone offers rates of retention with antagonist maintenance that rival those seen with buprenorphine. Prescription opioid abusers may be good candidates for naltrexone induction and maintenance. The rates at which all classes of opioids have been prescribed have increased in the past decade, and this rise has been most dramatic for oxycodone. The treatment of chronic pain in substance abusers poses a significant clinical challenge. 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. 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 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 reduced. Advantages and disadvantages of effective pharmacological choices for the treatment of opioid dependence are summarized.

S5-5

DETECTING AND MANAGING SEDATIVEHYPNOTIC AND Stimulant Abuse

John Mariani, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 66, New York, NY 10032

SUMMARY:
Sedativehypnotics and stimulants are widely prescribed classes of psychotropic agents. Despite extensive clinical experience, concerns about overprescribing, abuse liability, and the behavioral safety of sedativehypnotics and stimulants still remain. While these medications are effective treatments for psychiatric disorders, specifically sedativehypnotic agents for anxiety disorders and stimulants for attentiondeficit/hyperactivity disorder, both classes of medication have a significant risk of abuse and the incidence of nonprescribed use is substantial. An overview of the strategies to detect and manage abuse of these controlled substances will be provided. Special attention will be focused on the complex clinical issues that arise when prescribing sedativehypnotic and stimulants in the presence of cooccurring substance use disorders.

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SYMPOSIUM 6
HEALTH CARE REFORM AND MENTAL HEALTH CARE FINANCING
U.S. National Institute of Mental Health

Chair: Agnes E Rupp, Ph.D., 6001 Executive Blvd., Bethesda, MD 208929631
Discussant: Jurgen Unutzer, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Provide an overview of how health financing can be used to achieve some of the major goals of health care reform. This is accomplished through presentation of four research papers that examine outcome measurement for children with autism spectrum disorders, approaches to financing psychotropic medications, and understanding health disparities in the child welfare population.

OVERALL SUMMARY:
One of the goals of health reform is to reduce burdens associated with mental disorders, and to achieve this using the tools of health care financing. This task requires that federal, state and local policymakers, mental health care program directors, and practicing clinicians possess at least three important pieces of information. First, they need scientific guidance on how to reliably measure the resource use intensity and clinical outcomes of mental disorders. Second, they need information on various financial and reimbursement strategies and mechanisms that can be used to affect the greatest change in treating mental disorders with the least expenditures. And, third, they need research support information on whether or not these efforts will succeed without unintended, adverse clinical or economic consequences concerning all stakeholders involved. This symposium brings together four NIMHfunded empirical studies that provide precisely this kind of information. One paper examines the issue of measuring outcomes for children who have autistic spectrum disorder (ASD). By developing metrics that allow for quantification of symptomatology for children with ASD as well as the burden experienced by their caregivers, this paper presents a model that can be generalized to other childhood mental disorders and, by extension, adult pathology. Next, two papers funded as part of NIMH's pharmacoeconomics research portfolio, address issues of how best to pay for psychotropic medications. These papers study various strategies for sharing costs of psychotropic medications across purchasers and payors, and examine their impact on cost, quality and continuity of care. Such pharmacoeconomics work is critically important for health reform given the escalating expenditures of psychotropic medications incurred by Medicaid, Medicare, commercial health plans, and by patients' outofpocket expenses. Finally, the last paper treats

health disparities as a populationlevel marker of policy effectiveness. Using a population of children in the child welfare system, this paper investigates the determinants of health disparities among a nationally representative sample of children. Taken together, these papers address issues relevant to the measurement, mechanisms, and consequences of health reform. Findings from these studies have the potential to (a) inform child mental health program development in the publicly and privately financed sectors for children with ASD; (b) modify Med

S6-1

IMPACT OF MEDICAID PRESCRIPTION COST CONTAINMENT POLICIES ON ANTIPSYCHOTIC MEDICATION USE AMONG SCHIZOPHRENIA PATIENTS

Jalpa Doshi, Ph.D., 423 Guardian Drive, Blockley Hall, Rm. 1222, Philadelphia, PA 19104

SUMMARY:
Objective: Little is known about the impact of Medicaid prescription copayment policies on medication use among patients with serious mental illnesses. This study aimed to determine the impact of increases in Medicaid prescription copayments and generic/brand copayment differentials on use of antipsychotic and other nonantipsychotic medications in patients with schizophrenia. Methods: The study sample included nondual eligible feeforservice Medicaid patients >21 years with a schizophrenia diagnosis (ICD9CM: 295.xx) between 2003 and 2005. A quasiexperimental study design was employed using personmonth level Medicaid analytic extract (MAX) data from 2003 to 2005 for Medicaid programs from 44 states plus D.C. linked with the Area Resource File (ARF), and a state Medicaid policy survey conducted by the authors. Patient level fixedeffects models were used to examine how copayment changes impacted monthly antipsychotic and other drug use while using observations without policy change as contemporaneous controls. The outcomes included antipsychotic and nonantipsychotic medication use (number of fills and number of 30days supply equivalent fills) per patient per month. We also calculated antipsychotic adherence using the proportion of days covered (PDC) measure in each month. Results: The prescription copayment changes had a statistically significant, albeit modest impact on antipsychotic use and adherence. For every one dollar increase in the generic or minimum copayment there was a reduction of 0.015 antipsychotic fills (or 0.03 antipsychotic fills in 30day equivalents) per patient per month. Conclusions: Increases in prescription copayments and generic/brand copayment differentials resulted in only a minimal decline in antipsychotic medication use and adherence, but had a relatively larger negative effect on nonantipsychotic medication use.

S6-2

MEDICARE PART D'S COVERAGE GAP AND DEPRESSION

Yuting Zhang, M.S., Ph.D., 130 DeSoto Street, A664 Crabtree Hall, Pittsburgh, PA 15261

SUMMARY:
Objectives: To evaluate the effects of Medicare Part D's coverage gap on medication use among beneficiaries with depression and to determine whether the provision of generic coverage would protect them from discontinuing their medications. Method: We obtained Medicare Part D events, enrollment, and plan characteristics files for a random sample of 5% of national Medicare beneficiaries enrolled in a standalone Part D plan from the Centers for Medicare & Medicaid Services. We identified all aged and disabled beneficiaries diagnosed with depression but not with bipolar disorder and schizophrenia and with a fullyear Part D enrollment in 2007. We used a prepostrollingcohortwithacomparisongroup design to compare likelihood of use, monthly prescription counts and spending before and after the coverage gap between each pairwise comparison of three groups: those with 1) no coverage, 2) genericonly, and 3) lowincomesubsidies in the coverage gap. Results: When faced with a fullgap in drug coverage, the disabled reduced pharmacy spending for psychiatric drugs more than nonpsychiatric drugs (35% vs 31%), the aged cut back on their use of drugs, equally for psychiatric vs nonpsychiatric drugs (23%). Those with generic coverage only cut their use of branded drugs and their use of generic drugs remained almost the same (aged) or increased (disabled). This suggests some shifting from branded to generic drugs if beneficiaries had genericonly coverage in the gap. Conclusions: The coverage gap will remain in the next 10 years. Our findings

reinforce the necessity to evaluate the unique benefit design of Medicare Part D in order to create the best approach to cover the essential medications for beneficiaries whose total drug spending exceeds the coverage gap threshold. The first step to develop the optimal pharmacy benefit designs for these high drug spenders is to know exactly how these individuals responded to the different coverage types.

S6-3

MEASURING QUALITY ADJUSTED LIFEYEARS FOR ECONOMIC EVALUATIONS OF TREATMENT SERVICES FOR CHILDREN WITH AUTISM

J. Mick Tilford, Ph.D., 4301 West Markham, #820,, Little Rock, AR 72205

SUMMARY:
Objective: Costeffectiveness analysis has the potential to improve access to services for children with autism by demonstrating the value of treatment to public and private payers, but methods for measuring qualityadjusted life years (QALYs) in children and incorporating family effects remain understudied. This paper measures QALYs in a population of children with autism spectrum disorders (ASDs) and tests whether family effects can be measured using generic instruments. Failure to include family effects associated with effective services could bias estimated costeffectiveness ratios. Method: This paper reports on data from respondents at two sites of the Autism Treatment Network that diagnosis children with autism meeting *DSM-IV* criteria. Clinical data from the network was combined with survey data to measure QALY scores in children and caregivers according to ASD severity and symptoms. The primary hypothesis is that generic QALY instruments will be sensitive to symptom severity in children with ASDs and their caregivers. We anticipate a final sample of 200 families will be reported on for this meeting. Main Outcome Measures: The study compares findings from the Health Utilities Index and Quality of WellBeing scale for children in relation to intellectual disability, age, and ASD type and severity. For caregivers, the SF6D and EQ5D are compared in relation to the CESD and the CarerQol7D. Findings: Based on initial responders, children were diagnosed as having autistic disorder (82.4%), pervasive developmental disorder (PDDNOS) (9.8%), and Asperger's disorder (7.7%). IQ scores varied across the three diagnoses with the highest rate of intellectual disability in children with autistic disorder followed by children with PDDNOS. QALY scores as measured by the HUI3 averaged 0.68 (range: 0.0721.0). Conclusions: Financing intensive services for all children with ASDs may not be optimal because of unknown benefits for different diagnoses.

S6-4

REDUCING DISPARITIES IN MENTAL HEALTH EXPENDITURES AMONG CHILDREN IN THE CHILD WELFARE SYSTEM

Ramesh Raghavan, M.D., Ph.D., One Brookings Drive, Campus Box 1196, St. Louis, MO 63130

SUMMARY:
Objective: Children in the child welfare system have the highest mental health needs of all child populations, and possess entitlements to Medicaid in order to cover needed mental health services. Despite these entitlements, children in the child welfare system display considerable racial/ethnic disparities across several domains of mental health service use. The objective of this paper is to quantify the magnitude of disparities in Medicaid expenditures, and identify children at greatest risk for such disparities among a national sample of children in child welfare. This information is critical to inform Medicaid policymaking that can reduce such disparities, especially given the forthcoming expansion of the program as a result of health reform. Method: We have been engaged in linking child participants in the nation's first national study of children in the child welfare system – the National Survey of Child and Adolescent WellBeing – to their Medicaid claims data. Main Outcome Measures: We examined Medicaid expenditures for ambulatory and inpatient psychiatric services, prescription drug costs, other inpatient treatment such as care within residential treatment centers, and use of case management funds for children belonging to different race/ethnicities. Findings: Significant expenditure differences were observed between white and AfricanAmerican children who had nonzero expenditures. On regression analysis that controlled for demographic characteristics,

child mental health need, abuse history, and state of residence, being of AfricanAmerican race/ethnicity was associated with a marginal decrease of $2,206 in overall mental health expenditures. Marginal effects were highest for children with scores in the clinical range of the Child Behavior Check List and for sexually abused children. Conclusion: Medicaid coverage per se does not seem to reduce disparities in receipt of health care among child welfare populations.

S6-5

REDUCING DISPARITIES IN MENTAL HEALTH EXPENDITURES AMONG CHILDREN IN CHILD WELFARE

Derek Brown, Ph.D., 3040 Cornwallis Rd Hobbs 107, Research Triangle Park, NC 277092194

SUMMARY:
Objective: Children in the child welfare system have the highest mental health needs of all child populations, and possess entitlements to Medicaid in order to cover needed mental health services. Despite these entitlements, children in the child welfare system display considerable racial/ethnic disparities across several domains of mental health service use. The objective of this paper is to quantify the magnitude of disparities in Medicaid expenditures, and identify children at greatest risk for such disparities among a national sample of children in child welfare. This information is critical to inform Medicaid policymaking that can reduce such disparities, especially given the forthcoming expansion of the program as a result of health reform. Method: We have been engaged in linking child participants in the nation's first national study of children in the child welfare system – the National Survey of Child and Adolescent WellBeing – to their Medicaid claims data. Main Outcome Measures: We examined Medicaid expenditures for ambulatory and inpatient psychiatric services, prescription drug costs, other inpatient treatment such as care within residential treatment centers, and use of case management funds for children belonging to different race/ethnicities. Findings: Significant expenditure differences were observed between white and AfricanAmerican children who had nonzero expenditures. On regression analysis that controlled for demographic characteristics, child mental health need, abuse history, and state of residence, being of AfricanAmerican race/ethnicity was associated with a marginal decrease of $2,206 in overall mental health expenditures. Marginal effects were highest for children with scores in the clinical range of the Child Behavior Check List and for sexually abused children. Conclusion: Medicaid coverage per se does not seem to reduce disparities in receipt of health care among child welfare populations.

REFERENCES:
1) The Patient Protection and Affordable Care Act. PL 111148. March 23, 2010
2) The NIH Common Fund Home Page: http://commonfund.nih.gov/healtheconomics
3) McGuire, TG (guest ed.): Special Section on Health Reform and Mental Illness, Psychiatric Services, Vol. 61, Num. 11. pp 10731092

SYMPOSIUM 7
MOOD DISORDERS ACROSS THE LIFESPAN: IMPLICATIONS FOR *DSM-5*
American Psychiatric Institute for Research & Education

Chair: Darrel A Regier, M.D., M.P.H., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209,
Co-Chair: David J Kupfer, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to identify pertinent issues related to diagnosing mood disorders, including major depressive disorder and bipolar disorder, across the age spectrum. Participants will also be able to discuss how these issues are being addressed specifically within the context of revisions to *DSM-5*.

OVERALL SUMMARY:
The *DSM-5* Mood Disorders Work Group has made a number of recommendations to potentially improve the diagnosis of mood disorders across all patient populations, including major depressive disorder and bipolar disorder. The unique role that development and age play in the presentation of mood disorders has been of particular interest, and as a result, the Mood Disorders Work Group has drafted proposed revisions with input from colleagues from the Childhood and Adolescent Disorders Work Group and the Neurocognitive Disorders Work Group. This symposium will discuss the diagnosis of mood disorders within the

context of the age spectrum and the ways in which developmental lifespan issues have impacted the decisionmaking process behind the work groups' proposed revisions. Specifically, presentations will cover mood disorders and issues relevant to pediatric (Temper Dysregulation Disorder with dysphoria), young adult (Bipolar Disorder), adult (Major Depressive Disorder with and without Bereavement; Major Depressive Disorder and the relationship between mood and anxiety symptoms), and geriatric populations (geriatric depression and the confluence of mood, anxiety, and somatic symptoms). Emphasis will be added to demonstrating how proposed changes to mood disorders in *DSM-5* may impact diagnosis and treatment and "real world" implications for patients and the general public.

S7-1
MOOD DISORDERS ACROSS THE LIFESPAN: IMPLICATIONS FOR *DSM-5*

David Shaffer, M.D., 1051 Riverside Dr Unit 78, New York, NY 10032

SUMMARY:
Burned by previous enthusiasm for childspecific presentations of adult disorders, such as childhood schizophrenia (autism), the approach to understanding mood disorders in children has been generally conservative, dismissing such concepts as "masked depression" and relying on a search for features similar to those identified in adults. This approach has shown that depression in recognizable format—with expected risk factors, symptoms, and natural history—is rare before puberty, occurs without the expected gender differences, and is associated with a more varied outcome than depression in teens. However, stimulated, perhaps, by the finding that parental mood is a major determinant of disturbance in youth, a new generation of research is examining childhood mood in relation to parental mood and the childhood antecedents of later depression. Together, this research suggests that a childhooddepression profile characterized by irritability and aggression might be an agespecific format for youth depression. What this relationship might mean for *DSM-5* will be discussed.

S7-2
YOUNG ADULTHOOD: PRIME TIME FOR ONSET OF BIPOLAR DISORDER

Ellen Frank , Ph.D., 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:
Across virtually all cultures, late adolescence/ young adulthood appears to be the highest risk period for onset of bipolar disorder; yet, it often goes unrecognized at initial presentation. Indeed, multiple studies indicate that the typical delay from onset to correct diagnosis is approximately ten years. Why this might be so and how the revisions proposed for *DSM-5* might address this problem will form the basis of this presentation. Reasons for the long delay to correct diagnosis include the fact that the first syndromal episode in most individuals with bipolar disorder is depression, not mania or hypomania, that the most prominent features of a manic episode may not necessarily be euphoria and that patients rarely present for treatment voluntarily when they are in an episode of mania or hypomania so that the diagnosis must often be made on the basis of history. The *DSM-5* Mood Disorders Work Group is proposing several changes to the Mood Disorders section that may increase the likelihood of correctly identifying bipolar disorders in late adolescents and young adults. These changes include the possibility of assigning a 'with manic/hypomanic features' specifier to an episode of depression when only 3 symptoms of mania/hypomania are present rather than requiring the full manic syndrome to qualify for a mixed episode. This should have the effect of identifying earlier those young individuals with depression who are at greater risk for eventual onset of mania. Perhaps more important, we are proposing greater emphasis on the psychomotoric activation aspects of mania/hypomania relative to the mood aspects, by adding the requirement for abnormally and persistently increased activity or energy to criterion A for mania and hypomania. The Mood Disorders Work Group is hopeful that these proposed revisions will increase the likelihood of identifying mania/hypomania in young people, both at time of presentation and on the basis of history.

S7-3
ADULT MAJOR DEPRESSIVE DISORDER AND THE BEREAVEMENT EXCLUSION

Sidney Zisook, M.D., Psychiatry Department, University

of California, San Diego, 9500 Gilman Drive, 9116A,, La Jolla, CA 92093

SUMMARY:
In *DSM-IV*, bereavement is the only life event that excludes the diagnosis of Major Depressive Episode (MDE). Thus, an individual who meets all symptomatic, duration and impairment criteria for MDE but is recently bereaved may not have Major Depressive Disorder (MDD). In contrast, a recently divorced or disabledbut nonbereaved individual with the same symptoms would be diagnosed with MDD, as would someone with identical symptoms who could not identify any recent losses or adversity. As we prepare for *DSM-5*, it makes sense to reevaluate this distinction. On the one hand, if major depressive syndromes following the death of a love one are fundamentally different than other, nonbereavement related instances of depression, then the bereavement exclusion may be valid and should be retained. On the other hand, if depressions following bereavement do not differ substantially from nonbereavementrelated depression, with respect to chronicity, recurrence, severity, or treatment response, then the bereavement exclusion may be invalid and should be dropped from *DSM-5*. Our review finds no compelling studies showing that bereavement related depressions are fundamentally different than nonbereavement related depressions; on the contrary: a comprehensive literature review found that their similarities far outweighed their differences. Thus, risk factors, clinical characteristics, course, complications, biological indices and treatment response were similar for both types of depression. At least 3 subsequent secondary analyses of large populationbased data bases have demonstrated substantial similarities between bereavementrelated major depressive syndromes and other lifeevent related depressions, with respect to demographic and clinical characteristics, severity, course, familial pattern, associated features and treatment response. A fourth, populationbased prospective study found global symptom profile and risk of depressive recurrence to be similar in bereaved and nonbereaved depressed subjects. None of these reviews or studies provides support for the special treatment given to bereavementrelated depression in the *DSM-IV*. Accordingly, we conclude that the bereavement exclusion is probably not valid and should be dropped from *DSM-5*.

S7-4
THE PROGNOSTIC IMPORTANCE OF ANXIETY SYMPTOMS IN UNIPOLAR AND BIPOLAR DEPRESSIVE EPISODES

William Coryell, M.D., 2205 MEB, University of Iowa Carver College of Medicine,, Iowa City, IA 52242

SUMMARY:
Numerous studies have associated the presence of anxiety symptoms in major depressive episodes with lower likelihoods of treatment response, longer times to recovery, and greater amounts of depressive morbidity over extended followups. Recent analyses from the NIMH Collaborative Depression Study have tested a broad array of anxiety symptoms as baseline predictors of depressive morbidity across two decades of prospectively observed morbidity in large unipolar (n=476) and bipolar (n=335) disorder cohorts. Results show that the severity of concurrent, but not of preexisting, anxiety has robust and sustained prognostic import for both unipolar and bipolar depressive episodes. Longterm depressive morbidity increases in a stepwise fashion with the severity of anxiety symptoms present at the beginning of followup and this effect does not diminish across decades. Both the sum of severity ratings for 8 individual anxiety symptoms and the number of symptoms scored dichotomously were predictive. The severity of endogenous depressive symptoms, in contrast, does not appear to be predictive of longterm symptom persistence. These findings suggest that high levels of anxiety within depressive episodes mark a temporally stable phenotype and this characterization may thus help to refine samples for genetic investigation.

S7-5
THE ORIGINS AND PRESENTATION OF DEPRESSION IN LATER LIFE: A REVIEW

Dan Blazer, M.D., Ph.D., Duke University Medical Center PO Box 3003, Durham, NC 27710

SUMMARY:
In this presentation, the epidemiology of late life depression will be reviewed. In community samples, the frequency of major depression is lower compared to midlife though suicide rates have been higher until recently. The biological, psychological and social origins of late life depression will be

reviewed. Emphasis will be placed on current research into subcortical vascular changes, unique life experiences of older adults, and social factors which increase the risk of late life depression. Yet older persons also may be protected psychologically and socially despite the increased biological risk. The symptoms of major depression in the elderly do vary but not dramatically from those earlier in the life cycle if the depression is not associated with physical and psychiatric comorbidities. Nevertheless, comorbidities are frequently associated with late life depression, especially with cognitive impairment (which has led some to propose specific criteria for depression in Alzheimer's Disease), vascular disease in the brain (which has led some to propose specific criteria for vascular depression) and depression associated with a host of physical disorders, such as cardiovascular disease, diabetes, and cancer.

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1) Goldberg D, Kendler KS, Sirovatka PJ, & Regier DA. Diagnostic Issues in Depression and Generalized
Anxiety Disorder: Refining the Research Agenda for DSM-V. Arlington, VA: American Psychiatric Association, 2010.
2) Brotman MA, Schmajuk M, Rich BA, Dickstein DP, Guyer AE, Costello EJ, Egger HL, Angold A, Pine DS,
Leibenluft E: Prevalence, clinical correlates, and longitudinal course of severe mood and behavioral dysregulation in children. Biol Psychiatry, 60:9917, 2006
3) Zisook, S., Kendler, K.S.: Is bereavementrelated depression different than nonbereavementrelated depression. Psychological Medicine: 131, 2007

SUNDAY, MAY 15, 2011
8:00 AM-11:00AM

SYMPOSIUM 8
THE NIMH BIPOLAR TRIALS NETWORK LITHIUM TREATMENT MODERATE DOSE USE STUDY (LITMUS): A RANDOMIZED COMPARATIVE EFFECTIVENESS TRIAL OF ADJUNCTIVE LITHIUM

Chais: Terence A Ketter, M.D., 401 Quarry Rd Rm 2124, Stanford, CA 943055723,
Co-Chair: Andrew C Leon, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate important innovative design features of randomized, pragmatic intervention trials with ecological validity in bipolar disorders; 2) Recognize strengths and limitations of alternative design methodologies and statistical procedures for bipolar intervention studies; and 3) Identify the efficacy and safety/tolerability of adjunctive, moderatedose lithium in bipolar disorder.

OVERALL SUMMARY:
Lithium as monotherapy is used infrequently; combination therapy regimens predominate for all clinical states of bipolar disorder. This symposium will focus on the recently completed Bipolar Trials Network longerterm comparative effectiveness study of adjunctive moderately dosed lithium in patients with bipolar disorder receiving optimized pharmacological treatment (OPT). First, recent pragmatic intervention studies in bipolar disorder and their impact upon study design will be described. These considerations yielded the following design features – (1) at entry, participants included individuals with bipolar I disorder or bipolar II disorder who were currently symptomatic, defined as having a Clinical Global Impression for Bipolar Disorder overall illness severity (CGIBPS) score of greater than or equal to 3 (mild); (2) participants were randomized to 6 months of administration of moderatedose (target 600 mg/day) lithium plus OPT versus OPT without lithium, with a singleblind rater; and (3) the coprimary outcome measures were degree of improvement on CGIBPS and number of Necessary Clinical Adjustments (NCAs, i.e. medication changes) over the course of 6 months. Next, the baseline demographics and illness characteristics of the 283 participant sample will be described. This included at baseline 58% having syndromal acute major depressive episodes, 31% having syndromal acute mood elevation (manic/hypomanic) episodes, and 11% having subsyndromal symptoms. Then the sample disposition will be described – this included having an uncommonly high retention rate (84% of participants completed the 6month study). Next, efficacy (change in CGIBPS and NCAs) findings will be presented, followed by a detailed description of the design considerations and performance of the novel NCA outcome. Safety/tolerability findings will be described, followed by a group

discussion of how the efficacy and safety/tolerability findings of this study will provide an evidence base to inform decisionmaking regarding the use of adjunctive moderatedose lithium in clinical practice. Background: The NIMH Bipolar Trials Network LiTMUS Study included two primary outcome measures. First, the CGIBPS is a standard primary outcome of illness severity. Second, an innovative coprimary outcome measure was Necessary Clinical Adjustments (NCAs). Objective: NCAs represent a count of modifications of all medications used to treat psychiatric disorders or side effects, including dose changes, which are triggered in response to a patient's symptom severity, inadequate function, or side effects. More specifically, NCAs consist of all adjustments in medications that are classified as necessary to respond to clinical need, e.g. exacerbation of mood, emergence of a mood episode, persistence of symptoms, or adjustments because of adverse events. NCAs did not include decreases in doses based on positive responses or a clinician's judgment that a medication is no longer required. NCAs did not directly influence subsequent changes in treatment. Yet, NCAs did serve as a proxy for overall effectiveness of treatment. Discussion: A further reason for including an innovative coprimary outcome was based upon the effectiveness aspect of the LiTMUS Study design, which meant to reflect physician prescribing behavior in clinical practice. That is, study clinicians were instructed to manipulate treatment as aggressively as needed to control participant's symptoms and ameliorate adverse effects. Importantly, we also assessed relationships between NCA and conventional mood and quality of life outcomes. Limitations of the NCA metric included its novelty, which initially may elicit skepticism from the field, and its operational challenges.

S8-1

REVIEW OF RECENT PRAGMATIC INTERVENTION STUDIES IN BIPOLAR DISORDER AND LITMUS DESIGN CONSIDERATIONS

Charles Bowden, M.D., 7703 Floyd Curl Drive, MC 7734, San Antonio, TX 782293900

SUMMARY:
Most large registration trials in bipolar disorder conducted over the past decade have employed designs that emphasize efficacy over tolerability and sustainability of benefit. Adjunctive designs have come to be preferred for bipolar disorder maintenance studies since patients take a median of 3 medications for optimal outcomes. The adjunctive study designs inflate therapeutic effect sizes for the experimental drug by using enriching samples to favor the experimental drug, excluding recently depressed, bipolar II, and difficult to treat patients with rapid cycling and cooccurring substance use and anxiety disorders. Yet, clinicians in real world practice also need information relevant to comparative differences in risks of adverse effects, costs, and adherence to treatment. Furthermore, only by enrolling patients with few exclusion criteria can studies be analyzed to identify predictors of personalized differences among patient groups regarding tolerability, response, and sustainability of a response to a particular drug or regimen. Finally, outcome criteria for generalizability of results of studies need to include high proportions of patients throughout the trial rather than simply terminate patients at the first point that signs of a new episode occur. This presentation reviews recent studies which have such desired design features, e.g., the NIMH Systematic Treatment Enhancement Program for Bipolar Disorder (STEPBD), Stanley Foundation Network and Balance

S8-2

LITMUS BASELINE DEMOGRAPHICS AND ILLNESS CHARACTERISTICS FINDINGS

Joseph Calabrese, M.D., 10524 Euclid Ave 12th Fl, Cleveland, OH 44106

SUMMARY:
Knowledge of treatment response and characteristics of bipolar disorder is shaped by the samples selected and recruited into treatment trials. Public health populations are not routinely included in research. Samples for controlled randomized clinical trials conducted for regulatory approval exclude patients with comorbidities, complex presentations and high illness severity. LiTMUS (Lithium Moderate Dose Use for Bipolar Disorder) addressed this efficacyeffectiveness gap in bipolar disorder treatment by recruiting patients from ethnically and socioeconomically diverse settings. The principle criterion for illness severity in LiTMUS was that subjects be currently symptomatic, defined as a

CGIBPS of greater than or equal to 3 (mild). The illness history, presenting severity, clinical states and functional status of the sample will be presented. The bottom line from these results is that this simple metric yielded a sample noteworthy for high illness severity, ecological validity and generalizability to community practices in bipolar disorder. This presentation will provide an overview of the baseline demographics and illness characteristics of subjects enrolled and randomized into this treatment trial.

S8-3

LITMUS SAMPLE DISPOSITION: AN UNCOMMONLY HIGH RETENTION RATE

Edward Friedman, M.D., M.A., 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:
This presentation will examine the disposition of subjects enrolled n the Lithium Use for Bipolar Disorder Study (LiTMUS) study. Clinically relevant intervention studies require broad inclusion and narrow exclusion criteria to be highly generalizable. How these criteria were operationalized in the LiTMUS will be presented. Because high attrition rates occur frequently in longerterm clinical trials of interventions for bipolar disorder, the LiTMUS investigators sought to minimize the subject loss and attrition that often limit the interpretation of results. Design issues to minimize attrition in the LiTMUS study are presented, specifically: (1) the use of an intenttotreat design; (2) a randomized adjunctive singleblind design; (3) participant reimbursement; (4) intenttoattend procedures; (5) quality care with limited participant burden; and (6) target windows for study visits. These elements in LiTMUS study design and implementation may have helped produce a highly representative sample of ill bipolar subjects and a very low attrition rate (17%).

S8-4

NECESSARY CLINICAL ADJUSTMENTS (NCAS): DESIGN CONSIDERATIONS AND PERFORMANCE OF A NOVEL OUTCOME MEASURE

Andrew Leon, Ph.D., 525 East 68th Street WMC/PWC Box 140, New York, NY 10065

SUMMARY:
Background: The NIMH Bipolar Trials Network LiTMUS Study included two primary outcome measures. First, the CGIBPS is a standard primary outcome of illness severity. Second, an innovative coprimary outcome measure was Necessary Clinical Adjustments (NCAs). Objective: NCAs represent a count of modifications of all medications used to treat psychiatric disorders or side effects, including dose changes, which are triggered in response to a patient's symptom severity, inadequate function, or side effects. More specifically, NCAs consist of all adjustments in medications that are classified as necessary to respond to clinical need, e.g. exacerbation of mood, emergence of a mood episode, persistence of symptoms, or adjustments because of adverse events. NCAs did not include decreases in doses based on positive responses or a clinician's judgment that a medication is no longer required. NCAs did not directly influence subsequent changes in treatment. Yet, NCAs did serve as a proxy for overall effectiveness of treatment. Discussion: A further reason for including an innovative coprimary outcome was based upon the effectiveness aspect of the LiTMUS Study design, which meant to reflect physician prescribing behavior in clinical practice. That is, study clinicians were instructed to manipulate treatment as aggressively as needed to control participant's symptoms and ameliorate adverse effects. Importantly, we also assessed relationships between NCA and conventional mood and quality of life outcomes. Limitations of the NCA metric included its novelty, which initially may elicit skepticism from the field, and its operational challenges.

S8-5.

OVERVIEW OF LITMUS EFFICACY FINDINGS

Terence Ketter, M.D., 401 Quarry Rd Rm 2124, Stanford, CA 943055723

SUMMARY:
This presentation will provide an overview of LiTMUS efficacy findings. LiTMUS had two coprimary outcome measures: (1) Clinical Global Impression for Bipolar Disorder overall illness Severity (CGIBPS), an integrated measure of illness severity incorporating social and vocational functioning, assessed by a blinded, independent rater; and (2) Necessary Clinical Adjustments

(NCAs), a novel measure reflecting medication changes necessary to respond to clinical need, and a proxy for the clinical burden of interventions. This presentation will begin by describing findings regarding the first coprimary hypothesis – that lithium plus optimized treatment (Li+OPT) compared to OPT without lithium would yield greater and more rapid improvement in CGIBPS scores over the 6month course of the study. The prior presentation will describe design considerations and performance of the novel NCA metric, including findings regarding the second coprimary hypothesis (that Li+OPT compared to OPT would yield fewer NCAs over the course of 6 months) and key secondary hypotheses involving NCAs. This presentation will go on to describe findings regarding different secondary as well as exploratory hypotheses such as moderators and mediators of response, and changes in mood rating scales such as the Montgomery Asberg Depression Rating Scale (MADRS), 16item Quick Inventory of Depressive Symptomatology SelfReport (QIDSSR 16), Young Mania Rating Scale (YMRS), and Clinician Administered Rating Scale for Mania (CARSM), as well as suicidality as assessed by the Modified Columbia SuicideSeverity Rating Scale (MCSSRS), and quality of life as assessed by the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ).

S8-6
LITHIUM TOLERABILITY

Michael Thase, M.D., 3535 Market Street, Suite 670, Philadelphia, PA 19104

SUMMARY:
Lithium salts, particularly lithium carbonate, have been a mainstay of treatment of bipolar disorder for the past 40 years. Although lithium has unquestioned efficacy, for both acute treatment of mania and prophylaxis against subsequent episodes, therapy is often complicated by untoward effects. The most common side effects include: diarrhea, nausea, and other gastrointestinal side effects; tremor; increased thirst; and polyuria. During longer term therapy additional side effects can develop, including weight gain, acne and other skin conditions, hypothyroidism, and impaired renal function. These side effects and others lead to a significant number of patients to discontinue an otherwise highly effective and inexpensive therapy. As many of the side effects of lithium therapy are dosedependent and, in the 21st century lithium is much more commonly utilized in combination with other mood stabilizers and second generation antipsychotics than as a monotherapy, it is important to determine if the therapeutic benefits can be retained and the tolerability issues kept to a minimum by adopting a strategy that emphasizes moderate doses. The LiTMUS study was designed to specifically test this hypothesis. This presentation will describe the tolerability outcomes of lithium therapy during LiTMUS, including the incidence of specific side effects among patients receiving moderate dose lithium therapy as compared to those randomized to treatment not including lithium, as well the comparative proportions of patients who withdrew from their randomized treatment as a result of intolerable adverse effects

REFERENCES:
1) Nierenberg AA, et al. Lithium treatmentmoderate dose use study (LiTMUS) for bipolar disorder: rationale and design. Clin Trials 2009;6(6):63748.

SYMPOSIUM 9
CLINICIANS IMPRESSIONS OF THE *DSM-5* PERSONALITY DISORDERS
Association for Research in Personality Disorders

Chair: James H Reich, M.D., M.P.H., 2255 North Point Street #102, San Francsico, CA 94123
Discussant: Paul S Links, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize and gain understanding of how experienced clinicians think the change to *DSM-5* personality disorders will change practice and perceptions of the personality disorders.

OVERALL SUMMARY:
The *DSM-5* personality disorders will represent a major change in our diagnosis of the personality disorders. This symposium's focus will be to have experienced clinicians in the area of personality discuss the implications of these changes for clinical practice. This is not the "official" version, rather people who have long worked in the field of personality disorders thinking about the implications

of this change. Topics discussed will include the evolution of the concept of the personality disorder, the general diagnosis of a personality disorder, using the personality prototypes, levels of functioning in the personality disorders, personality traits and views of experts outside of the United States on the *DSM-5* personality disorders.

S9-1
THE EVOLUTION OF PERSONALITY DISORDERS AND *DSM-5*

Donald W. Black, M.D., Psychiatry Research MEB, Iowa City, IA 52442

SUMMARY:
Maladaptive personality traits have been recognized since Cain killed his brother Abel. In ancient Greece, four temperaments were described, and variations of this classification were used up to the 20th century. Formal attempts to list personality disorders took root with DSMI published in 1952, in which 7 different "personality disturbances" were described. In DSMIII in 1980, based on clinical and research observations, personality disorders were accorded new status with a separate axis in the new multiaxial system. Eleven disorders were divided among three clusters based on their phenomenologic similarity. The disorders have been pared back to 10, and in *DSM-5* further changes have been proposed that involve both categorical and dimensional components. The 4part assessment includes: 1) a new general definition of personality disorder; 2) evaluation of level of function, 3) graded ratings of personality "type", and 4) ratings of "higher level" personality trait domains. The proposed changes will be placed into historical perspective and both advantages and disadvantages of the system will be discussed.

S9-2
MAKING A PERSONALITY DISORDER DIAGNOSIS IN GENERAL CLINICAL PRACTICE: PITFALLS AND INDICATIONS

James Reich, M.D., M.P.H., 2255 North Point Street #102, San Francsico, CA 94123

SUMMARY:
Making the general diagnosis of a personality disorder is a difficult task for a clinician. Experts will describe various symptom clusters that might be indicative of a personality disorder. Experts might also describe types of functional deficits characteristic for given personality disorders. However, the clinician virtually never sees a personality disorder in isolation. He sees the patient who also has Axis I disorders with their own effect on personality functioning and overall functioning. There are frequently also what seem to be independent life stressors which seem at times to affect personality and functioning. Basically the clinician is facing a patient disabled by multiple factors. When asked to diagnose a personality disorder the clinician is, in effect, asked to do a careful dissection of causation usually without the aid of the "gold standard" several hour semi-structured diagnostic interview. This presentation will discuss these complications that the clinician must grapple with in order to make a personality disorder diagnosis in the ordinary clinical situation.

S9-3
MEASURING LEVELS OF PERSONALITY FUNCTIONING IN PERSONALITY DISORDERS IN *DSM-5*

Kenneth Silk, M.D., 4250 Plymouth Road, Ann Arbor, MI 48109

SUMMARY:
Functional impairment has long been a construct of personality disorders. Research reveals that despite improvement in symptoms and behaviors, patients with personality disorders continue to show impairment in "in social, occupational, or other important areas of functioning". However, the nature of this impairment and how to measure it has not been elaborated upon in previous and current editions of the DSM. DSM 5 attempts to improve on the concept of "functional impairment". It provides a 5 point scale from 0 (no impairment) to 4 (extreme impairment) by which to rate the patient on "Levels of Personality Functioning". Areas of functioning that are assessed are "levels of self and interpersonal functioning". The concept of "self" functioning consists of identity integration, integrity of self concept, and selfdirectedness encompassing the idea of a consistent sense of self and one's abilities and behaviors across various settings and stressors combined with a coherent sense of one's standards and life goals. The concept

of "interpersonal" functioning consists of empathy, intimacy and cooperativeness, and complexity and integration of representations of others encompassing the ability to mentalize and fairly accurately assess the feelings and thoughts of others, to be able to appreciate others' perspectives, to be able to tolerate and be consistent in feeling close and attached to another person, and to be able to see others as cohesive individuals even when one does not at the moment hold positive feelings about them. Focus groups were held among the staff clinicians (consisting of psychiatrists, psychiatric residents, social workers, psychologists and clinical nurse specialists) of a University outpatient clinic to gather those clinicians' impressions of the user friendliness of these rating scales. The qualitative results of those focus groups will be presented and discussed.

S9-4

DSM-5 PROTOTYPES: ISSUES AND CONTROVERSIES

Larry Siever, M.D., 130 W Kingsbridge Rd Rm 6A44, Bronx, NY 104683904

SUMMARY:
DSM-V personality disorders will be organized to include both overall levels of personality function, specific traits, and specific prototypes representing identified personality disorders. This structure is based on a model that personality disorder can be represented by numbers of traits that vary between individuals but specific prototypes emerge as clinically useful and supported by empirical evidence. However, criteria of clinical utility may not always converge with available empirical data, particularly since some of the personality disorders have received relatively little study. identified ten personality disorders. Five have been supported to varying degrees by empirical studies including schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, avoidant personality disorder, and obsessive compulsive personality disorder and will be included as prototypes. The other disorders have received relatively less investigative attention and have less sound empirical bases. Indeed, only the first three have both extensive external validators and construct validity. Some of the personality disorders have also been argued to be representative of expanded definitions of single traits. Whether the other DSM-V personality disorders would be represented by traits or have some acknowledgement in DSM-V has yet to be determined. Another outstanding issue is how to accommodate disorders like schizotypal personality disorder and to a certain extent borderline personality disorder where there may be relationships to one or more valid major psychiatric syndromes spectra such as the case for schizotypal personality disorder and schizophrenia. The data and controversial issues will be addressed.

S9-5

GUIDELINES AND ALGORITHMS: AN EUROPEAN PERSPECTIVE ON PERSONALITY DISORDERS

Simone Kool, M.D., Ph.D., Frederik Hendrikstraat 47, Amsterdam, 1052 HK Netherlands

SUMMARY:
In the last decade several evidence-based clinical guidelines for the diagnosis and treatment of patients with personality disorders were introduced (e.g. APA, 2001; WFSBP, 2007; Nice, 2009). Although these guidelines converge on starting points and global recommendations, they also differ in many respects on relevant treatment issues. In the Netherlands a clinical guideline for the diagnosis and treatment of personality disorders was presented in 2008, constructed as a collaborative effort of psychiatrists, psychologists, general practitioners, psychiatric nurses and other disciplines working in mental health care, as well as patients and family members organizations. In this duo presentation we present a general outline of the Dutch personality disorder guideline (CBO, 2008), focusing on similarities and differences with guidelines from other countries and organizations. As a demonstration we present our systematic review on pharmacotherapeutic interventions (Rinne & Ingenhoven, 2007), the constructed treatment algorithms, and the validation of our efforts by current metaanalyses (Ingenhoven et al., 2010). We reflect on the impact of the introduction of the guideline on every day clinical practice in mental health care in the Netherlands. Finally, we summarize recommendations for empirical research in the service of revising current algorithms and guidelines.

S9-6

The *DSM-5* Personality Disorder Dimensional Model

Thomas Widiger, Ph.D., 115 Kastle Hall, Lexington, KY 405060044

SUMMARY:
DSM-5 is likely to include a supplementary dimensional model for the description of personality disorders. The current version consists of 6 domains and 37 traits. The dimensional model can be used in two ways: as a means to diagnose the personality disorder categories or as an entirely independent method for patient description. Concerns and limitations with respect to both potential uses will be discussed.

REFERENCES:
1) Reich, J Personality Disorders: Current Research and Treatment, Taylor and Francis, New York, 2005.

SYMPOSIUM 10
NEW PERSPECTIVES ON GLOBAL MENTAL HEALTH
U.S. National Institute of Mental Health

Chair: Pamela Y. Collins, M.D., M.P.H., 6001 Executive Blvd, Room 8125, Bethesda, MD 20892

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Give examples of the impact of globalization on mental health and people with mental illness; 2) Describe the role of genetics research in diverse populations and environments; 3) Identify hypothesized risk factors associated with increased incidence of mental disorder in the context of migration; and 4) List principles for integrating mental health interventions into global public health efforts.

OVERALL SUMMARY:
Global mental health invites the clinical and scientific communities to wrestle with differences and disparities in mental health status and access within and between countries. Research conducted in the context of globalizing social forces must extend the gaze of investigators so that they are inclusive of vulnerable populations in the formulation of research questions. This approach ensures that the economic, political and sociocultural diversity in which humans live informs our understanding of the development, prevention, and treatment of mental disorders. Similarly, the mental health outcomes associated with these varied environmental exposures can enlighten our understanding of the underlying neurodevelopmental processes that are sensitive to them. This symposium presents a new perspective on global mental health and mental health disparities that is informed by globalizing influences on communities. The symposium will explore the environmental and genetic risk factors of mental disorders across low, middle, and highincome countries; examine the impact of migration on disorder and probe the roles of culture, racial density, age, and epigenetics in differential rates of disorders in highincome countries; consider the contribution of globalization and increasing urbanization throughout the world to mental health outcomes; and demonstrate how interventions can support community resilience while building on existing global public health interventions.

S10-1
MENTAL HEALTH EQUITY: LEARNING FROM A GLOBAL CONTEXT

Pamela Collins, M.D., M.P.H., 6001 Executive Blvd, Room 8125, Bethesda, MD 20892

SUMMARY:
Neuropsychiatric disorders account for a significant proportion of the burden of noncommunicable disease in high, middle, and lowincome countries. Yet, marked inequities in financing of health services and supply of human resources for mental health care are evident between countries and within countries. Global mental health research requires that investigators address questions of equity while acknowledging the global economic, political, and cultural interconnections that shape the experience of mental illness and the lives of people with mental illness. Consequently, researchers engage with populations affected by poverty, displacement, and migration; they recognize the social consequences of global events on local communities. Within countries, mental health inequities must be examined through the complex relationships of socioeconomic status, culture, sex, gender, genetics, race and ethnicity. A global research perspective can facilitate exploration of the underlying mechanisms

that produce difference and disparity in diverse populations.

S10-2

GENETICS RESEARCH IN LOW AND MIDDLE INCOME COUNTRIES: THE SCIENCE, THE CAPACITY, AND THE ETHICS

Vishwajit Nimgaonkar, M.D., Ph.D., 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:
Background: Global disorders may share etiological factors across national boundaries, particularly genetic risk factors. Hence we have conducted crossnational genetic studies of schizophrenia (SZ) and bipolar disorder (BP) in Egypt in India. The Egyptian studies followed anecdotal reports of increased consanguinity (inbreeding) rates among patients with psychoses in certain Middle Eastern populations. Such research also invites research capacity building and raises ethical questions. Methods: Systematic genetic epidemiological studies were conducted, including whole genome polymorphism analyses (WGA). Simultaneously, we trained new investigators in research methods, established genetics laboratories and fostered ethical discussions in our host collaborating countries. Results: Consanguinity is consistently associated with increased risk for SZ or BP1 in Egypt (odds ratios ~24), suggesting recessive modes of inheritance. WGA suggest that consanguineous individuals, particularly consanguineous patients are more likely to have longer homozygous segments. Several homozygous segments are more frequent or are unique among cases. Our simultaneous capacity building efforts have led to publications, grant applications and additional novel research by our trainees. Conclusions: Consanguineous SZ or BP1 cases are more likely to have longer homozygous segments. Further homozygosity by descent analysis may help detect recessively inherited chromosomal regions. Infrastructure building has a multiplicative/spinoff effect on the host country's research.

S10-3

LIC MEETS HIC, SCHIZOPHRENIA AMONG IMMIGRANT POPULATIONS IN THE NETHERLANDS: THE MANY FACETS OF ENVIRONMENTS AND ILLNESS

Wim Veling, M.D., Mangostraat 15, The Hague, 2552 KS

SUMMARY:
The risk for schizophrenia is increased among nonWestern ethnic minorities in the Netherlands compared to the Dutch population. Studies in The Hague suggest that the excess risk for schizophrenia among first and secondgeneration immigrants can be understood by taking into account the social and cultural context in which they live. The increased incidence is likely to be determined by factors on multiple levels, including the neighborhood, the ethnic group, and the individual. Specifically, young age at migration, belonging to a group that experiences a high degree of discrimination, living in a neighborhood with few others of one's ethnic group, and having a weak and negative identification with one's own ethnic group may increase the risk of psychotic disorders. It is proposed that these factors represent a situation of chronic social stress, which might precipitate schizophrenia in individuals who have a (genetic) predisposition for the illness.

S10-4

RAPID URBANIZATION, SOCIAL CAPITAL AND MENTAL HEALTH

Kwame McKenzie, M.D., 455 Spadina Avenue, Suite 300, Toronto, Ontario, M5S 2G8

SUMMARY:
Objectives: One of the consequences of globalisation has been rapid urbanisation this may be linked with deterioration in the mental health for groups that move into cities. This paper will use the concept of social capital to develop a model for the impact of rapid urbanisation on mental health. Methods: The literature concerning the association between the urban environment and mental health was searched using standard techniques and reported associations were listed. The concept of social capital was disaggregated into its constituent parts and a logic model was developed for their possible impacts on the parts of the urban environment that are associated with mental illness. Results: Vertical social capital and the development of bridging social capital between groups at the same level may be most important for the mental health of populations undergoing rapid urbanisation. Conclusion: If

countries are to take seriously the need to avoid the mental health impacts of rapid urbanization they may want to consider how to promote the maintenance of existing social capital for migrants, how to develop bridging social capital between migrant groups and how to produce urban areas with structures that allow new city migrants to be involved in local governance.

S10-5

PROMOTING PROTECTIVE PROCESSES AND RESILIENCE IN RWANDAN FAMILIES AFFECTED BY HIV/AIDS: DEVELOPMENT OF A FAMILY STRENGTHENING INTERVENTION

Theresa Betancourt, Sc.D., M.A., 651 Huntington Avenue, Boston, MA 02115

SUMMARY:
OBJECTIVES: Research in several international settings indicates that children affected by HIV/AIDS are at increased risk for a range of mental health problems including depression, anxiety, and social withdrawal. Preventionfocused and familybased interventions have important public health applications in preventing mental health problems, including behavioral problems that may increase risk of HIV infection. METHODS: In collaboration with Partners in Health, our Specific Aims are to: 1) Adapt a USdeveloped, familyfocused, and strengthsbased prevention program to the context of HIV/AIDS in postgenocide Rwanda; 2) pilot test the intervention protocol within a small set of families to assess acceptability, feasibility and further refine an intervention manual; and 3) conduct a pilot feasibility study among 80 families to examine whether the intervention a) improves caregiverchild relationships using measures of family connectedness, good parenting and social support, and b) is associated with reduced mental health symptoms, HIV risk behaviors and increased functioning in children. RESULTS/CONCLUSIONS: Our mixed qualitative and quantitative research methods have revealed a range of locally and culturally relevant protective processes and mental health problems. This information and culturallyappropriate practices for building resilience in vulnerable families, with input from local clinician, community advisory boards and the government has strengthened intervention development.

REFERENCES:
1) McKenzie K. Urbanization, social capital and mental health. Global Social Policy 2008; 8; 359. DOI: 10.1177/1468018108095633.
2) Mansour H et al. Consanguinity and increased risk for schizophrenia in Egypt. Schizophr Res. 2010 Jul; 120(13):10812.
3) Veling W, Hoek HW, Wiersma D, Mackenbach JP. Ethnic identity and the risk of schizophrenia in ethnic minorities: a casecontrol study. Schizophr Bull. 2010 Nov; 36(6):114956.
4) Zraly M, RubinSmith J, Betancourt T. Primary mental health care for survivors of collective sexual violence in Rwanda. Global Public Health. 2010 Jul 22:114.

SYMPOSIUM 11
PEDIATRIC BIPOLAR DISORDER: ADVANCES AND CHALLENGES IN DIAGNOSIS, BIOMARKERS AND TREATMENT MODALITIES.
APA Council on Children, Adolescents & Their Families

Chair: Erin C Soto, M.D., 215 West 101st Street Apt #4D, NY, NY 10025
Discussant: Harsh Trivedi, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the session, the participant should be able to: 1). List the diagnostic criteria for both narrow and broad phenotypes of pediatric bipolar disorder; 2). Explain the current evidence regarding the bipolar prodrome; 3) Discuss the existing biomarkers of pediatric bipolar disorder in neuroimaging; and 4). Describe the current evidence based psychopharmacologic and nonpsychopharmacologic treatments for pediatric bipolar disorder.

OVERALL SUMMARY:
Despite large increases in the reported incidence of pediatric bipolar disorder, consensus on the required phenotypic criteria and the prodromal symptoms remain challenging and controversial. This symposium aims to inform both adult and child and adolescent psychiatrists about this evolving diagnosis in order to inform improved identification and treatment. Dr. Catherine Galanter will describe

the narrow and broad phenotype diagnostic criteria for pediatric bipolar disorder and the challenges of distinguishing this disorder from ADHD and ODD. Dr. Kiki Chang will review existing data on prodromal bipolar disorder and the controversies surrounding this diagnosis. Dr Melissa DelBello will present updates on existing biomarkers in neuroimaging for pediatric bipolar disorder. Dr Erin Soto will review the evidence based psychopharmacololgic and nonpsychopharmacologic treatments for pediatric bipolar disorder. Dr Harsh Trivedi will then lead a summary and discussion between the presenters and audience members regarding the practical implications for clinicians in working with this vulnerable patient population.

S11-1

AN EVIDENCE BASED APPROACH TO CAREFUL ASSESSMENT AND ACCURATE ASSESSMENT OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Cathryn Galanter, M.D., 1051 RSD, #78, NY, NY 10032

SUMMARY:
Objective: This presentation will review the literature on bipolar phenotypes in children and adolescents describe evidence based approaches to careful assessment of children with bipolar disorder and possible bipolar disorder (BD) and to differentiating BD from ADHD, ODD and other disorders. Background: The number of children and adolescents diagnosed with bipolar disorder has increased greatly in recent years. Whether these increased rates of diagnosis reflect a true increase in prevalence, better identification of the disorder, overdiagnosis (misdiagnosis) or a combination is an unanswered question. Careful assessment of BD in children and adolescents is crucial to accurate diagnosis and effective treatments. Method: We will review the research relevant to evidence based assessment of BD in children and adolescents. In particular we review proposed bipolar phenotypes the course and outcome associated with these phenotypes. We will also review research on evidence based approach to assessing bipolar disorder such as the use of rating scales, structured interviews and use of these tools in clinical practice. Finally, we will review new data on clinician diagnostic decision making differentiating BD from ADHD and ADHD with manic symptoms. Conclusion: Clinicians treating children and adolescents may be challenged in assessing BD. This presentation will review proposed research phenotypes for BD as well as information to support evidence based assessment of BD in clinical practice.

S11-2

PRODROMAL BIPOLAR DISORDER IN YOUTH: DIAGNOSIS AND EARLY INTERVENTION

Kiki Chang, M.D., 401 Quarry Road, Stanford, CA 943055719

SUMMARY:
Objectives: It is becoming clear that the onset of bipolar disorder (BD) in children and adolescents often includes a prodromal period during which symptoms of ADHD, anxiety, depression, and/or mania appear. It is important to be able to recognize children during this period in order to employ effective early intervention and prevention. This talk discusses the controversies and difficulties in diagnosing children at highrisk for BD development, and presents biological data that informs pathophysiology of BD development and treatment interventions that have ben studied in this population. Methods: Children and adolescents with a firstdegree relative with BD and mood symptoms themselves were evaluated by MRI and genetic analysis, and clinical trials of medications and psychotherapies were performed. Results: First, familial and genetic factors influencing age at onset and progression towards BD in a cohort of bipolar offspring will be discussed. Symptom presentations of prodromal states will be discussed. Second, brain morphometric and chemical characteristics that distinguish bipolar offspring with mood symptoms from healthy siblings and controls will be presented. Third, results from an open and a randomized trial of Family Focused Therapy for youth at highrisk for BD will be given. Conclusions: Genetic and neurobiological mechanisms, including SERT and glutamatergic processes, may increase risk of BD in youth. Youth with ADHD, depression, and BD NOS and a family history of BD are at high risk for BD development. Psychosocial interventions in atrisk populations may be effective in treating mood symptoms acutely. Additional longitudinal studies are needed to clarify risk variables and efficacy of

psychotherapies for prevention of full mania.

S11-3
NEUROBIOMARKERS OF ADOLESCENT BIPOLAR DISORDER

Melissa DelBello, M.D., 231 Albert Sabin WayPO Box 670559, Cincinnati, OH 45267

SUMMARY:
Objective: To examine findings from recent neuroimaging studies of adolescents with bipolar disorder (BP) in order to identify neural substrates underlying adolescent BP as well as neural markers of illness development and treatment response. Methods: We will review structural and functional magnetic resonance imaging (sMRI and fMRI) and MR spectroscopy (MRS) studies of adolescents with BP and compare findings with those reported in BP adults. Results: BP adolescents exhibit structural and functional abnormalities in the striatum, amygdala, and ventral prefrontal regions. Specifically, in contrast to BP adults, BP adolescents have smaller amygdala volumes. Additionally, alterations in ventral prefrontal cortical development and in prefrontalamygdala connections are present in BP adolescents. MRS studies reveal abnormalities in markers of neuronal integrity and membrane metabolism in the cerebellum and prefrontal cortex of adolescents with and at risk for BP. Findings from studies also suggest that medications may minimize these abnormalities. Conclusion: Structural, functional and neurochemical abnormalities in the ventral lateral prefrontal cortex, amygdala, striatum, and cerebellar vermis are present in BP adolescents and may represent neurobiological predictors of illness development and treatment response.

S11-4
EVIDENCE BASED TREATMENTS FOR PEDIATRIC BIPOLAR DISORDER

Erin Soto, M.D., 215 West 101st Street Apt #4D, NY, NY 10025

SUMMARY:
Bipolar Disorder is being diagnosed with increasing frequency and at increasingly earlier ages in children and adolescents. Early recognition and treatment of this disorder is crucial to minimize psychosocial disability and improve prognosis. This presentation aims to inform both adult, and child and adolescent psychiatrists of the current evidencebased psychopharmacologic and nonpsychopharmacologic treatments for pediatric bipolar disorder. Based on a comprehensive review of current literature, Dr. Erin Soto will discuss the evidence supporting use of several treatments for pediatric bipolar disorder including: traditional mood stabilizers and atypical antipsychotics; complementary and alternative treatments including omega3fatty acids, inositol, St. John's wort, SAMe, melatonin, lecithin, and acupuncture; and psychosocial interventions including multifamily psychoeducation groups, familyfocused treatment, dialectical behavior therapy, interpersonal and social rhythm therapy, and cognitivebehavioral therapy. Increased knowledge of this growing but limited area of clinical research may improve treatment of this vulnerable patient population and promote further investigation into promising new treatment modalities.

REFERENCES:
1). Galanter CA, Leibenluft E. Frontiers between attention deficit hyperactivity disorder and bipolar disorder.
Child Adolesc Psychiatr Clin N Am. 2008 Apr;17(2):32546, viiiix.
2).Miklowitz DJ, Chang KD. Prevention of bipolar disorder in atrisk children: theoretical assumptions and empirical foundations. Dev Psychopathol. 2008 Summer;20(3):88197.
3.) DelBello MP, Adler CM, Strakowski SM. The neurophysiology of childhood and adolescent bipolar disorder. CNS Spectr. 2006 Apr;11(4):298311.

SYMPOSIUM 12
THE IMPORTANCE OF BIOLOGICAL PSYCHIATRY AND CLINICAL PSYCHOPHARMACOLOGY IN TEACHING PSYCHIATRIC RESIDENTS

Chair: Eric D Peselow, M.D., 308 Seaview Ave., Staten Island, NY 10305
Co-Chair: Ira Glick, M.D.
Discussant: Alan F Schatzberg, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the importance of biological psychiatry and clinical psychopharmacology within the context of

psychiatric residency education.

OVERALL SUMMARY:
One of the many challenges residents face is learning how to choose and prescribe psychotropic medications in a manner that is scientifically sound and maximally safe and effective1. When teaching clinical psychopharmacology, it is important to balance a comprehensive didactic curriculum that provides a base of knowledge with case based learning. Many residents feel that the comprehensive didactic curriculum alone may lead to knowledge overload, thereby making it difficult to practice. A more practical and useful way for residents to learn and retain information may be through discussing case studies in conjunction with didactics. There are several objectives and key points that need to be emphasized. Most important: keep it simple and clinically practical. In this course the goal is to talk about the definitive usage of psychotropics. Though it is important to talk about the pharmacokinetics and mechanism of action of these drugs, the majority of the lecture should be focused on how to use the drugs, possible side effects (see Table 3) and important drugdrug interactions, including interactions with recreational drugs or alcohol. This is based on a combination of practice guidelines and expert clinical use. Other biological topics such as mechanism of action should be covered in detail in a separate neuroscience course. Although there is widespread satisfaction about advances in neuroscience and clinical psychopharmacology, a ratelimiting step involves translating the wealth of new and exciting knowledge to actually improving the teaching of psychopharmacology and (ultimately) clinical care. The key question this paper attempts to answer is this: "how do we best teach clinical psychopharmacology to trainees and clinicians so they not only increase their knowledge base, but even more important, learn to practice the most informed, evidencebased practice possible?" Accordingly, this paper is targeted to all of us in psychiatry who teach psychopharmacology – whether in adult, geriatric, or child psychiatry – to residents or clinicians –in classes or CME venues. Among the many challenges facing residents is learning to choose and prescribe psychotropic medications in a manner that is scientifically sound, maximally safe, acceptable to the patient and effective. To help residents achieve these goals, programs must balance uptodate, welldelivered didactics with opportunities to apply and master the knowledge in wellsupervised clinical settings. We will describe the tools used to do this which include: lectures, conferences, casebased learning modules, specialty clinics, journal clubs, games, the internet and other innovative modalities

S12-1
THE DEVELOPMENT OF A PSYCHOPHARMACOLOGY CURRICULUM TO PSYCHIATRIC RESIDENTS

Ira Glick, M.D., Departments of Psychiatry and Behavioral Sciences, and Psychopharmacology, Stanford University School of Medicine300 Pasteur Drive, Stanford, CA 94305

SUMMARY:
Although there is widespread satisfaction about advances in neuroscience and clinical psychopharmacology, a ratelimiting step involves translating the wealth of new and exciting knowledge to actually improving the teaching of psychopharmacology and (ultimately) clinical care. The key question this paper attempts to answer is this: "how do we best teach clinical psychopharmacology to trainees and clinicians so they not only increase their knowledge base, but even more important, learn to practice the most informed, evidencebased practice possible?" Accordingly, this paper is targeted to all of us in psychiatry who teach psychopharmacology – whether in adult, geriatric, or child psychiatry – to residents or clinicians –in classes or CME venues. Among the many challenges facing residents is learning to choose and prescribe psychotropic medications in a manner that is scientifically sound, maximally safe, acceptable to the patient and effective to help residents achieve these goals, programs must balance uptodate, welldelivered didactics with opportunities to apply and master the knowledge in wellsupervised clinical settings. We will describe the tools used to do this which include: lectures, conferences, casebased learning modules, specialty clinics, journal clubs, games, the internet and other innovative modalities.

S12-2
THE ACTUAL TEACHING OF PSYCHOPHARMACOLOGY AND BIOLOGICAL PSYCHIATRY TO

PSYCHIATRIC RESIDENTS

Eric Peselow, M.D., 308 Seaview Ave., Staten Island, NY 10305

SUMMARY:
It is important that in teaching clinical psychopharmacology, one must develop a balance a comprehensive didactic curriculum that provides a base of knowledge with case based learning. It is felt by many residents that the comprehensive didactic curriculum alone may lead to knowledge overload that is hard for the resident to utilize but in conjunction with having a case and teaching didactics and management related to that case is more useful for learning and retaining information and might be more practical. Thus keep it simple and clinically practical. Throughout the following recommendations residents input should be asked for to see if the following objectives are met Examples of what should be done include core lectures in clinical psychopharmacology in the first 2 years include antipsychotics, anti depressants, mood stabilizers and anxiolytics + Emergency Room Psychopharmacology, hypnotics and herbal agents in addition to teaching the critiquing the psychiatric literature on drug efficacy. For the 3rd and 4th year teaching should include Pharmacology with special populations, (geriatric, child, pregnant patients, Addictive psychopharmacology, Psychopharmacology of the medically ill Interactions between psychopharmacology and psychotherapy (both lecture case conferences), how to manage and split treatment with a therapist, issues of when and how to discontinue medications, and issues of compliance in pharmacologic treatment. The importance of supervision will be highlighted in all years. Within the supervision, it would be good for the teacher to talk about his personal cases and ask the resident what their experience was up to this point—This has been found by many residents to help engage their interest, ask interactive questions and this has been found by many to better retain material and apply what they learn to real life situations

S12-3
THE CHAIRMAN'S ROLE IN TEACHING PSYCHOPHARMACOLOGY AND BIOLOGICAL PSYCHIATRY TO RESIDENTS

Stephen Deutsch, M.D., Ph.D., 825 Fairfax Avenue, Norfolk, VA 23507

SUMMARY:
Support for psychiatric education must ultimately come from the psychiatric chair. He must establish an environment conducive to and support of all areas of psychiatric education. An important part of this is his role in teaching psychopharmacology and biological psychiatry to residents both actively and in encouraging and developing faculty to teach the residents. Clinical psychopharmacology and biological psychiatry have become extremely important in treating patients over the last 1520 years and will become even more important in the future. The purpose of this talk is to propose methods to do this. From a chair's point of view it is important for the resident being instructed in psychopharmacology to understand first line treatments which are evidenced base. However since this does not always work it is important for the resident to understand "practical clinical guidelines" so that the resident when inappropriate may introduce unique treatments for treatment resistant cases. From a neurobiological standpoint because it is evident that neural mechanisms underlie higher mental processes. It is important that the residents understands these mechanisms in how they understand the brain structures involved, the results of how the flow of information between these circuits affects various disorders, the recognition of how psychotropic medications have therapeutic effects and side effects thru these mechanisms and how these circuits are involved along with medication in affecting gene transcription in addition to receptors These biological issues will be discussed in the context of how understand, predict and lead to the design of new treatments for patients.

S12-4
THE ADVANTAGES AND DISADVANTAGES OF ALGORITHMS FOR SELECTING APPROPRIATE PSYCHOPHARMACOLOGICAL TREATMENT

David Osser, M.D., 150 Winding River Road, Needham, MA 02492

SUMMARY:

Lucian Leape stressed the high error rate in medicine. The remedy is said to be EvidenceBased Medicine (EBM) – the rigorous application of scientific research in the care of patients. For each clinical decision, one is to step back and ask what evidence pertains to this situation. However, you have to search for, find, read, and interpret the pertinent literature. This is an arduous process that requires much time and some skills (e.g., how to read papers in a discriminating manner) that few possess. These barriers have limited the usefulness of EBM. However, rigorously evidenceinformed psychopharmacology algorithms developed and updated frequently with peer review, could be helpful. Algorithms provide a way of organizing the knowledge base and describing best practice for typical as well as complex situations. They provide a scaffolding structure for assembling the data relevant to specific patients. When new data are published, the information can be incorporated by comparing with the other knowledge on the shelf for that decision point. The authors should be distant from drug company support to minimize bias toward expensive newer products. Informatics applications are being developed that help clinicians quickly find evidencedriven recommendations that they may consider before making a prescribing decision. Smart phones and computerized orderentry systems can display this information. Many assert that algorithms, no matter how thoughtfully constructed and close to the evidencebase, equal "cookbook medicine." They worry that algorithms will degrade the quality of care by empowering less welltrained prescribers and convincing healthcare managers to displace psychiatrists from the front lines of care. It must be emphasized that although quality algorithms may someday be considered a necessary contributor to clinical decisionmaking, they should never be the sole basis. Broad training and clinical experience add essential elements.

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SYMPOSIUM 13
DECISION MAKING AND ADDICTIONS: NEUROBIOLOGY AND TREATMENT IMPLICATIONS

U.S. National Institute on Drug Abuse

Chair: Frederick G Moeller, M.D., 1941 East Road, Houston, TX 77054
Discussant: Antoine Bechara, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the basic and clinical neurobiology of decision making, its association with drug addiction disorders, and its role in improving the outcome of drug addiction treatments.

OVERALL SUMMARY:

In recent years, substantial strides have been made in the understanding of the etiology and clinical neurobiology of drug addiction. In addition to understanding the effects of drugs of abuse on the brain and the mechanisms of addiction, studies have found that impaired decisionmaking is critically important in initiation and maintenance of drug addiction. Moreover, therapeutic interventions aiming at decisionmaking can greatly improve the outcome of drug addiction treatments. The purpose of this symposium is to present new findings on the clinical neurobiology of decisionmaking, discuss the relevance of decisionmaking on the onset and progression of drug addiction, and review the latest research findings of behavioral and pharmacological interventions aiming at improving decisionmaking and therefore enhancing the outcomes of drug addiction treatments. Data will be presented from animal, human behavioral laboratory, imaging, and treatment research studies. From animal studies data will be presented showing that neurotransmitters such as dopamine, serotonin and norepinephrine play a critical role in the mediation decisionmaking under risk and uncertainty. Data from human psychopharmacology and neuroimaging projects will demonstrate some ways in which risky decision making is altered following acute and chronic drug use. From human treatment studies, data will be presented showing that behavioral measures of decision making, such as the Iowa Gambling Task are predictive of treatment response in drug addiction, and impaired decision making may be a target for pharmacotherapy and behavioral therapies for addictions. At the end of this symposium,

attendees will gain knowledge about the basic and clinical neurobiology of decisionmaking, its association with drug addiction disorders, and its role in improving the outcome of drug addiction treatments.

S13-1
BASIC NEUROBIOLOGY OF DECISIONMAKING

Catharine Winstanley, Ph.D., 2136 West Mall, Vancouver, V6T1Z4

SUMMARY:
Maladaptive decisionmaking is increasingly recognised as an important factor in the generation and maintenance of the addicted state. In particular, it would appear that substance abusers show high levels of impulsive choice, in that they prefer smallersooner vs. largerlater rewards in delaydiscounting paradigms. This clinical population also exhibits impaired decisionmaking under risk and uncertainty, in that they show elevated levels of choice for highrisk highreward options on the Iowa Gambling Task even though such a choice pattern results in less reward in the longterm. Experiments using animal models of decisionmaking can help elucidate the neural and neurochemical systems involved in regulating such choices. Furthermore, animal experiments can help to determine whether decisionmaking deficits are a preexisting vulnerability factor for substance abuse, or arise due to the chronic misuse of addictive substances. Recent data suggest that a previous history of chronic selfadministration of cocaine can enhance impulsive choice in rats, as well as increasing other forms of impulsive behaviour. Such data suggest that repeated intake of addictive drugs can lead to impulse control deficits. Furthermore, highly impulsive animals also show a greater propensity to selfadminister addictive substances, indicating that impulsivity may be both a cause and a consequence of drug intake. Data from rodent analogues of both the delaydiscounting and Iowa Gambling Tasks, as well as other models of impulsivity and sensitivity to risk, suggest that the dopamine and serotonin systems play a prominent role in these forms of decisionmaking. Optimal decisionmaking in many of these paradigms also critically depends on the integrity of the amygdala and the orbitofrontal cortex. In combination with clinical observations, data from preclinical models can be used to generate a more detailed and comprehensive understanding of the mechanism by which addictive substances modulate decisionmaking and impulse control.

S13-2
THE IMPACT OF DRUGS OF ABUSE ON DECISIONMAKING

Scott Lane, Ph.D., 1941 East Road, Houston, TX 77054

SUMMARY:
Decision making under conditions of uncertainty and potentially aversive consequences (risk) involves psychological and neural processes that may be rendered awry by drugs of abuse. Specifically, the effects of acute and chronic drug administration (and eventually dependence) tend to be associated with bias towards highrisk and highreward alternatives, and undersensitivity to aversive outcomes. Using both laboratorybased tests of risky decision making and neuroimaging techniques, the presentation will provide data from (i) studies of acute dosing across a number of abused drugs, and (ii) differences between chronic drug users and controls. Under states of both acute drug intoxication and drug dependence, individuals tended toward more risky alternatives, even when the alternatives were less adaptive. It is hypothesized that the neurobehavioral changes engendered by drug abuse overlap considerably with (and thus impair) the process that govern decision making under normative conditions, which is characterize by more conservative (risk averse) behavior patterns.

S13-3
NEUROCOGNITIVE AND BEHAVIORAL INTERVENTIONS TO IMPROVE ADDICT DECISION MAKING

Warren Bickel, Ph.D., 4301 W. Markham, Slot 843, Little Rock, AR 72205

SUMMARY:
A new theory suggests that addiction results from an interaction of competing neurobehavioral decision systems. Specifically, those with addiction have a hyperactive impulsive system embodied in the limbic and paralimbic brain regions and a hypoactive executive system embodied in the prefrontal cortex. As a result, when individuals with addiction are faced with intertemporal choice (discounting of

delayed rewards) they exhibit a strong bias for the most immediate option. In this presentation, we show the effects of (1) neurocognitive training and (2) multimodal addiction treatment on this form of decision making. Overall, these two types of interventions can result in improvement in consideration of the future and likely involve restoration of the regulatory balance of the two neurobehavioral decision systems. Implication for diagnosis and treatment are explored.

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SYMPOSIUM 14
PUBLIC SECTOR CHALLENGES IN MEETING PATIENTS' NEEDS

Chair: Darrel A. Regier, M.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209
Discussant: Lisa Dixon, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the general clinical complexity of psychiatric patients treated in public inpatient and outpatient settings; 2) Identify potential gaps in continuity of care for patients treated in the public sector; and 3) Discuss the challenges and potential approaches in providing appropriate care for psychiatric patients treated in the public sector.

OVERALL SUMMARY:
Psychiatric patients receiving care in public inpatient and outpatient settings may face multiple challenges in obtaining access to appropriate treatment and continuity in their care. This symposium will present a series of empirical papers describing the clinical complexity of publicly insured patients, including dimensional measures of symptom severity in addition to DSM-IV diagnostic categories; existing health disparities in access to care; patterns of polypharmacy; treatment access problems associated with prescription drug coverage and formulary restrictions; and potential consequences of disruptions in medication access and continuity, including adverse clinical and life events experienced by patients, and increased use of emergency departments and psychiatric hospitalization. A formal discussion of the papers will be followed by an audience discussion of the challenges and potential approaches in providing appropriate care for psychiatric patients treated in the public sector.

S14-1
CLINICAL COMPLEXITY OF PUBLICLY INSURED PATIENTS AND IMPLICATIONS FOR CLINICAL PRACTICE

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

SUMMARY:
Aims: To characterize the clinical complexity of publicly insured patients by examining patterns and combinations of cooccurring DSM-IV Axis I psychiatric diagnoses and psychotic, depressive, anxiety, manic, substance use, and sleep problem symptoms. 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-IVTR Axis I and II disorders and rated the severity level of six symptoms on a simple dimensional scale. Results: Overall, 39% of patients had a diagnosis of schizophrenia; 29% a major depressive disorder; 16% bipolar disorder; and 11% a substance use disorder. The majority of patients 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 measures indicated publicly insured patients have very high rates of psychopathology and comorbidity, particularly when compared to DSM IV categorical measures. The dimensional symptom severity measures revealed a more clinically complex

characterization of patients' psychopathology, identifying many heterogeneous patient subgroups with different, multidimensional symptomatology clusters within the major diagnostic groups. Dimensional symptom measures have potential value in assessing publicly and privately insured patients' clinical status and treatment decisions, beyond information conveyed by categorical diagnoses. These findings suggest simple dimensional measures of psychopathology are feasible and potentially useful in routine practice. Consequently, plans for incorporating dimensional assessments in *DSM-5* will also be discussed.

S14-2

HEALTH DISPARITIES IN ACCESS TO CARE FOR PSYCHIATRIC PATIENTS IN THE PUBLIC SECTOR

Ruth Shim, M.D., M.P.H., 720 Westview Drive, Atlanta, GA 30310

SUMMARY:
Objective: Previous research on mental health disparities shows that persons from racialethnic minority groups have less access to mental health care, engage in less treatment, and receive poorerquality treatment than nonHispanic whites. Attitudes and beliefs about mental health treatment were examined to determine whether they contribute to these disparities. Methods: Data from the National Comorbidity Survey Replication (NCSR) were analyzed to determine attitudes toward treatmentseeking behavior among people of nonHispanic white, AfricanAmerican, and Hispanic or Latino raceethnicity. Additional sociodemographic variables were examined in relation to attitudes and beliefs toward treatment. Results: AfricanAmerican raceethnicity was a significant independent predictor of greater reported willingness to seek treatment and lesser reported embarrassment if others found out about being in treatment. These findings persisted when analyses adjusted for socioeconomic variables. Hispanic or Latino raceethnicity also was associated with an increased likelihood of willingness to seek professional help and lesser embarrassment if others found out, but these differences did not persist after adjustment for the effects of socioeconomic variables. Conclusions: Contrary to the initial hypothesis, African Americans and Hispanics or Latinos may have more positive attitudes toward mental health treatment seeking than nonHispanic whites. To improve access to mental health services among racialethnic minority groups, it is crucial to better understand a broader array of individual, provider, and systemlevel factors that may create barriers to care.

S14-3

POLYPHARMACY AMONG MEDICAID PSYCHIATRIC PATIENTS: IS THERE A CLINICAL RATIONALE FOR THIS TREATMENT?

Farifteh Duffy, Ph.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209

SUMMARY:
Background: Increasing polypharmacy among patients with mental illness raises concerns regarding the safety and quality of care. Study Aims: Examine patterns and correlates of polypharmacy among Medicaid patients treated by psychiatrists and assess whether polypharmacy regimens reflect patients' diagnostic and symptom profiles. Methods: 4,866 psychiatrists in ten states were randomly selected from the AMA Physician Masterfile: 62% responded; 32% met study eligibility criteria, reported clinically detailed data on 1,625 systematicallyselected Medicaid patients. Analyses were weighted and adjusted for the sampling design. Polypharmacy was defined as: concurrent use of two or more psychopharmacologic medications: a) within the same class; or b) in more that one class (betweenclass). Results: 26% of patients received 2 or more medications within the same class; 66% received medications in 2 or more different classes. The mean number of medications prescribed was 2.3; the mean number of medication classes was 2.0. Patients with a diagnosis of schizophrenia with moderatetosevere depressive, anxiety and sleep problems had significantly higher mean number of medications overall (range 2.4 to 2.5) in contrast to those without such symptoms (1.8 to 1.9) ($p<0.05$). Patients with a major depressive disorder diagnosis with moderatetosevere anxiety symptoms and mildtosevere psychotic symptoms had significantly higher mean number of medications overall (2.4 to 2.7) in contrast to those without such symptoms (2.0 to 2.1) ($p<0.05$). The overall mean number of medications for patients with bipolar disorders

(2.8 to 3.1) and alcohol or substance use disorders (2.4 to 2.8) were generally high but did not vary by symptom severity. Adjusting for patient case mix, factors independently and positively associated with betweenclass polypharmacy included: age over 45, diagnosis of schizophrenia, bipolar, or anxiety disorders and number of psychiatric symptoms. Factors independently and positively associated with withinclass polypharmacy included: female gender and a diagnosis of cognitive disorder. Conclusions: Findings suggest that psychiatric patients' diagnostic and symptom profile are associated with betweenclass polypharmacy, providing some evidence of clinically rationale treatment.

S14-4

HOMELESSNESS AND INCARCERATION AMONG MEDICAID PSYCHIATRIC PATIENTS IN 10 STATES

Eve Moscicki , Sc.D., M.P.H., 1000 Wilson Blvd Ste 1825, Arlington, VA 22209

SUMMARY:
Objective: Examine risk for homelessness and incarceration and identify potential gaps in continuity of care among psychiatric patients in ten states. Method: 4,866 psychiatrists in ten states were randomly selected from the AMA Physician Masterfile; 61% responded; 34% met study eligibility criteria and reported clinically detailed data on 1,625 systematicallyselected patients. Multivariate logistic regression models examined odds of homelessness and incarceration controlling for sociodemographic and clinical characteristics. Results: Overall rates were 11.6% for homelessness (SE=1.3%) and 13.4 % for incarceration (SE=1.3%), with higher rates among males, nonwhites, and young adults 1830 years. Patients diagnosed with substance use (43% homeless, 38% incarcerated), alcohol use (36% homeless, 25% incarcerated), and schizophrenia (24% homeless, 22% incarcerated) disorders were at higher risk. Onethird of public and private inpatients experienced homelessness; onethird of public inpatients experienced incarceration; nearly 1 in 5 experienced both. Onequarter of patients with emergency department (ED) visits also experienced homelessness or incarceration. Patients who were treated in the public sector, with severe substance abuse symptoms, or ED visits had a 2.0 (95% CI 1.33.1) to 6.1 (95% CI 2.117.9) increased likelihood of homelessness or incarceration. Patients who discontinued their medication had 2.4 (95% CI 1.34.4) increased odds of homelessness or incarceration. Conclusion: The findings highlight potential gaps in the mental health treatment infrastructure for patients with substance use, psychotic disorders, and psychiatric symptom exacerbation and suggest inpatient facilities and EDs treating Medicaid psychiatric patients could play a more effective role in preventing homelessness and incarceration through improved discharge planning and care coordination.

S14-5

MEDICATION SWITCHING AND OTHER ACCESS PROBLEMS AND ADVERSE EVENTS FOR PUBLICLY INSURED PATIENTS

Joyce West, Ph.D., M.P.P., APIRE 1000 Wilson Blvd, Suite 1825 Arlington, VA 22209

SUMMARY:
Background: Medicare Part D has expanded medication access; however, dually eligible psychiatric patients have experienced medication access problems. Aims: Characterize medication switches and access problems for dual eligible psychiatric patents and associations with adverse events, including emergency department visits, hospitalizations, homelessness, and incarceration. Methods: 1,556 psychiatrists randomly selected from the AMA Masterfile responded (62%); 63% met eligibility criteria reporting on 986 systematically sampled patients. Results: 27.6% (SE=2.3%) of patients were reported previously stable, but required to switch medications because clinically indicated and preferred refills were not covered/approved. An additional 14.0% (SE=1.6%) were unable to have clinically indicated/ preferred medications prescribed because of drug coverage/approval. Adjusting for case mix, switched patients (p=.0009) and patients with problems obtaining clinically indicated medications (p=.0004) had significantly higher adverse event rates. Patients at greatest risk were prescribed a medication in a different class or were unable to have clinically indicated atypical antipsychotics, other antidepressants, mood stabilizers, or CNS agents/stimulants prescribed. Patients with problems obtaining clinically preferred/indicated

antipsychotics had 17.6 increased odds (p=.0039) of adverse events. Conclusion: These findings support caution in medication switches for stable patients and provide substantiation for prescription drug policies which promote access to clinically indicated medications and continuity for clinically stable patients.

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SYMPOSIUM 15
COMBINING EXTENDEDRELEASE GUANFACINE AND PSYCHOSTIMULANTS IN THE TREATMENT OF PEDIATRIC ADHD: RESULTS FROM A MULTISITE CONTROLLED CLINICAL TRIAL

Chair: Timothy E Wilens, M.D., 55 Fruit Street YAW 6A, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Efficacy of guanfacine extended release (GXR; dosed either upon awakening or at bedtime) with a longacting psychostimulant for treating ADHD in children and adolescents; 2) Efficacy of GXR as assessed in the morning and evening; 3). Improvement in ADHD symptoms as examined by responder and remission criteria; 4) Efficacy in children and adolescents; 5) Safety of GXR coadministered with psychostimulants.

OVERALL SUMMARY:
Objective: To examine the efficacy and safety of guanfacine extended release (GXR) coadministered with psychostimulants for the treatment of ADHD. Methods: This was a 9week, multicenter, doubleblind, placebocontrolled, doseoptimized study of GXR in subjects aged 617 years with ADHD and suboptimal response to a psychostimulant per investigator's opinion. Subjects continued their stable psychostimulant dose with addition of morning (AM) or evening (PM) GXR (<=4 mg/d) or placebo. Results: Of 461 randomized subjects, 386 (84%) completed the study. At endpoint, ADHD Rating Scale IV scores were significantly reduced with both AM and PM administration of GXR + psychostimulant vs placebo + psychostimulant (both P<=0.002). Results were similar for children (612 years; both P<=0.023) as well as adolescents (1317 years; both P<=0.033). The GXR groups showed greater improvement vs placebo on the Conners' Global Index – Parent at morning (both P<=0.019) and evening assessments (both P<=0.002) and on the BeforeSchool Functioning Questionnaire (both P<=0.002). GXR subjects were more likely to meet symptomatic remission criteria (ADHDRSIV <=18) at endpoint vs placebo (both P<=0.002). Small mean (SD) decreases from baseline to endpoint were observed in supine pulse (5.6 [12.02] bpm), systolic (2.2 [9.75] mm Hg), and diastolic BP (1.2 [8.00] mm Hg) with GXR vs placebo (2.1 [10.65] bpm, 0.6 [8.38], and 0.0 [7.61], respectively). Headache was the most commonly reported TEAE in each group (AM: 21.3%, PM: 21.1%, and placebo: 13.1%). No

unique TEAEs were reported compared with those reported historically for either treatment alone. Conclusions: Coadministration of GXR resulted in statistically significant improvements in ADHD symptoms overall, in both children and adolescents, and in morning and evening symptoms. A greater proportion of subjects receiving GXR achieved remission compared with placebo. The combination was relatively well tolerated with no new safety concerns emerging.

S15-1

EXTENDEDRELEASE GUANFACINE COADMINISTERED WITH PSYCHOSTIMULANTS IN THE TREATMENT OF ADHD ASSESSED IN THE MORNING AND EVENING

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

SUMMARY:
Objective: To examine the efficacy and safety of guanfacine extendedrelease (GXR) when coadministered with psychostimulants for the treatment of ADHD. Methods: This was a multisite, doubleblind, placebocontrolled, doseoptimized study of GXR (<=4 mg/d) in children and adolescents 617 years old who met a priori criteria for suboptimal response to psychostimulants with suboptimal response to psychostimulants according to a priori criteria and investigator opinion. Subjects continued their stable morning psychostimulant dose over 5 weeks of dose optimization and 3 weeks of dose maintenance. Subjects (N=461) were randomized to receive GXR dosed in the morning (AM) or evening (PM), or placebo. Secondary efficacy measures included Conners' Global Index – Parent (CGIP) to assess subject behaviors in both the morning and evening, and the BeforeSchool Functioning Questionnaire (BSFQ).Results: At endpoint, subjects who received GXR (either AM or PM dosing) plus psychostimulant showed significantly greater improvement from baseline on the CGIP morning assessment (AM, P=0.019; PM, <=0.001), the CGIP evening assessment (AM, P=0.002; PM, P<0.001) and the parentrated BSFQ (AM, P<=0.001; PM, P=0.002) compared with placebo plus psychostimulant. No unique TEAEs were reported with coadministration compared with the known effects of either treatment alone. Headache was the most commonly reported TEAE in each group (21.3% for AM, 21.1% for PM, and 13.1% for placebo). Conclusions: In suboptimal responders to a psychostimulant, GXR coadministered with a psychostimulant was associated with significant reductions in morning and evening symptoms compared with a psychostimulant alone, regardless of dose timing, and was generally well tolerated.

S15-2

EFFICACY AND SAFETY OF MORNING OR EVENING DOSING OF GUANFACINE EXTENDED RELEASE COADMINISTERED WITH PSYCHOSTIMULANTS IN ADOLESCENTS WITH ADHD

Oscar Bukstein, M.D., M.P.H., BBS second floor, 1941 East Road, Houston, TX 77054

SUMMARY:
Objective: Examine the efficacy and safety of guanfacine extended release (GXR) with psychostimulants in adolescents with ADHD. Methods: A doubleblind, placebocontrolled, doseoptimized study of GXR in youths aged 617 years (N=461) with suboptimal response to psychostimulants according to a priori criteria and investigator opinion. Subjects were randomized to GXR in the morning (AM), or evening (PM), or placebo in addition to their stable psychostimulant dose over 5 weeks of dose optimization and 3 weeks of dose maintenance. Efficacy measures included the ADHD Rating Scale IV (ADHDRSIV), assessed at baseline and each study visit. Safety assessments included adverse event (AE) reports, vital signs, and physical examinations. Results: The safety population/FAS included 455 subjects: 20.7% were adolescents aged 1317 years (n=94). In this subpopulation of adolescents, significantly greater improvements from baseline in ADHDRSIV total scores compared with placebo + psychostimulant were observed from treatment week 2 through endpoint in the GXR AM + psychostimulant group (P=0.003 at endpoint) and from treatment week 3 through endpoint in the GXR PM + psychostimulant group (P=0.033 at endpoint). Treatmentemergent AEs (TEAEs) were reported by 68.8% of subjects receiving GXR and 73.3% of subjects receiving placebo + psychostimulant. Most TEAEs were mild or moderate in severity. The

most common TEAEs were headache (25.0%) and somnolence (15.6%) in subjects receiving GXR + psychostimulant and headache (13.3%) and upper respiratory tract infection (13.3%) in subjects receiving placebo + psychostimulant. Conclusion: Adolescents receiving GXR + psychostimulant had greater reductions in ADHD symptoms than adolescents receiving placebo + psychostimulant. Overall TEAE incidence was similar when GXR was added to a psychostimulant compared with a stimulant plus placebo.

S15-3

SYMPTOMATIC REMISSION OF ADHD IN CHILDREN AND ADOLESCENTS WITH COADMINISTRATION OF GUANFACINE EXTENDED RELEASE AND A PSYCHOSTIMULANT

Andrew Cutler, M.D., 3914 SR64E, Bradenton, FL 34208

SUMMARY:
Objective: To assess ADHD symptomatic remission and changes in global severity of illness in children and adolescents treated with guanfacine extended release (GXR) coadministered with a psychostimulant. Methods: Multicenter, randomized, doubleblind, placebocontrolled, doseoptimization study of GXR in subjects aged 6 to 17 years with ADHD and suboptimal response to a longacting psychostimulant according to a priori criteria and investigator opinion. Subjects continued their stable psychostimulant dose with addition of morning (AM) or evening (PM) GXR or placebo. Efficacy measures included the ADHD Rating Scale IV (ADHDRSIV) and Clinical Global ImpressionSeverity (CGIS) scale. Safety measures included adverse events (AEs), vital signs, clinical laboratory evaluations, and electrocardiograms. Results: At endpoint, a significantly greater proportion of subjects in the GXR AM + psychostimulant (61.1% [n=91/149, P=0.010]) and GXR PM + psychostimulant (62.2% [n=92/148, P=0.005]) groups met symptomatic remission criteria (ADHDRSIV, <=18) compared with placebo + psychostimulant (46.1% [n=70/152]). At endpoint, subjects in both GXR AM + psychostimulant and GXR PM + psychostimulant groups were judged to be less severely ill, as measured by CGIS scores, than subjects in the placebo + psychostimulant group (AM, P=0.013; PM, P<0.001). The most common treatmentemergent AEs in subjects receiving GXR + psychostimulant were headache (21.2%) and somnolence (13.6%). There were no new safety signals. Conclusion: GXR, coadministered with a psychostimulant, and dosed either in the morning or evening, resulted in a significantly greater percentage of symptomatic remission and reduced global illness severity compared with placebo plus a psychostimulant in suboptimal responders to psychostimulant monotherapy. Coadministration was generally well tolerated.

S15-4

COMBINING EXTENDEDRELEASE GUANFACINE AND PSYCHOSTIMULANTS IN THE TREATMENT OF PEDIATRIC ADHD: RESULTS FROM A MULTISITE CONTROLLED CLINICAL TRIAL

Timothy Wilens, M.D., 55 Fruit Street YAW 6A, Boston, MA 02114

SUMMARY:
Objective: To examine the efficacy and safety of guanfacine extended release (GXR) coadministered with psychostimulants for the treatment of ADHD. Methods: This was a 9week, multicenter, doubleblind, placebocontrolled, doseoptimized study of GXR in subjects aged 617 years with ADHD and suboptimal response to a psychostimulant per investigator's opinion. Subjects continued their stable psychostimulant dose with addition of morning (AM) or evening (PM) GXR (=4 mg/d) or placebo. Results: Of 461 randomized subjects, 386 (84%) completed the study. At endpoint, ADHD Rating Scale IV scores were significantly reduced with both AM and PM administration of GXR + psychostimulant vs placebo + psychostimulant (both P=0.002). Results were similar for children (612 years; both P=0.023) as well as adolescents (1317 years; both P=0.033). The GXR groups showed greater improvement vs placebo on the Conners' Global Index – Parent at morning (both P=0.019) and evening assessments (both P=0.002) and on the BeforeSchool Functioning Questionnaire (both P=0.002). GXR subjects were more likely to meet symptomatic remission criteria (ADHDRSIV =18) at endpoint vs placebo (both P=0.002). Small mean (SD) decreases from baseline to endpoint were observed in supine pulse (5.6 [12.02] bpm), systolic

(2.2 [9.75] mm Hg), and diastolic BP (1.2 [8.00] mm Hg) with GXR vs placebo (2.1 [10.65] bpm, 0.6 [8.38], and 0.0 [7.61], respectively). Headache was the most commonly reported TEAE in each group (AM: 21.3%, PM: 21.1%, and placebo: 13.1%). No unique TEAEs were reported compared with those reported historically for either treatment alone. Conclusions: Coadministration of GXR resulted in statistically significant improvements in ADHD symptoms overall, in both children and adolescents, and in morning and evening symptoms. A greater proportion of subjects receiving GXR achieved remission compared with placebo. The combination was relatively well tolerated with no new safety concerns emerging.

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NOON- 3:00 PM

SYMPOSIUM 16
DISTURBED PAIN PROCESSING IN PSYCHIATRIC DISORDERS

Chair: Christian Schmahl, M.D., J 5, Mannheim, D68159 Germany,
Co-Chair: Karl Bär, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate the importance of disturbances of pain processing in schizophrenia, depression, posttraumatic stress disorder, and borderline personality disorder.

OVERALL SUMMARY:
In recent years, disturbed pain processing has been found in several psychiatric disorders such as depressive and anxiety disorders or borderline personality disorder or posttraumatic stress disorder. In the latter two, alterations in pain processing are central to the disorder and are closely linked to other aspects of psychopathology such as dissociation or selfinjurious behavior. Patients with depression and schizophrenia also display altered pain thresholds as well as differential disturbance of affective and cognitive aspects of pain processing. This symposium will build a bridge between basic mechanisms of pain processing in animals and humans and disturbance of these mechanisms in clinical populations. A special focus will be on the neural correlates of disturbed pain processing assessed via fMRI. The complex sensory experience of pain involves cognitive, behavioral and emotional aspects which are closely interrelated. While patients suffering from major depressive disorder (MDD) mainly exhibit increased thresholds towards experimentally induced thermal pain applied to the skin, aberrant pain processing at central level might lead to increased clinical pain complaints. Neurobiological underpinnings of the discrepancy of pain perception in depression and after sad mood induction in healthy volunteers will help to understand aberrant pain perception in the disease and will be presented. Behavioral data on interoception and central pain processing will demonstrate various aspects of altered processing of pain at central level in depressed patients. FMRI and EEG studies will be used to demonstrate differences to healthy volunteers. In contrast, we will present evidence for changes of pain processing in patients with schizophrenia. Here, apart from increased thresholds to heat and cold pain a lack of perception to the “illusion of pain” will be shown in contrast to depressed patients. Central correlates of this phenomenon will be discussed for patients with schizophrenia during the meeting.

S16-1
PAIN PERCEPTION IN SCHIZOPHRENIA AND DEPRESSION: FROM INTEROCEPTION TO ‘ILLUSION OF PAIN’

Karl Bär, M.D., Philosophenweg 03, Jena, 07743

SUMMARY:
The complex sensory experience of pain involves cognitive, behavioral and emotional aspects which are closely interrelated. While patients suffering from major depressive disorder (MDD) mainly

exhibit increased thresholds towards experimentally induced thermal pain applied to the skin, aberrant pain processing at central level might lead to increased clinical pain complaints. Neurobiological underpinnings of the discrepancy of pain perception in depression and after sad mood induction in healthy volunteers will help to understand aberrant pain perception in the disease and will be presented. Behavioral data on interoception and central pain processing will demonstrate various aspects of altered processing of pain at central level in depressed patients. FMRI and EEG studies will be used to demonstrate differences to healthy volunteers. In contrast, we will present evidence for changes of pain processing in patients with schizophrenia. Here, apart from increased thresholds to heat and cold pain a lack of perception to the "illusion of pain" will be shown in contrast to depressed patients. Central correlates of this phenomenon will be discussed for patients with schizophrenia during the meeting.

S16-2

UNDERSTANDING PAIN PROCESSES IN DEPRESSION AND ANXIETY WITH BRAIN IMAGING

Irina Strigo, Ph.D., 3350 La Jolla Village Dr MC 9151B, La Jolla, CA 92161

SUMMARY:
Many psychiatric disorders are highly comorbid with chronic pain. Both, depressive (e.g., Major Depressive Disorder) and anxiety (e.g., PTSD) disorders show greater than 50% comorbidity, which contributes significantly to poorer outcomes, greater disability and increased cost of treatment. Despite such high cooccurrence little is known about the neurobiological basis of pain processing in these disorders. This talk will discuss several brain imaging (fMRI) studies in patients with depression and anxiety disorders while they undergo experimental pain testing in the MRI scanner. Specifically, several brain imaging and behavioral experiments incorporating over 100 participants were conducted in individuals with MDD and PTSD related to intimate partner violence (IPV). Behavioral pain responses and painrelated brain activation in MDD and PTSDIPV individuals were computed and compared to the responses of healthy comparison subjects. The results of these experiments show that, despite the lack of clear differences in the subjective pain report when compared to healthy comparisons subjects, individuals with these disorders exhibit hyperarousal of painprocessing circuitry, which is related to maladaptive coping cognitions (e.g., catastrophizing, avoidance) and possibly to the impaired ability to modulate pain experience. Future studies should extend these findings into several domains, such as examining whether aberrant painrelated brain responses in individuals with depressive and anxiety disorders predict the development of chronic pain conditions.

S16-3

MODELING PAIN STATES IN PTSD: HUMAN AND ANIMAL EXPERIMENTS

Tobias MoellerBertram, M.D., Ph.D., 3350 La Jolla Village Drive, San Diego, CA 92161

SUMMARY:
Post Traumatic Stress Disorder (PTSD) shows an unusually high cooccurrence with pain syndromes and pain complaints. However, the mechanisms linking PTSD and pain are incompletely understood. I will briefly review the clinical evidence for comorbid PTSD and pain and discuss theoretical models of the potential underlying mechanisms. I will then discuss animal and human studies that model experimental pain in PTSD, highlighting the important role translational approaches play in understanding mechanisms of painPTSD comorbidities.

S16-4

PAIN PROCESSING IN BORDERLINE PERSONALITY DISORDER A POSSIBLE LINK TO THE UNDERSTANDING OF SELF-INJURY

Christian Schmahl, M.D., J 5, Mannheim, D68159

SUMMARY:
Background: Patients with Borderline Personality Disorder (BPD) experience intense emotional stress and display a high prevalence of selfinjurious behavior (SIB). Patients engage in SIB because of its immediate relief effects on emotional tension. Pain in BPD has further been observed to lead to a reduction in neural activity in the amygdala and anterior cingulate cortex (ACC). Methods: To

investigate the potential role of pain as a means of affect regulation in patients with BPD, we conducted two studies: (1) an eventrelated fMRI study using negative and neutral pictures followed by thermal stimuli to induce heat pain (versus warmth perception). (2) A study using incisioninduced pain to model tissue damage and its influence on tension regulation. A 4 mm wide incision with a scalpel as well as a "sham" treatment (touching the skin with the blunt end of the scalpel) were conducted by an investigator after a stress induction while subjective stress levels and heart rate were measured. Results: In study (1), both negative and neutral pictures led to stronger activation of amygdala, insula, and ACC in patients with BPD than in HC. During sensory stimulation, we found decreased amygdala and ACC activation independent of painfulness. Pain led to increased activation of the left insula for HC, but not when the arousal was already high in BPD. In study (2), the incision resulted in an increase of subjective stress levels in HC, while stress levels decreased in the BPD group. Sham treatment led to a decrease of stress levels in both groups. In the BPD group, heart rate increased after the sham treatment, but decreased after the incision. Discussion: Our data preliminarily support the idea of a general mechanism of attentional shift underlying the stressreducing effect of pain in BPD. Also, we could demonstrate that incisioninduced pain may be suited as a model for the mechanism of tension reduction in the context of SIB.

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SYMPOSIUM 17
MOODS, MEMORY AND MYTHS: WHAT REALLY HAPPENS AT MENOPAUSE?

Chair: Neill Epperson, M.D., 3535 Market Street, Ste 3001, Philadelphia, PA 19104

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Distinguish normal menopause symptoms from onset or exacerbation of psychiatric disorders; 2) Demonstrate that they know how to advise their menopausal patients regarding the impact of aging on mood, memory and sexuality; 3) Demonstrate knowledge regarding common treatments for symptoms frequently experienced by menopausal women such as but not limited to; hot flashes, sleep disturbance, depression and sexual dysfunction.

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 wellbeing 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 patient's presenting symptoms related to a normal menopause transition and its associated hormonal changes? Of their ongoing 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 ongoing psychiatric disorder? This symposium seeks to examine these issues in a practical manner through lectures and opendiscussion. In addition, attendants will gain an appreciation of the complexity of the hormonal/brain interaction as it relates to menopause, mood and memory.

S17-1
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 midlife 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 populationbased 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.

S17-2
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. Menopauseassociated 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 overthecounter treatment strategies that can be tailored for the management of symptomatic, menopausal women.

S17-3
WHERE DID I PUT MY KEYS? THE

ONGOING SAGA OF ESTROGEN, SEROTONIN, MOOD AND MEMORY AT MENOPAUSE

Neill Epperson, M.D., 3535 Market Street, Ste 3001, Philadelphia, PA 19104

SUMMARY:
During the menopause transition, many women report a worsening of mood and a 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.

S17-4
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 comorbid medical/psychiatric 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 all of the above factors. Identifying sexual problems in midlife women allows for interventions to reestablish satisfactory sexual functioning, and includes lubricants, hormonal therapy, phosphodiesterase5 inhibitors, bupropion, lifestyle changes, and psychotherapy.

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SYMPOSIUM 18
TRANSLATIONAL PSYCHIATRY: FROM DISCOVERY TO HEALTHCARE

Chair: Julio Licinio, M.D., Bldg 131 Garron Rd, Canberra, ACT 2601 Australia
Co-Chair: Cyndi S Weickert, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) To identify new predictors of psychiatric disorders; 2) To recognize new predictors of psychiatric treatment; and 3) To learn new treatments for psychiatric disorders.

OVERALL SUMMARY:
Translating discovery to healthcare is the major challenge of modern psychiatry. While the last few

decades have witnessed a veritable explosion of new knowledge in neuroscience, very few – if any – such discoveries made their way to the clinical care of psychiatric patients. Examples abound. The key principle underlying the initial mechanism of action of most antidepressants is inhibition of monoamine transport from the synapse back into the presynaptic neuron. The discovery that monoamines are transported in this manner and that such transport is therefore a drug target for depression was made by Nobel laureate Julius Axelrod in 1957, fiftythree years ago. One of the "new" treatments currently being investigated for depression is ketamine, a drug developed in 1962, forty years ago. Nothing discovered in the last 20 years has made its way into commercially available treatments for mood disorders or schizophrenia. A very concerted effort is needed to develop a new area of psychiatry, namely translational psychiatry that is specifically aimed at facilitating and shortening the process from discovery to the identification of new biomarkers and to the establishment of new treatments. New biomarkers have the potential to facilitate diagnosis and to guide and personalize treatment. New and more effective treatments are truly needed for our patients. In this symposium experts from three continents will present exciting new results that provide the foundation to the new field of translational psychiatry by bridging the gap between discovery and healthcare. Females with schizophrenia have worse symptoms when estrogen is low and estrogen replacement reduces schizophrenia symptoms. Both males and females with schizophrenia show more estrogen receptor alpha (ESR1) gene and cortical ESR1 mRNA variation than controls, suggesting that both genders may not respond normally to circulating sex steroids. The "at risk" ESR1 genotype was associated with lower frontal cortex ESR1 mRNA levels in schizophrenia. Eighteen ESR1 splice variants encoding truncated ESR1 protein and decreased frequencies of wild type ESR1 mRNA were detected in the schizophrenia sample. Using a luciferase assay, we found that truncated ESR1 significantly attenuates gene expression induced by wildtype ER, demonstrating a dominantnegative function. In cell culture, we found that the Selective Estrogen Receptor Modulator (SERM) raloxifene was able to stimulate estrogen response element driven gene expression and to partially reverse the impact of the truncated variants that are overabundant in schizophrenia. In translating these basic findings from the lab into the clinic we have initiated a trial in which raloxifene will be administered to both males and females with schizophrenia using a doubleblind, withinsubjects, crossover, placebo controlled design with the aim of stimulating estrogenrelated neurotrophic activities and improving positive and negative symptoms and cognition. We hypothesize that individual genetic variation in ESR1 will help to identify those people with schizophrenia who will benefit from treatment. This type of approach can help to move the field closer to a personalized and preventative approach to psychiatry.

S18-1

DISEASE BIOMARKERS FOR SCHIZOPHRENIA

Sabine Bahn, M.D., Tennis Court Rd, Cambridge, CB12AN United Kingdom

SUMMARY:
Schizophrenia almost certainly presents a heterogeneous group of aetiologies which may not be reflected in the symptomatic/clinical presentation of patients. Therefore, a better molecular understanding of the disease onset and progression is urgently needed. Multiomics profiling approaches were employed to investigate large numbers of patient and control samples. These largescale experiments are required to identify disease intrinsic molecular signatures as well as patient subgroups with potentially distinct biochemical pathways underpinning their symptoms. Recently, we have identified a candidate biomarker panel in patient serum, specifically upor downregulated in drug naive, first onset schizophrenia patients compared to healthy controls using high throughput proteomic profiling and multiplexed immunoassay profiling technology. A panel of 51 markers was found to yield an average sensitivity and specificity of >85% across five clinical centres comprising 572 firstonset drugnaive and recent onset schizophrenia patients versus 235 matched healthy control samples. Abnormalities remained significant after adjustment for all recorded baseline characteristics. Our findings demonstrate the applicability of a rapid and noninvasive blood test to confirm the presence of schizophrenia. Several animal models of schizophrenia show significantly similar serum

changes as observed in humans.

S18-2
PSYCHIATRIC PHENOMICS: FOUND (NOT LOST) IN TRANSLATION

Alexander Niculescu III, M.D., Ph.D., 791 Union Dr, Indianapolis, IN 462024887

SUMMARY:
Psychiatric phenotypes are currently characterized by consensus criteria derived primarily from clinical experience, as embodied in *DSM-IV* and being discussed for *DSM-5*. While this is an advance over the past, when categorization relied on somewhat vague clinical descriptions, there is significant room for improvement. The current criteria have, as a strength, provided a common language for psychiatrists across different sites and different countries, with good interrater reliability. The major potential limitations are that they are categorical rather than dimensional, and not empirically derived on a consistent basis. As such they may not entirely and accurately reflect the phenomenological reality, or have a direct correspondence with the underlying biology. There is a need for more quantitative, empirical approaches to psychiatric phenotyping, for both research purposes and clinical practice. Specifically, the multitude of negative or contradictory candidate gene association studies or, more recently, wholegenome association studies, for genes with clear biological evidence of relevance to bipolar disorder and schizophrenia may be due, at least in part, to this fundamental issue. We will present data from translational studies of psychiatric disorders based on empirical phenomic analyses integrated with genomic biomarkers, to help clarify and quantify the issues of complexity, heterogeneity and overlap, and thus place the field on a stronger footing towards personalized medicine.

S18-3
PREDICTING ONSETS OF MAJOR PSYCHIATRIC DISORDERS: THE ROLES OF NEUROPSYCHOLOGICAL, MR IMAGING AND CIRCADIAN MARKERS

Ian Hickie, M.D., 94 Mallet St, Sydney, 2050 **Australia**

SUMMARY:
In longitudinal cohort studies of young adults (aged 16 30 years) presenting for mental health care, we are testing the utility of a new clinical staging model for describing pathways to major psychotic and affective disorders as well as exploring the predictive capacity of various objective biological and genetic measures. Our goal is to develop more effective early interventions as well as identify those at greatest risk of progression to major disorders. In the initial cohort of 450 young subjects, the clinical staging model has been successfully applied by experienced raters. Approximately half the cohort are rated as being in 'at risk' or as having 'attenuated syndromal' states. When followed longitudinally, approximately 20% progress within a twoyear period to development of discrete psychotic or major affective disorders. The biological characteristics of those who progress (when assessed at baseline and longitudinally) are being progressively described. To date, the strongest correlates of progression to more severe illness have been neuropsychological evidence of premorbid global deficits as well as specific performance decrements in visual and verbal learning. Correlations between these neuropsychological markers and specific MRI, resting state fMRI and integrity of white matter tracts are being explored. For those who progress to bipolar spectrum disorders, various circadian markers appear to have some predictive capacity.

S18-4
TRANSLATING GENETIC AND BIOLOGICAL FINDINGS INTO NEW TREATMENTS FOR SCHIZOPHRENIA

*Cyndi Weickert, Ph.D., Neuroscience Research Australia Hospital Rd, Randwick, NSW 2031***Australia**

SUMMARY:
Females with schizophrenia have worse symptoms when estrogen is low and estrogen replacement reduces schizophrenia symptoms. Both males and females with schizophrenia show more estrogen receptor alpha (ESR1) gene and cortical ESR1 mRNA variation than controls, suggesting that both genders may not respond normally to circulating sex steroids. The "at risk" ESR1 genotype was associated with lower frontal cortex ESR1 mRNA levels in schizophrenia. Eighteen ESR1 splice variants encoding truncated ESR1 protein and decreased frequencies of wild type ESR1 mRNA were detected in the schizophrenia sample. Using

a luciferase assay, we found that truncated ESR1 significantly attenuates gene expression induced by wildtype ER, demonstrating a dominantnegative function. In cell culture, we found that the Selective Estrogen Receptor Modulator (SERM) raloxifene was able to stimulate estrogen response element driven gene expression and to partially reverse the impact of the truncated variants that are overabundant in schizophrenia. In translating these basic findings from the lab into the clinic we have initiated a trial in which raloxifene will be administered to both males and females with schizophrenia using a doubleblind, withinsubjects, crossover, placebo controlled design with the aim of stimulating estrogenrelated neurotrophic activities and improving positive and negative symptoms and cognition. We hypothesize that individual genetic variation in ESR1 will help to identify those people with schizophrenia who will benefit from treatment. This type of approach can help to move the field closer to a personalized and preventative approach to psychiatry.

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SYMPOSIUM 19
NOVEL TREATMENTS FOR NEURODEVELOPMENTAL DISORDERS

U.S. National Institute of Mental Health

Chair: Christopher Sarampote, Ph.D., 6001 Executive Blvd Room 6182, Rockville, MD 20852
Discussant: James T. McCracken, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and understand how advances in scientific methods are being used to investigate the mechanisms underlying mental disorders in children; and 2) Recognize and learn about innovative research to evaluate novel treatment approaches targeting childhood mental disorders.

OVERALL SUMMARY:

Traditionally, treatments for mental disorders in children have been adapted from approaches first tested in adults. More recent advances in scientific methods have the potential to specifically elucidate the mechanisms underlying mental disorders in children and facilitate the discovery of new treatments aimed at developmentallyrelevant targets. This symposium will provide an update of innovative work recently funded by NIMH that builds on these advances to develop and evaluate novel interventions for neurodevelopmental disorders in children. The first presenter (Dr. Bearden) will describe the rationale—based on a mouse model—for an exploratory intervention using an inhibitor of Ras activity to reverse cognitive deficits in Neurofibromatosis type 1 and will present findings related to molecular and neural bases of working memory deficits in a mouse model and humans. The second presenter (Dr. Singer) will review the role of the glutamate in the development of Tourette Syndrome (TS) and introduce work to evaluate potential new treatments for TS that modulate glutamate neurotransmission. Another presenter (Dr. Reiss) will review the role that functional cholinergic deficits may play in cognitive behavioral dysfunction in Fragile X Syndrome and the potential therapeutic use of agents to augment the cholinergic system to target these deficits in adolescents. The final presenter (Dr. Mundy) will discuss innovative treatment approaches to address impairments in social skills and attention in children with Autism Spectrum Disorders. The discussant (Dr. McCracken) will provide commentary on the above presentations and discuss challenges and advances in novel treatment development for childhood disorders.

S19-1

NEUROFIBROMATOSIS TYPE I AS A MODEL FOR PHARMACOTHERAPY OF COGNITIVE DISABILITY

Carrie Bearden, Ph.D., 300 MP, Suite 2265, Los Angeles, CA 90095

SUMMARY:
Developmental learning disabilities present a major public health burden and are associated with substantial psychiatric morbidity. However, to date no effective pharmacologic treatments have been developed for these severely disabling conditions. Neurofibromatosis type 1 (NF1) is a valuable singlegene model for understanding mechanisms of cognitive disability. The development of a mouse model of the disorder led to the key discovery that increased Ras activity is responsible for the learning deficits in NF1. Next, our preclinical studies showed that treatment with lovastatin, which acts as a potent inhibitor of Ras activity and is commonly used for the treatment of hypercholesterolemia, can reverse the cognitive deficits observed in NF1 mice. For the first time, this allows us to assess a pharmacologic treatment for cognitive deficits, using a medication that has been validated in pre clinical studies and for which substantial clinical safety data is available. We recently conducted parallel experiments to further examine the molecular and neural basis of working memory deficits in both the mouse model and human subjects with NF1; these studies provide evidence for a common mechanism related to dysfunction of GABAmediated inhibition. We are now conducting a translational exploratory clinical trial, in which we are extending our preclinical findings to studies in human subjects with NF1, to determine whether analogous changes in brain structure and function are observed following lovastatin treatment in humans.

S19-2
GLUTAMATERGIC MODULATORY THERAPY FOR TOURETTE SYNDROME

Harvey Singer, M.D., 200 N. Wolfe Street, Room 2158, Baltimore, MD 21287

SUMMARY:
Tourette syndrome (TS) is a neuropsychiatric disorder characterized by the presence of chronic, fluctuating motor and vocal (phonic) tics. The disorder is commonly associated with a variety of comorbidities including obsessivecompulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), school problems, anxiety, and depression. Therapeutically, if tics are causing psychosocial or physical problems, symptomatic medications are often prescribed, typically alphaadrenergic agonists or dopamine antagonists. Recognizing that therapy is often ineffective and frequently associated with unacceptable sideeffects, there is an ongoing effort to identify new ticsuppressing therapies. Several lines of evidence will be presented that support the use of glutamate modulators in TS including glutamate's major role in corticostriatalthalamocortical circuits (CSTC), the recognized extensive interaction between glutamate and dopamine systems, results of familial genetic studies, and data from neurochemical analyses of postmortem brain samples. Since insufficient data is available to determine whether TS is definitively associated with a hyper or hypoglutamatergic state, potential treatment options using either glutamate antagonists or agonists are reviewed. Data from studies using these agents in the treatment of OCD and TS will be presented. If validated, modulation of the glutamate system could provide a valuable new pharmacological approach in the treatment of tics associated with Tourette syndrome.

S19-3
WHAT DOES THE FUTURE HOLD FOR DIAGNOSIS AND TREATMENT OF NEUROPSYCHIATRIC DISORDERS?

Allan Reiss, M.D., 401 Quarry Street, Stanford, CA 94305

SUMMARY:
For more than three decades, we have relied on diagnostic taxonomies comprised of symptom clusters. Though an improvement on previous diagnostic systems, such "phenomenological" taxonomies have not served to advance the state of scientific understanding as much as was originally hoped. It has also become increasingly clear that many of our most important diagnoses (from a public health perspective) are associated with a large number of disparate risk factors and pathophysiological mechanisms that we are only now just beginning to identify and understand. Complicating matters further, these specific risk factors and pathophysiological mechanisms do not appear to map to a single phenomenological diagnosis in a predictable fashion. Thus, a radical change in our approach to diagnosis and treatment

of neuropsychiatric disorders is required. The change from a phenomenological diagnostic system to one that focuses on specific risk factors and brain diseases represents a major inflection point for the field and will likely transform clinical neuroscience (defined as comprising both the behavioral and neurosciences). Though a large number of practitioners and researchers across disciplines will need new training to achieve this transformation, many current concepts will continue to be relevant such as the importance of moderating and mediating factors in altering phenotypic expression, and a longitudinaldevelopmental perspective in considering intervention. In this talk, I will discuss how the continuing elucidation of pathophysiological mechanisms leading to cognitive and behavioral impairment in particular diseases, such as fragile X syndrome, can serve as a leading example for the coming transformation in clinical neuroscience and psychiatry.

S19-4

COMPLEX SOCIALATTENTION, VIRTUAL REALITY AND SCHOOL AGED CHILDREN WITH AUTISM

Peter Mundy, Ph.D., 2825 50th Street, Sacramento, CA 95817

SUMMARY:
This study examined the hypothesis that impairments in complex forms of social attention may be characteristic of the school aged development of children with higher functioning autism (HFA). Complex social attention abilities refer to those that require considerable effort because of several factors, such as attending to multiple social partners while also expressing one's own thoughts. The identification of impairments in these abilities, and the examination of their malleability, may be pivotal to advancing the treatment and prevention of impediments to positive outcome for these individuals. To address this possibility HFA children and controls were asked to answer questions about themselves, while directing their visual attention to 9 avatar "peers" in a 3D virtual classroom paradigm. This required dual task regulation of social attention deployment and the generation and expression of one's own thoughts. Preadolescent HFA and Controls (811 years) did not differ on numbers of looks to the avatar peers (106.8 vs. 98.3) but there was a significant difference between the Adolescent HFA and Controls (1216 years), F (1,14) = 6.28, eta2 = .31 (105.4 vs. 144.5 respectively). Thus, HFA children displayed evidence of impairments in complex social attention abilities that emerge later in life. The social attention of all children was malleable such that Social Orienting while talking improved dramatically in the fade Cuing Condition (e.g. p < .009 HFA). However, HFA children with Higher ADHD scores (Tscore > 75) had the lowest rates of social attention compared to all other subgroups (82.93 looks to avatars, F = 6.15, eta2 = .20). Finally, regardless of ADHD symptoms poorer socialorienting was strongly associated with parent reports of School Learning Problems on the Conners' scale in both groups (r = .64, HFA, .65, TD, ps < .002).

SYMPOSIUM 20
THE APA AND THE WORLD PSYCHIATRIC ASSOCIATION: GLOBAL RESOURCES FOR THE PRACTICING PSYCHIATRIST
World Psychiatric Association

Chair: Nada L. Stotland, M.D., M.P.H., 1000 Wilson Blvd, Arlington, VA 22209
Discussant: Carol Nadelson, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the programs and products of the World Psychiatric Association; 2) Describe the relationship between the APA and the World Psychiatric Association; and 3) Utilize the rich resources of the World Psychiatric Association to improve patient care and mental health policy.

OVERALL SUMMARY:
The World Psychiatric Association (WPA) is the vehicle for the exchange of clinical and policy information; the provision of support; and the development of multinational psychiatric research; around the globe. Countries and cultures have much to learn from each other, and, given the increasing movements of large and small populations from one country and culture to another, many of us treat patients with whose beliefs, histories, values, and customs we are not familiar. Most psychiatrists are not familiar with the work of the WPA or the roles of the United States and other countries within it. The WPA has developed a wealth of resources and

publications on a wide range of crucial psychiatric topics. This session features the current president of the WPA, Dr. Mario Maj, from Italy; the WPA presidentelect, Dr. Pedro Ruiz, a multicultural American; Dr. Helen Herrman, WPA Secretary for Publications, from Melbourne, Australia; and Dr. David Kupfer, Chair of the multinational DSM 5 Task Force of the American Psychiatric Association. Our discussant will be Dr. Carol Nadelson, the first woman president of the APA and past editorinchief of the American Psychiatric Press. This symposium is an opportunity to broaden our horizons by hearing from the world leaders of our field.

S20-1

LESSONS LEARNT IN THE IMPLEMENTATION OF COMMUNITY MENTAL HEALTH CARE: INPUT FROM A WPA GUIDANCE

Mario Maj, M.D., Ph.D., Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, Naples, 80138

SUMMARY:
The World Psychiatric Association (WPA) supports the development of community mental health care worldwide, so that people with mental disorders can have services available as close as possible to their locality, can be treated in the least restrictive environment, and can maintain their links with the community. However, there are several lessons we have learnt from the experience of the countries in which the development of community care has been most active in the past few decades. The WPA has recently published a guidance (1) bringing these lessons to the attention of psychiatrists (as well as other professionals and policy makers) of countries in which the process is starting now. The following points deserve a special emphasis (2): a) our objective should not be the complete shifting from hospitalbased to communitybased psychiatric care, but a balance and integration of community and hospital services, ensuring continuity of care; b) psychiatrists' clinical skills have to be cultivated, so that they are preserved in spite of the variety of new commitments related to community care; c) communitybased services should avoid an exclusive focus on psychotic conditions, and should develop the appropriate resources and synergies to ensure an adequate coverage of the whole range of mental disorders existing in the community; d) communitybased services should ensure the protection and promotion of physical health in the patients they have in charge; e) community care is a vehicle for the delivery of treatments, not the treatment itself; interventions provided in communitybased services should be validated by research evidence; f) there should be a carefully considered sequence of events linking hospital bed closure to community service development; g) families of discharged patients with severe mental illness should not be left alone with their problem, since evidencebased family interventions are available.

S20-2

ADDRESSING POVERTY AMONG PSYCHIATRIC PATIENTS WORLDWIDE

Pedro Ruiz, M.D., University of Miami Miller School of Medicine 1458 Clinical Research Building, Miami, FL 33136

SUMMARY:
Poverty is one of the factors that most seriously impact visavis the deterioration of mental health and the increase of mental illness across the world. In this respect, poverty and unemployment are primarily affecting ethnic minority groups in most regions of the world. The deleterious effect of poverty and unemployment has been shown to have a direct and negative impact in the development of mental illness among the populations worldwide that are most affected by poverty, unemployment, and lack of resources. Additionally, migrant groups are very much affected in this regard. This situation is rampant among the Hispanic ethnic groups that migrate to the United States. A similar situation is also nowadays present in certain regions of Spain where large number of Hispanic migrants has settle lately. Good examples of this situation can be easily seen in Barcelona and Madrid where large numbers of Ecuadorians, Peruvians, Dominicans and Venezuelans have recently settled. In this presentation, I will examine the negative impact of poverty visavis many psychiatric disorders and conditions. The hope is to offer to the participants good examples of how to intervene in these situations and also implement preventive measures in this patient populations.

S20-3

WORKING WITH THE WORLD PSYCHIATRIC ASSOCIATION TO PROMOTE DISSEMINATION OF MENTAL HEALTH RESEARCH WORLDWIDE

Helen Herrman, M.D., M.B., ORYGEN Research Centre, University of Melbourne, 35 Poplar Road, Parkville
VIC, Melbourne, 3052 Australia

SUMMARY:
The World Psychiatric Association (WPA) has a wellestablished books and journals publishing program – e.g. the official journal World Psychiatry (IF 4.39), edited by Mario Man, is available freely on the WPA website and Medline consistent with its goal to promote dissemination of mental health research globally. A recent project contributes further to this goal. Low and middleincome countries (LAMIC), with over 80% of the global population, bear the greatest burden of mental disorders. Yet there is a striking underrepresentation of these countries in published psychiatric research. This situation reflects limitations in the production of scientific research. It also reflects barriers to the publication of mental health research from LAMIC and to the representation of research from these countries in the main literature databases worldwide. The WPA investigated the reasons for the underrepresentation of LAMIC in published psychiatric research and considered how to support improved research dissemination, relevant for better mental health and mental health care in all countries. A survey in Medline and ISI Web of Science identified the global distribution of journals in the field of psychiatry. Information about unindexed journals was obtained from the WPA zonal representatives and from a project of the World Forum for Global Research and the World Bank. A directory was created of all available mental health and psychiatric journals worldwide (lead by CK). A taskforce was established to assist LAMIC mental health editors in fulfilling the requirements for full indexation. Several journals have achieved indexation in the past two years. The next step is to scale up the support including peer support for journal editors in LAMIC. The taskforce members are Helen Herrman (Chair, WPA Secretary for Publications), Jair de Jesus Mari (Co-Chair), Mario Maj, Christian Kieling, Peter Tyrer, Vikram Patel, Christopher Szabo, Norman Sartorius, and Shekhar Saxena as observer.

S20-4

CROSSCULTURAL ASPECTS OF PSYCHIATRIC DIAGNOSIS AND DEVELOPMENT OF *DSM-5*

David Kupfer, M.D., Dept of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:
There is a clear need for diagnostic criteria that better accounts for variations in the symptomatology and presentation of psychiatric disorders across cultural groups. Not only does a crosscultural approach allow for more accurate diagnoses within the U.S. healthcare system, it helps bridge the gap between use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), thereby bringing greater harmony to the conceptualization and implementation of psychiatric diagnosis worldwide. As such, development of the fifth edition of DSM (*DSM-5*) will actively address the role of cultural aspects of psychiatric diagnosis and nosology to a greater extent than in previous revisions of the manual. An initial effort to fulfill this need came from the creation of a *DSM-5* Study Group to specifically examine cultural gaps in *DSM-IV* and how *DSM-5* may potentially remedy these issues. The study group has conducted literature reviews across the diagnostic categories to identify empiric evidence that indicates for which disorders the current criteria do not adequately capture racial, ethnic, linguistic, and other cultural expressions of a given diagnosis. The group is also discussing whether there is a need for cultural specifiers among certain disorders. The *DSM-5* field trials present a unique opportunity for examining in "real world" settings use of a proposed Outline for Cultural Formulation to determine if prompting clinicians to inquire about crosscultural factors elicits information that yields more accurate diagnoses. Consideration of potential text revisions, including specific statements about cultural features across all diagnoses; integration of data from secondary analyses; and development of an introductory chapter to the manual to orient clinicians and

researchers to pertinent issues, currently parallels these efforts.

Symposium 21
THE PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION CONTINUUM: HOW PSYCHIATRISTS CAN FUNCTION AND LEAD
American Association of Community Psychiatrists

Chair: David A Pollack, M.D., UHN80, Oregon Health and Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97239,
Co-Chair: Lori Raney, M.D.
Discussant: Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the importance of effective integration of mental health and addictions services and providers with primary care; 2) Identify various roles that would be appropriate for psychiatrists in these settings; and 3) Identify and utilize sources of information and training to enhance psychiatrist skills in such settings/programs.

OVERALL SUMMARY:
Primary Care Behavioral Health (PCBH) Integration is an emerging research supported model for provision of mental health services. Based in a foundation of care management provided at the point of contact in primary care and supported by psychiatrists providing timely consultation to primary care providers, this model has caught the attention of healthcare reform proponents and others. Various models have been implemented around the country, engaging psychiatrists in unique and interesting ways. However, the training and preparation to work in these clinical settings has been lacking, with the exception of psychiatrists learning more by experience than by any formal didactic training or access to clinically relevant materials. This has led to a significant knowledge gap for psychiatrists who want to work in PCBH integrated care settings in informed and meaningful ways. This Symposium will address this knowledge deficit by presenting models of integration from around the country, focusing on the level of collaboration for each site, the makeup of the care team, the psychiatrist's role, primary care acceptance of the model and any outcome measures collected. Each of the speakers was selected to represent differing levels of PCBH integration as well as geographical variation in the models. These models will offer symposium participants detailed information on programs that could be replicated in other settings and resources to guide them through the process. The Colorado Behavioral Healthcare Council launched the Collaborative Care Mapping Project in 2010, providing descriptions of over 70 sites around the state where Primary Care Behavioral Health (PCBH) Integration projects have been implemented. Each site has a description of the Level of Collaboration as well as details of the staff and services available. This project provides the viewer with an opportunity to examine different models of PCBH collaboration in both rural and urban areas of Colorado. Dr. Raney, the Medical Director of Axis Health System in Durango, CO and Senior Clinical Instructor in the Department of Family Medicine at the University of Colorado at Denver, will present models from the Four Corners area of Colorado, a rural and frontier setting that has 4 of the sites included in the Mapping Project. The Level of Collaboration at each site will be described. Dr. Raney will discuss her involvement as the Team Consultant Psychiatrist in these settings, describing ways to provide support for the treatment of mental illness in primary care settings over a large geographical area. This discussion will provide participants with examples of PCBH Integration models that could be implemented in other rural areas.

S21-1.
OVERVIEW OF INTEGRATION ISSUES: RATIONALE, MODELS OF CARE, AND STAFFING

David Pollack, M.D., UHN80, Oregon Health and Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97239

SUMMARY:
This presentation will provide a brief overview of the importance of integrating behavioral health and primary care. Care for mental health, addiction, and general medical conditions has too often been segregated into separate care settings or systems, resulting in poorer outcomes, less efficient but more costly care, duplication of services, and decreased

patient satisfaction. Depending on the level of symptom severity and comorbidity, persons with mental health and addiction conditions are usually better served if their care is provided in a more integrated setting. Much work has been done over the past 1015 years to identify the most effective models of care and to develop implementation strategies for clinical practices to become more integrated. The presentation will highlight the general conceptual framework for integration of care, the most common models of care that have emerged, some of the implementation challenges in moving towards integration, and staffing considerations that must be addressed. The development of primary medical homes is a key delivery system design component of the current health reform process. Integration of behavioral health and primary care should be promoted throughout the health care system, but, most importantly, such integration should be considered an essential part of these newly emerging primary medical homes.

S21-2.

THE COLORADO BEHAVIORAL HEALTHCARE COUNCIL'S COLLABORATIVE CARE MAPPING PROJECT: MODELS OF INTEGRATION FOR RURAL AREAS

Lori Raney, M.D., 281 Sawyer Drive, Durango, CO 81303

SUMMARY:

The Colorado Behavioral Healthcare Council launched the Collaborative Care Mapping Project in 2010, providing descriptions of over 70 sites around the state where Primary Care Behavioral Health (PCBH) Integration projects have been implemented. Each site has a description of the Level of Collaboration as well as details of the staff and services available. This project provides the viewer with an opportunity to examine different models of PCBH collaboration in both rural and urban areas of Colorado. Dr. Raney, the Medical Director of Axis Health System in Durango, CO and Senior Clinical Instructor in the Department of Family Medicine at the University of Colorado at Denver, will present models from the Four Corners area of Colorado, a rural and frontier setting that has 4 of the sites included in the Mapping Project. The Level of Collaboration at each site will be described. Dr. Raney will discuss her involvement as the Team Consultant Psychiatrist in these settings, describing ways to provide support for the treatment of mental illness in primary care settings over a large geographical area. This discussion will provide participants with examples of PCBH Integration models that could be implemented in other rural areas.

S21-3.

PSYCHIATRIC SERVICE IN AN URBAN, RURAL COMMUNITY HEALTH CENTER

Charlotte N. Hutton, M.D., 240 Bayou Gentilly Lane, Kenner, LA 70065

SUMMARY:

After Hurricane Katrina 2005, New Orleans, Louisiana had no hospital and one citybased clinic to provide medical services. As of January 2006, there were 22 adult and/or child psychiatrists for the growing population returning to abject desolation and no local infrastructure. The sudden loss of all things New Orleans and the protracted recovery were going to be new emotional insults added to evacuation, multiple moves, fluctuating economic resources, and rising emotional health distress. Before Hurricane Katrina, mental health issues were addressed after an episode of physical violence for most residents. Enrollment criteria for communitybased services prior to the hurricane matched imminent risk criteria for psychiatric admission. A paradigm shift in service delivery needed to occur. Depression, anxiety, substance abuse, suicide and murder suicides recognized by the federal government pushed for more universal, integrate community based services. DHHS Secretary Levine's support of the medical home model facilitated access. The City of New Orleans and EXCELth, Inc. had been partners in federally qualified community health centers; they were primed and ready to address the integrated health model. A psychiatrist was added to the roster of providers. Subsequent grants led to use of PHQ9, electronic health record, and universal screening for depression. Challenges arose in the paradigm shift, psychiatric practice guideline integration, collaboration between silos of medicine, and state statutes regarding service delivery were just the

beginning of welcoming psychiatry into the primary care fold.

S21-4.
PRIMARY CARE INTEGRATION: THE SAN DIEGO VISION OF SYSTEM TRANSFORMATION FOR THE SERIOUSLY MENTALLY ILL

Marshall Lewis, M.D., 3255 Camino Del Rio South, San Diego, CA 92108

SUMMARY:
The San Diego vision has been driven by the psychiatric leadership of the County Health & Human Services Agency. This presentation will review key elements, emphasizing the role of physicians in changing interorganizational relationship paradigms. San Diego County has a population over 3M, and provides care to the Seriously Mentally Ill through independent networks of private Mental Health (MH) clinics and Federally Qualified Health Centers. There had been little if any communication between FQHCs and MH clinics, even about shared patients. Recently, the San Diego County Health and Human Services Agency has embarked on an ambitious 10 year plan to transform the healthcare safety net, emphasizing health system transformation with integration as a central goal. The San Diego vision is unusual in that it is a "ground up" approach, emphasizing the development of virtual, functional patientcentered medical homes across pairs of existing primary and MH clinics throughout the county, blurring traditional boundaries, in lieu of a more traditional approach of developing specific programs that include integration as a function. The goal is to provide integrated health care for all patients within the disparate primary care and MH clinics, with a special emphasis on assuring primary care access for those with Serious Mental Illness who otherwise suffer a 25 year mortality disparity. Countycontracted MH organizations develop relations with specific FQHCs, making arrangements for SMI patients to move seamlessly between the two entities, with accompanying clinical information. MH clinics offer the FQHCs unprecedented access for acute care, as well as psychiatric consultation, education and staff destigmatization training, in exchange for easier patient access to the FQHCs. With this support primary care teams are actually encouraged to mainstream selected SMI patients on the stable end of the care continuum, assuming total care in furtherance of their recovery.

S21-5.
INTEGRATED CARE AT REGIONAL MENTAL HEALTH CENTER/NORTH SHORE HEALTH CENTERS: PROTOCOLS, PALM PILOT AND PHONE SUPPORT

John Kern, M.D., 8555 Taft St, Merrillville, IN 46410

SUMMARY:
Regional Mental Health and North Shore Health Center share a service location in the rust belt region of northwest Indiana. In 2008, Dr. Kern began a formal relationship with the primary care providers in the clinic, prioritizing immediate psychiatric consultation and toolkits to assist the PCPs without routine patient contact with the psychiatrist. In order to meet the need and provide better care, this model evolved over time to include key aspects of the IMPACT model, incorporating a Behavioral Health Provider (BHP) on the team. In addition, protocols were developed for specific disease states to aid the primary care providers in the provision of mental health treatment. This talk will focus on the key aspects of this evolving model of care. It will demonstrate how to provide effective and efficient psychiatric consultation to a busy primary care clinic with limited psychiatric time. Dr. Kern will also discuss the development of protocols for the treatment of Bipolar Disorder in primary care and describe the outcomes and acceptance by primary care of these guidelines.

REFERENCES:
1) Collins C, Hewsonn DL, Munger R, and Wade T: Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund, May, 2010. http://www.milbank.org/reports/10430EvolvingCare/10430EvolvingCare.html

SYMPOSIUM 22
OBESITY AND PSYCHIATRIC CARE: CURRENT EVIDENCE AND BEST PRACTICE

Chair: *Valerie H Taylor, M.D., 100 West 5th Street, Hamilton, L8N 3K7 Canada*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe and etiological framework for the assessment of obesity; 2) List the brain regions that control appetite; 3) Appreciate the mechanisms through which psychiatric conditions affect appetite, weight and metabolism; 4)Consider the role of psychiatric illness as both a precipitating and a perpetuating factor affecting weight regulation; and 5) List pharmacologic and nonpharmacologic strategies for weight management.

OVERALL SUMMARY:
Obesity is directly related to chronic conditions that are associated with early mortality and now has the dubious honour of having overtaken smoking as the health problem that has the biggest impact on quality of life, mortality and morbidity. Despite this, little work has been undertaken to understand the determinants that contribute to this problem, and very little funding has been allocated to implementing and evaluating prevention programs. To provide context, according to the Public Health Agency of Canada, H1N1 has killed 415 Canadians. Since 2002 there have been 38 West Nile virus deaths in Canada with the last death occurring back in 2005. Conservative estimates indicate that 25,000 people in Ontario died as a direct consequence of obesity related illness in 2009. The allocation of resources, research and treatment does not reflect burden of illness. This may be due in part to the fact that obesity is a multifaceted illness and is affected by a number of psychological and sociological factors. If obesity is termed an "epidemic" in the general population, then the current trends with respect to weight in patients with a psychiatric illness defy description. Individuals with mental illness are differentially affected by weight gain via mechanisms that both overlap with, and are distinct from, individuals in the general population. The goals of the obesity education symposium and workshop are to focus discussion of obesity in the psychiatric setting beyond iatrogenic blame. The objectives of this program are to discuss issues related to the neurobiology of weight gain, to focus on clinical areas relevant to the management of weight gain and to provide a comprehensive overview of obesity management, with a focus on areas relevant to mental health.

S22-2.
HUNGER AS ADDICTION

Alain Dagher, M.D., 3801 University St, Montreal, H3A 2B4 Canada

SUMMARY:
The brain reward system is responsive to drugs of abuse as well as natural rewards such as food and sex. The view that hunger is an addiction to food, originally proposed by Donald Hebb over 50 years ago, is gaining greater support recently from human and animal experiments. The brain reward system includes the ventral striatum, amygdala, insula and orbitofrontal cortex. Dopamine is an important neurotransmitter in this system, and all known drugs of abuse, as well as food, release dopamine in the brain. We have used functional magnetic resonance imaging and positron emission tomography to study the role of the brain reward system in food intake and drug craving. We and others have shown that the neural response to food and drug cues demonstrates considerable homology. We have also shown that the appetite stimulating hormone ghrelin, a putative homeostatic signal, acts on the brain reward system to make food stimuli more appetitive. Animal and our own human studies show that the reward system is also targeted by psychosocial stress. This could partly explain the role of stress in addiction, relapse, and even obesity. Finally, dopamine release can be measured in healthy human volunteers using positron emission tomography and [11C] raclopride, a D2 receptor ligand. We have used this method to study dopamine release in response to abused drugs (alcohol, amphetamine, nicotine), natural rewards such as food and money, and psychosocial stress.

S22-3.
PSYCHIATRIC ILLNESS AND OBESITY CLINICAL COMORBIDITY.

Brian Stonehocker, M.D., 1E6.13 Walter Mackenzie Centre, Edmonton, T6G 2B7 Canada

SUMMARY:
The intent of this session is to review the role of mental health as either a potential contributor to obesity, or a barrier to effective obesity management. The session will focus on common psychiatric

comorbidities seen in obesity such as ADHD, Affective Disorders, and Binge Eating, and the role these can play as a precipitating or perpetuating factor for obesity. Although from a physical health perspective, weight loss is almost always a healthy goal; the session will discuss relative psychiatric contraindications to active weight loss attempts. Potential negative psychiatric outcomes with weight loss will also be addressed.

S22-4.
AN ETIOLOGICAL APPROACH TO OBESITY

Arya Sharma, M.D., Ph.D., Royal Alexandra Hospital 10240 Kingsway Avenue, Edmonton, T5H 3V9 Canada

SUMMARY:
Obesity is characterized by the accumulation of excess body fat and can be conceptualized as the physical manifestation of chronic energy excess. Using the analogy of oedema, the consequence of positive fluid balance or fluid retention, obesity can be seen as the consequence of positive energy balance or calorie 'retention'. Just as the assessment of oedema requires a comprehensive assessment of factors related to fluid balance, the assessment of obesity requires a systematic assessment of factors potentially affecting energy intake, metabolism and expenditure. Rather than just identifying and describing a behaviour ('this patient eats too much'), clinicians should seek to identify the determinants of this behaviour ('why, does this patient eat too much?'). This presentation will provide an aetiological framework for the systematic assessment of the sociocultural, biomedical, psychological and iatrogenic factors that influence energy input, metabolism and expenditure. The presentation will discuss factors that affect metabolism (age, sex, genetics, neuroendocrine factors, sarcopenia, metabolically active fat, medications, and prior weight loss), energy intake (sociocultural factors, mindless eating, physical hunger, emotional eating, mental health, medications) and activity (sociocultural factors, physical and emotional barriers, medications). It is expected that the clinical application of this framework can help clinicians systematically assess, identify and thereby address the aetiological determinants of positive energy balance resulting in more effective obesity prevention and management.

REFERENCES:
1) 1.Eikelis N, Esler M, The neurobiology of human obesity. Exp Physiol. 2005;90:673682.
2) McIntyre RS, McCann SM, Kennedy SH. Antipsychotic metabolic effects: weight gain, diabetes mellitus,
and lipid abnormalities. Can J Psychiatry. 2001;46:27381.

SYMPOSIUM 23
TRAUMATIC BRAIN INJURY IN THE ATHLETE: PSYCHIATRIC IMPLICATIONS
INTERNATIONAL SOCIETY FOR SPORT PSYCHIATRY

Chair: *Antonia L Baum, M.D., M.D., 5522 Warwick Place, Chevy Chase, MD 20815*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Diagnose and establish a treatment plan for traumatic brain injury in the athlete; 2) Provide clinical assessment of athletes, from recreational to elite, to professional, who have endured brain injury; and 3) Identify the optimal way to handle the injury as it relates to future sports participation.

OVERALL SUMMARY:
Traumatic brain injury in the athlete has thankfully, increased in its visibility in recent times, leading to more research and awareness about this entity, which affects athletes at every level of competition, from recreational, to elite, to professional. There are computerized neuropsychological batteries being used to assess such patients which will be presented. The psychiatric sequelae of such brain injury will be presented, including attentional deficits, depression, and suicidal ideation, as well as cases of completed suicide. We will have several athletes presenting their experience with traumatic brain injury. There will be a discussion of the appropriate way to handle these patients clinically, and what special considerations there need to be in returning to athletic competition.

S23-1.
CONCUSSION IN SPORTS AND EXPERIENCE WITH THE NFL

David Baron, D.O., 100 E Lehigh Avenue, MAB, Suite

305, Philadelphia, PA 19125

SUMMARY:
According to the CDC, 1.6 to 3.8 million sports related traumatic brain injuries occur every year. They recommend the symptoms be evaluated in 4 primary domains; 1) physical, 2) cognitive, 3) emotional, and 4) sleep. Despite the dramatic increase in public awareness of TBI/concussion in sports (largely related to the media coverage of this issue in pro football) little research has been conducted into the emotional and sleep related problems. The NFL has recently taken important steps to address this problem, including informational material in every locker room, requiring independent medical clearance before an injured player may return to compete, standardized neurocognitive screening measures, and increased vigilance by referees to penalize helmet to helmet blows to the head. All well intended, these efforts do not seem to have substantially addressed the ever growing problem. One positive outcome has been the increased awareness of the importance of head and neck trauma in all sports, particularly youth sports. Despite 3 international consensus conferences on TBI in Sports, many more questions exist than answers. This presentation will review the extant knowledge of TBI in sports and highlight the critical areas yet to be addressed, with a special emphasis on the psychiatric issues related to TBI , concussion, and subclinical multiple head and neck trauma.

S23-2.
USE OF A COMPUTERIZED NEUROPSYCHOLOGICAL TEST BATTERY FOR THE EVALUATION OF CONCUSSIONS I HAWAII HIGH SCHOOL ATHLETES

William Tsushima, Ph.D., 888 South King Street, Honolulu, HI 96813

SUMMARY:
The high number of head injuries and mild traumatic brain injuries(mTBI) sustained by high school athletes calls for improved methods of assessing the neurocognitive sequelae of sportsrelated concussions. In the late 1990s, researchers at the University of Pittsburgh Medical Center, as part of their work with the Pittsburgh Steelers football team concussion program, developed a reliable, sensitive, and practical apporach to the neuropsychological assessment of mTBI. Instead of the labor intensive conventional paperandpencil psychometric instruments, the research tem constructed a computerbased neurocognitive assessment, referred to as ImPACT (Immediate PostConcussion Assessment and Cognitive Testing), that evaluates verbal and visual memory, processing speed, and reaction time. The computerized testing provides a relatively brief (2030 minutes), costefficient evaluation with clinically useful information for the management of head injured athletes. A growing body of research attests to the reliability and validity of ImPACT in the neuropsychological evaluation of sportsrelated concussion. Currently, ImPACT is utilized by over 125 Division I1 and IAA colleges, over 300 high schools across the United States, as well as the majority of National Football League teams, and professional motor sports participants. Despite the growing number of research reports on the ImPACT, the influence of factors such as geographic region or ethnic minority membership on ImPACT test performance has not been examined. This paper will present the ImPACT scores of 751 Hawaii student athletes to be compared with national norms. The scores of 26 concussed athletes tested in a week after a single concussion will also be examined.

S23-3.
SPORT PSYCHIATRY AND TRAUMATIC BRAIN INJURY: A NEW FRONTIER IN A CHALLENGING WORLD

Ira Glick, M.D., Departments of Psychiatry and Behavioral Sciences, and Psychopharmacology, Stanford University School of Medicine300 Pasteur Drive, Stanford, CA 94305

SUMMARY:
The field of sport psychiatry has steadily evolved and grown since its origin in 1990. Traumatic brain injury (TBI) in athletes has brought increasing attention to the field, both in clinical settings and in the media. The goal of the sport psychiatrist is to (1) optimize health, (2) improve athletic performance—or suspend it, as deemed necessary, and (3) manage psychiatric symptoms, including sequelae of TBI. We will address (1) the literature on epidemiology, diagnosis and treatment of TBI, (2) the evolution

of our recognition of and treatment of TBI, and (3) unique challenges for the sport psychiatrist in this process. One such challenge is stigma. The athletic ethos leads to reluctance to consult any physician, especially a psychiatrist. A second challenge is the athlete's fear that he or she will not be allowed to continue to participate. A final challenge is negative behavior of some professionals, e.g., allowing athletes with TBI to continue to participate even when it is unsafe to do so. We discuss potential directions for future research on TBI in athletes.

REFERENCES:

1) 1. Patel DR, Reddy V SportRelated concussion in adolescents, Pedatri Clin North Am 2010 Jun;57(3):64970.
2) Covassin T et al Investigating baseline neurocognitive performance between male and female athletes with a history of multiple concussion. J Neurol Neurosurg Psychiatry 2010 Jun;81(6):597601.
3) Kuehl MD et al Impact of prior concussions on healthrelated quality of life in collegiate athletes 2010 Mar;20(2):8691.
4) Theriault M et al Electrophysiologic abnormalities in well functioning multiple concussed athletes Brain Inj 2009 Oct;23(11):899906.
5) McCrory P et al Consensus statement on concussion in sportthe Third International Conference on Concussion in Sport held in Zurich, November 2008. Phys Sportsmed 2009 Jun;37(2):14159.
6) Omalu BI et al Chronic Traumatic Encephalopathy, suicides and parasuicides in professional American athletes: the role of the forensic pathologist Am J Forensic Med Pathol 2010 Jun;31(2):1302.

SYMPOSIUM 24
PROS AND CONS OF SPECT BRAIN IMAGING: WHAT IS THE STATUS OF THE SCIENCE?

Chair: Theodore A Henderson, M.D., Ph.D., 3979 E. Arapahoe Road, Suite 200, Centennial, CO 80122, Co-Chair: Joseph C Wu, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the radiation exposure in a SPECT scan; 2) Understand & interpret the risk from such radiation exposure; 3) Recognize the correlation between neuroimaging findings & specific psychiatric conditions; 4) Interpret the scientific data supporting or prohibiting the use of SPECT neuroimaging; and 5) Make a sound & reasoned medical opinion concerning the use of SPECT neuroimaging in Psychiatry and their own practice.

OVERALL SUMMARY:
Perfusion SPECT is the oldest and most widely available functional neuroimaging technique in the world. A large body of research literature has been compiled over the past 25 years on SPECT findings is a variety of neurological and psychiatric conditions. The results have been mixed and in some cases, inconclusive. Nonetheless, SPECT neuroimaging is being utilized in some arenas as part of the diagnostic evaluation of psychiatric and neurological conditions, ranging from ADHD to dementia. Recently, criticism of the use of perfusion SPECT neuroimaging in the diagnosis and treatment of psychiatric and neurological conditions has increased. However, much of the published critiques fail to present a thorough review of the relevant scientific literature. Given that neuroimaging, in all its forms, is gaining validity in Psychiatry, a thorough review of the scientific data supporting and detracting from SPECT neuroimaging is overdue. The purpose of this symposium is to present arguments and data for and against the use of SPECT neuroimaging in the evaluation of psychiatric and neurological conditions. Areas of focus will include: 1) the correlation of neuroimaging findings to DSM IV diagnostic entities or lack thereof; 2) a valid and scientific analysis of the risk from exposure to a radioactive isotope; 3) criteria for selecting a SPECT scan as an aid in the diagnosis of a complex psychiatric condition, particularly when suspected neurological conditions are comorbid; and 4) current and upcoming advances in the technology and statistical analysis of SPECT.

S24-1.
WHAT CONSTITUTES CLINICAL UTILITY FOR SPECT BRAIN IMAGING?

Michael Devous, Ph.D., 5323 Harry Hines Blvd, Dallas, TX 753909061

SUMMARY:
SPECT brain imaging is a powerful tool for the study of human brain function, and some aspects of its use have achieved value in clinical practice (diagnosis of Alzheimer's Disease, localization of seizure foci, delineation of ischemic penumbra in stroke). Such applications are supported by numerous publications in peerreviewed literature that include appropriate control populations, wellestablished technical procedures, and duplication at multiple laboratories. Unfortunately, there are also research studies that, while informative regarding the disease pathobiology, have been used clinically without appropriate documentation. Specifically, there is no evidence to support neuroimaging to aid, support, or illuminate the diagnosis or treatment of psychiatric disorders. Camargo (J Nucl Med 42, 2001) notes that "Brain SPECT in psychiatric disorders is still investigational. Despite considerable research interest in this area, specific patterns of the various diseases have not been definitely recognized." Brockman et al. (Psych Res 173, 2009) note that the use of SPECT in predicting treatment response "is beyond the sensitivity of this method." There are several dangers to patients associate with premature use: 1) they are administered a radioactive isotope without sound clinical rationale, 2) they pursue treatments contingent upon an interpretation of a SPECT image that lacks empirical support, and 3) they are guided toward treatment that may detract from clinically sound treatments. There is also danger to our field. It is likely that within the next decade some of these research findings will be translated into practice and that psychiatrists will enjoy the ability to diagnose and prescribe treatments based, in part, on neuroimaging findings. Unfortunately, if previously misled by unsupported claims, patients and their doctors may be less inclined to utilize scientifically proven approaches once these are shown in the peer reviewed literature to be effective.

S24-2.
HOW BRAIN SPECT IMAGING CAN BE IMMEDIATELY USEFUL IN CLINICAL PRACTICE

Daniel Amen, M.D., 4019 Westerly Place, Suite 100, Newprt Beach, CA 92660

SUMMARY:

Brain SPECT imaging is a nuclear medicine study that uses isotopes bound to neurospecific pharmaceuticals to evaluate regional cerebral blood flow (rCBF) and indirectly metabolic activity. With current available technology and knowledge SPECT has the potential to add important clinical information to benefit patient care in many different areas of a psychiatric practice. This presentation explores the clinical controversies and limitations of brain SPECT, plus seven ways it has the potential to be immediately useful in clinical practice, including: helping clinicians ask better questions; helping them in making more complete diagnoses and preventing mistakes; evaluating underlying brain system pathology in individual patients; decreasing stigma and increasing compliance; visualizing effectiveness via followup evaluations; helping to decide between treatments and encouraging the exploration of innovative and alternative treatments.

S24-3.
PUTTING SPECT FUNCTIONAL NEUROIMAGING IN PERSPECTIVE

Theodore Henderson, M.D., Ph.D., 3979 E. Arapahoe Road, Suite 200, Centennial, CO 80122

SUMMARY:
Many look to neuroimaging to provide a "fingerprint" or pathognomonic sign of a DSM diagnosis. This is an unrealistic expectation. Neuroimaging, with an emphasis on SPECT perfusion imaging, will be put in the context of the scientific understanding of the neurophysiology of psychiatric symptoms, as well as the nature of diagnostic tests. Comorbidity, selection criteria and the absence of "gold standards" for diagnosis also will be considered. In addition, the technical aspects of SPECT perfusion scanning, including specific doses of radiation, will be reviewed. The risk from this radioactivity exposure will be discussed in the context of the Linear NoThreshold Model versus the Threshold Model, along with a review of pertinent literature concerning large populations exposed to radioactivity. The key points of the two presenters will be reviewed in the context of the available research literature on SPECT perfusion imaging in psychiatric and neurological disorders.

SYMPOSIUM 25
THE IMPACT OF THE PARENTCHILD RELATIONSHIP ON CHILD MENTAL HEALTH: ATTACHMENT, PARENTAL DEPRESSION, BEREAVEMENT, AND TRAUMA

APA Council on Children, Adolescents & Their Families

Chair: Laurie B Gray, M.D., 3535 Market Street, 2nd floor, Philadelphia, PA 19104

EDUCATIONAL OBJECTIVES:
The participant should be able to: 1) Understand how to apply attachment research to promote resilience in children and adolescents; 2) Identify risk factors for psychpathology in recently bereaved children; 3) Identify and assess the impact of parental depression on the mental health of children; and 4) Understand the association between adverse childhood events and later psychiatric and medical morbidities.

OVERALL SUMMARY:
This symposium will explore the impact of the parentchild relationship on child mental health. Dr. Radwan will begin with a review of recent studies on attachment theory and discuss the importance of attachment on the child's emerging emotional and behavioral self regulation. He will also explore the practical implications of these studies in relation to resilience promotion and violence prevention. Dr. Thomas will then discuss one subset of challenges in the parentchild relationship: parental depression. Many studies document children's maladaptive emotional and/or behavioral responses to parental depression. Child mental health has also been shown to improve significantly with treatment of parental depression. This presentation will focus on the broad epidemiologic and treatment studies that underline the urgency of identifying and treating parental depression as early as possible. Dr. Gray will then present on the impact of the death of a parent on a child. After a parent dies, the child must not only cope with the death of the parent but also with the changes in his relationship with the surviving parent. She will present results from a 2year prospective study following children recently bereaved of a parent. The bereaved children's psychiatric sequelae and risk and protective behavior for the development of psychopathology in the bereaved child will be discussed. Then Dr. Berkowitz will discuss the impact of adverse events and trauma in childhood, including child abuse. He will review the psychiatric and medical morbidities of adverse childhood events and will review the emerging evidence that epigenetic changes link adverse childhood events to psychiatric and medical complications later in life. He will also review evidencebased early intervention and prevention strategies designed to reduce children's exposure to violence. The presentations and subsequent discussion will address significant concerns of parents and of both general psychiatrists and child and adolescent psychiatrists. It is well recognized that a significant source of stress for parents is their worry regarding "what will happen to the kids?" and "what can I do?" All psychiatric professionals working with parents are vital in the early identification, prevention, and treatment of child mental health problems.

S25-1.
ATTACHMENT THEORY AND DEVELOPMENT: TOWARDS AN UNDERSTANDING OF SELFRREGULATION AND IMPLICATIONS FOR INTERVENTION

Karam Radwan, M.D., 5841 S. Maryland, MC 3077, Chicago, IL 60637

SUMMARY:
Attachment theory is currently one of the best articulated theories for understanding parentchild relationships, which, in turn, impact a child's physical and mental health via direct and indirect mechanisms. Attachment theory provides an empiricallybased framework from which related constructs can be readily assessed across time. Clinicians with a good grasp of the nature and process of how attachments develop are in a better position to form therapeutic relationships with children and families. Attachment theory has led to a new understanding of child development. Specifically, children develop different styles of attachment based on experiences and interactions with their caregivers. Four different attachment styles are identified in children: secure, anxiousambivalent, anxiousavoidant, and disorganized. Research has repeatedly shown the positive role of good social relationships. It is clear that early childhood is an important window of time for understanding and promoting resilience.

Factors associated with resilience are thought to include secure attachments to significant others, absence of early loss and trauma, high selfesteem, social empathy, and an easy temperament. (Fonagy in Howe, 1994). Easy temperament has only been found to be a protective factor when support is also present (Emery & Forehand, 1994). Arguably, quality of attachment is instrumental in the four central areas associated with resilience, individual characteristics, supportive family, positive connections with adults and culture. The goals of this presentation include an overview of attachment theory, as it pertains to child development and relationships; a review of current research on different styles of relating. Particular focus is devoted to the role of attachment to the primary caregiver and the promotion of resiliency. Understanding the development of violence, argued as a failure of development of secure attachments, provides impetus for investment in early intervention.

S25-2.
TARGETING PARENTAL DEPRESSION FOR CHILD MENTAL HEALTH

Jean Thomas, M.D., 5301 Reno Road, N.W., Washington DC, DC 20015

SUMMARY:
Three domains: (toddler, parent, and toddlerparent relationships) all contribute wellknow risk for depression, anxiety and disruptive behavior disorders in preschool children (Taylor et al., 1999). Because of limited data regarding fathers, this presentation focuses primarily on maternal depression and anxiety, which correlate with depression, anxiety and disruptive behavior in young children (Luoma et al., 2001). Risk associated with the caregiving environment centers around parenting that is negative and inconsistent, and family social adversity (Warren et al., 2000). Maternal depressive symptoms at any time (prenatal, postnatal, and current) and the course of parental depressive symptoms over the child's development are associated with disruptive behavior in young children (Luoma et al., 2001). Parent psychopathology influences and is influenced by family contextual factors; both increase the risk of psychopathology in offspring (Seifer et al., 2001). Of special importance is the first year of life, which has been shown to be a "sensitive period" for the development of a child's later behavior problems (Bagner et al., 2010). Maternal major depressive disorder during this "sensitive period" was predictive of their 2to3 yearold child's internalizing and total behavior problem scores on the Child Behavior Checklist/23 (CBCL/23) (Achenbach, 1992). Maternal depression is "among the most consistent and wellreplicated risk factors for childhood anxiety…depressive…and disruptive behavior disorders." These "childhood disorders "often begin early and continue into adulthood" (Weissman, et al., 2006). This study shows that with remission of maternal depression, there was a significant decrease in psychiatric symptoms of 7 to 17 year old children who were living with their mothers. These findings highlight the need for early treatment of depressed mothers and their symptomatic children. This presentation focuses on parental depression and the urgency of identifying and treating depressed parents and their children who have increased mental health risk. At the end of this presentation, participants will have 10 minutes for questions and discussion of intervention strategies and advocacy that address this urgency.

S25-3.
BEREAVEMENT IN CHILDREN AFTER THE DEATH OF A PARENT

Laurie Gray, M.D., 3535 Market Street, 2nd floor, Philadelphia, PA 19104

SUMMARY:
The loss of a parent is one of the most significant stressors a child or adolescent can experience. Unfortunately, an estimated 4% of children experience the death of a parent before they reach age 18. This presentation will review research on the psychiatric sequelae of parental death in children. Data on 360 bereaved children ages 518 followed longitudinally for 2 years after the death of one parent will be discussed. Psychiatric symptomology is increased in bereaved children compared to a community control group over the 2 years after parental death. The most common psychiatric disorder is depression. 25% of bereaved children experience a depressive episode at one month after the death of a parent. However, depressive symptoms in bereaved children decline over time. Risk and protective factors for the development of prolonged psychopathology in the bereaved child

will be reviewed, with special attention given to associations between function in the child and in the surviving parent. Understanding the relationship between bereavement and psychopathology in children should result in improved interventions for bereaved children. This presentation is given in partial fulfillment of the requirements for the APA Child and Adolescent Psychiatry Fellowship awarded to Dr. Gray.

S25-4.

CHILDHOOD ADVERSE EXPERIENCE AND TRAUMA: A PREVENTABLE PATHWAY TO MEDICAL AND PSYCHIATRIC MORBIDITY

Steven Berkowitz, M.D., 245 South 8th Street, Philadelphia, PA 08033

SUMMARY:
The presentation summarizes the well established association between childhood adverse experience and trauma and many psychiatric and medical morbidities. The research demonstrating a key mechanism for this association, the epigenetic changes in the genome with a focus on the Stress Circuit, will be reviewed. Effective prevention models that decrease children's exposure to adverse experiences and decrease poor outcome will be described. The presentation will describe findings including: 1) the Adverse Childhood Experiences (ACE) Study, which is a large retrospective survey that describes the relationship between cumulative adverse events in childhood and behavioral, medical and psychiatric outcomes in adults 2) studies that describe associations between early adverse experiences and antisocial and other problematic behaviors 3) animal and human studies describing physiological, neurophysiologic and epigenetic changes that occur in response to maltreatment and trauma 4) prevention research that has shown multiple models to be effective in decreasing children's exposure to adverse experience. It is increasingly clear that much morbidity is rooted in developmental processes which involve early adverse experience. Arguably early adverse experience is the leading public health issue in the U.S. Research points to a clear pathway by which the process of cumulative childhood adverse experience affect the genome and subsequent down stream processes. While there are likely multiple mechanisms by which adverse experience affect physical and mental health, epigenetic changes appear to a primary cause with the alterations in the Stress Circuit being central to a range of disease processes. Early prevention strategies have demonstrated effectiveness in the decreasing children's exposure to, but have yet to be implemented at needed levels. Psychiatrists advocating for evidenced based interventions must include and even emphasize the importance of early prevention models.

SYMPOSIUM 26
MENTAL HEALTH TREATMENT IN THE ARMY: A CLOSE LOOK AT CLINICIANS AND THEIR PATIENTS

Chair: Charles W Hoge, M.D., 503 Robert Grant Dr, Silver Spring, MD 20910

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Characterize the Army's mental health workforce and the challenges they face, including the clinical complexity of patients; 2) Recognize the patterns and quality of care for service members; and 3) Identify key factors affecting mental health treatment access and quality.

OVERALL SUMMARY:
This session will highlight new findings from a recent study, "The Army Behavioral Health Practice and Treatment Study." The Walter Reed Army Institute of Research collaborated with the American Psychiatric Institute for Research and Education in surveying the Army's specialty mental health clinicians to provide critically needed workforce and clinically detailed patientlevel data for this study. The primary aims of this study were to: 1) Characterize routine practice in Army behavioral health treatment settings, including patient, clinician, setting, and clinical characteristics; 2) Assess the degree to which clinical practice in Army behavioral health settings conforms to treatment guideline recommendations, particularly in regards to PTSD treatment and the assessment and treatment of suicidal ideation and behavior; and 3) Test methods to regularly collect basic practice and clinical level data to facilitate tracking practice patterns in Army behavioral health treatment settings. In total, 2,311 specialty mental health clinicians, including psychiatrists, psychologists, and

social workers, were invited to participate in this electronic survey which was fielded MaySeptember, 2010. Approximately onequarter of those clinicians targeted to participate in the study responded. Study participants provided practice level data on their professional activities, patient caseloads, clinical training, and issues related to retention and career satisfaction. In addition, indepth data were provided on one systematically selected patient to generate clinically detailed information on a representative sample of patients. This session will highlight the key findings from this recent study and will focus on reporting those findings which have significant implications for mental health planning and services delivery in the Army. The five presentations will focus on the following themes: 1) Mental Health Treatment in the Army: Current Status of Mental Health Clinicians, Patients, and Treatment Access; 2) Patterns and Quality of Care for Service Members with PTSD, Depression, and Substance Use Disorders; 3) A First Look at Suicidal Ideation and Behavior among Patients in Army Behavioral Health Settings; 4) What's Working? Identifying Key Factors Affecting Treatment Access and Quality; and 5) What Does This all Mean? Implications for Mental Health Planning and Services Delivery in the Army.

S26-1.

MENTAL HEALTH TREATMENT IN THE ARMY: CURRENT STATUS OF MENTAL HEALTH CLINICIANS, PATIENTS, AND TREATMENT ACCESS

Joshua Wilk, Ph.D., 503 Robert Grant Dr., Silver Spring, MD 20910

SUMMARY:
Given increased demand for mental health treatment among service members in the military, there is a need to better understand the current capacity and challenges being faced by specialty mental health clinicians practicing in the Army's behavioral health settings. In addition, there is a need for more rigorous, clinically detailed data on the clinical and psychosocial attributes of service members seeking treatment, including the types and intensity of treatments they are receiving, in order to inform and improve mental health services delivery. These basic, clinically detailed data are essential to understanding levels of treatment needs, access and quality and identifying opportunities to strengthen mental health services delivery in the Army. Consequently, this presentation uses data from a recent survey of 2,311 behavioral health clinicians practicing in the Army's Military Treatment Facilities (MTFs) as part of the Walter Reed Army Institute of Research's Army Behavioral Health Practice and Treatment Study to describe the current status of mental health clinicians, patients, and treatment access in the Army. In characterizing the Army's specialty mental health workforce, data on various disciplines practicing in military treatment facilities and their professional activities, including describing their clinical caseloads, will be presented. Data on formal psychotherapy training, career satisfaction, and retention/professional burnout, and comfort treating service members with various mental health conditions will be presented. In characterizing patients, data on the diagnostic and clinical features of service members, including diagnostic/clinical symptomatology and complexity, psychosocial problems and functioning, and war experience and combat exposure will be presented. Data on the types and intensity of psychosocial and pharmacologic treatments provided to service members will also be presented.

S26-2.

PATTERNS AND QUALITY OF CARE FOR SERVICE MEMBERS WITH PTSD, DEPRESSION, AND SUBSTANCE USE DISORDERS

Farifteh Duffy, Ph.D., 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209

SUMMARY:
The Army currently has scant systematic, clinically detailed data on the patterns and quality of mental health treatment provided to service members suffering from PTSD, depression and substance use disorders. Consequently, the primary focus of this presentation will be on examining patterns and quality of treatment for a systematically selected sample of service members with PTSD, depression, and substance use disorders who receive treatment from specialty mental health clinicians practicing in the Army's military treatment facilities. This study uses clinically detailed data from a recent survey of 2,311 behavioral health clinicians practicing in the Army's MTFs as part of the Walter Reed Army

Institute of Research's Army Behavioral Health Practice and Treatment Study. For each disorder group, data will be presented to characterize the diagnostic and clinical complexity of the patients, as well as the type, intensity, and combinations of psychosocial and pharmacologic treatments provided. Importantly, this presentation will also examine the extent to which service members with PTSD, depression, and substance use disorders receive clinical assessments and psychosocial and pharmacologic treatment consistent with Department of Defense, Veterans Affairs, and American Psychiatric Association evidencebased treatment guideline recommendations.

S26-3.

A FIRST LOOK AT SUICIDAL IDEATION AND BEHAVIOR AMONG PATIENTS IN ARMY BEHAVIORAL HEALTH SETTINGS

Eve Moscicki , Sc.D., M.P.H., 1000 Wilson Blvd Ste 1825, Arlington, VA 22209

SUMMARY:
In the context of increasing concern focused on suicide deaths among Army personnel, more information is needed on nonfatal suicidal thinking and behaviors among service members and the salient risks that may be antecedent to suicidality. A better understanding of the risk processes associated with suicidality among Army personnel will help identify potential opportunities for intervention. This study provides an initial look at suicidal ideation, nonsuicidal selfinjurious behaviors, and suicidal selfinjurious behaviors among servic members seen in behavioral health settings in Army military treatment facilities (MTFs). Data were collected from a survey of 2,311 behavioral health clinicians practicing in the Army's MTFs as part of the Walter Reed Army Institute for Researchsponsored Army Behavioral Health Practice and Treatment Study. Behavioral health clinicians reported on one systematicallysampled patient. Data on suicidality included information on suicidal ideation, severity of ideation, presence of a suicide plan, selfinjurious behavior without intent to die, selfinjurious behavior with intent to die, and whether the selfinjurious behavior required urgent medical care. Clinicians also reported on any steps taken to assure the patient's safety, such as removing patient accessibility to lethal means, hospitalization, or other steps. This presentation will describe an initial examination of patient suicidal ideation and behavior reported by clinicians in Army MTFs, and will characterize patients who experienced suicidality. Data will include patient sociodemographic characteristics, diagnoses, psychiatric symptom severity levels, general medical conditions, patient deployment experience, and presence of any war injuries.

S26-4.

WHAT'S WORKING? IDENTIFYING KEY FACTORS AFFECTING TREATMENT ACCESS AND QUALITY

Joyce West, Ph.D., M.P.P., APIRE 1000 Wilson Blvd, Suite 1825 Arlington, VA 22209

SUMMARY:
In recent years, numerous studies have examined mental health treatment in the military given intense public interest and concern in preventing mental illness and ensuring service members and their families who need services receive the best available treatments. This current study takes advantages of two unique approaches to examine key factors affecting mental health treatment access and quality among service members in the Army. Using data from the Walter Reed Army Institute of Research Behavioral Health Practice and Treatment Study, the first approach uses qualitative data from a survey of 2,311 specialty mental health clinicians practicing in the Army's military treatment facilities. These clinicians were asked to report and characterize treatment approaches, strategies, or other factors they believe significantly facilitated timely, high quality mental health and substance abuse treatment for the systematically sampled patients studied. They were also asked to report perceived barriers or obstacles to providing timely, high quality mental health or substance abuse treatment for the sampled patients. Qualitative research methods will be used to systematically summarize and synthesize key factors which were reported to have affected treatment access and quality. The second approach takes advantage of clinically detailed data from the Walter Reed Army Institute of Research Behavioral Health Practice and Treatment Study to quantitatively examine clinician, setting, services delivery, and patient factors associated with receiving treatment consistent with evidencebased

practice guideline treatment recommendations for patients with PTSD, depression and substance use disorders. These analyses will be used to assess how characteristics of the military health care system such as staffing, colocation with other sources of care, including primary care, and services utilization patterns relate to provision of evidencebased mental health treatments in MTFs.

S26-5.
WHAT DOES THIS ALL MEAN? IMPLICATIONS FOR MENTAL HEALTH PLANNING AND SERVICES DELIVERY IN THE ARMY

Charles Hoge, M.D., 503 Robert Grant Dr, Silver Spring, MD 20910

SUMMARY:
This concluding presentation will highlight the key findings from these presentations and the recent Walter Reed Army Institute of Research Behavioral Health Practice and Treatment Study which have significant implications for mental health planning and services delivery in the Army. Implications for the Army's training and retention of the behavioral health workforce will be highlighted. Treatment needs and services delivery implications of key findings related to patients' diagnostic case mix, clinical symptomatology, war experience/combat exposure, psychosocial problems, and functioning will also be presented. Implications of findings related to patterns and quality of treatment for patients with PTSD, depression, substance use, and suicidal ideation and behavior will also be discussed, focusing on opportunities to further strengthen mental health services delivery and coordination to improve treatment access and quality.

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SYMPOSIUM 27
HOT TOPICS IN AFRICANAMERICAN MENTAL HEALTH: IMPACT OF PAST AND CURRENT PREJUDICES; WOMENS MENTAL HEALTH; HIV/AIDS; UNIQUE PSYCHOPHARMACOLOGICAL FINDINGS

Chair: David W Smith, M.D., 1500 21st Street, Sacramento, CA 95814

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the effect of past and present mental health injustices perpetrated against AfroAmerican and how that effects current treatment; 2) Develop better mental health interventions for AfroAmerican females and understand barriers to wellness; 3) Appreciate the mental health challenges of living with HIV/AIDS; and 4) Become more thoughtful in making psychomacological choices for AfroAmerican patients.

OVERALL SUMMARY:
This presentation will begin with Harriett Washington's eloquent discussion of the history of unethical medical experimentation on black Americans from the beginning of our history to current times. This background provides the foundation of mistrust of the medical establishment by many Afroamerican patients. THe next presentation will make use of video taped interviews to discuss the plight of AfroAmericans with regard to HIV/AIDS. The themes of spirituality, misdiagnosis and stigma will be highlighted.There is an alarming disproportionate number of AfroAmericans with HIV infections and current uptrends being found in women and teens. Dr Taylor will discuss the unique plight of Afro-American women who have frequently burdened with the image of needing

to be strong while not allowing their needs to be met setting the stage for suffering in silence. Treatment interventions for helping AfroAmerican women will be discussed. Dr Lawson, noted ethnophycopharmocologist will discuss findings suggestive of differencing in psychotrophic medication response based on unique racial differences that could effects liver metabolic systems as well as the serotonin transporter.

S27-1.
HISTORY OF RACISM IN MENTAL HEALTH; SEEDS OF DISTRUST

Harriet Washington, B.S., Rochester, 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 illness that spanned from antiquity 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.

S27-2.
AFROA-MERICANS AND HIV

David Smith, M.D., 1500 21st St, Sacramento, CA 95814

SUMMARY:
There has been a disproportionate number of AfroAmerican 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 only obvious drug interactions but the high rates of kidney disease and diabetes in this population. The presentation will include taped interviews with patients highlighting key areas of stigma, spirituality and misdiagnosis.

S27-3.
BLACK WOMEN AND DEPRESSION: THE ROLE OF STIGMA IN TREATMENT.

Janet Taylor, M.D., M.P.H., 103 Hardscrabble Lake, Chappaqua, NY 10514

SUMMARY:
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 helpseeking behavior in black women.

S27-4.
PSYCHOPHARMACOLOGY OF AFRICAN AMERICANS: PERCEPTION VERSUS REALITY

William Lawson, M.D., Ph.D., 2041 Georgia Avenue, Washington, DC 20060

SUMMARY:
African Americans (AA) with mental and substance abuse disorders often have poorer outcomes or greater disease burden despite few ethnic differences in prevalence. Perception by the provider or false beliefs by the larger society clearly play a role. Controlled studies show that AA tend to require less medication. Yet they are often overmedicated, given more types of medication, or given excessive antipsychotics. Misinterpretation of symptoms, and perceived hostility when there is none are factors. Similar AA are less likely to be prescribed newer medications even when income is taken into account. Because of a legacy of exploitation, AA are more likely to be distrustful of medical treatment, mental health providers, and biological explanations of mental disorders. Treatment is delayed or refused especially from specialized mental health providers. More needs to be done to educate and bridge the gap of cultural mistrust.

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Marie 2008; Personal communication Dr Gail Wyatt PhD. Director UCLA Center for Health Sciences Aids Project; Position paperCalifornia African American HIV/Aids Initiative 2008;article Misdiagnosis of Black Patients With Manic Depressive Illness; Second in a seriesCarl Bell M.D Jour of the National Medical Association vol 73,no 2 1981,Article Self identification as "downlow among men who have sex with men from 12 US cites; Aids Behavior,2006 sep;10 (5) pg 51929 Wolitski, Jones; How Schizophrenia Became a Black Disease (hardcover by Jonathan M. Metz (Beacon , 2010) Methamphetamine use patterns among urban Black Men who have sex with men. Culture Health and Sexuality vol 11, no 4 May 2009; Another look at HIV in African American Women: The impact of Psychosocial and Contextual Factors, The Journal of Black Psychology 30 (3:366385) " Deadly Monopolies; How life and related Patents Styme Research, Inflate Prices and Sabotage Global Healthcare (Doubleday, 2010) Harriet Washington. Article Minority Stress and Sexual Problems among AfricanAmerican gay and bisexual men Arch of sexual behavior 2007 aug 36 (4):56978. " Identifying interethnic variations in psychotropic response in African Americans and other ethnic minorities Chapter in Ethnopsychopharmacology by Dr Wm Lawson Cambridge press 2008.

SYMPOSIUM 28
PSYCHOTIC DISORDERS IN ICD11

Chair: Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany,
Co-Chair: Keith H Nuechterlein, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of the symposium, participants should be able to: 1) Describe the current issues discussed in the development process of ICD11 visavis *DSM-V* as regards psychotic disorders; and 2) Understand the consequences of the global use of ICD11 in a range of mental healthcare systems.

OVERALL SUMMARY:
The diagnostic classification systems are currently being revised with a The diagnostic classification systems are currently being revised with a view to harmonize and publish the final forms of ICD11 and *DSM-V* in 2014. Psychotic disorders play an important role in psychiatry and accordingly both the WHO (for ICD11) and APA (for DSM-V) have created Work Groups dealing with the revision of the diagnostic criteria of psychotic disorders. This symposium will first describe the current activities of the WHO Work Group on Psychotic Disorders focussing on the classification of schizophrenia. A review of the methods employed to collect evidence of putative significance to the revision process will be presented. Any novel ICD11 criteria will need to be developed not only on a scientific evidence base, but will also need to take into account the perspectives and needs of lowincome countries. The consequences of revising diagnostic criteria for different mental healthcare systems need to be assessed before the introduction of such a revision. Some special issues arise in this context, like the diagnostic classification of acute and transient psychotic disorders. Also, cognitive and functional criteria may become of increasing importance for the diagnosis of psychotic disorders. In recent years the core role of cognitive deficits in psychotic disorders has been increasingly accepted (1). and the evidence for a link of cognitive deficits to everyday functioning in these disorders has become very strong (2). This evidence has led cognitive deficits to be prominent new targets for treatment development (3). Developing standard methods for measuring cognitive change has therefore become important (4). This presentation will consider whether cognitive and functional factors should now be included among the diagnostic criteria for psychotic disorders in ICD11. Pros and cons of this incorporation into diagnostic criteria will be discussed. One conception of cognitive deficits is that they are necessary core elements of certain psychotic disorders and should be placed among the basic criteria that lead to a diagnosis. An alternative conception is that the severity of cognitive deficits is a dimension within psychotic disorders that modifies the level of functional recovery that occurs. These alternatives have different implications for incorporation into diagnostic systems. The implications of the patterning of cognitive deficits across psychotic disorders will also be considered in relationship to possible inclusion of these factors as diagnostic criteria or dimensional modifiers within diagnoses.

S28-1.
DIAGNOSTIC CRITERIA FOR PSYCHOTIC DISORDERS IN THE DEVELOPMENT OF

ICD11

Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany

SUMMARY:
The psychiatric diagnostic classification systems are currently being revised with a view to harmonize and publish the final forms of ICD11 and DSM-V in 2014. Psychotic disorders play an important role in psychiatry and accordingly both WHO (for ICD11) and APA (for DSM-V) have created Work Groups dealing with the revision of the diagnostic criteria of psychotic disorders. Guiding principles and ways to achieve harmonization will be discussed. As the main areas of revision, the following fields are currently in the focus of attention: assignment of psychotic disorders within the planned metastructures of both diagnostic systems, subtyping psychotic disorders, the definition of prepsychotic risk states, and the definition of course specifiers, among others. These areas will be discussed with a view to assess the evidence for and against such revisions of the diagnostic criteria for psychotic disorders.

S28-2.
ACUTE AND TRANSIENT PSYCHOTIC DISORDERS (ATPD): SHOULD IT BE LISTED IN ICD11 ?

Pichet Udomratn, M.D., Prince of Songkla University, Hat Yai, Songkhla, 90110

SUMMARY:
Background: Acute and transient psychotic disorders (ATPD), which were firstly introduced in the ICD10 diagnostic system, have not received much attention in Asia. As WHO is in the process of revising the ICD10 and since ICD11 is expected to be published in 2014, it seems appropriate now to review the status of ATPD in this region. Objective: The aim of this study was to review all publications on ATPD in Asia and to find evidence distinguishing ATPD as a separate group. Methods: A search through PUBMED using the words acute + psychosis + Asia or transient + psychosis + Asia was conducted. Only the papers that fulfilled the inclusion and exclusion criteria were selected. Results: A total of 103 papers were found, but only 9 publications were related to ATPD. There were 390 Asian patients from 9 papers who received a diagnosis of ATPD. It appeared that foreigners were prone to ATPD, especially foreign domestic workers. ATPD, as a group, had a differential family history, course and outcome compared to schizophrenia. However, ATPD was diagnostically unstable over time. It was found that only 35.5%73.3% of Asian patients with baseline ATPD retained their diagnoses over 312 years. Polymorphic subtype of ATPD cases in India and Hong Kong were mostly rediagnosed as bipolar disorder after 35 years. Yet, in Japan, 31.2% of polymorphic cases were changed to schizophrenia after 12 years of followup. Conclusion: This review supports the ICD10 concept of separating ATPD into its own group. However, the polymorphic subtypes or other criteria may need revision in ICD11. Before firm suggestions are submitted to the WHO, further research and data review from other regions are necessary.

S28-3.
MENTAL HEALTHCARE AND ICD11: WHAT NOVEL CLASSIFICATION SYSTEMS NEED TO CONSIDER FOR EVERYDAY CLINICAL PRACTICE

Veronica Larach, M.D., Los Carpinteros 10182, Santiago, 7591110

SUMMARY:
As part of WHO Work Group on Psychotic Disorders for ICD11 we will discuss one of the main utilities of classification systems in everyday clinical practice, that resides in its ability to indicate where to “draw the line” for identification and care strategy of an entity, more so in the case of the diagnosis of schizophrenia because of the dramatic consequences for everyone involved, regarding course, outcome and stigma. Discussion will be addressed to try to determine to what extent should non specialized management reach and when or which should be the features that would require specialized secondary or tertiary care. These issues should comprise from first prodromal or early stage episodes to multiepisode patients. We will discuss the need of specification and staging of profiles not only in symptomatology but also in relation to deficits in cognition, social competence, adequacy and community function that would enable patient assessment in terms of treatment plans. We will also discuss that patient care takes place within the context of culture and therefore must take into

account the particular social structure organizations, the available resources and the different forms of stigma that directly affect our practice.

S28-4.

SHOULD COGNITIVE AND FUNCTIONAL CRITERIA BE ELEMENTS OF THE DIAGNOSTIC CRITERIA FOR PSYCHOTIC DISORDERS IN ICD11?

Keith Nuechterlein, Ph.D., 300 UCLA Medical Plaza, Room 2240, Los Angeles, CA 900956968

SUMMARY:
In recent years the core role of cognitive deficits in psychotic disorders has been increasingly accepted (1). and the evidence for a link of cognitive deficits to everyday functioning in these disorders has become very strong (2). This evidence has led cognitive deficits to be prominent new targets for treatment development (3). Developing standard methods for measuring cognitive change has therefore become important (4). This presentation will consider whether cognitive and functional factors should now be included among the diagnostic criteria for psychotic disorders in ICD11. Pros and cons of this incorporation into diagnostic criteria will be discussed. One conception of cognitive deficits is that they are necessary core elements of certain psychotic disorders and should be placed among the basic criteria that lead to a diagnosis. An alternative conception is that the severity of cognitive deficits is a dimension within psychotic disorders that modifies the level of functional recovery that occurs. These alternatives have different implications for incorporation into diagnostic systems. The implications of the patterning of cognitive deficits across psychotic disorders will also be considered in relationship to possible inclusion of these factors as diagnostic criteria or dimensional modifiers within diagnoses.

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SYMPOSIUM 29
NONPHARMACOLOGICAL TREATMENT ALTERNATIVES IN THE ACUTE MEDICAL SETTING FOR PSYCHOSOMATIC MEDICINE PRACTITIONERS

Chair: 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 and appreciate the principles, formulation, efficacy data and specific techniques of Cognitive Behavioral Therapy and Motivational Interviewing; 2) Learn and appreciate the rationale, principle, and techniques of brief bedside psychotherapy in the medically ill; and 3) Understand the components of hypnosis, how to measure its presence, and review the literature supporting its usefulness in the medical setting.

OVERALL SUMMARY:
This symposium will cover the basics of four nonpharmacological treatment interventions to be used in the acute medical setting: CBT, Brief Psychotherapy, Motivational Interviewing, and Hypnosis. The presenters will focus on the basic principles associated with, the possible applications, and available evidencebased uses for each treatment intervention. The principles of Cognitive Behavioral Therapy in acutely ill medical patients will be outlined with an emphasis on how a case is formulated from the cognitive therapy perspective. Efficacy data for Cognitive Therapy in Psychosomatic Medicine will be reviewed by Dr Levin. Strategies such as problem solving, behavioral activation and relaxation/ breathing exercises will also be considered. Specific techniques will be discussed from a practical perspective illustrated by case vignettes. Brief

psychotherapy at the bedside is not only possible, but invaluable in some hospitalized medicalsurgical patients. Despite limited time and privacy, many patients respond quickly and preferably to psychotherapeutic techniques delivered by psychosomatic medicine practitioners. In his talk Dr Lolak will review the general principle and practical steps of how to deliver such therapy efficiently and effectively. Motivational interviewing (MI) is an interviewing style that can improve empathic understanding between the clinician and patient, fostering a collaborative approach to the medical decisionmaking process and facilitating change in harmful behaviors. Dr Suzuki will introduce the basic principles of MI, briefly review the literature, and describe how this approach can be adapted as a brief intervention for consultants in the general hospital setting, with a special emphasis on substance use disorders. Hypnosis, the oldest Western form of psychotherapy, is also one of the newest means of helping people cope with the rigors of high tech medicine. Hypnosis utilizes a patient's ability to focus attention to help with many medically related problems such as anxiety management, pain control, habit control, somatic conditions (e.g., warts, pain), and psychosomatic disorders (e.g., asthma, psoriasis, conversion disorders). Dr Maldonado will cover the basis of the mechanisms of hypnosis, how to measure hypnotizability, and the evidence for its usefulness in the acute medical setting.

S29-1.
COGNITIVE THERAPY FOR PATIENTS IN ACUTE MEDICAL SETTINGS

Tomer Levin, M.B., B.S., 641 Lexington Ave, 7th Floor, New York City, NY 10022

SUMMARY:
The principles of Cognitive Behavioral Therapy in acutely ill medical patients will be outlined with an emphasis on how a case is formulated from the cognitive therapy perspective. Efficacy data for Cognitive Therapy in PM will be reviewed by Dr Levin. Strategies such as problem solving, behavioral activation and relaxation/breathing exercises will also be considered. Specific techniques will be discussed from a practical perspective illustrated by case vignettes.

S29-2.
Brief Bedside Psychotherapy in the Medically Ill: Practical Steps and Suggestions

Sermsak Lolak, M.D., 401 Quarry Rd, Stanford, CA 94305

SUMMARY:
Brief bedside psychotherapy in the acute medical setting is not only possible, but invaluable in some hospitalized medicalsurgical patients. Despite limited time and privacy, patients respond quickly and preferably to psychotherapeutic techniques delivered by psychosomatic medicine practitioners. In his talk, Dr Lolak will review the general principle and practical steps and suggestions of how to deliver such therapy efficiently and effectively, using a variety of techniques tailored to the acute medical environment.

S29-2.
BRIEF BEDSIDE PSYCHOTHERAPY IN THE MEDICALLY ILL: PRACTICAL STEPS AND SUGGESTIONS

Sermsak Lolak, M.D., 401 Quarry Rd, Stanford, CA 94305

SUMMARY:
Brief bedside psychotherapy in the acute medical setting is not only possible, but invaluable in some hospitalized medicalsurgical patients. Despite limited time and privacy, patients respond quickly and preferably to psychotherapeutic techniques delivered by psychosomatic medicine practitioners. In his talk, Dr Lolak will review the general principle and practical steps and suggestions of how to deliver such therapy efficiently and effectively, using a variety of techniques tailored to the acute medical environment.

S29-3.
MOTIVATIONAL INTERVIEWING IN THE ACUTE MEDICAL SETTING

Joji Suzuki, M.D., 75 Francis St, Boston, MA 2115

SUMMARY:
Abstract: Motivational interviewing (MI) is an interviewing style that can improve empathic understanding between the clinician and patient, fostering a collaborative approach to the medical

decisionmaking process and facilitating change in harmful behaviors. Dr Suzuki will introduce the basic principles of MI, briefly review the literature, and describe how this approach can be adapted as a brief intervention for consultants in the general hospital setting, with a special emphasis on substance use disorders.

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SYMPOSIUM 30
A BIOPSYCHOSOCIAL EXPLORATION OF AMERICAN RACISM AND AMERICAN HEALTH AND MENTAL HEALTH DISPARITIES

APA Council on Minority Mental Health & Health Disparities

Chair: Donald H Williams, M.D., 650 Lexington Ave, East Lansing, MI 48823,
Co-Chair: Sandra C Walker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify relationships between American "racialized science" and AfricanAmerican and EuropeanAmerican health disparities; 2) Recognize the biological, psychological, and social mechanisms that maintain current racist beliefs and behaviors; and 3) Explore strategies to address racist behaviors and health disparities in their practice settings.

OVERALL SUMMARY:

This symposium examines the effects of race and racialized science on the health and mental health disparities of African Americans. The first paper is a historical review of AfricanAmerican health disparities utilizing the conceptual framework of Byrd and Clayton's "slave health deficits". The paper will then examine how racism has created the psychological and social rationales for the various forms of American enslavement of its African populations. These forms include chattel slavery, legal segregation, and the current mass incarceration. Dr. Chester Pierce's writings on racism, sexism,

torture, terrorism and disaster as well as "mundane hostile environments" will be discussed. The second paper presents current studies of human genotypic and phenotypic adaptations to their geographic environments. These studies establish that "race" is a social construct to maintain the "Other" and not a biological construct. The third paper reviews neurocognitive mechanisms that maintain racism. The mechanisms of "stereotype threat", "microaggressions", and "implicit associations" will be highlighted. The final paper examines racial stereotypes that maintain subtle prejudice. This paper then offers strategies to address racism in healthcare and other institutional settings.

S30-1.

A HISTORY OF THE RACE AND HEALTH DISPARITIES: A BIOPSYCHOSOCIAL EXPLORATION OF AMERICAN RACISM IN AMERICAN HEALTH AND MENTAL HEALTH DISPARITIES

Donald Williams, M.D., 650 Lexington Ave, East Lansing, MI 48823

SUMMARY:
The presenter will briefly describe the history of slavery in European nations in the Middle Ages. The English enslavement of the Irish in the 15th century will be particularly noted as this enslavement was the model for the enslavement of Africans as chattel slavery in the American colonies. The ideology of race evolved to justify the chattel enslavement of Africans. Pearce argues that racism and sexism embody submissiondominance relationships. Its victims are stressed by unrelenting oppression and discrimination. He characterizes the oppressive agency of sexism or racism, individual or situational (mundane hostile environment) attempt to control the victims' space, time, energy and motion (STEM). The more successful the impression the more likely the victim will have a shattered self image a theory or two in the adaptation, and a hatred and dissatisfaction with their own group and self. The victor will focus on what cannot be done rather than what can be done to improve his lot. The victim will come to accept his situation with resignation and hopelessness. Byrd and Clayton argue that African slaves entered North America and European colonies with health deficits. These deficits were caused by epidemiologic exposures to indigenous African diseases (spread during the mass imprisonment of captured Africans prior to their transportation to America), the Middle Passage, and then confronted by diseases foreign to the African continent upon the arrival in the colonies. The authors maintain White physicians came to accept poor health status and poor health outcomes as the "norm" for Blacks. This "norm" contributes to the patterns of nihilism and inattention by today's medical systems to its race and class problems. This paper will then examine the institutions of chattel slavery, legal segregation, and the current mass incarceration of criminalized drug addicts and chronically mentally ill AfricanAmericans utilizing the above concepts.

S30-2.

HUMAN GENOTYPIC AND PHENOTYPIC ADAPTATIONS TO THEIR ENVIRONMENTS

Jimmie Harris, D.O., 4236, Okemos, MI 48864

SUMMARY:
This paper will present a review of current anthropological and genetic studies on humans worldwide. These studies provide an alternative model to "scientific" racism. This paper will first briefly summarize the findings of Jared Diamond on human evolution and the genetic/environmental determinants of human intelligence. This paper will then discuss the current paleoanthropological and genetic findings on the evolution of the human skin and skin color. This paper will then discuss the Tishkoff et al. report on the genetic structure of current Africans and AfricanAmericans. The writer and panel will then discuss the implications of these findings on the racist beliefs of the biologic inferiority of AfricanAmericans.

S30-3.

STRATEGIES FOR MINIMIZING RACIST BELIEFS AND PRACTICES IN HEALTHCARE SETTINGS: A BIOPSYCHOSOCIAL EXPLORATION OF AMERICAN RACISM AND AMERICAN HEALTH DISPARITIES

Lee June, Ph.D., 153 Student Services Building, East Lansing, MI 48824

SUMMARY:
This paper will examine strategies for minimizing racist beliefs and practices in health care settings. After reviewing the current demographics relative to the race and gender of the population of health care providers, strategies regarding both the beliefs and practices that are still prevalent which covertly and overtly help to maintain the status quo will be addressed. Too often when racist beliefs and practices are examined, they are done at the individual level. While the individual level is crucial and will be addressed, a primary focus of this paper will be on the group and systems/organizational level. Hence, an examination will occur relative to how the organizations/systems develop policies, practices and procedures which contribute to maintaining racist beliefs and practices and what things can be done to minimize these outcomes. This paper will also draw upon the literature relative to community psychiatry and psychology and well as the concept of "Blaming the Victim" as articulated years ago by William Ryan. Additionally, the roles, responsibilities and opportunities provided to administrators of healthcare systems for minimizing racist beliefs and practices will be addressed.

S30-4.
NEUROCOGNITIVE MECHANISMS MAINTAINING RACISM

DeColius Johnson, Ph.D., 207 Student Services Bldg., East Lansing, MI 488241113

SUMMARY:
This paper will acquaint the audience with specific constructs for categorizing current forms of benign racism and sexism. This writer believes that such categorizations will stimulate the victims of these ideologies develop more effective counterresponses. The Presenter will give a detailed explanation of the constructs "stereotype threat", and "microaggressions". The panel and audience members will be encouraged to give personal examples that demonstrate these constructs. The Presenter will review prejudicial beliefs as described in Anderson's book Benign Bigotry. Further audience discussion of these topics will take place at the end of the formal presentations.

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SYMPOSIUM 31
THE PACIFIC PSYCHOLOGICAL HEALTH TASK FORCE: BUILDING PARTNERSHIPS TO ENHANCE PSYCHOLOGICAL HEALTHCARE IN THE PACIFIC REGION

Chair: *Carroll J. Diebold, M.D., 1 Jarrett White Road, Tripler Army Medical Center, HI 968595000*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the overall structure of Military Psychological Healthcare service delivery system; 2) Describe the geographical, cultural, and political challenges in establishment and maintenance of a psychological healthcare delivery system throughout the Pacific Region for TRICARE beneficiaries; and 3) Illustrate the current initiatives to enhance screening and clinical care for TRICARE beneficiaries within the Pacific Region.

OVERALL SUMMARY:
The Pacific Region encompasses a vast area vital to the continued preservation of our Nation's security. This region has thousands of Active Duty Service Members, Reservists, National Guard, Veterans, and their dependents, many of whom are located in areas with limited healthcare infrastructure, to include psychological health services. In addition, many of these Service Members have deployed in support of combat operations in the Middle East. This symposium will provide an overview of the origin of the Pacific Psychological Health Task Force to include the unique challenges of behavioral healthcare delivery in the Pacific Region and then focus on initiatives of the Task Force during the past year. Established in June 2008, the Pacific Psychological Health Task Force actively strives to enhance psychological health service delivery for military beneficiaries throughout the Pacific Region via a collaborative effort to include assets from the Active Component Army, Navy, and Air Force; Veterans Administration; Army National Guard and Reserve; TRICARE Contractor; Hawaii Community Health Centers; and independent behavioral healthcare organizations. Over the past three years, such collaboration has produced enhanced behavioral health screening and clinical services to remote locations, especially through the utilization of telebehavioral health. The symposium will feature presenters who are the proponents of initiatives to enhance services such as telehealth for screening, assessment, and treatment of Service Members; telehealth services to family members in remote locations; School Mental Health Services on military installations; treatment programs available to Veterans; services offered by the managed care contractor; and continuity of treatment between the Active Component healthcare system, Veterans Administration, TRICARE contractor, and the private sector. The symposium will conclude with a panel discussion in addition to an audience question and answer session.

S31-1.
CREATION OF TREATMENT TEAM RELATIONSHIPS IN THE SOLDIER ASSISTANCE CENTER AND CHILD AND FAMILY ASSISTANCE CENTER FOR THE PACIFIC REGION

Matthew Cody, D.O., 95 1039 Akaluli St, Mililani, HI 96789

SUMMARY:
With two ongoing wars imposing stress upon the active duty military as well as the guard and reserve military, it was imperative to identify and create new psychological healthcare relationships and responsibilities within the pacific region due to the rapid increase in demand for care. Implementation of novel ideas and new organizational developments were utilized to create a system that could care for soldiers and their families from all over the pacific region. As demand still continues to rise, this model continues to evolve and progress to meet the ever increasing demand to provide the very best validated medical care models in a military setting.

S31-2.
EVOLUTION OF TELEBEHAVIORAL HEALTH IN THE DEPARTMENT OF DEFENSE AND ITS IMPLENTATION IN THE PACIFIC AND ASIA

Raymond Folen, Ph.D., 1 Jarrett White Road, Tripler AMC, HI 96859

SUMMARY:
Tripler Army Medical Center is responsible for the health care of Uniformed Service Members and their Families in an area that covers 52% of the Earth's surface. This task makes telehealth, the ability to treat patients located thousands of miles away from the provider, a necessary option. In addition to significantly enhancing access to care, recent data suggests that, in some aspects, telehealth may facilitate treatment outcomes superior to that resulting from facetoface patientprovider interactions. This presentation will discuss current telebehavioral health practices in the DoD, recent telebehavioral health initiatives in the Pacific region, and program outcome data.

S31-3.
PTSD RESIDENTIAL RECOVERY PROGRAM (PRRP): A VA PROGRAM TREATING SEVERE, COMBATRELATED PTSD IN BOTH VETERANS AND ACTIVE DUTY SERVICE MEMBERS

Kenneth Hirsch, M.D., Ph.D., 459 Patterson Road, Honolulu, HI 96819

SUMMARY:
The PRRP is a 12bed, 9week residential treatment program for male patients suffering from severe, combatrelated PTSD. Over the past three fiscal years approximately 62% of patients have been active duty (including activated Reserve and National Guard) and 77% are OEF/OIF. Most patients have coexisting major depressive disorder and substance use disorder; treatment for coexisting conditions is provided. Consults for active duty members can be initiated by any DoD mental health provider in the Pacific basin via CHCS. The program is strongly evidencebased, with the core of treatment consisting of Cognitive Processing Therapy (CPT), Seeking Safety and both group and individual in vivo exposure. Nearly all treatment is groupbased, except for biofeedback and limited individual therapy. On a variable basis, EMDR or Prolonged Exposure therapies are provided as treatment adjuncts. Additional treatment components include medication, substance use, acupressure, yoga, exercise, relaxation training, understanding emotions, communication skills, anger management, spirituality, grief/loss, health maintenance/men's health, sexuality and PTSD, sleep hygiene… Family night, open to family members aged 14 and above, friends and Command are offered three times during each treatment cycle, and a spouse's group is offered weekly. Average PCLM score improvement is approximately 22%, though patient and family report and clinician observation indicate considerably greater functional improvement than suggested by test scores. Average improvement for those not facing disability boards is approximately 42%.

S31-4.
COMMON BEHAVIORAL HEALTH IM/IT PLATFORM

Brown Millard, M.D., 1 Jarrett White Road, TAMC, HI 96859

SUMMARY:
The Automated Behavioral Health Clinic (ABHC) is a prototype IM/IT system that has been developed over the last 5 years in the Army to help standardized initial evaluations, measure clinical outcomes and manage patients in a clinic. We are now moving to create a more robust IM/IT solution that synchronizes behavioral health (BH) screening throughout the deployment cycle with BH clinical care systems to enable one coherent IM/IT platform. This improved standardization of clinical business process for a military system will allow for improved quality of care for our Soldiers and improved execution of process improvement initiatives in our care system.

S31-5.
TELE-BEHAVIORAL HEALTH OUTREACH SERVICES TO REMOTELY LOCATED MILITARY YOUTH OF NATIONAL GUARD, RESERVES AND ACTIVE DUTY SERVICE MEMBERS OF HAWAII AND THE PACIFIC RIM

Stanley Whitsett, Ph.D., 1 Jarrett White Rd, Tripler Army Medical Center, HI 968595000

SUMMARY:
It is widely recognized that the increased Operations Tempo (OPTEMPO) associated with prolonged war and repeated deployments has placed new and extreme psychological pressures on Military Family

Members. There is a concomitant increase in Youth behavioral health (BH) needs associated with both the general stress of a wartime environment, and this increased OPTEMPO. Many Youth and Families are able to seek and obtain BH services from agencies and providers local to their homes, but others who live more remotely have difficulties in their efforts to access BH care. This presentation will identify the needs, challenges and solutions associated with a program designed to improve access to quality BH services for Youth of National Guard, Reserve, and Active Duty Service Members throughout regions of the Pacific Rim. These services have been built on a "community of practice" model, which integrates providers from the program (including through telehealth connections), with other existing Federal, State and local agencies and services, to build synergy in caring for these clients. Through this collaborative effort, the program has been able to dramatically improve access to care, to enhance service delivery to those in need, and to offer very high quality clinical BH services with significantly positive outcomes.

S31-6.

DEVELOPMENT OF SCHOOL BASED BEHAVIORAL HEALTH SERVICES ON MILITARY SITES

Albert Saito, M.D., 1 Jarrett White Rd., Honolulu, HI 96859

SUMMARY:
School based behavioral health services represents a collaboration of the Child and Adolescent Psychiatry Service from Tripler Army Medical Center and the Hawaii State Department of Education. The goals include providing community based services to enhance accessibility and reduce stigma of behavioral health services for children and parents. The services include the entire spectrum of care including behavioral health promotion to evidence based direct clinical services. Clinicians in the program need to be sensitive to the unique challenges families face with the prolonged and multiple deployments. They must also work to support the teaching faculty, counselors and school administrators who face pressures as they strive to meet academic goals for the children they serve.

S31-7.

THE DOD MANAGED CARE SUPPORT CONTRACTOR CONTINUITY OF CARE WITH THE CIVILIAN NETWORK PROVIDERS, AND ENHANCING ACCESS TO TELE-BEHAVIORAL HEALTH

Karl Kiyokawa, B.A., 3375 Koapaka St., C310, Honolulu, HI 96819

SUMMARY:
TriWest Healthcare Alliance (TriWest) is the Department of Defense's Managed Care Support Contractor (MCSC) who supports the TRICARE Program (military's health plan) in the 21State West Region. As the MCSC, TriWest works collaboratively with Military Treatment Facilities (MTF) to optimize MTF behavioral healthcare, coordinate referrals to civilian providers, and enhance access via telebehavioral health. This segment will help demonstrate how TriWest not only works closely with MTFs, but also with military line commands, Wounded Warriors, and the National Guard and Reserve. Targeted and sustained approaches bring the right information to the right people at the right time.

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SYMPOSIUM 32
INTERNET, VIDEO GAMES, AND MENTAL HEALTH: UPDATE ON THE EVIDENCE

Chair: *Erick L Messias, M.D., Ph.D., University of Arkansas for Medical Sciences, Little Rock, AR 72205*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the associations between internet use and mental health outcomes in teenagers; 2) Identify risk factors associated with video game use and mental disorder in adolescents;

3) Assess the impact of different forms of computer use in mental health; and 4) Assess computer, internet and video game use in patients.

OVERALL SUMMARY:
This symposium will bring together experts in the field of internet and video game misuse and its consequences to mental health. The current bombardment of media into the lives of teens – from Facebook to Halo – has significant consequences and mental health implications. These media may become a main source of social interaction and practicing psychiatrists should be aware of the current stateofart knowledge about the associations between internet and video game use and mental health outcomes. This symposium will include the participating of leading experts in the field, along with an epidemiologist to help translate populationbased findings into practical implications and will also include the participation of a child psychiatrist expert to give examples of real life interactions between clinicians and this new generation of patients. One recent example includes the use of social network sites for cyberbullying as well as for means to communicate suicidal intent. This symposium will try to bridge epidemiological findings and clinical observations.

S32-1.
THE EFFECT OF PATHOLOGICAL USE OF THE INTERNET ON ADOLESCENT MENTAL HEALTH: A PROSPECTIVE STUDY

Lam Lawrence, Ph.D., 160 Oxford Street Darlinghurst, Sydney, NSW 2010 Australia

SUMMARY:
Objective: This study aimed to examine the effect of pathological use of the Internet on the mental health, including anxiety and depression, of adolescents in China. It is hypothesised that pathological use of the Internet is detrimental to adolescents' mental health. Design: A prospective study with a randomly generated cohort from the population. Setting: High schools in a Guangzhou city, China. Participants: Adolescents aged between 1318 years. Main Exposure: Pathological use of the Internet was assessed using the Pathological use of the Internet Test (IAT). Outcome Measures: Depression and anxiety were assessed by the Zung Depression and Anxiety Scale. Results: After adjusting for potential confounding factors, the relative risk for depression was about two and a half times (IRR=2.5, 95%C.I.=1.34.3) for those who used the Internet pathologically when compared to those who did not exhibit the targeted pathological internet use behaviours. No significant relationship between pathological use of the Internet and anxiety at followup was observed. Conclusions: Results suggested that young people who are initially free of mental health problems but use the Internet pathologically could develop depression as a consequence. These results have direct implications on the prevention of mental illness among young people particularly in developing countries.

S32-2.
LONGITUDINAL STUDIES OF TWO POTENTIAL RISK FACTORS: PATHOLOGICAL GAMING AND VIOLENT GAME EFFECTS

Douglas Gentile, Ph.D., W112 Lagomarcino Hall, Ames, IA 50011

SUMMARY:
This presentation describes two threeyear longitudinal studies of children and adolescents in the United States and Singapore. 3034 Singaporean youth participated in study 1. Pathological videogaming was measured over three years, along with depression, social phobia, anxiety, social competence, impulsivity, home environment, school performance, and several other variables. Although several studies have demonstrated some construct validity for pathological video gaming, all have been at single points in time. Therefore, information on predictors and outcomes of pathological gaming is greatly needed. The prevalence of pathological gaming was similar to other countries (~9%). Greater amount of gaming, lower social competence, and impulsivity appeared to act as risk factors for becoming pathological gamers, whereas depression, anxiety, social phobias, and school performance appeared to act as outcomes of being a pathological gamer. 1422 American youth participated in Study 2. Violent gaming was measured over three years, along with normative beliefs about aggression, violent ideation, and aggressive behaviors, among several other variables. Greater exposure to violent video games predicted later aggressive behavior, which

was partially mediated by aggressive cognitions such as normative beliefs and fantasies about aggression. In summary, both the amount of gaming and the content of gaming appear to have unique effects. Total amount is related to school performance and the risk of dysfunction, whereas violent gaming is related specifically to increased aggressive cognitions and behaviors.

S32-3.

CLINICAL IMPLICATIONS OF EXCESSIVE DIGITAL GAMING IN CHILDREN AND ADOLESCENTS

Juan Luis CastroCordoba, M.D., 1501 Rahling Road, Little Rock, AR 72223

SUMMARY:
Video game playing and internet use are a prevalent activity among children and adolescents today (Marshall et al., 2006; Lenhart et al., 2007b). A study published by The Kaiser Family foundation (Rideout et al., 2005) concluded that 83% of American youths between 8 and 18 years old, have video game consoles at home, the average time they spend gaming was estimated to be 49 minutes a day. The same study concluded that 86% of youngsters have a computer at home, 35% have a computer in their room and the average time of internet use was estimated to be one hour and nine minutes for recreational activities (gaming, visiting websites, email, chats, and graphic programs). 38% of the hour and nine minutes was spent playing online video games. There is an extensive body of literature linking excessive digital gaming/internet to physical and mental health problems (Dorman, 1997) The present symposium pretends to give a general overview of the evidence regarding digital gaming and evidence based mental health outcomes. Furthermore we pretend to provide an insight into the clinical implications that these may have for children and adolescents.

REFERENCES:
1) Effect of Pathological Use of the Internet on Adolescent Mental Health: A Prospective Study. Lam LT, Peng ZW.Arch Pediatr Adolesc Med. 2010 Aug 2. [Epub ahead of print]
2) Pathological videogame use among youth ages 8 to 18: a national study. Gentile D. Psychol Sci. 2009 May;20(5):594602. Erratum in: Psychol Sci. 2009 Jun;20(6):785.

SYMPOSIUM 33
TRANSGENDER CARE ACROSS THE LIFE SPAN

Chair: Dan H Karasic, M.D., SFGH, 1001 Potrero Ave, Ste 7M, San Francisco, CA 94110

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Better assess and treat the adult patient presenting with gender dysphoria; 2) Understand approaches to care of gender variant children; 3) Understand issues in psychotherapy with transgender patients in late life; and 4) Work with family and/or partner of transitioning patients.

OVERALL SUMMARY:
Principles of transgender care are changing to match the widening array of presentations of transgender identity and expression in our patients. Gender identity and expression not only vary along a spectrum, but can vary over the life span. Issues in transgender care in early, middle and late life will be presented by a faculty of experts. Principles for working with the families of gender variant children and with the spouses and families of transgender adults will be discussed as well. Each presenter will discuss different aspects of life span issues in transgender care, sharing their expertise to improve competency in care for trans people by the clinicians attending the session. Dan Karasic, MD will discuss gender spectrum presentations across the life span. Diane Ehrensaft, PhD will discuss the diversity of the conceptions of gender expressed by young gender variant children, and model an approach to the care of these children and their families. Michele Angello, PhD will discuss the development of gender identity in gender variant children as they age into adolescence, and approaches to care for trans youth. Nathan Sharon, MD will discuss his own experiences in young adulthood, including transitioning femaletomale while in medical school, and his experiences as a trans man in psychiatry residency training. Randall Ehrbar, PsyD will discuss working with partners and families of transitioning adults. Lin Fraser, EdD will present issues in psychotherapy with older transgender clients. The presentation will be followed by an open discussion between the panelists and the audience on approaches to

providing optimal care for transgender patients.

S33-1.

MENTAL HEALTH CARE ACROSS THE LIFE SPAN AND THE GENDER SPECTRUM

Dan Karasic, M.D., SFGH, 1001 Potrero Ave, Ste 7M, San Francisco, CA 94110

SUMMARY:
Mental health care for transgender people is evolving to reflect changing conceptions of transgender identities. Once focused on transition within the gender binary of maletofemale and femaletomale, clinicians now recognize a broad spectrum of gender identities and of presenting issues related to gender dysphoria, and are adapting models of clinical decisionmaking and therapy. The expression of gender identity also varies across the life span. Approaches to mental health care for transgender patients across the life span that accommodate the gender spectrum will be discussed, using clinical vignettes and video clips.

S33-2.

PRIUSES, SMOOTHIES, AND TRANYSTRANSGENDER DEVELOPMENT IN ITS BEGINNINGS: THE EARLY CHILDHOOD YEARS

Diane Ehrensaft, Ph.D., 445 Bellevue Avenue Suite 302, Oakland, CA 94610

SUMMARY:
As the twentyfirst century unfolds, children at earlier and earlier ages are presenting as either gender nonconforming or transgender. To date, theories of gender development and methods of treatment for these children are both outmoded and harminducing, suppressing or prohibiting an unfolding healthy gender development and enforcing a false or externally imposed adaptive but inauthentic gender identity or expression. This paper critiques the traditional binary theories of gender development, as taught in psychiatry and other mental health training programs, and offers an alternative model of gender health and development predicated on the assumption that gender is not a binary construct but rather a complex threedimension web that weaves together nature, nurture, and culture. The alternative model relies on concepts adapted from D.W. Winnicott's theory of individual development and identity: True Self, False Self, and Individual Creativity. In the context of gender development, these concepts are translated to exemplify True Gender Self, False Gender Self, and Gender Creativity as the core functional components of gender development. A schematic categorization pattern of variations of childhood binary gender normsboy/girl, is articulated, one that removes the stigma of Gender Identity Disorder and replaces it with affirmation of a wide variation of childhood gender identities and expressions that fall under the umbrella of gender health rather than pathology. Clinical data from the author's case studies and other clinicians' case studies will be presented to demonstrate 1) the primacy of mental functioning and brain development over genitalia and secondary sexual characteristics in determining a child's gender identity; 2) the experience reported by parents that their gender nonconforming child just "comes to them" rather than being shaped by them; and 3) the unfolding development of the young transgender child and the socialization needs for that child.

S33-3.

VARIABLES TO SUCCESS FOR GENDERVARIANT CHILDREN AND ADOLESCENTS

Michele Angello, Ph.D., 987 Old Eagle School Rd, Suite 719, Wayne, PA 19087

SUMMARY:
Gendervariant children and youth experience unique challenges during transition. Everything from dealing with peers, parents, secondary sex characteristics, and typical issues of coming into adolescence become major impediments to development. It is imperative for healthcare professionals to take into account the relevant system variablesfamily, friends, school, spiritual connection, extracurricular activities, medical communitywith which a young person interacts. This paper will examine the clinician's role in helping the child and family members navigate their way through these systems by detailing two case studies including discussion of family dynamics that can arise when a young person identifies as gender nonconforming, transgender or transsexual
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S33-4.
A PATH TO METAMORPHOSIS: RECOUNTING THE JOURNEY FROM FEMALE TO MALEBODIED

Nathaniel Sharon, M.D., 107 Claremont Ave, South San Francisco, CA 940801619

SUMMARY:
Dr. Sharon is a transgender man, currently completing residency training in psychiatry at UCSF. He discusses past experiences surrounding his transition from female to malebodied during medical school. This includes a discussion around events leading up to the decision to transition, experiences with the health care system as a transgender patient and medical student, and how transitioning has influenced his outlook on how the medical community moves forward in treating patients with gender dysphoria.

S33-5.
PARTNERS AND FAMILIES OF TRANSGENDER PEOPLE

Randall Ehrbar, Psy.D., Center for Community, Room S440, 104 UCB, Boulder, CO 80309

SUMMARY:
This presentation focuses upon issues and concerns faced by partners and children of transgender people. Specifically, this presentation focuses on issues that arise when a person comes out in the context of an existing relationship and family. Partners of trans people may face a variety of challenges to their personal identity and their relationship. What does it mean to be someone partnered with a trans person? How do others see our relationship differently? Are we still sexually compatible? Is this relationship sustainable, and if not then what? Partners are also involved in negotiating the impact of a transition on the family including stigma management and finances. Additional issues arise when children are involved. How do we tell our children about their trans parent? How do we maintain a positive parentchild relationship? What do children call their trans parent? How do we help children deal with stigma associated with having a trans parent? Attendees will be introduced to these clinical issues through a review of the literature.

S33-6.
TRANSGENDER CARE ACROSS THE LIFE SPAN AGING AND THE TRANSGENDER PERSON

Lin Fraser, Ed.D., 2538 California St, San Francisco, CA 94115

SUMMARY:
The aging transgender person has consciously, and often at great cost, chosen his or her expression of identity, and may be able to reflect upon a life lived true to this identity. Obstacles in this path may include stigma, faulty mirroring, lack of competent healthcare, grief over what could have been, and unresolved earlier life issues (such as trust, identity and intimacy) due to the mind/body mismatch. These hindrances can complicate an already complex clinical picture. Moving from the general to the specific, this presentation will review the universal developmental tasks, challenges and rewards of aging, describe those unique to the transgender person and conclude with examples of how these concerns may be addressed in the consulting room. Clinical vignettes from the writer's 35+year practice include people she has seen on and off for years and thus take into consideration personal observations of their aging process.

REFERENCES:
1) Lev, A. I. (2004). Transgender emergence: Counseling gendervariant people and their families. Binghamton,NY: Haworth Press.

MONDAY, MAY 16, 2011
8:00 AM-11:00 AM

SYMPOSIUM 34
UPDATES ON PSYCHOLOGICAL IMPACTS OF THE WARS IN AFGHANISTAN AND IRAQ: BEST MODALITIES OF SCREENING AND TREATMENT

Chair: Elspeth C Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901
Co-Chair: Carroll J. Diebold, M.D.
Discussant: Sonja V Batten, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant

should be able to 1) Identify and treat service members and veterans experiencing the psychological effects of war, to include PTSD and TBI.

OVERALL SUMMARY:
This symposia will provide a range of presentations on the care of service members from the battlefield to the military treatment facilities to the VA. The initial focus will be on the acute symptoms of psychological reactions to war. Care at Walter Reed and Balboa Naval Hospital will be outlined. Follow up care in the VA system will be discussed. Pitfalls for the clinician will be emphasized, to include family issues, confusing diagnoses, and reluctance of the service member to engage in care. The Pacific Psychological Health Task Force was established in 2008 with the goal of enhancing access to psychological health services for Service Members and their Families in the Pacific Region, especially Reserve and National Guard Soldiers on the outer Hawaiian Islands, American Samoa, Guam, and Saipan. The Task Force is comprised of psychologincal health professionals from the Army, Navy, Air Force, and Veterans Administration; Pacific Regional Medical Command Psychological Health leadership; TRICARE contractor; US Army Reserves and Hawaii National Guard; psychological health advocacy organizations; federally funded community health centers; and telehealth subject matter experts. Discussion will focus on the enhancement of psychological health assessment, evaluation, and treatment services for Service Members, Veterans and their Families with emphasis on the utilization of telehealth in conjunction with traditional office based interventions.

S34-1.
MANAGING THE EFFECTS OF COMBAT TRAUMA: THE EVOLVING PRACTICE AT WALTER REED ARMY MEDICAL CENTER

John Bradley, M.D., 6900 Georgia Ave NW, Washington, DC 203070003

SUMMARY:
As the wars in Iraq and Afghanistan continue, increasing numbers of soldiers continue to need complex, comprehensive medical, surgical, and psychiatric care. As the premier tertiary referral center in military medicine, Walter Reed Army Medical Center (WRAMC) receives the vast majority of the medical and psychiatric casualties. Comprehensive evaluations of the injured patient and evidencebased interventions are essential in the treatment of trauma patients. Using a biopsychosocial approach in the evaluation and treatment of the trauma patient and his family provides a framework to explore vital issues such as mortality, grief and loss, anger, chronic pain, substance abuse, and suicide. This Discussion will focus on the universal experiences of returning combat veterans as well as the approach to the treatment of psychological casualties returning from a battle zone. Themes will include dimensions of traumatic loss and growth, risk factors for psychological wounds, survivor guilt, family dynamic issues, and how this informs the clinical support. Treatment approaches for the primary psychiatric casualties of wars; the anxious, depressed, suicidal, or psychotic patient as a result of battle will also be highlighted. The authors will also describe the toll that the long term effects of caring for some of the most complex combat trauma patients has had on the health care team and organization after 10 years, and discuss the efforts to mitigate the impact that this secondary stress has caused and improve overall wellness and resilience of clinical staff.

S34-2.
MANAGING THE EFFECTS OF COMBAT TRAUMA: THE EVOLVING PRACTICE AT WALTER REED ARMY MEDICAL CENTER

Scott Moran, M.D., 6900 Georgia Ave NW Bldg 6 Rm 2060, Washington, DC 203075000

SUMMARY:
As the wars in Iraq and Afghanistan continue, increasing numbers of soldiers continue to need complex, comprehensive medical, surgical, and psychiatric care. As the premier tertiary referral center in military medicine, Walter Reed Army Medical Center (WRAMC) receives the vast majority of the medical and psychiatric casualties. Comprehensive evaluations of the injured patient and evidencebased interventions are essential in the treatment of trauma patients. Using a biopsychosocial approach in the evaluation and treatment of the trauma patient and his family

provides a framework to explore vital issues such as mortality, grief and loss, anger, chronic pain, substance abuse, and suicide. This Discussion will focus on the universal experiences of returning combat veterans as well as the approach to the treatment of psychological casualties returning from a battle zone. Themes will include dimensions of traumatic loss and growth, risk factors for psychological wounds, survivor guilt, family dynamic issues, and how this informs the clinical support. Treatment approaches for the primary psychiatric casualties of wars; the anxious, depressed, suicidal, or psychotic patient as a result of battle will also be highlighted. The authors will also describe the toll that the long term effects of caring for some of the most complex combat trauma patients has had on the health care team and organization after 10 years, and discuss the efforts to mitigate the impact that this secondary stress has caused and improve overall wellness and resilience of clinical staff.

S34-4.

THE PACIFIC PSYCHOLOGICAL HEALTH TASK FORCE: ENHANCING TREATMENT THROUGH ESTABLISHMENT OF PARTNERSHIPS IN THE PACIFIC REGION

Carroll Diebold, M.D., 1 Jarrett White Road, Tripler Army Medical Center, HI 968595000

SUMMARY:
The Pacific Psychological Health Task Force was established in 2008 with the goal of enhancing access to psychological health services for Service Members and their Families in the Pacific Region, especially Reserve and National Guard Soldiers on the outer Hawaiian Islands, American Samoa, Guam, and Saipan. The Task Force is comprised of psychological health professionals from the Army, Navy, Air Force, and Veterans Administration; Pacific Regional Medical Command Psychological Health leadership; TRICARE contractor; US Army Reserves and Hawaii National Guard; psychological health advocacy organizations; federally funded community health centers; and telehealth subject matter experts. Discussion will focus on the enhancement of psychological health assessment, evaluation, and treatment services for Service Members, Veterans and their Families with emphasis on the utilization of telehealth in conjunction with traditional office based interventions.

S34-5.

PHARMACOTHERAPY FOR PTSD IN COMBAT VETERANS: CHALLENGES AND OPPORTUNITIES

David Benedek, M.D., 12294 Wake Forest Road, Clarksville, MD 21029

SUMMARY:
In response to increased concern over the mental health of U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine reviewed and summarized the evidence supporting treatment for PTSD in 2007. Their report concluded that existing evidence was sufficient only to establish the efficacy of exposurebased psychotherapies in the treatment of PTSD. However, the report included a dissenting opinion by one author about the strength of the evidence for pharmacotherapy (1). Recent studies bolster support for pharmacological intervention in many circumstances, but randomized controlled trials have indeed called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans (2). Emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (dcycloserine) but efficacy in combatexposed populations has not been established and studies of combined medication and pharmacotherapy for PTSD are lacking. Other recent studies suggest that in certain patient populations new pharmacological options, such as prazosin, may be more effective than other widely prescribed medications (e.g., selective serotonin reuptake inhibitors) indicated for PTSD. Increased understanding of the neuromolecular basis for the stress response points to the possibility that new agents with other mechanisms of action may be helpful but clinical trials are needed to demonstrate efficacy. While present pharmacologic options for management of combatrelated PTSD may be helpful, additional psychotherapeutic and pharmacologic approaches must be explored.

S34-6.

BUILDING DOD/VA/STATE AND COMMUNITY PARTNERSHIP IN SERVICE TO OEF/OIF VETERANS AND THEIR FAMILIES: MILITARY CULTURE AND COMMUNITY COMPETENCE

Harold Kudler, M.D., 605 Churchill Drive, Chapel Hill, NC 27517

SUMMARY:
Less than one percent of our nation's population has served in Operation Enduring Freedom in Afghanistan (OEF) or in Operation Iraqi Freedom (OIF) yet these deployments resonate within every American community and across current and future generations of Americans. Ideally, deployment mental health issues would be managed within the continuum of care offered by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) but a "silent majority" of combat veterans seek care outside of either system and most military family members are also receiving their care within the civilian community. The critical questions are: (1) whether civilian providers have the military cultural competence required to effectively identify, assess, and treat Service Members, Veterans and their family members for clinical and functional problems stemming from deployment stress and; (2) whether civilian providers have the necessary understanding of DoD and VA medical, benefits and support systems needed to appropriately refer to and collaborate with them. This presentation builds upon past experience and current best practices to define a public health response capable of enhancing community competence in deployment health within a nation at war.

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.

SYMPOSIUM 35
TEACHING WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT NEUROSCIENCE

U.S. National Institute of Mental Health

Chair: Mayada Akil, M.D., 10 Center Drive, 4N222, Bethesda, MD 208921381
Co-Chair: Thomas R. Insel, M.D.
Discussant: David A Lewis, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate the relevance of neuroscience to clinical psychiatry; 2) Identify large areas of neuroscience research of importance to clinical psychiatrists; 3) Identify specific neuroscience stories and how they can contribute to discovery and practice; 4) Learn about model neuroscience curricula in psychiatry training programs; 5) Learn about creative means of bringing neuroscience to psychiatrists in training.

OVERALL SUMMARY:
Although modern neuroscience has much to contribute to the understanding of psychiatric disorders and the practice of psychiatry, it is often not taught to psychiatrists in training in an effective manner. The problem does not seem to be a lack of interest in teaching neuroscience but rather the difficulty of identifying relevant content for clinicians and devising an effective and engaging way to teach it. In this symposium, we will start with an overview of the relationship between psychiatry and neuroscience presented by Dr. Thomas Insel, Director of the National Institute of Mental Health (NIMH). I will follow with a presentation on the NIMHsponsored initiative to identify areas of neuroscience most relevant to psychiatry and to design online teaching tools that can be used alone or as a part of a more extensive neuroscience curriculum. Next, Dr Amit Etkin from Stanford will describe a neuroscience course that he organized around the Research Domain Criteria project (RDoC). RDoC is a new way of defining psychopathology that identifies basic dimensions of functioning that cut across disorders (such as fear circuitry or working memory). In his presentation, Dr. David Ross from Yale will describe an exciting new approach to teaching neuroscience to residents by integrated it into the four year curriculum and combining it with clinical cases, phenomenological, psychodynamic and other perspectives. Next, Dr. James Hudziak from the University of Vermont will present his approach to teaching the genetics and developmental neurobiology of major mental illnesses of childhood via a teleconference series. The lectures can be viewed at multiple locations simultaneously and viewers can participate in real time. Last but not least, Dr. David Lewis the chair of psychiatry at the University of Pittsburgh will

lead the discussion. Dr. Lewis is a psychiatrist and a renowned neuroscientist and will bring his perspective and experience to the discussion.

S35-1.
ORGANIZING A NEUROSCIENCE COURSE AROUND THE RESEARCH DOMAIN CRITERIA PROJECT (RDOC)

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

SUMMARY:
Psychiatry has undergone several major revolutions with respect to the core concepts and frameworks driving our understanding of mental illnesses. Over the past decade, this has increasingly involved a neurobiological understanding of emotion, thought and behavior. Neuroscience research has delineated a set of neurobehavioral systems, underpinned by defined neural circuits, and described how deficits in these systems are associated with a range of psychiatric disorders. As these disorders can now be increasingly better understood as a set of partiallyoverlapping alterations in a set of neural circuits and not discrete "natural kinds", an idea recently brought together through the launch of the NIMH's Research Domain Criteria (RDoC) project, it becomes imperative to incorporate this new information and conceptual framework into the education of psychiatric residents. Doing so, however, encounters several challenges: 1) residents often have little background in neuroscience to draw upon, 2) mindbrain dualism (and at it's extreme, phobia of brainbased explanations) remains prevalent in psychiatry, 3) a perceived tension exists between biological formulations and humanistic or psychological ones, and 4) DSMbased diagnostic schemes are heavily emphasized throughout training, and may hamper development of the crossdiagnostic viewpoint captured by RDoC. In this talk I will discuss these challenges and how they can be addressed, from the context of my experience designing a PGY3 neuroscience course around RDoC ideas at Stanford. I will argue that while restructuring neuroscience teaching in this way is challenging, such an approach is necessary for ensuring that residents can keep up with stateoftheart science in psychiatry, embrace this "disruptive" revolution in our field, and are then better able to bring the new tools neuroscience is continually developing to the benefit of their patients.

S35-2.
TEACHING NEUROSCEINCE TO PSYCHIATRY RESIDENTS: WHAT TO TEACH AND HOW TO TEACH IT

Mayada Akil, M.D., 10 Center Drive, 4N222, Bethesda, MD 208921381

SUMMARY:
Neuroscience is the basic science of psychiatry. Recent advances in genetics, neuroimaging and optical imaging of neural circuits promise a better understanding of the biology of psychiatric disorders and better tools for diagnosis, prevention and treatment. However, it is a challenge for psychiatry training programs to find ways to integrate neuroscience advances into their curricula in a clinically relevant fashion. NIMH set out to identify specific areas of neuroscience of greatest relevance to psychiatry that can be integrated into the training of psychiatrists. NIMH sponsored two "Brain Camp" meetings to initiate multidirectional dialogue between neuroscientists, translational researchers and psychiatry residents involved in research to identify the most relevant and engaging areas of neuroscience. Focusing on these areas, we started developing online teaching modules accompanied with pedagogic tools. We identified six areas of neuroscience that are of most relevance to psychiatrists: Cognitive Neuroscience, Social Neuroscience, Developmental Neurobiology, Genetics and Genomics, Circuitry, and Rational Development of Novel Therapeutics. We started developing online modules centered on these areas. Each module includes a pretest, clinical case, a "story of discovery", posttest and teaching instructions. We held a meeting of partners representing organizations invested in the training of psychiatrists including the APA, AADPRT and others. The neuroscience areas identified were presented and the first online module was shown. Feedback and suggestions from partners were incorporated in future plans. Neuroscience literacy is an important competency for psychiatrists in training. We identified areas of relevance in neuroscience and started developing online modules to illustrate them. These are tools that can be used alone or as a part of a more extensive neuroscience curriculum in the

training of the psychiatrists of the future.

S35-3.
INTEGRATING NEUROSCIENCE IN THE TRAINING OF PSYCHIATRISTS: THE YALE EXPERIENCE

David Ross, M.D., Ph.D., 300 George St., Suite 901, New Haven, CT 06511

SUMMARY:
Current research in neuroscience is redefining how we conceptualize mental illness. For example, we are increasingly recognizing the role that disruptions of neural circuits play in various disease entities. As the 21st century unfolds, it is clear that integrative perspectives that incorporate neuroscience will have an expanding influence on how we understand psychiatric illness and how we approach patient care. Despite the importance and promise of neuroscience, several factors may make it difficult for residency programs to successfully integrate it into their curricula. Foremost, it is a daunting task to keep up to date with the everexpanding scope and complexity of modern neuroscience—let alone to select appropriate content and to recruit optimal instructors. Second, adding new material to a curriculum entails reconciling it with competing interests, including the many ACGME requirements. Since the primary role of residency programs is to train skilled clinicians, programs may be reluctant to prioritize neuroscience over topics with more immediate clinical relevance. Finally, residents may also struggle with the complexity and relevance of the material, making it particularly difficult to engage them in the learning process. In this talk we will present the integrated four year curriculum that we have designed to address these challenges. Our overall goals are that residents will: 1) appreciate the centrality of neuroscience to the future of psychiatry; 2) demonstrate an understanding of core concepts in neuroscience, including how complex interactions between environmental stressors and disruptions in neural circuitry may contribute to psychiatric disorders; and 3) be comfortable accessing and appraising current neuroscience literature. To optimally engage residents, the curriculum has been designed around principles of adult learning. Additionally, it is structured in a flexible and modular format that we hope may be exportable for use by other programs.

S35-4.
THE VERMONT NEUROSCIENCE LECTURE SERIES: THE USE OF TELEMEDICINE TO TEACH THE GENETICS AND DEVELOPMENTAL NEUROBIOLOGY OF PSYCHIATRIC DISORDERS

James Hudziak, M.D., 1 South Prospect Street, MS 446AR6, Burlington, VT 05401

SUMMARY:
The Institute of Medicine's Report: Research Training in Psychiatry Residency: Strategies for Reform made a strong case for the importance of training psychiatry residents in the principles of research including but not limited to neuroscience and genetics. These recommendations ultimately informed ACGME RRC training criteria as goals for competency based teaching and also embodied in the RRC requirement of 'Scholarship'. As part of the IOM review, it became evident that many psychiatry residency programs do not have the person power or expertise to teach many of the key basic and translational knowledge, skills and attitudes of modern neuroscience and genomics. The conundrum of requiring expert knowledge content be taught universally in the absence of content experts is a problem in all of medicine, but is particularly a problem in the areas of neuroscience and genomics education to psychiatry residents. The presenter will detail a pedagogical approach in which modern technology (telemedicine, podcasts, jpegs) are used to teach 'core' lessons of developmental neuroscience and genomics. It is proposed that such an approach is a reasonable and sensible substitution to the impossible goal of having content experts in every psychiatry residency program. The Vermont Telemedicine Lecture series on developmental neuroscience and genomics will be presented as such an example. We are in our 10th year of presenting a short introductory course on developmental neuroscience, neuroimaging, and genomics with specific emphasis on child psychiatry competencies. This course is delivered by teletechnology to training programs in the US and Canada. It is offered as an example that other content experts could mimic and modify in order to develop a real time library of competency based education in Neuroscience and Genetics for psychiatry trainees

regardless of whether they are training at an academic/research center of excellence.

SYMPOSIUM 36
THE SHRINKING PSYCHOTHERAPEUTIC PIPELINE: WHY HAS THE SPIGOT BEEN TURNED OFF?

U.S. National Institute on Drug Abuse

Chair: Margaret Grabb, Ph.D., 6001 Executive Blvd, Rockville, MD 20852
Co-Chair: Ivan D Montoya, M.D., M.P.H.
Discussant: Steven Paul, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the root causes for contraction of psychiatry research in the pharmaceutical industry; and 2) Identify the relative merits and weaknesses of both animal models and clinical trial designs used to predict the efficacy of compounds for the treatment of depression, schizophrenia, and Alzheimer's disease.

OVERALL SUMMARY:
Despite record expenditures by the pharmaceutical industry, the number of novel drugs approved to treat CNS disorders has shrunk to an all time low. Both the high failure rate in late stage clinical trials and the high costs associated with CNS drug development have caused several major pharmaceutical companies to abandon programs in psychiatric drug discovery and development. The premise of this symposium is to inform the audience about the root causes for the shrinking CNS pipeline, beyond the obvious "high failure rates, high costs". The speakers are charged with considering two segments of the drug development pipeline that have historically been considered essential to the successful development of a CNS therapeutic: the predictive validity of preclinical models and the design (and proper execution) of clinical trials. The panel will critically evaluate the relative strengths and weaknesses of these aspects of CNS drug development, and suggest possible alternatives to increase success rates. The panel will present three areas that have proven problematic for compounds acting through novel (i.e., nontraditional) mechanisms: depression (Drs. Lucki and Michelson), schizophrenia (Dr. Geyer), and Alzheimer's Disease (Dr. Greig). Irwin Lucki will discuss preclinical models of depression, describing new data suggesting that modeling geneticenvironmental interactions may increase their predictive validity; David Michelson will discuss failures in the development of antidepressants, despite preclinical evidence for efficacy. He will also review data from clinical trials that illustrate methodological flaws from traditional designs and suggest ways to address these. Mark Geyer will overview an innovative murine model that simulates the continuous performance test (CPT) used to evaluate sustained attention in schizophrenics and discuss how the data obtained from this model informs clinical trials using novel (nondopaminergic) therapeutic approaches. Nigel Grieg will overview data from therapeutic strategies that appear effective in animal models of Alzheimer's Disease and the "translational fidelity" of these data to both clinical trials and real world practice.

S36-1.
INCREASING THE VALIDITY OF ANIMAL MODELS OF DEPRESSION BY GENETIC ENVIRONMENT INTERACTIONS

Irwin Lucki, Ph.D., 125 South 31st Street, Rm. 2204, Philadelphia, PA 19104

SUMMARY:
Concerns have been raised about the validity of some of the rodent tests for depressive behavior that have been used historically to measure the effects of antidepressant drugs. Behavioral tests for antidepressant activity have evolved from measuring drug responses in unperturbed "normal" animals to include genetic and environmental models of stress vulnerability. Genetic background, exposure to stress and chronic drug treatment are major factors in determining the clinical response to antidepressant drugs. The development of newer designs of rodent models for drug discovery are based on genetic stress vulnerability or resilience, the inclusion of exposure to chronic stress or other medical risk factors for depression and evaluate the effects of chronic drug treatments. An overview, and specific examples from new research, will be presented on the use of specific rodent strains to model stress vulnerability or resilience and the restorative effects of chronic antidepressant drug treatment.

S36-2.

NEW DRUGS TO NO DRUGS: ANTIDEPRESSANTS AND DRUG DISCOVERY/DEVELOPMENT

David Michelson, M.D., 351 N. Sumneytown Pike, North Wales, PA 19454

SUMMARY:
New, nonmonoamine candidate mechanisms to treat depression have generally disappointed hopes they could become therapeutics, even when effects in preclinical models have been demonstrated or initial clinical trials have been encouraging. As a result, and despite continuing and considerable unmet medical need, within the pharmaceutical industry skepticism about the likelihood that new programs will be successful has grown, scrutiny of the evidence that supports going forward with new programs has risen, and willingness to undertake new drug discovery and development efforts for depressive illness has waned. Without an understanding of why past efforts have failed and how the probability of success can be improved goin forward, the situation is unlikely to improve. In this presentation, with the help of a case example from the NK1 antagonist experience, we will review the issues that have driven the retreat from new antidepressant drug discovery and development within industry, and consider what would constitute convincing and sufficient evidence to take a new candidate antidepressant forward.

S36-3.
CROSSSPECIES TESTS FOR COGNITION ENHANCEMENT IN SCHIZOPHRENIA

Mark Geyer, Ph.D., 9500 Gilman Dr., La Jolla, CA 920930804

SUMMARY:
The NIMHfunded MATRICS Program (Measurement and Treatment Research to Improve Cognition in Schizophrenia) developed a broad consensus regarding the cognitive impairments in schizophrenia and how they might best be assessed and treated. There is an urgent need for improved translational tools to facilitate preclinical drug discovery and associated clinical proof of concept studies relevant to developing new treatments for cognition in schizophrenia. This presentation will focus on how preclinical scientists can develop and refine animal tests to identify novel procognitive agents for use in schizophrenia patients. For example, attention/vigilance is commonly assessed in humans using the continuous performance test (CPT), which requires a response to signal events and an inhibition of response to nonsignal events. Signal detection theory (SDT) is used to evaluate performance in the CPT. A recently developed rodent 5choice (5C)CPT requires both responses to target stimuli and the inhibition of responses to other stimuli, thereby enabling the use of SDT in assessing vigilance. Initial validation of the 5CCPT as a test of vigilance in mice was examined by comparisons of different strains of mice, studies of dopamine and acetylcholine receptor mutant mice, and tests of pharmacological challenges such as nicotine. The 5CCPT enabled the: a) use of SDT to assess vigilance; b) identification of a vigilance decrement over time; c) differentiation of impulsivity in response to nontarget stimuli (false alarms) and motor impulsivity (premature responses); and d) identification of nicotineinduced improvements in vigilance in normal animals. These effects are consistent with human studies using the CPT. These studies suggest that the 5CCPT enables vigilance testing in mice and is therefore available for use in efforts to develop and assess procognitive compounds having efficacy that may translate from rodent to human CPT testing.

S36-4.
ALZHEIMER'S DISEASE CLINICAL TRIAL FAILURES: INEFFECTIVE DRUGS OR FLAWED CLINICAL TRIALS?

Nigel Greig, Ph.D., 251 Bayview Blvd, BRC Room 05C220, Baltimore, MD 21224

SUMMARY:
The recent phase 3 clinical trial (CT) failures of Semagacestat (Eli Lilly), Dimebon (Pfizer/ Medivation) and Tarenflurbil (Myriad) extend the drought of unsuccessful new drug developments for Alzheimer's disease (AD). Based on two recent reviews of AD drug developments being able to identify over 100 [Becker & Greig, 2008] and 172 [Lindner et al., 2008] failed trials we estimate over 200 currently with a success rate in AD drug developments of ~3%. In recent studies we described how methodological (Type II) errors explained the failures of some recent AD CTs. Authors agree that preclinical and clinical investigators give

too little attention to error risks able to account for later clinical failures as we have documented for tarenflurbil, metrifonate, and phenserine for example [Becker & Greig 2010]. Out of this work we have demonstrated a potential source for these high error risk rates in clinical trial: the failure of neuropsychiatric drug developments to comply with core or fundamental scientific practices and the implications for vulnerabilities to failure. In this presentation we will discuss the importance to success in neuropsychiatric drug development of mechanistic hypotheses as a core organizing and orienting concept essential to the orderly development of drug related neuroscience and the reorientation of clinical trial aims away from unitary concepts of testing efficacy of a drug into biphasic steps for fully characterizing the optimal or required drugdrug target conditions to predict clinical efficacy and then confirmation of chosen drugdrug target conditions in a Phase III clinical trial. Why will numbers of AD trials some day shrink? We worry that they will for the same reasons that other neuropsychiatric drug developments have decreased in numbers. Without stronger scientific structure the risks are simply uncontrollable!

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SYMPOSIUM 37
IS WHOLE PERSON PSYCHIATRY POSSIBLE?

Chair: 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 the meanings of whole person care in psychiatry; 2) Recognize the practical relevance of research on healthy human functioning; and 3) Better incorporate patients' values and spirituality into evidencebased treatment of complex clinical conditions.

OVERALL SUMMARY:

Both scientific and economic forces increasingly shift psychiatric treatment away from the traditional ideal of caring for the patient as a whole person. These developments raise questions about the goals of contemporary psychiatry, the nature and importance of whole person care, and the feasibility of achieving it. Participants in this session will explore potential answers to such questions derived from several sources: (1) comparison of the history of psychiatry and the evolution of palliative medicine; (2) research on what constitutes healthy human functioning, as an antidote to psychiatry's current emphasis on pathology; (3) incorporation of the patient's values into the treatment, as an undeveloped component of evidence based medicine; (4) data on national competencies in spirituality and health; and (5) the comprehensive treatment of patients with complex problems such as chronic fatigue syndrome and trauma.

S37-1.

WHOLE PERSON CARE IN PSYCHIATRY AND IN PALLIATIVE MEDICINE

John Peteet, M.D., 75 Francis Street, Boston, MA 02115

SUMMARY:

After considering potential meanings of whole person care, this presentation will compare its history within psychiatry and palliative medicine. Psychoanalysis, neuroscience and social psychiatry all contributed to the embrace during the last half century by psychiatry of George Engle's biopsychosocial model. However, this model has had more heuristic than practical value in guiding clinical care, and psychiatry remains subject to both internal strains and external pressures. During the same period, following Cicely Saunders' focus on "total pain", which she described as "physical, spiritual, psychological and social pain that must be treated", the specialty of Palliative Medicine has become an important force within mainstream medicine. The similarities and differences between these specialties shed light on what they offer to each other, and on the challenges of attempting to provide whole person care.

S37-2.

CLINICAL IMPLICATIONS OF RESEARCH ON HEALTHY PERSONALITY FUNCTIONING

C. Robert Cloninger, M.D., 660 South Euclid, St. Louis, MO 63110

SUMMARY:
Research on personality in both the general population and in psychiatric patients have identified the personality traits that are characteristic of health and happiness. As proposed by the *DSM-5* workgroup on personality, healthy people are both selfdirected and cooperative. In addition, health depends on the interaction of these traits with other aspects of personality, including vulnerability to anxiety, anger, and loneliness, and with the character trait of selftranscendence. These interactions determine a person's health including physical, emotional, social, intellectual, and spiritual wellbeing. Individual traits are not adequate to predict health however in either crosssectional or longitudinal studies. It is essential for clinicians to consider profiles of traits in a biopsychosocal context in order to understand mental health status. These findings will be described in relation to a holistic personcentered approach to assessment and treatment planning.

S37-3.
PATIENT PREFERENCES AND VALUES: THE CONNECTING THREAD BETWEEN EVIDENCEBASED MEDICINE AND CULTURAL COMPETENCE

Francis Lu, M.D., 2230 Stockton Blvd., Sacramento, CA 95817

SUMMARY:
This presentation will examine the importance of patient preferences and values in connecting evidencebased medicine and cultural competence. While the concept of patient preferences and values is often included in the definition of evidencebased medicine, the concept is often neglected or underutilized in research and practice. When it is included, it is often seen as an "add on" rather than an integral part of research and practice. Yet, emerging studies by Margarita Alegria and others are beginning to demonstrate the critical importance of operationalizing this concept for research and practice that lead to better patient outcomes. Secondly, understanding and responding to patient preferences and values is a critical aspect of cultural competence, both at the clinical encounter level as well as at the systems level. For example at the clinical encounter level, patient preferences and values can be seen first in section B. of the *DSM-IV* Outline for Cultural Formulation, where the clinician is asked to understand the cultural expressions and explanations of illness as well as the treatment pathway preferences seen historically and in the present, and then in section E. where the clinician is asked to incorporate patient preferences and values in the differential diagnosis and treatment plan. The *DSM-IV* Outline for Cultural Formulation was incorporated in the APA Practice Guideline for the Psychiatric Evaluation of Adults, Second Edition (2006). Patient preferences and values will be illustrated at the systems level in reviewing the DHHS Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) standards for cultural competence for health care organizations. Finally, the presentation will conclude with a discussion about how patient preferences and values are increasingly important for practice guidelines both for the process of development as well as content within APA and other disciplines.

S37-4.
SPIRITUALITY AND HEALTH: GUIDELINES FOR CLINICAL CARE AND CURRICULUM DEVELOPMENT

Christina Puchalski, M.D., 2300 K. St NW Suite 313, Washington, DC 20037

SUMMARY:
Spirituality is an essential element of patient care. Numerous studies have demonstrated that spiritual and/or religious beliefs can impact healthcare outcomes for patients including recovery from depression, coping with anxiety and can impact quality of life. Studies as well as anecdotal data have shown that spiritual beliefs and practices can also help healthcare professionals cope with the stresses of daily clinical practice. Over the last fifteen years there has been significant development in curricula in spirituality and health for medical school and residency programs in primary care and psychiatry led by the George Washington Institute for Spirituality and Health (GWish). Currently over 75% of medical schools have required courses in spirituality and health. In psychiatry, part of the ACGME requirements is training in spirituality as part of the residency programs. As a result of this work spirituality and health is now a recognized field of medicine. In 2009, GWish led

a national consensus conference of leading medical educators in the development of a national set of competencies in spirituality and health education for physicians. These competencies are currently being piloting in a number of medical schools.
IN 2009, GWish, in partnership with the City of Hope, convened experts in spirituality and palliative care, to develop an innovative implementation model in interprofessional spiritual care as well as recommendations for clinicians in implementing spiritual care programs. This model is premised on the principle that all clinicians have the obligation to attend to all dimensions of a patient's suffering, including the spiritual and existential. The model outlines ways of assessment of spiritual distress as well as developing treatment plans and highlights the role of chaplains in providing spiritual care.
This work has significantly informed the content of curriula in this area.

S37-5.
COMPREHENSIVE TREATMENT OF COMPLEX PATIENTS: THE PSYCHIATRIST'S ROLE

Nadine Nyhus, M.D., M.A., 25 Hyland Road, Guelph, Ontario, Canada, N1E 1T2

SUMMARY:
Chronic fatigue syndrome is recognized to be a disorder with multifactorial causation. Thus, a comprehensive treatment approach is recommended. This presentation will consider the medical, psychodynamic and spiritual context of one person's experience of chronic fatigue syndrome, and specifically how a background of trauma and disempowerment played a role in the precipitation and evolution of her symptomatology. Then it will explore the impact of the multidimensional treatment of that trauma on the chronic fatigue symptoms.
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SYMPOSIUM 38
INTEGRATING COUPLES AND FAMILY TREATMENT INTO PATIENT CARE

Chair: Alison M. Heru, M.D., 1400 Jackson Street, Denver, CO 80206
Co-Chair: Ira Glick, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should: 1) Have knowledge of the evidence for the efficacy of integrated treatment; 2) Know how to deliver integrated care; and 3) Understand which family and couples interventions are appropriate for specific disorders

OVERALL SUMMARY:
This symposium outlines how to include the family in the assessment and treatment of a wide range of psychiatric illnesses. An integrated approach to patient care means completing a comprehensive assessment of the patient and their family environment. Session 1. A comprehensive assessment is central to developing a formulation to guide treatment. A thorough assessment can be

the treatment. The assessment process is outlined, with an emphasis on developing an understanding of what aspects of family functioning are disrupted with particular psychiatric illnesses. Excerpts from a DVD of a family assessment may 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 are discussed. The family is then involved in a clinical decisionmaking process that engages the family in a discussion of treatment options. A Heru MD. Session 2. Different models of family and couples therapy are outlined. The evidencebase for family interventions in schizophrenia, bipolar disorder, major depression and other illnesses are discussed. Case examples of how to provide integrated care are given. The overarching objective of this session is to provide the evidence base for working with families and to discuss couples/ family techniques for the prescribing clinician in a variety of settings, i.e. inpatient, outpatient and for specific disorders. I. Glick MD The evidencebase for family interventions in schizophrenia, bipolar disorder, major depression and other illnesses are discussed. Case examples illustrate how to provide integrated care for specific diagnoses and illness stage. Specific couples/family techniques are described in a variety of settings, i.e. inpatient, outpatient and for specific disorders. In addition, this session reviews the evidencebase for combined and integrated care, discusses which treatments to choose and how to sequence treatments, and how to determine who carries out the different treatments: pharmacotherapy, individual and family therapies. The session addresses issues such as confidentiality and boundaries when working with an individual and their family.

S38-1.

This Session Teaches Skills to Incorporate a Family Assessment Into a Comprehensive Biopsychosocial Assessment

Alison Heru, M.D., 1400 Jackson Street, Denver, CO 80206

SUMMARY:
Steps of sharing a biopsychosocial assessment with the family are: establish relationship with patient and family, assess and overcome barriers to engagement, use empathic engagement to mobilize the family as allies, discuss meaning of diagnosis, discuss how factors (e.g., medical comorbidity, genetic vulnerability, personality, family, and cultural factors) interact, identify family's typical ways of handling illness and their meaning of illness, correct inaccurate explanatory models of illness, normalize emotional reactions to diagnosis of psychiatric illness, lay out treatment options, explaining rationale and merits for each option and reach agreement about treatment. Case examples illustrate this process. This session uses the McMaster Model of family functioning and the Problem Centered Systems Therapy of the Family (PCSTF) as a family assessment and treatment model. The McMaster Model provides a conceptual framework for assessing a wide range of family functions including; communication, problemsolving, affective involvement, affective responsiveness, roles, and behavior control. The PCSTF is a shortterm, timelimited family intervention that consists of defined stages of treatment (assessment, contracting, treatment, closure).

S38-2.

THIS SESSION REVIEWS THE DIFFERENT MODELS OF FAMILY AND COUPLES THERAPY

Ira Glick, M.D., Departments of Psychiatry and Behavioral Sciences, and Psychopharmacology, Stanford University School of Medicine300 Pasteur Drive, Stanford, CA 94305

SUMMARY:
The evidencebase for family interventions in schizophrenia, bipolar disorder, major depression and other illnesses are discussed. Case examples illustrate how to provide integrated care for specific diagnoses and illness stage. Specific couples/family techniques are described in a variety of settings, i.e. inpatient, outpatient and for specific disorders. In addition, this session reviews the evidencebase for combined and integrated care, discusses which treatments to choose and how to sequence treatments, and how to determine who carries out the different treatments: pharmacotherapy, individual and family therapies. The session addresses issues such as confidentiality and boundaries when working with an individual and their family.

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SYMPOSIUM 39
HARM REDUCTION AND PREVENTION OF STALKING

Chair: Gail E Robinson, M.D., Toronto General Hospital 8231 EN200 Elizabeth St., Ontario, Toronto, M4W 3M4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the harm caused by stalking; and 2) Recognize ways of reducing the risk of being stalked.

OVERALL SUMMARY:
Stalking is a serious offence perpetrated by disturbed offenders. It can cause major mental health consequences that are often poorly understood by society. The majority of victims are female. Up to 1 in 20 women will be stalked during her lifetime. Victims may experience anxiety, depression, guilt, helplessness and symptoms of posttraumatic stress disorder. They may also experience vandalism and personal violence. Victims also suffer from a lack of understanding by family, friends, society, police and the legal system, all of which may minimize the behaviour or not enforce laws. Therapists must also know about practical ways in which the victim can reduce their risk. Stalkers present as treatment problems as they are seldom motivated to change. Offenders may begin the path toward being a stalker even in their teens. Health care professionals have an elevated risk of being stalked but often are unaware of how to prevent or stop this. Stalking on campus has become an increasing concern and often precedes violent outbursts. Identification and management of stalking risk is an important aspect of reducing negative mental health and physical consequences. This symposium will focus on reducing risk by dealing with victims, treating offenders and advising health care professionals. It will also present an approach handling juvenile stalkers and reducing stalking on campus.

S39-1.
STALKING OF HEALTHCARE PROFESSIONALS: REDUCING THE RISK

Gail Robinson, M.D., Toronto General Hospital8231 EN200 Elizabeth St., Ontario, Toronto, M4W 3M4 Canada

SUMMARY:
Healthcare workers are vulnerable to being a victim of stalking by their patients, most often from stalkers who are intimacy seeking, resentful or incompetent. Healthcare workers regularly see lonely or mentally unstable individuals who may idealize the professional and misconstrue sympathy and attention as romantic interest. Therapists may be vulnerable as a result of erotic transference. The literature suggests that a significant number of clinicians experience some type of stalking and suffer adverse consequences yet most lack any type of training to deal with this. Physicians in the Greater Toronto Area were surveyed about their stalking experiences to obtain information on various types of stalking, impact on the physicians harassed, types of patients who stalk, perceived reasons for the stalking, and strategies used to deal with the situation. Increased awareness of this phenomenon and appropriate interventions could reduce escalation of harassing behaviors. The warning signs and suggestions for management of stalkers in the healthcare setting will be discussed.

S39-2.
TREATMENT OF STALKERS

Werner Tschan, M.D., PO Box 52,, Basel, 4012 Switzerland

SUMMARY:
The presenter will discuss treatment approaches for stalking offenders as part of the case management. Stalking covers a wide range of problematic behavior, ranging from delusion problems to severe personality disorders. Participants will learn how

to plan interventions with this type of clients. The treatment focuses on behavior changes.

S39-3.

STALKING BEHAVIOR AMONG JUVENILES: OPPORTUNITIES FOR EARLY INTERVENTION

Rosemary Purcell, Ph.D., 35 Poplar Rd, Parkville, 3052

SUMMARY:
There is emerging evidence that stalking is a problem behavior among juveniles. In the largest empirical study of juvenile stalking to date, the author conducted a comprehensive review of court applications for a restraining order against a juvenile in a major Children's Court in Melbourne, Australia. Over the 3year study period, 299 juveniles were found to meet the criteria for stalking. The majority of perpetrators were male (64%) and their victims predominantly female (69%). Most pursued a previously known victim (98%), typically a school peer, estranged friend or exintimate partner. Direct means of contact with the victim was favored, usually via unwanted approaches and telephone calls. The rates of associated violence among this sample was high, with 75% making threats and 50% physically assaulting the victim. The stalking behaviors emerged in several contexts, most commonly as an extension of bullying (28%), retaliation for a perceived harm (22%) and rejection following the termination of a relationship (22%). In 5% the stalking was sexually predatory, with 2% motivated by infatuation. Some notable gender differences in stalking behavior were observed, with higher rates of same gender pursuit and stalkingby proxy among female juveniles, and greater variation in the motivations for stalking and the choice of victim among males. The results of this study indicate that juvenile stalkers differ from their adult counterparts in terms of the contexts in which the stalking emerges, as well as the greater involvement of female perpetrators and the higher propensity for violence. The seriousness that is afforded to adult forms of stalking should similarly apply to juveniles. Furthermore, the opportunities for early intervention with juvenile stalkers to reduce future offending against the same or different victims is compelling, although a currently neglected issue.

S39-4.

ASSESSMENT AND MANAGEMENT OF STALKING AND THREATENING ACTIVITY IN CAMPUS SETTINGS

Mario Scalora, Ph.D., 238 Burnett Hall, Lincoln, NE 685880308

SUMMARY:
Since the shootings at Virginia Tech and Northern Illinois University, institutions and police departments have dedicated substantial resources to alleviating concerns regarding campus safety. These incidents have brought renewed attention to the prevention of violence at colleges and universities. Mental health practitioners both inside and outside of campus settings have been consulted to assist campus administrators and law enforcement with the assessment and management of challenging situations that may pose a threat to campus safety. Though much attention has focused upon student behaviour, a risk and threat management strategy must address the various internal and external threats to campuses, especially stalking behaviour. Campuses must develop partnerships to evaluate the range of observable behavioural factors (e.g., the individual's motivations and mental functioning). Threat assessment methodology considers contextual, target and subjectspecific, and behavioural factors to determine the risk of violence. A preventionoriented strategy, threat assessment strives to accurately identify risks and to implement appropriate measures designed to minimize the potential of violence. Much of the targeted violence literature has focused upon K12 institutions. The author will detail some of the unique challenges to college and University campuses as well as practical strategies for the mental health practitioner. Attention will also be paid to relevant legal issues influencing risk management within campus settings (i.e., FERPA, HIPPA) as well as constructive strategies in consideration. Finally, data from over 200 cases managed within a large university setting will be provided to detail the wide ranging nature of risks to campus settings as well as relevant risk factors for problematic activity.

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SYMPOSIUM 40
EVIDENCEBASED OUTCOMES IN PSYCHIATRY: UPDATES ON MEASUREMENT USING PATIENTREPORTED OUTCOMES (PRO)

APA Task Force on DSM-5

Chair: June Cai, M.D., 10903 New Hamphire Ave, Silver Spring, MD 20895
Co-Chair: Massimo Moscarelli, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to learn an updated *DSM-5* progress and new directions of PRO measures in psychiatry, and enrich the knowledge in clinical assessment.

OVERALL SUMMARY:
This Symposium intends to address the increasing relevance of PRO in treatment of psychiatric disorders. PROs are not unfamiliar to psychiatry community and have long been used in clinical and research settings. Using PROs in clinical trials enables us to know aspects of interventions that are best known only to patients, both efficacy and safety. Systematic assessment of the patient's perspective provides invaluable information of treatment benefit. The newly issued FDA Guidance on PRO Measures: Use in Medical Product Development to Support Labeling Claims concerns PRO measures used for determining treatment benefits in clinical trials reflected in prescribing information. In the development of *DSM-5* emphasizing inclusion of dimensional assessments of psychopathology, PRO will likely have a more significant impact in psychiatry in qualifying and determining severity, assessing response to treatment, as well as in facilitating tailored interventions and enhancing therapeutic alliance. These new directions stimulate research aimed at the development and validation of rating scales and encourage PRO assessment in mental disorders. In this session, the audience will also have an opportunity to learn the proposed incorporation of dimensional assessments of psychopathology and disability in *DSM-5*, its rationale, and its potential value for clinicians and for psychiatric researchers. The audience will also acquire a synopsis of the NIH PROMIS (patientreported outcome measure information system) project, have a preview of a potential PRO measure of schizophrenia under development to broaden their experience, and gain knowledge of key considerations of PRO measures in clinical trials from the FDA perspective. Through this symposium, the audience will get a peek at *DSM-5* progress and new directions of PRO measures in psychiatry, and enrich the knowledge in clinical assessment.
The "International Pilot Study on Patient Reported Outcomes (PRO) in Schizophrenia" is aimed to assess diagnosisspecific PROs in the US and internationally, taking into account language and cultural adaptation. The Scale for the Assessment of Passively Received Experiences (PRE) operationally defines and measures the relevant "passively received experiences" in schizophrenia (i.e. thought insertion/intrusion), the subjective disturbance they cause to the patient, and their frequency, and may be considered similar to the PROs in medical disorders (i.e. somatic pain). The clinical rating scales currently adopted for the assessment of symptoms in schizophrenia (i.e. SAPS/SANS, PANSS) do not measure the subjectively disturbing "passively received experiences" of the disorder and this neglect may bias the results of treatments efficacy, effectiveness and comparative effectiveness because it is not measured: (i) if these experiences and their subjective disturbance specifically respond to treatment, and (ii) if they persist in spite of the fulfilled "remission" ratified by criteria that ignores them. In addition, to measure the treatment effects on the subjectively disturbing "passively received experiences" of schizophrenia may be crucial in patient's decision about treatment continuation. The assessment of diagnosisspecific PROs, like the PRE in schizophrenia, have the potential to qualify the patient perspective in the DSM-5 development, significantly broadening clinical assessment and enhancing the patientclinician shared decision making about personalized medication regimens and other nonpharmacological interventions.

S40-1.
PATIENTREPORTED OUTCOME MEASURES IN *DSM-5*

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

SUMMARY:
One of the earliest recommendations for the upcoming *DSM-5* was to include dimensional

measures of psychopathology, to be used in conjunction with categorical diagnostic criteria. This recommendation was carried out in the proposals of the *DSM-5* diagnostic work groups. Two types of measures have been recommended: crosscutting measures of common psychopathological symptoms and diagnosisspecific severity measures. These proposed measures are expected to provide clinicians with useful information about their patients, both at initial diagnostic evaluations and at followup visits after treatment has been initiated. Most of these proposed measures use patient reports. This presentation will describe the principles and development of patientreported measures in *DSM-5*, their recommended uses, and the *DSM-5* field trials in which they will be tested for feasibility, clinical utility and reliability. Finally, the potential advantages of these measures for future clinical and research uses will be discussed.

S40-2.

PATIENT REPORTED OUTCOMES MEASUREMENT INFORMATION SYSTEM (PROMIS): OVERVIEW AND APPLICATIONS FOR MENTAL HEALTH RESEARCH

William Riley, Ph.D., 6701 Rockledge DR, MSC 7936, Bethesda, MD 20892

SUMMARY:
PROMIS (Patient Reported Outcomes Measurement Information System) is an NIH Roadmap Initiative to develop a publicly available, adaptable, and sustainable system to improve outcome assessment of patient reported symptoms, functional capabilities, and healthrelated quality of life for a wide range of chronic diseases. PROMIS utilizes Item Response Theory (IRT) and Computer Adaptive Testing (CAT) to produce highly reliable and efficient assessments of patientreported domains such as physical functioning, pain, fatigue, depression, anxiety, sleep disturbance, and satisfaction with social functioning. This presentation will report on the research leading to the released item banks currently available, progress on additional banks and validation research in progress, the features and functions of Assessment Center which provides computerized adaptive testing administration of the PROMIS item banks and other patient reported outcome measures, and the use of PROMIS as a crosscutting dimensional measure in *DSM-5* field trials.

S40-3.

PATIENTREPORTED OUTCOME MEASURE IN CLINICAL TRIALS – AN FDA PERSPECTIVE

June Cai, M.D., 10903 New Hamphire Ave, Silver Spring, MD 20895

SUMMARY:
The objective of this presentation is to introduce the role and impact of "FDA Guidance on PRO Measures: Use in Medical Product Development to Support Labeling Claims" in clinical psychiatry. This presentation will provide an overview of PRO measures in clinical trials and focus on key considerations and rationale for use of these measures in clinical trials for treatment benefit claims in labeling. Issues of their use in different countries or ethnic groups as well as special populations will also be presented. Through this presentation, the audience will learn the FDA perspectives on PRO measures in clinical trials as well as the significance and rationale of treatment benefit claims presented in the labeling.

S40-4.

INTERNATIONAL PILOT STUDY ON PATIENT REPORTED OUTCOMES IN SCHIZOPHRENIA

Massimo Moscarelli, M.D., Via Daniele Crespi 7, Milano, 20123

SUMMARY:
The "International Pilot Study on Patient Reported Outcomes (PRO) in Schizophrenia" is aimed to assess diagnosisspecific PROs in the US and internationally, taking into account language and cultural adaptation. The Scale for the Assessment of Passively Received Experiences (PRE) operationally defines and measures the relevant "passively received experiences" in schizophrenia (i.e. thought insertion/intrusion), the subjective disturbance they cause to the patient, and their frequency, and may be considered similar to the PROs in medical disorders (i.e. somatic pain). The clinical rating scales currently adopted for the assessment of symptoms in schizophrenia (i.e. SAPS/SANS,

PANSS) do not measure the subjectively disturbing "passively received experiences" of the disorder and this neglect may bias the results of treatments efficacy, effectiveness and comparative effectiveness because it is not measured: (i) if these experiences and their subjective disturbance specifically respond to treatment, and (ii) if they persist in spite of the fulfilled "remission" ratified by criteria that ignores them. In addition, to measure the treatment effects on the subjectively disturbing "passively received experiences" of schizophrenia may be crucial in patient's decision about treatment continuation. The assessment of diagnosisspecific PROs, like the PRE in schizophrenia, have the potential to qualify the patient perspective in the DSM-V development, significantly broadening clinical assessment and enhancing the patientclinician shared decision making about personalized medication regimens and other nonpharmacological interventions.

SYMPOSIUM 41
LONGITUDINAL COURSE AND OUTCOME IN BORDERLINE PERSONALITY DISORDER

Chair: Paul H Soloff, M.D., 3811 O'Hara St., Pittsburgh, PA 15213
Discussant: Kenneth Silk, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify developmental antecedents of BPD; 2) Appreciate the longitudinal course of acute and temperamental symptoms; 3) Identify predictors of suicidal behavior; and 4) Evaluate effects of treatment on suicide risk.

OVERALL SUMMARY:
Prospective and longitudinal studies of the development, course and outcome of BPD have radically altered our understanding of this disabling and potentially fatal disorder. This symposium will present current research on developmental antecedents of BPD, stability of diagnostic and symptomatic criteria, prospective predictors of suicidal behavior, and effects of treatment on suicide risk. Using an Internetbased survey of parents with BPD offspring, Goodman et al. have assessed prodromal symptoms and developmental trajectories that differentiate BPD probands from their nonBPD siblings in periods from birth through adolescence. In female probands, predictors of BPD can be identified as early as infancy and toddlerhood, with phenotypic expression of BPD apparent by adolescence. The developmental antecedents of BPD in male probands will be presented in this symposium. Prospective, longitudinal study of BPD adults over 10 years has found high rates of symptomatic remission, particularly for the acute symptoms of BPD. Zanarini et al. will present results from a 16year followup of this cohort, finding that rates of recurrence are substantially lower for the acute symptoms of BPD (e.g., selfmutilation, suicide attempts) than they are for the temperamental symptoms of BPD (e.g., chronic feelings of anger, intolerance of aloneness). In a prospective study of suicidal behavior in BPD, Soloff et al. have shown that clinical predictors of suicidal behavior change over time. Acute stressors such as MDD, predict suicidal behavior in short term followup (1 year), but poor psychosocial function and illness severity increase risk in the longer term (25 years.) Predictors of suicidal behavior at 6year followup will be presented. Links et. al. have addressed the effects of treatment on suicide risk in BPD in a prospective trial comparing DBT to a treatment intervention based on the APA Practice Guideline for BPD. After one year of treatment, patients who attempted suicide were compared to nonattempters to define predictors of attempt status and maximum suicide lethality scores.

S41-1.
PARENTAL VIEWPOINTS ON TRAJECTORIES TO THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER IN MALES

Marianne Goodman, M.D., 440 Sicomac Ave, Wyckoff, NJ 07481

SUMMARY:
Background: In efforts to identify precursors and describe trajectories for the development of borderline personality disorder (BPD) in males, we sought to solicit viewpoints from parents with children diagnosed with BPD. Methods: We surveyed parents of BPD offspring with an online, anonymous questionnaire to identify and model the developmental trajectory of this disorder in males. Two hundred items covered clinical variables from infancy through adolescence. Survey responses on

BPD offspring (identified as such with embedded diagnostic criteria and a professional diagnosis of BPD) were compared to those of nonBPD siblings. Regression analyses were run to identify key symptom dimensions that predict future diagnosis in males. Results: Of 1205 completed parental surveys of offspring with and without BPD, 561 pertained to offspring who met the strict entry criteria for diagnosis of BPD including 464 females and 97 males. We report data on the 97 male offspring with BPD and 166 male sibling controls. Parents identified differing developmental trajectories for their male offspring who develop BPD in adulthood as compared to their unaffected male siblings. Beginning in infancy/toddlerhood male probands with BPD had statistically increased levels of unusual sensitivity, excessive separation anxiety and inability to soothe as compared to their male unaffected siblings. During childhood, BPD males were described as moody, impulsive, empty, victimized and having trouble with authority figures. By adolescence, mood and impulsive symptoms dominate along with high levels of anger, lying, recklessness, substance abuse, and often, selfharm. Conclusions: These data suggest that BPD prodromal features can be identified as early as infancy. BPD may be viewed as a temperamental disturbance in affect and inability to soothe coupled with impulsivity and interpersonal difficulties manifesting in childhood and serious behavioral problems by adolescence. These preliminary results will updated with a larger data set and results compared with trajectories in females offspring with BPD.

S41-2.

RATES OF RECURRENCE OF THE SYMPTOMS OF BPD AFTER SUSTAINED SYMPTOMATIC REMISSION

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

SUMMARY:
Objective: The main objective of this study was to assess the rate of recurrence of 24 symptoms of borderline personality disorder (BPD) after stable remissions of these symptoms lasting at least four consecutive years and at least six consecutive years. Method: 290 patients meeting both *DIBR* and *DSM-IIIR* criteria for BPD were interviewed concerning their borderline psychopathology nine times over 16 years of prospective followup. These blinded assessments were made every two years using two semistructured interviews of proven reliability. Results: Not surprisingly, the rates of symptom recurrence were higher after symptom remissions lasting four years or more than symptom remissions lasting six years or more. The 12 symptoms that we had previously termed acute symptoms of BPD (e.g., selfmutilation, suicide efforts, and quasipsychotic thought) because of their more rapid time to remission had substantially lower rates of recurrence than the 12 symptoms that we had previously termed temperamental symptoms of BPD (e.g., chronic feelings of anger, general impulsivity, and intolerance of aloneness) because of their relatively slow time to remission. More specifically, we found recurrence rates of 13%55% (median rate=28%) for the acute symptoms of BPD. We also found recurrence rates of 33%94% (median rate=70%) for the temperamental symptoms of BPD. Conclusions: Taken together, the results of this study suggest that there are relatively low rates of recurrence for most acute symptoms of BPD. They also suggest that the temperamental symptoms of BPD tend to wax and wane over time.

S41-3.

PROSPECTIVE PREDICTORS OF SUICIDE ATTEMPTS IN BORDERLINE PERSONALITY DISORDER AT 6 YEAR FOLLOWUP.

Paul Soloff, M.D., 3811 O'Hara St., Pittsburgh, PA 15213

SUMMARY:
Objective: Recurrent suicidal behavior is a defining characteristic of BPD. Although most patients achieve remission of suicidal behaviors over time, 3% to 10% die by suicide. We are conducting a prospective longitudinal study of suicidal behavior in BPD to identify predictors of suicide attempts. At the first year followup, increased risk was associated with comorbid MDD and poor psychosocial functioning; by the second year, with prior psychiatric hospitalization (a measure of illness severity), and poor psychosocial functioning. Between 2 and 5 years, measures of illness severity and poor global functioning predicted suicide attempts. We now present predictors of

suicide attempt after 6 years of study. Method: Demographic, diagnostic, clinical and psychosocial risk factors assessed at baseline were examined for predictive association with suicide attempts in the 6 year interval using proportional hazards models. Timetoevent was computed as the difference between date of baseline assessment and the first medically significant suicide attempt in the interval. Results: The sample consisted of 90 subjects who completed 6 years in the study. Subjects were predominantly female (73%), Caucasian (78.9%), with a mean (s.d.) age of 29 (8.4) years. Twentyfive (27.8%) subjects made at least one suicide attempt in the interval. Significant predictors included: a.) Low socioeconomic status, b.) poor social adjustment, c.) a family history of suicide, d.) prior psychiatric hospitalization; e.) no outpatient treatment prior to any attempt. Higher global functioning at baseline was associated with decreased risk. Conclusion: Predictors of suicidal behavior change over time. Acute psychiatric stressors such as MDD are predictive only in the short term, while vulnerability factors such as poor psychosocial functioning have persistent and long term effects on suicide risk. Treatment focused on social and vocational rehabilitation may have a protective effect on risk for suicide in BPD.

S41-4.
PROSPECTIVE RISK FACTORS FOR SUICIDE ATTEMPTS IN A TREATED SAMPLE OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER (BPD)

Paul Links, M.D., 30 Bond St., Rm 2010d Shuter St., Toronto, M5B 1W8 Canada

SUMMARY:

Objective: Older age, MDD, impulsivity, previous suicide attempts, childhood sexual abuse, a low Social Adjustment Scale score, and psychiatric hospitalization are the strongest predictors of suicide attempts in natural history studies of BPD patients. However, risk factors for suicide attempts in treated samples of patients with BPD have not been investigated. Method: We prospectively examined these risk factors among participants in an RCT comparing DBT to General Psychiatric Management (GPM), a comparison intervention derived from the APA practice guidelines for BPD. Those with suicide attempts over the 1year of treatment (46/180) were compared with those who did not attempt (134/180) and a similar comparison was made at 2years follow up. Those reporting suicidal behavior with no or minimal intent were included with the nonattempters group and those with missing assessments were assigned to the nonattempters group. Results: Based on a forward logistic regression, the number of attempts in the 4 months prior to baseline and level of exposure to sexual abuse significantly predicted attempter versus nonattempter status after 1year of treatment. At 2years follow up, based on a forward logistic regression, the number of attempts in the four months prior to baseline, level of exposure to sexual abuse and the number of hospitalizations over the 4 months prior to baseline significantly predicted attempter versus nonattempter status. In terms of the maximum suicidal lethality score after 1year of treatment, the baseline highest medical risk rating was the only significant predictor. At 2years follow up, the number of attempts in the 4 months prior to baseline significantly predicted the maximum suicidal lethality score. Conclusions: The predictive factors for this treated sample were similar to those found in naturalistic studies. Most of these risk factors are not modifiable but define a group to be closely monitored.

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SYMPOSIUM 42
MADNESS AND THE CITY: FACING DE AND REINSTITUTIONALIZATION IN Western European Metropolises

Chair: Joséphine Caubel, M.D., 18 rue Rémy de Gourmont, Paris, 75019 France
Co-Chair: Jürgen Gallinat, Ph.D., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the characteristics and impact of de and reinstitutionalization in Western Europe; 2) Learn about the current views on urbanicityrelated psychiatric problems; 3) Identify strategies of public mental health care organizations in Berlin, Amsterdam, Birmingham and Paris to face the challenges of their clinical practice; and 4) Perceive the importance of a public and professional debate.

OVERALL SUMMARY:
Deinstitutionalization in psychiatry is a worldwide phenomenon over recent decades. Driven by ideological, societal, political and financial motives, mental health care still changes considerably. Asylums are progressively closed down, with bedreduction going handinhand with the development of alternatives including daycare, active outreach services and sheltered housing. Recent studies also suggest an international process of reinstitutionalization characterized by a rising number of forensic beds, involuntary hospital admissions, and places in supported housing. Involuntary outpatient treatment has become a possibility in some countries. Psychiatric institutions in highly urbanized regions face specific problems suc as homelessness, drug abuse and diverse populations. Research also suggests that urbanicity is an environmental riskfactor for psychiatric disorders. Representatives of major public mental hospitals in Berlin, Amsterdam, Birmingham and Paris will present different ways of coping with the challenges they meet in their everyday practice. About 20% of the patients with the diagnosis schizophrenia have complex medical and psychosocial needs and are very high intensity users of hospital emergency departments in Germany. Their care is often poorly coordinated and expensive resulting in a portion of cost of 6080% in schizophrenia care. Social and health resources are available but insufficiently coordinated. The talk presents a health care model recently established in the urban area of Hamburg and Berlin focusing on chronic and severe mental disorders including schizophrenia. Assertive community teams with a high professional standard, high availability and favourable physician/patient ratio shift the therapeutic setting from inpatient to outpatient care. Data on medical, psychosocial and economic outcome of the model are presented and implications for future care systems are discussed.

S42-1.
CHARACTERISTICS AND IMPACT OF DE AND REINSTITUTIONALIZATION IN WESTERN EUROPE

Joséphine Caubel, M.D., 18 rue Rémy de Gourmont, Paris, 75019 France

SUMMARY:
Understanding the process of mental health care reform is necessary to ensure a coherent vision on future developments. Although the process of de and reinstitutionalization progresses at a different pace, it is an undeniable trend in many parts of the world. Characteristics of deinstitutionalization are the closing down of asylums, bedreduction and development of alternative care such as daycare and active outreach treatment. A rising number of forensic beds, involuntary hospital admissions, and places in supported housing suggest re or transinstitutionalization. In order to describe this phenomenon in Western Europe, an overview and analysis of relevant papers on the subject will be presented. Positive and negative consequences for patients and their support system will be discussed, as well as the impact on mental health care systems and society.

S42-2.
CITIES AS CREATORS OF MADNESS I

Wilco Tuinebreijer, M.D., Nieuwe Teertuinen 14A, Amsterdam, 1013LV Netherlands

SUMMARY:
World cities are a challenge for social and urban psychiatry. In big cities the incidence of psychopathology is higher than in rural areas. In this lecture the reasons why cities create their own patients will be explained. Cities have their governmental institutes on public mental health. Their activities vary from city to city. The Amsterdam Institute of Municipal Health Care (GGD) is very active in tracing the most ill and vulnerable patients. It takes the temperature of the

cities gutter. Their 24hr outreach service focuses on this difficult to reach population and tries to give them the care they need. Where the regular mental health care is not ready to treat difficult marginalized groups of patients the GGD starts treatments in their facilitations as long as necessary. As soon the mental health institutes are capable of providing the right care the programs are transferred to the institutions. Examples will be given about how the GGD works. Their relation to both politics and mental health care institutions will be explained.

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S42-3.

INTEGRATIVE CARE: THE WAY FROM HOSPITAL TO OUTPATIENT SETTINGS IN GERMANY

Jürgen Gallinat, Ph.D., M.D., Charitéplatz 1, Berlin, 10117 Germany

SUMMARY:
About 20% of the patients with the diagnosis schizophrenia have complex medical and psychosocial needs and are very high intensity users of hospital emergency departments in Germany. Their care is often poorly coordinated and expensive resulting in a portion of cost of 6080% in schizophrenia care. Social and health resources are available but insufficiently coordinated. The talk presents a health care model recently established in the urban area of Hamburg and Berlin focusing on chronic and severe mental disorders including schizophrenia. Assertive community teams with a high professional standard, high availability and favourable physician/patient ratio shift the therapeutic setting from inpatient to outpatient care. Data on medical, psychosocial and economic outcome of the model are presented and implications for future care systems are discussed.

S42-4.

BIRMINGHAM: AN INTEGRATED MODEL OF HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICE PROVISION.

Mervyn Morris, M.A., Ed.D., Room 028 Bevan House, Esgbaston, Birmingham, B15 3TN United Kingdom

SUMMARY:
Birmingham, England is the second largest city in the UK, with a population of over 1,000,000 (approx 10,000 per sq.mile), over 30% of whom are members of ethnic minority groups, and a wide socioeconomic demographic including some of the most deprived communities in Europe. Almost all adult mental healthcare is funded by direct taxation and in Birmingham provided by a single organisation with services ranging from interfacing with Primary Care (General Practitioner) Services and providing shortterm intervention through to long term Medium Secure Forensic Services. In the 1990's Birmingham pioneered an integrated system of community based services to replace 5 large psychiatric hospitals. A range of teams were developed to serve communities of approximately 150,000 (morbidity adjusted), including Home Treatment, Assertive Community Treatment, Rehabilitation, Early Intervention and Primary Care Liaison teams, each with specific responsibilities to treat and support the person at home as alternatives to admission, and shortening length of stay. For a population of 1.2 million there are currently 234 acute psychiatric beds across 8 sites and 112 'longstay' residential beds. The presentation will firstly outline the model of service, focusing on the significance of an integrated model of community and inpatient services/team, developed to enable the process of deinstitutionalisation. It will then identify the current pressures particularly on acute care facilities (reinstitutionalisation) and how these pressures are managed. Factors to be highlighted include occupancy rates, bed management, risk assessment, the use of data and targets, and team management. The discussion will then move to ideas about how our understanding of psychiatric problems and interventions are influenced by the context of actively providing services in an urban environment, and the role psychiatry has in recognising and responding to the health risks associated with city living.

S42-5.

ASSERTIVE COMMUNITY TREATMENT IN AMSTERDAM: THE DUTCH ANSWER TO DEINSTITUTIONALIZATION.

Jeroen Zoeteman, M.D., Nieuwe Achtergracht 100, Amsterdam, 1018WT Netherlands

SUMMARY:
The deinstitutionalization of the Provencal Psychiatric Hospital Santpoort, situated outside

Amsterdam, the Netherlands, was definitely completed in 2006. During the nineties smaller regional hospitals were installed In Amsterdam, called Social Psychiatric Services Centres (SPDC). Psychiatric patients could be admitted for short periods of time and were mainly living in the community, treated by 'transmural' treatment teams. Needs of certain groups of patients were hardly met by these teams, as they didn't seek treatment for their symptoms, lost there housing or caused trouble in the city of Amsterdam. After 2005 (by government funding) ten Assertive Community Treatment (ACT)teams were started in Amsterdam to serve these different groups of patients. These groups consisted of homeless clients with severe mental illness or dual diagnosis, patients with first episode psychosis and homeless prostitutes with addiction and mental illness. In the United States the effects of ACT in treatment of both housed and homeless severe mentally ill are no longer controversial. In Europe the effects of ACT compared to treatment as usual is less convincing. ACT for homeless patient has not been studied in Europe until now. A recent Amsterdam randomized controlled trial shows evidence for benefits of ACT over the regular community treatment teams.

S42-6.

CITIES AS CREATORS OF MADNESS II

Jack Dekker, Ph.D., Arkin Overschiestraat 65,, Amsterdam, 1062XD Netherlands

SUMMARY:

World cities are a challenge for social and urban psychiatry. In big cities the incidence of psychopathology is higher than in rural areas. In this lecture the reasons why cities create their own patients will be explained. Cities have their governmental institutes on public mental health. Their activities vary from city to city. The Amsterdam Institute of Municipal Health Care (GGD) is very active in tracing the most ill and vulnerable patients. It takes the temperature of the cities gutter. Their 24hr outreach service focuses on this difficult to reach population and tries to give them the care they need. Where the regular mental health care is not ready to treat difficult marginalized groups of patients the GGD starts treatments in their facilitations as long as necessary. As soon the mental health institutes are capable of providing the right care the programs are transferred to the institutions. Examples will be given about how the GGD works. Their relation to both politics and mental health care institutions will be explained.

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5) Tuinebreijer W, Cunninghham Ch,Sohler N:Urban health A tale of two cities. TLC, Flemish Dutch Association, 2009

SYMPOSIUM 43
PLACEBO EFFECTS IN PSYCHIATRY

Chair: Devdutt Nayak, M.D., Richmond University Medical Center, 355 Bard Avenue, Staten Island, NY 10310

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Evaluate the accumulating literature on placebo effects in all areas of psychiatric practice and research; 2) Analyze how placebo works in research clinical trials; 3) Evaluate the ethics of placebo use for research purposes; 4) Identify the neural mechanisms of placebo responses; and 5) Utilize techniques for enhancing the role of placebos in everyday practice.

OVERALL SUMMARY:

Bane or boon, trickery or treatment, imagined or real, adding more depth to our thinking or taking aim at the shibboleths of medicine, the placebo effects are always fascinating, intriguing, and controversial. In this symposium, the overarching theme will be to find the 'meanings' of placebo effect from psychodynamic, neurobiological, ethical, clinical, and research perspectives. Suffering ceases to be suffering in some way at the moment it finds a meaning (Victor Frankl). Unconscious healing

can be enhanced by exploring early life experiences in the familial and social contexts, searching for the 'meaning' of suffering in the therapeutic encounter, and by reversing demoralization and instilling hope. Research clinical trials remain the best scientific method to evaluate efficacy of new interventions but placebos have become a "nuisance" to statisticians in analyzing their confounding effects. Metaanalyses of placebo responses in mental disorders show 60% response in major depression, 53% in GAD, and only 23% in OCD. Cointerventions can lead to improvement. FDA, AMA, and WHO have contrasting positions on use of placebo. Placebo opponents argue that ethical obligations to a single subject override the benefits to science and society and even minor discomfort of symptoms does not justify the use of placebo. The informed consent issue remains problematic and intensely debated in suicidal and schizophrenic patients. Placebo can induce activation of muopioid circuitry. In depression, drugs and placebo may act through different pathways. Analgesics and antianxiety meds are much less effective in 'hidden' administrations. Loss of prefrontal executive circuits (e.g. Alzheimer's, Schizophrenia, ADHD) reduces placebo effectiveness. Learning and positive expectations may work through activation rewards circuitry. All therapeutic approaches may be equally efficacious and have common factors. All effective therapists appear confident, communicate clearly, express concern and are empathic. Lately, the focus has been how to maximize placebo 'cures' without lying. The most reliable source of a strong placebo effect is a doctor. The professionals need to acquaint themselves with pleasing properties of placebo.

S43-1.

THE PSYCHOLOGY AND PSYCHODYNAMICS OF THE PLACEBO RESPONSE

Javier Garcia, M.D., Richmond University Medical Center, 355 Bard Avenue, Staten Island, NY 10310

SUMMARY:
Throughout history healing has taken many forms. The gamut ranges from faith healing and shamans to modern day medications and a dizzying array of distinct forms of psychotherapy. Rather than just confounding variable, the placebo effect is a powerful healing mechanism on its own right and harnessing its power may be one of our connecting forces underlying the myriad healing traditions. Psychological approaches to activating the placebo response have included Pavlovian conditioning and the power of suggestion. However our theoretical framework needs extension to account for findings that cannot be attributed to these two factors alone; there is also evidence for gender factors and differences in the placebo response. A useful context for placebo use is to evaluate the common factors of the provider, the patient, the interaction between the two and the social/cultural and physical environment that help to activate the placebo response.
These factor include an instillation of hope, the transformation of suffering by giving meaning to symptoms, a motivation to please, the therapeutic impact of relationship building and patient treater contact, and positive response expectancies. Psychodynamic concepts (such as non erotic positive transference, basic trust, therapeutic alliance, self object transferences, transitional objects and attachment) may be helpful tools in understanding psychological factors responsible for activating the placebo response and promoting unconscious healing in all kinds of therapy.

REFERENCES:
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S43-2.

PLACEBO EFFECT IN CLINICAL TRIALS

Intikhab Ahmad, M.D., Richmond University Medical Center, 355 Bard Avenue, Staten Island, NY 10310

SUMMARY:
It has now become standard practice that clinical trials include some form of placebo comparison with the drug of interest to prove the efficacy of the drug itself. This discussion will examine the placebo response versus drug response in clinical trials, focusing on key antipsychotic and antidepressants trials. First, we will examine earlier studies showing

drugs to be initially more effective over placebo. These studies will be compared with the more recent trials showing higher placebo responses over drug responses. Some main points of discussion to explain this particular phenomenon will include problems inherent in the clinical trial itself, include problems of clinical trial design, variations of site characteristics, variations of clinical settings, influence of inclusion and exclusion criteria, and statistical measurements explaining the trial results. The concluding topic will focus on possible solutions to reduce bias. These include improvements in participant selection criteria, better reliability of assessment instruments and methods, innovative methods to encourage greater subject adherence, increasing quality assurance by improving rater training and accountability metrics, and advancing methods of pharmacodynamic modeling to optimize dosing prior to phase 3 trials.

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drugs? A metaanalysis of placebocontrolled trials. Molecular Psychiatry (2009) 14, 429–447.
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Versus Placebo and Other Agents for Depressive Disorders: A Systematic Review and MetaAnalysis. J Clin Psychiatry 2007; 68: 18451859.

S43-3.

ETHICAL DILEMMAS IN THE USE OF PLACEBO

Joel Idowu, M.D., 355 Bard Avenue, Staten Island, NY 10310

SUMMARY:
There is an ongoing lively debate on the ethical use of placebos in psychiatric research and practice. The ethical guidelines for research, in general, were developed from three important documentsthe Nuremberg Code, the Declaration of Helsinki, and the Belmont Report. The clinical trials have always employed an informed consent, an adequate sample size, and use a placebo control; they do not profess a guarantee of benefit to every patient. Using placebo in clinical care requires great sensitivity and a fiduciary responsibility to the patient. Those who oppose using placebo state that it is against the Declaration of Helsinki, that depriving an individual of treatments of the benefit of society is not ethical, and that delaying treatment may have a negative impact on the long term outcomes. Another issue of concern is the decisional capacity of participants and their motivation for participating in a clinical trial. Alternatives to using placebo have been recommended: using an active drug; changing the FDA guidelines; reassessing the current statistical approach. FDA guidelines have to encourage the utilization of the Helsinki code and Belmont report in the approval process of a new drug. The AMA should consider evaluating the role of placebo in clinical trial.

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S43-4.

THE NEUROBIOLOGY OF PLACEBO EFFECTS

William Head, M.D., Richmond University Medical Center, 355 Bard Avenue, Staten Island, NY 10310

SUMMARY:
The neurobiology of placebo effect and response is a complex phenomenon where different mechanisms are involved in various medical conditions and in various therapeutic interventions. Most research shows that expectation and anticipation of a clinical response to the therapeutic intervention plays a crucial role along with classical conditioning for physiological functions to be involved. Expectation of a response may activate several brain mechanisms, such as reward circuitry, to prepare the body to anticipate that response. This is only one aspect of the placebo effect. Research studies indicating many other aspects of placebo effects such as verbal communication, encompassing neural

topdown and changes in the neurochemicals, brain circuitries and alterations in the immune system. The evidence of the placebo effects on the brain is supported by different neuroimaging techniques. The best studied neurophysiological reaction to the placebo expectancy effect is the neurophysiological response to pain, which has served as a model for how other placebo expectancy neurophysiological responses may work. In our presentation, we will discuss the nature of the placebo expectancy response, the neurological pathways now known to be involved, and those hypothesized to be involved in the placebo responses noted to date in various specific neuropathological and psychopathological conditions. In addition, we will examine the existing research and areas for further exploration, including the efficacy of placebos in other forms of treatment and the duration of the benefits of placebo effects.

REFERENCES:

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S43-5.

THE PLACEBO EFFECTS IN CLINICAL PRACTICE

Sheldon Blackman, Ph.D., Richmond University Medical Center, 355 Bard Avenue, Staten Island, NY 10310

SUMMARY:

In a narrow sense placebos are defined as interventionsinert pills, sham ECT or other practices based on deceptionwhich hopefully will lead to improvement. This belief is thought to be based on subjective as well as objective effects of the active drug or placebo. Broadly speaking all treatments have a range of placebo effects (simple suggestion, coaugmentation, even potentially 'curative'). The environment and settings are ageold practices (Shaman's mask, Dr. Mesmer's orchestrated ambiance, Freud's welldecorated office, and modern physicians' white coats and prominently displayed diplomas). The emphasis was in giving a "perception of concerned optimism". More recently, Walter Brown has suggested employing placebos themselves as antidepressants in selected patients. This presentation will highlight the importance of treatment settings, characteristics of therapists' styles, patient factors, and treatment techniques themselves.

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1) Hyland, M.E. Using the placebo response in clinical practice; Clinical Medicine Vol 3 No 4, July/ August 2003
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MONDAY, MAY 16, 2011
NOON-3:00 PM

SYMPOSIUM 44
COMPREHENSIVE HIV PSYCHIATRY UPDATE

Chair: Karl Goodkin, M.D., Ph.D., 8730 Alden Dr., Suite E101, Los Angeles, CA 90048

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to: 1) Understand current HIV treatment; 2) Understand the incidence of neuropsychiatric and psychiatric illness in HIV/ AIDS; 3) Understand the diagnostic and treatment approaches to neuropsychiatric and psychiatric symptoms in people with HIV/AIDS; 4) Understand the pathophysiology of HIV1associated neurocognitive impairment and disorders; and 5) Recognize drug interactions between HIV medications and psychiatric medications.

OVERALL SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIVinfected 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 HIVinfected persons, however, is becoming

increasingly complex. While antiretroviral regimens have fewer side effects, adherence to treatment is as crucial as ever to maintain a nondetectable viral load and to maximize immune reconstitution and must be durable for many years. This session will provide the most uptodate epidemiological information, guidelines for antiretroviral therapy, and considerations for patients with a history of drug use, hepatitis C virus coinfection, and mental illness. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.

S44-1.
AN OVERVIEW OF THE CHANGES AND CONTROVERSIES IN DIAGNOSIS AND TREATMENT OF HIV/AIDS OVER THE LAST 30 YEARS

Drew Kovach, M.D., 1010 Pensacola St., Honolulu, HI 96814

SUMMARY:
I will discuss the additional disease states, medical and psychological that occurs in patients with good virologic control over extended periods of time. I will review the psychiatric issues that patient present to me living with this chronic disease. I will conclude with my thoughts about the comprehensive care of HIV/AIDS patients.

S44-2.
NEUROPSYCHIATRIC OVERVIEW

Marshall Forstein, M.D., 24 Olmsted St., Jamaica Plain, MA 02130

SUMMARY:
Since the beginning of the epidemic nearly 30 years ago, the role of the psychiatrist has been critical in the management of HIV/AIDS. 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 drugdrug interactions. Approximately 12% of people with HIV have a concurrent diagnosis of drug dependence, further complicating assessment and treatment. This session 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.

S44-3.
NEUROCOGNITIVE DECLINE

Karl Goodkin, M.D., Ph.D., 8730 Alden Dr., Suite E101, Los Angeles, CA 90048

SUMMARY:
Neurocognitive impairment ranging from subtle to severe remains prevalent among people with HIV despite widespread use of potent antiretroviral therapy (ART) that has significantly prolonged life. According to findings from the large CHARTER (CNS HIV Antiretroviral Therapy Effects Research) study presented at the XVIII International AIDS Conference in July 2010, 53% of the total sample in one cohort showed neurocognitive decline. Classified as HAND (HIV associated neurocognitive disorders), HIV in the central nervous system (CNS) causes a range of impairment from asymptomatic neuropsychiatric impairment (ANI) to mild neurocognitive disorder (MND) to HIV associated dementia (HAD). HAND can develop at any stage of infection. These disorders now represent what might be thought of as a "hidden epidemic" within the HIV infected patient population. Investigators have concluded that neurocognitive impairment remains prevalent despite longstanding suppression of viremia. These findings underline the benefits of routine and comprehensive cognitive screenings, identification and treatment of other risk factors for HAND, integration of data into treatment guidelines, and earlier initiation of ART (of particular note are CSFpenetrating antiretroviral

medications). Data indicate that preventing impairment is important, since once HAND occurs, many individuals can progress to more severe patterns of CNS involvement. This session will review HIV neurocognitive disorders, discuss diagnostic strategies, and describe effective therapies (including CNSpenetrating antiretroviral regimens and the psycho stimulants). A question and answer session will follow.

S44-4.
PSYCHOPHARMACOLOGY

Stephen Ferrando, M.D., New York Presbyterian Hospital, Payne Whitney Clinic, 525 E 68th St., Box 181,
New York, NY 10021

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 drugdrug interactions as well as other prescribed and over the counter medications. Recreational drugs (including "club" drugs) and their interactions will be discussed as well. 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.

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SYMPOSIUM 46
RECOVERY: PRACTICAL AND POLICY LESSONS FROM AROUND THE WORLD

Chair: Nada L. Stotland, M.D., M.P.H., 1000 Wilson Blvd, Arlington, VA 22209
Discussant: Helen E Herrman, M.D., M.B.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Define recovery; 2) Identify the key elements of recovery; 3) Advocate for recovery as a matter of public policy; and 4) Facilitate recovery in their own patients.

OVERALL SUMMARY:
Recovery is the core purpose of psychiatry, the reason for diagnosis and treatment. For centuries, major mental disorders were considered incurable; patients and their families were told not that their disorders would keep them from functioning in and making contributions to society. Tragically, this attitude consigned millions of people to stigmatization and isolation. It deprived them of the normal challenges and gratifications of education, productive work, and intimate relationships. Psychiatric treatment focused on symptom management. Replacing symptom management with recovery as the goal of treatment reframes our work. It provides the essential core of care: hope. This symposium explores the meaning of recovery and how the concept of recovery is faring and being implemented around the world, with presentations from psychiatrist administrators, policy makers, and clinicians working in the United States and on three other continents. Recovery is within our patients' reach. This session will help us to help them achieve it.

S46-1.
THE EXPERIENCE OF SOUL/ATMAN/ CENTER/HARA/SEIKA TANDEN/SPIRIT AS AN ESSENTIAL ELEMENT OF BEING NECESSARY FOR FLOURISHING TO PROGRESS TO RECOVERY

Carl Bell, M.D., 8704 S Constance, Chicago, IL 60617

SUMMARY:
Using metaphors (Soul/Atman/Center/Hara/ Seika Tanden/Spirit/Chi), Dr. Bell will highlight the importance and dangers of "spiritual practice" found in Zen, Martial Arts – Tai Chi and Chi Kung, Eastern Meditation, and Yoga necessary to cultivate an essential element of "Being." "Being," being an aspect of existence necessary for certain characteristics of "flourishing," i.e. 1) positive affect regularly cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life; 2) purpose in life finds own life has direction and meaning; 3) autonomy guided by own, socially accepted, internal standards and values; and 4) personal growth seeks challenges, has insight into own potential, feels a sense of continued development. Examples of spiritual practices from other cultures involving synergy between the mind (psyche), body (soma), and spirit (pneuma) will be discussed and demonstrated. In addition, the dangers of encouraging "magical thinking," and psychiatry's difficulty addressing issues of spirituality with their patients will be addressed.

S46-2.
THE IMPACT OF HEALTH REFORM ON THE RECOVERY MOVEMENT IN AMERICA

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

SUMMARY:
In March 2010, President Barack Obama signed into law the most sweeping change in health care in the United States since the passage of Medicare and Medicaid in the mid1960s. The Mental Health and Substance Use Parity Act was also signed into law a year prior, establishing the principle that mental illness and substance use disorders should not be treated differently than other medical disorders by insurance companies. These two laws, in combination, create the opportunity for increased access to care for many un and underinsured individuals for whom financial barriers have been insurmountable in the past. How will these opportunities play out in the real world, especially as it effects the recovery movement in America? The recovery movement in America is more than a philosophy of active treatment, rehabilitation, and hope. It is a series of specific opportunities that require support from both public and private monies. Health reform will help support the direct treatment costs for mental illness and substance use, but recovery as a sustaining concept requires psychosocial rehabilitation, housing, peer support, assertive community treatment, and a number of evidencebased interventions (such as family psychosocial education) that will not qualify under traditional health insurance. Expansion of Medicaid, a pillar of health reform in America, to individuals at 133% of the poverty line by 2014 will diminish the number of uninsured but the costs associated with this expansion could lead to a diminishing of support for services currently paid by Medicaid that are not direct treatment services, which are essential to recovery. This presentation will examine ways to support and sustain the recovery movement during the era of health reform in America.

S46-3.
RECOVERY: PRACTICAL AND POLICY LESSONS FROM AROUND THE WORLD

Jair Mari, M.D., U Federal de Sao Paulo, Sao Paulo, NA

SUMMARY:
Recovery is the core purpose of psychiatry, the reason for diagnosis and treatment. For centuries, major mental disorders were considered incurable; patients and their families were told not that their disorders would keep them from functioning in and making contributions to society. Tragically, this attitude consigned millions of people to stigmatization and isolation. It deprived them of the normal challenges and gratifications of education, productive work, and intimate relationships. Psychiatric treatment focused on symptom management. Replacing symptom management with recovery as the goal of treatment reframes our work. It provides the essential core of care: hope. This symposium explores the meaning of recovery and how the concept of recovery is faring and being implemented around the world, with presentations from psychiatrist administrators, policy makers, and clinicians working in the United States and on three other continents. Recovery is within our patients' reach. This session will help us to help them achieve it.

S46-4.
RECOVERY, PSYCHIATRY AND FEDERAL MENTAL HEALTH POLICY IN THE US

Kenneth Thompson, M.D., 6108 Kentucky Avenue, Pittsburgh, PA 15206

SUMMARY:
The recovery movement first found its expression in Federal mental health policy after the findings of the New Freedom Commission were released. Though the resources dedicated to promoting the "transformation" of mental health services were slim, recovery became the nationally sanctioned goal of care. The first tentative steps toward reorienting mental health services were initiated. This presentation will review what was actions were proposed, what was accomplished (such as the creation of the Recovery to Practice Initiative) and what needs to be done, while observing the challenges that have been faced from conflict with the world of Substance Abuse treatment over the term itself to the dilemmas created by the change in administration and the passage of Health Care Reform.

SYMPOSIUM 47
TREATMENT RESISTANT DEPRESSION: A ROADMAP FOR EFFECTIVE CARE

Chair: John F. Greden, M.D., 4250 Plymouth Road, Ann Arbor, MI 481092700,
Co-Chair: John F. Greden, M.D.
Discussant: Melvin G Mcinnis, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this symposium, the participant will be able to: 1) Identify clinical features and warning signs of Treatment Resistant Depression; 2) Diagnose and treat with new strategies (a "roadmap") most likely to achieve and preserve recovery; and 3) Apply longterm management approaches and newer treatment approaches such as neuromodulation (rTMS, VNS, DBS) and ketamine infusion for those who have otherwise failed to respond.

OVERALL SUMMARY:
Treatment Resistant Depression (TRD) designates the 30 40% of those with Major Depressive Disorder (MDD) who have failed to respond to multiple courses of evidencebase antidepressant treatments. MDD accounts for approximately 10% of the entire burden of all major diseases in the worlda huge impact. Perhaps 40% of that burden is attributable to those with TRD. More effective diagnostic and treatment approachesa lifetime roadmapneed to be applied from the first clinical evaluation onward. The presentations will describe the best ways to prevent, and once developed, treat those with TRD. Strategic steps are summarized, sequenced, clinically described, and documented with evidencebased data whenever available. A newly created National Network of Depression Centers and a burgeoning collaboration with Clinical Translational Science Awards (CTSAs) provide promising venues for advancing and promoting new research and coordination of large samples of data. Treatment Resistant Depression (TRD) develops among 30% of the millions that suffer from Majo Depressive Disorder (MDD) and is responsible for a huge percentage of the burden

of depression. This proposed "Roadmap" provides sequential steps to diagnose, screen, prevent, and treat TRD; summarizes clinical barriers to achieving remission among patients; recommends screening and severity rating scales to use on a routine basis, clinical warning signs of TRD; stepwise, evidencebased treatment strategies; how to integrate pharmacotherapy and psychotherapy; guidelines for identifying patients who need indefinite antidepressant treatment to prevent recurrences; when to use the newly approved neuromodulation treatments such as rTMS and VNS; and strategies for preventing the development of TRD. Incorporating improved strategies to prevent TRD may be the most important step clinicians may take to overcome the huge burdens of clinical depression.

S47-1.

TREATMENT RESISTANT DEPRESSION: OVERVIEW OF THE UNIVERSITY OF MICHIGAN DEPRESSION CENTER ROADMAP

John F. Greden, M.D., 4250 Plymouth Road, Ann Arbor, MI 481092700

SUMMARY:
Treatment Resistant Depression (TRD) develops among 30% of the millions that suffer from Major Depressive Disorder (MDD) and is responsible for a huge percentage of the burden of depression. This proposed "Roadmap" provides sequential steps to diagnose, screen, prevent, and treat TRD; summarizes clinical barriers to achieving remission among patients; recommends screening and severity rating scales to use on a routine basis, clinical warning signs of TRD; stepwise, evidencebased treatment strategies; how to integrate pharmacotherapy and psychotherapy; guidelines for identifying patients who need indefinite antidepressant treatment to prevent recurrences; when to use the newly approved neuromodulation treatments such as rTMS and VNS; and strategies for preventing the development of TRD. Incorporating improved strategies to prevent TRD may be the most important step clinicians may take to overcome the huge burdens of clinical depression.

S47-2.

PSYCHOPHARMACOLOGICAL ROADMAP FOR TREATMENT RESISTANT DEPRESSION

Srijan Sen, M.D., Ph.D., 5047 BSRB, 109 Zina Pitcher Place, Ann Arbor, MI 48105

SUMMARY:
Antidepressant medications currently are the primary treatments used to resolve Major Depressive Disorder (MDD). Reliance upon them began to grow following the introduction of the monoamine oxidase inhibitors (MAOIs) and the tricyclic antidepressants (TCAs) in the 1950s, and by 2008, they had become the third most commonly prescribed class of all drugs in the United States. Medications are relatively easy to disseminate, reasonably safe, widely available, heavily promoted, generally reimbursed by payers, and quite effective for some individuals, but by no means all. While used for depressions of all severities, they are virtually the mainstay in the initial management of those with Treatment Resistant Depression (TRD). Nevertheless, antidepressant medications have important limitations for many individuals with clinical depression, including those with TRD. Recent realworld effectiveness trials such as the STAR*D study, and metaanalyses of clinical trials indicate they achieve remission for only about 30 – 40 percent of individuals in the first stages, and a lessening percent following each additional treatment failure. Here, we discuss a sequential decision approach to pharmacology in the management of TRD. We include: 1) strategies for optimizing existing medication regimens 2) the use of complementary or augmenting treatments 3) how to decide whether to switch or combine multiple medications and 4) successful switching and combining strategies.

S47-3.

THE UTILITY AND EVIDENCE FOR INTEGRATION OF PSYCHOTHERAPY INTO THE CONCEPTUALIZATION AND CLINICAL CARE OF TREATMENT RESISTANT DEPRESSIOn

Heather Flynn, Ph.D., 2101 Commonwealth Road, Ann Arbor, MI 48105

SUMMARY:
This presentation will review evidence supporting the role of psychotherapy, including previous

clinical response, in the conceptualization and treatment of Treatment Resistant Depression (TRD). Current conceptualizations and operational definitions of TRD are based exclusively on lack of expected response to pharmacotherapy. This conceptualization omits a vast and growing research literature which supports the efficacy of psychotherapeutic treatments for chronic, recurrent depression. Depressionspecific psychotherapies share a primary focus on depression symptom remission and improvement in depressionrelated areas of functioning (such as social functioning). This presentation will present evidence that psychotherapy may effectively target and treat specific residual symptoms that leave patients prone to relapse. The evidence for the effectiveness of psychotherapy in combination with medications for the treatment of chronic depression and for the prevention of relapse will be reviewed. In addition, practical and clinical considerations in integrating psychotherapy for TRD will be discussed. Evidence for the overall prophylactic effect of psychotherapy for chronic depression will also be reviewed. The presentation will culminate in a "call to action" to revise the current conceptualizations of TRD to include psychotherapeutic treatment response and will outline an accompanying clinical research agenda and clinical and training implications.

S47-4.

TREATMENT RESISTANT DEPRESSION (TRD) AMONG ADOLESCENTS

Neera Ghaziuddin, M.D., 4250 Plymouth Rd, Ann Arbor, MI 48109-2700

SUMMARY:
Aim: to describe a group of adolescents with major depressive disorder (MDD) who were highly resistant to conventional antidepressant treatment. Although, there is no clear definition for treatment resistant depression (TRD) among adolescents, a small but a significant number fail to respond to multiple treatment trials with three or more antidepressants (usually combined with psychotherapy). Method: IRB approval was obtained for retrospective data collection for adolescent patients (12 to < 18 years), who were treated with electroconvulsive therapy at a midwestern university center, over a 19 year period. Treatment resistance was defined at the point when patients were treated with electroconvulsive therapy (ECT), because of failure to respond to conventional treatment. Result: subjects are 33 adolescents, females = 19 (57%), males = 14 (42%), who were diagnosed with MDD and had failed to respond to multiple treatment interventions. Mean age at ECT was = 15.8 ± 1.5 years, Children's Depression Severity ScaleRevised (CDRSR) = 67 ± 17, Global Assessment Functioning score (GAF) = 20 ± 8, illness duration in months = 20.3 ± 22, number of psychotropic medication trials = 8.2 ± 4.2, duration of psychotherapy in weeks = 127 ± 144. Fluoxetine, generally regarded as a first –line treatment, was only received by 9 out of 33 subjects. However, the majority had received one or more agent from the SSRI class (32/33; 97%). Twenty seven (27/33; 82%) were treated with one or more nonSSRI antidepressant (bupropion, venlafaxine, duloxetine, mirtazapine). Mood stabilizers were administered to 18 (54.5%), while neuroleptic agents were received by 24 (73%). The mean number of suicide attempts was = 1.9 ± 2. Conclusion: a subgroup of adolescents with MDD is highly resistant to the currently available treatments. These data underscore an urgent need for the systematic study of adolescent TRD and for the need of novel treatments. Additional data will be presented.

S47-5.

TREATMENT RESISTANT DEPRESSION: A ROADMAP FOR EFFECTIVE CARE

Michelle Riba, M.D., M.S., 4250 Plymouth Road, Room 1533 Rachel Upjohn Building, Ann Arbor, MI 48109-2700

SUMMARY:
The prevalence of depression is quite high in comorbid medical conditions, especially in diabetes, cancer, heart disease. In some diseases, there is a bidirectionality between depression and the disease, such as type 1 and 2 diabetes. In this presentation, we will discuss some of the issues in diagnosis and evaluation, treatment and management in this area of psychosomatic medicine, especially as it relates to prevention of depression, and in treatmentresistant depression. Case examples will be used to highlight points and we will try to encourage audience participation, using cases, questions and answers.

S47-6.

DEVICERELATED NEUROMODULATION IN TREATMENT RESISTANT DEPRESSION

Daniel Maixner, M.D., M.S., 1500 E. Medical Center Dr. SPC5118, Ann Arbor, MI 48109

SUMMARY:
Although definitions vary, the concept of TRD refers to the failure of patients to respond to adequate courses of therapy. Around 1/3 of patients treated with antidepressants fail to achieve a satisfactory remission of symptoms after 3 4 courses of therapy. The concept, and the practice, of treating depression resistant to multiple therapies inevitably leads to nonpharmacologic somatic therapy, although many patients are not exposed to the benefits of devicerelated treatments. Up until the 2005, only one devicerelated procedure existed for TRD electroconvulsive therapy (ECT) whereas now, two additional 'neuromodulatory' therapies have been approved for the treatment of resistant depression (vagus nerve stimulation and repetitive transcranial magnetic stimulation), and several more devicebased treatments are in various stages of research. In the context of devices applied to the brain, neuromodulation refers to the use of electrical and magnetic currents to alter, or modulate, neural circuitry. The brain has its own neuromodulators, in the form of monoamines, neuropeptides and cholinergic systems, and psychotropic drugs work largely by altering the functions of these endogenous neuromodulators. Complementing the pharmacologic approach, new methods to modulate brain activity focus stimulation at specific structures, beyond the nonspecific technique of ECT. The FDA approved vagus nerve stimulation (VNS) for TRD in 2005, and repetitive transcranial magnetic stimulation (rTMS) for patients in the early stages of treatment resistance in 2008. We will review these approved treatments, including ECT, in addition to touching upon new therapies at various stages of investigation.

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SYMPOSIUM 48
PSYCHIATRIC MALPRACTICE: MAINTAINING SOLID FOOTING ON SHAKY GROUND

Chair: Praveen R Kambam, M.D., 149 S Barrington Ave #555, Los Angeles, CA 90049
Discussant: Carolyn R Wolf, Esq., M.S.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify major clinical and legal concepts pertaining to psychiatric malpractice; 2) Describe practical strategies to minimize malpractice risk and tools to effectively navigate the legal system in the event of a lawsuit; 3) Describe the "nuts and bolts" steps of what to do if named in a malpractice action; and 4) Discuss the emotional, ethical, and practical impacts of being sued.

OVERALL SUMMARY:
Although among the least sued of physicians, the number of claims against psychiatrists has increased in the last 20 years. Few events in a physician's professional life cause as much stress as a malpractice action. However, most psychiatrists receive minimal training in this area. This symposium, led by two forensic psychiatrists and two attorneys with expertise in mental health/ healthcare law, seeks to increase awareness of risk exposure in psychiatric practice and to demystify the legal process so that clinicians can maintain the most defensible position in the event of a lawsuit. The symposium will address key clinical and legal concepts pertaining to psychiatric malpractice including: elements of negligence; documentation; compliance with ethical and licensure requirements; boundaries; and legal requirements for admission, treatment, capacity determinations and treatment refusal. Categories of malpractice encountered will

be reviewed, such as suicide, informed consent, negligent diagnosis, harm caused by treatment, abandonment, and breach of confidentiality. An outline of defense strategies will also be presented. Using a casebased approach, presenters will focus on practical strategies to minimize risk and present tools to effectively navigate the legal system. Illustrated concepts will include: when and how a therapistpatient relationship arises; documentation; informed consent; appropriate boundaries; patient risks for harm; and the least restrictive treatment. The symposium will also provide insights into what really occurs during a malpractice action and offer suggested courses of action. The following topics will be addressed: what happens when you are served with a summons, when to contact your insurance carrier, and when to get additional private counsel. The symposium will cover the litigation process and litigation tools, such as document exchange, motion practice, interrogatories, deposition, expert witnesses and the trial. Finally, the presentation will address potential ramifications of being sued, with respect to the practitioner, malpractice carrier, hospital privileges, state medical boards, and the National Practitioner Data Bank (NPDB). Ms. Wolf, healthcare attorney, will educate participants about legal concepts and insights foreign to many practitioners. The legal focus will provide a road map of what to do to avoid a malpractice action and, should a lawsuit arise, how to effectively navigate the legal system. The following topics will be addressed: what happens when you are first served with a summons and complaint whom do you contact and not contact, when should you contact your insurance carrier, when do you need private counsel in addition to insurance counsel, what happens when you first meet with your assigned counsel? The symposium will cover the litigation process and the important and necessary litigation tools pertaining to psychiatric malpractice, such as providing your attorney with pertinent medical records, document exchange, motion practice, interrogatories, depositions, expert witnesses and the trial itself, should one ultimately occur. The purpose of this portion of the discussion is to provide participants with a window into what really occurs during the course of a medical malpractice action (35 minutes) Ms. Wolf will also address the potential impact being sued has on the practitioner, malpractice carrier, hospital privileges, state medical boards, and the National Practitioner Data Bank (NPDB). The potential ramifications will be considered as they impact practitioners emotionally and practically, including how they can impact one's ability to practice psychiatry before, during, and after the threat or ultimate filing of a malpractice action (10 minutes). Finally, all speakers will lead a discussion and question and answer session pertaining to the material covered (45 minutes).

S48-1

BASIC CLINICAL AND LEGAL CONCEPTS PERTAINING TO PSYCHIATRIC MALPRACTICE

Craig Beach, M.D., M.S.C., 500 Church Street, Penetanguishene, L9M 1G3

SUMMARY:
Dr. Craig Beach, forensic psychiatrist, will increase awareness of risk exposure in psychiatric practice and demystify the legal process so that clinicians can place themselves in the most defensible position in the event of a lawsuit. Specifically, he will address important clinical and legal concepts pertaining to psychiatric malpractice including, but not limited to: the elements of negligence and the distinction between errors of omission and commission and errors of fact and judgment; proper medical record documentation; complying with ethical and licensure requirements; boundaries; and in and outpatient legal requirements for admission, treatment, refusal of treatment and capacity determinations. Categories of malpractice encountered in inpatient and outpatient settings will be reviewed, such as suicide, informed consent, negligent diagnosis, harm caused by psychotropic medications and ECT, abandonment from treatment, breach of confidentiality, and failure to protect third parties from potentially dangerous patients (i.e., Tarasoff/ Duty to Warn). An outline of defense strategies will also be presented (40 minutes). Finally, all speakers will lead a discussion and question and answer session pertaining to the material covered (45 minutes).

S48-2.

PRACTICAL STRATEGIES TO MINIMIZE MALPRACTICE RISK AND NAVIGATE THE LEGAL SYSTEM IN THE EVENT OF A LAWSUIT

Praveen Kambam, M.D., 149 S Barrington Ave #555, Los Angeles, CA 90049

SUMMARY:
Dr. Praveen Kambam, forensic psychiatrist, will provide an overview of psychiatric malpractice. Although, in general, psychiatrists are among the least frequently sued of all physician specialties, the past two decades have shown an increase in the number of claims asserted against psychiatrist. A recent survey indicated that 22% of psychiatrists reported having been sued. Few events in a physician's professional life cause as much anxiety and concern as being a defendant in a medical malpractice action. Despite these statistics, however, most psychiatry trainees and practitioners receive minimal training in this important area. The question to be asked is not "can I be sued," as generally anyone can sue a psychiatrist for anything; the real question to consider is "how defensible am I" if and when I am sued. Next, Dr. Kambam will begin the discussion of important clinical and legal concepts pertaining to psychiatric malpractice including, but not limited to: the elements of negligence and the distinction between errors of omission and commission and errors of fact and judgment (20 minutes). Dr. Beach will continue this discussion. Finally, all speakers will lead a discussion and question and answer session pertaining to the material covered (45 minutes).

S48-3.
WHAT REALLY OCCURS DURING A MALPRACTICE ACTION

Louis DelSignore, J.D., Esq., 699 Aberdeen Blvd, Suite 1001, Midland, NY L4R 5P2

SUMMARY:
Using a casebased approach, Mr. DelSignore, healthcare attorney, will focus on practical strategies to minimize malpractice risk and, in the event that a lawsuit ensues, present tools to effectively navigate the legal system. Illustrated concepts will include: the importance of knowing when and how a therapistpatient relationship arises; conducting and documenting a thorough psychiatric evaluation; obtaining and documenting informed consent; maintaining appropriate therapistpatient boundaries; assessing and managing patient risks of harm toward self and/or others, including protecting third parties; and utilizing the least restrictive and most narrowly tailored treatment (30 minutes). Finally, all speakers will lead a discussion and question and answer session pertaining to the material covered (45 minutes).

S48-4.
EMOTIONAL, ETHICAL, AND PRACTICAL IMPLICATIONS OF BEING SUED

Carolyn Wolf, Esq., M.S., 1111 Marcus Ave Ste 107, Lake Success, NY 11042

SUMMARY:
Ms. Wolf, healthcare attorney, will educate participants about legal concepts and insights foreign to many practitioners. The legal focus will provide a road map of what to do to avoid a malpractice action and, should a lawsuit arise, how to effectively navigate the legal system. The following topics will be addressed: what happens when you are first served with a summons and complaint whom do you contact and not contact, when should you contact your insurance carrier, when do you need private counsel in addition to insurance counsel, what happens when you first meet with your assigned counsel? The symposium will cover the litigation process and the important and necessary litigation tools pertaining to psychiatric malpractice, such as providing your attorney with pertinent medical records, document exchange, motion practice, interrogatories, depositions, expert witnesses and the trial itself, should one ultimately occur. The purpose of this portion of the discussion is to provide participants with a window into what really occurs during the course of a medical malpractice action (35 minutes) Ms. Wolf will also address the potential impact being sued has on the practitioner, malpractice carrier, hospital privileges, state medical boards, and the National Practitioner Data Bank (NPDB). The potential ramifications will be considered as they impact practitioners emotionally and practically, including how they can impact one's ability to practice psychiatry before, during, and after the threat or ultimate filing of a malpractice action (10 minutes). Finally, all speakers will lead a discussion and question and answer session pertaining to the material covered (45 minutes)

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SYMPOSIUM 49
CHALLENGES AND CONFLICTS IN PROFESSIONAL LEADERSHIP AT PSYCHIATRIC INSTITUTIONS

Chair: Otto F. Kernberg, M.D., 21 Bloomingdale Road, White Plains, NY 10605

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify main priorities of leadership tasks; 2) Identify personality aspects of leaders influencing the role; and 3) diagnose and manage major, frequent constraints and crises.

OVERALL SUMMARY:
This symposium will explore the professional, financial, administrative and human constraints and pressures on the leader, and the combination of the leader's conceptual, technical and human skills required to confront these pressures successfully.

S49-1.
CHALLENGES AND CONFLICTS IN PROFESSIONAL LEADERSHIP AT PSYCHIATRIC INSTITUTIONS

Robert Michels, M.D., 418 E. 71 Street, Suite 41, New York, NY 10021

SUMMARY:
Personal and professional conflicts encountered by those in leadership roles of psychiatric organizations are varied and complex. Tactics employed in the management and resolution of these conflicts will be discussed, with an emphasis on practical problem solving.

S49-2.
THE EVOLVING CLINICALADMINISTRATIVE FUNCTION

Richard Munich, M.D., 286 Madison Ave., PH 23, New York, NY 10017

SUMMARY:
The contemporary practice of hospital psychiatry has led to a dramatic increase in the complexity of the specific leadership role of the Unit Chief or Program Director, also known as the ClinicalAdministrative function. Some of the contributions to this complexity include ongoing reductions in reimbursable length of stay, admission of increasingly difficult to treat patients, the growth of stringent documentation and regulatory constraints, dwindling staffing resources and education and the regular challenge to leadership and authority that characterize modern culture. Under these conditions, what factors might the leader of an inpatient clinical enterprise ideally keep in mind? Clearly the overarching dilemma for the clinicaladministrator, as implied in his title, is balancing organizational and human needs. Under ideal circumstances and with appropriate resources, from the organizational point of view, the role involves active management of the boundaries between the unit or the team and its workings and the hospital or unit in which they exist. Each side must be carefully respected both in order to maintain census as well as effective treatment that is also consistent with the values of the particular context. The human needs that are essential to address include building consensus among the staff and endorsing effective consultation and evaluation to individual staff member's performance. In the current scene, however, these matters have led to a focus on the bottom financial line, the resentful adherence to documentation and regulatory constraints, generalized rather than specific concerns with quality of care, and an avoidance of staff function, education and morale. This presentation suggests that the current conflict between the ideal and current realities may best be resolved by four strategies: 1) reducing the distance between organizers of care and its providers; 2) reducing the distance between the providers of care and its recipients; 3) by utilizing active consultation, case conference participation, and actual contact and care, reduce the distance between the organizers of care and its recipients; and 4) ongoing recognition that effective care cannot be unrelated to its context.

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SYMPOSIUM 50
NEURAL CORRELATES OF RAPID EYE MOVEMENT (REM) AND DREAMING: IMPLICATIONS FOR DREAM THEORY

Chair: *J. Allan Hobson, M.D., 138 High Street, Brookline, MA 02445*
CoChai: *Jimmie L Harris, D.O.*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) describe the functional MRI correlates of REM and their potential in studying major brain systems of uncooperative persons and studying development of human brain/consciousness; 2) describe the functional MRI, near infrared spectroscopy and quantitative EEG correlates of lucid dreaming; 3) discuss the hypothesis that 'protoconsciousness' in REM sleep may develop into waking consciousness.

OVERALL SUMMARY:
The work to be presented strongly supports important revisions of dream theory and construction of a solid foundation for psychiatric science. In particular, it is now clear that dreaming is the subjective experience of brain activation in sleep. Moreover, the formal features of dreams reflect specific aspects of sleeprelated changes in brain activation pattern (e.g., intrinsic brain stimulation in the case of percepts; chemical and regional changes in the case of concepts). Hobson suggests that dreaming is not the enemy of consciousness, but its ally and a state of consciousness, occurring in sleep, that serves as an internal reality generator. Evidence for the new theory to be reviewed includes very surprising functional data regarding temperature control. Hong et al. studied the neural substrates of REMs using fMRI. Findings suggest that REMs are reflexive scans of dream imagery. Unexpected findings include multisensory activation timelocked to REMs. REMs might serve as a taskfree probe to examine several major brain systems simultaneously even in uncooperative persons & neonates, facilitating study of the development of the brain/consciousness. Voss et al. have studied the EEG correlates of lucid dreaming. They found that it is a hybrid state between waking and sleeping. It is accompanied by enhanced power in the 40 Hz band and a frequencyunspecific increase in coherences. These changes were maximally frontal, suggesting that conscious awareness in dreams is mediated through an activation of the frontal areas of the brain. On the background of imaging correlates of REM sleep, Wehrle presents data on lucid dreaming using fMRI/EEG and near infrared spectroscopy. Localized brain activation associated to predefined dream activity is contrasted to corresponding patterns obtained when acting out during waking, and with patterns obtained when imagining the respective movement, presenting new insights into the different levels of subjective experience. This paper will present a review of current anthropological and genetic studies on humans worldwide. These studies provide an alternative model to "scientific" racism. This paper will first briefly summarize the findings of Jared Diamond on human evolution and the genetic/environmental determinants of human intelligence. This paper will then discuss the current paleoanthropological and genetic findings on the evolution of the human skin and skin color. This paper will then discuss the Tishkoff et al. report on the genetic structure of current Africans and AfricanAmericans. The writer and panel will then discuss the implications of these findings on the racist beliefs of the biologic inferiority of AfricanAmericans.

S50-1.
HUMAN GENOTYPIC AND PHENOTYPIC ADAPTATIONS TO THEIR ENVIRONMENTS

Jimmie Harris, D.O., 4236, Okemos, MI 48864

SUMMARY:
This paper will present a review of current anthropological and genetic studies on humans worldwide. These studies provide an alternative

model to "scientific" racism. This paper will first briefly summarize the findings of Jared Diamond on human evolution and the genetic/environmental determinants of human intelligence. This paper will then discuss the current paleoanthropological and genetic findings on the evolution of the human skin and skin color. This paper will then discuss the Tishkoff et al. report on the genetic structure of current Africans and AfricanAmericans. The writer and panel will then discuss the implications of these findings on the racist beliefs of the biologic inferiority of AfricanAmericans.

S50-2.

FMRI EVIDENCE FOR MULTISENSORY RECRUITMENT ASSOCIATED WITH RAPID EYE MOVEMENTS DURING SLEEP

Charles ChongHwa Hong, M.D., Ph.D., F.M. Kirby Research Center for Functional Brain Imaging, Kennedy Krieger Institute, 707 North Broadway, Baltimore, MD 21205

SUMMARY:
Hong et al. studied the neural substrates of rapid eye movements (REMs) in sleep by timing REMs from video recording and using eventrelated fMRI. Regional pattern of REMlocked activation was consistent with the hypothesis that REMs are scans that reflexively explore dream imagery. Unexpectedly, robust activation also occurred in nonvisual primary sensory cortices (NVPSC), language areas, and the ascending reticular activation system (ARAS), including thalamic reticular nucleus (TRN) and cholinergic basal forebrain. REMassociated activation of these areas, especially NVPSC, TRN and claustrum, parallels findings from waking studies on the interactions between multiple sensory data, and their 'binding' into a unified percept, suggesting that these mechanisms are also shared in waking and dreaming and the sharing goes beyond the expected visual scanning mechanism. Surprisingly, REMs were associated with periventricular deactivation in areas matching the distribution of the dense serotonergic network. REMs might serve as a taskfree probe to examine several major brain systems simultaneously even in uncooperative persons with schizophrenia and dementia and a powerful natural probe to study the development of the brain/consciousness starting from birth.

S50-3.

IMAGING CORRELATES OF LUCID DREAMING

Renate Wehrle, Ph.D., Trappentreustr. 23, Munich, D80339 Germany

SUMMARY:
Current imaging techniques provide valuable knowledge on brain networks underlying fundamental functions including consciousness. Using imaging approaches to study consciousness phenomena during sleep is hampered by technical and by methodological issues, as usually no information on ongoing mental activity can be obtained. Imaging studies of spontaneous network activity and on the brain´s reactivity to stimuli during sleep can highlight basic mechanisms occurring during the different sleep stages. Combining imaging with classic evoked potential studies during sleep, showing cortical and subcortical structures involved in the altered processing mechanisms that enable reduced awareness and continuation of sleep. A further approach is lucid dreaming, where the sleeping person can actually communicate subjective states by voluntary eye movement patterns, allows to investigate phenomena of dreaming and consciousness during dreaming. In a combined effort, several experienced lucid dreamers were studied using functional magnetic resonance imaging (fMRI) and nearinfrared spectroscopy (NIRS), both techniques combined with simultaneous electrophysiological recordings. Both methods reveal dynamic changes in regional blood oxygenation levels of the brain. The state of subjectively moving hands during a – lucid – dream could be associated to respective signal changes in corresponding sensorimotor brain areas, with similar temporospatial behaviour displayed in both methods. Mapping the switch from REM sleep background to the state of lucidity, i.e. to a higher level of conscious awareness, could be associated with a specific neocortical network possibly reflecting the neuronal basis of higherorder consciousness. These data present unique and new insights into the different levels of subjective experience.

S50-4.

QUANTITATIVE EEG CORRELATES OF LUCID DREAMING

Ursula Voss, Ph.D., KaiserKarlRing 9, Bonn, 60433 Germany

SUMMARY:
Lucid dreaming is an altered state of consciousness that arises out of rapid eye movement (REM) sleep. Its most characteristic phenomenon is the realization that one is dreaming while the dream continues. Voss et al. have studied the EEG correlates of lucid dreaming. They found that it is a hybrid state between waking and sleeping. It is accompanied by enhanced power in the gamma frequency band (40 Hz) and a frequencyunspecific increase in coherences. These changes were maximally frontally, suggesting that conscious awareness in dreams is mediated through an activation of the frontal areas of the brain. Findings are relevant for the understanding of the brain basis of consciousness.

REFERENCES:
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SYMPOSIUM 51
BIPOLAR DISORDER: CONTROVERSIES IN EPIDEMIOLOGY AND TREATMENT IN CHILDREN AND ADULTS IN THE US AND FRANCE: VIVE LA DIFFERENCE!

Chair: Francois C Petitjean, M.D., 1 Rue Cabanis, Paris, 75674 France

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand controversies about the epidemiology and treatment of bipolar disorder in children and adults 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 two decades on the subject of differences in approaches to psychiatric issues. This year's symposium is entitled "Bipolar Disorder: Controversies in Epidemiology and Treatment in Children and Adults 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 Robert Post (US) will begin by summarizing the state of epidemiology of bipolar disorder in the USA He will be followed by Dr. J.M. Azorin (FR) who will address whether Bipolar Disorder is under or over diagnosed. Then Dr Robert Hendrin (US), Past President of the American Academy of Child and Adolescent Psychiatry will discuss the controversies concerning diagnosis and treatment of bipolar disorder among children and adolescents and Dr. P. Courtet (FR) will talk about the French therapeutic recommendations. Finally, Dr Charles Bowden (US) of the University of Texas San Antonio will speak on "What is novel in terms of better ascertainment and treatment strategies" and Dr. Francois Petitjean (FR) will discuss treating bipolar depression. There will be ample time for questions and answers.

S51-1.
MORE CHILDHOOD ONSET BIPOLAR ILLNESS IN THE U.S. THAN IN EUROPE

Robert Post, M.D., 5415 W. Cedar Lane Suite 201B, Bethesda, MD 20814

SUMMARY:
Introduction: Prognostic factors and differential outcomes in the naturalistic treatment of outpatients with bipolar disorder in the U.S. vs. European countries have not been systematically examined. Methods: 529 patients (average age 42) in 4 sites in the U.S. (Los Angeles, Dallas, Cincinnati, Bethesda) and 3 in Europe (Utrecht, Freiberg, Munich) completed questionnaires and were rated daily by clinicians on the NIMHLCM during prospective naturalistic treatment for at least one year. "Responders" had to show sustained improvement for at least 6 months. Results: Not only was there dramatically more childhood onset (before age 13) bipolar illness in the U.S. (22%) than in Europe

(2%), but also more: positive parental history of affective disorders, physical or sexual abuse, anxiety and substance abuse comorbidity, more than 20 affective episodes, and rapid cycling in the past year. Only psychosis and inability to work were more common in Europe than in the U.S. Prospective outcomes were more positive in Europe than in the U.S. Lithium and benzodiazepines were used more in Europe than in the U.S., while valproate (VPA), antidepressants (ADs), and atypicals (AA) were used more in the U.S. Lithium was more successful (involved in the regimen averaging 3 drugs in the "Responders" verses "Nonresponders") in Europe than in the U.S. Discussion: Outpatients recruited into a research network in the U.S. compared to Holland and Germany had more adverse historic and illness characteristics, poorer sustained response rates, differential patterns of drug utilization (less lithium and more VPA, ADs, AAs) and lower success rates to treatment with lithium. There may also be differences among countries within Europe that may be important in understanding the mechanisms of these disparities.

S51-2.
BIPOLAR DISORDER: UNDER OR OVER DIAGNOSED

Jean Michel Azorin, M.D., Hôpital SainteMarguerite, Marseille, 13274 France

SUMMARY:

The question as to whether bipolar disorder is currently under – or overdiagnosed has been the focus of major interest in recent years, as shown by an increasing number of papers devoted to this question in psychiatric literature. The purpose of the current study was to review the main issues associated with this topic. Relevant articles were selected from a PubMed literature search [19902010] using the keywords "bipolar disorder", "overdiagnosis", "underdiagnosis", "misdiagnosis" and "diagnosis". We augmented the search by manually reviewing bibliographies from identified reports and recent reviews and by searching published abstracts from recent scientific meetings. Articles were selected for review if their content was instructive to the current topic. Many factors were found to influence the answer to the question of under – or overdiagnosis. Among them, the prevailing ones were: age of the patients, care setting, theoretical background and education of professionals, adoption of the bipolar spectrum concept and extension given to this concept, diagnostic criteria used, illness stage, predominant polarity of the illness, and more generally typicity of clinical features as well as insurance coverage, disability payments and impact of marketing efforts and publicity (particularly from drug companies). Consequences of – and risks associated with both under – and overdiagnosis essentially consist in an increase in morbidity and mortality. Those more specifically associated with underdiagnosis are: delays to mood stabilizer treatment and inappropriate use of antidepressants and neuroleptics. Those linked to overdiagnosis are: stigmatization, delays to specific psychotherapeutic or drug (ritalin) treatment and unnecessary side effects of mood stabilizers. A reasonable answer to the question as to whether bipolar disorder is currently under – or overdiagnosed should take into account the great amount of factors liable to influence this answer, as well the consequences of – and risks associated with both underand over diagnosis.

S51-3.
BIPOLAR DISORDER IN YOUTH – CONTROVERSIES IN THE US AND ABROAD

Robert Hendren, D.O., 401 Parnassus Ave, Box F0984, San Francisco, CA 94143

SUMMARY:

The number of children and adolescents diagnosed with bipolar disorder in the United States has grown at an alarming rate; alarming if the figures are even somewhat accurate because we do not have a clear explanation of what this increase in incidence or prevalence represents; and alarming if the figures are not reflecting a true increase in incidence/prevalence represents and we have somehow been lead to use this diagnosis indiscriminately. This presentation will review the epidemiology of bipolar disorder among youth in the US in an effort to elucidate the factors that might help determine how much of the increase represents a true increase in incidence and how much might be due to over diagnosis or to changed diagnostic practices. The diagnostic criteria (e.g. irritability, grandiosity,

euphoria) highlighted by different research groups likely accounts for some or much of the differences found. But an actual increase in the number of young people with bipolar disorder may be due in part to geneenvironment interactions resulting in epigenetic modifications. Studies supporting this epigenetic mechanism will also be presented. The diagnosis of bipolar disorder is controversial not only in the US but also in Europe. Potential explanations for these differing perspectives will be discussed from an etiologic, diagnostic and cultural perspective. Affective instability, rapid cycling and mixed subtypes of bipolar disorder, broad and narrow spectrum, severe mood dysregulation and Temper Dysregulation Disorder will be discussed as alternative concepts to consider a spectrum of bipolar and related disorders in youth. Comparing and contrasting the perspectives of US and French psychiatrists and researchers will be encouraged in this presentation with the goal of developing a more useful perspective in research and clinical practice.

S51-4.
TREATMENT RECOMMENDATIONS: THE FRENCH EXPERIENCE

Philippe Courtet, M.D., Ph.D., Hopital Lapeyronie, Montpellier, 34295 Cedex 5 France

SUMMARY:

Association Française de Psychiatrie Biologique & Neuropsychopharmacologie developed recommendations in the management of patients with bipolar disorders for French practitioners. The recommendations aim to reflect both evidencebased practice and realworld experience. A formalized method by expert consensus panel was used. After synthesis of the literature, 239 questions were developed and sent to a panel of 40 French experts in order to assess six domains: 1) screening and diagnosis, 2) acute phase treatment, 3) maintenance and non pharmacological treatment, 4) somatic comorbidities, 5) psychiatric comorbidities and suicide risk management and 6) special populations. Special attention was made to situations where evidence based treatment are lacking. Experts have been chosen in regard to their publications and/or clinical activities in the field of bipolar disorders. A recommendation has been made when more than half of the experts agree on a specific recommendation. Recommendations on controversial issues will be presented. We provide here two examples. 1) In depression, experts recommend the same therapeutic strategies in BPD I or II. Unlike to other guidelines, experts recommend a combination of an antidepressant with a mood stabilizer in the absence of rapid cycling, and the use of a mood stabilizer in monotherapy or in combination, in their presence. 2) Although the dual diagnosis BPD and substance use disorders is very common, there are virtually no specific recommendations for this population. The experts recommend that the treatment of BPD and comorbid addictive disorders should be concurrent and the use of atypical antipsychotics or antiepileptic drugs during manic, mixed or depressive episodes as well as in prophylaxia. This method to provide recommendations may facilitate the dissemination of recommendations, closer to "real life" situations, and help generate hypotheses for subsequent evidencebase studies.

S51-5
PREVALENCE AND CHARACTERISTICS OF BIPOLAR DISORDERS IN PATIENTS WITH A MAJOR DEPRESSIVE EPISODE

Charles Bowden, M.D., 7703 Floyd Curl Drive, MC 7734, San Antonio, TX 782293900

SUMMARY:

Background: A portion of patients with major depressive episodes (MDE) have underlying, unrecognized, bipolar disorders and consequently receive treatment with ineffective regimens that do not include mood stabilizers. The primary objective of this study was to determine the frequency of bipolar symptoms in patients seeking treatment for a major depressive episode (MDE). Methods: This multicenter, multinational study included 5635 adult patients with a current MDE. Data were collected on sociodemographic variables, current and past psychiatric symptoms and known risk factors for bipolar disorder. The frequency of bipolar disorder was determined by applying both *DSM-IVTR* criteria and previously published bipolarity specifier criteria. Variables associated with bipolarity were assessed using logistic regression. Results: 903 patients fulfilled *DSM-IVTR* criteria for bipolar disorder (16.0% [95%CI: 15.1%17.0%]) whereas 2647 (47.0% [95% CI: 45.7%48.3%]) met the

bipolarity specifier criteria. Significant associations (odds ratios >2; p<0.001) with *DSM-IVTR* and bipolarity specifier criteria were observed for family history of mania/hypomania and multiple past mood episodes. The bipolarity specifier was also significantly associated with manic/hypomanic states while taking antidepressants, current mixed mood symptoms and comorbid substance use disorder. Conclusion: Bipolar specifier criteria identified 2.9 times as many MDE patients as having bipolar disorder as did *DSM-IVTR* criteria. Family history, illness course and clinical status may provide useful information for physicians, in addition to *DSM-IVTR* criteria, when assessing evidence of bipolarity in patients with MDEs. Such an assessment is recommended before deciding on treatment.

SYMPOSIUM 52
PSYCHIATRIC AND BEHAVIORAL GENETICS: ETHICAL AND LEGAL CHALLENGES

Chair: Paul S. Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10033
Co-Chair: Steven K Hoge, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the ethical and legal challenges of new genetic technologies in psychiatry; and 2) Better assist patients in making decisions about various forms of genetic testing.

OVERALL SUMMARY:
Advances in identifying the genetic underpinnings of psychiatric disorders and behavioral traits have created complex ethical and legal challenges for our society. These range from how individuals should make decisions regarding genetic testing for themselves and their offspring to the legal rules that should govern access to and use of new genetic technologies. This symposium addresses the social implications of several of the most exciting genetic advances in psychiatry and behavior. It begins with a consideration of the unhappy history of behavioral eugenics in the United States, and the social and legal forces that led to the sterilization of tens of thousands of Americans in the first half of the 20th century; the echoes of that history resonate whenever interventions based on genetic findings are discussed. We then consider new technologies being developed for noninvasive prenatal testing as early as 5 weeks of gestation, such as cellfree fetal DNA testing of maternal serum. Results will be reported on attitudes of the general public and clinicians towards such testing for psychiatric, cognitive, and other behavioral traits. Genetic screening of newborns takes place in every state, usually on a mandatory basis, and often to identify conditions that may impair cognitive development. Recent concerns about the use of these data have led to calls for limits on mandatory testing, with implications for the incidence of developmental impairment. At the same time, a paradigm shift appears to be taking place in genetics, with the recognition of the importance of epigenetic factors for behavioral traits and illnesses, one paradoxical consequence of which may be a return to a gendered discourse in which mothers are held responsible for their children's behavioral and emotional disorders. Probably the most common use of genetic screening in clinical psychiatry today is for pharmacogenetic testing. However, the potential for test results to have unwanted and unanticipated "secondary information," has been underappreciated, creating risks that need to be taken into account when developing standards for informed consent and confidentiality in pharmacogenetics. Genetic screening of newborns began in 1962 with testing for PKU, an enzyme deficiency that can lead to mental retardation unless a special diet is provided early. At present, all states have adopted mandatory genetic screening of newborns for an increasing number of conditions, many of which affect cognitive development. The broad application of newborn screening raises several issues. First, there are potential negative consequences associated with identification of genetic abnormalities. Some abnormalities do not lead to medical conditions immediately; for others treatment is not available. For children identified with these abnormalities, the potential for labeling and stigma are not offset by benefits. Second, adverse genetic findings may lead to disruption of familial relationships. Parents may feel guilty, reject atrisk children, or act in overly protective ways. Third, screening programs may lead to invasion of privacy by the states. Samples in many jurisdictions are held indefinitely. The legal protections of the samples, and the genetic information they contain, is not clear. The potential to create a national DNA database raises concerns.

Finally, given the universal use of screening, false negatives and positives will affect large numbers of people. Given these problems and complications it is reasonable to ask why genetic screening should be mandatory rather than voluntary, especially in light of findings from the small number of states with voluntary programs that almost all parents consent to screening.

S52-1.
PSYCHIATRIC AND BEHAVIORAL GENETICS AND THE EUGENIC LEGACY

Paul Appelbaum, M.D., 1051 Riverside Drive, Unit 122, New York, NY 10032

SUMMARY:
The history of the eugenics movement in the U.S. continues to play an important role in debates over application of genetic advances to psychiatric and behavioral conditions. At the turn of the 20th century, the biological and social sciences viewed evolution as a 2way street. Although natural selection favored adaptive evolution, inbreeding among less evolved populations could lead to retrogression. The result was thought to be feeblemindedness, epilepsy, alcoholism, mental illness, promiscuity, and much of the criminality in society. Moreover it was widely believed that immigrant groups were enriched with such people. Notions of this sort were popularized in series of case studies, e.g., The Jukes. At the same time, the rediscovery of Mendel's work led to the notion that genetics could be used to deal with this problem. Positive eugenics promoted marriage and childbearing by more "advanced" couples, while negative eugenics sought to restrict childbearing by the atavistic elements in society. All this occurred during the Progressive Era, when increased attention was being given to social problems and their solutions. Since it was believed that the more primitive classes could not be expected to restrict childbearing on their own, compulsory sterilization statutes were introduced, the first one adopted in Indiana in 1907. 14 states passed such laws by 1914, but 7 were struck down on constitutional grounds. New statutes begin to be adopted in 1923, and 17 states had laws by 1926, generally offering more extensive procedural protections than the earlier statutes. In a 1927 opinion by Justice Holmes (Buck v. Bell), the U.S. Supreme Court upheld Virginia's sterilization statute, and by 1931, 28 states had compulsory sterilization laws. Utilization of involuntary sterilization diminished, but did not completely disappear after WWII in response to revulsion at Nazi eugenic practices. The Virginia statute upheld in Buck was not repealed until 1974, and only in 1983 did the state agree to track down survivors, inform them that they had been sterilized, and provide a small amount of compensation. When considering the controversies that invariably arise over the application of genetic technologies to psychiatric and behavioral conditions, this history and the mistakes that were made are critical to informed discussion.

S52-2.
PRENATAL GENETIC SCREENING FOR PSYCHIATRIC DISORDERS AND BEHAVIORAL TRAITS

Mildred Cho, Ph.D., 1215 Welch Rd. ModA, Stanford, CA 94305

SUMMARY:
New technologies are being developed for relatively noninvasive prenatal testing as early as 5 weeks of gestation that could potentially be used to scan the entire genome at high resolution, such as cellfree fetal DNA testing of maternal serum. There is some evidence that prospective parents would want to use such tests to evaluate the fetus' future psychiatric, cognitive and personality traits. However, it is unknown whether these prospective parents or their clinicians deem any such traits inappropriate for fetal testing or why. Therefore we report results of studies to evaluate attitudes of the general public and clinicians towards cellfree fetal DNA testing for psychiatric, cognitive, and other behavioral traits.

S52-3.
NEWBORN GENETIC SCREENING: LEGAL AND ETHICAL CONCERNS

Steven Hoge, M.D., M.B.A., 420 Madison Avenue, Suite 801, New York, NY 10017

SUMMARY:
Genetic screening of newborns began in 1962 with testing for PKU, an enzyme deficiency that can lead to mental retardation unless a special diet is provided early. At present, all states have adopted mandatory genetic screening of newborns for an

increasing number of conditions, many of which affect cognitive development. The broad application of newborn screening raises several issues. First, there are potential negative consequences associated with identification of genetic abnormalities. Some abnormalities do not lead to medical conditions immediately; for others treatment is not available. For children identified with these abnormalities, the potential for labeling and stigma are not offset by benefits. Second, adverse genetic findings may lead to disruption of familial relationships. Parents may feel guilty, reject atrisk children, or act in overly protective ways. Third, screening programs may lead to invasion of privacy by the states. Samples in many jurisdictions are held indefinitely. The legal protections of the samples, and the genetic information they contain, is not clear. The potential to create a national DNA database raises concerns. Finally, given the universal use of screening, false negatives and positives will affect large numbers of people. Given these problems and complications it is reasonable to ask why genetic screening should be mandatory rather than voluntary, especially in light of findings from the small number of states with voluntary programs that almost all parents consent to screening.

S52-4.
IS EPIGENETICS A NEW PARADIGM FOR UNDERSTANDING BEHAVIOR?

Nancy Press, Ph.D., 3455 SW Veterans Hospital Road, Portland, OR 97239

SUMMARY:
Recent years have seen increasingly nuanced modeling of G(ene)+E(nvironment) interactions in many areas of behavioral genetics. Yet, a basic premise has remained unquestioned: that nurture cannot fundamentally change nature; that life experiences cannot change our genomes. This assumption has kept a static quality in even the most nuanced gene+environment interaction models. But a new paradigm may be emerging from work in behavioral epigenetics. Epigenetics research with animal models suggests a real synergy in which the biological substrate itself is affected by aspects of maternal nurture. If such findings are replicated and expanded, what will be the consequences for biological studies of behavior? Will this represent a fundamental change in the ideas of directionality in naturenurture interactions? A return to a gendered discourse in which mothers are held responsible for adult behavioral and emotional disorders? Renewed policy interest in support for prenatal and neonatal aid programs? Or will investigations and interpretations of epigenetics merely be incorporated within the existing rubrics of behavioral genetics, thus failing to fulfill its promise of paradigmatic shift?

S52-5.
ETHICAL ISSUES IN PSYCHOPHARMACOGENETIC TESTING

Jinger Hoop, M.D., 5000 S. 5th Ave, Hines, IL 60141

SUMMARY:
The most important ethical issue in pharmacogenetic testing is the potential for test results to have unwanted and unanticipated "secondary information". Due to genetic pleiotropy, a gene associated with drug response and metabolism may have multiple other effects, including raising or lowering a person's risk of disease. For example, genetic polymorphisms in the serotonin receptor gene and serotonin transporter gene have been associated with response to SSRI's as well as with a number of psychiatric illnesses and conditions, including major depressive disorder and suicidality. The potential for unwanted secondary information has been underrecognized in the literature on pharmacogenetic testing. This phenomenon has important ethical implications and should be taken into account in when developing standards for informed consent and confidentiality in pharmacogenetic testing.

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SYMPOSIUM 53
WHAT'S THE DIFFERENCE THAT MAKES THE DIFFERENCE? COMMONALITIES AND DIFFERENCES ACROSS EFFICACIOUS TREATMENTS FOR BPD

Chair: Linda A Dimeff, Ph.D., 2133 Third Ave Suite 210, Seattle, WA 98121
Co-Chair: Valerie Porr, M.A.
Discussant: Kenneth Silk, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants will be able to: 1) Identify and describe significant similarities and differences between 3 efficacious therapies for borderline personality disorder (BPD): MentalizationBased Treatment (MBT); TransferenceFocused Psychotherapy (TFP), and Dialectical Behavior Therapy (DBT); and 2) Participants will also be able to describe the utility/ application of an integrated approach.

OVERALL SUMMARY:
Borderline personality disorder (BPD) is characterized by intense and labile emotions, significant conflict in interpersonal relationships, and extreme behavioral impulsivity. Although a small percent of the general population, people with BPD account for disproportionately high use of psychiatric services, comprising up to 40% in some studies. BPD is notoriously difficult to treat, with many viewing BPD as a chronic condition. Several manualized, efficacious therapies have emerged providing hope for people with BPD and their families: MentalizationBased Treatment (MBT), TransferenceFocused Psychotherapy (TFP), and Dialectical Behavior Therapy (DBT). Some have advocated for comparison trials between the three to determine which is better. Others have argued against the socalled "horserace" studies, advocating instead that we focus attention on improving each through component analysis studies. Still others have encouraged a thorough examination of the similarities and differences between the approaches to aid in treatment matching, and to potentially further refinements of each by identifying common elements used across all three treatments. The proposed practice seminar will provide an opportunity to demonstrate and discuss the similarities and differences between MBT (Bateman), TFP (Yeomans), DBT (Dimeff), and an emerging integration of DBT and MBT developed for families (Porr). Panelists will first provide a highlevel description of their respective treatments, followed by a live clinical demonstration, commentary, and discussion. Special attention will be devoted to highlighting the structural, strategic, and stylistic similarities and differences between the four approaches. Family members generally spend more time with the person with BPD than any clinician while dealing with what appears to them as irrational, abusive and dangerous BPD behaviors without knowing what to do to deescalate the emotional eruptions or how to avoid triggering dysregulations leading to crisis situations. With DBT and MBT training, family members can learn how to become therapeutic parents &/or partners, reduce environmental stressors and reinforce effective behaviors. Research shows us that 70% of people with BPD drop out of treatment, leaving families alone on the front lines. According to John Gunderson, MD, "failure to involve the family as support for treatment of BPD makes patients' involvement in therapy superficial and is a major reason for premature dropout." Reinforcing this philosophy, the presenter will describe the elements of DBT and MBT incorporated into TARA's family workshops, highlighting specific DBT and MBT treatment strategies used successfully by family members in daily interactions. By definition, family relationships are the essential attachment relationships that are the focus of MBT. This presentation will illustrated a family crisis where a family member implements DBT and MBT techniques in the heat of the moment to restore mentalization and avert further emotional escalation by talking to their loved one in the compassionate, limbic language of validation, not personalizing or controlling, reinforcing effective DBT coping methods and building mastery and competence while clarifying the nuances and subtleties of the intentions of the interaction to restore mentalization.

S53-1.
MENTALIZATION BASED TREATMENT (MBT) AND ITS RELATIONSHIP TO OTHER PSYCHOTHERAPIES FOR BORDERLINE PERSONALITY DISORDER

Anthony Bateman, M.D., St Ann's Hospital, London, N15 3TH United Kingdom

SUMMARY:
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 selfawareness and other awareness. We have to be able to continue to do this in the midst of emotional states. Borderline personality disorder is specifically characterised by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of mentalizing interventions is to increase capacity to mentalize in order to ensure better regulation of affective states and to increase interpersonal and social function and to reduce the impact of traumatic memories. An outline of mentalizing interventions, structured and integrated into mentalization based therapy, will be provided and these will be contrasted with interventions that can reduce mentalizing. An argument will be made to suggest that mentalizing interventions are an effective component of many therapies including DBT and TFP both of which will be discussed in this symposium and that no therapy can be effective unless it specifically targets mentalizing or stimulates it as an epiphenomenon. Efforts will be made to identify techniques shared between therapies, particularly DBT and TFP, and to establish differences in clinical practice.

S53-2.

TRANSFERENCEFOCUSED PSYCHOTHERAPY: THE RELATIONSHIP IN THE HERE AND NOW AS THE KEY

Frank Yeomans, M.D., Ph.D., 286 Madison Avenue Suite 1602, New York, NY 10017

SUMMARY:
TranserenceFocused Psychotherapy (TFP) for patients with BPD and other serious personality disorders is a twice weekly individual therapy based on psychodynamic concepts. These concepts include the idea that conflicts within the mind play a large role in both the specific symptoms of BPD and in the associated relationship problems. The principle psychological conflict in BPD is believed to be the fundamental split in the patient's mind that divides internal representations of self and others into extremes of bad (negative affects) and good (positive affects). This split structure of the mind is seen as the basis of the patient's chaotic and troubling way of experiencing self, others and the environment, and leads to the stormy interpersonal relations and impulsive behaviors that constitute the symptoms of the disorder. TFP places special emphasis on collaborating with the patient to set up a frame of the treatment that anticipates likely threats to the patient's wellbeing and to the treatment. The treatment thus first contains destructive behaviors through structure, limit setting, and the developing relation with the therapist. Then elements of the split psychological structure are observed and reflected upon as they unfold in that relationship as they are TRANSFERRED from the patient's internal world to the therapeutic setting. 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 ultimate goal of the therapy is to integrate these extreme affects into a more coherent, textured, and realistic sense of self and others.

S53-3.

DIALECTICAL BEHAVIOR THERAPY

Linda Dimeff, Ph.D., 2133 Third Ave Suite 210, Seattle, WA 98121

SUMMARY:
Dialectical Behavior Therapy (DBT) is a comprehensive, multimodal treatment for borderline personality disorder (BPD). DBT assumes that (1) people with BPD lack important interpersonal, selfregulation (including emotional regulation), and distress tolerance skills, and (2) personal and environmental factors often both block and/or inhibit the use of behavioral skills that BPD individuals do have, and reinforce dysfunctional behaviors. DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, within an overarching dialectical worldview that emphasizes the synthesis of opposites. Standard outpatient DBT includes four modes: Individual Psychotherapy, Skills Training, Phone Consultation and Consultation Team. More important than the modes themselves are the functions they facilitate. These include: building motivation, enhancing skills capabilities, ensuring generalization to the natural environment, and structuring the environment. By articulating the functions of treatment, DBT can be transported to novel treatment environments where fidelity to the treatment can be preserved. The ultimate goal of DBT is to bring individuals closer to their ultimate goals. To date, nine randomized

controlled trials across five different institutions have demonstrated its efficacy, six of which focus specifically on the treatment of severely disordered individuals with BPD patients. Building on the theme for this symposium, the presenter will describe and highlight specific DBT treatment strategies used by the individual therapist when treating a person with BPD. Special effort will be made to draw comparisons and contrasts with DBT to TFP and MBT.

S53-4.
TARA DBTMBT FAMILY TRAINING

Valerie Porr, M.A., 23 Greene St, NYC, NY 10013

SUMMARY:
Family members generally spend more time with the person with BPD than any clinician while dealing with what appears to them as irrational, abusive and dangerous BPD behaviors without knowing what to do to deescalate the emotional eruptions or how to avoid triggering dysregulations leading to crisis situations. With DBT and MBT training, family members can learn how to become therapeutic parents &/or partners, reduce environmental stressors and reinforce effective behaviors. Research shows us that 70% of people with BPD drop out of treatment, leaving families alone on the front lines. According to John Gunderson, MD, "failure to involve the family as support for treatment of BPD makes patients' involvement in therapy superficial and is a major reason for premature dropout." Reinforcing this philosophy, the presenter will describe the elements of DBT and MBT incorporated into TARA's family workshops, highlighting specific DBT and MBT treatment strategies used successfully by family members in daily interactions. By definition, family relationships are the essential attachment relationships that are the focus of MBT. This presentation will illustrated a family crisis where a family member implements DBT and MBT techniques in the heat of the moment to restore mentalization and avert further emotional escalation by talking to their loved one in the compassionate, limbic language of validation, not personalizing or controlling, reinforcing effective DBT coping methods and building mastery and competence while clarifying the nuances and subtleties of the intentions of the interaction to restore mentalization.

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SYMPOSIUM 54
PREDICTORS, MODERATORS, AND MEDIATORS IN MAJOR DEPRESSIVE DISORDER

Chair: George I Papakostas, M.D., One Bowdoin Square, 6th floor, Boston, MA 02114

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the emerging role of clinical and biologic: Predictors, Mediators, and Moderators of treatment outcome in MDD.

OVERALL SUMMARY:
Major depressive disorder (MDD) is an, often, chronic and recurrent illness, associated with significant functional impairment, morbidity, and mortality. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), MDD is diagnosed by the presence of a number of diverse symptoms of psychological, cognitive, or somatic nature. As a result, MDD is a, clinically, highly heterogeneous illness. Although antidepressants have been found to be efficacious in the treatment of MDD, robust and replicable differences in overall

efficacy among contemporary antidepressants have not been demonstrated to date. In addition, whether individual antidepressant agents are more or less efficacious than others in the treatment of specific "subtypes" of patients with MDD, defined by the presence of a clinical or biologic marker, had not been firmly established. As a result, it was not possible to select one given therapy over another based on clinical presentation or the presence of a biological marker in order to enhance efficacy or tolerability. More recently, however, there is emerging evidence to suggest that several clinical and biologic factors may be relevant with regards to predicting the likelihood of responding to standard antidepressant therapy (predictors), as well as in defining subpopulations of patients whose depression may preferentially respond to one given treatment over another (moderators of treatment outcome). In parallel, attempts have also been made to identify whether the change in specific biological or clinical markers (mediators) during the course of therapy may also correlate with treatment outcome in MDD, the change of which may also serves as a moderator, mediator (correlate), or predictor of clinical improvement following the treatment of MDD with standard, 1stline antidepressants. Ultimately, being able to select an appropriate treatment based on clinical presentation or the presence of biologic markers may help improve the standard of care for MDD. The goal of the symposium is to review evidence suggesting how clinical and biologic measures can, potentially, serve as predictors, moderators, and mediators of treatment outcome during the acute phase of therapy for MDD.

S54-1.
PREDICTORS, MODERATORS, AND MEDIATORS OF SYMPTOM IMPROVEMENT IN MAJOR DEPRESSIVE DISORDER: FOCUS ON CLINICAL FACTORS

George Papakostas, M.D., One Bowdoin Square, 6th floor, Boston, MA 02114

SUMMARY:
Major Depressive Disorder (MDD) is a prevalent illness that is frequently associated with significant disability, morbidity, and mortality. Despite the development and availability of numerous treatment options for MDD, studies have shown that antidepressant monotherapy yields only modest rates of response and remission. Clearly, there is an urgent need to develop more effective treatment strategies for patients with MDD. One possible approach towards the development of novel pharmacotherapeutic strategies for MDD involves identifying subpopulations of depressed patients that are more likely to experience the benefits of a given (existing) treatment versus placebo, or versus a second treatment. Attempts have been made to identify such "subpopulations", specifically by testing whether a given biological or clinical marker also serves as a moderator, mediator (correlate), or predictor of clinical improvement following the treatment of MDD with standard, 1stline antidepressants. During the course of this lecture, the discussant will present the definitions of predictors, moderators, and mediators of clinical improvement in MDD, discuss the potential applications of such elements on clinical practice as well as future drug development, and review the literature in order to identify clinical factors which may serve in this role.

S54-2.
PHARMACOGENOMICS OF MAJOR DEPRESSION

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

SUMMARY:
Major depression is a highly common and complex disorder of unknown causes. Antidepressant drugs have a range of effectiveness that go from complete remission to nonresponse, and that may include adverse reactions. Part of the variability in antidepressant drug response is related to genetic factors, which are now being elucidated. The field is severely limited by the lack of funding for large, prospective, doubleblind, randomized, placebocontrolled studies that are specifically designed to study pharmacogenomic outcomes. Existing rigorous studies are small or alternatively pharmacogenomic approaches have been applied to large studies that were not optimally designed to test pharmacogenomic hypotheses. In this presentation we will show data on candidates in serotoninergic, phosphodiesterase and immune pathways and will also present data on resequencing of key candidate

genes. Those include brain derived neurotrophic factor (BDNF), the ATPbinding cassette subfamily B member 1 (ABCB1), the noradrenaline, dopamine, and serotonin transporters (SLC6A2, SLC6A3 and SLC6A4), cyclic AMPresponsive element binding protein 1 (CREB1), corticotropinreleasing hormone receptor 1 (CRHR1) and neurotrophic tyrosine kinase type 2 receptor (NTRK2). We discovered in 600 MexicanAmericans from Los Angeles that in these frequently studied genes, at least half of the genetic variation we found was novel and had never been previously deposited in public databases. Such variants were mostly rare with a frequency of under 5% in the population. If the common diseaserare variant hypothesis is correct, massive resequencing will be necessary to elucidate the pharmacogenomics of psychiatric disorders, including major depression, particularly in ethnic minority groups.

S54-3.

PHOSPHORUS31 MRS STUDIES OF HIGH ENERGY PHOSPHATES IN MDD: IMPLICATIONS FOR TREATMENT RESPONSE AND NOVEL THERAPIES

Perry Renshaw, M.D., Ph.D., 383 Colorow Drive, #309, Salt Lake City, UT 84108

SUMMARY:
Background: This talk will present an overview of the use of magnetic resonance imaging methods (MRI; fMRI; MRS; and DTI) to predict or moderate treatment outcomes in MDD. A March, 2010 MEDLINE search identifies over 600 publications on this topic. More detail will then be presented regarding studies involving the use of phosphorus31 (31P) magnetic resonance spectroscopy (MRS), which provides a means to detect and quantify regional brain levels of phosphocreatine (PCr) and nucleoside triphosphate (NTP; primarily adenosine triphosphate). Studies of depressed adults have demonstrated that increased ratios of PCr/NTP are (1) more common in depression and (2) are associated with a positive response to treatment. To determine whether creatine has antidepressant effects in humans, two studies were conducted. In the first study, unmedicated depressed females (N = 26) were assigned to take escitalopram plus either creatine or placebo. In the second study, adolescent females (N = 6) who had not responded to a full course of either fluoxetine or escitalopram treatment were treated with open label creatine. Results: Oral creatine supplementation (n=14) was associated with significantly greater symptom improvement, measured by the 17item HDRS, as compared with placebo supplementation (n=12) after 2 weeks through 8 weeks of treatment. For the adolescents, baseline CDRS scores of 72.3 +/ 9.5 decreased to 32.3 +/ 10.4, following eight weeks of open label treatment. Discussion: Alterations in highenergy phosphate metabolism are common in persons with major depression, especially women. Notably, high PCr/NTP ratios suggest that treatment responders have adequate highenergy buffer stores (PCr) but are not using these to support neuronal activity levels (which parallel NTP usage). To date, we have observed positive treatment outcomes in response to thyroid hormone augmentation and SSRI treatment).

S54-4.

NEUROPHYSIOLOGIC BIOMARKERS FOR PREDICTING TREATMENT OUTCOME IN MDD

Andrew Leuchter, M.D., 760 Westwood Plaza Room 37452, Los Angeles, CA 90024

SUMMARY:
The greatest challenge in the management of MDD is selection of the medication that is most likely to lead to response or remission. Certain neurophysiologic biomarkers may help select these medications. Use of low resolution electromagnetic tomography (LORETA), loudness dependent auditory evoked potentials (LDAEP), and resting state quantitative electroencephalography (QEEG) in the clinical setting is increasingly supported by studies indicating that these techniques may help identify particular medications that are most likely to lead to response or remission. One putative neurophysiologic biomarker, the Antidepressant Treatment Response (ATR) index, is based upon quantitative electroencephalographic (QEEG) data recorded from the frontal regions on two occasions, at pretreatment baseline (immediately before medication is started) and at the end of one week of treatment with medication. ATR is based upon a change in brain electrical activity integrated and scaled from 0 (low probability of response or remission to the medication) to 100 (high probability). In a study of 73 MDD subjects

treated with escitalopram, ATR predicted response and remission with 74% overall accuracy. A low ATR value not only predicted nonresponse to escitalopram, but also subsequent response to treatment with the antidepressant bupropion. Subjects with ATR values above the threshold were more than 2.4 times as likely to respond to escitalopram as those with low ATR values (68% vs. 28%, p=.001). Subjects with ATR values below the threshold who were switched to bupropion treatment were 1.9 times as likely to respond to bupropion alone than those who remained on escitalopram treatment (53% vs. 28%, p=.034). ATR is recorded with a simple laptop computerbased system and can be performed in 10 – 15 minutes in any officebased setting. ATR therefore could constitute a powerful and translatable clinical tool if these results are replicated by future studies.

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SYMPOSIUM 55
THE USE OF QUANTITATIVE EEG FOR PSYCHIATRIC TREATMENT BIOMARKERS

Chair: Charles Debattista, M.D., 401 Quarry Road, Stanford, CA 943055723

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize and understand the necessity and role of Biomarkers in Psychiatry; 2) Identify the different methods of using electrophysiology in the use of developing Biomarkers; 3) Analyze the role of Quantitative EEG in providing objective, evidencebased data in guiding treatments and psychotropic medication choices; and 4) The practical use and advantages of QEEG as a biomarker for medication treatment response.

OVERALL SUMMARY:

In psychiatric practice, the selection of a treatment regimen rests on clinical judgment and proceeds on a trialanderror basis. The selection of a medication may end up being an educated guess at best. NIMH is committed to new directions: 1) who will respond to a specific treatment 2) personalized and reliable response predictors (e.g. biomarkers) (2) 3) treatments that span multiple DSM diagnoses and yield biosignatures.(3) Biomarkers offer an important tool which can impact neurosciences by providing new CNS treatments, pharmacotherapy development, and objective evidencebased approaches to personalizing medication selection. Several approaches are in development for the use of biomarkers in psychiatry, including genetics and imaging. This symposium addresses EEG electrophysiology as biomarker indicators. It will also focus on the practical usability of this testing as well as scalability, cost, ease of utilization and noninvasiveness as advantages. Three approaches will be presented: 1) Use of QEEG to define an Antidepressant Treatment Response Index (ATR) at baseline and changes from baseline to week 1(45). ATR has been shown to identify future responders to SSRIs and buproprion (45) and to allow successful early changes of ineffective antidepressants using “cordance” (67). 2) ReferencedEEG (rEEG) guides selection of medications correlated with a database of known long term treatment outcomes (710). rEEG uses brainwave pattern recognition and provides a report on prospective medicationguidance. It addresses up to 30 medications, currently, by categorizing them according to probability of success, similar to an antibiotic sensitivity report. 3) The iSPOTD

international study utilizes a test battery that includes QEEG, genetic testing, cognitive testing and evoked potential to select more stable and quantitative markers to predict personalized treatment response. (11)

S55-1.
ANTIDEPRESSANT TREATMENT RESPONSE INDEX (ATR) A QUANTITATIVE EEGBASED BIOMARKER OF TREATMENT RESPONSE IN MAJOR DEPRESSION

Dan Iosifescu, M.D., M.S.C., 50 Staniford Street, Suite 401, Boston, MA 02114

SUMMARY:
From the 1) Mood and Anxiety Disorders Program, Mount Sinai School of Medicine; and 2) Massachusetts General Hospital and Harvard Medical School. There is a clear need for objective biomarkers to assist and optimize the selection of most efficacious antidepressant treatments. In this presentation we will review a growing body of evidence suggesting that several quantitative electroencephalography (QEEG) based technologies may be useful for predicting clinical response to antidepressants and eventually for guiding clinical treatment decisions. Frontal EEG measures in the alpha (8.512 Hz) and theta (48 Hz) EEG bands have been described as markers of the communication between the prefrontal and cingulate brain regions implicated in emotional regulation. Moreover, theta and alpha band abnormalities measured from prefrontal brain areas have been associated with clinical response to antidepressant medications. The Antidepressant Treatment Response Index (ATR) is a 3parameter QEEG index which combines prefrontal EEG theta and alpha power from baseline and week 1. Several recent large studies have shown that ATR (measured at baseline and week 1) has good ability to predict future antidepressant response (after 8 weeks of treatment). In the recent BRITEMD study, ATR predicted accurately rates of response to escitalopram or buproprion; patients with low predicted response to escitalopram had significantly superior outcomes if they switched early (after 1 week) to buproprion. This justifies the potential of ATR to guide treatment decisions (i.e., whether to continue or change an antidepressant treatment) after only 1 week. We will also review other QEEG measures (e.g., cordance) shown to be predictors of antidepressant response, as well as other studies suggesting that QEEG can be used to detect patients at risk to experience severe side effects (including suicidal ideation) during antidepressant treatment.

S55-2.
REFERENCED EEG (REEG)

Daniel Hoffman, Fapa, M.D., 2755 Bristol Street, Suite 285, Costa Mesa, CA 92626

SUMMARY:
The digitization of EEG (QEEG) heralded major advances in EEG technology. It allowed comparison of a patient's EEG pattern with the values of agematched, asymptomatic controls in large databases.13 There are several reports of QEEG changes in psychiatric disorders.410 Medicationinduced changes in EEG and QEEG data have been reported for a broad range of medications including SSRIs, benzodiazepines, stimulants, and mood stabilizers. ReferencedEEG is an objective assessment system, consisting of QEEG measurements, associated with an outcomes database. It correlates known patient longterm (~ 405 days) medication response with 74 biomarkers found to be predictive of positive outcomes. It is used particularly for treatment resistant nonpsychotic patients, guiding a personalized medication treatment strategy. The rEEG report is not diagnostic, as it has been shown that such phenotypes are evident in patients of varying diagnosis or no diagnosis. Instead, its value has been demonstrated in guiding trained physicians in integrating this information into a pharmacotherapy strategy with significantly improved treatment results. Through years of data accrual and associated mathematical analysis, a platform of electrophysiologic abnormalities or relationships (biomarkers) have been identified which correlate with specific medications providing either consistently successful or consistently unsuccessful clinical outcomes. Its guidance has been utilized in treating patients evidencing a wide range of symptom diagnosis including disorders of: depression, anxiety, bipolar, ADD, anorexia, bulimia, and chemical abuse.1114 Four randomized controlled and 8 open labeled studies have demonstrated an average improvement of 66% based on the outcomes measurements. The

latest national study performed at 12 sites used the STAR*D rankordered medications as a control algorithm against the rEEG guided medication choices. Research results and clinical use will be discussed in the symposium.

S55-3.
INTERNATIONAL STUDY TO PREDICT OPTIMIZED TREATMENT IN DEPRESSION (ISPOT)

Evian Gordon, Ph.D., Level 12, 235 Jones St, Ultimo, NSW 2007 Australia

SUMMARY:
iSPOTD is currently the largest international study on Depression. It is an effectiveness trial with the primary aim of identifying genetic, EEG, ERP, autonomic, MRI, fMRI, brain structure/function and cognitive markers (or combinations of markers) which predict drug treatment response or nonresponse in MDD. The secondary aim of the study is to identify which of these combinations of markers distinguish MDD from healthy subjects, and to determine whether markers of MDD overlap with markers of treatment prediction in MDD. A tertiary aim is to determine whether markers of acute treatment prediction are also predictive of functional outcome over 612 month followup periods. Successful identification of these markers could have widespread benefit by providing significant cost and treatment efficiencies. Currently, clinicians rely on the subjective observation of signs and symptoms to diagnose conditions and select treatment options. Identification of more objective markers could allow clinicians to more successfully match the right treatment at the right time to an individual. In addition, the identification of objective diagnostic and treatment response markers has the potential to enhance results of clinical drug trials by providing pharmaceutical and biotechnology companies with the means to identify and enroll the appropriate patient population(s) and more accurately assess treatment outcomes.

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SYMPOSIUM 56
ADVANCES ON SUICIDE PREVENTION: PREVENTING THE PREDICTABLE

Chair: Enrique BacaGarcia, M.D., Ph.D., Avenida Reyes Catolicos 2, Madrid, 28004 Spain
Co-Chair: Maria A Oquendo, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify which life events and personality traits are more important in preventing suicidal behavior; 2) Integrate all the information about the diverse risk factors that increase the likelihood of suicidal behavior; 3) Improve the prediction of risk of suicide with regard to age, gender, and setting; and 4) Acknowledge that the implementation f novel classification tools may help in suicidal behavior prediction/prevention.

OVERALL SUMMARY:
Suicide is a public health problem that accounts for approximately 1.5% of the Global Burden of Disease. Usually considered preventable, it is challenging to reduce the rates of suicide all over the world. As an example, public preventive policies are winning the battle against traffic accidents and the numbers of road traffic victims are decreasing across Europe and US. In contrast, suicide rates remain high and seem relatively insensitive to suicide prevention policies. Novel approaches to suicide prediction may provide new avenues for prevention. We present herein the implementation of novel statistical approaches to the field of suicidal behavior prediction from several but complementary perspectives. First, we will present data about the classification performance of Fisher Linear Discriminant Analysis compared with the traditional psychometrical approach using the HolmesRahe Social Readjustment Rating Scale (life events) and the International Personality Disorder ExaminationScreening Questionnaire (personality disorders). Next, we present the major models in suicidal behavior and a recently model suggested by our group. Then, we present two discriminative machinelearning procedures (Support vector machines and Gaussian process classifiers) that we are implementing in suicidal behavior prediction. We first describe support vector machines and how they implement the structural risk minimization principle. We introduce Gaussian process classifiers from its estimation counterpart and how they are able to produce accurate posterior probability estimates. We complete our presentation with some applications that have popularized these discriminative learning methods within the engineering and computer science communities. Then, we explain our experience on data mining and suicide prediction. We have previously used data mining in exploring complex clinical decisions in the study of suicide. We reported that data mining was better than traditional statistical techniques to classify the variables that predicted psychiatrists´ decisions to hospitalize suicide attempters. Data mining may be used to predict the patients that are at greater risk of suicidal behavior. Finally, we conclude explaining possible ways to use all these novel tools in suicide prevention from a clinical standpoint.

S56-1.
PERSONALITY AND LIFE EVENTS AS PREDICTIVE FACTORS OF SUICIDAL BEHAVIOR

Hilario BlascoFontecilla, M.D., Ph.D., Avenida Reyes Catolicos 2, Madrid, 28004 Spain

SUMMARY:
Suicide is a public health problem that accounts for approximately 1.5% of the Global Burden of Disease. Usually considered preventable, it is challenging to reduce the rates of suicide all over the world. As an example, public preventive policies are winning the battle against traffic accidents and the numbers of road traffic victims are decreasing across Europe and US. In contrast, suicide rates remain high and seem relatively insensitive to suicide prevention policies. Novel approaches to suicide prediction may provide new avenues for prevention. We present herein the implementation of novel statistical approaches to the field of suicidal behavior prediction from several but complementary perspectives. We will present data about the classification performance of Fisher Linear Discriminant Analysis compared with the traditional psychometrical approach using the HolmesRahe Social Readjustment Rating Scale (life events) and the International Personality Disorder ExaminationScreening Questionnaire (personality disorders). Next, we present the major models in

suicidal behavior and a recently model suggested by our group.

S56-2.
PREDICTIVE MODELS IN SUICIDAL BEHAVIOR

Jorge LopezCastroman, M.D., Ph.D., Gregorio Vacas 6C, 3A, Madrid, 28020 Spain

SUMMARY:
Risk reduction and preventive strategies usually target highrisk individuals in the aftermath of a suicide attempt. Despite the recurrence of suicide attempts, to date there are no universally accepted guidelines for managing attempters to prevent further attempts after discharge. This may be in part because there is no clear understanding of the hierarchy or relationship between a variety of factors that predict future attempts. These include demographic and clinical factors. At the same time, risk evaluation is frequently inaccurate because available predictive models are imprecise, hampering our ability to identify potential reattempters. To date, most studies addressing the prediction of suicide reattempts have used no measures of predictive accuracy, limiting the clinical utility of their findings. However, when the precision of the prediction is measured, the results are disappointing, the weak predictive value of risk factors leading to large numbers of falsepositives or falsenegatives. Accurate identification of highrisk suicide attempters is crucial to the development and implementation of targeted interventions to be provided according to the potential for reattempt and the available resources. We will revise the degree to which we can predict suicide attempts and consider newer approaches that may help to improve the existing models.

S56-3.
NOVEL CLASSIFICATION TOOLS FOR SUICIDE PREDICTION

Fernando PerezCruz, B.S.C., Av. Universidad 30, Madrid, 28911 Spain

SUMMARY:
Support vector machines were developed in the late nineteennineties for solving the general classification problem, in which the different nonparametric hypothesis are described by independent and identically distributed sampled data. Support vector machines are based on the statistical learning theory VapnikChervonenkis theory, which describes the necessary and sufficient conditions for learning algorithms, i.e. the minimization of the empirical risk, to converge to the minimum risk and it gives performance bounds for finite sets. Support vector machines generalize the optimal hyperplane decision rule by nonlinearly transforming the data into a highdimensional Hilbert space and describing its solution in terms of the kernel on that space. Gaussian process classifiers are Bayesian nonparametric machinelearning tools for solving the same discriminative classification problem. They assume that a Gaussian process prior describes the latent classification function and the observations shape the prior to obtain a posterior probability estimate for each sample. Gaussian process classifiers, similarly to support vector machines, produce nonlinear decisions functions using nonlinear parametric covariance functions, whose parameters can be learnt by maximum likelihood or be marginalized out. In this talk, we present both discriminative machinelearning procedures. We first describe support vector machines and how they implement the structural risk minimization principle. We introduce Gaussian process classifiers from its estimation counterpart and how they are able to produce accurate posterior probability estimates. We complete our presentation with some applications that have popularized these discriminative learning methods within the engineering and computer science communities.

S56-4.
DATA MINING, SUICIDE AND MORE: OUR EXPERIENCE

M. Mercedes PerezRodriguez, M.D., Ph.D., One Gustave L. Levy Place, Box 1230, New York, NY 10029

SUMMARY:
Preventing suicide can only be achieved if previously we are able to detect those subjects at risk. Traditional statistical approaches to suicide prevention have proved unsuccessful. Therefore, the implementation of novel statistical techniques with important exploratory and classificatory properties may help in preventing suicidal behaviors. Data mining are a set of novel statistical tools that allow

to explore large databases. Traditionally used in the travel industry, marketing, telecommunications, and banking, among others, in recent times, data mining strategies have been applied to the study of medicine in general, and cardiology and oncology in particular. A good example about the type of Studies where data mining is currently being applied is the study by Ray et al. (2007). These authors used machine learning to classify neurological patients as having Alzheimer or not by using a set of different blood signaling proteins. A type of algorithm called predictive analysis of microarrays (PAM) correctly classified 95% of all Alzheimer's cases (positive agreement) and 83% of nondementia controls (negative agreement). We have previously used data mining in exploring complex clinical decisions in the study of suicide. We reported that data mining was better than traditional statistical techniques to classify the variables that predicted psychiatrists´ decisions to hospitalize suicide attempters. Data mining may be used to predict the patients that are at greater risk of suicidal behavior. Indeed, we plan to apply data mining to the prediction of risk of suicide reattempt and suicide completion.

S56-5.
IMPLEMENTATION OF ALL THESE NOVEL TOOLS IN THE PREVENTION OF SUICIDE

Jose de Leon, M.D., UKMRC at ESH, 627 West Fourth St, Lexington, KY 40508

SUMMARY:
Suicide is a public health problem that accounts for approximately 1.5% of the Global Burden of Disease. Usually considered preventable, it is challenging to reduce the rates of suicide all over the world. In order to effectively prevent suicide, firstly we should be able to predict which subjects are at risk, and when they are acutely suicidal. Indeed, the prediction of suicidal behavior constitutes a major challenge for health professionals. We will explore possible ways to implementate novel tools in suicide prevention from a clinical standpoint. Novel approaches to suicide prediction may provide new avenues for prevention and help to decrease the daunting rates of suicide worldwide.

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1) Pokorny AD. Prediction of suicide in psychiatric patients. Report of a prospective study. Arch Gen Psychiatry 1983;40(3):24957
2) Das K, Giesbrecht B, Eckstein MP. Predicting variations of perceptual performance across individuals from neural activity using pattern classifiers. Neuroimage 2010;51(4):142537
3) Ponseti J, Granert O, Jansen O, Wolff S, Mehdorn H, Bosinski H, et al. Assessment of sexual orientation using the hemodynamic brain response to visual sexual stimuli. J Sex Med 2009;6(6):162834
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SYMPOSIUM 57
COLLABORATIVE STRATEGIES BETWEEN PSYCHIATRISTS AND JUDGES TO IMPROVE OUTCOMES FOR DEFENDANTS WITH MENTAL ILLNESSES

Chair: Fred C. Osher, M.D., 1809 Landfall Way, Johns Island, SC 29455
Co-Chair: Steve Leifman, J.D., B.S.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify five factors contributing to the overrepresentation of persons with mental illnesses in the justice system; 2) Name five programmatic interventions with documented effectiveness in reducing contact with the CJ system; 3) Define mental health courts and cite evaluation data on their effectiveness; and 4) Name four critical areas for judicial training.

OVERALL SUMMARY:
The number of individuals with serious mental illnesses (SMI) in the criminal justice system is between three and six times the number of individuals with SMI in the general U.S. population. A recent GAINS Center and Council of State Governments Justice Center (Justice Center) study of over 20,000 adults in five local jails found that 14.5 % of male inmates and 31% of female inmates met criteria for a serious mental illness. Last year, approximately 1.5 million people with serious mental illnesses were arrested. On any given day in

our country, there are almost 400,000 with mental illnesses in our jails and prison and another 900,000 in the community under correctional supervision. The overrepresentation of persons with SMI in the criminal justice system has a significant impact on the recovery path of these individuals, creates substantial stress for their families, and has a large effect on criminal justice systems, public safety, and government spending. To address this problem, communities have taken action by improving crosstraining of mental health and criminal justice personnel, launching specialized programs, and advocating for increased funding dedicated to this population. The role of judges in these initiatives is of paramount importance. In 2004, the Judges' Criminal Justice/Mental Health Leadership Initiative (JLI) was initiated to bring judges from all levels of state judiciaries together to improve judicial understanding of, and responses to, individuals with mental illnesses in our nation's courts. The JLI and Justice Center have initiated a new initiative with the American Psychiatric Foundation, to convene a "Psychiatric Leadership Group" (PLG) to advise the JLI. Psychiatrists must play an active role in identifying the needs of persons with SMI and the range of effective responses. One of the first objectives of this new collaboration will be the development of a training module for judges on mental illnesses and the criminal justice system. The crosstraining needs of psychiatrists must also be considered if effective collaboration is to be achieved. This symposium will provide judicial and psychiatric perspectives on the factors associated with the overrepresentation of persons with mental illnesses in the justice system, innovative collaborative responses to reduce their involvement with criminal justice agencies, and outline approaches to judicial and psychiatric crosstraining. The large overrepresentation of people with SMI in the criminal justice system has thrust judges into a new and unique role – leaders and advocates for an improved community mental health system. Judge Leifman will discuss the evolution of this movement, how the justice system is responding, opportunities to partner with psychiatric leaders, and new and effective strategies that are being developed to transform the mental health system. Judge Waldorf will discuss the Hawaii perspective and how this issue impacts Hawaii.

S57-1.

DEVELOPING AN EFFECTIVE COMMUNITY CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEM: THE JUDGE AS CHANGE AGENT

Steve Leifman, J.D., B.S., 1351 N.W. 12 Street, Miami, FL 33125

SUMMARY:
The large overrepresentation of people with SMI in the criminal justice system has thrust judges into a new and unique role – leaders and advocates for an improved community mental health system. Judge Leifman will discuss the evolution of this movement, how the justice system is responding, opportunities to partner with psychiatric leaders, and new and effective strategies that are being developed to transform the mental health system. Judge Waldorf will discuss the Hawaii perspective and how this issue impacts Hawaii.

S57-2.

WHY COLLABORATIVE STRATEGIES ARE ESSENTIAL

Fred Osher, M.D., 1809 Landfall Way, Johns Island, SC 29455

SUMMARY:
The number of individuals with serious mental illnesses (SMI) in the criminal justice system is between three and six times the number of individuals with SMI in the general U.S. population. A recent GAINS Center and Council of State Governments Justice Center (Justice Center) study of over 20,000 adults in five local jails found that 14.5 % of male inmates and 31% of female inmates met criteria for a serious mental illness. Last year, approximately 1.5 million people with serious mental illnesses were arrested. On any given day in our country, there are almost 400,000 with mental illnesses in our jails and prison and another 900,000 in the community under correctional supervision. The overrepresentation of persons with SMI in the criminal justice system has a significant impact on the recovery path of these individuals, creates substantial stress for their families, and has a large effect on criminal justice systems, public safety, and government spending. To address this problem, communities have taken action by improving crosstraining of mental health and criminal justice

personnel, launching specialized programs, and advocating for increased funding dedicated to this population. The role of judges in these initiatives is of paramount importance. Psychiatrists must play an active role in identifying the needs of persons with SMI and the range of effective responses. One of the first objectives of this new collaboration will be the development of a training module for judges on mental illnesses and the criminal justice system. This symposium will provide judicial and psychiatric perspectives on the factors associated with the overrepresentation of persons with mental illnesses in the justice system, innovative collaborative responses to reduce their involvement with criminal justice agencies, and outline approaches to judicial and psychiatric crosstraining.

S57-3
COLLABORATIVE STRATEGIES BETWEEN PSYCHIATRISTS AND JUDGES TO IMPROVE OUTCOMES FOR DEFENDANTS WITH MENTAL ILLNESSES

Annelle Primm, M.D., M.P.H., 1000 Wilson Blvd Ste 1825, Arlington, VA 222093901

SUMMARY:
This presentation will explore the important role that psychiatrists can play in minimizing contact with the criminal justice system among people with mental illness. In providing quality care that is culturally competent, recoveryoriented and evidence based, psychiatrists can maximize beneficial treatment outcomes and reduce the risk of relapse and adverse outcomes, such as homelessness, which make people with mental illness more vulnerable to incarceration. Furthermore, it is important for psychiatrists to develop and/or use resources in their communities specifically designed to prevent incarceration for people with mental illness including crisis intervention training for law enforcement personnel and collaboration with judges in developing mental health courts and other jail diversion mechanisms. Psychiatrists also play a key role in providing quality mental health care for people with mental illness in jails and prisons, developing thoughtful plans for community reentry and linking people exiting the correctional system to community mental health services and other supports. These actions increase the likelihood of reduced recidivism and community tenure.

S57-4.
HOW THE ISSUE IMPACTS HAWAIIANS

Marcia Waldorf, J.D., 2385 Waimano Home Rd Uluakupu Bldg 4, Pearl City, HI 96782

SUMMARY:
The large overrepresentation of people with SMI in the criminal justice system has thrust judges into a new and unique role – leaders and advocates for an improved community mental health system. Judge Leifman will discuss the evolution of this movement, how the justice system is responding, opportunities to partner with psychiatric leaders, and new and effective strategies that are being developed to transform the mental health system. Judge Waldorf will discuss the Hawaii perspective and how this issue impacts Hawaii.

REFERENCES:
1) Mental Health Courts: A Guide to ResearchInformed Policy and Practice, Council of State Governments
Justice Center, New York, 2009.

TUESDAY, MAY 17, 2011
8:00 AM-11:00AM

SYMPOSIUM 58
STATE OF THE SCIENCE ON DIAGNOSTIC CLASSIFICATION: IMPLICATIONS FOR *DSM-5*
American Psychiatric Institute for Research & Education

Chair: Darrel A Regier, M.D., M.P.H., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209
Co-Chair: David J Kupfer, M.D. Discussant: Norman Sartorius, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, attendees will be able to: 1) Describe advances in our scientific understanding of psychiatric nosology; and 2) Explain how this evidence is being considered in informing a revised metastructure for DSM's diagnostic categories.

OVERALL SUMMARY:
One critical element in the next phase of *DSM-5*

development concerns the clustering of psychiatric diagnoses across all major diagnostic categories. The current *DSM-IV* provides 16 such categories, but recent advances in our understanding of psychiatric etiology and phenomenology – informed by neuroscience, genetics, and epidemiology in particular – signal the need to reorganize the structure of the manual to better reflect the state of the science, thereby facilitating clinical care and enhancing future research on diagnosis and treatment of mental illnesses. The metastructure of *DSM-5* holds important implications for how psychiatric practice and research are carried out, and the final distribution of disorders is anticipated to also influence approaches by the World Health Organization in revising ICD10CM and ICD11. This symposium will give audiences an opportunity to learn about ongoing efforts of the *DSM-5* Task Force and Work Group members to reorganize diagnostic categories in *DSM-5* and how the proposed metastructure may impact research, diagnosis, and treatment. A broad overview of the purpose and goals of such efforts will be provided, followed by presentations on specific diagnostic areas, such as mood disorders, anxiety and traumarelated disorders, and childhood disorders. A presentation will also be made describing how the proposed metastructure relates to psychiatric diagnosis in primary care settings.

S58-2.
THE CLASSIFICATION OF MOOD DISORDERS IN *DSM-5*

Gavin Andrews, M.D., 390 Victoria Street, Darlinghurst NSW, 2010 Australia

SUMMARY:
DSMIII was atheoretical and *DSM-IV* emphasized reliability. The reliability of the diagnostic criteria in *DSM-IV* facilitated research into the nature of each disorder – research on genetic and environmental risk factors; on biomarkers, temperament and cognitive processing; and into the course, comorbidity, and treatment response of each disorder. As part of a proposal for a metastructure for *DSM-5* these validating criteria were used to propose an alternative classification of the mood disorders. The bipolar disorders share few validating factors with unipolar mood disorder and but do share some with schizophrenia (genetics, biomarkers, cognitive processing, comorbidity, treatment response). Bipolar disorders could thus be classified with schizophrenia or in a separate mood subcluster that distinguished these disorders from the unipolar mood disorders. Major depression shares many validating factors with generalized anxiety disorder and the other anxiety disorders (genetics, temperament, comorbidity, treatment response) and thus could be classified with these disorders. The *DSM-5* Task Force has proposed that the mood disorders chapter be divided, into two parts; 'disorders of negative affect' (Major Depression and GAD) and 'bipolar and related disorders' (Bipolar Disorder and Cyclothymia). The evidence for both positions will be reviewed.

S58-3.
THE METASTRUCTURE OF *DSM-5:* CONSIDERATIONS FOR THE ANXIETY, OBSESSIVECOMPULSIVE SPECTRUM, POSTTRAUMATIC, AND DISSOCIATIVE DISORDERS

Katharine Phillips, M.D., Coro West, 1 Hoppin Street Suite 2.030, Providence, RI 02903

SUMMARY:
DSM-IV contains 16 groupings, or chapters, of disorders (for example, anxiety disorders, somatoform disorders), which is often referred to as the "metastructure" of DSM. An important question for *DSM5* is whether some of the groupings in *DSM-IV*, and the disorders included within them, should be changed, given advances in knowledge over the past several decades, since *DSM-IV* was developed. The metastructure is important for a number of reasons. Disorders that are classified together are presumed to be related, reflecting similarities in clinical features, treatment response, tiology/pathophysiology, or other characteristics. Classifying presumably related disorders together may in turn usefully guide clinical practice. Ideally, the metastructure should be based on empirical evidence of relatedness among disorders as indicated by a range of validators (for example, symptom similarity, comorbidity, familiarity, neurobiology, genetic and environmental risk factors, treatment response). The metastructure should also reflect clinical utility considerations. This presentation will discuss considerations for the metastructure of *DSM-5* as it relates to anxiety, obsessivecompulsive

spectrum, posttraumatic, and dissociative disorders. Research evidence and clinical utility considerations that were reviewed by the *DSM-5* Work Group covering these disorders will be presented. Additional considerations and challenges for the development of a metastructure for *DSM-5* will be discussed.

S58-4.
STATE OF THE SCIENCE ON DIAGNOSTIC CLASSIFICATION: IMPLICATIONS FOR *DSM-5*

David Shaffer, M.D., 1051 Riverside Dr Unit 78, New York, NY 10032

SUMMARY:
Many of the concerns about possible changes to the DSM metastructure relate to displacing diagnoses from symptomatically similar conditions, suggesting that DSM is used as a clinical guide to differential diagnosis. This is in line with the goal to serve clinicians and sounds a warning about reorganizing disorders by etiology or pathology. Another concern has been the experience that, when plausible etiological mechanisms are uncovered, the full story emerges slowly and is usually complicated, although examples will be given of how biologicalenvironmental correlations can transform unmanageable complexity into a useful basis for organization. The dilemma facing skeptics of a physiologically or etiologically based system safely waiting for "the evidence" was pointed out by Michael Rutter in his paper on classification written over 50 years ago, "… disorders can be defined before the etiology is known … Indeed … advances in our knowledge about etiology are likely to be slow until we can identify and classify disorders …" We have to ask whether reassuring ourselves that current complacency is justified because we "don't know" is preferable to making a heuristic proposition and hastening what might otherwise be a leisurely process.

S58-5.
A CLASSIFICATION OF MENTAL DISORDERS FOR PRIMARY CARE: ICD11PHC

David Goldberg, D.M., D.P.M., 7 Woodhall Drive, London, SE21 7HJ United Kingdom

SUMMARY:
This lecture describes the World Health Organization has prepared the most recent version of the classification of mental disorders for primary care for the 11th edition of the International Classification of Disease has been prepared, building on the experience of the previous edition (ICD10PHC). A Working Group consisting of general practitioners and nurses with a special interest in mental disorders and psychiatrists all of whom are experienced in training GPs in mental health skills, has been formed – with equal numbers from developed and developing countries and representation of all 9 of the regions served by WHO. The revised classification will be described in detail, with information about how it differs from the DSM equivalent, and how it relates to the parent classification for all mental disorders in the ICD11. The Field Tests of the classification will be described, and final revisions will be made before approval by WHO's Advisory Group and final publication.

S58-6.
STATE OF CLASSIFICATION OF NEUROCOGNITIVE DISORDERS

Dilip V. Jeste, M.D., 9500 Gilman Drive, #0664, La Jolla, CA 92093

SUMMARY:
The Neurocognitive Disorders include acquired disorders, characterized by a decline in previously attained cognitive abilities, in which neurocognitive dysfunction is the most prominent or defining feature. We have made several revisions in our criteria based on the feedback and comments received on the *DSM-5* website. 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. An etiologybased subclassification of Delirium is proposed. Other Neurocognitive Disorders will be subdivided based on severity of functional and neurocognitive impairment into: Mild or Minor Neurocognitive Disorder (mNCD), and Major Neurocognitive Disorder (MNCD) or Dementia. The main distinction between these two categories is preservation (mNCD) versus loss (MNCD) of functional independence. Unlike

DSM-IV, memory impairment would not be necessary for diagnosing either condition. Both mNCD and MNCD will be subclassified according to etiology – e.g., Alzheimer disease, vascular neurocognitive disorder, Mixed. The criteria for nonAlzheimer dementing disorders are being developed by independent subspecialty groups (e.g., Frontotemporal dementia group, vascular dementia group), which we will incorporate as appropriate. The issues still being discussed include specification of both neuropsychological and bedside tests for diagnosing mNCD and MNCD, 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 on mNCD have already begun. Their results will help refine the criteria further.

REFERENCES:

1) Andrews G, Goldberg DP, Krueger RF, Carpenter Jr. WT, Hyman SE, Sachdev P & Pine DS. Exploring the Feasibility of a MetaStructure for DSM-V and ICD11: Could It Improve Utility and Validity? Psychological Medicine, 2009; 39: 19932000.
2) Goldberg DP, Krueger RF, Andrews G & Hobbs MJ. Emotional Disorders: Cluster 4 of the Proposed MetaStructure for DSM-V and ICD11. Psychological Medicine, 2009; 39: 20432059.
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4) Goldberg DP, Andrews G & Hobbs MJ. Where Should Bipolar Appear in the MetaStructure? Psychological Medicine, 2009; 39: 20712081.

SYMPOSIUM 59
BRAIN CIRCUITRY OF SERIOUS MENTAL ILLNESSES

U.S. National Institute of Mental Health

Chair: Cameron S Carter, M.D., 4701 X Street, Davis, CA 95817
Discussant: Bruce N Cuthbert, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify modern methods for measuring the function of brain circuits affected by common mental disorders (Major Depression, Anxiety Disorders, Bipolar Disorder and Schizophrenia) and the alterations that are seen in these circuits in these disorders; and 2) Recognize the overlap that can occur between altered circuitry and different disorders and the implications that this has for diagnostic classification in psychiatry.

OVERALL SUMMARY:

Over the past three decades the field of psychiatry has been increasingly informed through the development of methods for imaging the function of brain networks supporting cognitive and emotional processing in the human brain. Aided by our growing understanding of the normal brain mechanisms supporting these functions, a consistent pattern altered functional brain circuitry has been associated with each of the major common mental disorders. For example, a set of mostly cortical circuits encompassing dorsal lateral and medial prefrontal cortical show alterations in brain structure and function in schizophrenia in relationship to the higher cognitive deficits that are seen in this illness. Additional, more ventral lateral prefrontal cortical regions involved in emotional regulation appear disrupted in Bipolar disorder. In contrast, ventral and medial prefrontal circuits along with limbic structures such as the amygdala have been associated with major depression and anxiety. Each of these functional circuits is characterized by unique developmental trajectories, cortical architectures, and neurotransmitter systems and is also uniquely influenced by genetic and environmental factors that may be targeted therapeutically. Importantly, the association of each functional circuitry to symptoms and deficits in patients does not always respect diagnostic boundaries suggesting a categorical, rather than dimensional approach to diagnosis may more precisely "carve nature at its joints". In this symposium four experts in the field will present the state of our knowledge of altered functional brain circuitry in Major Depression (Dr Sheline), Anxiety disorders (Dr Etkin), Bipolar Disorder (Dr Drevets) and Schizophrenia (Dr Carter). Neuroimaging data will relate brain circuitry to specific disturbances in cognition, emotion and behavior. These circuit level data will be complemented by post mortem data and data from PET and other methods to inform

the neurobiology of this circuit based approach to understanding mood and psychotic disorders. The implications of this emerging understanding of the neural underpinnings of mental disorders for treatment will be emphasized.

S59-1.
CIRCUITS AND SYMPTOMS IN SCHIZOPHRENIA

Cameron Carter, M.D., 4701 X Street, Davis, CA 95817

SUMMARY:
The increasingly wide application of the tools and constructs of cognitive neuroscience, along with noninvasive structural and molecular brain imaging methods, has accelerated this growth in understanding the heterogeneous array of deficits and symptoms that define schizophrenia. In this talk I will review our understanding of the functional brain circuitry associated with three core aspects of the illness, impaired cognition, negative symptoms and psychosis. Data will be presented linking functional alterations in prefrontal cortical (PFC) circuitry to each of these deficits. First, data will be presented that show that people with schizophrenia are unable to engage their PFC to recruit task specific networks to support controlled, high level processing in the brain. Failure of this PFC based cognitive control mechanism is associated with a range of deficits in attention, working and longterm memory and some aspects of perception, as well as to behavioral disorganization and poor functional outcome. Second, data will be presented showing that people with schizophrenia process emotional information "in the moment" to a degree comparable to healthy subjects but that they are unable to actively maintain emotional information over time and this is also associated with impaired maintenance related activity in the PFC and with anhedonia symptoms. Finally data will be presented linking disrupted PFC activity during cognitive task performance to overactivity in midbrain dopaminergic nuclei and psychotic symptomatology. These data suggest that disrupted cognitive control functions of the PFC may be linked to a broad range of symptoms in schizophrenia. Candidate mechanisms at the cellular level and implications for treatments will be discussed. Since many of these symptoms are also seen in other disorders such as Bipolar Disorder the implications of understanding the role of PFC related circuitry for a noncategorical approach to understanding symptoms and deficits in severe mental disorders will be discussed.

S59-2.
INCREASED CONNECTIVITY ACROSS CIRCUITS IN MAJOR DEPRESSION

Yvette Sheline, M.D., Dept of Psychiatry, 660 S. Euclid Ave, Box 8134, St Louis, MO 63110

SUMMARY:
Background: An important NIMH objective is the creation of dimensional approaches to psychiatric diagnosis. Findings from neuroimaging studies that focus on disruptions in important brain circuits across individuals with both unipolar major depression and PTSD will be presented to probe the question of crosscutting neural system impairments. In studies of both depression and PTSD, disturbances of affect, cognitive control and emotional regulation have been found, however the extent to which there may be common disturbances in brain circuitry is not known. We examined similarities and differences in resting state BOLD fMRI in patients with depression and PTSD to better understand intrinsic brain connections. Methods: Healthy controls, MDD and PTSD patients were studied using resting state BOLD fMRI. We examined three different brain networks—the cognitive control network, default mode network and affective network. In addition we examined an emotional conflict paradigm using an emotional distractor. Results: Compared with controls, both depressed and PTSD participants had increased connectivity of each of these three networks to the same hub, the bilateral dorsal medial prefrontal cortex region, an area we term the dorsal nexus. This dorsal nexus region demonstrated dramatically increased fMRI connectivity with large portions of each of the three networks. In addition to this common finding between disorders, findings distinct to each disorder will be presented. Conclusions: The discovery that a hub exists linking these regions together through the dorsal nexus provides a potential mechanism to explain symptoms that arise in distinct networks, including decreased ability to focus on cognitive tasks, rumination, excessive selffocus, increased vigilance and emotional, visceral and autonomic dysregulation

could occur concurrently and behave synergistically. Since these symptoms are shared in depression and PTSD it suggests that the dorsal nexus plays a critical role, in effect "hot wiring" networks together through a common hub.

S59-3.
UNDERSTANDING ANXIETY: A NEURAL CIRCUIT PERSPECTIVE

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

SUMMARY:
Anxiety is a commonly experienced subjective state that can have both adaptive and maladaptive properties. Clinical disorders of anxiety are likewise also common, range widely in their symptomatology and consequences for the individual, and are often comorbid with other disorders, such as depression. Anxiety and depressive disorders are both associated with abnormalities in the processing and regulation of emotion. Despite this, little is known about the neurobiology of many anxiety disorders, or the similarities and differences between disorders. Such research is essential, however, for understanding the organization and structure of mental illness, informing ideas about vulnerability, and defining opportunities for intervention. I will present neuroimaging data on Generalized Anxiety Disorder (GAD), Posttraumatic Stress Disorder (PTSD), Social Anxiety Disorder (SAD), Specific Phobia (SP), as well as Major Depressive Disorder (MDD). Taken together, I will use these data to make the following arguments: 1) some symptoms of anxiety disorders can be conceptualized as exaggerated fear reactivity, involving regions such as the amygdala and insula; 2) a fearbased model is inadequate at explaining many symptoms, including most of the symptomatology of a disorder such as GAD, and these can better be explained in the context of deficits in anterior cingulate/medial prefrontalbased emotion regulation; 3) there is more evidence for similarities across disorders rather than disorders being "natural kinds", and this is most clear when combining the fear reactivity and emotion regulation frameworks; and 4) important similarities exist between anxiety disorders and MDD which point to a neural basis for their shared genetic or tempermental risk, but also allow for disorderspecificity in the context of engagement of compensatory neural circuitry. In sum, a more complete neural circuit perspective is now emerging on anxiety, which will be important in guiding future work, understanding the mechanisms of therapeutics, and helping design novel treatments.

S59-4.
NEUROCIRCUITRY OF BIPOLAR DISORDER

Wayne Drevets, M.D., NIH/NIMH/Mood and Anxiety Disorders Program, Bethesda, MD 20892

SUMMARY:
Increasing evidence exists regarding the presence of neuropathophysiological abnormalities in mood disorders. This presentation reviews the post mortem and neuroimaging literature relevant to the neuropathology of bipolar disorder (BD). These data support a neurocircuitrybased model of BD in which dysfunction arises within a "visceromotor network", comprising the perigenual region of the medial prefrontal cortex and its anatomical connections with regions of the brain such as the ventral striatum, medial thalamus, amygdala, hippocampus, hypothalamus, brainstem and habenula, which regulate emotional, behavioral and endocrine responses to stress. Glutamatergic and GABAergic neurons appear to be preferentially affected, displaying gene expression changes which may interfere with receptor function. In some cases, these functional changes may be secondary to altered modulatory input from monoaminergic neurotransmitter systems. They also involve a loss of neuropil that manifests as a reduction in neuron size or an increase in neuronal density at postmortem, as well as a decrease in gray matter volume at MRI. Furthermore, evidence exists for neuronal loss in the hippocampus, amygdala, and medial prefrontal cortex, and glial cell pathology, including a reduction in glial cell number. Oligodendrocyte cells responsible for the myelination of axons may be preferentially affected, correlating with diffusion tensor imaging studies that indicate of abnormalities of the white matter tracts connecting the medial and orbital prefrontal cortex with limbic regions such as the amygdala. The proximate cause of these structural changes may be excitotoxicity arising from an imbalance in excitatory and inhibitory neurotransmission. Many interacting factors may lead to this dysregulation of excitatory

neurotransmission, such as elevated expression or secretion of specific immune and endocrine factors, which show abnormalities in a significant number of patients with BD. Although the identity of the primary pathological construct or the etiological mechanisms that underlie dysfunction within these circuits remains unclear, models constructed on the basis of these data suggest several targets where novel therapeutics conceivably can interrupt the neuropathophysiological processes that support the clinical manifestations of BD.

REFERENCES:
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SYMPOSIUM 60
PEDIATRIC PALLIATIVE CARE: A NEW FRONTIER FOR CHILD AND ADOLESCENT PSYCHIATRY

Chair: David Buxton, M.D., 856 Hope Street, Providence, RI 02906

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Delineate the clinical goals of pediatric palliative care; 2) Describe psychiatry's unique role in pediatric palliative care; 3) Identify helpful communication strategies for pediatric palliative care; and 4) Identify three frequently occurring ethical dilemmas associated with pediatric palliative care.

OVERALL SUMMARY:
The topic of children dying is an uncomfortable and, at times, even taboo subject in the field of medicine. Many physicians and laypeople think of it as an infrequent event that only occurs in cases of rare medical failure. Unfortunately, this is not the reality. For example, in the year 2003, more than 50,000 infants, children, and adolescents died in the United States alone [1].Of these children, only 10 percent died in their own homes, with the remainder passing in hospitals [2].In 2005, the National Hospice and Palliative Care Organization noted that of the 4,100 hospice and palliative care programs that exist in the U.S., only 738 (18 percent) provided pediatric palliative and hospice services [3].In addition, it was found that less than 10 percent of children who met criteria for palliative or hospice services were enrolled in these programs [4].The World Health Organization defines palliative care as "… relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" [5].Given the number of children who die of terminal illness each year, why are so few of them receiving the benefits of palliative care? Multiple obstacles to creating a sustainable pediatric palliative care program at hospitals exist. These include resistance to discussions of death and dying in children, limited knowledge or access to pediatric pain specialists, and limited training in approaching families with end of life decisions. Certainly, most of the obstacles to instituting and maintaining pediatric palliative care derive from the most sensitive and difficult ethical, medical and psychosocial issues which surround chronically and terminally ill children. As psychiatrists, we are in an unique position given our training to understand these fluid dynamics and facilitate these discussions between the family and the medical team [6].The modeling of an atmosphere of open communication in itself may be helpful in decreasing suffering [7]. This symposium will address the roles, challenges and potential contributions of specific palliative care team members and in particular, highlight the unique skill set that a psychiatrist could bring to the team.

S60-1.
INTRODUCTION TO SYMPOSIUM

David Buxton, M.D., 856 Hope Street, Providence, RI 02906

SUMMARY:

I plan to introduce the audience to the field of pediatric palliative care with the story of a 3 year old girl with methylmalonic acidemia whom I was assigned to take care of during my third year medical school rotation. During this experience, I came to realize how difficult her illness was for her, her family and the treatment team. I was particularly drawn to the apparent psychological toll of her chronic illness. However, when I expressed my concern to her attending physician, he attempted to

reassure me that SB's psychological needs were being addressed by OT and PT services. After several affirming discussions with my child psychiatrist father regarding this case, he suggested that I spend my pediatric outpatient rotation under the tutelage of a pediatrician who practices palliative medicine. This experience was an epiphany. By making home visits with the palliative care team, I witnessed the provision of integrated medical care in a manner that was seamless and holistic in the best sense of the word. Equal attention and value were given to the patient's and family's psychological and medical needs. This experience clarified my professional goal to become a child psychiatrist and ultimately specialize in palliative care. I will then introduce the presenters with a short biography of each one.

S60-2.
INTRODUCTION TO PEDIATRIC PALLIATIVE CARE

Michelle Brown, Ph.D., 401 Quarry Rd., Stanford, CA 94305

SUMMARY:
Pediatric palliative care is a new interdisciplinary frontier in the comprehensive care of children. While children with lifethreatening and lifelimiting conditions have always been part of the healthcare system, it is only recently that an integrated vision toward their care has begun to emerge. Similar to the adult model of palliative care, quality of life is emphasized and comfort is a primary goal. Yet, in contrast to the adult model where transition to palliative care often occurs very close to the time of death, efforts to initiate palliative care for children earlier in the illness trajectory enables effective care planning for the entire family. Multiple models of pediatric palliative care exist, although differences mainly lie in the composition of the care teams rather than overall approach to care. Consistent across the models is the provision of care throughout the illness continuum. The medical, psychosocial, cultural and financial barriers to the ideal delivery of comprehensive pediatric palliative care are many. These include the misperception of curative and palliative care as mutually exclusive, misconceptions around medication, staffing issues, and lack of hospice and other health care professionals in the community familiar with pediatric symptom management. Finally, cultural, spiritual and religious considerations are central to the provision of palliative care. Specific areas of importance will be discussed.

S60-3.
PEDIATRIC PALLIATIVE CARE & PSYCHIATRY

Marcy Forgey, M.D., M.P.H., 760 Westwood Plaza, 48256A, Los Angeles, CA 90024

SUMMARY:
Objective: To review the literature to explore the current issues faced by child and adolescent psychiatrists working in a pediatric palliative care setting and to describe the unique role of the psychiatrist on the pediatric palliative care team. Method: Electronic database search using keywords Pediatric, Palliative Care, Psychiatry, Death, Dying, End of Life, Mental Health, Children, Families, on MEDLINE, PsycInfo, NLM Gateway, PubMed, Cochrane Database. Results: Children with life threatening illnesses and their families face physical, emotional, psychosocial, and spiritual challenges throughout the course of illness. Anxiety, depression, post traumatic responses, sleep deprivation, and delirium are very common. Child and adolescent psychiatrists in this setting may not only conduct a developmentally appropriate mental health evaluation in order to properly diagnose and treat psychiatric symptoms, but also develop a unique understanding of the family system, including spiritual and cultural beliefs. Armed with this knowledge, facilitating communication between the family and the medical team can be one of the psychiatrist's most important tasks. Conclusions: Child and adolescent psychiatrists have an essential role to play on the palliative care team from assessment and treatment of psychiatric symptoms, to individual and family therapy, to a critical liaison function with the child and his/her family to facilitate optimal coping with the terminal illness and healthy bereavement.
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S60-4.

ETHICS OF PEDIATRIC PALLIATIVE CARE: AN INTERPRETIVE CASEFORMULATION APPROACH

Dawson Schultz, Ph.D., 1156 High Street, Santa Cruz, CA 95064

SUMMARY:
Recent authors (e.g., Kelley and Meier in the New England Journal of Medicine) have stated the need to go beyond the current paradigm in palliative care in which care goals are often conceptualized in simple, dichotomous categories that juxtapose these goals into treatment associated with cure vs. nontreatment associated with Hospice and palliative care. In the new paradigm, however, nonhospice palliative care, provided together with lifeprolonging treatment, is distinguished from hospice palliative care where curative treatment is no longer appropriate. Still, many physicians at present understand palliative care as an alternative to lifeprolonging or curative treatment. This dichotomous thinking is especially entrenched in the pediatric setting, as the introduction to this symposium and literature references make clear. This presentation goes beyond recent appeals for a new paradigm by suggesting that an interpretive and narrative framework and tools can expand understanding of palliative care and help to remove obstacles that encourage seeing this care as a mere alternative to curative treatment. Ironically, the current emphasis upon evidencebased reasoning and empiricallyvalidated treatment, abstracted from a narrative context, goes against the new paradigm, and, hence, can, itself, become an obstacle. Facts, however, are not "selfevident" apart from organization, presentation, and interpretation in a narrative context, and a case report is not a mere "record of facts" but rather a story of the patient's illness. By focusing upon the "narrative truth" (Donald P. Spence) of what is going on in the patient's story and its lived meaning or significance, over and above the "scientific truth" concerning the record of mere facts, providers and patients communicating and working together to coconstruct and cointerpret the patient's illness narrative can more effectively and responsibly recognize and appreciate what goals of care, whether palliative or curative, are "indicated" by this patient's narrative.

S60-5.

ETHICS OF PEDIATRIC PALLIATIVE CARE: AN INTERPRETIVE CASEFORMULATION APPROACH

Lydia Flasher, Ph.D., 650 Clark Way, Palo Alto, CA 94304

SUMMARY:
Recent authors (e.g., Kelley and Meier in the New England Journal of Medicine) have stated the need to go beyond the current paradigm in palliative care in which care goals are often conceptualized in simple, dichotomous categories that juxtapose these goals into treatment associated with cure vs. nontreatment associated with Hospice and palliative care. In the new paradigm, however, nonhospice palliative care, provided together with lifeprolonging treatment, is distinguished from hospice palliative care where curative treatment is no longer appropriate. Still, many physicians at present understand palliative care as an alternative to lifeprolonging or curative treatment. This dichotomous thinking is especially entrenched in the pediatric setting, as the introduction to this symposium and literature references make clear. This presentation goes beyond recent appeals for a new paradigm by suggesting that an interpretive and narrative framework and tools can expand understanding of palliative care and help to remove obstacles that encourage seeing this care as a mere alternative to curative treatment. Ironically, the current emphasis upon evidencebased reasoning and empiricallyvalidated treatment, abstracted from a narrative context, goes against the new paradigm, and, hence, can, itself, become an obstacle. Facts, however, are not "selfevident" apart from organization, presentation, and interpretation in a narrative context, and a case report is not a mere "record of facts" but rather a story of the patient's illness. By focusing upon the "narrative truth" (Donald P. Spence) of what is going on in the patient's story and its lived meaning or significance, over and above the "scientific truth" concerning the record of mere facts, providers and patients communicating and working together to coconstruct and cointerpret the patient's illness narrative can more effectively and responsibly recognize and appreciate what goals of care, whether palliative or curative, are "indicated" by this patient's narrative.

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SYMPOSIUM 61
UPDATE ON THE TREATMENT OF COMORBID OPIOID ADDICTION AND CHRONIC PAIN

U.S. National Institute on Drug Abuse

Chair: Will Aklin, Ph.D., 6001 Executive Blvd, Rockville, MD 20892
Co-Chair: Richard A Denisco, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand specific diagnostic and treatment options for patients with chronic pain and cooccurring psychiatric disorder; 2) Obtain a greater understanding of the role of integrative treatment models used to treat acute pain and addiction concurrently.

OVERALL SUMMARY:
The proposed NIDA researchtrack workshop is a followup to last year's extremely wellreceived and attended workshop on the subject of chronic pain and opioid depedence. We will present updated research findings that underscore pathways of care that both reduce addiction and improve the treatment of pain. The specific management concerns of different types of pain will be discussed including patients who present with a wide variety of addiction histories. Conversely, how each of these addiction histories should be considered by the clinician in order to establish specific treatment plans 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 cooccurring 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? Recent research findings will be presented to bring some guidance to clinicians. 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 empiricallybased 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. This symposium will present the changes over the last year that have occurred in this rapidly evolving field.

S61-1.
UPDATE ON 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 update the audience on 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 nonopioid adjuvants for pain management, and the importance of nonpharmacologic pain management therapies.

S61-2.
A PROSPECTIVE, LONGITUDINAL, OBSERVATIONAL COHORT STUDY OF PAIN DURATION IN POSTSURGICAL PATIENTS

Ian Carroll, M.D., M.S., 780 Welch Rd, Palo Alto, CA 94304

SUMMARY:
To date, numerous studies have investigated the severity of postoperative pain, but few have characterized the duration of pain following surgery. We studied timetopain resolution following surgery to establish the natural history of pain cessation following five specific surgeries and to identify factors that predict persistent pain following surgery. A prospective, longitudinal observational study was conducted with 77 patients who underwent five distinct surgical procedures: thoracotomy, total hip replacement, total knee replacement, radical mastectomy, lumpectomy. Patients were consented before their surgery and asked to complete baseline assessments for psychological items implicated as risk factors for chronic pain. In addition, patients were given the Brief Pain Inventory (BPI) beginning with postoperative Day 1 and daily thereafter until their pain resolved (defined as five consecutive days of zero average pain). Time to pain resolution was analyzed using both univariate and multivariate survival analysis models, stratified by surgery type. Median time to pain resolution was 64 days, and 21% of patients reported ongoing pain at the surgical site 150 days post operation. Univariate analysis revealed that a number of risk factors were significantly associated with delayed pain resolution, independent of surgery type. Multivariate analysis identified preoperative PTSD symptomatology, selfperceived addictionsusceptibility, and elevated levels of PostOperative Day 1 pain severity as predictors of delayed pain resolution even when controlling for all other variables. In contrast, anxiety, depression, and preoperative opioid use did not predict delayed pain resolution in multivariate models. This study identifies risk factors that influence pain resolution and has facilitated development of a useful, practical methodology by which to investigate factors that promote pain persistence following injury.

S61-3.
COGNITIVEBEHAVIORAL TREATMENT FOR COOCCURRING CHRONIC PAIN AND OPIOID DEPENDENCE

Declan Barry, Ph.D., 34 Park Street, CMHC/SAC Room S220, New Haven, CT 065191187

SUMMARY:
Cooccurring chronic pain and opioid dependence (POD) is prevalent and associated with deleterious treatment outcomes in patients entering opioid agonist maintenance treatment (OMT). OMT may reduce nonprescribed 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 (a) the treatment needs of patients with POD, (b) providers' experiences treating patients with POD, and c) the development of integrated cognitive behavioral therapy (CBT for POD) for treating the dual, interrelated problems of chronic pain and opioid dependence during OMT with methadone or buprenorphine. CBT for POD is based on 7 CBT pain modules with the strongest empirical support for problems associated with POD and of greatest relevance to patients with POD. These modules include: 1) Education to provide a rationale for the other specific CBT modules; 2) Exercise and Behavioral Activation to counter deconditioning and increase flexibility and social functioning; 3) Coping with distress, pain, and craving without illicit drug use; 4) Cognitive Control to identify and challenge dysfunctional cognitive errors (e.g., catastrophizing); 5) Resilience Training; 6) Learning from previous drug use episodes; and 7) Assertiveness Training.

S61-4.
PAIN AND PRESCRIPTION OPIOID

DEPENDENCE: SECONDARY OUTCOMES FROM NIDA CLINICAL TRIALS NETWORK PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY

Roger Weiss, M.D., 115 Mill Street, Belmont, MA 2478

SUMMARY:
This symposium discussion will provide an opportunity to review important secondary outcomes from the NIDA Clinical Trials Network Prescription Opioid Addiction Treatment Study—the first multisite randomized controlled trial to examine treatments for individuals with prescription opioid dependence, including those with chronic pain. Chronic pain is highly prevalent among patients dependent on prescription opioids. Fortytwo percent of the study population had chronic pain. This presentation will review the characteristics and course of cooccurring chronic pain and prescription opioid dependence, as well as implications for clinical practice and areas for future research.

S61-5.
CO-OCCURRING CHRONIC PAIN AND OPIOID ADDICTION: IS THERE A ROLE FOR INTEGRATED TREATMENT?

Jennifer Potter, Ph.D., M.P.H., 7526 Louis Pasteur, San Antonio, TX 78229

SUMMARY:
Cooccurring chronic pain and opioid addiction is a complex public health problem. To better understand the relationship between chronic pain and opioid misuse, abuse, and addiction, it is critical to 1) investigate the reciprocal relationship between pain and opioid use; and 2) examine pain and opioid use disorder in different clinical populations for whom the interplay between the two may be distinct. To address these two issues, this presentation will examine clinical data from three recently completed studies in distinct populations with chronic pain: treatmentseeking prescription opioid dependent drug abusers, methadone maintained heroin abusers, and prescription opioid misusers on chronic opioid therapy. The clinical data presented supports various options for managing cooccurring pain and addiction and points toward an integrated care model. In addition to clinical characteristics and treatment needs, the mediating effects of pain severity on treatment outcomes for chronic pain patients enrolled in a recently completed, multisite, controlled clinical trial of buprenorphine and counseling for prescription opioid addiction will be discuss presented.

SYMPOSIUM 62
THE BENEFITS AND RISKS OF BROADENING THE CONCEPT OF BIPOLAR DISORDER

Chair: *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, participants should be able to: 1) Identify the benefits and risks of a broadening of the concept of bipolar disorder; and 2) Appreciate that the management of some patients could benefit from an extension of the concept, while some others could be exposed to a treatment with mood stabilizers which may be not effective or necessary.

OVERALL SUMMARY:
It has been often pointed out in the literature that bipolar disorder is underdiagnosed in ordinary clinical practice. The boundaries of the disorder with unipolar depression, with some personality disorders (borderline, antisocial) and with schizophrenia are not delineated appropriately, and several patients who actually fall within the bipolar spectrum are not diagnosed correctly and therefore do not receive the right treatment. Furthermore, the faulty delineation of the bipolar phenotype represents an obstacle to the progress of biological research. Several proposals have been put forward for a broadening of the concept of bipolar disorder in the *DSM-5*. On the other hand, it has been maintained that the common denominator shared by the conditions included in the "bipolar spectrum" is not clear; that the spectrum concept is likely to reduce the reliability of the diagnosis of bipolar disorder, reproducing the situation of the diagnosis of schizophrenia several decades ago; that the spectrum approach is likely to dilute the concept of bipolar disorder, hampering the collection of homogeneous patient samples for research; and that a broadening of the concept could lead to an overuse of mood stabilizers. This

is an issue of great clinical and scientific relevance, which needs to be addressed systematically. This symposium aims to provide an overview of currently available clinical and biological evidence in favour and against the broadening of the concept of bipolar disorder, and some recommendations for the reformulation of the concept in the *DSM-5*.

S62-1.

THE RISKS AND BENEFITS OF EXPANDING THE DIAGNOSIS OF BIPOLAR DISORDER: AN OVERVIEW

Stephen Strakowski, M.D., 260 Stetson, Suite 3200 (ML0559), Cincinnati, OH 452670559

SUMMARY:
Bipolar disorder is a dynamic illness that spans a variety of symptom domains. Consequently, the boundaries of the illness can be unclear. Classic bipolar I disorder is defined by the occurrence of mania. The distinction between bipolar I and bipolar II disorder hinges completely on the functional impairment of manic symptoms, plus the requirement for depressive episodes in the latter (which are also common in the former). However, beyond these two relatively welldefined conditions are many patients who exhibit "bipolarity", i.e., unstable mood states, that do not fit either bipolar I or II diagnoses. These 'Bipolar NOS' or cyclothymic patients may share familial risk with the better defined bipolar conditions. Expanding the diagnosis of bipolar disorder would be a means to acknowledge the potentially variable penetrance of genetic risk for these symptom profiles. On the other hand, doing so risks overlapping other psychiatric conditions, as well as boundaries of healthy ('normal') behavior. The utility of expanding a diagnostic group may vary depending on the use of the diagnosis e.g. for research versus clinical care. This overview will set the context for the other discussions within this symposium.

S62-2.

Research Evidence Supporting a Broadening of the Concept of Bipolar Disorder

Susan McElroy, M.D., 4075 Old Western Row Road, Mason, OH 45040

SUMMARY:
Controversy continues to exist as to where the boundary is between bipolar disorder and several other major psychiatric disorders. These include unipolar major depressive disorder, schizophrenia and schizoaffective disorder, and disorders characterized by impulsivity, such as cluster B personality disorders and attention deficit hyperactivity disorder. The bias of the Diagnostic and Statistical ManualIV is to diagnose the latter at the expense of bipolar disorder, which is very narrowly defined. In this presentation, data from phenomenology, comorbidity, family history, and treatment response studies will be summarized showing that a broader concept of the bipolar spectrum would offer a number of clinical advantages.

S62-3.

ARE THERE POSSIBLE DOWNSIDE RISKS OF A BROADER DEFINITION OF BIPOLAR DISORDER?

Ellen Frank , Ph.D., 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:
The *DSM-5* Mood Disorders Work Group proposals have the potential to expand the concept of bipolar disorder, primarily through the addition of a "with mixed features" specifier to episodes of depression even in individuals who have never experienced an experienced an episode of mania or hypomania. Needless to say, the Work Group would not have put forth their various proposals did they not think there were advantages to them; however, it is worth considering what might be the downside risks associated with such an expansion of the bipolar concept. There is the potential for behaviors that are not medical/psychiatric in etiology might be "excused" on that basis. There is also the potential of pathologizing individuals who do not suffer from "real" psychopathology. Given the fact that the term, "bipolar," and, even more, the term, "manicdepressive," is associated with greater stigma that the term, "depressed," there is the potential greater stigmatization of individuals who do not have classic bipolar disorder. Another potential risk is that we will create broad phenotypes that will impede genetic research, creating undue heterogeneity at a molecular level that will ultimately prevent us from discerning distinct

genotypes. At the interface with borderline disorder, there is the potential of even more frequently characterizing those who suffer from borderline disorder as having bipolar disorder with all the attendant risks of inappropriate treatment. Perhaps of greatest concern is the potential for inappropriate treatment of individuals with unipolar depression, particularly with atypical antipsychotic medication. This presentation will focus on the available data and case report literature that speaks to these potential risks.

S62-4.

WHAT DO GENETIC STUDIES TELL US ABOUT THE PHENOTYPE IN BIPOLAR ILLNESS?

John Nurnberger, M.D., 791 Union Drive, IUMC/IPR, Indianapolis, IN 462024887

SUMMARY:

Family studies tend to support a distinction between major subtypes of affective illness, such as Bipolar I, Bipolar II, Unipolar Depression Recurrent, and Schizoaffective Disorder, Bipolar Type. They also suggest some overlap between genetic vulnerability factors for those conditions. That is, they suggest that these subtypes are distinct but related. Some datasets also suggest genetic overlap between bipolar disorder and schizophrenia. Recent data from genomewide association studies (GWAS) and also from candidate gene studies support this idea of some common risk factors for the two major psychiatric disorders, bipolar disorder and schizophrenia. In terms of milder spectrum conditions, Bipolar I clearly has a relationship with Bipolar II and with Bipolar Disorder Not Otherwise Specified. Cyclothymia also appears to fall within this spectrum. There are some data suggesting that other conditions should also be considered part of the spectrum, such as Pathological Gambling. Other disorders occur comorbidly with bipolar disorder, such as substance abuse/dependence and anxiety disorders. These conditions probably should be considered subtypes of bipolar disorder (i.e. bipolar disorder with comorbid substance dependence; bipolar disorder with comorbid panic/anxiety disorder) rather than considering these as part of a spectrum. The contributions of new data from GWAS and other molecular studies will be a major focus of this presentation.

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SYMPOSIUM 63
MARIJUANA AND PSYCHOSIS: EPIDEMIOLOGY, NEUROSCIENCE AND CLINICAL PERSPECTIVES

U.S. National Institute on Drug Abuse

Chair: Wilson M Compton, M.D., 6001 Executive Blvd., MSC5153, Bethesda, MD 208929589,
Co-Chair: Steven Grant, Ph.D.
Discussant: Deepak Cyril D'Souza, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the risks of early marijuana exposure on the future development of psychosis, especially schizophrenia; 2) Understand differences in cannabinoid receptor function in persons with schizophrenia compared to persons without schizophrenia; 3) Understand the public health perspective on the relationship of marijuana consumption to psychosis.

OVERALL SUMMARY:

Marijuana has been implicated in the onset and progression of psychosis, especially schizophrenia. Family history of schizophrenia as well as specific variation in the catecholamine metabolism system may mediate the relationship of marijuana with psychosis. Recent evidence points to the importance of the cannabinoid receptor system in schizophrenia. This symposium will provide an integrative approach to the relationship of marijuana and psychosis linking work from epidemiology, genetics, clinical neuroscience, and basic science. Dr. David Ferguson of the University of Otago, Christchurch,

New Zealand will speak on the "Epidemiology of Marijuana and Psychosis"; Dr. Nathan Gillespie of Virginia Commonwealth University will speak on "Exploring the genetic and environmental association between cannabis use and psychosis"; Dr. Dean Wong of Johns Hopkins University will speak on "Imaging Cannabinoid Receptors in Patients with Schizophrenia Using PET"; Dr. Joseph Cheer of the University of Maryland will speak on "Endogenous Cannabinoids and the Neurobiological Control of Mental Illness", and Dr. Robin Murray of the University of London will serve as discussant, focusing on the clinical and public health implications of the findings linking marijuana and psychosis.

S63-1.
CANNABIS USE AND PSYCHOSIS: IS THERE A CAUSAL LINK?

David Fergusson, Ph.D., PO Box 4345, Christchurch, 8001 Australia

SUMMARY:
This presentation will review the evidence on the linkages between the use of cannabis and the development of psychosis / psychotic symptoms. Five lines of evidence suggesting a causal link will be reviewed. These lines of evidence are: a) Consistency of association across studies b) Evidence of dose / response. c) The resilience of the association to controls for observed and non observed sources of confounding. d) The resilience of the association to controls for reverse causality. e) The biological plausibility of a causal association. It is concluded that the weight of the evidence points in the direction of a cause and effect association between the use of cannabis and the development of psychosis.

S63-2.
EXPLORING THE GENETIC AND ENVIRONMENTAL ASSOCIATION BETWEEN CANNABIS USE AND PSYCHOSIS

Nathan Gillespie, Ph.D., 800 E Leigh St, Richmond, VA 23219

SUMMARY:
Cannabis is one the most commonly misused drugs among patients with psychosis. Family, twin and adoption studies have found that genetic factors play a major role in the etiology of psychosis. Likewise, empirical evidence indicates that cannabis use (CU) and cannabis use disorders (CUD) are explained by genetic risk factors. Yet despite their cooccurrence and known heritability, it is unclear to what extent genetic risk factors in CU and CUDs overlap with those of psychosis including schizophrenia. Family studies investigating a variety of illicit substances reveal that relatives of individuals with drug use disorders are at increased risk for a range of psychiatric disorders, including depression, anxiety disorders and antisocial personality disorder suggesting some form of shared environmental or genetic risks. Although several twin and adoption studies have suggested that the association between psychosis and drug abuse is attributable to shared genetic risk factors, less is known about any specific causal association between psychosis and cannabis in particular. The progression to daily cannabis use has been shown to increase the relative risk of psychosis onset as well as the number adverse psychotic symptoms in schizophrenia. Emerging evidence based on reviews of crosssectional and retrospective epidemiological reports now suggests that the cannabispsychosis association is more complex and heterogenous. Several review papers point towards three broad mechanisms to explain the association: cannabis use as a form of selfmedication; cannabis and psychosis cooccurring due to common genetic and environmental diatheses; and risk of psychosis as a consequence of heavy cannabis use among psychosisprone individuals. Recent empirical developments along with issues related to direction of causation and correlated liability models which can explain the cannabispsychosis association will be discussed.

S63-3.
IMAGING CANNABINOID RECEPTORS IN PATIENTS WITH SCHIZOPHRENIA USING PET

Dean Wong, M.D., Ph.D., 601 North Caroline Street, Baltimore, MD 21287

SUMMARY:
Despite evidence linking cannabinoid (CB1) receptors to psychosis, including schizophrenia, it has only been recently possible to provide direct

in vivo imaging to examine various hypotheses surrounding this body of evidence. Recently, at least 3 ligands for in vivo PET imaging of CB1 receptors have been successfully completed in humans. We will present our findings using our PET radioligand, [11C]OMAR (JHU75528). Methods: We have recently completed reports on studies involving the safety, tolerability and initial human study in healthy adult subjects and patients with DSM4 schizophrenia (SCZ) (Neuroimage, 2010;52:150513). These studies showed preliminary evidence of feasibility of studying CB1 receptor binding in schizophrenia and suggest some potential relationship between the in vivo binding and the ratio of the psychosis to BPRS scores. The initial study, which allowed some antipsychotic medications but excluded cannabis abuse or substance abuse, has been revised. Preliminary results showing potential effects of including SCZ with recent substance use will be presented. This work in progress will systematically examine and contrast subjects with recent drug use and alcoholism in contrast to subjects with stricter criteria of our 2010 paper. We also will review unpublished data on the use of CB1 receptor occupancy in the presence of a novel antagonist (AVE 1625) that had been studied in some therapeutic trials. These occupancy studies demonstrate the feasibility of measuring occupancy in controls and SCZ after a single dose of AVE1625 with occupancy from 2590%. Summary: It is now possible to test hypotheses about the role of CB1 with SCZ and in patients with psychosis. The PET occupancy studies indicate this tool can also be used in target engagement for CB1 drug development as well as providing further confirmation that [11C]OMAR can specifically bind to human CB1 receptors in vivo.

S63-4.

ENDOGENOUS CANNABINOIDS AND THE NEUROBIOLOGICAL CONTROL OF MENTAL ILLNESS

Joseph Cheer, Ph.D., 20 Penn Street, Baltimore, MD 21201

SUMMARY:
Clinical and experimental data suggest that plantderived as well as endogenous cannabinoids and their receptors are implicated in schizophrenia. Indeed, the brain levels of the endogenous cannabinoid anandamide are elevated in the spinal fluid of schizophrenic patients and postmortem studies have shown that the expression of cannabinoid receptors is greatly increased in brain areas associated with reward perception, a cognitive process altered in schizophrenia, such as the prefrontal cortex and the nucleus accumbens. Using a brain stimulation reward paradigm we found that cannabinoid receptor blockade induced a profound attenuation of reinforcement that is not principally due to a druginduced decrease in the sensitivity of brain reward circuitry but rather to a combination of decreased rewardcircuit gain and increased subjective costs. Dopaminergic dysfunction in schizophrenia and depression has been linked to depression and to a blunted reaction to rewards. Therefore, we next investigated whether antagonistinduced decreases in the willingness to pay for a reinforcer occur by counteracting reward related cueinduced increases in fast ventral striatal dopaminergic signaling. To asses the interplay between endogenous cannabinoid and dopamine in the pursuit of reward, we pharmacologically impeded endogenous cannabinoid transmission in the dopaminergic cell bodies of the midbrain while measuring subsecond changes in dopamine simultaneously with neural activity in the nucleus accumbens during reward seeking. We found that disrupting endogenous cannabinoid signaling dramatically reduced cueevoked dopamine, associated accumbal neural activity and rewarddirected behavior. These data suggest that endogenous cannabinoids in the midbrain regulate reward seeking by sculpting supranormal patterns of dopamine activity during rewarddirected behavior. The hypodopaminergic response elicited by cannabinoid receptor antagonism is consistent with a reduction in the gain of brain reward circuitry, a tenable explanation of the results reported here. In this regard, it is noteworthy that an increase in the incidence of depressed mood has been noted in participants in clinical trials involving cannabinoid receptor antagonist therapy.

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SYMPOSIUM 64
COMPLEMENTARY AND ALTERNATIVE MEDICINE: UPDATES RELEVANT FOR PSYCHIATRISTS

Chair: *Elspeth C Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the most promising forms of complementary and alternative medicine; 2) Understand how and who to refer for acupuncture or other therapies; and 3) Understand when canine assisted therapy may be useful for service members or civilians.

OVERALL SUMMARY:
This symposia will cover a range of both established and new complementary and alternative (CAM) therapies. Both the Defense Center of Excellence and the National Intrepid Center of Excellence are researching best practices. Medical acupuncture is increasingly being used by military psychiatrists. A combined use of different forms of CAM is being increasingly used; the program at Ft. Bliss will be described. The Army has been using canines increasingly in Army medicine, including service dogs for wounded service members and animal assisted therapy dogs in theater. The use of animals for PTSD should be explored further.

S64-1.
LEVERAGING INTEGRATIVE AND HOLISTIC HEALTH FOR TOTAL FORCE FITNESS AND WELLNESS

Mark Bates, Ph.D., 1335 East West Hwy, Silver Spring, *MD 20910*

SUMMARY:
Presentation about a conceptual framework of integrative health programs and additional resources that have been developed to help integrate and leverage complementary efforts across DoD, other federal, and nonfederal partners. This presentation will include: (1) key terms in related to integrative health, (2) overview of the range of clinical and nonclinical applications and range of resources with an emphasis on mindbody skills, (3) role of integrative health as part of a public health campaign for Total Force Fitness spanning multiple groups across the population in both clinical and nonclinical settings, and (4) resources for leveraging integrative resources including review papers on peertopeer programs, leveraging technology when using mindbody skills, conceptual model of biological factors underlying autonomic nervous system (ANS) regulation, and objective and subjective measures of ANS functioning. Dr. Nisha Money, M.D. is copresenting this part of the symposium.

S64-2.
COMPLIMENTARY AND ALTERNATIVE MEDICINE PRACTICES WITHIN THE WOUNDED WARRIOR POPULATION

Robert Koffman, M.D., M.P.H., 8901 Wisconsin Blvd, Bethesda, MD 208895600

SUMMARY:
Complimentary and Alternative Medical (CAM) modalities are a group of diverse medical and health care systems, practices, and products generally considered under the rubric of Integrative Medicine when combined with conventional medicine. According to 2007 statistics from the National Center for Complimentary and Alternative Medicine, almost 40% of American adults use some form of CAM with neck and back pain followed

by anxiety and stress as most frequent reasons cited. Given the degree to which prevalence rates of chronic pain, Traumatic Brain Injury, and Psychological Health concerns have increased within the DoD, military health care practitioners are increasingly turning to complimentary practices to augment traditional interventions. This session explores the use of CAM practices within the Wounded Warrior population, and highlights those techniques enjoying renewed popularity.

S64-3.
MEDICAL ACUPUNCTURE'S NEW POTENTIAL IN PSYCHOLOGICAL HEALTH

Charles Motsinger, M.D., 2034 N Cleveland St, Arlington, VA 222015506

SUMMARY:
The tradition of acupuncture has long included needle patterns to calm and center the psyche. An Eastern interpretation of traumatic stress can be used to inform a multimodality approach to the treatment of PTSD. Many centers blend Western and Eastern techniques to improve patient outcomes. Recent specific neuroanatomical protocols have shown great promise in military medicine to calm symptoms of acute battlefield stress and pain, and assist in resolving psychological and physical problems associated with PTSD and TBI. Dr. Joseph Helms is copresenting this part of the symposium

S64-4.
MEDICAL ACUPUNCTURE'S NEW POTENTIAL IN PSYCHOLOGICAL HEALTH

Joseph Helms, M.D., 2520 Milvia St, Berkeley, CA 94704

SUMMARY:
The tradition of acupuncture has long included needle patterns to calm and center the psyche. An Eastern interpretation of traumatic stress can be used to inform a multimodality approach to the treatment of PTSD. Many centers blend Western and Eastern techniques to improve patient outcomes. Recent specific neuroanatomical protocols have shown great promise in military medicine to calm symptoms of acute battlefield stress and pain, and assist in resolving psychological and physical problems associated with PTSD and TBI. Dr. Charles Motsinger is copresenting this part of the symposium

S64-6.
THERAPY AND SERVICE DOGS: POTENTIAL AS ALTERNATIVE MEDICINE

Elspeth Ritchie, M.D., M.P.H., 10014 Portland Place, Silver Spring, MD 20901

SUMMARY:
The use of service animals for persons with physical disabilities is well established. Now Soldiers and veterans are reporting reductions in symptoms of PTSD and depression in conjunction with the use of service animals. Animal assisted therapy dogs are increasingly being utilized, with much anecdotal information but little solid research. The Army has been using canines with Soldiers in the theater of war and with wounded warriors. This talk will describe the myriad ways that dogs are being used with Service Members and veterans. It will argue for consideration for them to be considered a form of alternative medicine. However clearly more research is needed in this area. Possible future directions are outlines.

S64-7.
Leveraging Integrative and Holistic Health for Total Force Fitness and Wellness

Nisha Money, M.D., 1335 East West Highway, Silver Spring, MD 20910

SUMMARY:
A conceptual framework of integrative health programs and additional resources that have been developed to help integrate and leverage complementary efforts across DoD, other federal, and nonfederal partners. This presentation will include: (1) key terms in related to integrative health, (2) overview of the range of clinical and nonclinical applications and range of resources with an emphasis on mindbody skills, (3) role of integrative health as part of a public health campaign for Total Force Fitness spanning multiple groups across the population in both clinical and nonclinical settings, and (4) resources for leveraging integrative

resources including review papers on peertopeer programs, leveraging technology when using mindbody skills, conceptual model of biological factors underlying autonomic nervous system (ANS) regulation, and objective and subjective measures of ANS functioning. Dr. Mark Bates, M.D. is copresenter of this part of the symposia with Dr. Nisaha Money.

REFERENCES:

1) The Therapeutic Use of Canines in Army Medicine, supplement to Military Medicine, in press.

SYMPOSIUM 65 INFORMATION TECHNOLOGY APPROACHES FOR IMPROVING OUTCOMES IN PATIENTS WITH SCHIZOPHRENIA

Chair: John Krackow, M.D., Ph.D., 1703 Bear Run Dr, Pittsburgh, PA 15237

EDUCATIONAL OBJECTIVES:

With this session, the participant should be able to: 1) Better understand how various information technology approaches are used to improve outcomes in patients with schizophrenia; 2) It will also discuss what new interventions and educational programs for this population of patients are currently under development; and 3) Discuss the special issues which need to be considered for this population, especially ways to deal with potential cognitive limitations.

OVERALL SUMMARY:

Telehealth technology has become more interactive, less costly and more available to health care providers. We present telehealth approaches being developed to help clinicians better care for patients with schizophrenia. Dr. Rotondi will discuss providing MultiFamily Psychoeducational Therapy to persons with schizophrenia and their family members using a webbased home delivery model. For people with schizophrenia, website design focused on reducing distractions, limiting the need to both think abstractly and to rely on executive functioning. In people with schizophrenia, the intervention lead to reductions in perceived stress, reduced positive symptoms and greater improvement in illness knowledge. Families showed an improvement in knowledge. Dr. Kreyenbuhl will discuss a patientcentered computerized intervention she developed to increase rates of screening for the metabolic side effects of secondgeneration antipsychotics in veterans with schizophrenia. The program, which is delivered immediately prior to an outpatient visit with the prescribing clinician on a laptop computer, informs patients whether or not they have received guidelinerecommended screenings and encourages them to talk with their prescribers, thereby increasing their participation in important healthcare decisions. Dr. Beebe will discuss a study in which nurses contacted outpatients with schizophrenia spectrum disorders weekly using cell phones. The objective was to gather feasibility data with cell phone use to enhance communication with research participants for future studies. Most participants used cell phones regularly; only 6 problems were reported difficulties retrieving messages, answering phones, charging phones and forgetting to take phones when leaving home. Dr. Kasckow will present on a phone based system using the Health Buddy to monitor suicidal ideation in patients with schizophrenia recently discharged following a hospitalization for suicidal behavior. The majority of patients were able to use the system. Within a 3 month period, Scale for Suicidal Ideation scores improved more rapidly in those using the telehealth system relative to controls; there was no improvement in symptoms of depression as measured by the Calgary Depression Rating Scale. The talks will represent the state of the art in telehealth technology to improve outcomes in people with schizophrenia.

S65-1.

ONE YEAR OUTCOMES FROM WEBBASED MULTIFAMILY PSYCHOEDUCATIONAL THERAPY DESIGNED FOR THOSE WITH SEVERE MENTAL ILLNESS

Armando Rotondi, Ph.D., 644 Scaife Hall, Pittsburgh, PA 15261

SUMMARY:

Objective: Assess the feasibility of delivering MultiFamily Psychoeducational Therapy to persons with schizophrenia and their family members via a website and home computers. Method: 31 persons with schizophrenia and 24 family members were randomly assigned to the telehealth or TAU condition. The treatment website (SOAR) was

designed to be accessible to persons with cognitive impairments. The design model reduced the need for users to: 1) rely on working memory; 2) think abstractly and; 3) use executive functions. The primary outcomes for patients were the Scale for the Assessment of Positive Symptoms, and the Knowledge About Schizophrenia Instrument (KASI). The primary family outcome was the KASI. Results: Telehealth patients showed significant and large (d = .88, p =.042) reductions in positive symptoms, and improvements in the KASI (t(24) = 2.34 d =.88, p =.028). Patients with more severe positive symptoms spent more time on (r =.65, p =.005) the website and accessed it more frequently (r =.62, p =.009), indicating that those most in need of treatment sought more therapy. Families showed a significant and large improvement in knowledge (t(14) = 2.32, p =.036, d=1.94). Comparing SOAR to three public mental health websites, subjects (n=32 persons with schizophrenia) completed on average 34% of tasks with the public sites, vs. 52% with SOAR (alpha =.0002), and >2 minutes to complete tasks vs. 49 seconds (alpha =.000007) using SOAR. Conclusions: There is a need for cost effective ways of disseminating evidence based treatments. Telehealth programs, if designed to be accessible to those with cognitive impairments, may offer an ideal solution. This study was funded by the NIMH (R01 MH63484). Educational Objectives: Participants should be able to: identify the elements of a successful telehealth program; define the characteristics of website accessibility for persons with severe mental illness, and; describe the elements of family psychoeducational therapy.

S65-2.

A PATIENTCENTERED HEALTH TECHNOLOGY INTERVENTION TO IMPROVE SCREENING FOR THE METABOLIC SIDE EFFECTS OF SECONDGENERATION ANTIPSYCHOTIC MEDICATIONS

Julie Kreyenbuhl, Pharm.D., Ph.D., 737 W. Lombard St., Suite 500, Baltimore, MD 21201

SUMMARY:
Introduction: Secondgeneration antipsychotic (SGA) medications are widely used to treat psychotic disorders but are associated with metabolic side effects such as weight gain, glucose dysregulation, and hyperlipidemia that may contribute to the high rates of cardiovascular disease in individuals with serious mental illnesses. Adherence to guidelines for regular screening for the metabolic side effects of SGAs is inadequate. This presentation will describe a VAfunded study of a patientcentered health technology intervention developed to increase rates of screening for the metabolic side effects of SGAs and to facilitate patientprescriber communication around screening. Methods: The health technology intervention, delivered on a laptop computer, provides veterans with psychotic disorders prescribed SGAs with personalized health information on how well their care adheres to metabolic screening recommendations and encourages them to talk with their prescribers about screening. The computerized tool uses principles shown to enhance usability in persons with cognitive impairments, which is common in individuals with schizophrenia. Half of study participants are randomized to receive the intervention up to 3 times over a oneyear period immediately prior to a visit with their prescriber. The other half of participants receive printed information on metabolic side effects and general recommendations for screening prior to an outpatient visit. Results: Of the 46 veterans enrolled in the study to date, the mean age is 55 years, 93% are male, 61% are AfricanAmerican, and 35% have never been married. Whereas 83% of participants had used a computer prior to the study, only 37% owned a computer and 54% had ever accessed the Internet. At baseline, most participants were completely interested in being screened for the metabolic side effects of SGAs (78%), knowing the results of the screenings (93%), and talking with their prescriber about the results of screenings (85%). Conclusion: This study will determine if an inexpensive health technology intervention can promote active participation by veterans with psychotic disorders in their own care. Additional studies will be needed to determine the effects of these interventions on clinical outcomes and in settings outside of the VA.

S65-3.

THE FEASIBILITY OF CELLULAR TELEPHONE USE TO FOSTER TREATMENT ENGAGEMENT IN SCHIZOPHRENIA SPECTRUM DISORDERS (SSDS)

Lora Beebe, Ph.D., 1200 Volunteer Blvd, Knoxville, TN 37996

SUMMARY:
Background: There is limited research exploring telephone intervention for psychiatric clients. A few small studies have shown improved appointment attendance and our prior work documented significant increases in psychiatric medication adherence after landline telephone intervention. The purpose of this pilot study was to describe the feasibility and acceptability of using cellular telephones to foster treatment engagement in persons with schizophrenia spectrum disorders (SSDs = schizophrenia and schizoaffective disorder). Methods: Ten outpatients with SSDs were provided previously activated cellular telephones for five months; trained nurses contacted participants weekly, provided a standardized telephone intervention protocol, and recorded feasibility data. Results: Seven participants completed the 5month study. Participants were spoken to an average of 12 times (SD = 4.7); on average, 4 attempts were needed to make contact. Calls ranged from 214 minutes with an average length of 5.8 minutes (SD = 4.8). A total of 59.3% of calls were completed during the 5 months; percentage of completed calls decreased over time. Reasons for missed calls were gathered during the next successful contact; the most common reasons for a missed call were psychiatric hospitalizations and psychotic symptoms. A total of only six problems were identified, including: difficulty retrieving messages, answering or charging telephones. Some problems were associated with memory deficits (forgetting telephone when leaving home), others with lifestyle (telephone stolen or sold). Conclusions: These preliminary findings indicate that a majority of persons with SSDs can use cellular telephones with few problems. Barriers to the use of cellular telephones in this group include memory deficits, lifestyle factors and poor decision making. Researchers and clinicians should consider the use of cellular telephones to foster treatment engagement, enhance personal safety, and contribute a sense of connectedness to others.

S65-4.
A TELEHEALTH INTERVENTION FOR SUICIDAL PEOPLE WITH SCHIZOPHRENIA

John Kasckow, M.D., Ph.D., 1703 Bear Run Dr, Pittsburgh, PA 15237

SUMMARY:
Background: Suicide is a leading cause of premature death in schizophrenia. We developed a telehealth intervention using the Health Buddy© device to reduce suicide risk among individuals with schizophrenia. It was hypothesized that the intervention would: a) be feasible with this population and b) lead to more rapid reduction in suicidal symptoms in recently discharged patients with schizophrenia admitted for suicidal behavior. Methods: Participants were recruited from a VA Psychosis Inpatient Unit. Inclusion criteria were: a Diagnosis of schizophrenia/schizoaffective disorder; age > 17; scores > 0 on items 4 or 5 of the Scale for Suicidal Ideation (SSI) and 17 item Hamilton Depression Rating Scale scores > 7. Participants needed to have a landline telephone. After discharge for a hospital for suicidal behavior, subjects entered a 6month intensive case management program with 2x weekly monitoring phone calls and weekly visits. Half were randomized to additional daily telehealth monitoring in which the patient responds to electronic queries about depressive symptoms and suicidal ideation. Patient responses were automatically sent to a secure website and checked by nursing staff every 4 hours, 24/7. Methods: Thirtyeight participants were randomized with a mean (SD) age of 51.0 (11.8) years; years of education = 12.5 (1.8); 16 were African American/22 were Caucasian. Mini Mental Status scores were 26.4(2.4); 17item Hamilton Scale scores were 16.4 (6.9); SSI scores were 10.2 (7.7). Adherence to monitoring schedule: 15/19 telehealth participants used the system regularly. Reasons why 4 subjects did not set up the system included: apartment complex not allowing use; cognitive dysfunction, relapse to ETOH dependence, patient unable to pay a previous phone debt causing shutoff of service. At 3 months, the telelehealth group exhibited a more rapid improvement in suicidal symptoms [$F(11, 267) = 4.87$; $p < .001$] based on logistic regression. Conclusions: The application of this technology provided a means of supporting regular postdischarge suicide risk monitoring. The majority of participants were able to make frequent use of the telehealth system. Importantly, telehealth monitoring was associated with more rapid remission of symptoms of suicidal ideation over a

period of three months following discharge.

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2) Frangou S, Sachpazidis BA, Stassinakis A, Sakas G: Telemonitoring of medication adherence in patients
with schizophrenia. Telemedicine and eHealth. 2005; 11:675683.
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Clinical Trial to Test the Feasibility of a Telehealth Psychoeducational Intervention for Persons with Schizophrenia and their Families: Intervention and Threemonth Findings. Rehabilitation Psychology, 50: 325336, Nov 2005.

SYMPOSIUM 66
INTERNATIONAL LINK PROJECTS IN PSYCHIATRIC EDUCATION AND PRACTICE: CHALLENGES AND OPPORTUNITIES

IndoAmerican Psychiatric Association

Chair: Subodh Dave, M.D., D.P.M., Psychiatric Unit, Derby City General Hospital, Derby, DE22 3NE United Kingdom,
Co-Chair: Anand K Pandurangi, M.B.B.S, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the session the participant will be able to: 1) Learn innovative methods to strengthen psychiatric knowledge and practices among medical students and clinicians internationally; 2) Learn key factors necessary in establishing a successful international link project while avoiding crosscultural pitfalls; and 3) Gain awareness of educational standards and evaluative frameworks that help assess the effectiveness of such projects.

OVERALL SUMMARY:

The incidence and prevalence of major psychiatric disorders in developing countries is no different to the Western world but the numbers of trained psychiatric health professionals in developing countries is proportionally very low as is the time allocated to psychiatric education at undergraduate level. This has a significant impact on the capacity available to deliver effective psychiatric healthcare. Diaspora organisations such as IndoAmerican Psychiatric Association and British Indian Psychiatric Association in conjunction with the Indian Psychiatric Society and other stakeholders in India have devised link projects aimed at capacity building. These link projects while offering a unique opportunity to improve psychiatric education and care amongst medical trainees and practitioners pose considerable crosscultural and practical challenges. This symposium outlines the challenges encountered in the context of specific UK/India and US/India link projects developed or in development over the last 5years. The presenters will also draw upon the experience of other link projects e.g. ScotlandMalawi and IndoUS neuropsychiatry workshop, to outline the key factors that make a link project successful including in particular, the robust outcome measures that are needed to evaluate such link projects. The second presentation will deal with the crosscultural difficulties in defining "core competencies" in psychiatry and explore the benefits/disadvantages of exporting an undergraduate psychiatric curriculum. The final presentation will discuss the experience of sharing the integrated primary/secondary mental health care model between centres in the US and India. Medical education and practice is increasingly global. For example, >15% of physicians in USA are IMGs with medical training in nonUS medical schools. Increasing number of students from the USA and Canada are seeking education in international medical schools. The specialty of psychiatry is especially diverse and IMGs comprise more than 25% of psychiatrists in the USA. Physicians from India account for 10% of all US psychiatrists. The quality of psychiatric education received in schools abroad is therefore of paramount importance to patients, employers and payers in the USA. Mental health disorders are amongst the most common and most disabling of illnesses, and depression, schizophrenia and bipolar disorders are amongst the top 10 disorders responsible for disability adjusted life years, according to the WHO. The quality of assessment and care received by our patients, no matter which country they reside in, is a matter of concern to our profession, not to mention patients, families and societies they live in. To address the above, a number of projects

have been developed by local education authorities as well as the World Psychiatric Association, FAIMER institute, APA and others. In India, there are over 300medical schools and the quality of psychiatric education is admittedly variable. An innovative method of educating and enthusing medical students in psychiatry was undertaken in the project titled "IndiaUS Neuropsychiatry Course" held in Kochi, India. This was a 6day immersion course in psychiatric neuroscience and cutting edge developments in our field. This was highly successful and many lessons were learnt. Since then, for the last 3years, psychiatric education has been part of the annual IndoUS & Global Health care summits to explore ways of incorporating the successful elements of the Kochi project into the curriculum of select medical schools in India. Collaborative IndoUS teams have since been identified and much ground work has been accomplished to implement these projects. The symposium will present the Kochi project results and the protocols and curriculum for two newer projects. Opportunities and challenges in international collaboration will be discussed with an eye towards creating more such projects to benefit psychiatric education internationally.

S66-1.
USINDIA PSYCHIATRIC EDUCATION PROJECTS

Anand Pandurangi, M.B.B.S, M.D., P.O. Box 980710, Richmond, VA 23298

SUMMARY:
Medical education and practice is increasingly global. For example, >15% of physicians in USA are IMGs with medical training in nonUS medical schools. Increasing number of students from the USA and Canada are seeking education in international medical schools. The specialty of psychiatry is especially diverse and IMGs comprise more than 25% of psychiatrists in the USA. Physicians from India account for 10% of all US psychiatrists. The quality of psychiatric education received in schools abroad is therefore of paramount importance to patients, employers and payers in the USA. Mental health disorders are amongst the most common and most disabling of illnesses, and depression, schizophrenia and bipolar disorders are amongst the top 10 disorders responsible for disability adjusted life years, according to the WHO. The quality of assessment and care received by our patients, no matter which country they reside in, is a matter of concern to our profession, not to mention patients, families and societies they live in. To address the above, a number of projects have been developed by local education authorities as well as the World Psychiatric Association, FAIMER institute, APA and others. In India, there are over 300medical schools and the quality of psychiatric education is admittedly variable. An innovative method of educating and enthusing medical students in psychiatry was undertaken in the project titled "IndiaUS Neuropsychiatry Course" held in Kochi, India. This was a 6day immersion course in psychiatric neuroscience and cutting edge developments in our field. This was highly successful and many lessons were learnt. Since then, for the last 3years, psychiatric education has been part of the annual IndoUS & Global Health care summits to explore ways of incorporating the successful elements of the Kochi project into the curriculum of select medical schools in India. Collaborative IndoUS teams have since been identified and much ground work has been accomplished to implement these projects. The symposium will present the Kochi project results and the protocols and curriculum for two newer projects. Opportunities and challenges in international collaboration will be discussed with an eye towards creating more such projects to benefit psychiatric education internationally.

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In: V Patel, R Thara, editors. New Delhi: Sage Publications India, Pvt. Ltd, 2003.
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3) Pandurangi A, Desai N (2009) IndoUS HCS report, Indian Journal of Psychiatry, 51 (4), OctDec 2009.

NOON - 3:00 PM

SYMPOSIUM 67
TIMELIMITED OUTPATIENT

PSYCHOTHERAPY FOR CANCER PATIENTS: FOCUS ON THE CONTINUUM FROM CANCER DIAGNOSIS TO SURVIVAL

Chair: Anton C Trinidad, M.D., 2150 Pennsylvania Avenue NW, Washington, DC 20037
Co-Chair: Lorenzo Norris, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify characteristics of those patients who are good candidates for time limited psychotherapies for cancer 2); Describe a psychotherapeutic treatment plan that considers the cancer treatment stage and treatment protocol; 3) Discuss specific interventions that could be utilized in the palliative phase of cancer treatment; 4) Appreciate case examples that illustrate these treatment modalities.

OVERALL SUMMARY:
The psychotherapy of depression, anxiety and other emergent psychopathologies cooccurring during the different phases of cancer diagnosis and treatment has not been adequately systematized. In this symposium, we will present a model of a coordinated care consisting of close alliance with the cancer clinic, brief psychotherapy (CBT inflected model) that is in concert with the cancer treatment continuum and one that has survival as a target. This model, we believe, has the potential to be a useful one not only in terms of setting up a viable outpatient psychosomatic medicine practice but also as adjunct in improving the outcome of cancer treatments in general. We will discuss patient selection, CBT and other psychotherapeutic strategies and present two cases for discussion. We hope that the participant will be able to apply these strategies to not only treat similar patients but also to reflect on the growth and viability of outpatient psychosomatic medicine clinics. In the difficult phase when remission could not be achieved for whatever reasons, the therapist confronts problems with helping the patient explore attendant existential issues of choice and the consolidation of meaning along with practical palliative issues such as helping manage pain, acceptance of hospice or nursing home care and other changes and discomforts. Specific practical strategies will be discussed that use an existentially focused modality along with liaison activities with the rest of the treatment team to achieve maximum comfort and minimize despair.

S67-1.
INTRODUCTIONS; ASSESSMENT OF CANCER PATIENTS FOR TIMELIMITED PSYCHOTHERAPY: WHO'S APPROPRIATE AT WHAT STAGE?

Anton Trinidad, M.D., 2150 Pennsylvania Avenue NW, Washington, DC 20037

SUMMARY:
Newlydiagnosed cancer patient often receive information that are overwhelming to them. It is therefore important for the therapist to modify his/her stance in devising a therapeutic strategy not only to help the patient through the stages of treatment but to help educate him/her into the specific vicissitudes of coping strategies required for each stage of the treatment. The therapist thus functions as an integral part of the cancer team and is ideally knowledgeable in the particular oncology treatment protocol. Patient characteristics amenable to brief psychotherapy will be discussed along with issues of patient triaging, crisis management and defining treatment decision trees.

S67-2.
PALLIATIVE PSYCHOTHERAPY – WHEN THE PROGNOSIS SEEMS BLEAK

Lorenzo Norris, M.D., 2150 Pennsylvania Avenue NW, Washington, DC 20037

SUMMARY:
In the difficult phase when remission could not be achieved for whatever reasons, the therapist confronts problems with helping the patient explore attendant existential issues of choice and the consolidation of meaning along with practical palliative issues such as helping manage pain, acceptance of hospice or nursing home care and other changes and discomforts. Specific practical strategies will be discussed that use an existentially focused modality along with liaison activities with the rest of the treatment team to achieve maximum comfort and minimize despair.

S67-3.
CASE PRESENTATIONS

Deyadira BaezSierra, M.D., 2150 Pennsylvania Avenue NW, Washington, DC 20037

SUMMARY:
To illustrate the foregoing principles, two case studies will be presented by Drs. Deyadera Baez Sierra and
Dr. Yavar Moghimi. These cases illustrate a CBTinformed brief psychotherapy and a case of end stage cancer with a palliative focus.

S67-4.
CASE PRESENTATIONS

Yavar Moghimi, M.D., 2150 Pennsylvania Avenue NW, Washington, DC 20037

SUMMARY:
To illustrate the foregoing principles, two case studies will be presented by Drs. Deyadera Baez Sierra and Dr. Yavar Moghimi. These cases illustrate a CBTinformed brief psychotherapy and a case of end stage cancer with a palliative focus.

REFERENCES:
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SYMPOSIUM 68
FIELD TRIAL TESTING OF PROPOSED REVISIONS TO *DSM-5*

American Psychiatric Institute for Research & Education

Chair: Darrel A Regier, M.D., M.P.H., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209
Co-Chair: David J Kupfer, M.D
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EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants will be able to: 1) Describe the overall strategy and planning process behind *DSM-5* field trials to assess select proposed revisions; 2) Identify the specific methods and techniques being utilized in *DSM-5* field trials; and 3) Be able to summarize the status of data collection and findings from both large field trial settings and routine clinical practice settings.

OVERALL SUMMARY:
The *DSM-5* field trials represent a crucial phase in the revision process wherein proposed changes to the manual are examined in realworld settings. Evaluation of draft criteria is a necessary and vital component to ensuring that DSM maintains its primary function as an effective clinical tool designed to guide patient care, while also providing diagnostic criteria that are empirically sound. This symposium will introduce attendees to the overall implementation strategy and logic behind the field trials for *DSM-5*. Presentations will describe specific components of draft revisions that are being examined during the field tests. This includes the diagnostic checklists containing proposed criteria for all disorders and the proposed dimensional measures for assessing crosscutting symptoms and diagnosticspecific severity ratings. Speakers will also discuss the two designs of field trials being utilized – one for large, academicmedical institutions and a second focusing on solo practitioners and routine clinical care settings. Though these two designs are unique, both were developed to answer specific questions about whether the proposed criteria and measures for *DSM-5* are stable over time, are reliably used by different clinicians, perform equally well across different age groups and cultural populations, and are useful in informing treatment decisions as well as making a diagnosis. If available, select preliminary findings from the initial phase of field testing will be shared.

S68-1.
***DSM-5* FIELD TRIALS**

Helena Kraemer, Ph.D., 1116 Forest Avenue, Palo Alto, CA 94301

SUMMARY:
The *DSM-5* process began in 1999 with a projected publication date of 2013, with field trials of proposed diagnostic criteria currently underway. The basic principles underlying the field trails are reviewed, including issue related to establishing the testretest reliability and validity of diagnoses, both categorical and dimensional, and of the "crosscutting measures." The design of the field trials, and how the design and proposed analysis, relates to the principles are discussed.

S68-2.
DIMENSIONAL APPROACHES IN *DSM-5*

Jack Burke, M.D., M.P.H., 1493 Cambridge Street, Cambridge, MA 2139

SUMMARY:
The *DSM-5* Task Force is testing several ways that dimensional approaches to diagnosis can enhance a clinician's ability to plan and monitor treatment of patients. While a categorical approach rests on a binary, "yes or no" decision about diagnosis, dimensional approaches use quantitative ratings to measure intensity, frequency, duration, severity or other characteristics. Following recommendations from a *DSM-5* Research Conference, the Task Force has developed two types of measures. One is a set of crosscutting items that would be of value in almost any patient, without regard to the specific disorder; the other is a recommendation for specific measures of severity that would be used for a specific disorder the clinician is managing. Both types of measure would be used to establish a baseline at initial evaluation and then to track changes over time. The crosscutting measures will rely whenever possible on patientreported outcome measures constructed by the NIH PROMIS initiative, which is generating scales useful for any field of clinical research. This presentation will provide examples of the various measures being tested in Field Trials, and will highlight further steps to develop dimensional measures once the initial field trial results are available.

S68-3.
TESTING NEW DIAGNOSTIC CRITERIA IN THE *DSM-5* FIELD TRIALS

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

SUMMARY:
The proposed *DSM-5* diagnostic criteria sets include both changes in existing diagnostic criteria and criteria for new diagnoses. Many of these changes will be subjected to testing in the *DSM-5* Field Trials. This symposium will review: 1) the rationale for choosing the diagnoses to be tested, 2) the diagnostic criteria sets that will be tested, 3) the methods that have been developed for assessing the feasibility, clinical utility, reliability and validity of these criteria, and 4) the analytic approach that will be used to answer the questions posed in the trials. The NIHsponsored REDCap system for gathering data about the diagnostic criteria will be reviewed. The possible implications of the field trial results for future changes in the *DSM-5* criteria will be previewed.

S68-4.
DSM-5 FIELD TRIALS: IMPLEMENTATION IN ACADEMIC/LARGE CLINICAL SETTINGS

Diana Clarke, M.S.C., Ph.D., 1000 Wilson Blvd Ste 1825, Arlington, VA 22209

SUMMARY:
The *DSM-5* Task Force and Work Groups have proposed a number of changes to the diagnostic criteria for many mental disorders. Some changes include amendments to existing disorders, proposals for new disorders, a change in how some disorders are conceptualized, as well as the integration of dimensional measures across diagnostic groups to augment the existing categorical classification of mental disorders. Since DSM is primarily a clinical tool that is used across the variety of clinical settings in which individuals seek help for their mental health problems, it is important that the proposed changes are examined for their feasibility, usefulness, reliability, and, where possible, validity in such settings. As such, field trials were designed and implemented to address these issues. One version of the *DSM-5* field trials aims to assess the feasibility, clinical usefulness, testretest and interrater reliabilities and validity of the proposed changes but focused on academic/large clinical settings. This presentation will describe the rationale and implementation strategies behind this field trial design. Attention will be given to describing the study protocol and the ways in which this field trial design was tailored specifically to meet the needs of the large psychiatric, specialty, and general medical clinics. Finally, as available, descriptive data (e.g., number of patients recruited, gender, age, ethnicity, etc.) from the 11 sites selected to participate in the field trials (from among 60 applicants to the *DSM-5* Field Trial Request for Proposals) will be discussed.

S68-5.

TESTING *DSM-5* IN ROUTINE CLINICAL PRACTICE SETTINGS: LARGESCALE SCIENCE IN SMALLSCALE PRACTICES

Eve Moscicki , Sc.D., M.P.H., 1000 Wilson Blvd Ste 1825, Arlington, VA 22209

SUMMARY:
The *DSM-5* Field Trials in Routine Clinical Practice Settings will examine the feasibility, clinical utility, and sensitivity to change of the proposed *DSM-5* diagnostic criteria and dimensional assessment measures as used by individual clinicians in routine clinical practice settings. This presentation will provide an overview of the design, sampling, and procedures for this important component of the *DSM-5* Field Trials. Study participants will include a representative sample of 1000 randomly selected general psychiatrists, 100 geriatric psychiatrists, 100 addiction psychiatrists, and 200 child psychiatrists; a volunteer sample of 1000 psychiatrists and 500 each of advanced practice psychiatricmental health nurses, licensed doctorallevel psychologists, and clinical social workers; and 7800 systematicallyselected patients. Each clinician will complete webbased *DSM-5* training and will enroll one new and one existing patient into the Field Trial, explain the study, and obtain informed consent or assent from the selected patients. Field Trial data collection methods and data security will be described. Data characterizing the representative and volunteer samples of clinicians will be presented, including sociodemographic characteristics, clinical discipline, specialty, caseload, nature of practice, practice setting, and patient caseload characteristics. The presentation will include a brief discussion of the unique challenges and opportunities found in implementing a largescale scientific endeavor in smallscale settings.

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SYMPOSIUM 69
INNOVATIVE USES OF PSYCHODYNAMIC PSYCHIATRY ACROSS THE LIFE CYCLE

American Academy of Psychoanalysis & Dynamic Psychiatry

Chair: Joan G Tolchin, M.D., 35 East 84 Street, Apt 2B, New York, NY 100280871
Discussant: Carolyn B. Robinowitz, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify some of the ways psychodynamic psychiatry can be utilized in a variety of settings within which psychiatrists work, including such areas as medication management and school consultation; and 2) Learn how psychodynamic understanding of patients can support innovative treatments.

OVERALL SUMMARY:
Psychodynamic psychiatry, in a tradition initiated by Freud, emphasizes the interplay of conscious and unconscious mental process, internal conflict, and the surviving importance of early childhood experience in determining behavior. The session will focus on the ways in which psychodynamic theory and understanding can inform a variety of therapeutic approaches. In the initial presentation, Dr. Charles Nemeroff will discuss the importance of the relationship between patient and physician in the patient's adherence to pharmacological treatment. Dr. Nemeroff will additionally elucidate the exchange of essential information not limited to psychopharmacology that occurs during the "med check," and how this information can be integrated into ongoing therapy. Dr. Joan Tolchin will then describe how the general psychiatrist, with psychodynamic understanding, can utilize techniques from child psychiatry such as art and story telling, to engage resistant adolescent patients. Dr. Eugenio Rothe will describe his work as a school consultant with special needs children whose unconscious communications were transmitted through acting out behavior, and how

this understanding could be utilized in therapeutic interventions. Dr. Richard Brockman will review the neurobiology of attachment and love in order to explore some innovative uses of the positive transference in working with more primitive patients. Dr. Carolyn Robinowitz will discuss and synthesize the presentations integrating the theoretical underpinnings of these presentations and their practical clinical applications in a broad array of clinical settings, patient demographics and disorders. The audience will be encouraged to ask questions after each presentation, and following the formal presentations will have an opportunity for further questions and discussion.

S69-1.
THE MYTH OF THE MED CHECK: PSYCHODYNAMICS AND PSYCHOPHARMACOLOGY

Charles Nemeroff, M.D., Ph.D., 1120 NW 14 Street, Miami, FL 33136

SUMMARY:
A substantial number of patients receive psychiatric care that is solely limited to 15 minute "med checks." This presentation raises a number of issues concerning this type of practice. Included in this discussion are a number of best practice guidelines that should be adhered to in any psychiatric practice and whether it is feasible to do so in such a practice setting. These include careful assessment of treatment efficacy and side effects, drugdrug interactions as well as the status of comorbid medical disorders. In addition, suicidality and substance and alcohol abuse must be assessed at each visit. The consequences of long term treatment with antipsychotic and antidepressant drugs must be continuously monitored including body weight, indices of the metabolic syndrome, various other laboratory measures, and sexual function. Patients expect psychiatrists to not only dispense medication, but provide some form of psychotherapy. There is excellent data suggesting that a combination of psychotherapypharmacotherapy is not only more effective, but markedly increases the rate of medication adherence.

S69-2.
WAYS THE GENERAL PSYCHIATRIST CAN WORK WITH RESISTANT ADOLESCENT PATIENTS

Joan Tolchin, M.D., 35 East 84 Street, Apt 2B, New York, NY 100280871

SUMMARY:
Adolescent patients often come to the psychiatrist's office at the behest of otherstheir parents, their schools. Even compliant teenagers may believe they are in treatment against their will. They may feel stigmatized by having to see a psychiatrist. At a time of life when being like their peers is of paramount importance, they may experience seeing a therapist as something that makes them shamefully different from their friends. It is not unusual for adolescents to be resistant to therapysilent, withdrawn, noncommunicative. With psychodynamic understanding, the general psychiatrist can learn to engage these difficult patients. During the session, the audience will learn how to utilize a number of techniques from child psychiatry, including art and story telling, to engage resistant patients and foster a therapeutic alliance.

S69-3.
VAMPIRES AND VAMPS: SCHOOL CONSULTATION WITH SPECIAL NEEDS CHILDREN

Eugenio Rothe, M.D., 2199 Ponce de Leon Blvd. Suite 304, Coral Gables, FL 33134

SUMMARY:
The neurodevelopmental changes in the adolescent brain account for a predominance of instinctual drives and exploratory behaviors emanating from the basal structures, with a decrease of function in the inhibitory frontalcortical areas. For this reason, actingout behaviors are considered to be a typical and sometimes a phasespecific manifestation of the adolescent stage of development. Seen from a psychodynamic viewpoint, actingout behaviors serve to relieve unconscious tensions and to discharge wardedoff impulses that express instinctual demands. They may also have a communicative function, by which the adolescent expresses motorically, complex feelings and inner conflicts that have yet to be processed and understood and cannot yet be expressed verbally. The author will present his work as a consultant to a Special Education School, treating an adolescent girl with sexual actingout

behaviors, a "vamp", and an adolescent boy who dressed and behaved like a "vampire". Both were dealing with feelings of alienation, rejection, abandonment and low selfesteem. Adolescent actingout behaviors present a diagnostic challenge to clinicians and an opportunity for engagement in treatment and for therapeutic change.

S69-4.
MAGIC, FANTASY, AND NEUROBIOLOGY

Richard Brockman, M.D., 285 Central Park West, #1n, New York, NY 100243006

SUMMARY:
In the prehistory of dynamic psychiatry certain pioneering figures stand out Mesmer, Bernheim, Charcot, Breuer, among others. They developed techniques that relied heavily on the ability of the doctor to actively guide (suggest, direct, lead) the patient to a desired clinical result. As described these techniques often seemed to work "like magic". Freud studied, applied, and then discarded this practice as he developed his own theory of the dynamic unconscious. Following Freud's lead, psychodynamic psychiatry all but abandoned these techniques as being inappropriate and naive. Recent neurobiology, however, has reopened a door. With an understanding of the biology of attachment and love in all phases of the life cycle uses of the positive transference have a new foundation and new possibilities. The session will explore some of the underlying neurobiology, and then it will go on to explore its implication for the positive transference and how this might be used in the clinical setting. Case examples will be given. There will be an emphasis on the value of this work in the psychodyamic treatment of patients with more primitive character pathology and working the other way, what this might mean about the nature of their underlying neurobiology. At the end of the session, the audience should have a better understanding of the neurobiology of attachment, and how this can guide the use of the positive transference.

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SYMPOSIUM 70
PSYCHIATRIC NOSOLOGY: A SEARCH FOR NEW MODELS
U.S. National Institute of Mental Health

Chair: Nancy C Andreasen, M.D., Ph.D., 200 Hawkins, Iowa City, IA 52242
Co-Chair: Carol A Tamminga, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify philosophical traditions that shaped the development of the DSM system; 2) Evaluate the limitations of the *DSM* system; 3) Recognize the rationale behind developing methods to define dimensions of psychopathology and brain function as an alternative approach; 4) Describe the emerging discipline of phenomics and to discuss its utility; and 5) Identify the utility of conceptualizing psychosis as an intermediate phenotype.

OVERALL SUMMARY:
For many years psychiatric nosology has been based on the "discrete disease entity" model, originally promulgated more than a century ago by Kraepelin and others. This model had a strong influence on the development of *DSM III* and subsequent diagnostic systems. Increasingly, during recent years, this model has been questioned on both clinical and scientific grounds, and alternative models have been proposed. Clinically the model has been criticized as being oversimplistic and rigid. Scientifically it has been criticized because it does not concur will with emerging evidence about the etiology and mechanisms of psychiatric disorders. For example, genomics—a discipline that promises to identify the etiologies of disorders at the molecular and cellular level—has frequently found overlapping genes in theoretically "discrete" disorders. Symptom patterns and neural circuits are also frequently found to be overlapping. Therefore, this symposium will provide an update on the search for new models. Andreasen will begin with an historical overview and initiate the discussion of the rationale for the search for new models. Cuthbert will discuss the NIMHsponsored initiative to develop research domains of psychopathology and describe its utility. Bilder will describe how phenomics, the systematic study of phenotypes on a genomewide scale, integrates tools from information science with multilevel molecular, systems, and behavioral

research, in an effort to construct the most likely mechanistic paths from genome to syndrome. Finally, Tamminga will present an example of the application of these principles to the search for the mechanisms and etiology of psychosis, conceptualized as an "intermediate phenotype." The current *DSM* diagnostic system has facilitated communication about psychiatric presentations and has provided the basis for practical transactions for treatment and reimbursement. However, after years of attempting to identify molecular mechanisms for *DSM* diagnoses, it now seems probable that the current system may not be segmenting serious mental illness into biologically meaningful groups. Because basic neuroscience has grown exponentially in the last half century, we know enough about brain structure and function to ask how pathology might be represented within specific neural systems. Based on these considerations, it seems possible that dimensions of cognition and affect might be useful not only in describing normal behaviors, but also in organizingmolecular pathophysiology and focusing on treatment pathways. Many scientists already propose that dimensions of psychosis, mood instability and anxiety are entities around which we should organize disease definitions. Speaking to one such dimension, we are examining psychosis as a dimension, an intermediate phenotype, using human brain imaging and postmortem tissue analysis; it has led us to propose a model of psychosis in schizophrenia that includes alterations in intrahippocampal circuitry generating CA3overactivity and hyperassociational thought, with mistaken associations, some with psychotic content. This model of psychosis pathophysiolgy implicates specific functional and molecular pathology, neural treatments, and risk factors, all consistent with known psychosis risk genes. This dimensional approach to psychosis diagnosis and pathophysiology is consistent with the RDoCs proposals made by NIMH, but requires stringent experimental testing.

S70-1.

PSYCHIATRIC NOSOLOGY: WHERE HAVE WE BEEN, AND WHERE SHALL WE GO?

Nancy Andreasen, M.D., Ph.D., 200 Hawkins, Iowa City, IA 52242

SUMMARY:

For many years psychiatric nosology has followed the medical model tradition that attempts to divide disorders into diagnoses that are discrete, using characteristics such as symptom patterns, course of illness, familial aggregation, and response to treatment. This approach was extensively instantiated when diagnostic criteria were developed for DSM III and subsequent editions. The framers of DSM III hoped that use of diagnostic criteria would enhance both research and clinical practice. Now (thirty years after the introduction of DSM III in 1980), investigators and clinicians have begun to question the utility of the DSM approach, expressing concerns can be oversimplistic and misleading. Contemporary genomic studies have suggested that formerly discrete disorders may in fact share overlapping genes; neuroimaging studies have identified overlapping regions of interest and circuits in these disorders; and treatments often overlap as well. Clinicians and educators have expressed concerns that overuse of diagnostic criteria for evaluation and even reimbursement may have actually diminished the quality of clinical care. During the twentyfirst century psychiatry will be using increasingly sophisticated tools to map the underlying mechanisms of mental illnesses. This search will be enriched by the development of more sophisticated nosological models.

S70-2.

THE NIMH RESEARCH DOMAIN CRITERIA PROJECT (RDOC)

Bruce Cuthbert, Ph.D., 6001 Executive Blvd, MSC 9632, Bethesda, MD 208169632

SUMMARY:

Contemporary advances in genomics and neuroscience have not resulted in the kinds of rapid advances in etiology and new treatments for mental disorders that many in the field had expected. Part of the problem appears to be that current definitions of psychiatric disorders antedate the extensive and growing knowledge base about the brain and behavior now available. Current diagnostic categories are based on presenting symptoms rather than information gained from genetics, neuroscience, or behavioral science. The resultant nosological problems include extensive comorbidity, heterogeneity of disorder definitions, overspecification, and Not Otherwise

Specified (NOS) categories. To foster research that facilitates the ability of contemporary brain science to inform diagnosis, the NIMH has incorporated in its new strategic plan a goal to "develop new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures." This presentation will include a description of a new initiative, the Research Domain Criteria (RDoC) project that was started to implement this goal. The approach is to develop a consensus process for identifying major dimensions of behavioral functioning, as defined and constrained by relevant brain circuits and other units of analysis. In turn, mental disorders are viewed in terms of extremes of these normal dimensions. The intent is not necessarily to explain current disorder conceptions in terms of such dimensions; the organizational scheme is agnostic with respect to current nosologies. Rather, the aim is to foster classifying patients for research in terms of common mechanisms that cut across usual diagnostic categories. Thus, a study of excessive fear might include patients from all anxiety disorders groups; an experiment concerning working memory problems might include patients from all of the psychotic disorders categories. The rationale of the Rod project will be described: its initial formulation, the specific aims for development, and the consensus process that is planned over the next 18 to 24 months. The talk will include examples of potential applications to particular classes of disorders and its implications for future clinical use; it will emphasize that the RDoC project is intended to create a research framework that can inform future versions of classification systems, but is not intended for clinical use in the near future.

S70-3.
PHENOMICS STRATEGIES TO RESHAPE NOSOLOGY

Robert Bilder, Ph.D., 760 Westwood Plaza, Mail Code 175919, Los Angeles, CA 90095

SUMMARY:
The initial wave of genomewide research targeting major mental illnesses has reinforced concerns that the prevailing diagnostic taxonomy fails to identify biologically meaningful categories. It now appears likely that risks for multiple behavioral syndromes are posed by a wide array of overlapping genotypic factors. It remains unclear to what extent a very large number of common genetic variants, each with very small effect, together with rare variants and epistatic and epigenetic factors, may converge on some phenotypic dimensions that will prove to be more fruitful targets of research. Intermediate phenotypes or endophenotypes have been examined, but these may have genetic architectures as complex as the syndromal entities they seek to replace. Phenomics – the systematic study of phenotypes on a genomewide scale – integrates tools from information science with multilevel molecular, systems, and behavioral research, in an effort to construct the most likely mechanistic paths from genome to syndrome. This presentation highlights the development of the "hypothesis web" project, which aims to provide methods for construction of evidencebased models to visualize and enable transdisciplinary collaboration on hypotheses spanning multiple levels of knowledge. These include genomic, proteomic, cellular systems and signaling pathways; neural circuits; cognitive phenotypes; psychiatric symptoms; and psychiatric syndromes. As a proofofconcept, we present a multiscale hypothesis model for the dimension of "working memory" and associated biological processes that have been identified as potentially valuable targets by the NIMH Research Domain Criteria (RDoC) project. These hypothesis models can serve: (a) as a scaffold for shared conceptual descriptions; (2) to aggregate evidence from prior research, enabling automated literature mining and metaanalysis; (3) to guide direct data mining from expanding repositories of genotypic and phenotypic data; and (4) to design new experimental approaches that can more effectively prune out dead ends and optimize identification of critical paths for discovery.

S70-4.
A NEW MODEL FOR CONCEPTUALIZING DIMENSIONS: PSYCHOSIS AS AN INTERMEDIATE PHENOTYPE

Carol Tamminga, M.D., 5323 Harry Hines Blvd, Dallas, TX 753907201

SUMMARY:
The current DSM diagnostic system has facilitated communication about psychiatric presentations and has provided the basis for practical transactions for treatment and reimbursement. However, after years

of attempting to identify molecular mechanisms for DSM diagnoses, it now seems probable that the current system may not be segmenting serious mental illness into biologically meaningful groups. Because basic neuroscience has grown exponentially in the last half century, we know enough about brain structure and function to ask how pathology might be represented within specific neural systems. Based on these considerations, it seems possible that dimensions of cognition and affect might be useful not only in describing normal behaviors, but also in organizing molecular pathophysiology and focusing on treatment pathways. Many scientists already propose that dimensions of psychosis, mood instability and anxiety are entities around which we should organize disease definitions. Speaking to one such dimension, we are examining psychosis as a dimension, an intermediate phenotype, using human brain imaging and postmortem tissue analysis; it has led us to propose a model of psychosis in schizophrenia that includes alterations in intrahippocampal circuitry generating CA3overactivity and hyperassociational thought, with mistaken associations, some with psychotic content. This model of psychosis pathophysiolgy implicates specific functional and molecular pathology, neural treatments, and risk factors, all consistent with known psychosis risk genes. This dimensional approach to psychosis diagnosis and pathophysiology is consistent with the RDoCs proposals made by NIMH, but requires stringent experimental testing.

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4) Tamminga CA, Stan AD, Wagner AD: The hippocampal formation in schizophrenia. Amer J Psychiatry, advance online publication, Sept 2010.

SYMPOSIUM 71
GUIDANCE ON QUALITY OF MENTAL HEALTH SERVICES: INTERNATIONAL PERSPECTIVES

Chair: Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany
Co-Chair: Harold A Pincus, M.D.
Discussant: Harold A Pincus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to: 1) Describe the current global issues in mental healthcare services research; and 2) know the major healthcare and research initiatives and projects to address gaps in mental healthcare worldwide.

OVERALL SUMMARY:

Several initiatives are underway globally to improve mental healthcare. The main aims are to review and internationally standardize measures of assessment of mental healthcare systems, to optimize treatment procedures, and to provide suggestions for the optimization of mental health care structures. The Mental Health Quality Indicator Project of the International Initiative of Mental Health Leadership coordinates a review and standardization of quality indicators used to assess mental healthcare systems worldwide. A review of initiatives and programs on mental healthcare quality indicators in selected countries has recently been completed. One of the concrete projects initiated by the European Psychiatric Association concerns the development and implementation of evidencebased treatment recommendations in psychiatry with a European dimension named 'Recommended Guidance'. The range of guidance papers to be developed will be described. They aim to achieve the objective to improve the quality of mental health care in Europe by providing evidencebased information and advice, and to identify and minimize mental health care gaps. This project develops recommendations on both structural and procedural aspects of treatment. As mental healthcare systems constantly undergo changes in both structures and procedures. With a global view on mental healthcare, an overview of the mental healthcare gaps especially in the low and middleincome countries will be given including a discussion about how such gaps are addressed.

S71-1.
CROSSING THE INTERNATIONAL QUALITY CHASM: MEASURING THE QUALITY OF MENTAL HEALTH CARE

Sharat Parameswaran, M.D., 1051 Riverside Drive, Mailbox 85, New York, NY 10032

SUMMARY:
The quality of care in mental health systems has gained increasing awareness amongst clinicians and policymakers across many countries. In 2008, 12 countries (Australia, Canada, England, Germany, Ireland, Japan, Netherlands, New Zealand, Norway, Scotland, Taiwan, and United States) initiated a project to develop a matrix of clinical and system performance measures that clinicians, administrators and consumers may consider in evaluating quality in the provision of mental health services. For Phase I of the project, a team of researchers based at the Columbia University Department of Psychiatry collected a wide range of mental health performance and outcome measures from participating countries to identify the most commonly used domains, indicators and data sources through a review of grey literature. We identified 58 quality performance measurement initiatives and over 600 mental health indicators across the US Institute of Medicine quality domains as well as across clinical categories and settings. In addition, a survey of policymakers in the participating nations identified 39 active or soontobe implemented mental health quality assessment programs, including information on how each country develops and applies these programs, which domains of quality these programs assess, and how collected data will be used. The range of indicators, domains and programs identified vary widely in their scope, intended use, and degree of development, reflecting not only differences in the organization and structure of each country's health care system but also in the sources, availability and analysis of data and the sociopolitical realities that determine mental health priorities. The ultimate goal of this project is to develop and implement a common framework of a limited number of performance measures that will allow for comparison of system performance across countries to inform initiatives that will help to improve and transform mental health services in these countries.

S71-2.
GUIDANCE ON THE QUALITY OF MENTAL HEALTH SERVICES FROM A EUROPEAN PERSPECTIVE

Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany

SUMMARY:
Several initiatives are underway globally to improve mental healthcare services. The main aims are to review and internationally standardize measures of assessment of mental healthcare systems, to optimize treatment procedures, and to provide suggestions for the optimization of mental health care structures. In a recent review within the framework of the EPA Recommended Guidance project, we identified 24 topics of quality indicators of mental health service structures, including among others structural recommendations like the necessity to develop integrated models of cooperative community mental healthcare, and process recommendations like to ascertain that wards have access to a range of diagnostic and therapeutic services, with the latter process recommendations having a direct influence on mental healthcare structures. These Guidances aim to achieve the objective to improve the quality of mental health care in Europe by providing evidencebased information and advice, and to identify and minimize mental health care gaps. This project develops recommendations on both structural and procedural aspects of treatment.

S71-3
MENTAL HEALTH SERVICES IN DEVELOPING COUNTRIES

Norman Sartorius, M.D., Ph.D., 14 Chemin Colladon, Geneva, 1209 Switzerland

SUMMARY:
The development of mental health services in developing countries over the past fifty years is disappointing. The services that are in existence are not satisfactory in either quality or in coverage. There are fine examples of a successful provision of services in the third world but most of them are due to the extraordinary charisma and efforts of individuals rather than to a successfully implemented national mental health policy. The reasons for this state of affairs are many, reaching from widespread poverty and ignorance to continuing stigmatization

and consequent discrimination of people with mental illness and of those who provide them care. Part of the blame can also be given to the mental health professions who have failed to reach consensus about minimal standards of mental health care and about the education of mental health care professionals. Blame could also be assigned to developed countries and international agencies because neither of them placed mental health of people in the countries to which they are providing help as high on the list of priority as the importance of mental health for development deserves. The presentation will describe the main obstacles to the improvement of mental health care in the third world and discuss some of the initiatives that have been taken to overcome them and develop appropriate mental health programs in the third world.

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SYMPOSIUM 72
REPRODUCTIVE ISSUES AND WOMEN'S MENTAL HEALTH: UPDATE AND CONTROVERSY

Chair: Gisële 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) Help patients make informed decisions about pregnancy; 2) Understand issues concerning infertility; 3) Help patients cope with early termination; and 4) Assess mental health issues during the peripartum and understand how social policies have implications in the promotion of women's mental health.

OVERALL SUMMARY:

These last years a number of studies have focused on pregnancy and psychiatric disorders linked to reproductive issues. Infertility has still to be encompassed as both an issue for women and a challenge for subsequent motherhood when overcome. Pregnancy termination and abortion have been linked to consequent mood and anxiety disorders and eventually PTSD. However past history of abuse, trauma and depression in women's lives and their association to depression in pregnancy often go neglected. Abortion and its supposed psychiatric sequelae have also been subject to heated debate in the US often confounding examination of scientific facts. On the other hand, the myth of pregnancy and motherhood as a blessed period, free of psychiatric disorders is still strong though continuously proved wrong whether it be for women with bipolar or major depressive disorder. Recognition and assessment of symptoms during the peripartum is therefore still insufficient. This symposium will focus on all these different aspects of psychiatric issues related to reproduction. Review of the literature, methodological issues and therapeutic management of all situations will take place. We will give specific attention to how gender and social policy have implications for promoting women's mental health. A general comprehensive discussion encompassing reproductive women's mental health issues will complete our presentations.

S72-1.
GENDER, SOCIAL POLICY AND PROMOTING WOMEN'S MENTAL HEALTH

Helen Herrman, M.D., M.B., ORYGEN Research Centre, University of Melbourne, 35 Poplar Road, Parkville VIC, Melbourne, 3052 Australia

SUMMARY:

The connections between mental health and a healthy life make the improvement of women's mental health a necessity for good health and community development. In countries of all types poor mental health is associated with social disadvantage, human rights abuses and poor health and productivity, as well as heightened risk of mental illnesses. Conversely, tackling important social and health problems such as maternal and child health, violence at home, substance abuse, gender equity and HIV prevention, requires interventions that focus on assertiveness and selfreliance and appropriate participation. Findings from a study of women in primary health care suggest that mental health and empowerment are closely aligned concepts. Primary

health care programs can indirectly promote mental health by addressing its determinants through empowerment; by enhancing social unity, minimizing discrimination and generating income opportunities. Promotion, prevention and treatment are all needed strategies for reducing the burden of mental illness and improving mental health. The World Health Organization (WHO) has recently published reports on mental health promotion and women's mental health, highlighting the emerging evidence base for effective public health actions. The reports highlight the need for practical collaborations between health and nonhealth sectors in promoting mental health and psychosocial wellbeing.

S72-2.
EFFECTS OF INFERTILITY ON WOMEN'S MENTAL HEALTH

Malkah Notman, M.D., 54 Clark Road, Brookline, MA 2445

SUMMARY:
The distress caused by infertility has been well known. It interferes with the desire to produce a family and fulfil the traditional feminine roles. Until relatively recently infertility has been attributed to problems of the woman. Recent data have established that a considerable component of infertility problems are male related and can be combined. Nevertheless the effects of infertility on self esteem, sense of competence and body image are considerable. These will be discussed.

S72-3
PSYCHIATRIC ASPECTS OF ABORTION

Nada L. Stotland, M.D., M.P.H., 1000 Wilson Blvd, Arlington, VA 22209

SUMMARY:
Abortion is among the most common procedures in the United States, with over 1/3 of women undergoing abortion at some time in their lives. Therefore most clinical psychiatrists treat women who contemplate having or have had induced abortions and should be familiar with the evidence regarding its psychiatric aspects. It is essential that the psychiatric sequelae of abortion always be compared with that of ongoing pregnancy and miscarriage or childbirth; those are the only alternatives for pregnant women. As the literature continues to accrue, it becomes increasingly evident that women with preexisting psychosocial stressors and mental illnesses may be more likely than other women to have abortions; that those stressors and illnesses may continue after the abortion; but that abortions are not the cause. Childbirth is associated with a higher incidence of adverse sequelae than abortion. Psychiatrists can help women patients to make informed choices and to deal with past reproductive decisions.

S72-4.
DILEMMAS CONCERNING MISCARRIAGE AND GENETIC TERMINATIONS.

Gail Robinson, M.D., Toronto General Hospital 8231 E.N., 200 Elizabeth St,, Toronto, ON, M4W 3M4 Canada

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 longlasting 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.

S72-5.
PREGNANCY: HOW TO RECOGNIZE AND MANAGE ANTENATAL MATERNAL MENTAL HEALTH ISSUES?

Gisele Pater, M.D., Ph.D., 14 rue de l'Abbaye, Antony,

92160 France

SUMMARY:
Pregnancy has long been wrongly considered a blessed period, free of psychiatric disorders. However, there is now strong evidence that pregnancy is in itself a major source of physiological and psychological upheaval and can therefore trigger relapse of major depressive disorders and bipolar episodes during the prepartum and after birth, if adequate management and treatment is not implemented. Recognizing psychiatric disorders and psychopathology during the prepartum can be a challenge. Somatic complaints and hormonal changes tend to be attributed to the pregnancy itself creating confounders of prenatal depression for physicians and primary care professionals. Women with past history of sexual abuse have more functional symptoms of depression during the prepartum. However, maternal history of trauma, PTSD, borderline personality and depression often overlap also creating major diagnostic difficulties and hindering recognition of mental health issues during pregnancy. This leaves even more women undiagnosed and untreated. Antenatal depression not only impeaches women during pregnancy but is also often followed by postnatal depression. Pregnancy is the time during which psychological preparation for mothering takes place. Selfdepreciation and undermining of selfesteem may even create situations where women feel unable to care for their newborn. This means that we need to reach out and offer specialized psychiatric care during this period. Physical followups and maternal motivation during pregnancy facilitate acceptance of treatments. The antepartum is thus a blessed period ... for care. After reviewing the different diagnostic challenges of prenatal depression, we will discuss treatment and specificity of management programs during the prepartum.

REFERENCES:
1) Stotland NL;StewartDE(Eds) Psychological Aspects of Women's Health Care. 2001. APPI

SYMPOSIUM 73
UPDATE ON CL ISSUES ACROSS THE LIFE SPAN

Chair: Tatiana Falcone, M.D., Cleveland Clinic, 9500 Euclid Avenue P57, Cleveland, OH 44195

***Co-Chair:** Kathleen S Franco, M.D., M.S.*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify some important CL issues in patients across the life span; and 2) To identify the essential role of the CL psychiatrist as an integral member of the multidisciplinary team in different specialties (epilepsy, oncology, transplant service, neonatal intensive care unit)

OVERALL SUMMARY:
The field of psychosomatic medicine has expanded tremendously in the last 5 years, more and more primary services incorporate CL psychiatrist as an integral part of their team. During this presentation issues facing consultation psychiatrist across the lifespan will be discussed. Dr. Forgey will discuss issues child CL psychiatrist faced when evaluating youth undergoing transplants, and how the issue of nonadherance is key in this population, also some of the important ethical dilemmas psychiatrist face when confronted with transplant patients. Dr. Schuermeyer will review the role of the psychooncologist as an integral part of the CL team, and the impact of psychiatric comorbidities such as PTSD in patients undergoing cancer treatment. Dr. Hatters Friedman will discuss guiding principles in the treatment of patients during the pregnancy and postpartum period, also an innovative psychosomatic program in the Neonatal Intensive Care unit will be discussed. Dr. Falcone will do a summary of innovative research in children with epilepsy, focusing on psychiatric comorbidities and specially depression. Also the role of the psychiatrist in the epilepsy team will be discussed. General psychiatrist are frequently faced with consults of patients with multiple other medical comorbidities this symposium will target important CL issues patients and psychiatrist encounter when delivering services in different medical teams across the life span.

S73-1.
CURRENT ISSUES IN ORGAN TRANSPLANTATION FOR THE PEDIATRIC CL PSYCHIATRIST

Marcy Forgey, M.D., M.P.H., 760 Westwood Plaza, 48256A, Los Angeles, CA 90024

SUMMARY:

Objective: To review the literature on current issues related to pediatric organ transplantation faced by the practicing pediatric CL psychiatrist. Method: Electronic database search using keywords Pediatric, Transplant, Organs, Psychiatry, Ethics, Mental health, Children, on MEDLINE, PsycInfo, NLM Gateway, PubMed, Cochrane Database. Results: In the United States, 23,846 solid organ transplants were performed between January and October 2009. Fewer than 8% of solid organ transplant recipients in the United States annually are younger than 18 years. However, pediatric CL psychiatrists are frequently called upon to evaluate pediatric patients for appropriateness for transplant and to assist the pediatric team with issues that arise in the pre and posttransplant period. Nonadherence is a common issue that pediatric CL psychiatrists are asked to address. Studies show that up to half of the people prescribed medication take at least 80% of prescribed dosages. In a transplant patient, such nonadherence can quickly lead to life threatening organ rejection. In pediatric liver transplant recipients, for example, history of child abuse is a risk factor for nonadherence that has been linked to poor outcome posttransplant. Psychiatrists are also frequently called upon to assist patients and families with posttraumatic stress symptoms that arise as a result of the medical procedures that take place as a consequence of the medical illness which necessitated the transplant and in the peritransplant period. Ethical dilemmas also arise when pressure for increased survival rates oppose quality of life issues. Conclusions: While solid organ transplants are still rare in the pediatric population, they are in increasing in frequency due to the advancement of medical technology. The pediatric CL psychiatrist plays an essential role in assessment of adherence, psychiatric symptom management, and in ethical dilemmas.

Bibliography:
1) Stuber ML, Psychiatric issues in pediatric organ transplantation. Child Adolsc Psychiatr Clin N Am. 2010; 19 2): 285300.
2) Shemesh E, et al. Childhood abuse, nonadherence, and medical outcome in pediatric liver transplant recipients. J Am Acad Child Adolesc Psychiatry. 2007; 46 (10): 1289.

S73-2.
UPDATE ON PSYCHOONCOLOGY

Isabel Schuermeyer, M.D., 9500 Euclid Ave/ P57, Cleveland, OH 44195

SUMMARY:
The field of PsychoOncology has had much growth since its development. It is well known that cancer patients have higher rates of depression and anxiety. If left untreated, there is a clear impact to their cancer course and quality of life. Cancer patients with depression have less pain tolerance, longer hospital stays and worse adherence to their cancer treatment compared to nondepressed cancer patients. Many interventions have been studied to treat depression and anxiety in this population and there is good evidence of effective treatments. However, because of the potential for drugdrug interactions, clinicians need to be cautious in their choice of psychotropic medication. With the improvement in cancer treatments, patients are living longer and cancer has become more of a chronic illness. The psychiatric illnesses found in cancer survivors have been an area of recent research, with much emphasis on the posttraumatic stress found in this population. It is believed that this will likely be a more common phenomenon as more patients survive cancer and that this may play a role in their adherence to further follow up. The diagnosis and treatment of depression and anxiety in cancer patients will be reviewed during this talk, including the potential for drugdrug interactions where clinicians need to be more cautious in medication choices. The newer literature on posttraumatic stress in the cancer population will also be summarized and treatments will be discussed.

S73-3.
PERINATAL PSYCHIATRY PRINCIPLES AND NOVEL OPTIONS

Susan Hatters Friedman, M.D., 24200 Chagrin Boulevard, Beachwood, OH 44122

SUMMARY:
Objective: To discuss guiding principles of treatment of mental disorders in pregnancy and the postpartum period, review recent findings, and describe novel treatment programs for these disorders in which rational patients may refuse medications. Methods: Major principles of diagnosis and treatment within perinatal psychiatry will be reviewed. Novel therapies and programs will be discussed

based on literature and recent work. Results: The treatment of mental illness during pregnancy and the postpartum period requires careful consideration of risks and benefits of treatment modalities, along with understanding of potentially significant risks of untreated mental illness. General guidelines for treatment will be discussed and illustrative cases presented. Specific diagnoses, including depression in pregnancy and the postpartum, bipolar disorder and postpartum psychosis, schizophrenia, and anxiety disorders will be discussed. A potential role for psychiatry in denial of pregnancy will also be discussed. Psychotherapy is an important component of treatment, especially in consideration of the desire to expose the fetus or breastfed infant to the lowest effective medication dose. Alternate therapies such as light therapy and music therapy will also be discussed. An innovative psychosomatic program in the Neonatal Intensive Care Unit will be described, which allows for significant liaison, and sheds further light on problems encountered by this mothers.Conclusions: Perinatal mental health treatment modalities fall within the purview of the CL psychiatrist. The overarching principals of riskbenefit decision making, violence/suicide risk management, and appropriate utilization of psychotherapy remain critical. At the conclusion of this session, the participant should be able to: discuss treatment options for various mental illnesses in pregnancy and the postpartum; and explain diagnostic clues in complicated perinatal psychiatric disorders.

S73-4.

EPILEPSY AND DEPRESSION IN YOUTH

Tatiana Falcone, M.D., Cleveland Clinic, 9500 Euclid Avenue P57, Cleveland, OH 44195

SUMMARY:
Introduction: Patients with epilepsy have two to four times increased mortality compared to the general population. Depression has been found to be 715 times higher in patients with epilepsy and is likely to be under recognized and under treated. While the presence of depression has been consistently reported in association with epilepsy, it remains unclear whether the presence of epilepsy affects the therapeutic response to treatment. Methods: A retrospective review study, conducted during 20062008 of all the patients evaluated by the child and adolescent psychiatry C/L service in the pediatric epilepsy monitoring unit (n=68), twenty six of them were diagnosed with MDD. This group was match by age, gender and ethnicity to a group of inpatient child and adolescent patients diagnosed with depression without epilepsy. A Brief Psychiatric Rating Scalechildren version was used to measure symptomatology in groups, suicidality and depression. A multivariate analysis was done. After using univariate methods to identify possible significant associations, subsets of those variables that exhibited significant univariate association, and whose associations are believed to be clinically meaningful were used in a multivariate analysis and regressed against the dichotomous variable depression. Results: Patients with epilepsy and depression had higher scores of the BPRS (p0.002), compared with the group of depression patients, even though the patients in the depression group were recruited from an inpatient psychiatry setting. Conclusion: The longer the depressive symptoms persist the more difficult is to treat in epilepsy patients, consequently is important to recognize the symptoms and the degree of severity early. This is one of the first studies to assess the efficacy of SSRI's in this common comorbidity. Early intervention is imperative to improve the quality of life with patients with epilepsy.

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2) Falcone T and Franco K. Coping with Chronic Medical illness. 2009 Current Clinic Medical Section 11.Psychiatry and Psychology. Saunders 1057 1059
3)Galbally M, Lewis A et al. Mother infant psychotherapy and perinatal psychiatry current clinical practice and future directions. Australasian Psychiatry 2006 14 (4) 384 389
4) Silveira D, Carlton E, Franco E, Janigro D, Falcone T. Response to antidepressant treatment in children with epilepsy. Epilepsia 2008 Suppl 7 270

SYMPOSIUM 74
CURRENT RESEARCH AND INTERVENTIONS FOR UNDERSERVED AND VULNERABLE YOUTH
APA Council on Children, Adolescents & Their Families

Chair: Niranjan S Karnik, M.D., Ph.D., 5841 S. Maryland, MC 3077, Chicago, IL 60637
Discussant: Scott J Hunter, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the psychiatric and substance use disorders experienced by different vulnerable youth groups; 2) Understand the current research on foster youth, refugee children, homeless youth and incarcerated adolescents; 3) Analyze and evaluate systems of care and interventions for highrisk and vulnerable youth; and 4) Understand the implications of research and interventions on current mental health policy.

OVERALL SUMMARY:
Investigators will present the findings from epidemiological and intervention research for diverse populations of underserved and vulnerable youth in the United States and Europe. First, Dr. Huemer will discuss her research on psychopathology and coping in unaccompanied refugee youth in Austria. The study employed quantitative and qualitative measures to assess trauma, psychopathology, and resilience in 41 unaccompanied refugee minors. Approximately onefifth of participants were diagnosed with PTSD. Results indicate that many youth use an avoidant defensive coping style to manage the nonnormative stressors that they experienced. Next, Dr. Edidin will present epidemiological data of psychopathology in a sample of homeless and street youth in San Francisco. Thirtyone youth were assessed for psychiatric and substance use disorders. Eightyseven percent of the sample met criteria for at least one psychiatric disorder. Thirtytwo percent of the sample met criteria for ASPD. Implications of the findings on the development of interventions and systems of care will be considered. Dr. Vostanis will bridge the topics of epidemiological and intervention research in his discussion of mental health interventions for youth in public care in the United Kingdom. He will present his findings on psychiatric disorders among youth in public care, as well as their developmental and psychosocial needs. Results indicate that difficulties in accessing services are associated with high levels of psychosocial needs. The implications of these emerging interventions and how current research can inform policy within the UK and internationally will be discussed. Finally, Dr. Steiner will present his research on psychopathology of youth in the juvenile justice system in California. Cluster analysis revealed 4 major domains of disorders: mood/anxiety, disorders of frontal and prefrontal dysfunction, internalizing and somatic disorders, and substance use disorders. The findings suggest that youth may benefit from the development of specialized programming and subspecialty clinics to address their specific psychiatric needs. Recommendations for changes in practice will be discussed. This submission has the support of the APA Council on Children, Adolescents and their Families, and is being organized as part of a "Child Track" for the 2011 meeting.

S74-1.
PSYCHIATRIC DISORDERS AMONG INCARCERATED JUVENILES AND IMPLICATIONS FOR CARE

Hans Steiner, M.D., 401 Quarry Road, Room 3324, Stanford, CA 94305

SUMMARY:
Objectives: Psychiatric and substance use disorders are common among youth who are incarcerated. Translation of this research into meaningful changes in care within the juvenile justice system has been difficult. Methods: This paper begins with a comprehensive review of the literature. Data is from a longterm study in California Division of Juvenile Justice (DJJ). 790 participants included 140 girls and ranged in age from 13 to 22 years old (x=16.8, SD=1.2 years). The sample was ethnically diverse and representative of the DJJ population. The SCIDIV diagnosed substance use, mood, anxiety, and personality disorders. Specific modules of the DICA determined ODD, ADHD and separation anxiety. The SIDPIV determined CD and personality disorders. Cluster analysis identified the ways that various diagnoses held together. Results: Cluster analysis showed four major domains. Cluster 1 included over 50% of the incarcerated juveniles and contained mood, anxiety, borderline personality and ODD diagnoses. Cluster 2 included over 15% of the juveniles with ADHD, psychosis, schizoid and schizotypal PD. Cluster 3 (6% of the population) contained somatoform and eating disorders. Finally Cluster 4 (37% of the population) contained

substance abuse and dependence. Gender differences were present with girls having greater findings in Clusters 13 and boys being greater on Cluster 4. Conclusions: This research indicates that four major psychiatric domains are represented in the juvenile justice population. Cluster 1 corresponds to a mood/anxiety domain with ODD & Borderline PD driven by affect. Cluster 2 has disorders of frontal and prefrontal dysfunction. Cluster 3 contains internalizing and somatically driven disorders. Cluster 4 contains substance use disorders. These findings suggest that the most effective structure for treatment of youth in juvenile justice settings would address these four domains in subspeciality clinics and specialized programming.

S74-2.
TRAUMA AND RESILIENCE IN UNACCOMPANIED REFUGEE MINORS

Julia Huemer, M.D., Waehringer Guertel 1820, Vienna, A1090 Austria

SUMMARY:
OBJECTIVES: To present a multimodal analysis of psychopathology among African unaccompanied refugee minors (URMs) in Austria. URMs experience well documented nonnormative stressors on their way from Africa to Europe. We report on PTSD diagnosis, the assessment of the whole range of psychopathology, personality profiles and qualitative analyses of narratives. We hypothesize that URMs need to exhibit strategies of stress response, which enable them to efficiently withstand the pressures of war and flight, and manage the challenges of life in a foreign country including multiple legislative hurdles. METHODS: Fortyone URMs participated in the study. The following standardized instruments were used: UCLA PTSD Index for DSM IV, Mini International Neuropsychiatric Diagnostic Interview for Children and Adolescents, Weinberger Adjustment Inventory, Linguistic analyses: (1) Number of Stories, (2) Number of Temporal Junctures/Narrative, (3) Word Count, (4) Referential Activity: to evaluate the degree to which words convey the speaker's nonverbal experiences. RESULTS: PTSD was assessed among 17% (selfreport instrument) and 20% (diagnostic interview) of youth. 68.3% of URMs belonged to the „suppressor" personality type. Features of narratives about distressing events revealed significant overlaps with results reported by avoidant defensive coping in previous research. CONCLUSIONS: While syndromal illness was less than expected, indicators of trauma related habitual function were all elevated. The present findings reveal that URMs manage the extreme stress of their lives by defensive selfregulation, reflecting their capacity of being resilient in the face of adversity. Risks for decompensation along with clinical implications for diagnosis and management are outlined.

S74-3.
DEVELOPMENT AND EVALUATION OF MENTAL HEALTH INTERVENTIONS AND SERVICES FOR CHILDREN AND YOUTH IN PUBLIC CARE

Panos Vostanis, M.D., M.B., Westcotes House, Westcotes Drive, Leicester, LE3 0QU United Kingdom

SUMMARY:
Children and youth in public care (foster or residential care) are at high risk of psychiatric disorders and interrelated developmental, social and educational needs. Evidence from different health and welfare systems will be presented, in particular from the UK national surveys for looked after children and the general population. Despite this high level of needs, there is also evidence that children and youth in public find it difficult to access mainstream services, because of their characteristics such as mobility and lack of advocacy, and input from different agencies is often fragmented and not applied to their particular needs. The emerging evidence on interventions and services will be discussed in relation to policy and evolving mental health services across different systems and societies. Several service models will be explored, as well as how therapeutic interventions need to be developed and implemented for children and youth who have suffered multiple traumas. In particular, service components to be discussed, include care pathways; assessment and diagnostic dilemmas; treatment modalities; consultation and training for frontline agencies; joint planning and commissioning; and service evaluation. Emphasis will be given on the implications of these findings on services for other groups of vulnerable children and youth, and for international collaboration.

S74-4.

SAN FRANCISCO HOMELESS YOUTH STUDY: SUMMARY DATA

Jennifer Edidin, Ph.D., 5841 S. Maryland Ave., MC 3077, Chicago, IL 606371470

SUMMARY:
Objectives: Research has found that psychiatric and substance use disorders are common among homeless and street youth. The objectives of the current study are to present epidemiological data of psychopathology in a sample of homeless and street youth in San Francisco. Findings for a range of psychiatric disorders will be presented, with a focus on Antisocial Personality Disorder (ASPD), as it is particularly prevalent in this population when compared to community samples. Methods: Thirtyone homeless and street youth were administered the Massachusetts Youth Screening Instrument (MAYSI), a selfreport questionnaire, and the MiniInternational Neuropsychiatric Interview (MINI), a semistructured interview. Results: Seventyseven percent of the sample was male and 22.3% was female. The racial/ethnic makeup up the sample was: 32% African American, 9.7% Latino, 51.6% Caucasian, and 6.5% other. High rates of various forms of psychopathology were found. Eightyseven percent of the sample met criteria for at least one psychiatric disorder on the MINI, with youth meeting criteria for an average of four diagnoses. Similarly, on the MAYSI, 87% endorsed elevated levels of symptoms on at least one psychiatric scale. Gender differences were only found for substance abuse. With regard to ASPD, 29% of males and 43% of females met *DSM-IV* criteria. Conclusions: The findings of the present study lend support to the findings of previous studies, which suggest that psychiatric disorders are common among homeless and street youth. As high rates of ASPD are consistently found in this population, the possibility that the criteria for ASPD are reflective of adaptive behavior rather than psychopathology will be discussed. Additionally, the authors will address the implications of these findings on interventions and systems of care.

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2) Huemer J, Karnik NS, VoelklKernstock S, Granditsch E, Dervic K, Friedrich MH, Steiner H. Mental Health
Issues in Unaccompanied Refugee Minors. Child and Adolescent Psychiatry and Mental Health. 2009. 3:13.
PMCID: PMC2682790

SYMPOSIUM 75
CHILD SEX TOURISM: EXTENDING THE BORDERS OF SEXUAL OFFENDER LEGISLATION

Chair: William J Newman, M.D., 2230 Stockton Blvd., Sacramento, CA 95817

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate the magnitude of the problem internationally; 2) Understand the basic legislation behind this issue; 3) Know how to report United States citizens suspected of participating in child sex tourism; 4) Have a more complete understanding of sexual offenders; and 5). Conduct more effective interviews of potential victims and avoid common pitfalls.

OVERALL SUMMARY:
Child sex tourism, the act of traveling to engage in sexual acts with minors, plagues developing nations worldwide. Several laws have been passed internationally in recent years designed to curtail this practice. Government entities and human rights organizations have driven these efforts. The PROTECT Act of 2003 prohibits U.S citizens from participating in sexual acts with minors while traveling and establishes extraterritorial jurisdiction. Dr. William Newman, a forensic psychiatry fellow, will present an overview of the topic and introduce the case of Michael Lewis Clark, the first U.S. citizen convicted under this legislation. He will introduce a proposed classification system for child sex tourism offenses. Dr. Newman will also describe the proper mechanism for reporting U.S. citizens suspected of participating in child sex tourism, as developed in conjunction with the U.S. Department of Homeland Security. Gary Phillips, a Special Agent for the U.S Department of Homeland Security, will discuss his years of experience investigating child sex tourism cases in Southeast Asia. He will highlight

the case of Michael Lewis Clark. Special Agent Phillips will also review challenges faced by agents when investigating child exploitation abroad and prosecuting alleged offenders for crimes committed while traveling. Dr. John Rabun, a forensic psychiatrist, will relate the topic to the evaluation, treatment, and punishment of sexual offenders. Child sex tourism poses unique issues to the courts that will require ongoing clarification as legal challenges arise. Dr. Rabun will discuss potential future challenges, describe strategies to address this problem, and discuss the relationship of child sex tourism to psychiatry. Dr. Charles Scott, a child forensic psychiatrist, will provide an overview of how to interview potential victims, including a proposed list of topics to cover during an initial assessment. The principles addressed will include key aspects in organizing interviews, how to begin questioning potential victims, and important components of sexual abuse investigation protocols. Faulty interview techniques that increase the risk of contaminating abuse reports will be highlighted.

S75-1.
INTRODUCTION TO CHILD SEX TOURISM

William Newman, M.D., 2230 Stockton Blvd., Sacramento, CA 95817

SUMMARY:
I will present an overview of child sex tourism, the act of traveling to engage in sexual acts with minors. The overview will include describing the magnitude of the problem and estimating how many children and adolescents are exploited internationally. Some of the techniques utilized by both government and nongovernment organizations to address this problem will also be mentioned. I will briefly discuss the history of the PROTECT Act and introduce the case of Michael Lewis Clark, the first United States citizen convicted under this legislation. I will introduce a classification system for child sex tourism offenses which is proposed by the presenters. This system allows mental health providers worldwide to characterize the offenses in a uniform manner. I will also describe the proper mechanism for reporting United States citizens suspected of participating in child sex tourism. The mechanism was developed by the presenters, in conjunction with the United States Department of Homeland Security.

S75-2.
CONDUCTING CRIMINAL INVESTIGATIONS ABROAD FOR THE DEPARTMENT OF HOMELAND SECURITY

Gary Phillips, B.S., 808 Harrison Avenue, Blaine, WA 98230

SUMMARY:
I am currently the Assistant Special Agent in Charge (ASAC) for the Department of Homeland Security, Homeland Security Investigations (DHSHSI), located in Blaine, Washington. I have been an agent since 1988 and have investigated a wide variety of federal and state cases; however, my expertise is in crimes against children. Prior to transferring to Blaine, Washington, I worked at the United States Embassy (DHSHSI) located in Bangkok, Thailand from 20022008. While in Thailand, I was a supervisory special agent that was responsible for conducting criminal investigations on Americans that traveled or lived in SE Asia. Along with 550 other federal laws that DHS is responsible for, we primarily investigated crimes against children, specifically sexual exploitation. Southeast Asia is a haven for pedophiles, hebephiles and others who choose to exploit children. As such, based on the PROTECT Act of 2003, we were authorized to investigate and prosecute Americans that sexually exploited children while travelling or temporarily residing abroad. I would be honored and delighted to convey front line information to the audience how we, as DHSHSI agents, act upon information that involves crimes against children. A short introduction of DHSHSI would lead off the presentation, which would then be followed by how we coordinate with nonGovernment organizations, foreign law enforcement, victims, embassy personnel and defendants. Several case studies are available for demonstrative purposes. I will highlight my role in the case of Michael Lewis Clark, the first United States citizen convicted under child sex tourism legislation. I will conclude the presentation with an overview of the situation in SE Asia as it pertains to child exploitation. This will include reviewing the challenges faced by agents when investigating child exploitation abroad and prosecuting alleged offenders for crimes committed while traveling.

S75-3.
FORENSIC EVALUATIONS AND LEGAL

CHALLENGES PERTAINING TO CHILD SEX TOURISM

John Rabun, M.D., 5300 Arsenal, St. Louis, MO 63139

SUMMARY:
I will discuss the type of forensic evaluations that address the suspected offender of child sex tourism. The discussion will focus on suspects who meet criteria for pedophilia versus hebephilia. The differences in behavior between the suspect with pedophilia and the suspect with hebephilia will be explored, focusing on the individual's history of offending, current alleged behavior, and sexual arousal pattern. Further, individuals who appear not to meet criteria for a paraphilia, but are engaged in child sex tourism, will also be discussed. I will then address the known risk factors for future offending in this unique area of offender behavior. Finally, a discussion of potential legal and ethical challenges to this area of the law will be noted, including the ethical challenges of being involved in this growing area of forensic psychiatry.

S75-4.
FORENSIC INTERVIEWING OF CHILDREN FOR ALLEGED SEXUAL ABUSE

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

SUMMARY:
I will provide an overview of how to interview child victims of alleged sexual abuse. Important collateral records to request prior to the investigative interview will be highlighted. Key aspects of practice parameters regarding the sexual abuse interview will be reviewed, to include key aspects in organizing interviews, how to begin questioning potential victims, and important components of sexual abuse investigation protocols. Faulty interview techniques that increase the risk of contaminating abuse reports will be highlighted. Possible influences of child statements by investigators, parents, therapists, and peers will be described. The emotional impact on children brought to the United States from a foreign country to testify will be discussed. Issues related to evaluating a foreign child's competency to be a witness in the US legal system will be reviewed.

REFERENCES:

1) Willis BM, Levy BS: Child prostitution: global health burden, research needs, and interventions. Lancet 359:141722, 2002

SYMPOSIUM 76
THE EVOLUTION OF RISK ASSESSMENT: WHERE WE HAVE BEEN, WHERE WE ARE NOW, AND WHERE WE ARE HEADED

Chair: Mini Mamak, Ed.D., 100 West Fifth Street, Hamilton, L8N 3K7 Canada
Co-Chair: Gary A Chaimowitz, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Have a solid understanding of the history of risk assessment instruments/ techniques; 2) Critically appraise various risk assessment instruments; 3) Implement a novel approach to risk assessment and management.

OVERALL SUMMARY:
The assessment of risk of violence and selfharm have become critical skills required of mental health professionals, particularly those working in Forensic settings. The use of actuarial and other risk assessment strategies has been a relatively recent development in the process of risk prediction and risk management. While significant gains have been made and our ability to assess and ultimately manage risk, the field continues to evolve. We have moved beyond the use of clinical judgement, and although actuarial risk tools were once the goal standard, the field is now recognizing the need for more process oriented approaches that are data driven but clinician lead. This symposium will review the evolution of risk assessment, review current risk assessment tools and speak to the future direction of risk assessment and management. Participants will also be introduced to two novel, yet user friendly, risk assessment instruments. This presentation will review the evolution of risk assessment and discuss how that impacts psychiatrist in clinical practice. We will examine the more widely used tools for assessing violence especially as it relates to clinical utility. Although a number of measures exist that assist in predicting risk in the long term, there are few tools that offer assistance with short term risk. Aggression and violence are issues faced by most mental health facilities but the discussion of inpatient risk assessment is rarely had in forensic literature. This

symposium will critically evaluate current limitations in the field of risk assessment and highlight the need for accurate violence risk assessments. We will also discuss the implementation of the Hamilton Anatomy of Risk Management (HARM) and the Aggression Incident Scale: two tools developed at St Joseph's Healthcare, CMHS, Hamilton.

S76-1.

THE HISTORY OF RISK ASSESSMENT... ADAPTATION FOR ASSESSING AND MANAGING VIOLENCE ON INPATIENT UNITS

Gary Chaimowitz, M.D., 100 West Fifth Street, Hamilton, L8N 3K7 Canada

SUMMARY:

This presentation will review the evolution of risk assessment and discuss how that impacts psychiatrist in clinical practice. We will examine the more widely used tools for assessing violence especially as it relates to clinical utility. Although a number of measures exist that assist in predicting risk in the long term, there are few tools that offer assistance with short term risk. Aggression and violence are issues faced by most mental health facilities but the discussion of inpatient risk assessment is rarely had in forensic literature. This symposium will critically evaluate current limitations in the field of risk assessment and highlight the need for accurate violence risk assessments. We will also discuss the implementation of the Hamilton Anatomy of Risk Management (HARM) and the Aggression Incident Scale: two tools developed at St Joseph's Healthcare, CMHS, Hamilton.

S76-2.

THE EVOLUTION OF RISK ASSESSMENT: WHERE WE HAVE BEEN, WHERE WE ARE NOW, AND WHERE WE ARE HEADED

Mini Mamak, Ed.D., 100 West Fifth Street, Hamilton, L8N 3K7 Canada

SUMMARY:

Dr. Mamak will focus on the future of risk assessment instruments and introduce two novel, yet user friendly risk assessment tools, the Aggressive Incident Scale (AIS) and the Hamilton Anatomy of Risk Management (HARM).

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SYMPOSIUM 77

INFECTION TO TRANSPLANTATION: MANAGING PSYCHIATRIC COMORBIDITY IN "DIFFICULT TO TREAT" HEPATITIS C PATIENTS

Chair: Sanjeev Sockalingam, M.D., 200 Elizabeth St. 8EN228, Toronto, M5G2C4 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Evaluate the bidirectional relationship between psychiatric illness and hepatitis C; 2) Manage patients with hepatitis C and severe mental illness or substance use disorders during interferonalpha therapy; and 3) Identify and treat common psychosocial issues arising in patients postliver transplantation for hepatitis C and experiencing hepatitis C recurrence.

OVERALL SUMMARY:

Hepatitis C (HCV) is a major health concern and the leading cause for liver transplantation in the United States. However, individuals suffering from chronic HCV commonly have high rates of comorbid psychiatric illness and substance use, which complicates treatment. Despite evidence suggesting that patients with severe mental illness or substance use can be treated for HCV with integrated mental health and hepatology treatment programs, many patients with psychiatric disorders are not receiving treatment. For those patients who are not successful with HCV treatment, liver transplantation is the next treatment alternative. However, psychiatric illness pretransplant is a barrier to transplantation and requires careful assessment. Moreover, HCV recurrence postliver transplantation is associated with its own psychosocial burden

and may require further psychiatric support and intervention. The following symposium will focus on the relationship between mental illness and HCV across the course of HCV treatment. We will discuss cases and data from the University Health Network Hepatology Program and the MultiOrgan Transplant Program, which manages approximately 8000 patients and provide liver transplants for approximately 140 patients per year, respectively. We will provide data on the bidirectional relationship between severe mental illness and HCV. We will also describe an innovative collaborative care program providing HCV treatment for patients with mental illness and active substance use and provide preliminary data on treatment outcomes. An update on the pharmacological and psychological treatment of substance use disorders in patients with HCV will be discussed during this symposium. We will also review psychosocial issues associated with liver transplantation for HCV and HCV recurrence, and provide an approach for managing psychiatric illness in this context. Lastly, we will use longitudinal case illustrations to review current data on the pharmacological management of interferonalpha side effects and psychiatric morbidity pre and postliver transplantation.

S77-1.
REVISITING "DIFFICULTTOTREAT" PATIENTS WITH SEVERE MENTAL ILLNESS AND HEPATITIS C

Sanjeev Sockalingam, M.D., 200 Elizabeth St. 8EN228, Toronto, M5G2C4 Canada

SUMMARY:
Psychiatric comorbidity is the "rule" rather than the exception. Yet, psychiatric comorbidity remains a significant barrier to HCV treatment with interferonalpha therapy. Concerns about neuropsychiatric sequelae are more pronounced in patients with severe mental illness. This is further complicated by research suggesting that patients with severe mental illness have higher rates of HCV infection suggesting a bidirectional relationship between psychiatric illness and HCV infection. Traditionally, patients with severe mental illness have been excluded from treatment; however, emerging evidence suggests that patients with severe mental illness can be treated with integrated HCV treatment models and appropriate pharmacotherapy. Using case examples, the presenter will discuss new research examining the bidirectional relationship between severe mental illness and HCV. Evidence on treatment outcomes for patients with comorbid HCV and severe mental illness will be reviewed. Innovative models for treating this "difficulttotreat" patient population will be explored.

S77-2.
MANAGING TRIMORBIDITY: HEPATITIS C, SUBSTANCE USE AND COMORBID PSYCHIATRIC ILLNESS

Diana Blank, B.A., M.D., PH 207 225 Sherway Gardens Rd, Toronto, M9C0A3 Canada

SUMMARY:
Hepatitis C (HCV) treatment guidelines require abstinence from drug and alcohol prior to commencing HCV treatment with interferonalpha therapy. The result is exclusion of those patients at greatest risk of HCV and in need of HCV treatment due to limitations in traditional HCV treatment models. Furthermore, patient preparation for HCV therapy may be an ideal opportunity for individuals to engage in harm reduction or substance use treatment. The presenter will review our current understanding of comorbid substance use in HCV patient populations. In addition, the presenter will discuss the emerging literature on the efficacy and safety of treating patients with HCV who are actively using substances and content will be reinforced with a case discussion. A brief review of emerging HCV treatment programs employing an interdisciplinary treatment approach to active substance users receiving treatment for HCV will be reviewed. The presenter will highlight the current recommendations for the pharmacological and nonpharmacological management for alcohol and other substance use disorder in HCV.

S77-3.
PSYCHOSOCIAL ISSUES ASSOCIATED WITH LIVER TRANSPLANTATION AND HEPATITIS C RECURRENCE

Sarah Greenwood, B.S.N., R.N., CSB 11C, 585 University Avenue, Toronto, M5G 2N2 Canada

SUMMARY:
Although multiple studies have shown an

overall improvement in healthrelated quality of life (HRQOL) postliver transplant (LTX), improvements in psychosocial outcomes differ in LTX patients transplanted for hepatitis C (HCV). Psychological distress, fatigue and physical functioning are also lower in patients transplanted for HCV in comparison to other LTX indications. HCV recurrence postLTX is also associated with increased depression and anxiety, and reduced HRQOL in LTX patients. The need for treatment with interferonalpha may also raise concerns about additional side effects and psychological distress. The presenter will review common psychosocial themes emerging postLTX and will share cases from a large multidisciplinary Liver Transplant Program at the University Health Network in Toronto. The impact of HCV recurrence on psychosocial functioning will be discussed. The presenter will review potential psychosocial treatments for managing stressors in the postLTX period and the impact of HCV recurrence.

S77-4.

LESSONS LEARNED IN MANAGING PSYCHIATRIC ILLNESS IN PATIENTS TRANSPLANTED FOR HEPATITIS C

Susan Abbey, M.D., 585 University Avenue, 11NCSB11C1114, Toronto, M5G 2N2 Canada

SUMMARY:

Hepatitis C (HCV) is a major health concern and the leading cause for liver transplantation in the United States. However, individuals suffering from chronic HCV commonly have high rates of comorbid psychiatric illness and substance use, which complicates treatment. Despite evidence suggesting that patients with severe mental illness or substance use can be treated for HCV with integrated mental health and hepatology treatment programs, many patients with psychiatric disorders are not receiving treatment. For those patients who are not successful with HCV treatment, liver transplantation is the next treatment alternative. However, psychiatric illness pretransplant is a barrier to transplantation and requires careful assessment. Moreover, HCV recurrence postliver transplantation is associated with its own psychosocial burden and may require further psychiatric support and intervention. This paper will review psychosocial issues associated with liver transplantation for HCV and HCV recurrence, and provide an approach for managing psychiatric illness in this context. Psychotherapeutic and psychopharmacologic management strategies will be described. The importance of working with the transplant team to help them in understanding and managing "difficult behaviour" will be emphasized.

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SYMPOSIUM 78
USING COMPUTER BASED STANDARDIZED NEUROCOGNATIVE ASSESSMENT TO IMPROVE PSYCHIATRIC CLINICAL PRACTICE.

Chair: Joseph J Parks, M.D., 5400 Arsenal St., St Louis, MO 63139
Co-Chair: John P Docherty, M.D.
Discussant: Philip D. Harvey, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe and differentiate the patterns of cognitive impairment pathognomonic to ADHD, schizophrenia, major depressive episodes, and anxiety disorders; 2) Identify standardized cognitive testing methods available for use in psychiatric practice and research; and 3) Describe the use of accurate standardized cognitive assessment in providing accurate diagnosis, prediction of impairment, and choice of appropriate medications.

OVERALL SUMMARY:

The World Health Organization ranks mental illnesses as creating the greatest burden of disease and cognitive impairments contribute substantially to this burden. Several studies have suggested that deficits in domains of cognition are associated with distinct functional outcomes: attention/vigilance with social functioning, verbal learning and memory with social, occupational and independent living capacity, executive function with independent living, and processing speed with employment. These impairments predict realworld functional outcomes more robustly and consistently than subjective and behavioral symptoms. Yet, clinical trials and diagnostic criteria typically focus on positive symptoms, such that identification of new pharmacological targets for cognitive impairment lags behind the evidence for its importance. This gap has been exacerbated by lack of standardized criteria and tests for evaluating cognition in mental illness. The addition of objective measures to routine psychiatric assessment may enhance the reliability of clinical decisions, and provide concrete benchmarks for monitoring progress. These benchmarks have the additional benefit of engaging both patient and family, and providing them with explicit feedback. In the move toward the fifth edition of the diagnostic and statistical manual for mental disorders (DSM-V), the importance of objective measures linked to underlying brain function has also been highlighted. Assessments of cognition provide such measures. In this regard, cognition encompasses the aspects of thinking that allow for attention, memory and planning (or executive function) and are linked to the interaction of cortical with subcortical brain systems. Objective measures of cognition and brain function correlates may provide further insights into the pathophysiological processes underlying the overt signs and symptoms of mental illnesses. In this symposium, we describe and differentiate the patterns of cognitive impairment pathognomonic to ADHD, schizophrenia, major depressive episodes, and anxiety disorders, identify standardized cognitive testing methods available for use in psychiatric practice and research and describe the use of accurate standardized cognitive assessment in providing accurate diagnosis, prediction of impairment, and choice of appropriate medications. It has been well documented that neurocognitive dysfunction is an e risk factor for and determinant of long-term outcome in patients suffering from Schizophrenia. A vast amount of literature has reported on these deficits and their relationship to impairments of brain function. Furthermore, consistent with the heterogeneity of this disorder, different patients may manifest very different patterns of cognitive dysfunction. Recognition of the importance of accurately assessing these impairments is reflected in such major initiatives as the NIMH development of the MATRICS consensus battery for the assessment of neurocognition in Schizophrenia. This battery assesses the core domains of speed of processing, attention/vigilance, working memory, verbal learning, visual learning, reasoning and problem solving and social cognition. It is hoped that the development of this battery will provide a standard measure for the accelerating studies of drugs and cognitive remediation to treat these cognitive deficits. Unfortunately, neurocognitive function in Schizophrenic patients is only infrequently assessed in clinical practice. As a result this important and clinically relevant information is not available to guide treatment or direct remedial intervention. A major reason for this neglect has been the lack of inexpensive, easy to use tools to accurately and reliably assess neurocognition. That situation has changed. This presentation will review available technologies for the assessment of neurocognition and illustrate the clinical application of this information for the improved treatment of schizophrenic patients

S78-1.

COMPUTERIZED TESTS TO ASSESS NEUROCOGNITIVE FUNCTION IN SCHIZOPHRENIA

John Docherty, M.D., 21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:
It has been well documented that neurocognitive dysfunction is an e risk factor for and determinant of long-term outcome in patients suffering from Schizophrenia. A vast amount of literature has reported on these deficits and their relationship to impairments of brain function. Furthermore, consistent with the heterogeneity of this disorder, different patients may manifest very different patterns of cognitive dysfunction. Recognition of the importance of accurately assessing these impairments is reflected in such major initiatives as the NIMH

development of the MATRICS consensus battery for the assessment of neurocognition in Schizophrenia. This battery assesses the core domains of speed of processing, attention/vigilance, working memory, verbal learning, visual learning, reasoning and problem solving and social cognition. It is hoped that the development of this battery will provide a standard measure for the accelerating studies of drugs and cognitive remediation to treat these cognitive deficits. Unfortunately, neurocognitive function in Schizophrenic patients is only infrequently assessed in clinical practice. As a result this important and clinically relevant information is not available to guide treatment or direct remedial intervention. A major reason for this neglect has been the lack of inexpensive, easy to use tools to accurately and reliably assess neurocognition. That situation has changed. This presentation will review available technologies for the assessment of neurocognition and illustrate the clinical application of this information for the improved treatment of schizophrenic patients

S78-2.
APPLYING CURRENT RESEARCH IN ADHD TO CLINICAL PRACTICE: INTEGRATING COGNITION, EMOTION AND BRAIN BASIS

Leanne Williams, Ph.D., 71 Stevenson Street, San Francisco, CA 94105

SUMMARY:
There remains a translational gap between research findings and their implementation in clinical practice that applies to Attention Deficit Hyperactivity Disorder (ADHD), as well as to other major disorders of brain health. Research studies have identified potential 'markers' to support diagnostic, functional assessment and treatment decisions, but there is little consensus about these markers. Of these potential markers, cognitive measures of thinking functions such as sustaining attention, and associated brain activity, show promise in complementing the clinical management process. Emerging evidence highlights the relevance of emotional, feeling and self regulation functions in ADHD, as well as thinking ones. We outline an integrative neuroscience framework for ADHD that offers one means to bring together cognitive measures of thinking functions, with measures of emotion, feeling and self regulation and their brain and genetic correlates. These markers have been established in 175 adolescentschildren with ADHD vs matched controls, and validated in a second sample of 170. The markers have been applied to assessment using an internet platform, WebNeuro (or touchscreen equivalent, IntegNeuro). Results from the marker assessment are provided to the clinician immediately in the form of a summary report that includes considerations for clinical decisions based on the existing evidence base. The goal is to provide additional objective information to the clinician, and is not prescriptive. This exemplar serves to illustrate the way that the systematic integration of information with brainbased markers may be implemented in a clinically feasible manner, consistent with what is available in other areas of medicine.

S78-3.
IDENTIFYING NEUROCOGNITIVE DEFICITS IN ADOLESCENT ANOREXIA NERVOSA AND TREATMENT IMPLICATIONS

Ainslie Hatch, Ph.D., 1000 Sansome Street Suite 200, San Francisco, CA 94111

SUMMARY:
Neurocognitive deficits are involved in the development, course, and outcome of anorexia nervosa (AN). Further, deficits have been linked with poor prognosis and response to treatment in AN. In planning effective treatments, identification or assessment of neurocognitive deficits is the necessary starting point. Recent findings from computerized neurocognitive testing of adolescent anorexia nervosa sample before and after weight gain will be reported. The role of these deficits in the maintenance of the illness will be considered. Remediation of these deficits and is the implications for engagement in psychotherapy (such as cognitivebehavioural therapy) will be discussed.

S78-4.
USE OF MULTISTUDY INTERNATIONAL DATABASES IN ADVANCING RESEARCH ON COGNITION AND MENTAL ILLNESS

Stephen Koslow, Ph.D., 250 W 93rd St., New York, NY 10025

SUMMARY:
BRAINnet Foundation was established to facilitate the cure of human brain disease. It is a 501(c) 3 US based Tax Exempt research Foundation. The BRAINnet Foundations operating principals are: (1) Free and open electronic sharing of all data; (2) Open research network of collaborating members; (3) Continued expansion of the global database of human brain function in health and disease across the life span with its global membership; (4) Using the same proven standardized protocols and measurements techniques in all studies allowing for data pooling across disorders, sites and studies; (5) Integrates data across the genome, Brainmarkers*, and clinical measures; (6) Open sharing of data without data contribution; (7) Self organizing, cooperative collaboration and openness within the global scientific community to analyze and publish data; (7) Successful competing for grant support with collaborators to carry our large clinical studies of human brain disorders. Currently it has as part of its global consortium of 243 researchers from 13 countries. The database contains clinical, cognitive, brain imaging and gene data acquired on the same subjects with same standardized methods and protocols, with datasets from healthy and multiple clinical brain disorders. Currently 252 peerreviewed papers reporting on the data have been published. This presentation will provide additional information on the establishment of the Foundation, details of its operation and standardized methods and protocols as well as participation and membership opportunities. *Direct brain measurements of structure and function.

S78-5.
FITTING COMPUTERIZED COGNITIVE TESTING INTO YOUR PSYCHIATRIC PRACTICE CREATING THE PROCESS AND GETTING PAYMENT

Joseph Parks, M.D., 5400 Arsenal St., St Louis, MO 63139

SUMMARY:
The presenter describes the process used to integrate computerized cognitive testing into his psychiatric practice. Topics covered include equipment needed, choosing between onsite testing versus patient at home testing, utilization of cognitive testing reports to enhance the therapeutic relationship and for patient education, presenting the testing recommendation to the patient, using a computerized cognitive testing process to screen for inappropriate drug seeking of stimulant medication. Presentation will conclude with an overview of CPT coding and billing options available for reimbursement of computerized cognitive testing by psychiatrists.

REFERENCES:
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SYMPOSIUM 79
THE IMPACT OF CHRONIC ILLNESS: A MORE OPTIMAL ALLIANCE

Chair: Kenneth Olson, M.D., M.S., 2040 N. 22nd Ave., Suite 2, Bozeman, MT 59718
Co-Chair: Paige T Taylor, M.S.

EDUCATIONAL OBJECTIVES:
At the end of the session, the participant should be able to: 1) Have a richer appreciation of the impact of illness on the self and the family; 2) Have an increased understanding about what really goes on with people who suffer from chronic illness; and, 3) Leave the session with the necessary information to not only evaluate but to assist patients in their adjustment to illness and facilitate an understanding

that their reactions are normal.

OVERALL SUMMARY:
The Impact of Chronic Illness: A More Optimal Alliance symposium challenges the existing paradigm of the revolving door of the primary care physicians managing chronically ill patients. Empowering participants to learn to more effectively manage their emotional health will have a positive impact on their ability to manage their physical illness, and thereby reduce their overall utilization of health care services. The pilot study of the Bridger Research Institute [BRI] program consists of eight weekly meetings, lasting for one hour and fifteen minutes each. Each group meeting has a specific focus and includes both an educational portion and a process/supportive portion. The groups cover a variety of topics including, but not limited to; improving emotional mastery, improving communication with one's support network and with their primary care provider, stress reduction, cognitivebehavioral techniques, growth through the adversity of illness, the inclusion of family members to improve daytoday support, and building preventative skills. It is our belief that when participants learn to more effectively manage their emotional health, this will have a positive impact on their ability to manage their chronic illness, and thereby reduce their overall utilization of health care services. The longterm objective of this study will be to empirically demonstrate the effectiveness of a preventative approach to chronic illness that will be replicable in all areas of the U.S. The study will help define the protocols that will include assessment, feasibility of recruiting and retaining participants and developing supportive materials and resources. The effectiveness of the modalities used will be evaluated based on outcome data acquired through the SF36 Health Survey assessment, which each participant will complete prior to their participation in the program and upon completion of the program. The longterm objective of the study will be to empirically demonstrate the effectiveness of a preventative and emotionfocused approach to chronic illness that will be replicable in all areas of the U.S. Utilization of this program will improve healthcare attitudes, optimize rapport with healthcare providers, diminish health care visits, improve coping, and ultimately allow patients to more effectively manage the emotional component of their illness. The program will also minimize felt alienation and normalize emotional reactions to illness. Many sufferers of chronic pain possess few emotional resources to cope well emotionally with their chronic pain and as a result their overall health suffers. Four skill sets that can promote emotional health in the face of chronic illness are; cognitivebehavioral techniques, assertiveness and social skills training, stress management techniques, and principles of positive psychology. Each subject area offers unique insights into the coping process and highlights the power of perspective to transcend the realities of chronic pain. Education about these skill sets and proficiency in their utilization will allow those managing chronic illness to emotionally thrive in spite of their physical limitations.

S79-1
COPING WITH CHRONIC ILLNESS: FOUR SKILL SETS TO EMOTIONALLY THRIVE

Paige Taylor, M.S., 2040 N. 22nd. Suite #2, Bozeman, MT 59718

SUMMARY:
Many sufferers of chronic pain possess few emotional resources to cope well emotionally with their chronic pain and as a result their overall health suffers. Four skill sets that can promote emotional health in the face of chronic illness are; cognitivebehavioral techniques, assertiveness and social skills training, stress management techniques, and principles of positive psychology. Each subject area offers unique insights into the coping process and highlights the power of perspective to transcend the realities of chronic pain. Education about these skill sets and proficiency in their utilization will allow those managing chronic illness to emotionally thrive in spite of their physical limitations.

S79-2.
BEYOND THE BARRIER: THE IMPACT OF CHRONIC ILLNESS ON SELF AND EMOTIONS

Kenneth Olson, M.D., M.S., 2040 N. 22nd Ave., Suite 2, Bozeman, MT 59718

SUMMARY:
The impact of illness on the patient's life is not often addressed. Being diagnosed can promote mixed emotional reactions those of grief and posttraumatic

stress disorder. Providing an arena for support and validation can impact treatment outcome, foster a more optimal alliance with caregivers, and normalize responses to illness.

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Schneider, JP:

SYMPOSIUM 80
THE CLINICAL COMPLEXITIES OF TOURETTE'S DISORDER: IT'S ALL IN THE FAMILY

Chair: Cathy Budman, M.D., NSLIJHS 400 Community Drive, Manhasset, NY 11030
Co-Chair: Barbara J Coffey, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the natural history of TD and its clinical phenomenology in both children and adults, in individuals and family members; 2) Recognize and consider the clinical implications of current genetic and environmental factors underlying TD; and 3) Diagnose and treat tics/ psychiatric comorbidities in individuals and in family members.

OVERALL SUMMARY:

Most presentations on Tourette's Disorder focus primarily on how this condition presents in children and impacts on the pediatric population. In contrast, this symposium focuses on the challenges of diagnosing and treating this familial neuropsychiatric disorder across the life cycle and includes presentations from both child psychiatrists and adult psychiatrists who are experts in the diagnosis and treatment of TD. An overview of TD phenomenology, epidemiology, and natural history will introduce this topic. Important updates on the genetic and environmental contributors to the development and expression of TD and its related comorbidities, a comprehensive overview of the diagnosis and treatment of common psychiatric

disorders that accompany tics in individuals and family members, along with the latest findings from large pediatric and adult clinical trials investigating the nonpharmacological intervention habit reversal therapy (HRT) for treatment of tics will be presented. The symposium will conclude with the presentation of a typical, complex case that involves multiplyaffected family members across two generations with audience participation and discussion about strategies to systematically assess and treat TD in this family context. Tourette's Disorder (TD) is a childhood onset neuropsychiatric disorder characterized by multiple motor and vocal tics that can be associated with marked impairment, disability and significant reduction in quality of life. The majority of clinically referred youth with TD also meet criteria for a comorbid psychiatric disorder, such as obsessivecompulsive disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD) and mood and nonOCD anxiety disorders, increasing the complexity of the clinical picture. The decision to treat tics requires comprehensive diagnostic assessment to ascertain presence of psychiatric comorbid disorders. Tics are generally treated only when they cause distress and/or impairment to the child. Comorbid disorders, such as ADHD and OCD, usually require treatment. Systematic review of the extant evidence base for pharmacological treatment of tics, with or without psychiatric comorbidity, will take place. There is a growing evidence base for the efficacy of pharmacological treatment of tics, but results of randomized clinical trials indicate only about 3066% reduction in symptoms. Given the need to balance both efficacy and risk, a suggested algorithm for a systematic approach to treatment of TD will emphasize evidence based data.

S80-1.

OVERVIEW OF TOURETTE'S DISORDER THROUGH THE LIFE CYCLE

Cathy Budman, M.D., NSLIJHS 400 Community Drive, Manhasset, NY 11030

SUMMARY:
Tourette's Disorder(TD)is a neuropsychiatric syndrome of childhood onset characterized by multiple, repetitive, stereotypic movements and vocalizations (i.e. "tics") that wax and wane in severity and change in location over time. Tics typically emerge around age 6 years, peak in intensity at puberty, and then gradually diminish significantly in most cases by early adulthood. However, a number of individuals with TD continue to experience intrusive tic symptoms throughout their lives. Others may enjoy a lengthy hiatus from disruptive tics for many years followed by an explosive and unpredictable recurrence and persistence of disruptive tics later in life. In addition, clinical and populationbased samples indicate that TD alone is the exception rather than the rule; most clinicallyreferred individuals meet diagnostic criteria for one or more psychiatric comorbid disorders (e.g. obsessive compulsive disorder, attention deficit hyperactivity disorder) whose symptom also have childhood or adolescence onset and commonly persist into adulthood. Over the lifespan, these psychiatric comorbidities are a leading cause of morbidity in TD. Both genetic and environmental factors influence the expression and course of TD. Because this condition and related psychiatric comorbidities frequently affect multiple family members and/or generations, effective treatment of the individual with TD often requires involvement, assessment, and in some cases concurrent clinical management of both affected and nonaffected family members. This presentation will highlight recent findings regarding the clinical epidemiology, phenomenology, and natural history of TD through the life cycle.

S80-2.

GENETIC AND ENVIRONMENTAL CONTRIBUTORS TO THE DEVELOPMENT AND EXPRESSION OF TOURETTE'S DISORDER AND RELATED COMORBIDITIES

Carol Mathews, M.D., 401 Parnassus Ave, San Francisco, CA 941430984

SUMMARY:
Tourette Disorder (TD) is a childhoodonset neurodevelopmental disorder affecting approximately 1:300 individuals. Although multiple motor and vocal tics form the core of the diagnosis, individuals with TD often present with a variety of additional symptoms and comorbid disorders, most commonly obsessivecompulsive disorder (OCD) and attentiondeficit hyperactivity disorder (ADHD), which occur in 3050% of individuals with TD.

TD has a complex etiology, with both genetic and environmental factors contributing to its expression. Genetic epidemiology studies suggest that TD and OCD have up to 90% shared genetic factors. In contrast, there is little evidence for a shared genetic susceptibility between TD and ADHD, despite the high rates of comorbidity between them; rather, they appear to share environmental factors. Genetic studies of TD have included candidate gene studies, linkage analyses in large pedigrees, studies of TDaffected individuals carrying chromosome abnormalities, examination of copy number variation (CNV), and genomewide association studies. These studies have identified several gene families and chromosomal regions that appear to be involved in the development and/or expression of TD. Perhaps the most promising of these regions is chromosome 2p23. Several lines of evidence converge to suggest that one or more TD susceptibility genes may be harbored here, including linkage analyses, studies of a TDaffected family with a chromosome translocation in this region, and CNV analyses. Chromosome 2p harbors many brainexpressed genes, among them the neurexin gene. The complex etiological underpinnings of TD and the variability in symptom presentation can make for real challenges for genetic counselors and treating clinicians. Etiological studies, which are progressing rapidly, will ultimately have a direct impact on diagnosis, prediction, and treatment of TD and its related comorbidities.

S80-3.

PHARMACOLOGICAL TREATMENT OF TOURETTE'S DISORDER AND PSYCHIATRIC COMORBIDITY

Barbara Coffey, M.D., M.S., 63 Westminster Road, Lake Success, NY 11020

SUMMARY:
Tourette's Disorder (TD) is a childhood onset neuropsychiatric disorder characterized by multiple motor and vocal tics that can be associated with marked impairment, disability and significant reduction in quality of life. The majority of clinically referred youth with TD also meet criteria for a comorbid psychiatric disorder, such as obsessivecompulsive disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD) and mood and nonOCD anxiety disorders, increasing the complexity of the clinical picture. The decision to treat tics requires comprehensive diagnostic assessment to ascertain presence of psychiatric comorbid disorders. Tics are generally treated only when they cause distress and/or impairment to the child. Comorbid disorders, such as ADHD and OCD, usually require treatment. Systematic review of the extant evidence base for pharmacological treatment of tics, with or without psychiatric comorbidity, will take place. There is a growing evidence base for the efficacy of pharmacological treatment of tics, but results of randomized clinical trials indicate only about 3066% reduction in symptoms. Given the need to balance both efficacy and risk, a suggested algorithm for a systematic approach to treatment of TD will emphasize evidence based data.

S80-4.

NONPHARMACOLOGICAL TREATMENTS OF TOURETTE'S DISORDER AND COOCCURRING CONDITIONS

John Walkup, M.D., NewYorkPresbyterian, Rm.F1109, 525 E. 68th St, New York, NY 10065

SUMMARY:
The treatment goals for people with Tourette syndrome include reducing tic severity, but also improving symptoms of common cooccurring conditions including ADHD and OCD. The mainstay of treatment for all age groups has been medication management. Over the past 10 years the evidence base for nonpharmacological treatments for tics and cooccurring conditions substantially increases opportunities for symptom relief without medication. With established efficacy of nonpharmacological treatment an increased pool of clinicians can care for patients with Tourette syndrome. Given the shortage of psychiatrists and neurologists with expertise in Tourette syndrome, the addition of psychologist to the pool of providers increases the chance that people with Tourette will have improved outcomes. The evidence base for the nonpharmacological treatment of ADHD, OCD, mood and anxiety disorders has a longhistory in psychiatry. Just recently, however, large studies of a behavioral intervention for reducing tic severity have been completed and demonstrate the efficacy of a behavioral approach in reducing tic severity and impairment. In the first large published study

126 children ages 917 years with a chronic tic disorder were randomized (1:1) to a comprehensive behavioral treatment that includes competing response training and a functional intervention vs. supportive therapy. Of those randomized to the behavioral intervention 53% were much or very much improved as compared to 18% in the control condition. The treatment was well tolerated and concerns regarding behavioral treatments causing tic worsening were not observed. A similar large study in adults using the same methodology have recently been completed. The efficacy of behavioral treatments in reducing tic severity, changes the approach to the patients with tics dramatically. Behavioral treatments can be used before starting medication, as an adjunct to medication; and as a strategy to reduce medication usage. In this presentation we will review the evidence base for the nonpharmacological treatment of TS and its common cooccurring condition but will focus on the changes in conceptualization of TS and approach to patient management as result of the success of behavioral treatments for reducing tic severity.

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2) Piacentini, J. et al. "Behavior Therapy for Children with Tourette Disorder: A Randomized Controlled Trial." JAMA 2010;393(19):19291937.

SYMPOSIUM 81
DR. STONEWALL STICKNEY: IN HIS OWN WORDS

Chair: J. Luke Engeriser, M.D., 2400 Gordon Smith Drive, Mobile, AL 36617
Discussant: J. Tuerk Schlesinger, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the major legal issues involved in the landmark case Wyatt v. Stickney; 2) Consider the balance between individual rights and the right to treatment with the need for involuntary confinement in individuals with mental illness; and 3) Evaluate the psychiatrist's role in preserving human rights in mental health treatment.

OVERALL SUMMARY:

On October 23, 1970, patients involuntarily confined for mental health treatment at Bryce Hospital in Tuscaloosa, Alabama filed a class action lawsuit against the Alabama Department of Mental Health and Mental Retardation. This case, Wyatt v. Stickney, and the 33 years of litigation which followed, changed the face of institutional mental health treatment in the United States. At the center of the controversy was Dr. Stonewall Stickney, the Alabama State Commissioner of Mental Health at the time. In this symposium, participants will learn about the historical circumstances and the legal issues surrounding this landmark case. A Grand Rounds presentation by Dr. Stickney in 1993 at the University of South Alabama will be shown. This was the first and only time that Dr. Stickney spoke publicly about his role in this case. Finally, participants will discuss the role of psychiatrists in safeguarding the human rights of vulnerable individuals with mental illness as well as the positive and negative sequelae of this and similar cases establishing the right to treatment for individuals with mental health disorders.

S81-1.
THE HISTORICAL BACKDROP OF WYATT VERSUS STICKNEY

J. Luke Engeriser, M.D., 2400 Gordon Smith Drive, Mobile, AL 36617

SUMMARY:

In the nineteenth century, mental health treatment in Alabama was a model of progressive and humane methods. In 1861, a hospital later named after its first Superintendent Dr. Peter Bryce was opened in Tuscaloosa. The mental health pioneer Dorothea Dix was instrumental in the establishment of this institution and the hiring of Dr. Bryce. The facility was designed in the Kirkbride model which emphasized secluded, rural settings and windows looking out onto large open areas. In the mid20th century, the census at Alabama's state institutions skyrocketed, and funding for the state mental health system began to fall far short of what was required to continue to provide adequate treatment. Conditions deteriorated throughout the 1960's and set the stage for the Wyatt v. Stickney case in 1970. This presentation will review the history of Alabama's system of public mental health care and the

changing social pressures that resulted in the poor conditions which precipitated the lawsuit.

S81-2.
REVIEW OF THE LEGAL ASPECTS OF WYATT VERSUS STICKNEY

William Billett, M.D., 2400 Gordon Smith Drive, Mobile, AL 36617

SUMMARY:
The landmark case Wyatt v. Stickney was filed on October 23, 1970 on behalf of the patients at Bryce Hospital. Initially, the case was a dispute by 100 employees of the hospital who had been laid off, and they alleged that the layoffs would prevent involuntarily committed patients from receiving adequate treatment which would be in violation of their civil rights. The named plaintiff was a 16yearold male patient by the name of Ricky Wyatt who was a relative of one of the employees who had been laid off and the defendant was Dr. Stonewall Stickney who was the Alabama State Commissioner of Mental Health. Judge Frank M. Johnson dismissed the portion of the case relating to the layoffs, but he was willing to consider whether the lack of adequate treatment caused by the layoffs raised constitutional questions regarding civil rights. The Alabama Department of Mental Health appealed the case unsuccessfully, and in 1975, the Department of
Mental Health was placed under court rule for its inability to comply with the minimum standards, and the case did not officially come to an end until 2003. The precedent of Wyatt v. Stickney that involuntarily committed patients have a right to adequate medical treatment resulted in lawsuits and reforms in the mental health systems of numerous other states.

S81-3.
BIOGRAPHY OF DR. STICKNEY

Sandra Parker, M.D., 2400 Gordon Smith Drive, Mobile, AL 36617

SUMMARY:
Dr. Stonewall Stickney was the Alabama State Commissioner of Mental Health at the time this lawsuit was filed. Although he was the named defendant, some have suggested that Dr. Stickney may have had a role in instigating the lawsuit as a way of advocating for improved conditions in state mental health facilities. Dr. Stickney's relationship with Gov. George C. Wallace deteriorated over issues that included Dr. Stickney's reasonable advocacy for patients during the Wyatt v. Stickney case as well as efforts to integrate Alabama's psychiatric hospitals. Governor Wallace subsequently fired him in 1973. This presentation will present a biography of this important and fascinating figure in the history of psychiatry and will conclude with a presentation of Dr. Stickney's 1993 Grand Rounds to the University Of South Alabama Department Of Psychiatry in which he discusses his insider perspective on this case. This was the first and only time that Dr. Stickney spoke publicly about Wyatt v. Stickney.

REFERENCES:
1) Stickney SB: Problems in implementing the right to treatment in Alabama: the Wyatt v. Stickney case. Hosp Community Psychiatry 1974; 25(7): 45360.
2) Byrne G: Wyatt v. Stickney: retrospect or prospect. Conference report. Hosp Community Psychiatry 1981; 32(2):1236.
3) Schwartz LH: Litigating the right to treatment: Wyatt v. Stickney. Hosp Community Psychiatry 1974; 25(7): 4603.

SYMPOSIUM 82
PREDICTORS OF TREATMENT UTILIZATION AND TREATMENT RESPONSE IN BORDERLINE PERSONALITY DISORDER

Chair: Marianne S Goodman, M.D., James J Peters VA Medical Center 130 West Kingsbridge Road, Bronx, NY 10468,
Co-Chair: Larry J Siever, M.D.
Discussant: Larry J Siever, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify general predictors of treatment usage and treatment response for individuals with borderline personality disorder (BPD); 2) Learn about specific predictors of response for one treatment over another; and 3) Become informed about recently completed and current clinical trials for BPD.

OVERALL SUMMARY:
Surprisingly little is known about the predictors of treatment response in Borderline Personality Disorder (BPD), a chronic illness affecting 10% of psychiatric outpatients and 20% of psychiatric inpatients, and responsible for one of the highest mortality rates from suicide in Psychiatry. In recent years, the grim prognosis for a diagnosis of BPD has been challenged by results from longitudinal studies indicating that remission with treatment is common coupled with the development and testing of several psychotherapeutic approaches and medication trials. However, despite these advances, there exist minimal data delineating general predictors of a positive treatment response, as well as specific factors that may predict a beneficial response to one treatment over another. This gap in the literature is important to address as Identifying potential predictors of treatment efficacy may help clinicians make decisions about who will benefit from one intervention over another, clarify features critical for treatment success and may also ultimately lead to the development of biomarkers for treatment response. This symposium will review longitudinal data pertaining to predictors of treatment usage and then examine predictors of treatment response to several different modalities including medication, Dialectical Behavioral Therapy (DBT) and Mentalizationbased treatment (MBT). A variety of predictors will be discussed including demographic, clinical and neurobiological variables by investigators working with BPD populations or conducting clinical treatment trials.

S82-1.
PREDICTORS OF TIME TO CESSATION OF INDIVIDUAL THERAPY FOR BORDERLINE PATIENTS

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

SUMMARY:
Objective: The main purpose of this study was to describe the baseline predictors for timetocessation of individual therapy for borderline patients followed prospectively for 16 years. Methods: 290 patients meeting both DIBR and DSMIIIR criteria for BPD were interviewed concerning their use of mental health services nine times over 16 years of prospective followup. These blinded assessments were made every two years using a semistructured interview of proven reliability. Results: Only 64% of borderline patients had at least one twoyear period during which they stopped participating in individual therapy. Twentyone variables were found to be significant baseline predictors of cessation (for at least two consecutive years) of individual therapy in bivariate analyses. Seven of these predictors remained significant in multivariate analyses: younger age, being nonwhite, having a good vocational adjustment in the two years prior to index admission, the absence of a history of mood disorder, lower levels of neuroticism and childhood neglect, and a higher IQ. Conclusions: Taken together, the results of this study suggest that prediction of timetocessation of individual therapy for borderline patients is multifactorial in nature, involving demographic factors, vocational performance, axis I psychopathology, temperament, childhood adversity, and intellectual endowment.

S82-2.
USE OF fMRI TO PREDICT TREATMENT RESPONSE WITH DIALECTICAL BEHAVIORAL THERAPY IN BORDERLINE PERSONALITY DISORDER

Marianne Goodman, M.D., James J Peters VA Medical Center 130 West Kingsbridge Road, Bronx, NY 10468

SUMMARY:
REVIEW: Borderline Personality Disorder (BPD) is characterized by dysregulated emotional processing and amygdalar hypersensitivity. Dialectical Behavioral Therapy (DBT) is an empirically supported psychotherapy for BPD. We aimed to identify neurobiologicallybased predictors of treatment response. METHODS: 19 medicationfree individuals with BPD, received structured diagnostic interviews, fMRI and structural MRI prior to a 12month DBT trial. Imaging task was viewing of emotional pictures with positive, neutral and negative valence. Clinical progress was tracked with serial OASM and ZANBPD and treatment response was determined by duration and clinical response. Amygdala volumes were traced for each participant on their individual structural MRI, coregistered to the BOLD images. Amygdala responses were examined used a mixeddesign multivariate ANOVA with repeated measures. RESULTS: 8 subjects

were treatment responder, 11 subjects were nonresponders. Amygdala habituation response (defined as the difference between amydgala BOLD response in repeated picture minus novel picture) for negative pictures (R=.498, p=.030), but not neutral and pleasant pictures (p values >0.52) correlated with responder status. CONCLUSIONS: Greater difficulties in the amydala's ability to habituate to negative emotional stimuli correlates with positive DBT response. This is consistent with Siegle et al. (2006) similarly designed CBT study in depression noting treatment response correlated with sustained amygdala reactivity on baseline fMRI. Continued identification of predictors to psychotherapeutic interventions may assist in treatment choice and clarify underlying pathologies. Data on psychophysiological measures will also be presented.

S82-3.

PREDICTING TREATMENT OUTCOMES, RETENTION AND ALLIANCE IN DBT AND SSRI TREATMENT WITH BORDERLINE PERSONALITY DISORDER

Barbara H. Stanley, Ph.D., NYSPI Unit 42 1051 Riverside, New York, NY 10032

SUMMARY:
This presentation reports findings on differential predictors of treatment retention, response, and alliance from a randomized controlled trial comparing DBT, fluoxetine and their combination in the treatment of selfinjury and suicidal behavior in borderline personality disorder (BPD). Patients were randomly assigned to one of four treatment conditions. The main outcomes were: frequency of non suicidal selfinjurious behavior and suicide attempts, depressive symptoms suicidal ideation, and impulsivity. Other predictive measures of treatment retention and outcome included demographic characteristics and neuropsychological measures of IQ, executive control and visual memory performance. Treatment retention was predicted by better baseline executive control and visual memory performance. We also examined the relationship between baseline measures of impulsivity, depression, anxiety, and aggression with the primary outcomes of the study. We found that suicidal ideation (ExpB=1.13, p=.033) and depression severity (ExpB=1.14, p=.047) independently predicted suicide attempts. We also examined the baseline characteristics of patients with BPD that prospectively predicted the quality of the patienttherapist alliance 2 months into treatment. Mood symptoms, including depression (Becks Depression Inventory; p=0.047), and anxiety (Hamilton Anxiety Scale: p=0.000) predicted better patientrated alliance, whereas impulsivity, aggression and hostility did not predict patient or therapistrated alliance. By contrast, therapists' alliance ratings were not associated with patients' mood symptoms. Our findings suggest that depression severity and certain neuropsychological impairments, in addition to history of suicidal behavior and trait impulsivity, are significant factors in predicting treatment outcome and retention in patients with BPD. Therapists may be able to improve the alliance with their BPD patients by focusing more attention on patient's subjective mood states early in treatment rather than on their impulsive and aggressive behaviors. In addition, neuropsychological measures hold promise in predicting treatment retention, and may also lead to the development of cognitive remediation interventions that could enhance treatment retention in BPD patients.

S82-4.

PREDICTORS OF TREATMENT UTILIZATION AND TREATMENT RESPONSE IN BORDERLINE PERSONALITY DISORDER

Peter Fonagy, Ph.D., University College London, Gower Street, London WC1 6BT, London, WC1 6BT United Kingdom

SUMMARY:
We report the results of a randomized controlled trial of 130 subjects randomized to mentalizationbased treatment or structured clinical management, a treatment matched for intensity and level of support. Clear differences emerged over an 18 month treatment period between the two treatments in terms of clinical variables (selfharm, hospitalization, suicidal acts) and selfreported symptoms, social adjustment and interpersonal problems. Several variables moderated outcome; those associated with positive outcome included higher levels of education; those associated with negative outcome included physical abuse, antisocial behaviour, severe alcohol use, and comorbidity with other personality disorders. We also examined

whether the difference between mentalizationbased treatment and the comparison condition was moderated by demographic and clinical variables available at baseline in order to help us identify patient characteristics which suggest the usefulness of either of the two forms of treatment. We report that age, use of alcohol, narcissistic personality disorder, and antisocial personality disorder identified individuals particularly likely to benefit from a mentalizationbased approach. We also examined individuals who are least likely to show remission on MBT. The characteristics of these individuals were fewer obsessional symptoms, lower levels of depression, and somewhat lower levels of anxiety. The results, which require replication, suggest that MBT may have particular value for more chronic individuals with BPD who have failed in previous forms of therapy.

REFERENCES:

1) Lenzenweger MF, Desantis Castro D. Predicting change in borderline personality: Using neurobehavioral systems indicators within an individual growth curve framework. Dev Psychopathol. 2005 Fall;17(4):120737.

SYMPOSIUM 83
INNOVATIVE MODELS OF COMMUNITY OUTREACH AND COMMUNITY BASED PARTNERSHIPS IN MENTAL HEALTH CARE

Chair: Gregory W. Dalack, M.D., F6327, 1500 E. Medical Center Drive, Ann Arbor, MI 48109
Co-Chair: Marcia T. Valenstein, M.D., M.S.
Discussant: Michelle B. Riba, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe 2 challenges in outreach and community based partnerships seeking to improve community mental health care; 2) Describe 2 peer to peer interventions; 3) Describe interventions to involve family in individuals' management of their chronic mental health and general medical conditions; and 4) Consider how community outreach and community based partnerships might be developed and implemented.

OVERALL SUMMARY:

Health systems have increasingly focused on approaches to improve patient selfmanagement of conditions like diabetes and major depressive disorder. Increasingly, health care personnel are also working with community leaders, community organizations and patient supporters to improve management of mental health conditions. Combined care management approaches have been developed to address high rates of comorbidity among psychiatric and somatic medical conditions. Interventions have been introduced in divergent settings, targeting different stakeholders, and have had a differential impact on treatment outcomes. These efforts have included educational and information resource support for healthcare providers, patients and community members, officebased care management interventions, peertopeer support and family support. Common goals have been to improve symptom recognition, reinforce patient coping strategies, and connect patients to formal care when needed. In all cases, the ultimate goal has been to improve selfmanagement and achieve better health outcomes. In this symposium, five innovative programs reflecting a broad spectrum of outreach efforts, and patient, family, and community partnerships will be presented. The partners in these programs vary from the military community, to community centers, to primary care professional offices. They have been designed to meet the needs of soldiers, military veterans, and civilians across the life cycle. These approaches have broad applicability and have increasingly been shown to improve outcomes in the management of major depression and comorbid medical conditions. Costeffectiveness of these interventions is a key component in the evaluation of these programs, and demonstrating costeffectiveness remains a significant challenge. The presenters will highlight the successes and the challenges they have faced in their community partnerships and outreach work and describe next steps to improving community based interventions efforts. In December 2008, the Welcome Back Veterans initiative funded the University of Michigan Depression Center to conjointly develop and implement a peer outreach program with the Michigan Army National Guard (MI ARNG). The peer outreach program, BuddytoBuddy (B2B) was developed through an iterative, participatory process by partners representing MI ARNG members, Michigan State University and University of Michigan faculty members, and veteran

advocates. In the B2B program, each returning NG soldier is assigned a firsttier Buddy (Buddy One) from the same demobilized unit. Buddy Ones are trained and systematically make telephone contacts with returning soldiers in their panel to identify those who may benefit from further evaluation or referral. A second tier of veteran volunteers (Buddy Two Veteran Volunteers) are outside of the Guard but also readily available to the unit. These Buddy Twos receive further, more intensive training in motivational interviewing approach, local resources, and also receive weekly telephone supervision. Buddy Twos visit Guard armories during drill weekends and are available by telephone to all soldiers. The first tier of the BuddytoBuddy program is funded and now "owned and operated" by the MI ARNG and the National Guard Bureau (NGB). The second tier is supported through foundation monies through Major League Baseball charities and the McCormick Foundation. VA facilities (medical centers, CBOCs, and Vet Centers) throughout the state of Michigan have been highly cooperative with this effort and work. The BuddytoBuddy program has gained national recognition within the National Guard and more recently international attention. The National Guard Bureau considers it a best practice in Guard reintegration programming, and team members have recently received funding from VA research division to rigorously evaluate the implementation of the program and collect early data on its efficacy in improving soldier outcomes.

S83-1.

DEPRESSION DISEASE MANAGEMENT: OUTREACH, OUTCOMES, AND COSTS

Kevin Kerber, M.D., 4250 Plymouth Rd, Ann Arbor, MI 48109

SUMMARY:
A wide range of research demonstrates that depressive illness is underrecognized, undertreated, and often chronic or recurrent. Research shows that depression can have an amplifying effect on other chronic diseases, such as diabetes and cardiac disease. Most patients with depression receive their treatment in the primary care setting where there may be little opportunity for education of patients, use of treatment guidelines, or referral to community resources. The Michigan Depression Outreach and Collaborative Care (MDOCC) program was started several years ago and has worked closely with primary care practices in supporting depression treatment. MDOCC emphasized longterm tracking of patients, structured outcome assessments, selfmanagement, and monitoring of costs. Most studies have focused on short term outcomes with little attention to developing sustainable interventions at acceptable cost. We will report on our impact on patient remission rates and costs per patient as well as the operational realities that are involved in maintaining the program nearly ten years.

S83-2.

TELEPHONEBASED MUTUAL PEER SUPPORT FOR PATIENTS IN DEPRESSION TREATMENT: THE PILOT AND INPROGRESS RCT

Paul Pfeiffer, M.D., M.S., 4250 Plymouth Road, Room 2409, Ann Arbor, MI 48109

SUMMARY:
Objective: We conducted a pilot to assess the acceptability, feasibility and depressionrelated outcomes of a telephonebased mutual peer support intervention for individuals with continued depressive symptoms in specialty mental health treatment. Methods: Participants were depressed patients with continued symptoms or functional impairment treated at one of the three outpatient mental health clinics. Participants were partnered with another patient, provided with basic communication skills training, and asked to call their partner at least once a week using a telephone platform that recorded call initiation, frequency and duration. Depression symptoms, quality of life, disability, selfefficacy, overall mental and physical health and qualitative feedback were collected at enrolment, 6 weeks and 12 weeks. Results: Fiftyfour participants enrolled in the 12week intervention and 32 participants (59.3%) completed the intervention. Participants completing the study averaged 10.3 calls, with a mean call length of 26.8 min. The mean change in BDIII score from baseline to study completion was 4.2 (95% CI: 7.6, 0.8; p<.02). Measures of disability, quality of life and psychological health also improved. Qualitative assessments indicated that participants found meaning and support through interactions with

their partners. Discussion: Telephonebased mutual peer support is a feasible and acceptable adjunct to specialty depression care. Larger trials are needed to determine efficacy and effectiveness of this intervention. A larger randomized controlled trial is now underway in 4 Veterans Affairs Health Systems and their 16 associated community based outpatient clinics. This trial will enroll approximately 400 patients, with randomization to telephone based dyadic peer support or enhanced usual care.

S83-3.

WELCOME BACK VETERANS: BUDDYTOBUDDY, A PEER OUTREACH PROGRAM FOR RETURNING SOLDIERS

Marcia T. Valenstein, M.D., M.S., PO Box 130170, Ann Arbor, MI 481130170

SUMMARY:
In December 2008, the Welcome Back Veterans initiative funded the University of Michigan Depression Center to conjointly develop and implement a peer outreach program with the Michigan Army National Guard (MI ARNG). The peer outreach program, BuddytoBuddy (B2B) was developed through an iterative, participatory process by partners representing MI ARNG members, Michigan State University and University of Michigan faculty members, and veteran advocates. In the B2B program, each returning NG soldier is assigned a firsttier Buddy (Buddy One) from the same demobilized unit. Buddy Ones are trained and systematically make telephone contacts with returning soldiers in their panel to identify those who may benefit from further evaluation or referral. A second tier of veteran volunteers (Buddy Two Veteran Volunteers) are outside of the Guard but also readily available to the unit. These Buddy Twos receive further, more intensive training in motivational interviewing approach, local resources, and also receive weekly telephone supervision. Buddy Twos visit Guard armories during drill weekends and are available by telephone to all soldiers. The first tier of the BuddytoBuddy program is funded and now "owned and operated" by the MI ARNG and the National Guard Bureau (NGB). The second tier is supported through foundation monies through Major League Baseball charities and the McCormick Foundation. VA facilities (medical centers, CBOCs, and Vet Centers) throughout the state of Michigan have been highly cooperative with this effort and work. The BuddytoBuddy program has gained national recognition within the National Guard and more recently international attention. The National Guard Bureau considers it a best practice in Guard reintegration programming, and team members have recently received funding from VA research division to rigorously evaluate the implementation of the program and collect early data on its efficacy in improving soldier outcomes.

S83-4.

COMMUNITY PARTNERS IN CARE: A PARTNERSHIP TO IMPROVE DEPRESSION CARE IN LOS ANGELES

Bowen Chung, M.D., M.S., 10920 Wilshire Blvd., Suite 300, Los Angeles, CA 90024

SUMMARY:
Depression is the largest cause of disability in U.S. Access to depression care is limited, particularly in urban communities like Los Angeles due to the lack of available providers with depression care capacity. Providing and developing resources with community agencies may improve access and care delivery. We report on Community Partners in Care, an NIMH funded, randomized trial comparing two different approaches, Resources for Services (RS) and Community Engagement and Planning (CEP), to build capacity, as well as to disseminate evidencebased, depression care to agencies in minority communities. RS is a lowimpact intervention providing training in Partners in Care (PIC), a collaborative care intervention comprised of care management, cognitive behavioral therapy, and medication management for depression. CEP utilizes a multiagency planning process to adapt PIC, to create a network of depression care providers, and to train CEP agencies in the adapted PIC trainings. Currently, CPIC partners include 105 diverse agencies (mental health, community safety net primary care, social service, substance use, and community friendly locations such as churches, homeless serving agencies, parks and recreations) from two L.A. neighborhoods, Hollywood and South Los Angeles. Out of the 2580 people screened for study eligibility, 31% have screened eligible (PHQ9= 10) with probable depression. All aspects of the study are done under conditions of

equal partnership and power sharing between two lead community partners, Healthy African American Families II (South Los Angeles) and QueenCare Health and Faith Partnership (Hollywood) and two lead academic partners, UCLA and RAND Health. Depression is a common condition in underserved, urban communities of color. Participatory community planning, training, and implementation approaches are feasible with a diverse set of agencies in the context of a scientifically rigorous randomized trial under conditions of equal partnership.

S83-5.

THE CAREPARTNER MODEL FOR IMPROVING MENTAL HEALTH

John Piette, Ph.D., PO Box 130170, Ann Arbor, MI 481130170

SUMMARY:

Patients with mental health problems often need more support for selfmanagement than they can realistically obtain in busy practices. CarePartners is designed to improve management of depression by: (1) providing patients with tailored selfcare information and health education in weekly automated telephone assessment and behaviorchange calls; (2) providing clinicians with timely information about patients' health and selfcare needs via automated reports; (3) providing patients' informal caregivers (including adult children or others living at a distance) with structured feedback about patients' status via email or an automated callin service; and (4) providing high risk patients with immediate access to suicide hotlines during automated assessment calls. The content of the automated assessments, tailored selfcare support information, and fax feedback was developed with input from mental health specialists, primary care physicians and experts in chronic illness care. More than 63 patients with depression have been recruited from 12 primary care sites in Michigan. Roughly 2/3 of depressed patients enroll with a "CarePartner", often an adult child living outside of their household. Ongoing evaluation uses a mixedmethods, implementation science approached based on the REAIM model for determining the service's reach, effectiveness, adoption, implementation, and maintenance. Other CarePartner programs are being evaluated in parallel for patients with diabetes and with heart failure. Across studies, more than 400 patients have been enrolled, including the 63 with depression. Patients have completed more than 4,909 assessments with completion rates consistently higher than 85%, with no difference between patients with depression, diabetes, and heart failure. In qualitative interviews, depression patients and their caregivers have been enthusiastic about the service, and the program is now implemented as part of usual care in several practices.

REFERENCES:

1) Gilbody S, Whitty P, Grimshaw J, Thomas R: Educational and organizational interventions to improve the management of depression in primary care: a systematic review. JAMA 2003; 289(23):314551.
2) Rosland AM, Piette JD: Emerging models for mobilizing family sport for chronic disease management: a
structured review. Chronic Illness 2010; 6(1): 721.
3) Klinkman M, Bauroth S, Fedewa S, Kerber K, Kuebler J, Adman T, Sen A: Longterm clinical outcomes of
care management for chronicallydepressed primary care patients: a report from the Depression in Primary
Care project. In press, Annals of Family Medicine.

SYMPOSIUM 84
WITHDRAWN

WEDNESDAY, MAY 18, 2011
8:00 AM-11:00AM

SYMPOSIUM 85
TREATING BEHAVIORAL DISTURBANCES IN DEMENTIA IN THE ERA OF BLACK BOX WARNINGS

Chair: Rajesh R Tampi, M.D., M.S., 41 Nutmeg Hill Road, Hamden, CT 6514

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define behavioral disturbances in dementia; 2) Discuss the prevalence of behavioral disturbances in dementia; 3) Enumerate the treatments for behavioral disturbances in dementia; 4) Analyze the data for risk of stroke and death with antipsychotic medications; and 5) Describe an evidencebased algorithm for the treatment

behavioral disturbances in dementia.

OVERALL SUMMARY:
Behavioral disturbances in dementia are comparatively neglected despite the fact that they are increasingly recognized as a major risk factor for caregiver burden, institutionalization, greater impairment in ADLs, more rapid cognitive decline, and a poorer quality of life. They contribute significantly to the direct and indirect costs of caring for patients with dementia after adjusting for the severity of cognitive impairment and other comorbidities. Research on these symptoms has indicated a complex interplay between the biological, psychological and social factors involved in the disease process. Although some psychotropic medications have shown modest efficacy in the treatment of these behaviors, their use has recently generated controversy due to their limited efficacy and the increasing recognition of their sideeffect profile. In this presentation, we review various aspects of these complex behaviors and discuss an evidencebased algorithm for their treatment.

S85-1.
TREATING BEHAVIORAL DISTURBANCES IN DEMENTIA IN THE ERA OF BLACK BOX WARNINGS

Sunanda Muralee, M.D., 41 Nutmeg Hill road, Hamden, CT 6514

SUMMARY:
Behavioral disturbances in dementia are comparatively neglected despite the fact that they are increasingly recognized as a major risk factor for caregiver burden, institutionalization, greater impairment in ADLs, more rapid cognitive decline, and a poorer quality of life. They contribute significantly to the direct and indirect costs of caring for patients with dementia after adjusting for the severity of cognitive impairment and other comorbidities. Research on these symptoms has indicated a complex interplay between the biological, psychological and social factors involved in the disease process. Although some psychotropic medications have shown modest efficacy in the treatment of these behaviors, their use has recently generated controversy due to their limited efficacy and the increasing recognition of their sideeffect profile. In this presentation, we review various aspects of these complex behaviors and discuss an evidencebased algorithm for their treatment.

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SYMPOSIUM 86
STIGMATIZING OF PSYCHIATRY AND PSYCHIATRISTS – AN INTERNATIONAL PERSPECTIVE

Chair: Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany,
Co-Chair: Norman Sartorius, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this symposium, participants should be able to: 1) Understand the scope and mechanisms of stigmatizing psychiatry and psychiatrists; 2) Assess the factors of importance in recruiting and retaining psychiatrists; 3) Evaluate means to reduce the stigma of psychiatry as a medical specialty; and 4) Assess the importance of relabelling severe mental disorders in order to reduce stigmatization.

OVERALL SUMMARY:
While the stigma of persons suffering from mental disorders has received widespread attention in the last years, the stigma of psychiatry as a medical specialty and the psychiatrist as a medical specialist has been neglected. However, stigmatizing psychiatrists or psychiatry leads to "psychiatry bashing" in medical school and may have negative consequences for choosing psychiatry as a medical specialty. This contributes to the lack of psychiatric specialists. On the other hand, several studies have shown that contact and positive educational experiences with persons with mental disorders may counteract stigmatization not only of the affected person but also of the specialty. General factors involved in the stigmatization of mental illnesses and people with mental disorders will be discussed. The World Psychiatric Association has recently initiated study on the stigma of psychiatry and psychiatrists. In this symposium, members of this WPA project group will first describe the scope of the problem and review the current findings on the modes and effects of stigmatizing psychiatry and the psychiatrist. The critical epidemiological factors about choosing psychiatry as a career will be discussed and factors of retaining psychiatrists will be elucidated. An essential element to reduce the stigma of psychiatry and psychotherapy is the learning experience of medical students and therefore ways how to reduce stigmatization of psychiatrists and psychiatry in medical teaching need to be developed. A final critical issue is whether reducing the stigma of mental disorders may also help to reduce the stigmatization of the specialty and therefore a presentation on the Japanese experience with renaming „schizophrenia" is included. The stigmatization of mental disorders is the most important obstacle to the improvement of mental health programs worldwide. Some other diseases also attract stigma but none is as pervasive as that related to mental illness. Stigma affects every aspect of mental health services, the persons with mental disorders, their families and all efforts to provide care to either of those. Stigmatization is usually accompanied by discrimination in all walks of life and by selfstigma, a loss of confidence in oneself and a deterioration of selfesteem of people with mental illness and those who care for them. The past two decades witnessed several major programs against stigma. The evidence and experience gained in these programs indicates that the paradigms of antistigma work developed in the late 20th century are no longer valid and that they need to be replaced by a new understanding of the problem and different strategies of intervention. The presentation will address the previous paradigms of antistigma work and changes that are necessary for fighting stigma now and in the immediate future.

S86-1.
STIGMATIZATION OF MENTAL DISORDERS

Norman Sartorius, M.D., Ph.D., 14 Chemin Colladon, Geneva, 1209 Switzerland

SUMMARY:
The stigmatization of mental disorders is the most important obstacle to the improvement of mental health programs worldwide. Some other diseases also attract stigma but none is as pervasive as that related to mental illness. Stigma affects every aspect of mental health services, the persons with mental disorders, their families and all efforts to provide care to either of those. Stigmatization is usually accompanied by discrimination in all walks of life and by selfstigma, a loss of confidence in oneself and a deterioration of selfesteem of people with mental illness and those who care for them. The past two decades witnessed several major programs against stigma. The evidence and experience gained in these programs indicates that the paradigms of antistigma work developed in the late 20th century are no longer valid and that they need to be replaced by a new understanding of the problem and different strategies of intervention. The presentation will

address the previous paradigms of antistigma work and changes that are necessary for fighting stigma now and in the immediate future.

S86-2.
IMPROVEMENT OF VALUE OF PSYCHIATRY

Tsuyoshi Akiyama, M.D., Ph.D., Akiyama Management 81126401 Akasaka, Minatoku, Tokyo, 1070052 Japan

SUMMARY:
Through a thorough review by the World Psychiatric Association, Antistigma task force, we have identified various stigma related problems. Now we should focus our efforts to solve the problems and may develop following approaches. 1.Normalizing program: We need to provide specific rehabilitative programs so that people with psychiatric disorder return to workplace or society as a functioning member. 2. Consultation: In areas such as industry and education, there are concerned nonmental health professionals, who nonetheless have to support people with psychiatric disorder. We need to provide efficient consultation to these people. 3. Limited Knowledge of Psychiatry: In order to achieve consultation purpose in a real setting, we should not assume that people will have an extensive knowledge about psychiatry. Rather we should provide consultation, which people with a limited knowledge of psychiatry can understand and carry out. 4.Strategic Appeal: In order to improve the images of psychiatry and psychiatrists, we may develop strategic appeal, which are positive and emphasize that there is so much to gain through the knowledge of psychiatry. Hopefully these approaches will lead to improved value of psychiatry in the eyes of general society.

S86-3.
STIGMATIZING PSYCHIATRY AND PSYCHIATRISTS: THE SCOPE OF THE PROBLEM

Wolfgang Gaebel, M.D., Bergische Landstr. 2, Duesseldorf, 40629 Germany

SUMMARY:
The stigmatization of psychiatry and psychiatrists has a large scope. Psychiatry as a medical specialty is often considered of low interest to medical students and psychiatry is one of those medical specialties which receive comparatively often negative comments. Such factors negatively influence the perception of psychiatry career by medical students. On the other hand, psychiatry is a medical specialty which advances the integrating biopsychosocial approach to human disorders. Its therapeutic methods are highly efficient compared to other medical specialties, and it is often perceived as an intellectually challenging discipline. This presentation will discuss the kinds and frequency of stigmatization of psychiatry and psychiatrists, and will describe methods to overcome negative prejudices with a view to increase the attractiveness of psychiatry for medical students.

S86-4.
STIGMATIZATION AND THE MEDIA

Allan Tasman, M.D., 401 E. Chestnut St., Ste. 600, Louisville, KY 40202

SUMMARY:
Stigmatization of mentally ill persons and psychiatrists is common in nearly every society around the world. This presentation is aimed at examining the role and influences the media, specifically television, films, and print media has played in this stigmatization. There will be a brief review of the distorted portrayals of both psychiatrists and their patients. There will also be an examination of the influence this has had on the general public's opinion of the field. This influence will be backed by studies carried out over the last three decades on increasingly prevalent forms of media.

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SYMPOSIUM 87
PREDICTORS OF DISEASE VULNERABILITY AND TREATMENT RESPONSE: PERSONALIZED MEDICINE IN PSYCHIATRY

Chair: Charles B Nemeroff, M.D., Ph.D., 1120 NW 14 Street, Miami, FL 33136

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) To understand recent studies on the psychotic major depression endophphenotype; 2) To assess potential genetic markers for the disorder; 3) Appreciate the role of genetic effects on treatment response in schizophrenia; and 4)Understand pharmacogenetic insights on drug side effects and implications for antipsychotic drug development.

OVERALL SUMMARY:
In identifying biological markers of disease vulnerability and treatment response, marked advances in other branches of medicine such as oncology, cardiology, and infectious diseases have occurred over the last decade. These burgeoning advances in molecular biology, genomics, epigenetics, proteomics, metabolomics, and imaging are now increasingly being applied to major psychiatry disorders and provide the basis for the emerging field of personalized medicine in psychiatry. This symposium seeks to bring together leaders in the field to discuss the state of the art of personalized medicine in mood disorders (Nemeroff and Schatzberg), anxiety disorders (Kalin), Alzheimer's disease (Wahlestedt), and schizophrenia (Buckley). Because the vast majority of these disorders are complex diseases with both prominent genetic and environmental contributions to vulnerability, gene environment interactions will be prominently featured.

S87-1.
PERSONALIZED MEDICINE: DEPRESSION

Charles Nemeroff, M.D., Ph.D., 1120 NW 14 Street, Miami, FL 33136

SUMMARY:
In spite of the repeated demonstrations of a large genetic component to vulnerability for mood disorders including bipolar disorder and major depression, GWAS Studies have not revealed any single gene that mediates this risk. In contrast, a number of genetic polymorphisms, all conferring small effects, have now been demonstrated to act in concert to underlie, at least in part, this heritable component of diathesis for mood disorders. This presentation will review work from our group and others on the identification of vulnerability genes for major depression with a focus on their interaction with a well documented environmental cause of increased risk, child abuse and neglect. Data demonstrating the importance of the following genes will be described including studies of genegene interactions: CRF1 receptor, serotonin transporter, BDNF, HTR3A, and the CRFB binding protein. In addition to the burgeoning "omics" arena which includes proteomics, transcriptomics, metabolomics, and epigenetics, is the area of functional and structural brain imaging. Positron emission tomography (PET) and fMRI is being utilized both to study neurobiological vulnerability to depression as well as response to individually effective treatments.

S87-2.
PERSONALIZED MEDICINE: PSYCHOTIC MAJOR DEPRESSION

Alan Schatzberg, M.D., 401 Quarry Road, Stanford, CA 943055717

SUMMARY:
Personalized medicine remains a goal for psychiatry. In this presentation we discuss recent research on major depression with psychotic features that point to this subtype of depression as being a specific endophenotype than can allow for personalized approaches. Data from research by our group and others point to the disorder being characterized by hypercortisolemia; decreased amygdala volumes; impaired performance on tests for working memory, verbal memory, and response inhibition; disordered brain activation on fMRI during memory tasks; disordered connectivity on fMRI involving specific brain regions; and potential clinical response to a glucorticoid receptor antagonist – mifepristone. Many of the cognitive deficits appear to be due to the elevated cortisol activity. Data on these characteristics from over 200 subjects are reviewed; recent results on variations in genes that encode for proteins involved in the regulation of cortisol are presented. The implications of these data for understanding the biology and endophenotype of psychotic major depression are discussed as are the implications for developing a personalized medicine approach to patients with the disorder.

S87-3.
USING FMRI TO PREDICT TREATMENT RESPONSE IN PATIENTS WITH GAD AND DEPRESSION

Ned Kalin, M.D., 6001 Research Pk Blvd, Madison, WI 53719

SUMMARY:
While anxiety and depressive disorders are common and effective treatments exist, there are marked individual differences in response to different pharmacologic agents and/or psychotherapy. The ability to more accurately select effective treatments for patients will enable more efficient treatment and improved outcomes. Data from studies examining alterations in the neural circuitry underlying dysregulated anxiety and affect in patients with GAD and depression will be presented. These data will be linked to other studies examining the predictive value of pretreatment brain function as it relates to efficacy of treatment. Across a number of studies, increased pretreatment activity in the anterior cingulate cortex predicts magnitude of treatment response to SSRIs and SNRIs in patients with GAD and major depression. Initial data suggests that response to cognitive behavioral therapy may show an opposite relation between prepscyhotherapy anterior cingulate activity and treatment response. Additional data that is necessary to validate fMRI techniques for more routine clinical use will be a topic of discussion.

S87-4.
PERSONALIZED MEDICINE IN PSYCHIATRY: ALZHEIMER'S DISEASE

Claes Wahlestedt, M.D., Ph.D., 130 Scripps Way, Jupiter, FL 33480

SUMMARY:
Recent largescale transcriptomics efforts by us and others have revealed that most of the human genome is transcribed resulting in the formation of large numbers of long and small noncoding RNAs (1,2). Such noncoding RNAs have been broadly implicated in brain function in higher organisms (3) and relate to specific aspects of Alzheimer's disease (AD) drug targets and biomarkers (4,5). Using RNAseq (RNA deep sequencing) we have examined the entorhinal cortex (ECTX), hippocampus (HPC) and cerebrospinal fluid (CSF) of AD cases and controls. We averaged 16.4 million reads/sample across 15 samples (ECTX=5, HP=4, CSF=6). Initial analysis indicates ~200 protein coding gene alterations greater than 2fold ($p<0.05$) in ECTX and HPC. We also find evidence for exon usage changes in an AD specific manner. RNAseq on CSF material revealed a large range of RNA species present with over 11,000 transcripts detected, of which ~500 are changed in abundance in an AD specific manner. We are currently screening specific candidates in >100 CSF, 30 HPC and 30 ECTX samples for replication. In addition, for HPC material, we used a newly modified protocol to preserve RNA orientation on the Illumina Genome analyzer IIx. This directional sequencing has allowed us to distinguish between mRNA, natural antisense transcripts (NATs) and other noncoding RNA species. We find abundant evidence for novel NATs and pseudogene expression. We also find preliminary evidence that many of these novel transcripts may also be dysregulated in AD. In sum, we are now able to accurately measure low concentrations of very large numbers of diverse RNA transcripts not only in human brain tissue samples but also in human CSF samples. Many RNA species appear to be altered in AD and such differentially expressed RNAs can be included in emerging CSF biomarker panels along with more established AD biomarkers such as Ttau, Ptau, and Abeta42.

S87-5.
PERSONALIZED MEDICINE IN PSYCHIATRY: EMERGENT THERAPEUTIC ADVANCES IN SCHIZOPHRENIA

Peter Buckley, M.D., 997 St Sebastian Way, Augusta, GA 30912

SUMMARY:
Rapidly expanding knowledge in neuroscience, with new developments in commercialization of genetic tests, and broadening domains of outcome, collectively create new opportunities for advancing pharmacogenetic strategies to develop more effective, customized treatments for schizophrenia. These complimentary paths of innovation in neuroscience and psychopharmacology will advance a more rapid translation of basic genetics and clinical pharmacogenetics research findings

into personalized care delivery for people with schizophrenia. Dr. Buckley will discuss the role of specific genetic influences upon treatment response and adverse effect profiles among antipsychotic medications currently in use to treatment schizophrenia.

REFERENCES:

1) Keller J et al. Hippocampal and amygdalar volumes in psychotic and nonpsychotic unipolar depression. Am J Psychiatry 165: 872880, 2008.

SYMPOSIUM 88
CANNABINOID MEDICINE: DISCOVERY, EVOLUTION, AND STATUS IN 2011

Chair: *Lawrence K Richards, M.D., 714 S. Lynn, Champaign, IL 61820*
Discussant: Lawrence K Richards, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how H.sapiens' relationships with the plant Cannabis sativa have evolved into an understanding of the existence of the Endocannabinoid System as part of the C.N.S. and the strengths and weaknesses of the current legal and medical standing.

OVERALL SUMMARY:

After a very well attended (n=35+2 who left with the NEJMed and slide handouts) N. Orleans W/ shop, (Medicinal Cannabis Update for 2010) the decision was to expand into a full 3hr Symposium, add new material, and review material from the W/shop as there were so much interactions with audience, much presenter material got unspoken. Therefore the plan of this Symposium is to build upon the W/shop with new material and emphasize the progression of the science regarding cannabinoid chemistry while still attending to the psychosocial aspects. Some of the W/shop material will be repeated (and expanded) as most attendees probably never made the N.O. W/S. A 2010 law review article by a recently graduated M.D., who was active in AMA and is now pursuing Physiatry training, serves as a good summary of past "history" in re Cannabis; this will be abbreviated in the presentation. Material related to the biopsychosocial aspects associated with Cannabis sativa plant derivatives follows: expansion of "political" dynamics, in 20th C USA, the mid 1990's discovery of the Endocannabinoid System within the CNS,Raphael Mechoulam, an organic chemist in Israel, is usually credited as having proven the existence of the ECS, aka ESreview of current "streams" of medicinal cannabis research in Canada & USA and associated results, analysis of the interrelationships between DEA,FDA, Congress, Big Pharma, Law Enforcement, and the citizenry are featured heavily. An analysis of research and quality and meaningfulness of what may be found in the professional literature is discussed, and a special abstract has been devised primarily to list the journal articles that will be highlighted during the Discussant's work. This is entitled Discussion of quality, pertinence, reliability, and usefulness of relevant literature. This uses journal articles of interest and applicability to internal medicine, neurology, and psychiatry. Of course Chair/discussant will see to it major amounts of input occurs from the audience once again. AS we know from the last few years of "big pharma" fiascos making the news, replete with academic psychiatrists of the highest stature who have in various ways fudged their results so as to yield findings interpretable as favorable for the company's products, journal articles are not all undeniable sources of truth and the word guaranteeing the path of good medical treatment. AS I described at several sessions during the N. Orleans A.M.without rebuttal many, and probably most, of the published research articles dealing with marijuana, medical marijuana, or medicinal cannabis are essentially outdated and in today's (reality)are now often worthless, primarily because of a lack of standardization of the dosage of active chemicals being studied. The Cannabis sativa plant may still have cpds not yet delineated. This section of the Symposium will be used to illustrate weaknesses of published research by using articles from major medical journals, and if Q/A should lag, Discussant will return reviewing Rand Corporation's extensive review of the pros and cons of the Nov. 2010 California Proposition 19, aka the referendum on whether to fully legalize Marijuana possession and use in that state, above and beyond M.C. laws. Journal article content will be from Neurology, 2002;59: 13371343, (neurocognitive effects of MJ) and NEJMed, 2010;362,23: 21862193, (Valproate, 1st Trimester, Teratogenicity), and NEJMed, 2010; v362,#25:23412343,(FDA & Transparency) and Arch Int.Med. e'pub Sept.13,2010 doi 10.1001/

archinternmed.2010.341.(From Disclosure to Transparancy: the Use of Company Payment Data) Analysis and discussion about cancer disease connects with: a) U.Mich./ Hashibe study , http://cebp.aacrjournals.org/content/15/10/1829.full and the Brown U. / Liang study, http://www.ncbi.nlm.nih.gov/pubmed/19638490 .

S88-1.

CANNABIS: A COMMONWEALTH MEDICINAL PLANT, LONG SUPPRESSED, NOW AT RISK OF MONOPOLIZATION

Sunil Aggarwal, M.D., Ph.D., 4725 15th Ave NE, #31, Seattle, WA 98105

SUMMARY:
Cannabis is a commonwealth medicinal plant that evolved 37 million years ago, whose standing as a legitimate cannabinoid botanical medicine has been undermined through repeated dueprocess denials. This talk will weave together history, medicine, politics, and science to describe how we arrived at a 21st C. Orwellian classification of Cannabis as a Schedule I dangerous substance, with no accepted safety for use under medical supervision. In 1937, The AMA's Chief of Legal Medicine testified to Congress that Cannabis had at least one medical use that no other drug in the Pharmacopoeia at the time could replace—namely, its ability to aid in the revivification of forgotten memories in psychotherapy. The AMA's position to oppose neartotal prohibition of the useful medicinal plant was actually falsified on the Congressional floor before the official vote was taken, establishing the federal position that carries on to this day. In the last two decades, with the understanding that has been achieved about the newlydiscovered, ancient endogenous cannabinoid signaling system—involved in the regulation of a host of essential physiologic functions such as mood, appetite, pain, and movement regulation—it is has become increasingly obvious that the purported therapeutic actions of Cannabis are verifiable through both goldstandard clinical trials AND underlying mechanism of action plausibility. Despite this, pharmaceutical companies are continuing to collude with federal agencies' intentions of maintaining generalized prohibition of Cannabis while at the same time federal agencies are granting such companies exclusive licenses to develop blockbuster drugs through wholeplant extractions. As far back as 1972, the Schedule I classification of cannabis was called into question by the Presidential Commission that was congressionally tasked to investigate its proper classification in the Controlled Substances Act. The Nixon tapes suggest that the Administration at the time was keener on purposely conflating "marijuana" with other drugs rather than implementing the Commission's studied recommendations. The medical facts about Cannabis that necessitate its downscheduling will have to overcome its historical overpoliticization if physicians, patients, and the public are to benefit from all that cannabinoid botanicals can offer.

S88-2.

PROBLEMS IN CURRENT POLICIES TOWARD MARIJUANA USAGE

Ronald Abramson, M.D., 25 Main Street Suite 7, Wayland, MA 1778

SUMMARY:
In 1972 Edward M. Brecher and the Editors of Consumer Reports wrote "Licit and Illicit Drugs," documenting the combination of histrionic stories in the Press, the advocacy of BNDD commissioner Harry J. Anslinger, and the paucity of medical research that led, in 1937, to the banning of marijuana as a legally usable substance. The report cited the findings of five previous commissions including the Canadian LeDain commission report of 1970 that the illegal status of marijuana was irrational. Compton et al. in 2004 cited routine use of marijuana by a temporally stable 4% of the population most of whom use it in a mostly recreational context similar to social alcohol use. In 19711973 I interviewed about 1,100 drug users who were returned to the United States from overseas stations because of drug use. This population of drug users overwhelmingly regarded the claimed dangers of marijuana use as not credible. Currently, drug users and others still regard marijuana usage as not dangerous and possibly beneficial to them. Marijuana use has recently been connected to the development of psychotic states, but most recently has been shown to improve cognition in first episode psychotic patients. It is not as clearly causally linked to serious mental or physical illnesses as are other addictive substances such as alcohol and tobacco. However, its illegal status causes

adversity for research, clinical treatment, and in legal consequences for users. The Brecher Consumers Union report made recommendations toward the reduction of criminal penalties and the creation of a Federal marijuana commission to carefully revisit and revise policy. These recommendations are just as relevant now as they were then and will be reviewed.

S88-3.

NAVIGATING THE THREE STREAMS OF MEDICINAL CANNABIS RESEARCH IN NORTH AMERICA

David Ostrow, M.D., Ph.D., 733 W Melrose St, 1st Flr, Chicago, IL 60657

SUMMARY:
Modern basic and clinical cannabinoid research may be conceptualized as contributing to three distinct 'tributaries' of knowledge regarding the use of cannabinoids in medical practice. This presentation will outline and develop this paradigm using examples from published literature. The 'tributaries are: 1. Academic (exemplified by preclinical research on the endocannabinoid system and the pharmacocological actions and properties of natural and synthetic components of cannabis); 2. Pharmaceutical (exemplified by the clinical uses of dronabinol, nabilone and the recent approval of the Sativex®, a mixture of extracts from both a high THC and a high CBD containing strains, for chronic pain syndromes in Canada); 3. Community (exemplified by attempts to organize communitybased clinical cannabis research networks, and patientcentered conferences, such as the biannual Patients Out of Time Conference see "Cannabis: The Medicine Plant. Proceedings of the Sixth National Clinical Conference on Cannabis Therapeutics," April 1517, 2010, Warwick, RI. Available at www.medicalcannabis.com). Among the benefits of uniting these three sources of knowledge about the medicinal properties of cannabis and its constituents are a growing understanding of both the benefits (see Fraser GA. The use of a synthetic cannabinoid in the management of treatmentresistant nightmares in posttraumatic stress disorder (PTSD). CNS Neurosci Ther. 2009 15(1):8488) and abuse potential of both natural and synthetic cannabinoids. (see Ware MA, St. Trempe E. The abuse potential of nabilone. Addiction 2010;105(3):494503; and Calhoun SR, Galloway GP, Smith DE. Abuse potential of dronabinol (Marinol). J Psychoact Drugs 1998; 30: 18796) Scientific, clinical, legal, and political roadblocks will be examined and solutions to these challenges will be proposed. Dr. Mark A. Ware, M.D., MSc., is copresenting and coauthor of the abstract for this session with Dr. Ostrow.

S88-4.

NAVIGATING THE THREE STREAMS OF MEDICINAL CANNABIS RESEARCH IN NORTH AMERICA

Mark Ware, M.D., M.S.C., 1650 Cedar Ave Rm E19128, Montreal QC, H3G 1A4 Canada

SUMMARY:
Dr. Ware is coauthor with Dr. David Ostrow abstract is the same.

S88-5.

AN ILLUSTRATIVE DISCUSSION OF QUALITY, PERTINENCE, RELIABILITY, AND USEFULNESS OF MEDICAL LITERATURE RELEVANT TO THE CONCEPTS PRESENTED ABOVE

Lawrence Richards, M.D., 714 S. Lynn, Champaign, IL 61820

SUMMARY:
As we know from the last few years of "big pharma" fiascos making the news, replete with academic psychiatrists of the highest stature who have in various ways fudged their results so as to yield findings interpretable as favorable for the company's products, journal articles are not all undeniable sources of truth and the word guaranteeing the path of good medical treatment. AS I described at several sessions during the N. Orleans A.M.without rebuttal many, and probably most, of the published research articles dealing with marijuana, medical marijuana, or medicinal cannabis are essentially outdated and in today's (reality)are now often worthless, primarily because of a lack of standardization of the dosage of active chemicals being studied. The Cannabis sativa plant may still have cpds not yet delineated. This section of the Symposium will be used to illustrate weaknesses of published research by using articles from major medical journals, and if Q/A should lag, Discussant will return reviewing Rand Corporation's

extensive review of the pros and cons of the Nov. 2010 California Proposition 19, aka the referendum on whether to fully legalize Marijuana possession and use in that state, above and beyond M.C. laws. Journal article content will be from Neurology, 2002;59: 13371343, (neurocognitive effects of MJ) and NEJMed, 2010;362,23: 21862193, (Valproate, 1st Trimester, Teratogenicity), and NEJMed, 2010; v362,#25:23412343,(FDA & Transparency) and Arch Int.Med. e'pub Sept.13,2010 doi 10.1001/archinternmed.2010.341. (From Disclosure to Transparency: the Use of Company Payment Data)Analysis and discussion about cancer disease connects with: a) U.Mich. / Hashibe study, http://cebp.aacrjournals.org/content/15/10/1829.full and the Brown U. / Liang study, http://www.ncbi.nlm.nih.gov/pubmed/19638490

S88-6.

DECONSTRUCTING MARIJUANA ABUSE, DEPENDENCE, AND MEDICATION

John Halpern, M.D., 115 Mill Street, Belmont, MA 024789106

SUMMARY:
Many psychiatrists rapidly discharge patients from their care who repeatedly test positive for drugs of abuse, including marijuana. This may happen anywhere, including those States that have passed various medical marijuana initiatives. Marijuana use comorbid to mental illness is better screened for and includes an association to psychosis, and yet clinical reports of benefits, including psychiatric, are primarily anecdotal due to a convoluted system of research regulation unique to marijuana. Much about marijuana appears (or can be) distorted. Scientific method led to the discovery of a withdrawal syndrome from chronic use, but the research also noted such effects are, essentially, mild.1 While the FDA confirms the active ingredient in marijuana, Delta9THC, is a medicine (when it is synthetic and suspended in sesame oil), FDA also released a unique report claiming that there are no accepted medical properties from Delta9THCcontaining plants.2 While the USA required all American marijuana research to source it exclusively from the supply grown under contract for the National Institute on Drug Abuse, other countries, such as the UK, allowed private companies (notably GW Pharmaceuticals) to experiment with strains and concentrates free from government intrusion and now GW Pharmaceuticals has plantderived medications for multiple sclerosis in Great Britain, Canada, and even now possibly the USA. Current federal government policy, some of which organized medicine (including the AMA and APA) supports, is the greatest impediment to permitting peerreviewed research on marijuana to move forward in the USA. This lecture will detail how individual psychiatrists +/ APA can forge a breakthrough to improve the conditions for necessary research and clinical practice. Unencumbered, research will lead to evidencebased, cannabinoid medicine protocols and better data on the management of psychopharmacology, comorbid psychopathology, and substance abuse mental health.

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2) FDA Statement, 4/20/06, "InterAgency Advisory Regarding Claims That Smoked Marijuana Is a Medicine."
3) Aggarwal SK: Cannabis: A commonwealth medicinal plant, long suppressed, now at risk of monopolization. Denver University Law Review (Epub ahead of print, Sept 14, 2010)
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5) Aggarwal SK, Carter GT, Sullivan MD, Morrill R, ZumBrunnen C, Mayer JD. Medicinal use of cannabis in the United States: Historical perspectives, current trends, and future directions. Journal of Opioid Management 2009 May; 5(3): 153168.
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SYMPOSIUM 89
DEPRESSION AND DISPARITY: A GLOBAL PERSPECTIVE

Chair: Julie Adams, M.D., M.P.H., 1022 Starlight Drive, Durham, NC 27707

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the projected impact of the growing epidemic of depression worldwide; 2) Analyze ways in which inequities of care contribute to the epidemic nationally and internationally; 3) Describe and evaluate three unique treatment strategies to address these inequities, and 4) Appreciate the need to train and collaborate with nonphysician and nonmental health professionals to adequately address the epidemic.

OVERALL SUMMARY:
Depression is projected to be a leading cause of disability by 2020, second only to ischemic heart disease. The greatest burden will be borne by the developing world where disability adjusted life years (DALYs) could be seven times that of the developed world (68.8 million vs. 9.8 million DALYs). Contributing to the burden is an inequitable distribution of mental health professionals for which the gap between high and lowincome countries is even greater (10.50 vs. 0.05 psychiatrists per 100,000 population). While an estimated 15% of individuals with neuropsychiatric illness receive necessary care in lowincome countries, only 54% of those in highincome countries do, indicating a significant problem worldwide. In addition to its own contribution to disability, depression complicates the treatment of chronic and physical illnesses such as ischemic heart disease and HIV, contributing to the burden of these illnesses. The growing epidemic of depression demands aggressive and creative approaches to recognition and treatment. Pervasive barriers to be overcome in order to adequately reduce depression worldwide include poor recognition of mental illness and understanding of the benefits of care; discrimination between physical and mental problems by policy makers, insurance companies, and the public; inequitable contribution of health expenditures to mental health in low and middleincome countries; and devastating shortfalls in human resources for health. The current symposium will present innovative solutions to and provocative discourse on the challenges faced in addressing some of these barriers. Topics to be presented include making psychotherapy and psychopharmacology work by training nonphysician and nonpsychiatric providers to recognize and meet the needs of depressed individuals in the developing world and nonWestern settings along with ongoing challenges to meeting the needs of overlooked and marginalized populations here at home.

S89-1.
OVERCOMING DISPARITIES IN DEPRESSION MANAGEMENT IN OLDER ADULTS

Helen Lavretsky, M.D., M.S., 760 Westwood Plaza Rm C9948A, Los Angeles, CA 90095

SUMMARY:
Depression is among the leading causes of disabilityadjusted life years in the world and a serious public health problem in both developed and developing countries. Even in developed countries such as the United States, large segments of the population do not experience evidencebased, effective treatments. This is particularly true for older adults. Healthcare providers may be less likely to recognize and treat depression when an ethnic or cultural mismatch occurs in the physicianpatient relationship. Patients, patients' family members, and physicians may assume that depression is an expected and 'normal' consequence of conditions such as old age, and leave many depressed patients undertreated. The population in the U.S. and other developed nations is aging with the expected doubling of the population in the next twenty years including those suffering from depression or dementia. This may place more burden on caregivers and increase their depressive symptoms. Such a demographic shift will add substantially to a global burden of depression. In an effort to address such problems, the search is on for better diagnosis and treatments for depression in older adults. Pharmacological and nonpharmacological treatment approaches, such as mindbody interventions (TaiChi and meditation) in older adults and in family dementia caregivers will be reviewed.

S89-2.
LESSONS LEARNED FROM TWO RANDOMIZED CLINICAL TRIALS OF INTERPERSONAL PSYCHOTHERAPY IN UGANDA

Helen Verdeli, Ph.D., 525 West 120th Street, New York, NY 100276605

SUMMARY:
Group Interpersonal psychotherapy (IPTG) was adapted and tested for ecological validity and effectiveness in two randomized controlled trials: with depressed adults in southern Uganda, and depressed waraffected adolescents in Internally Displaced Persons (IDP) camps in northern Uganda. Both trials were conducted with laypersons from the local communities, who received IPTG training. IPTG was shown to be feasible, acceptable and effective in both settings. The current presentation will summarize lessons learned on 1) how IPTG was adapted, manualized, and tested for use with these two populations; 2) how community members with minimal or no mental health background were trained to deliver IPTG; 3) successes and failures of scalingup IPTG ; and 4)the longterm impact of IPTG on the local communities.

S89-3.
ADAPTATION OF A DEPRESSION TREATMENT INTERVENTION FOR HIV PATIENTS IN CAMEROON

Bradley N. Gaynes, M.D., M.P.H., CB # 7160, School of Medicine, Chapel Hill, NC 275997160

SUMMARY:
Depression greatly impacts management of chronic illness throughout the world. In subSaharan Africa, home to nearly twothirds of the 39 million people infected with HIV, depression is especially concerning for its impact on the clinical management of HIV. HIV+ individuals in resourcepoor countries experience elevated rates of mental illness, including depression. Further, depression has been linked to a range of negative HIVrelated behavioral and clinical outcomes, including more sexual risk behaviors, worse antiretroviral therapy (ART) adherence, poorer response to ART, faster immune system decline, and higher mortality. Management of the depression epidemic is therefore critical to managing the HIV epidemic in SSA. Approaches known as "MeasurementBased Care" (MBC) integrated into primary care settings and using clinical coordinators with depression expertise to help physicians implement guidelineconcordant, algorithmdriven antidepressant treatment have effectively addressed comorbid depression in nonHIV patient populations. We are undertaking a study to assess the feasibility and acceptability of implementing a randomized controlled trial of an MBC depression management program primarily staffed by nurses and integrated into HIV clinical care sites. Project activities are underway in Cameroon, a resourcepoor Central African country with a stated national commitment to mental health treatment and a high HIV prevalence. The current talk will present early evidence and lessons learned as we aim to establish the validity, reliability, and cultural appropriateness of a protocol to identify patients with major depressive disorder (MDD) at an HIV clinic in Cameroon; adapt an MBC treatment intervention for patients with MDD to the context of HIV treatment in Cameroon by training HIV providers and nurses to implement the intervention; and gather pilot data on recruitment, retention, and trends in HIV behavioral and health outcomes.

S89-4.
FACILITATORS TO IMPROVE MENTAL HEALTH CARE IN UNDERSERVED COUNTRIES

Wei Jiang, M.D., 200 Trent Drive, Durham, NC 27710

SUMMARY:
Millions of people worldwide suffer with mental illnesses. Depression, for example, affects more than 150 million people globally is the leading cause of disability as measured by YLDs, and will become the second leading cause of global burden of disease in 2020. While antidepressants and brief, structured psychotherapy are effective for 6080% of those affected and can be delivered in primary care, fewer than 25%, and in some countries fewer than 10%, of those affected receive such interventions. Main barriers to effective care include lack of resources, lack of trained providers, and social stigma associated with depression and other mental illnesses. To enhance mental health care in underserved countries, I undertook an initiative with collaborators in China, my native country, to establish a training program. The overall goal of the training program is to build a broad system that can recognize and manage common mental health conditions, such as depression and anxiety,

in nonpsychiatric medical settings and promptly triage severely ill patients to specialized psychiatric services. Specifically, we provided training to medical professionals (physicians and nurses who have not had formal psychiatric training) who have been in clinical practice for several years and are interested in developing mental health skills. With training, we hope these health providers will become the main providers of mental health care in nonpsychiatric settings, as well as trainers for other nonpsychiatric health providers. The first training course was successful. However, a number of obstacles, such as funding resources, infrastructure, commitment of team members, and other supports will need to be overcome to reach our ultimate goal. Experiences of potential approaches to these barriers will be shared in detail.

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SYMPOSIUM 90
RECENT ADVANCES IN THE CROSSCULTURAL, ETHNIC AND ETHNOPSYCHOPHARMACOLOGICAL ASPECTS OF MOOD DISORDERS

Chair: Shamsah B Sonawalla, M.D., Jaslok Hospital and Research Center, 15, Dr. G. Deshmukh Marg, Bombay, 400 026 India
Co-Chair: David Mischoulon, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate that culture and ethnicity interact to influence the phenomenology and response to treatment in mood disorders; 2) Understand the principles and application of ethnopsychopharmacology: and 3) Recognize crosscultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders, with a focus on recent advances.

OVERALL SUMMARY:

This symposium will focus on recent advances in crosscultural, ethnic and ethnopsychopharmacological aspects of mood disorders, and response to psychopharmacological and psychotherapeutic treatment. Culture influences symptom presentation, helpseeking behavior and attitudes towards medication, treatment expectations, therapeutic compliance, family involvement, and the interpretation of side effects, all of which help determine whether or not treatment will be effective. Ethnopsychopharmacology examines biological and nonbiological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. Dr. David Henderson will review the basic principles of ethnopsychopharmacology, and discuss the impact of race, sex, and culture on drugdrug interactions and metabolism, adverse events, compliance, and response to treatment. He will also review various approaches to improving clinical compliance and outcomes, by reducing adverse events and medication interactions. Dr. David Mischoulon will discuss and review different approaches to the treatment of mood disorders in the Hispanic population, including the impact of culturebound syndromes on diagnostic assessment, and the role of natural remedies and folk healing as part of the comprehensive treatment program. Dr. Albert Yeung will present the impact of cultural beliefs on the treatment of Chinese Americans with mood disorders and discuss possible solutions to improve pharmacological treatment of this population. Dr. Rajesh Parikh will discuss challenges in the diagnosis and treatment of mood disorders in the AsianIndian population and will review suggested psychopharmacological and psychotherapeutic modifications for treatment in this subgroup. Dr. Shamsah Sonawalla will discuss how culture influences the experience and presentation of mood disorders in women, with a focus on premenstrual, postpartum and perimenopausal depression, the role of family and social support and strategies for diagnosis and treatment among women of different cultures. Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the HispanicAmerican population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including

the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culturebound syndromes (such as "ataque de nervios", and "susto") on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

S90-1.
ETHNOPSYCHOPHARMACOLOGY UPDATE

David Henderson, M.D., Massachusetts General Hospital, 25 Staniford Street,, Boston, MA 02114

SUMMARY:
Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance. Ethnopsychopharmacology examines biological and nonbiological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter and intragroup differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are one of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9, 2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. This lecture will also review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders. The role of genetic screening for poor and slow metabolizers will be discussed.

S90-2.
PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSSCULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D., Ph.D., 1 Bowdoin Sq, 6th Floor, Boston, MA 2114

SUMMARY:
Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the HispanicAmerican population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culturebound syndromes (such as "ataque de nervios", and "susto") on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

S90-3.
CULTURALLY SENSITIVE TREATMENT OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Albert Yeung, M.D., Sc.D., One Bowdoin Square 6/F, Boston, MA 02114

SUMMARY:
In European and North American cultures, depression is a wellaccepted psychiatric syndrome characterized by specific affective, cognitive

behavioral and somatic symptoms. In many nonEuropean cultures, including Nigerians, Chinese, Canadian Eskimos, and Japanese, and Southeast Asians, equivalent concepts of depressive disorders are not found (Marsella et al., 1985). Studies exploring illness beliefs of depressed among depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or unfamiliar with the concept of major depressive disorder (MDD). The discrepancy of illness beliefs between less acculturated Chinese Americans and their physicians has led to underrecognition and undertreatment of MDD among Chinese Americans. The Culturally Sensitive Collaborative Treatment was designed to improve recognition, acceptability, and adherence to treatment of depression. It includes systematic depression screening in primary care and culturally sensitive psychiatric assessment. The outcomes of implementing the CSCT in a primary care clinic will be discussed.

S90-4.

MANAGEMENT OF MOOD AND ANXIETY DISORDERS IN THE ASIANINDIAN POPULATION: AN UPDATE ON CROSSCULTURAL FACTORS AND PSYCHOPHARMACOLOGICAL CONSIDERATIONS

Rajesh Parikh, M.D., Jaslok Hospital & Research Center, 15 DR. G. Deshmukh Marg, Bombay, 400 026 India

SUMMARY:
The AsianIndian population is a diverse subgroup of individuals, with their own set of cultural norms, family traditions and religious belief systems, which may influence manifestation of depression and response to treatment. Mood and anxiety disorders are underdiagnosed and undertreated in this population, and mental illness is frequently viewed as an embarrassment or stigma. Young women often face unique pressures in the system, both from the family as well as from society. Family involvement is important in all stages of treatment of mental illness, including interactions with the treating physician and compliance with treatment. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements and adverse event profiles for antidepressant medications in this population. Cultural sensitivity is important during interactions with patients and their families. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particularly with antidepressant medications. Suggested modifications for managing depression in the Indian population will be discussed. Findings from crosscultural studies comparing depression among college students in the India and the United States will be discussed.

S90-5.

A CULTURAL PERSPECTIVE ON THE DIAGNOSIS AND TREATMENT OF MOOD DISORDERS IN WOMEN: AN UPDATE

Shamsah Sonawalla, M.D., Jaslok Hospital and Research Center, 15, Dr. G. Deshmukh Marg, Bombay, 400 026 India

SUMMARY:
This presentation will focus on providing a cultural perspective on mood disorders associated with a woman's reproductive cycle. During periods of increased hormonal changes, women are more prone to depression, e.g. the premenstrual phase, the postpartum and the perimenopausal period. Up to 80% women experience premenstrual symptoms to some extent. The menstrual phase is viewed differently in different cultures, and the experience of premenstrual symptoms is also affected by culture, in addition to biological and psychological factors. Up to 15% of women experience postpartum depression, a potentially serious condition. Researchers have found a relationship between postpartum depression and factors such as a cultural preference for a male child, lack of social organization of postpartum events and a lack of social recognition of the role transition for the new mother. Menopause is a normal transition in a woman's life; however, every woman's experience with menopause is unique and is influenced by several factors, including culture. Up to 80% of women in western societies suffer from physical and psychological difficulties at menopause. Interestingly, women in some nonwestern cultures appear to be significantly less affected by menopausal ills, e.g., Rajput women in India, who report minimal or no 'symptoms' of menopause.

Studies suggest that women experience greater levels of stress, depression and anxiety when seeking treatment for infertility, which is traditionally viewed as a woman's problem, even if a male factor is responsible for the couple's infertility. Findings from a study on couples undergoing invitro fertilization in an assisted reproductive clinic in India will be discussed. The importance of understanding the cultural context and a holistic approach in treating women with mood disorders will be discussed.

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SYMPOSIUM 91
WHY DO ANTIDEPRESSANT TRIALS FAIL?

Chair: *Arif Khan, M.D., 1951 152nd Pl NE #200, Bellevue, WA 98007*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session participants should be able to: 1) Gain an understanding of the nature of clinical trials and factors that influence antidepressant trial outcomes.

OVERALL SUMMARY:
Data from controlled clinical trials allow clinicians and researchers to evaluate antidepressant efficacy, and success rate for antidepressant trials is a disappointing 50 %(1). Some go so far as to argue that antidepressant therapy only benefits severely depressed patients (2, 3). Given the high prevalence of depressed patients (some severe, some not so severe) concern over utility of antidepressant therapy can be troublesome. Thus the question, why do antidepressant trials fail? Several clinical trial design features are influential to antidepressant trial outcomes. Factors including the dosing schedule and duration, number of treatment arms, and patient severity of depression influence trial outcome (48). One underlying mechanism is the expectation patients have for improving throughout the course of the trial. Active medication and placebo response rates are highly variable in antidepressant randomized controlled trials (RCTs) (6). Efficacy measures for both the active antidepressant and placebo trial arms are influenced by the odds of receiving a placebo (7, 8). A combination of these two factors may influence the separation observed between drugs and placebos in RCTs. Rutherford et al. recently found that manipulating patient expectancy during a prospective, randomized controlled trial influenced the outcome of antidepressant treatment. Understanding the impact of expectancy on antidepressant treatment may allow it to be maximized in clinical treatment for the benefit of patients and minimized in the context of drug development studies to facilitate signal detection for new medications. Many investigators have sought to develop innovative RCT designs that seek to decrease the impact of factors such as placebo response, and provide more robust efficacy findings without requiring larger samples. Examples of such designs include the Sequential Parallel Comparison Design (9). The fact that antidepressant clinical trials do not have a higher success rate does not necessarily mean that antidepressant therapy is not clinically effective. Interaction with the doctor and medical staff, frequent visitation schedule and symptom assessments, and the opportunity to verbalize distress parallel psychotherapy (10). Thus, placebo controlled antidepressant clinical trials are in effect comparing an antidepressant to an alternative treatment widely recognized as effective in all but the severest forms of depression.

S91-1.
ROLE OF PLACEBO IN ANTIDEPRESSANT CLINICAL TRIALS

Arif Khan, M.D., 1951 152nd Pl NE #200, Bellevue, WA 98007

SUMMARY:
Although there is little question that modern day antidepressants work, the clinical trial research is fraught with doubt and controversy. Because the placebo response is substantial and fluctuates fivefold among these clinical trials, showing efficacy for the antidepressants approved in the past couple of decades or new ones being tested is at best difficult. For example, antidepressant clinical trials conducted between 1975 and 1990, about half of the approved doses of antidepressants showed significant change over placebo. Several factors including the number of trial arms, HAMD version used, patient dosing schedule, trial duration and severity of depression at trial beginning predict antidepressantplacebo differences and as such are determinants of trial success. Curiously, as attention to antidepressant

clinical trial design features has increased, drugplacebo difference scores have decreased from 6.0 mean total Hamilton Depression rating scale (HAMD) points in 1982 to 3.0 HAMD points in 2008 among published trials. Throughout this time period the complexity of antidepressant trial designs has increased. Some of my colleagues in this panel will highlight what they have in relation to study design and what may be useful for future. In this context, it is worth noting that placebo is not a nontreatment in antidepressant clinical trials. Much of the ingredients that go into nonspecific psychotherapy are part of the experience of placebo treated depressed patients. Furthermore, patients suffering from illnesses such as schizophrenia and acute mania that may include a lack of insight or perceived distress are relatively insensitive to placebo effects. Such factors suggest that using placebo as a control in antidepressant trials may be flawed. These and other data and ideas will be discussed by our panel.

S91-2.
PATIENT EXPECTANCY IN ANTIDEPRESSANT CLINICAL TRIALS

Bret Rutherford, M.D., 1051 Riverside Drive, New York, NY 10032

SUMMARY:
Major Depressive Disorder (MDD) remains a significant public health problem, as 120 million people worldwide suffer from MDD and only 51% of patients experience remission of their depression after 4 sequential trials of antidepressant medications. Interventions capable of increasing remission rates, lowering dropout rates, and improving remission durability are urgently needed to lower the burden of illness due to MDD. High rates of placebo response in antidepressant trials complicate the search for new antidepressant agents. Placebo effects are particularly important in MDD, where placebo response in acute randomized controlled trials (RCTs) of antidepressant medications averages 30% and the proportion of medication response attributable to placebo is estimated at 5075%. Increasing placebo response over the last 30 years has resulted in increasing numbers of trials failing to demonstrate the superiority of investigational drugs to placebo. Negative trials may delay the availability of new treatments for depression, increase costs of drug development, and affect pharmaceutical company decisions to continue developing compounds with psychiatric indications. Therefore, in the drug development setting, the goal has been to minimize or eliminate placebo effects. In order to manipulate the magnitude of placebo effects, it is necessary to understand their mechanisms of action. Evidence suggests patient expectancy, which refers to patients' beliefs about how treatment will affect them, is a primary mechanism of placebo effects in antidepressant RCTs. In this presentation, a series of metaanalyses exploring the effect of study design and patient expectancy on antidepressant response will be reviewed. Next, results will be presented from a prospective RCT measuring the effect of expectancy on antidepressant response. Together, these data suggest that investigators should consider changes in RCT design that could control patient expectancy effects and limit placebo response.

S91-3.
HOW DO THE ODDS OF RECEIVING A PLACEBO IMPACT ANTIDEPRESSANT TRIAL RESULTS

Mark Sinyor, M.S.C., M.D., 2075 Bayview Ave, Toronto, M4N3M5

SUMMARY:
High placebo response rates in the antidepressant randomized controlled trial (RCT) literature and relatively low efficacy separation between medication and placebo are well known concerns for researchers designing RCTs. There is a growing body of literature in psychiatry and other areas of medicine which suggests that, on one hand, the presence of a placebo group influences response to the active antidepressant and that, on the other hand, the number of active antidepressant arms influences response to placebo. This presentation examines the work of our group and others demonstrating that active antidepressant response rates diminish as odds of receiving a placebo increase and that placebo response rates increase as the odds of receiving an active medication increase. These observations are likely the result of varying patient expectations with different study designs which in turn influence outcomes, however, rater biases may also play a role. The significance of these findings on the design and interpretation of antidepressant

RCTs will be discussed.

S91-4.

ARE THERE ALTERNATIVE TRIAL DESIGNS?

David Mischoulon, M.D., Ph.D., 1 Bowdoin Sq, 6th Floor, Boston, MA 2114

SUMMARY:
Many reviews and metaanalyses have examined the various problems inherent in randomized clinical trials (RCTs) that may result in a greater placebo response rate, or other problems that may generally result in a less robust separation between active treatments and placebo. Strategies used to circumvent these problems have included attempting to predict what patients may be more likely to respond to placebo or drug based on depression characteristics, increasing sample sizes for greater power, or increasing duration of studies for a greater chance of drugplacebo separation. Yet all these solutions have their own limitations, which may create new problems that continue to plague clinical trials and restrict their usefulness. Many investigators have sought to develop innovative RCT designs that may decrease the impact of factors such as placebo response, and provide more robust efficacy findings without requiring larger samples. Examples of such designs include the Sequential Parallel Comparison Design, which uses a statistically predetermined allocation of study interventions to enrich the sample for placebo nonresponders, thus allowing for a greater chance of separation between active treatment and placebo, with a smaller sample than required with conventional RCT designs. Other strategies include the SAFER interview, designed to specifically select for patients whose depression is more likely to be responsive to a biological therapy. There are also clinical trial designs that seek to avoid or minimize the use of placebo, while still providing information about the efficacy of a given drug. Examples of such designs include PlaytheWinner, Deterministic Allocation, Dose Control, Biased Coin Adaptive WithinSubject, and others. This presentation will review the strengths and weaknesses of these designs and discuss their potential use in the field of depression research.

S91-5.

CLINICAL TRIAL PROCEDURES THAT CONTRIBUTE TO THE PLACEBO RESPONSE

Walter Brown, M.D., 108 Driftwood Drive, Tiverton, RI 02878

SUMMARY:
Clinical trial participants assigned to placebo get much more than a pharmacologically inert substance. Like the patients assigned to a "real" drug they get all the common components of the treatment situation. These include a thorough evaluation, a chance to discuss their condition, a diagnosis, a plausible treatment and the enthusiasm, commitment and positive regard of doctors, nurses and study coordinators. Research shows that these and other elements of the treatment situation account for a substantial portion of the placebo response. In fact, a more evocative and accurate term than "placebo response" would be "response to the treatment situation." Further, placebo treatment encompasses features common to all the psychotherapies. These include; a person in distress; an expert; an explanation for the condition; sympathetic listening; and, a healing ritual promoting positive expectation. These elements that the psychotherapies and placebo treatment have in common are arguably the curative elements. Not surprisingly, the overwhelming majority of studies show that in the treatment of depression the psychotherapies (cognitive and others) and placebo produce similar results. The sort of depressed patients (those who are mildly and moderately ill) who recover with psychotherapy also recover with placebo treatment Accordingly, when antidepressant medication is compared to placebo the comparison is in effect similar to that between antidepressants and psychotherapy. As is the case in comparisons with placebo, studies that compare antidepressant medication with one of the psychotherapies typically find no difference in outcome in the mildly and moderately depressed and find an advantage for medication only in the severely depressed. Thus, placebo controlled antidepressant clinical trials are in effect comparing an antidepressant to an alternative treatment widely recognized as effective in all but the severest forms of depression.

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SYMPOSIUM 92
MENTAL HEALTH AND LEGAL PERSPECTIVES OF SAMESEX CIVIL MARRIAGE IN THE UNITED STATES

Association of Gay & Lesbian Psychiatrists

Chair: David A Tompkins, M.D., 5510 Nathan Shock Dr., Baltimore, MD 21231
Discussant: Jeffrey L Akaka, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the historical and legal struggle for Samesex Civil Marriage; 2) Identify the mental health benefits of Samesex Civil Marriage to individuals and society; 3) Identify and manage unique issues that arise in psychotherapy with samesex individuals and couples involved or contemplating civil marriage; and 4) Understand the importance and means of advocacy for Samesex Civil Marriage by the psychiatric community.

OVERALL SUMMARY:
In 2005, the American Psychiatric Association issued a position statement in support of samesex civil marriage. The site of this year's annual meeting, Hawaii, has struggled with this complex issue longer than any other state in the union. As of September 2010, samesex civil marriage is legal in 10 countries with an additional 18 countries recognizing civil unions or other samesex legal partnerships. In the United States, 16 states and the District of Columbia offer some form of legal partnerships. However, other states and countries have specifically denied samesex couples access to civil marriage. An expanding research literature shows the beneficial mental health effects associated with marriage in the general population and the psychological harm of denying civil marriage to lesbians, gay men, and their families. This symposium will provide an overview of the struggle for samesex civil marriage, with particular emphasis on the involvement of organized psychiatry. It will also review current research on the mental health impact of public campaigns to exclude lesbians and gay men from the institution of civil marriage, the effects of stigma inherent in nonmarital legal partnerships, and the characteristics of lesbian and gay relationships and families that are pertinent to questions of marriage. New opportunities for research on lesbian and gay mental health will also be discussed. The symposium will include a presentation by a psychiatrist who is in a samesex civil marriage discussing the personal impact of these complex legal decisions on her

work and her family. These personal experiences, both with statesanctioned marriage denial and legal recognition of her relationship, will solidify and explicate the research literature. The symposium will also take up the public affairs aspect of how psychiatrists are engaging in public and political discourse encompassing mental health issues of samesex civil marriage, with a particular focus on an ongoing project by the LGBT Committee of the Group for Advancement of Psychiatry (GAP). The final discussion will be led by a native Hawaiian who, among other issues raised by symposium panelists, will discuss issues surrounding samesex civil marriage in Hawaii today.

S92-1.
HOW APA'S 1973 DECISION TO REMOVE HOMOSEXUALITY FROM THE DSM CONTRIBUTED TO TODAY'S CULTURE WARS ABOUT MARRIAGE EQUALITY

Jack Drescher, M.D., 420 West 23 Street, #7D, New York, NY 10011

SUMMARY:
In 1973, APA's Board of Trustees voted to remove homosexuality from DSMII. The World Health Organization followed suit in 1992, removing homosexuality from ICD10. These actions deprived religious, government, military, media, and educational institutions of medical/scientific rationalizations for discrimination, shifting debates about homosexuality and gay people out of the realm of medicine into those of morality, politics and social policy. Without psychiatry's official participation in stigmatizing homosexuality, a historically unprecedented social acceptance of openly gay men and women gradually ensued. Those accepting scientific authority on such matters gradually came to agree with APA's position and a new cultural perspective emerged: (1) if homosexuality is not an illness; (2) if one does not literally accept biblical prohibitions against homosexuality; (3) if contemporary, secular democracy separates church and state; and (4) if openly gay people are able and prepared to function as productive citizens, then what is wrong with being gay? And if nothing is wrong with being gay, what moral and legal principles should the larger society endorse to help gay people openly live their lives? Since 2001, in answer to these questions, ten countries and five US states grant marriage equality to samesex couples. In 2005, APA issued a position statement in support of samesex civil marriage. Other legal recognition, such as civil unions and domestic partnerships, are now available to samesex couples in many parts of the US and the world. None of these changes would have been possible without the 1973 APA decision. Nevertheless, opposition to marriage equality persists in many quarters. The debates about marriage have raised questions about the institution's definition and purpose. This presentation first reviews the historic role of APA in the samesex marriage debate. It then goes on to outline some of the "culture war" issues in these debates.

S92-2.
A MENTAL HEALTH RESEARCH PERSPECTIVE ON MARITAL RIGHTS AND CIVIL MARRIAGE FOR LESBIANS AND GAY MEN

Robert Kertzner, M.D., 2154 Broderick Street, San Francisco, CA 94115

SUMMARY:
An expanding research literature has studied the psychological effects of civil marriage denial experienced by lesbians, gay men, and their families, and the beneficial mental health effects associated with marriage in the general population. This research has been increasingly cited in judicial rulings on extending marital rights to lesbians and gay men. This presentation will present an overview of current research on the mental health impact of public campaigns to exclude lesbians and gay men from the institution of civil marriage, the effects of stigma inherent in nonmarital legal recognition of samesex relationships, and the characteristics of lesbian and gay relationships and families that are pertinent to questions of marriage. New opportunities for research on lesbian and gay mental health at a time of increasing marital enfranchisement will also be discussed.

S92-3.
ADVOCATING FOR MARRIAGE EQUALITY THROUGH ENDS

Mary Barber, M.D., 140 Old Orangeburg Rd, Orangeburg, NY 10962

SUMMARY:
Psychiatrists, by virtue of being mental health experts and physicians, are often viewed by the public as leaders and experts on a variety of issues. Yet psychiatrists themselves may feel uncomfortable addressing the public, unsure about whether a policy issue is relevant to mental health, and may be uncertain of their authority to speak outside the clinical role. This presentation will describe an ongoing project with the LGBT Committee of the Group for Advancement of Psychiatry (GAP), to write oped pieces on issues relevant to LGBT mental health. Marriage equality is a prime example of such an issue, and has become a frequent topic of committee authors. Difficulties overcome in developing and publishing our work will be discussed, including finding our voice, overcoming doubts about extending our reach beyond the usual professional circles, and getting pieces written and approved in a timely manner. Through using a media expert for training and placing work, supporting each others' writing, and getting support from the larger organization (GAP), the committee has successfully published several pieces in support of marriage equality.

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S92-4.
MARRIAGE PLANS INTERRUPTED AND THEN FULFILLED: THE IMPACT ON A FAMILY

Ellen Haller, M.D., 401 Parnassus Ave, San Francisco, CA 941430984

SUMMARY:
Her first planned wedding was cancelled due to a state supreme court ruling. However, in 2008, Dr. Ellen Haller married her partner of 22 years when samesex civil marriages were briefly legal in California. Dr. Haller will discuss the personal impact of the complex legal decisions on her work and her family.

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SYMPOSIUM 93
ACTIVATED INFLAMATORY RESPONSE SYSTEM IN PATIENTS WITH PSYCHIATRIC DISORDERS ACROSS THE LIFESPAN

Chair: *Tatiana Falcone, M.D., Cleveland Clinic, 9500 Euclid Avenue P57, Cleveland, OH 44195*
Co-Chair: *Kathleen S Franco, M.D., M.S.*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize and correlate the evidence of immunological abnormalities from metaanalysis, animal models, genetic studies with mood disorders and schizophrenia across the life span.

OVERALL SUMMARY:
There is increase evidence that an activation of the inflammatory response systems plays an important role in the pathogenesis of psychiatric disorders specially schizophrenia and mood disorders. During this symposium we will discuss immunological findings in patients with schizophrenia, bipolar disorder, depression and substance abuse disorders,

across the lifespan and postmortem data supporting the evidence of the role of inflammation as an important step in the mechanism of psychiatric disorders. These results provide evidence supporting a link between systemic inflammation, subsequent Blood Brain Barrier failure (as measured by levels of S100Beta) and firstepisode psychosis and bipolar in patients across the life span. New research on the role of inflammation in patients with substance abuse disorders will also be discussed. Abnormalities of neurons and synapses have been the main focus of attention for research in major psychiatric disorders. S100B a glia cell marker and also a marker of Blood Brain Barrier disruption is giving us clues of the possible role of glia cells in the pathogenesis of schizophrenia. Studies on a younger age group with schizophrenia and mood disorders are rare, but crucial, since they can provide us with invaluable information about the varying levels of these biomarkers in earlyonset schizophrenia and bipolar. Postmortem studies in several brain regions of schizophrenic and bipolar patients also reported increased microglial cell activation in patients with mood disorder and schizophrenia. In conclusion, taken together our studies point towards an important role of the monocyte macrophage system in patients with mood disorders and schizophrenia, supporting the inflammatory theory of schizophrenia and mood disorders.

S93-1.

IS THERE AN INCREASE IN THE INFLAMMATORY RESPONSE SYSTEM IN PATIENTS WITH SUBSTANCE DEPENDENCE?

Albana Dreshaj, D.O., 9500 Euclid Avenue P57, Cleveland, OH 44195

SUMMARY:
Several psychiatric conditions such as mood disorders and schizophrenia have been consistently linked to an increased inflammatory response system (IRS). However, conflicting results in patients with substance abuse disorders and the IRS have been reported. S100B, a calcium binding protein that is a marker of glial cell activation and blood brain barrier (BBB) integrity has been used as a biomarker for the inflammatory response in several psychiatric conditions. No previous studies have reported the role of this protein in patients with substance abuse disorders. The purpose of our study was to assess the levels of S100B in patients with substance abuse or dependency. We recruited 35 patients from our inpatient substance abuse program and 20 controls from our outpatient substance abuse maintenance program. The two groups were age and gender matched from 1870 years old and the control group consisted of patients in substance remission for over six months. Both groups were given The Brief Psychiatric Rating Scale (BPRS) and the experimental group was also given the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) were administered at the same time levels of S100B were drawn, comparison in the two groups were studied. We hypothesize that patients with higher scores on the SOCRATES and the BPRS will correlate with higher levels of S100B. As in other psychiatric disorders reported in the literature.

S93-2.

CEREBRAL ACTIVATION OF THE MONONUCLEAR PHAGOCYTE SYSTEM IN DEPRESSION AND SCHIZOPHRENIA: POSTMORTEM STUDIES ON THE ROLE OF MICROGLIA

Johann Steiner, M.D., Leipziger Str. 44, Magdeburg, 39120

SUMMARY:
Previous studies in peripheral blood indicate a role of the mononuclear phagocyte system in depression and schizophrenia. Microglia belongs to this cell system and is a sensitive indicator of neuroinflammatory and degenerative processes. Of note, microglia is activated by S100B, and several factors are released from microglia (interleukin1, 6, nitric oxide, quinolinic acid) that modulate dopaminergic, noradrenergic, serotonergic and glutamatergic neurotransmission. Therefore, microglial activation is potentially related to the pathogenesis of major psychiatric disorders. Our postmortem studies showed increased microglial HLADR expression in the dorsolateral prefrontal cortex, anterior cingulum, mediodorsal thalamus and hippocampus of schizophrenia and depression cases – particularly in acutely ill suicidal patients. Moreover, elevated microglial quinolinic acid immunoreactivity (an endogenous NMDA receptor agonist) was observed in the dorsal and ventral

anterior cingulum of acutely ill depressed patients. This finding is in line with studies that were showing dysbalanced kynurenine metabolites in the blood and altered glutamatergic neurotransmission in the anterior cingulum (in vivo MR spectroscopy). In conclusion, postmortem studies indicate mononuclear phagocyte system activation in the brains of patients with major psychiatric disorders. These findings set the stage for novel therapeutic approaches, modulating neurotransmission by microglial immunomodulators (e.g., minocycline, Cox2 inhibitors, soluble TNFalpha receptors).

S93-3.

SERUM S100B: A POTENTIAL BIOMARKER FOR SUICIDALITY IN ADOLESCENTS?

Tatiana Falcone, M.D., Cleveland Clinic, 9500 Euclid Avenue P57, Cleveland, OH 44195

SUMMARY:
Objective: To assess immunological abnormalities in suicidal patients. Studies have shown that patients suffering from depression or schizophrenia often have immunological alterations that can be detected in the blood. Others reported a possible link between inflammation, a microgliosis and the bloodbrain barrier (BBB) in suicidal patients. Serum S100B is a marker of BBB function commonly used to study cerebrovascular wall function. Methods: We measured levels of S100B in serum of 40 adolescents with acute psychosis, 24 adolescents with mood disorders and 33 healthy controls. Patients were diagnosed according to *DSM-IV* TR criteria. We evaluated suicidal ideation using the suicidality subscale of the Brief Psychiatric Rating Scale for Children (BPRSC). Results: Serum S100B levels were significantly higher ($p < 0.05$) and correlated to severity of suicidal ideation in patients with psychosis or mood disorders, independent of psychiatric diagnosis. Patients with a BPRSC suicidality subscores of 14 (low suicidality) had mean serum S100B values +/ SEM of 0.152 +/ 0.020 ng/mL (n= 34) compared to those with BPRSC suicidality subscores of 57 (high suicidality) with a mean of 0.354 +/ 0.044 ng/mL (n=30). This difference was statistically significant ($p<0.05$). Conclusion: Our data support the use of S100B as a biomarker to assess suicidal risk in patients with mood disorders or schizophrenia.

S93-4.

MONOCYTE AND T CELL ACTIVATION IN PSYCHIATRIC AND PREPSYCHIATRIC DISEASE

Roosmarijn Drexhage, M.D., Dr. Molewaterplein 5060, Rotterdam, 3037CC Netherlands

SUMMARY:
Accumulating evidence indicates an activated immune system as a vulnerability factor for the development of schizophrenia (SZ) and bipolar disorder (BD). In support of this view we detected: 1.Monocytosis and monocyte activation (e.g. a specific gene expression signature consisting 34 inflammation related genes in a coherent pattern) in 27 SZ patients and 56 BD patients (all patients naturalistically treated), and 2.T cell activation in the same patients, be it that it were specifically Treg cells that were more numerous in BD, while in SCZ Th17 and Treg cells numbers were raised. T cell activation occurred independently from monocyte activation. We also tested 7080 children who all have one or two parent(s) with BD type I or II at the mean ages of 16 yrs and 21 yrs. This offspring have a higher chance of developing a mood disorder and indeed over 25% had already developed a mood disorder at 21 yrs of age. Not only the offspring with a lifetime diagnosis of bipolar or unipolar disorder had activated monocytes and more Treg cells (similar as BD patients), but also around 4050% of euthymic offspring had this immune activation profile. Importantly children who were psychiatrically healthy at 16yrs, and had developed a mood disorder at 21 yrs of age, all had activated monocytes at 16yrs of age. Our data show that the both the monocyte and T cell arm of the immune system are activated in SCZ and BD and that this activation precedes the onset of first episodes in individuals at risk. Our approach thus opens new avenues for early detection of psychiatric disease based on the immune activation state of individuals at risk, enabling selection of those individuals who might benefit from an immune modulation treatment to prevent disease.

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SYMPOSIUM 94
SUICIDE AND ANXIETY: WHAT ARE THE RISKS?

Chair: Igor Galynker, M.D., Ph.D., Beth Israel Medical Center, 9th Floor313 E 17th Street,, New York, NY 10003,
Co-Chair: James M Bolton, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand that anxiety disorders are associated with making lethal suicide attempts; 2) Appreciate that suicidal process involves altered anxious mental state characterized by rigidity, ruminative flooding, and frantic hopelessness; and 3) Recognize the importance of assessing for suicidal behavior in patients with anxiety disorders.

OVERALL SUMMARY:
The major mood disorders are well established as risk factors for suicide. However, most individuals with a major mood disorder do not attempt suicide. Understanding the factors that lead a minority to do so may inform treatment and enhance suicide prevention. This symposium examines the possible role of comorbid anxiety disorders and symptoms as risk factors for suicide. The four speakers at the symposium will present epidemiological and clinical data relevant to the role of anxiety states in suicide. Dr. Bolton will discuss epidemiological data from the CPES study regarding the relationship between anxiety disorders as a whole, and the frequency and lethality of suicide attempts. Social phobia and generalized anxiety disorder appear to be associated with the more worrisome patterns of suicidal behavior, including multiple and lethal suicide attempts. Dr. Yaseen will add to the above with a discussion of evidence regarding a proposed anxietyrelated 'suicide trigger state.' He will report on the construct validity and the exploratory and the confirmatory factor analysis of the "Suicide Trigger Scale" that identifies three factors in the proposed state: ruminative flooding, frantic hopelessness, and nearpsychotic somatization, and discuss the differential association of these factors with past suicide attempts and current severity of ideation. Curren Katz will then discuss the relationship between panic attacks, panic symptoms and suicidality in individuals with a major mood disorder in the NESARC epidemiological study. Panic attacks, particularly those characterized by prominent catastrophic cognitions, may mediate the transition from suicidal ideations to suicide attempts in subjects with depressive illness. Dr. Diesenhammer will continue by presenting data on the relationship between the course of the suicidal process, defined as the period between the first current thought of suicide and the accomplishment of the suicidal act, and cognitive rigidity. His data indicate that choice of method appears to remain relatively stable during the suicidal crisis and suggests that rigid patterns of thinking present during the suicidal process. Rigidity in ideation about suicide method may have implications for prevention via restriction of the availability of suicide means. The concluding discussion will focus on integration and clinical significance of the data presented at the symposium and on future research directions. Objective: The current study aimed to determine whether individuals with anxiety disorders are more likely to make lethal suicide attempts and to further investigate the characteristics of their suicidal behavior. Method: Data came from the Collaborative Psychiatric Epidemiological Surveys (CPES) (N = 20,130; age 18 years and older; response rate = 72.3%). People endorsing a history of suicide attempts were subcategorized as those who made lethal suicide attempts (n=159; individuals who intended to die), versus those who made suicidal gestures (n=85; individuals who did not intend to die). Multiple logistic regressions were used with *DSM-IV* anxiety disorders (agoraphobia with/without panic disorder, panic disorder, PTSD, social phobia, generalized anxiety disorder) as the

predictor variables and lethality of suicide attempts as the outcome variables. Results: Anxiety disorders were associated with both lethal suicide attempts (adjusted odds ratio [AOR] = 5.62; 95% confidence interval [CI] 3.199.90) and nonlethal gestures (AOR = 7.35; 95% CI 3.5015.45). People with generalized anxiety disorder (AOR = 3.02; 95% CI 1.277.19) and social phobia (AOR = 2.34; 95% CI 1.085.08) were more likely to have made a lethal suicide attempt than a nonlethal gesture, even after adjusting for the effects of comorbid mental disorders. In addition, individuals with generalized anxiety disorder (AOR = 1.63; 95% CI 1.002.63) and social phobia (AOR = 2.52; 95% CI 1.783.57) were more likely to make multiple versus single suicide attempts. Conclusions: The current study suggests that anxiety disorders are associated with lethal suicide attempts, independently of the effect of comorbid mood and substance use disorders. Social phobia and generalized anxiety disorder appear to be associated with the more worrisome patterns of suicidal behavior, including multiple and lethal suicide attempts.

S94-1.

LETHALITY OF SUICIDE ATTEMPTS AMONG INDIVIDUALS WITH ANXIETY DISORDERS IN A NATIONALLY REPRESENTATIVE SAMPLE

James Bolton, M.D., PZ430771 Banadyne Ave, Winnipeg, R3E 3N4 Canada

SUMMARY:
Objective: The current study aimed to determine whether individuals with anxiety disorders are more likely to make lethal suicide attempts and to further investigate the characteristics of their suicidal behavior. Method: Data came from the Collaborative Psychiatric Epidemiological Surveys (CPES) (N = 20,130; age 18 years and older; response rate = 72.3%). People endorsing a history of suicide attempts were subcategorized as those who made lethal suicide attempts (n=159; individuals who intended to die), versus those who made suicidal gestures (n=85; individuals who did not intend to die). Multiple logistic regressions were used with *DSM-IV* anxiety disorders (agoraphobia with/without panic disorder, panic disorder, PTSD, social phobia, generalized anxiety disorder) as the predictor variables and lethality of suicide attempts as the outcome variables. Results: Anxiety disorders were associated with both lethal suicide attempts (adjusted odds ratio [AOR] = 5.62; 95% confidence interval [CI] 3.199.90) and nonlethal gestures (AOR = 7.35; 95% CI 3.5015.45). People with generalized anxiety disorder (AOR = 3.02; 95% CI 1.277.19) and social phobia (AOR = 2.34; 95% CI 1.085.08) were more likely to have made a lethal suicide attempt than a nonlethal gesture, even after adjusting for the effects of comorbid mental disorders. In addition, individuals with generalized anxiety disorder (AOR = 1.63; 95% CI 1.002.63) and social phobia (AOR = 2.52; 95% CI 1.783.57) were more likely to make multiple versus single suicide attempts. Conclusions: The current study suggests that anxiety disorders are associated with lethal suicide attempts, independently of the effect of comorbid mood and substance use disorders. Social phobia and generalized anxiety disorder appear to be associated with the more worrisome patterns of suicidal behavior, including multiple and lethal suicide attempts.

S94-2.

PANIC AS AN INDEPENDENT RISK FACTOR FOR SUICIDE ATTEMPT IN DEPRESSIVE ILLNESS: FINDINGS FROM THE NESARC SURVEY.

Zimri Yaseen, M.D., 317 E 17th St 9th Fl, New York, NY 10003

SUMMARY:
Context: The relationship between comorbid panic and suicide in depressed persons remains unclear. Objective: To examine the relationship between panic attacks, panic symptoms and suicidality in individuals with a major mood disorder meeting *DSM-IV* criteria for past year major depressive episodes in a large epidemiological study. Methods: In data on 2,679 participants of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) with major depressive episodes, the associations of panic attacks and panic symptoms with lifetime suicidal ideation and suicide attempts were assessed. Results: Past year panic attacks were associated with increased risk of lifetime suicidal ideations and suicide attempts and significantly increased risk of suicide attempts among those reporting suicidal ideations. Some panic symptoms, most notably catastrophic

cognitions (fear of dying and fear of "losing control" or "going insane"), were more strongly and specifically associated with SA, while others were more related to SI. Conclusion: Panic attacks appear to be an independent risk factor for suicide attempt among depressed individuals with and without suicidal ideation. Further, panic attacks, particularly those characterized by prominent catastrophic cognitions, may mediate the transition from suicidal ideations to suicide attempts in subjects with depressive episodes. Assessment of these symptoms may improve prediction of suicide attempts in clinical settings.

S94-3.

PANIC AS AN INDEPENDENT RISK FACTOR FOR SUICIDE ATTEMPT IN DEPRESSIVE ILLNESS: FINDINGS FROM THE NESARC SURVEY.

Curren Katz, Ed.M., 317 East 17th St 5th Fl Rm 13C, New York, NY 10003

SUMMARY:

Context: The relationship between comorbid panic and suicide in depressed persons remains unclear. Objective: To examine the relationship between panic attacks, panic symptoms and suicidality in individuals with a major mood disorder meeting *DSM-IV* criteria for past year major depressive episodes in a large epidemiological study. Methods: In data on 2,679 participants of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) with major depressive episodes, the associations of panic attacks and panic symptoms with lifetime suicidal ideation and suicide attempts were assessed. Results: Past year panic attacks were associated with increased risk of lifetime suicidal ideations and suicide attempts and significantly increased risk of suicide attempts among those reporting suicidal ideations. Some panic symptoms, most notably catastrophic cognitions (fear of dying and fear of "losing control" or "going insane"), were more strongly and specifically associated with SA, while others were more related to SI. Conclusion: Panic attacks appear to be an independent risk factor for suicide attempt among depressed individuals with and without suicidal ideation. Further, panic attacks, particularly those characterized by prominent catastrophic cognitions, may mediate the transition from suicidal ideations to suicide attempts in subjects with depressive episodes. Assessment of these symptoms may improve prediction of suicide attempts in clinical settings.

S94-4.

THE COURSE OF THE SUICIDAL PROCESS DURATION AND CHOICE OF METHOD

Eberhard Deisenhammer, M.D., Anichstr. 35, Innsbruck, Austria

SUMMARY:

The course of the suicidal process, defined as the period between the first current thought of suicide and the accomplishment of the suicidal act, is of utmost importance for the understanding of what brings people to act against the natural instinct of self preservation and safeguarding. Thus, it has also a potential impact on the development of suicide preventive strategies. However, this crucial period has received relatively little scientific interest. The cognitive rigidity which is often present during this process is an important risk factor for the completion of a suicidal act since the ability to utilize problem solving strategies then is limited. On the other hand, the cognitive constriction on a specific way to act on suicidal ideation (including the choice of method) may be useful for preventive interventions. In this presentation data from our research into the course of the suicidal process and the mental preoccupation of suicide attempters are reported. In a study in 82 suicide attempters, nearly half of the patients (48%) reported that the period between the first current thought of suicide and the actual attempt had lasted less than 10 minutes. Those patients in which this process had taken longer showed a higher suicidal intent. Although the majority of the patients were alone during the suicidal process, 77% reported to have had tried to contact somebody. In another study, 130 suicide attempters were interviewed with regard to changes in the envisaged suicide method during the suicidal process. In 63% the method considered for the suicidal act remained identical during the entire process, in 27% the initial and the actual method differed. A decrease in violence of method occurred in more cases than an increase. Choice of method appears to remain relatively stable during the suicidal crisis. This finding supports the hypothesis

that rigid patterns of thinking present during the suicidal process also include the envisaged suicide method. This may have implications for prevention in terms of the usefulness to restrict the availability of suicide means.

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SYMPOSIUM 95
THE STATUS OF PSYCHIATRIC RESEARCH IN THE ARAB WORLD

Arab American Psychiatric Association

Chair: Ossama T Osman, M.D., M.B.A., P.O. Box 17666, AlAin, 0 U. Arab Emirates
Discussant: Ahmed Elkashef, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the overall nature and characteristics of psychiatric research in the Arab World with detailed specific examples; 2) Identify the status of Arab research on substance abuse and dependence; and 3) Become aware of the proposed directions which are recommended to enhance the status of Arab psychiatric Research.

OVERALL SUMMARY:

Most of the psychiatric studies were either epidemiologic, or psychometric with rare studies addressing mental health systems research. Underrepresented were studies on health promotion and interdisciplinary, crosscultural, ethnic, and gender research. There is an urgent need for respectable international collaborations and for developing policies which link research with services provided. Longitudinal studies will be important to test the longterm impact of early interventions. Addiction treatment practices has also been rapidly developing for over a decade in the Arab world. The increased demands for treatment led to establishment of substance dependence service centers and regional networks of substance abuse organizations. The Majority of the performed research was observational and descriptive in nature and targeted patient populations in treatment facilities and to a lesser extent those in criminal justice settings. Epidemiological studies were not geared towards developing integrated surveillance systems1. Treatment outcome studies were very limited and described current treatment protocols and relapse precipitants2. Most of the studies performed carried methodological challenges and employed non standardized tools. No systemic Interventional or economic studies (disease burden and cost effectiveness) or molecular genetics research were published. In summary, there is a scarcity of substance dependence research in the Arab and Muslim world. In addition to the common challenges of biomedical research, substance dependence research is impeded by several factors including high level of stigma, deficiency in specialized training and education programs, poorly differentiated field of practice and service delivery systems, deficiency in scientific data bases specialized in substance dependence, lack of accreditation systems that would drive evidence based and performance and outcome treatment programs hence research. There is a need for developing departnerships between psychiatric and substance abuse service centers with academic and research entities locally and internationally to bridge the gap between research and practice

S95-1.

PSYCHIATRIC RESEARCH IN THE ARAB WORLD: WHERE TO GO FROM HERE

Ossama Osman, M.D., M.B.A., P.O. Box 17666, AlAin, Cairo Egypt

SUMMARY:

The Challenges and priorities for mental health research in the Arab world has been similar to that

of other developing countries around the globe. Examples of these challenges include; the scarcity of research funding, the Constraints on researchers' time due to service delivery obligations and teaching commitments, and the need to develop strong research environments. There is a need to develop basic and clinical research and to integrate it with education and health care delivery systems. In the past, the traditional progression toward better health outcomes was from the pathophysiologic basic sciences, to the diagnostic and interventional clinical sciences, to the outcome oriented evaluations. We need an additional integrative step, in order to successfully and efficiently deliver seamlessly integrated and research informed global mental health resources to those in need. The scaling up of psychiatric research in the Arab World would therefore, require investing in longterm institutional research capacity building through engaging in global partnership and enhancing financial commitments. This will develop shared knowledge that would enable local scientists, researchers, educators service providers and policy makers to find more optimum and culturally relevant solutions for mental health related problems. Aligning the goals and objectives for regional psychiatric education and training with that of research would enhance the research mission and would guarantee a more optimum outcome that is sensitive and relevant to local cultural values and beliefs. We suggest a need for research transformation through partnerships and integration. We propose Creating Centers for Excellence in Global Mental Health with the primary mission of promoting advances in mental health and substance abuse research in affiliation with world leading academics, researchers, public service professionals, industry and health care facilities. This presentation will describe a model for a joint partnership that could help the implementation of new ideas and solutions and would promote local sustainable capacity building for research and researchers.

S95-2.

A CLOSER LOOK AT THE PSYCHIATRIC RESEARCH IN EGYPT

Afaf Khalil, M.D., Faculty of Medicine, Ain Shams Cairo, Egypt

SUMMARY:

The institute of psychiatry, Faculty of Medicine, Ain Shams University has conducted a systematic review and appraisal to the available Egyptian research in psychiatry in order to uncover the limitation facing the progress in this area and to generate recommendations to improve psychiatric research in Egypt. Analysis of the data revealed very little community based epidemiologic studies. Meanwhile, there were several epidemiological studies in students and clinical psychiatric populations. In spite of the great development of research in psychiatry over the last 22 years, research in the field of molecular biology, genetics, and Neuroimaging are limited because the complexity of methodology and the limited resources. There were several limitations regarding study designs, sample sizes and statistical analyses. There were also several good clinical research studies were conducted based on clinical experience, assessment tools and psychiatric rating scales. Most of the research studies were published in local or regional Journals, while few were published in International Journals. Despite of the noticeable great efforts spent in the Egyptian research, it lacked coordination between the team workers and the scarcity of funds. The presentation will discuss the evaluation of the Egyptian psychiatric research over two decades and will highlight several recommendations to improve it.

S95-3.

SUBSTANCE DEPENDENCE RESEARCH IN THE ARAB WORLD: THE CURRENT SITUATION AND FUTURE DEVELOPMENT

Hesham Elarabi, Pharm.D., M.S., Mohamed Bin Khalifa Street, Abu Dhabi, 55001

SUMMARY:

Addiction treatment practice has gained increasing recognition over the past decade in the Arab world. This is partially due to inflated demand for treatment that commensurate with establishment of substance dependence response and service centers and regional networks of international organizations. Research efforts commenced prior to the establishment of some of these services and the focus of such research was not to drive and enhance practice. The Majority of the performed research was observational and descriptive in nature and targeted patient population in

treatment facilities and to a lesser extent those in criminal justice settings. Epidemiological studies described the prevalence and sociodemographic characteristics of substance users and was not geared towards developing integrated surveillance system1. Treatment outcome studies were very limited and described current treatment protocols and relapse precipitants2. Most of the studies performed carried methodological challenges and employed non standardized tools. No systemic Interventional or economic studies (disease burden and cost effectiveness) or molecular genetics research were published. In summary, there is a scarcity of substance dependence research in the Arab and Muslim world. In addition to the common challenges of biomedical research, substance dependence research is impeded by several factors including high level of stigma, deficiency in specialized training and education programs, poorly differentiated field of practice and service delivery systems, deficiency in scientific data bases specialized in substance dependence, lack of accreditation systems that would drive evidence based and performance and outcome treatment programs hence research. Recently the partnership between a comprehensive substance dependence response service center in the United Arab Emirates with an academic and research body has come up with an integrated research plan to bridge this gap between research and practice.

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4) Ghanem M., Gadallah M., Meky F.A., Mourad S., and lElKholy G. National Survey of prevalence of mental disorders in Egypt: preliminary survey, Eastern Mediterranean Health Journal 2009;15:15.
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SYMPOSIUM 96
PSYCHIATRIC AND SOMATIC SYMPTOMS CLOSELY ENTWINED

Chair: Selene Veerman, M.D., Karveel 10, Volendam, 1132 GT Netherlands
Co-Chair: *Henry Dijkstra*
Discussant: *Esmée Arredondo, Ph.D.*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Acknowledge the importance of multidisciplinary collaboration in acute somatic disease; 2) Recognize clinical features of GHB withdrawal syndrome; 3) Manage and prevent severe withdrawal of GHB; 4) Recognize atypical presentation of lithium intoxication; and 5) Identify life threatening acute physical illness in patients suffering from severe mental disorders.

OVERALL SUMMARY:
This symposium illustrates the importance of multidisciplinary collaboration when psychiatric and somatic symptoms are closely entwined. Several points of view are outlined why somatic symptoms can be a challenge to diagnose and treatment can be specifically complicated in psychiatric patients. The first presentation depicts two patients, who develop a severe gamma hydroxybutyric acid (GHB) withdrawal syndrome and potentially life threatening complications. Recommendations focus on the early diagnosis and treatment of GHB withdrawal. Detoxification with medicinal GHB seems to be a promising alternative treatment for fixation and highdose benzodiazepines. Physicians practicing in the emergency setting should be aware of the presentation, clinical features and management of acute withdrawal of GHB. Rapid tranquilization of an uncontrollable patient in a life threatening situation requires immediate medicinal intervention with strong sedatives. Ketamine is highly efficacious and safe and has a distinct advantage over sufentanil, due to the absence of respiratory depression and the resulting hypoxia and hypercapnia. A multidisciplinary approach and close collaboration between psychiatrists and doctors specialized in intensive care, internal medicine and addiction is a prerequisite. The second speech addresses the complexity of the diagnostic process

in lithium intoxication. Lithium intoxication can be fatal when it is not recognized soon enough. Exchange of knowledge between psychiatrist and cardiologist is imperative. The third lecture emphasizes the difficulties in recognizing somatic disease in psychiatric patients. Referring psychiatric patients to somatic specialists can be a challenge due to several factors, including a different presentation of complaints, transference and counter transference. The fourth address shows how psychological processes are expressed in physical phenomena in a conversion disorder. The expertise of the neurologist is essential to exclude a neurological explanation for a somatic symptom such as paralysis in a conversion disorder. In conclusion, psychiatric patients with acute severe somatic disease warrant close collaboration of medical specialists. Psychiatrists plays a key role in early recognition of physical illness, distinction of somatic symptoms from psychiatric symptoms and communication between medical specialists, patients and family members.

S96-1.
GHB DETOXIFICATION DEMANDS A MULTIDISCIPLINARY APPROACH

Selene Veerman, M.D., Karveel 10, Volendam, 1132 GT

SUMMARY:
Objective: 1) Recognize clinical features of GHB withdrawal syndrome; 2) Identify serious psychiatric and somatic complications; 3) Manage and prevent acute withdrawal of GHB with particular reference to adequate sedation; 4) Acknowledge the importance of a multidisciplinary approach. Method: Two case presentations illustrate the unpredictable course and the potentially life threatening complications of gamma hydroxybutyric acid withdrawal. A thirtyoneyearold drug dealer develops tachycardia, tachypnea and dehydration with rhabdomyolysis, after fixation and sedation fail. Ultimately aspiration pneumonia leads to septic shock. A twentysixyearold kick boxer shows signs of an acute overdose of GHB, followed by severe symptoms of withdrawal and rhabdomyolysis, despite the administration of large quantities of benzodiazepines. Results: Treatment was complicated due to uncontrollable aggression and insufficient experience on treatment of a GHB withdrawal syndrome. Highdose treatment with benzodiazepines is considered to be the mainstay of therapy, but appears to be insufficiently effective when GHB dependence is severe. A more aggressive initial approach with intramuscular anesthetics such as sufentanil or ketamine is more advisable, when trying to prevent extreme agitation and potential violence. An alternative treatment for a withdrawal syndrome is a regime of gradual and careful dose reduction of medicinal GHB, which is still experimental in the Netherlands. Conclusions: The increasing trend in abuse of GHB and its prodrugs is alarming. Early recognition of symptoms of GHB withdrawal can avoid life threatening emergencies. In order to prevent states of excitement accompanied by aggression, it is advisable to intervene by administering strong sedatives. It is argued that GHB should be tapered off as an alternative treatment for fixation and highdose benzodiazepines. Detoxification with medicinal GHB has been found to be successful and safe.

S96-2.
FATAL LITHIUM INTOXICATION

Maartje de Graaf, M.D., Haarlemmerweg 46, Amsterdam, 1014 BE Netherlands

SUMMARY:
Objective: 1) Evaluate and raise clinical awareness concerning lithium intoxication in mentally disordered patients with severe somatic comorbidity.2) Assess underlying physical mechanism and pharmacokinetics of lithium intoxication.3) Acknowledge that atypical disease course in mentally disordered patients requires attention and management skills of both psychiatrists and consultant somatic specialists. Methods: A case presentation of an elderly woman diagnosed with bipolar disorder who is admitted to a psychiatric ward of a general hospital because of an exacerbation of a depressive episode. Somatic illness rapidly increases and a measured toxic lithium plasma level is adjusted and stabilized. Physical examination at that point shows no shock signs or other deviations, while she is severely confused. Urine production is normal. The plasma level is not remeasured. Shortly after, she becomes hypotensive with decrease of heart rate, rapid progression into shock, coma and ultimately an AVblock. Results: Because the lithium level was normal, the connection between the rapid onset and progression of cardiac complications, the lithium intoxication was not recognized and

no adequate therapy was started. Rehydration, adjusting lithium dosage and finally hemodialyses are possible treatment options which could have saved our patient. Conclusion: A multidisciplinary approach is necessary to prevent potentially lethal cardiac arrest due to acute lithium intoxication by volume depletion and change in pharmacokinetics. Because of the somatic complexity and low incidence the role of the psychiatrist should be prominent. The psychiatrist is the one who should recognize the clinical presentation of lithium intoxication. The diagnosis is compromised when the onset and progression are atypical and the lithium level is normal. Because of the low therapeutic index and possible induction of multisystem dysfunction, knowledge of the pharmacokinetics of lithium is necessary.

S96-3.

SEVERE MENTAL DISORDERS AND AN ATYPICALLY PRESENTED ACUTE PHYSICAL ILLNESS; A CHALLENGE FOR THE PSYCHIATRIST

Willemijn Noom, M.D., William Sternstraat 50, Haarlem, 2037 KN

SUMMARY:
Objective: 1) be aware of atypical presentation of life threatening acute physical illness in patients suffering from severe mental disorders. 2) optimize collaboration with medical specialists in dealing with patients with a severe mental disorder. Method: A thirtyyearold female suffering from severe hypokalemia and malnourishment due to an extensively investigated unexplained chronic diarrhoea and a not otherwise specified eating disorder is involuntarily admitted to the psychiatric unit of a general hospital. Previously she abandoned the cardiac care unit (CCU) where she was admitted for ECG monitored suppletion of a hypokaliemia. The patient pulls out the feeding tube repeatedly as a result of which fixation of her limbs is needed. She receives thrombosis prophylaxis but presents a few weeks later with limping. Physical examination shows no typical signs of deep vein thrombosis (DVT). The department of internal medicine consulted on the suspicion of DVT is hesitant to evaluate her because of a low probability of DVT due to the atypical presentation, use of prophylaxis and previous admission on the CCU. Results: After discussing the probability of atypical symptoms of DVT due to malnourishment and offering treatment options on the psychiatric unit, a DVT is confirmed by ultrasound. Conclusions: Atypical symptoms and problems in referring patients with a severe mental illness are not uncommon and a challenge for any doctor. Difficulties are faced in recognizing atypical symptoms as potentially life threatening, because patients with a severe mental illness are often not able to present their complaints as expected. Seeking adequate treatment can be compromised due to capacity problems in dealing with behavioral problems and counter transference in doctors, faced with this vulnerable heterogeneous group. Psychiatrists are a key chain in signaling physical illness and communication between medical specialists and patients. Key elements for psychiatrists to optimize collaboration with other specialties are addressed.

S96-4.

FROM PSYCHOSIS TO RELIEF OF CONVERSION DISORDER

Nathalie den Ouden, M.D., Bloemartsweg 15, Venlo, 5915PE

SUMMARY:
Method: A woman in her midtwenties was submitted to the hospital due to strange “spasms” in her legs. She was diagnosed with dystrophy in her leg after surgery when she was in her early teens and was unable to walk ever since. The neurologist did not find any abnormalities in her legs. Within two days after admission to the hospital, she became anxious, confused and demanding. She showed regressive behavior and psychotic symptoms increased. She was treated with haloperidol 5 mg and benzodiazepines. After three weeks an attempt was made to stop medication, but she became psychotic again. A new five week period of treatment with haloperidol was long enough to become free from psychotic symptoms. She had never been in psychiatric treatment. Results: She understood the mechanism of conversion and was very motivated to walk again. However, she focused more on rehabilitation and less on her psychiatric symptoms, while she complained a lot of sadness and anxiousness. When the psychosis was gone, she started to walk, after twelve years in a wheel chair. She practiced walking with a physiotherapist every day. She was admitted

in the hospital for three months. Even two months after release, there was no relapse. Conclusions: It seems that in somatoform disorders and more specific in conversion disorder it is possible to reverse the symptoms of paresis. The most important elements seem to be psychoeducation and safety. Furthermore, before discussing the diagnosis with the patient, careful examination of medical records, interviewing previous doctors and heteroanamneses should be done to gain more certainty about the diagnosis of conversion disorder. It is also important to involve family members in the treatment process: patient and family feel more comfortable to share feelings and thoughts about illness and treatment and it promotes compliance.

REFERENCES:

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SATURDAY, MAY 14, 2011
7:00 AM - 8:30AM

WORKSHOP 1
SUPERVISION: THE SLIPPERY SLOPE TEACHER? MENTOR? POLICE? THERAPIST?
Chairperson.: Yener A Balan, M.D., 444 Manhattan Ave Apt 7K, New York, NY 10026
Presenter(s): Malkah Notman, M.D., David Preven, M.D., Rika Suzuki, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the challenges of being a supervisor; 2) Analyze the various roles the supervisor plays; and 3) Identify aspects of the relationship that might be causing a conflict between the supervisor and the supervisee.

SUMMARY:
Supervision is the central teaching method used in the training of psychiatrists. This workshop includes experienced supervisors and recent residency graduates who will identify some important elements of supervision as experienced by both the supervisor and supervisee. The intense relationship that can develop during supervision often inhibits or facilitates its success and contributes to the quality of patient's treatment. The workshop participants will address how issues of content and process interfere with the remarkable professional growth that can occur with effective supervision. The faculty will use vignettes from their experience and the literature to illustrate some of the obstacles to achieving mutually satisfying work. Reluctance to deal with some of the following issues in the transference and, especially, the counter transference hampers the awareness of self, which separates the mature from the pedestrian psychiatrist. They include pregnancy, sexuality, bisexuality, gender conflicts, race, sexual orientation, obesity, political beliefs and religious practices to name a few of these emotionally loaded topics. When conflict arises between supervisor and supervisee, what are the strategies available to resolve it? A daunting responsibility of the supervisors is to balance the fine line between treating the patient or the supervisee. Vignettes will highlight these boundary issues. When does addressing counter transference, cross the line into treatment with the resident? Finally, the workshop will address the topic of how the supervisor becomes a mentor to the resident and, a less pleasant task, how the supervisor manages the problem resident, either because of unacceptable performance or psychological issues. The workshop will elaborate on a facet of this year's theme: educating mental health professionals through leadership, discovery and collaboration.

WORKSHOP 2
RECOGNITION, DIAGNOSIS AND TREATMENT OF THE WORKPLACE MOBBING VICTIM
Chairperson.: James R. Hillard, M.D., 440 Administration Building, East Lansing, MI 48824

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the process of workplace mobbing and the symptoms that it can elicit; 2) Describe the evaluation and differential diagnosis of patients presenting with workplace related stress; 3) Describe a rational treatment approach for patients with psychiatric symptoms related to workplace mobbing; and 4) Describe ways in which workplaces may be redesigned to minimize occurrence of mobbing behavior and its psychiatric sequel

SUMMARY:
Workplace mobbing is a process by which multiple coworkers engage in a pattern of malicious communication about a given individual and "gang up" to exclude, punish, and humiliate that individual. Often management personnel are also involved. The targeted individual will experience severe psychological stress and will frequently develop severe psychiatric symptoms. The process has been widely recognized in Europe for at least the past decade but has received little attention and been little researched by psychiatrists in North America. The consequence has been frequent failure to recognize the process, often leading inaccurate diagnosis and inappropriate (often countertherapeutic) treatment. This workshop will outline the development of the concept of mobbing, which grew out of the ethological studies of Konrad Lorenz in Austria and the clinical work of Heinz Leymann in Sweden. The similarities and differences between "mobbing", "bullying", "harassment" and other forms of workplace

abuse will be discussed. The characteristics of work environments which are conducive to the development of mobbing will be reviewed, as will the characteristics of individuals who are most likely to become the targets of mobbing. Common clinical presentations of mobbing victims will be discussed, along with a discussion of the differential diagnosis of individuals who present with paranoid, depressive or anxious symptoms. Most individuals who have been the victims of mobbing will be suffering from post traumatic stress disorder and many will have developed major depressive disorders, substance abuse, marital discord, or other syndromes secondary to the stress reactions. The possibility of imaginary mobbing and factitious disorders will also be discussed. Treatment strategies based on careful differential diagnosis will be reviewed, focusing on ways in which standard treatment approaches should be modified in the face of mobbing. Potentially counter therapeutic interventions will be highlighted. Throughout the presentations and, particularly, during the discussion period, audience members will be encouraged to share their experiences and their thoughts about how to improve recognition, diagnosis, treatment and prevention of psychiatric disorders related to mobbing

WORKSHOP 3
PANPACIFIC PERSPECTIVES ON ASIANS/ PACIFIC ISLANDERS, SUBSTANCE ABUSE, AND THEIR TREATMENT

Chairperson.: John W. Tsuang, M.D., 1000 W. Carson St., Box 488, B3 Bldg., Torrance, CA 90509
Presenter(s): ChihKen Chen, M.D., Ph.D., Kazufumi Akiyama, M.D., Ph.D., John Tsuang, M.D., ChiaoChicy Chen, M.D., Ph.D., Christopher Chung, M.D., ShihKu Lin, M.D

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Learn about the rates of substance abuse among Asians/Pacific Islanders in differences countries; 2) Become culturally sensitive towards the diagnosis of addictive disorders among Asians/Pacific Islanders; and 3) Be more informed about the potential barriers facing these substance abusers across the world and ways to overcome these obstructions.

SUMMARY:
Asians/Pacific Islanders are one of the fastest growing ethnic groups in the world. Due to many factors such as cultural differences, stereotypical beliefs, genetic impact and familiar influences, Asians/Pacific Islanders have been perceived to have lower rates of substance use/abuse and less substance related problems as compared to other groups. Recent studies published from the United States as well as from Asia demonstrated that this perception of lower substance abuse by Asians/ Pacific Islanders is not true. This workshop is designed to educate clinicians to issues specifically relating to Asians and substance abuse. In celebration of the APA holding its annual conference 2011 in Hawaii with the theme of "Transforming Mental Health Through Leadership, Discovery, and Collaboration", we have invited six substance abuse experts from Asia and the United States to discuss this relevant issue pertaining to Asians and Pacific Islanders. We will present prevalence data and discuss different types of substances abused by Asians in various areas of the Pan Pacific region. The differences in terms of cultural factors and the current treatment availability in the different regions will be discussed. Finally the role of the government, the use of psychopharmacology agents for substance abuse treatment, the barriers, and the need for collaboration for substance abusing treatment programs in different countries will be addressed.

WORKSHOP 4
APPLICATIONS AND LESSONS LEARNED FROM THE HIV PSYCHIATRY LIAISON EXPERIENCE FOR GENERAL PSYCHIATRIST

Chairperson.: Philip A Bialer, M.D., Memorial Sloan Kettering Cancer Center, 641 Lexington Ave., New York, NY 10022
Presenter(s): Mary Ann Cohen, M.D., Kenn Ashley, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the multiple psychosocial issues faced by patients with HIV/ AIDS; 2) Describe an integrated model of care for patients with HIV/AIDS that addresses the medical and psychosocial problems of these patients; and 3) Demonstrate increased knowledge about how to best manage the psychiatric problems of patients with

HIV/AIDS.

SUMMARY:
Psychiatrists have been involved in the care of patients with HIV/AIDS since the beginning of the AIDS epidemic in the early 1980's. While some of these psychiatrists were seeing these patients in their individual clinical practices, others were developing and following models of integrated care where patients were being psychiatrically evaluated and managed directly onsite at dedicated HIV/AIDS clinics. Working in such an integrated model, HIV/AIDS psychiatrists have developed a particular expertise through close liaison with the patients' medical care providers. Early studies indicated that the prevalence of comorbid psychiatric disorders was higher in the HIV population compared to the general population reinforcing the need for close collaboration among psychiatrists and others involved in the care of patients with HIV/AIDS. In addition, the predilection for HIV to infect the CNS early in the course of the disease has been associated with the development of the neurocognitive disorders, Minor Cognitive Motor Disorder and HIVassociated dementia, which can also lead to referral to psychiatry. These issues and others, such as management of drugdrug interactions in patients with complicated medication regimens, multidisciplinary treatment of patients with a dual and often triple diagnosis of HIV disease, psychiatric disorder, and substance use disorder, and addressing the multicultural issues of this diverse population have led to a unique set of skills for HIV/AIDS Psychiatrists. The workshop presenters will share their experiences of working in an integrated clinic setting and address the collaborative treatment of patients with HIV/AIDS. One presenter will describe the details of an AIDS Psychiatry service based in an HIV clinic. Another presenter will discuss the specifics of potential drugdrug interactions between HIV medications and psychotropics. Finally there will be presentations about working with triple diagnosis patients and the evaluation and management of patients with HIVassociated neurocognitive problems. We will engage the audience to share their own experiences in working with this population by asking for specific examples and case presentations. We will also poll the audience to uncover areas where knowledge and skills may be lacking. The workshop panel will also share tips and pearls learned from the liaison experience and elicit further examples from the audience.

WORKSHOP 5
MAINTENANCE OF CERTIFICATION: LESSONS FROM THE TRENCHES
Chairperson.: Annette M Matthews, M.D., 3710 SW US Veterans Hospital Road, Portland, OR 97237
Presenter(s): Annette Matthews, M.D., Mary Lu, M.D., Melissa Buboltz, M.D., Victor Reus, M.D., Sahana Misra, M.D.

EDUCATIONAL OBJECTIVES:
By the end of this workshop participants should be able to: 1) Outline necessary steps for maintaining board certification (MOC), and understand resources available to complete each; 2) Develop a timeline based on their board certification year for when each step in the MOC process needs to be completed; and 3) Describe how they will organize their continuing medical education credits (CME), Selfassessment, and Performance in Practice (PIP) documentation in case of audit.

SUMMARY:
This workshop will describe the four components of the maintenance of certification (MOC) process in psychiatry: maintaining professional standing, lifelong learning/selfassessment, performance in practice modules, and the cognitive examination. Participants will learn how to develop a timeline for completion of each of these requirements based on their year of initial board certification. They will learn the variety of resources available to complete with the lifelong learning (CME) and selfassessment parts of the maintenance of certification process, and strategies for storing and documenting these activities in case of audit. They will also learn about resources for completing the Performance in Practice (PIP) units and ways that these can be accomplished in different practice settings. Finally one presenter will give tips and tricks from her experience with maintenance of certification. The audience will be provided to share their questions, concerns, and ideas for conducting the MOC process as adapted to their practice setting. Victor Reus, MD, who is the Chair of the American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification Committee, will be available to discuss the content of the presentation, and answer any questions best directed towards the ABPN.

WORKSHOP 6
HELPING PATIENTS WHO DRINK TOO MUCH: USING THE NIAAA CLINICIAN'S GUIDE
U.S. National Institute on Alcohol Abuse & Alcoholism
Chairperson.: Robert B Huebner, Ph.D., 5635 Fishers Ln Room 2049, Rockville, MD 208929304
Presenter(s): Mark Willenbring, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Screen for atrisk and dependent drinking; 2) Diagnose alcohol dependence; 3) Conduct brief motivational counseling for atrisk drinking; and 4) Treat alcohol dependence using pharmacotherapy and behavioral support.

SUMMARY:
Heavy drinking and alcohol dependence are common among psychiatric patients, yet few psychiatrists receive the training necessary to effectively manage them. Although standard practice is to refer patients with severe alcohol dependence to a rehab program, most patients will decline or will not have access, or will relapse after a period of abstinence. Fortunately, most patients who drink too much will respond to relatively brief nonintensive outpatient psychiatric management. In this workshop, participants will be introduced to the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Helping Patients Who Drink Too Much: A Clinician's Guide, an evidencebased guide for nonaddiction specialists. They will develop skills in screening for alcohol problems using a singlequestion, diagnosing and staging alcohol dependence, brief motivational counseling, and treatment of alcohol dependence with medication and brief behavioral support. In addition, chronic care management for patients with severe recurrent dependence will be discussed. Also covered in this workshop will be a new online resource devoted to the Guide and related professional support materials, including downloadable forms, publications, and training resources (www.niaaa.nih.gov/guide). NIAAA has fulfilled requests for many thousands of copies to individual practitioners as well as treatment centers, health maintenance organizations, state and community health programs, medical societies, and schools of medicine, nursing, and social work.

9:00 AM - 10:30AM

WORKSHOP 7
CHILDREN OF PSYCHIATRISTS
CoChairperson(s): Michelle B. Riba, M.D., M.S., 4250 Plymouth Road, Room 1533, Ann Arbor, MI 481092700, Leah J. Dickstein, M.D., M.A.
Presenter(s): Erica Riba,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize and understand how as psychiatristparents, their children think and feel about their psychiatristparents.

SUMMARY:
This annual workshop, which enables children of psychiatrists to share personal anecdotes with the audience of psychiatristparents and parentstobe, 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. The presenters will speak for 15 minutes each about their personal experiences and also offer advice to attendees. There will be a brief introduction by Dr. Dickstein to set the tone for the audience, and she and Dr. Riba will lead the 30minute discussion.

WORKSHOP 8
INTRODUCTION TO THE EVALUATION OF THE PAIN PATIENT:
CoChairperson(s): Manu Mathews, M.D., 9500 Euclid Avenue, Cleveland, OH 44138, Ed C Covington, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the key components in the evaluation of a patient with chronic pain; 2) Identify the diagnosis of common psychiatric disorders associated with the condition; and 3) Describe the basic principles of management introduced in this discussion of the patient with chronic pain.

SUMMARY:
Abstract: Chronic nonmalignant pain is a widespread health concern with a significant impact on the individual, families and society in general. Although

the prevalence of psychiatric co morbidities are common in this population, the access to professionals trained in the management of this can be limited. The prevalence of comorbid addictive disorders complicates the accurate management and diagnosis. A structured clinical interview with the concurrent use of appropriate scales is the most reliable evaluation tool. Accurate identification of not only the primary organic problem, but also the diagnosis of the comorbid major psychiatric illness, addictive disorders, and personality traits of the patient along with the other biopsychosocial factors is key to the formulation of an accurate diagnosis and comprehensive management plan. This workshop highlights the key components of such an evaluation and highlights the points that the physician should pay particular attention to in the evaluation. It also touches on the key components of the neurobiology of pain from the psychiatric perspective and multidisciplinary pain program.

WORKSHOP 9
ELECTRONIC HEALTH RECORDS: TAKING THE PLUNGE

The APA Committee on Electronic Health Records
CoChairperson(s): Robert M Plovnick, M.D., M.S., 1000 Wilson Boulevard Ste 1825, Arlington, VA 22209, Laura J. Fochtmann, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) List common questions and issues faced by small and solo practitioners considering the adoption of Electronic Health Records, e.g., selection, implementation, and use; 2) Improve practices by learning from challenges faced and lessons learned allow solo and small practice psychiatrists who have adopted an Electronic Health Record; and 3) Provide actionable details on the Medicare/Medicaid EHR Incentive program.

SUMMARY:
Electronic Health Records (EHRs) have been touted for their potential to improve documentation and communication to impact quality, but have also raised numerous concerns regarding their cost, complexity, and privacy limitations. Starting in 2011, physicians who treat Medicaid or Medicare patients and demonstrate "meaningful use" of electronic health records will be eligible for significant financial incentives. Starting in 2015, Medicare reimbursement rates will be reduced for physicians who do not meet this requirement. The momentum for the increased use of EHRs in Medicine continues to build. While psychiatrists are increasingly expressing interest in EHRs, for physicians in solo and small practices, the tasks of selecting, implementing, and effectively using an EHR are daunting. This workshop, sponsored by the APA's Committee on Electronic Health Records, will start with an overview of EHRs and the Medicare/ Medicaid EHR Incentive Programs. Next, several psychiatrists in solo and small practice settings who have already adopted EHRs will share highlights of their experiences with the audience, including challenges faced and lessons learned. The workshop will conclude with ample time for attendees to pose questions to members of the Committee as well as the EHR adopters.

WORKSHOP 10
THE TUMULTUOUS MARRIAGE OF PSYCHIATRY & RELIGION AND THE BIRTH OF THE BIOPSYCHOSOCIOSPIRITUAL FORMULATION

APA/SAMHSA Minority Fellows
CoChairperson(s): Amelia K Villagomez, M.D., 950 Campbell Ave, 9th Floor, Psychiatry, Mail Stop: 116A, West Haven, CT 06516, Billina R Shaw, M.D.
Presenter(s): Nicole King, M.D., Crystal Bullard, M.D., Ranjan Avasthi, M.D., Mabel Onwuka, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Analyze the historical interplay between religious and psychiatry; 2) Identify adaptive vs. maladaptive uses of religious views while coping; 3) Perform a spiritual assessment and make a corresponding formulation; and 4) Identify ways to manage and recognize the impact of diverging religious views between patient and clinician.

SUMMARY:
The history of the interplay between religion and psychiatry has been fraught with complexities and conflicts. Freud, an atheist of Jewish heritage, described religion as "an illusion and it derives its strength from the fact that it falls in with our instinctual desires." In the history of religious practice, some professed that psychosis was a result of possession by evil spirits; however progressive

views of the mentally ill were also present in early Christian hospitals, medieval Jewish physicians, and Islamic hospitals of the Middle Ages. Multiple research studies have shown the positive effects of religion in coping; however, for some religion fuels and ignites feelings of guilt, shame, and abandonment. Religion can play a multifaceted role in a patient's life; however, inquiring into a patient's spirituality can at times feel to clinicians as uncomfortable as asking about their sexual lives. This workshop will help clinicians perform a spiritual assessment and create a corresponding formulation as well as examine ways to manage and recognize the impact of diverging religious views between patients and clinicians. Special emphasis will be placed on minority populations. Case studies with roleplay will be used.

WORKSHOP 11
THE NY STATE OMH SHAPEMEDS PROJECT: CREATING AND IMPLEMENTING AN ANTIPSYCHOTIC PRESCRIBING CARE PATHWAY VIA PUBLICACADEMIC PARTNERSHIP

CoChairperson(s): Sharat Parameswaran, M.D., 1051 Riverside Drive, Mailbox 85, New York, NY 10032, Matthew Erlich, M.D. Presenter(s): Lloyd Sederer, M.D., Jeffrey Lieberman, M.D., Gregory Miller, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the reasons for and methods of the development of a statewide antipsychotic medication care pathway; 2) Identify the method being used to assess implementation of a novel statewide antipsychotic medication prescribing project, and 3) Understand the use of a publicacademic partnership in the development and implementation of a statewide antipsychotic medication quality initiative.

SUMMARY:
In 2009, the New York State Office of Mental Health's SHAPEMEDs care pathway was created in recognition of the complexities inherent to the prescribing and monitoring of antipsychotic medications. The intention of SHAPEMEDs is to guide clinicians in considering a set of essential aspects of quality mental health care, rather than obliging prescribers what to do or not do. SHAPEMEDs is an acronym created to address eight pertinent issues intrinsic to antipsychotic prescribing: Side effects, health concerns in the recipient population, adherence, patient preference, expense, effectiveness, and use of the minimum effective dose of medication. SHAPEMEDs is the culmination of a twoyear project by a workgroup comprised of faculty of the Columbia University Department of Psychiatry and leadership from the New York State Office of Mental Health. Drawing from prior conferences and guidelines about antipsychotic prescribing, the workgroup created a product which includes a querybased clinical care pathway, a checklist of realistic clinical monitoring issues, and a comprehensive guide to prescribing considerations, side effects and cost. The process of implementing SHAPEMEDs in the OMH system has commenced initially as a pilot demonstration project. This includes a preassessment and postassessment process to provide a systematic analysis and understanding of contributing factors, hindrances, and sitespecific targets for implementation strategies involved in the highfidelity uptake of this novel program, as well as to evaluate the potential effectiveness of SHAPEMEDs in improving antipsychotic prescribing. This APA workshop seeks to present the SHAPEMEDs project in order to stimulate discussion regarding the development of evidencebased public mental health prescribing initiatives, the implementation of novel statewide programs, and the use of publicacademic partnerships to improve antipsychotic medication prescribing in public psychiatric settings.

WORKSHOP 12
MOOD AND MENOPAUSE: A CLOSER LOOK INTO DIAGNOSTIC AND TREATMENT PERSPECTIVES

Chairperson.: Claudio N Soares, M.D., Ph.D., 208 Queens Quay W, Toronto, M5J 2Y5 Canada, Presenter(s): Benicio Frey, M.D., Ph.D., Joyce Bromberger, Ph.D., Pauline Maki, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the multiple contributing factors to heightened risk for depression in women during midlife; 2) Evaluate menopause/mood symptoms among ethnically diverse, economically disadvantaged women; 3)

Apply evidencebased, tailored treatment strategies for mood and menopauserelated symptoms; and 4) Understand how the crosstalk between sex hormones and neural circuits may translate to new treatment options in midlife women

SUMMARY:
A growing body of evidence suggests that, for some women, the menopausal transition may represent a period of vulnerability for developing somatic symptoms and increased risk for experiencing symptoms of depression or developing new/ recurrent major depressive episodes. Recent research has shed some light on potential mechanisms and broadened our knowledge of the many risk factors that influence this vulnerability. In addition, a number of clinical trials conducted over the past decade have provided data regarding efficacy and safety of various treatment interventions, some of which has caused a shift in the current thinking of how menopausal symptoms and mood symptoms should be appropriately managed. Clinicians who care for midlife women still face a tremendous challenge in sorting out this information and can certainly benefit from a better understanding of the interplay between menopause and mood. The ultimate goal is to translate the current knowledge and evidence from various sources into appropriate strategies for recognizing and managing menopausal and mood symptoms. The main objective of this workshop is to review the stateoftheart concepts and knowledge related to mood symptoms, depression, and menopause, including both diagnostic and treatment perspectives. The discussion will include an overview of what is known about risk factors for depressive symptoms/depression during midlife and the risk posed by the transition, its associated symptoms, and alterations in the reproductive hormonal milieu; a review of findings from a recent study of risk factors for depressive symptoms among economically disadvantaged women; and a critical overview of what has been learned over the past decade about efficacy and safety of various treatment strategies for symptomatic perimenopausal and postmenopausal women. Lastly, we will present preclinical and clinical evidence related to the hormonal dynamics and neurobiological aspects of depression during the menopausal transition and discuss how the crosstalk between sex hormones and neural circuits may contribute to the development of new treatment strategies for this population at risk. Audience polling questions will be used during the workshop to engage the audience in various aspects of the didactic presentations. This direct audience feedback will help to define the focus of the Question and Answer/ Faculty Discussion periods, ensuring that essential topics are further explored.

11:00 AM - 12:30 PM
WORKSHOP 13
EMERGENCY PSYCHIATRY: A GLOBAL PERSPECTIVE
American Association for Emergency Psychiatry CoChairperson(s): Rachel L Glick, M.D., 1663 Snowberry Ridge Road, Ann Arbor, MI 48103, Julien JC de Carvalho, M.D. Presenter(s): Mitsuru Suzuki, M.D., Ph.D., Andres Rousseaux, M.D., Yutaka Sawa, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the approach to handling psychiatric emergencies in 3 or more different countries;2) Discuss differences and similarities to managing the agitated patient in different countries; and 3) Analyze the differences and similarities in involuntary treatment laws around the globe.

SUMMARY:
We live and work in a global environment. Information sharing across continents is instantaneous. We should be using this fact to learn from others, as sharing theories, thoughts and best practices can improve care for all of our patients. To begin a dialogue on emergency psychiatry around the world, the American Association for Emergency Psychiatry (AAEP) is sponsoring this symposium. Psychiatrists from Europe, North America, South America and Asia will briefly outline the current state of psychiatric emergency care in their home country, and describe the psychiatric emergency service in which they work. They have been asked to include their approach to dealing with agitated patients. They have also been asked to share their thoughts about involuntary treatment and how and when this should occur, including the legal framework for such treatment in their country. In addition, they are asked to summarize any research initiatives in emergency psychiatry. After these presentations, there will be ample time for discussion and interchange to begin the dialogue that we hope will continue after the annual meeting.

WORKSHOP 14
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES
CoChairperson(s): Larry R Faulkner, M.D., 2150 E Lake Cook Road, #900, Buffalo Grove, IL 60089, Victor I Reus, M.D.

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 the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as in the interdisciplinary 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 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 content and format of the new certification examination in general psychiatry will be presented. The content of the extant Part I (computeradministered 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.

WORKSHOP 15
PROMISES AND PROBLEMS IN COMPENSATION AND PENSION EXAMINATIONS FOR VETERANS
Chairperson.: Jagannathan Srinivasaraghavan, M.D., Southern Illinois University School of Medicine, Choate Mental Health Center, 1000 N. Main Street, Anna, IL 62906 Presenter(s): Antony Fernandez, M.D., Rudra Prakash, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the challenges in the compensation and pension examination of veterans; and 2) Relationship between post traumatic stress disorder and traumatic brain injury and the appropriate use of testing and templates.

SUMMARY:
The Veterans Health Administration (VHA) is the largest integrated health system in the United States. The system mainly provides clinical care for eligible veterans and along with the multiple hospitals and community based outpatient clinics (CBOC) facilitate the education of trainees. In addition, the VHA is tasked with compensation and pension examinations of veterans seeking benefit for physical as well as psychiatric problems by the Veterans Benefit Administration (VBA). The wars in Iraq (Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom) have resulted in repeated deployment of same troops of long duration each time, increasing the stress levels of soldiers. Improved protective gear has decreased mortality but increased morbidity of our troops. The claims for Post Traumatic Stress Disorder and Traumatic Brain Injury have increased significantly. The July 2010 decision reduced the evidence needed if the PTSD stressor claimed by a Veteran is related to fear of hostile military or terrorist activity and is consistent with the places, types, and circumstances of the Veteran's service. This new standard has further added to the numbers seeking compensation. The veterans advocacy groups were pleased but many hospitals are struggling to adequately address the timely examinations of the veterans, given the complexity due to concussions, alcohol and substance use and mood disorders. The experienced presenters will discuss the process of examinations, evolving knowledge of traumatic brain injury and mental disorders, appropriate use of psychological tests and templates on the computer and the importance of unambiguous reports that can help the raters, who are generally neither mental health nor legal professionals.

WORKSHOP 16
CARING FOR THE CAREGIVER: THE "HIDDEN" PATIENT
Chairperson.: Amita R. Patel, M.D., 1435 Haven Hill

Drive, Dayton, OH 45459
Presenter(s): Sanjay Vaswani, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the damaging effects on family caregivers of the burden of caring for a disabled elderly family member; 2) Identify those family caregivers excessively burdened by their responsibilities and at risk for burnout; 3) Implement a variety of preventative strategies to those at risk for burnout; and 4) Provide counseling resources for overburdened family caregivers.

SUMMARY:
Providing care for disabled older adults often erodes the physical and psychological health of the caregiver, and as the elderly population grows, the pressure on both family and professional caregivers will undoubtedly grow as well. Most often elderly persons with dementia are cared for by family members in their own homes, and this role is linked to damaging changes in the caregivers' psychosocial and psychological status, as well as physical health. Research has shown that caregivers to persons with dementia rarely utilize social support/services. It is important to recognize and assess those at risk for caregiver burnout, and provide these caregivers with the strategies and tools needed to deal with the stresses of caring for a disabled elderly family member and prevent excessive burden and eventual burnout. Burnout syndrome is characterized by emotional exhaustion, decreased personal satisfaction, increased marital problems, substance use, depression and anxiety, among other difficulties. Psychiatrists have a unique understanding of biological, psychological, social, and spiritual factors that affect caregivers and therefore can play a leading role in educating to prevent debilitating consequences. The same concerns for family caregivers must be given to professional healthcare workers and caregivers. An increased elderly population coupled with the high turnover rate of professional caregivers means that more pressure will be placed on those caregivers remaining in the field, and consequently, they are also at a greater risk for burnout. Several forms of interventions for dementia caregivers have been suggested such as practical assistance, education, emotional support provision, and multicomponent interventions. By understanding the reasons behind the high turnover rate of professional caregivers and providing them with strategies and a support network for dealing with the stresses of caring for elderly disabled patients however, it is possible to decrease both the overall burden that professional caregivers feel and their risk of burnout. In this seminar we will review the literature on caregiver burnout and discuss a case study in one of our nursing homes to look at caregiver burnout in skilled patient care recently transferred from a hospital. We will review the literature on caregiver burnout and discuss a few case studies. We will also discuss group therapy intervention for staff in one of our nursing homes to prevent caregiver burnout.

WORKSHOP 17
PRESURGICAL PSYCHIATRIC EVALUATION OF PATIENTS SEEKING BARIATRIC SURGERY

Chairperson.: Zubeida Z Mahomedy, M.D., M.Med., PO Box 11932, Erasmuskloof, 0048 South Africa,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Successfully evaluate patients seeking Bariatric surgery; and 2) Make informed decisions regarding inclusion or exclusion or need to delay surgery.

SUMMARY:
Obesity has been identified as an International problem reaching epidemic proportions. It is linked to significant morbidity and excess mortality. Weight loss programs based on diet, medication and exercise have demonstrated modest success in sustained weight loss reduction. A NIH consensus panel in the USA recommended Bariatric Surgery or well informed, motivated obese patients. In South Africa the obesity epidemic has begun and Bariatric Surgery has also proliferated with numerous centres of excellence. A presurgical psychiatric evaluation has been advocated as part of a multidisciplinary approach to Bariatric Surgery. Research documents high rates of psychiatric disorders among candidates for surgery. A recent study found that 66% of candidates had a lifetime history of at least one Axis I diagnosis and 38% met the criteria for a current Axis I diagnosis. Mood (15.6%), anxiety (24%) and binge eating (16.3%) disorders were the most common. This evaluation seeks to determine the patient's capacity to understand the risks and benefits

of surgery and to appreciate the consequences of surgery. Given the comorbidity of psychiatric illness in the obese, the evaluation also screens for psychopathology with special attention being paid to disorders of eating behaviour.

WORKSHOP 18
POLYPHARMACY IN SCHIZOPHRENIA: TO BE OR NOT TO BE!
CoChairperson(s): Durga Bestha, M.B.B.S, 9222 Burt Street 118, Omaha, NE 68114, Vishal Madaan, M.D.
Presenter(s): Jayakrishna Madabushi, M.B.B.S, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the limitations of currently available empirical and research evidence base for polypharmacy in schizophrenia, which will facilitate judicious prescribing of medications; and 2) Identify various clinical presentations in schizophrenia which might warrant the use of multiple medications.

SUMMARY:
Despite the emergence of numerous antipsychotic medications over the last two decades, treatment of positive, negative and cognitive symptoms of schizophrenia continues to pose a challenge for the clinician. In a significant proportion of patients with schizophrenia, positive symptoms show a partial or limited response and are resistant to treatment. Furthermore, there is a dearth of pharmacological agents which can help with negative and cognitive symptoms. To enhance treatment response and improve the rehabilitation potential and longterm prognosis, clinicians are often forced to use a combination of antipsychotics or augment them with other psychotropic agents. In a majority of cases, this is based on either clinician's preference or empirical evidence given the limited literature on polypharmacy in schizophrenia. In the first part of this interactive workshop, the speakers will explore various clinical presentations in schizophrenia which are most often associated with polypharmacy such as presence of significant comorbid mood or obsessivecompulsive symptoms, treatment resistance with clozapine, and the extremely important but frequently neglected negative symptoms and cognitive deficits. This will be followed by a review of the literature on combination treatment with two different antipsychotics which will segue into a discussion of strategies to manage treatment resistant schizophrenia. The final part of the workshop will involve a discussion of adjunctive use of mood stabilizers, antidepressants and other novel agents with antipsychotics in the treatment of schizophrenia. Throughout the workshop, there will be a focus on the potential for cumulative toxicity with polypharmacy and also safeguards that can be implemented to monitor and minimize adverse events.

1:00 PM - 2:30PM

WORKSHOP 19
THE KAONA OF HULA
Chairperson.: Nanette H Orman, M.D., M.D., 700 Mill Street, Suite 6, Half Moon Bay, CA 94019

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize that the surface layer of each individual patient and each cultural group is merely the most obvious layer of several which underlie and sustain that surface; 2) Perceive via a historical dance illustration of the evolution of hula in Hawai'i, how the deeper layers of a person's or a culture's identity are partly hidden by the more superficial layers; and 3) Recognize more clearly their own biases.

SUMMARY:
On the surface, hulathe Hawaiian performed art which embodies the identity, history and values of Hawai'imay appear to be simply a pretty or sensual dance. Many a visitor to these islands thinks he or she has watched an understood hula. However, this is seldom actually the case. The hotel and lu'au hula shows in Hawai'i often are misunderstoodtaken as cute entertainment in much the same way the first European visitors to these islands misunderstood what they saw before trying to suppress it as primitive and heathenish. This workshop will depict, with performed hula and accompanying lecture and music, the authentic, multilayered meanings of hula, clarifying its structure and cultural essence. The presenter, Nanette Kilohana Kaihawanawana Orman, MD, has performed hula since 1957 and has practiced psychiatry since 1988. Each of 4 hulas will be introduced by the presenter with specific psychological details and historic background, details of the meanings of the

poetic words which hula depicts in pantomime, and information about the composer, his time in the history of Hawai'i, and the musicians whose recordings are used for the presentation. If possible, local musicians from the entertainment community will be present to provide the music accompaniment. Each hula will represent an everdeeper layer of both the hidden meaning of hula and a deeper layer of the human psyche. Handouts with translations and an extensive bibliography will be provided. Clarification of the presentation will occur during the halfhour interaction with the attendees. This presentation will confirm and deepen for practitioners the awareness that the surface of each patient and each cultural group is merely the most obvious layer of many which underlie and sustain that surface. The program will also help to explain the world view of Hawaiians and other Polynesians, and will remind the watchers that each human mind is a complex, interwoven system of thinking which must be considered in each patient's care.

WORKSHOP 20
STRESS MANAGEMENT FOR RESILIENT WOMEN IN PSYCHIATRY:IN TRIBUTE TO TANA GRADY-WELIKY, M.D.

Association of Women Psychiatrists
Chairperson.: Mary Kay Smith, M.D., 3000 Arlington Ave., MS 1193 (RHC, Rm. 0004), Toledo, OH 43614
Presenter(s): Eva Szigethy, M.D., Ph.D., Toi Harris, B.A., M.D., Patricia Ordorica, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify at least two risk factors for burnout among physicians and physiciansintraining; 2) List at two consequences of burnout in physicians; 3) Identify at least two strategies to reduce development of burnout and enhance resilience; and 4) List at least two techniques to promote resilience and reduce burnout in physicians.

SUMMARY:
Burnout is a syndrome characterized by depersonalization, emotional exhaustion, and a sense of low personal accomplishment that leads to decreased effectiveness at work. This phenomenon has been increasingly recognized among medical students, residents and physiciansinpractice and has been shown to negatively impact career satisfaction and patient safety. Medical students are at risk for burnout during the course of their medical education. Burnout may influence special choice and impact the affected individual's perception of worklife balance. Up to 76% of residents have been shown to meet criteria for burnout and those respondents believe they provided suboptimal patient care. The rates of burnout among physicians in practice range from 2560% with 3747% of academic faculty, and 5567% of private practice physicians meeting established criteria for burnout. Increased stress and burnout also lead to health consequences including chronic headaches, hypertension, depression and anxiety. The data regarding the negative impact of burnout are alarming and sound a clear bell for the need for effective interventions to promote resilience and wellness among physicians and physiciansintraining. Krasner and colleagues described an intervention in which the indicators of stress and burnout were reduced following physician completion of a mindfulness based stress reduction program. The goals of this workshop are to address burnout among physicians and discuss and demonstrate methods to reduce burnout and promote resilience and wellness.

WORKSHOP 22
MULTIPLE PERSPECTIVES ON OVERCOMING CHALLENGES TO CBT TRAINING FOR PSYCHIATRY RESIDENTS

CoChairperson(s): Vicki Gluhoski, Ph.D., Fierman Hall, 9th floor, 317 E. 17th Street, New York, NY 10003, Hulya M Erhan, Ph.D.
Presenter(s): Anne Buchanan, D.O., David Roane, M.D., Donna Sudak, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the challenges involved in teaching residents to be adherent and competent at cognitive therapy; 2) Apply learned strategies to help residents overcome the technical and attitudinal barriers to good cognitive therapy practice; and 3) Discuss how to develop a robust cognitive therapy training program that fits into a comprehensive approach to psychotherapy education in psychiatry residency training.

SUMMARY:
Challenges to adherence to the cognitive therapy (CT) model emerge at various points

in training psychiatry residents. Difficulties in case conceptualization, setting and adhering to agendas, completing thought records, assigning and following up on CT homework and seeking client feedback are some of the challenges identified when resident videotapes are reviewed and rated. Therapist factors that can interfere with CT adherence may include: drift into therapy models that are taught concurrently, reluctance to learn a new model in the context of competing clinical demands, a sense of unfamiliarity with and lack of mastery of the CT model, difficulty in negotiating patient non compliance to CT methods, and insufficient number of CT cases during training. We will discuss a training model that addresses these challenges. This model, developed through a grant supported program at Beth Israel Medical Center (BIMC), teaches psychiatry residents to apply CT for the treatment of mood, anxiety, and personality disorders. Training consists of a didactic course addressing basic concepts of the CT model, manualized treatment for different psychiatric conditions, and use of diverse CT tools. Supervision is provided in a group format by clinicians trained in CT. These issues of teaching CT and developing resident compliance and competence will be addressed from multiple perspectives and by faculty from two institutions. CT supervisors will discuss how CT training is delineated from training in other psychotherapy models, such as psychodynamic psychotherapy. They will show how the process of internalizing the basic concepts of CT can occur and how both resident and patient resistance to CT can be overcome. A senior resident will describe how she began to master CT. Tapes of two of her sessions will demonstrate how supervision can address problems encountered by the beginning CT therapist. The program director from BIMC will focus on the tremendous training opportunity afforded by a program that utilizes group supervision, videotaping, and a combination of scales that rate both CT adherence and CT competency. In addition, the director of psychotherapy training from Drexel University will discuss other approaches for managing these challenges and will describe and problem solve how residencies can develop CT programs that fit into their own training philosophies.

WORKSHOP 23
ALL IN THE GAY FAMILYLESBIAN AND GAY FAMILIES: PAST, PRESENT, AND FUTURE

Chairperson.: Kenneth Ashley, M.D., 317 E 17 St Ste 1F35, New York, NY 10003
Presenter(s): Littal Melnik, M.D., Daniel Medeiros, M.D., Eric Yarbrough, M.D., Shelly Cohen, M.D., J.D., Lorraine Lothringer, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify legal status and psychosocial issues associated with samesex marriage/civil unions and adoption by lesbian and gay people; 2) Understand the psychosocial issues of children raised in lesbian and gay households; 3) Demonstrate increased knowledge about treatment of lesbian and gay couples in therapy; and 4) Appreciate the role of psychiatrists as advocates.

SUMMARY:
Lesbian and gayparented families have been present for many years. As they are becoming increasingly visible the issues around these families have become part of the daily discourse in our lives, including both the mental health field and the political sphere. The issues of marriage equality and adoption have become flash points in the current culture wars. Mental health professionals are addressing the issues of lesbian and gayparented families in treatment, as the numbers of such families in the population become more evident. This workshop will present an overview of the legal status of samesex marriage/unions. The significant mental health implications of marriage for lesbians and gay men as supported by several lines of research will be discussed. Marriage itself confers a variety of material and symbolic benefits that provide psychosocial resources to couples and their dependents; these resources, in turn, enhance mental health. The mental health impact of marital rights denial, which can be understood in light of research linking sexual orientation stigmatization and discrimination to increased psychological distress, will also be discussed. There will be a presentation of the legal status on adoption and parenting rights of lesbian and gay people, followed by a discussion of the mental health impact of such legislation on the parents and the children. The research is showing that children raised in lesbian and gayparented families have similar gender, emotional, and social development. Data will be presented from the results

of the recent empirical studies addressing these findings. Finally, there will be a presentation on issues the clinician should be aware of when working in therapy with lesbian and gay couples. During the discussion, in addition to answering questions about the presentation, we will collaborate with the audience to uncover areas where knowledge may be lacking and develop ideas for future research. The workshop panel will also discuss the role mental health professionals and their organizations may take as advocates for the mental health of lesbian and gay families, including the use of examples of the position statements of APA and other professional organizations on civil marriage and parenting and adoption rights of samesex couples.

WORKSHOP 24
PSYCHIATRIC SYMPTOMS IN PATIENTS WITH PARKINSON'S DISEASE

Chairperson(s): Mateusz Zurowski, M.D., M.S., 399 Bathurst St., Toronto, M5T2S8Canada,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify treatment options and their ramifications in patients with Parkinson's Disease; 2) Recognize the common presentations of psychopathology in patients with PD; and 3) Demonstrate awareness of risk factors for Impulse Control Disorders in patients with PD.

SUMMARY:
Parkinson's Disease occurs in 1% of the population over 60 years old and increases in incidence with age. It is a progressive neurological disorder characterized by bradykinesia, rigidity, rest tremor, and impaired balance. The societal burden of PD has been shown to include increased costs of drugs and heath care utilization, as well as longer and more frequent hospital admissions compared to agematched controls. Symptoms of PD are predominantly due to degeneration of the dopaminergic neurons within the midbrain. Effective treatments exist for the motor symptoms of PD based on dopamine replacement, either as the dopamineprecursor, levodopa or with directly acting dopamine receptor agonists. It is now well recognized that aside from motor symptoms, patients with PD also frequently present with neuropsychiatric symptoms. The most common are depression, anxiety and sleep disorders. The younger population is at increased risk of developing impulse control disorders (ICDs) while the older cohort is generally more prone to dementia and psychosis. At all stages of the disease process, neuropsychiatric symptoms have a significant impact on patients' quality of life and are now the leading cause of morbidity in PD. Psychotic symptoms in particular are the main reason for admission to nursing home facilities and one of the leading causes of caregiver burden. The appropriate recognition and treatment of psychiatric disorders in patients with PD requires an understanding of PD and its treatments and how they relate to patient presentation. This is perhaps best exemplified in psychosis that can be caused or exacerbated by all parkinsonian medications and therefore current treatment options for psychosis in PD are to reduce the dose of antiparkinsonian medication; however, this frequently results in the worsening of motor symptoms. This dilemma of appropriate treatment is also present in the treatment of other neuropsychiatric symptoms. This workshop will provide a forum for the discussion of the relative merits of various interventions on patient motor and neuropsychiatric wellbeing. To increase the interactive component of the session we will use case vignettes to illustrate clinical points and ask the audience to use remote clickers in answering multiple choice questions posed following each vignette. The use of these clickers will allow us to immediately view answers during the presentation and foster audience participation and engagement.

WORKSHOP 25
TRANSLATING EXPERT OPINION INTO STRONG RECOMMENDATIONS: NEW APA PRACTICE GUIDELINES ON PSYCHIATRIC MANAGEMENT

APA Steering Committee on Practice Guidelines
Chairperson.: Joel Yager, M.D., 13001 E 17th Pl, A01104, Denver, CO 80045
Presenter(s): Laura Fochtmann, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) understand the difference between strength of evidence and strength of recommendation in the context of a clinical practice guideline; 2) appreciate challenges of determining what is "expert opinion" or "expert consensus"; and 3) describe ongoing therapeutic activities ("psychiatric management") that experts agree

psychiatrists should do but which are difficult to support with evidence from clinical trials.

SUMMARY:
New APA guidelines on psychiatric evaluation and management are being developed using an innovative process intended to meet new standards from the Institute of Medicine for "trustworthiness." In this workshop, speakers will describe the new process, which includes a systematic evidence review, blind nomination of expert panels, a formal survey to assess expert opinion, and a formal method for grading strength of recommendation. Attendees will complete a sample survey about interventions related to psychiatric management, and their responses will be compared with responses from "experts." Speakers will then lead attendees in a discussion about how guideline recommendations (or "suggestions") about the interventions might be worded and rated either "strong" or "weak."

WORKSHOP 26
COLLABORATING WITH PRIMARY CARE IN THE DISASTER SETTING: CLINICAL ISSUES FOR PSYCHIATRISTS

CoChairperson(s): Catherine S May, M.D., 2000 P St NW Ste 601, Washington, DC 20036, Elspeth C Ritchie, M.D., M.P.H.
Presenter(s): David Benedek, M.D., Brooke Parish, M.D., Lorna Mayo, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the completion of this session, the participant will be able to: 1) Understand how collaboration with Primary Care colleagues in the pre and post disaster period increases access to psychiatric care; 2) Identify the most common medical conditions in post disaster patient populations; 3) Demonstrate awareness of best medical practices in diagnosing and treating these conditions; and 4) Be encouraged to volunteer their services in the disaster setting.

SUMMARY:
Historically, psychiatrists providing services in the disaster setting were often assigned to Mental Health Teams which functioned separately from Medical Response Teams. Physical and administrative separation often meant patients presenting with medical complaints in the post disaster setting did not have immediate access to psychiatric care. Unfortunately, lack of collaboration with primary care has meant that mental health is only consulted after a disaster and psychiatric services are often seen as a priority. In the wake of each new disaster faced by the global population, there is a growing awareness of the need for immediate mental health services and the need to involve psychiatry in predisaster planning. Psychiatrists are increasingly deployed as part of an integrated disaster response team and work closely along side medical colleagues to provide care to patients with medical and psychiatric comorbidities. It is crucial that integrated response teams are able to adapt to the particular needs of a given population. When need is great, psychiatrists may even be called upon to deliver direct medical care. In order to function effectively in an integrated setting, it is essential that psychiatrists are familiar with the most common medical issues in disaster settings such as basic would care, musculoskeletal injuries, common infections, pulmonary and gastrointestinal illnesses. This workshop will provide psychiatrists with an overview of the diagnosis and treatment of these conditions and encourage discussion of how the successful collaboration of psychiatry and primary care in the pre and post disaster setting can improve access to psychiatric services. This workshop will provide the opportunity for the audience to contribute observations and experience.

WORKSHOP 27
TREATMENT CHALLENGES IN SCHIZOPHRENIA WITH COMORBID CONDITIONS: TAILORED MANAGEMENT

CoChairperson(s): Michael Y Hwang, M.D., B.S., F.D.R VAMC, 2094 Albany Post Rd., Montrose, NY 10548, Henry A Nasrallah, M.D.
Presenter(s): Michael Hwang, M.D., B.S., Alec Roy, M.D., Sun Young Yum, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to recognize, diagnose, and manage common and clinically challenging comorbid conditions in schizophrenia.

SUMMARY:
Schizophrenic illness present with diverse clinical phenomena with varied psychopathological pathogenesis and treatment response. This heterogeneity is due to the diverse nature of biological and psychosocial pathogenesis in

schizophrenia. In spite of recent increase in the clinician awareness and treatment options, the schizophrenic patients with comorbid conditions continue to challenging the practicing clinicians. The emerging clinical and research evidence suggest varied comorbid psychiatric conditions may constitute a schizophrenic subtype with a distinct psychobiological pathogenesis. Consequently the new DSMV emphasize recognition and management of the specific coexisting conditions in patients with schizophrenia. The current clinical and research evidence show that the comorbid conditions such as affective, obsessivecompulsive, and impulsiveaggressive disorders are prevalent and warrant specific pharmacological and behavioral intervention for optimal outcome. This workshop will review the recent clinical and research findings and discuss their pathogenesis and suggest individualized treatment intervention for optimal outcome. Dr. Hwang will examine the current epidemiological, clinical and biological evidence for comorbid mood disorders in schizophrenia and discuss the pathogenesis, subtyping strategy, and clinical management bases on currently available evidence. Specifically he will discuss psychobiologically based subtyping strategy and optimal treatment approaches based on the pathogenesis. Dr. Yum will discuss the complex biopsychosocial perspective of abnormal eating behaviors in schizophrenia. She will review the behavioral effects of biopsychosocial factors in pathogenesis of obesity and metabolic disorders in schizophrenia and discuss the optimal individualized pharmacobehavioral treatment. Dr. Alec Roy will review the psychobiological pathogenesis of impulsive aggressive behaviors and suicide in patients with schizophrenia. He will discuss diverse nature and the implications of underlying causes and discuss the pharmacobehavioral treatment intervention in high risk schizophrenic patient subgroup. Finally, Dr. Henry Nasrallah will review current evidence of biopsychosocial pathogenesis of clinically challenging and common comorbid conditions in schizophrenia and discuss their optimal management.

WORKSHOP 28
MOVEMENT DISORDERS IN PSYCHIATRY: A VIDEO WORKSHOP

CoChairperson(s): Peter N. Van Harten, M.D., Ph.D., Utrechtseweg 266, Amersfoort, 3818 EW Netherlands

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize and differentiate the most common movement disorders in psychiatry; 2) Treat or prevent the most common movement disorders in psychiatry; and 3) Examine a patient on movement disorders.

SUMMARY:
Movement disorders can cause severe distress to patients. They are very common in psychiatry and can interfere with social functioning and activities of daily living and may result in a reduced quality of life. If movement disorders are related to medication, patients may become noncompliant increasing the risk of a relapse. Several studies show that many psychiatrists are insufficiently skilled in recognition and differentiation of movement disorders. Missing the diagnosis or misclassification may cause needlessly suffering of the patient all the more because many movement disorders can be treated effectively. Movement disorders in psychiatry can be divided in four categories: (i) those related to an underlying neurological or other somatic disease, (ii) related to a psychiatric syndrome, (iii) drug induced and (iv) psychogenic. On video, movement disorders of each category will be demonstrated such as essential tremor and Parkinson's disease, catatonia and stereotypes, acute dystonia, akathisia, parkinsonism, and tardive dyskinesia (dystonia) and psychogenic dystonia and psychogenic tremor. The participants will be asked to differentiate and clarify the typical clinical aspects of each of these movement disorders. The treatment of acute drug induced movement disorders (acute dystonia, akathisia, parkinsonism and myoclonus) will be discussed. Tardive movement disorders such as tardive dyskinesia and tardive dystonia start months or years after using dopamine receptor blocking agents and treatment is often disappointing. Therefore strategies to prevent these side effects are essential and will be discussed. To reveal these movement disorders, a systematic investigation of the patient is required. In this workshop participants will learn and practice a highly sensitive examination that takes less than 5 minutes and will reveal all drug induced movement disorders. It is of clinical value to add such an investigation to standard screening procedures. Firstly, because patients with movement disorders do not always complain about

their 'troubles with muscles' spontaneously, and sometimes, often out of shame, they try to hide their involuntary movements. Secondly, movement disorders can be misclassified as a psychiatric symptom, e.g. parkinsonism can be misclassified as depression and akathisia as agitation, which hinder an appropriate treatment.

SUNDAY, MAY 15, 2011
7:00 AM - 8:30AM

WORKSHOP 29
UNCONSCIOUS PROJECTIONS: THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson.: Steven E Pflanz, M.D., 68A Fort Warren Ave, Cheyenne, WY 82001

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the impact of the portrayal of psychiatry in film on the public perception of psychopathology and the profession of psychiatry; and 2) Be able to critically analyze films containing psychiatric content.

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 any art form, movies can be seen as literal projections of the unconscious minds of their Hollywood creators and screen writers regularly use psychiatry as a thematic device. 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 farreaching 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, such as A Beautiful Mind, 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.

WORKSHOP 30
PSYCHOTHERAPY UPDATE FOR THE PRACTICING PSYCHIATRIST

Chairperson.: Priyanthy Weerasekera, M.D., M.Ed., McMaster University, St. Joseph's Hospital,301 James Street South, Fontbonne 415,Hamilton, Ontario, L8P 3B6Canada,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Prescribe the appropriate evidencebased psychotherapy for a patient with a specific psychiatric disorders; 2) Obtain resources to stay up to date with the empirical psychotherapy literature and maintain an ongoing knowledge base in the area; and 3) Identify unique patient variables that predict differential outcome to treatment.

SUMMARY:
The last few decades have witnessed significant advances in psychotherapy research. This research has demonstrated that there are evidencebased psychotherapies for patients with psychiatric disorders, that the therapeutic alliance is a key variable in outcome, and that individual variables help tailor treatments to patients. Of the evidencebased therapies studied to date, cognitivebehavioral, interpersonal, psychodynamic, emotionfocused, dialectical behavioral, motivational interviewing, couple, family, group, and other therapies target specific psychiatric disorders or problems that commonly accompany these conditions. Level 1 evidence (that is metaanalyses or doubleblind controlled trials) exists for most of these therapies across a variety of conditions. The therapeutic alliance has also been found to predict outcome early in treatment independent of therapy type, and is related to therapist skill and attributes, and to patient variables. Individual variables such as attachment styles and personality traits have also been shown to differentially predict response to treatment, indicating that not all patients with the same disorder respond similarly to the same psychotherapy. The purpose of this workshop is to

provide a psychotherapy update for the practicing psychiatrist, who is not familiar with the extensive literature in this area. By reviewing this literature the clinician will become familiar with the current indications and contraindications of the various psychotherapies for patients with psychiatric disorders. How research informs practice will also be closely examined with clinical case examples. References will be provided as well as resources to assist the clinician to keep up with this challenging and exciting area.

WORKSHOP 31
NEUROETHICAL DIALOGUES: CONSCIOUSNESS, RESPONSIBILITY, AND FREE WILL IN THE AGE OF BRAIN IMAGING.

CoChairperson(s): Carl Erik Fisher, M.D., 1051 Riverside Dr, Unit 103, New York State Psychiatric Institute, New York, NY 10032, Paul S Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe and discuss recent examples of neuroscience findings that inform questions in psychiatric ethics; 2) Impact the legal system, and 3) Challenge public understandings of the mind.

SUMMARY:
Recent developments in neuroscience and psychiatry may have profound ethical, legal, and social implications. Examples include: 1) Functional brain imaging for lie detection In May 2010, a Brooklyn court heard arguments about the admissibility of fMRI evidence intended to establish the truthfulness of a psychiatrist charged with Medicare and Medicaid fraud; 2) Obesity and nosology The eating disorders literature is debating whether obesity should be a formal diagnosis in DSMV, though evidence about the neural systems underlying obesity suggest a highly heterogeneous condition, with important implications for disease classification, and more broadly, for questions of behavioral determinism and free will; 3) Neuroimaging investigations of consciousness at the end of life Recent studies suggest that patients who are diagnosed with vegetative states may retain more awareness than may be apparent from their clinical assessments. These findings have relevance to the varied behavioral definitions of consciousness found in endoflife statutes, as well as to folk psychological concepts of brain death and consciousness; 4) Moral psychology research and criminal responsibility Evidence from studies of how moral decisions are made, including fMRI data, are being used to argue for a reconceptualization of responsibility for crime and a reorientation of the legal system away from punishment. This workshop will lead participants in an interactive discussion of a selection of these issues, beginning with a brief summary of the recent research. Structured exercises will be used to help participants clarify their positions on these issues. Time will be divided equally between topic presentations and discussion periods, and the session will end with openended discussion about the overall ramifications of these topics.

WORKSHOP 32
ADDRESSING SUBSTANCE USE AND MENTAL HEALTH ISSUES IN RETURNING IRAQ AND AFGHANISTAN VETERANS: CHALLENGES, STIGMAS, AND EFFECTIVE APPROACHES

CoChairperson(s): Michael M Scimeca, M.D., 200 W 90th St 11H, New York, NY 10024, Felicity L Laboy, Ph.D.
Presenter(s): Eddie Marcano, M.P.S., M.S.W.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the special psychological stresses of war veterans returning to civilian life; and 2) Evaluate and consider specific treatment approaches for their complex clinical needs aimed at minimizing feelings of stigma and shame and enabling their return to functioning in their communities.

SUMMARY:
Combat veterans have always needed special care in evaluation and treatment. As this growing population of recently returned veterans has entered the VA system, the national VA has hosted ongoing dialogue and shared efforts to address the gaps in knowledge and clinical practice necessary to adequately serve these veterans. This workshop will focus on innovative approaches developed in an outpatient dual diagnoses program (DDP) in response to special needs identified in young men and women returning from duty in Iraq (OIF) and Afghanistan

(OEF). This population is younger, generally higher functioning than our older veterans, and attempting to return to active, meaningful roles with family, education or work. They have rarely had any previous experience with Mental Health treatment systems. Diagnostic profiles, as well as, special concerns regarding stigma will be presented. Special issues of medication management and compliance, as well as, concrete examples of the personalized approach recommended to engage and retain these vulnerable patients will also be addressed. Available supporting data from clinical records will be presented. Dr. Michael Scimeca, Psychiatrist and Medical Director will discuss diagnostic presentation and differences from older DDP patients as well as special challenges in medication utilization and management. Dr. Felicity LaBoy, Psychologist and Clinical Coordinator for the DDP and OIF/OEF Recovery Services, will describe historic approaches that were found ineffective, and, those retained or enhanced for the OIF/OEF program, with discussion of specific bases for changes in documentation and clinical practice. She will also discuss efforts to coordinate referral and care of these veterans as they enter the VA system. Finally, Mr. Eddie Marcano, CSW, will share specific case examples illustrating his experiences and approaches providing direct services to these veterans with a special focus on engagement and retention.

WORKSHOP 33
RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson.: Eric M Plakun, M.D., Austen Riggs Center, 25 Main Street,, Stockbridge, MA 012620962
Presenter(s): Jane Tillman, Ph.D., Edward Shapiro, M.D.

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 medicolegal perspectives.

SUMMARY:
It has been said that there are two kinds of psychiatriststhose 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 nonpsychiatric 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 reports 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 affected 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.

WORKSHOP 34
NEUROFUNCTIONAL CONVERGENCE IN BIPOLAR DISORDER, ADHD, AND PTSD: IMPACT ON TREATMENT

CoChairperson(s): Alina Marin, M.D., Ph.D., 166 Brock St., Rm. J008, Kingston, K7L 5G2Canada,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Review the functional neuroanatomy of Bipolar Disorder, ADHD, and PTSD; 2) Identify and understand how functional neuroanatomy convergence can explain the high cooccurrence of these disorders; and 3) Discuss how Psychotherapy could address the emotional dysregulation present in all the diagnoses.

SUMMARY:
Studies on brain functionality conducted with patients presenting with Bipolar Disorder, ADHD and PTSD have led to entangling results. However, the present understanding of the functional changes occurring in these overlapping conditions which share emotional pathology points to similar areas. Interestingly, these converging brain structures have been identified as important for both emotional and social processing, which supports

the concept of modularity of brain functioning. Neural selections underlying the brain's emotional modulatory architecture may have an adaptive value by integrating appraisals of the situations and preparations for actions. This implies a continuous sequence of changes in both appraisals and action readiness. It has been recently hypothesised that the hierarchical architecture of the brain can change depending on the context, due to cerebral associative plasticity. Therapeutic approaches addressing modular neurofunctional links promise to be mostly effective. Models incorporating a continuous feedback loop in which the results of the appraisal process are fed back into the formation of realistic representation and adoption of coping responses are expected to improve emotion regulation. Although the role of social cognition in emotion regulation has been extensively investigated in the past, previous treatments have favoured cognitive techniques while social approaches have been underestimated. Contingent interpersonal experiences may shape the sense of self and enable emotional coherence. This symposium will be organized as active discussions among the presenters and with the audience about shared neurofunctional damages and complementary treatment strategies for these clinical entities which often coexist and have unsatisfactory prognosis.

WORKSHOP 35
ARE ALL ASIANS GOOD AT MATH? ASIAN AMERICANS AS THE MODEL MINORITY: MYTH OR REALITY? IMPLICATIONS FOR ASIAN AMERICAN MENTAL HEALTH

APA Caucus of AsianAmerican Psychiatrists
Chairperson.: Russell F Lim, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817
Presenter(s): Alan Koike, M.D., Dan Tzuang, M.D., Francis Lu, M.D., Paul Yeung, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant will be able to: 1) Define "Model Minority" as applied to Asian Americans (AsAms) and how it is a racist stereotype that can have deleterious effects on AsAms, such as depression, substance abuse, and suicide; 2) Describe the mental health issues of NonModel Minority AsAms such as Southeast Asians; and 3) Describe treatment approaches for AsAms patients struggling with the burden of high expectations and pressure of the Model Minority stereotype.

SUMMARY:
According to the latest Census reports, Asian Americans (AsAms) comprise 4.0% of the U.S. population, and have the image of the "Model Minority," a term coined in 1966 to describe AsAms as ethnic minorities who, despite discrimination and marginalization, have achieved success. However, as attention is placed on the success of the group, it draws attention away from racism against AsAms, and other problems that need attention, such as substance abuse and/or depression in poor or immigrant AsAms. While it is true that AsAms as a group are doing well with a median income of $55,161, and they are well represented in higher education, making up at least 30% of the graduates of the top 40 universities in the United States, most Southeast Asian youth do not graduate from high school, let alone college. Although 11.3% of AsAms live in poverty, and are the lowest ranking racial category, the nonHispanic white poverty level is 8.6%. For students, the model minority myth creates a distorted portrait of all AsAm students as hard working, studious, persevering without complaint; while all other students of color are lazy, disruptive, and complaining. Even for the successful AsAms, the stereotype may be harmful, putting the burden of higher expectations on students, increasing pressure on them to succeed, and may also result in less higher achieving students to feel that they are not as smart as they should be, and not getting the academic help they need, leading to failure, depression and suicide. The presentation will describe the history of AsAm discrimination in the United States, as well as how AsAms came to be perceived during the Civil Rights Movement of the Sixties. Faculty will then discuss current AsAm mental health problems, and how the Model Minority stereotype worsens many of these conditions. Finally, we will present ways that psychiatrists can reduce the burden of expectations created by the Model Minority myth.

WORKSHOP 36
STRATEGIES FOR PROVIDING CULTURALLY COMPETENT MENTAL HEALTH CARE TO DIVERSE POPULATIONS

Chairperson.: Felicia K. Wong, M.D., 2921 10th Street, Unit 5, Santa Monica, CA 90405
Presenter(s): Sonia Krishna, M.D., Judith Joseph, M.D.,

M.B.A., Mabel Onwuka, M.D., Jeremy Martinez, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Discuss the barriers that minority patients face with regards to obtaining mental health care, including stigma, access, and cultural beliefs; 2) Appreciate the benefits and potential disadvantages that come with cultural and linguistic matching of patient to provider; and 3) Consider alternative strategies and solutions to providing culturally competent care to our multicultural patient population.

SUMMARY:
In today's global society, providing culturally appropriate care to diverse populations is becoming increasingly important for psychiatrists, and psychiatrists in training. Ethnic minorities comprise approximately one third of the population in the United States, yet are underrepresented among people receiving mental health services. This disparity in the use of mental health services can be attributed to factors including language, culturespecific stigmas, religious barriers, and the subjective impression that the mental health system is hard to navigate and may not provide appropriate care for them. Research indicates that matching clients from a minority group with clinicians from the same background may increase community mental health services utilization, improve patient satisfaction and compliance, and reduce emergency room use. However, this is not the only, nor best, strategy for providing psychiatric services to multicultural populations. We are a group of Psychiatry residents and fellows representing the American Psychiatric Association Substance Abuse and Mental Health Services Administration (SAMHSA) Minority Fellowship Program. We come from diverse backgrounds, including ChineseAmerican, MexicanAmerican, IndianAmerican, NigerianAmerican and Caribbean AfroSouth Asian heritage. We speak a variety of languages, including English, Chinese, Hindi, and Spanish. In this workshop/ symposium, we will present some of the challenges we have experienced providing psychiatric care to culturally diverse populations in the United States. We will use case examples to share some insights we have learned from working with diverse populations, which have helped us become better "global" psychiatrists. Following the presentation, we hope to engage the audience in a lively discussion.

WORKSHOP 37
PROFESSIONALISM AND ETHICS IN PSYCHIATRIC TRAINING.
For Residents Only
Chairperson.: Kelly M Morton, M.D., M.P.A., 306 E.96th St. Apt 15B, New York, NY 10128
Presenter(s): Kelly Morton, M.D., M.P.A., Jan SchuetzMueller, M.D., Emily Steinberg, B.A., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify potential ethical issues and challenges to professionalism; 2) Understand "per se" analysis and "discretionary" analysis; and 3) Establish ways to address professional and ethical concerns.

SUMMARY:
Professionalism in the medical context has become a mantra of medical education reformers over the past three decades and widespread efforts have been made to incorporate "medical professionalism" or "professional ethics" into the curricula of medical students and house officers. Unfortunately, both the parameters of what should be taught, and even the boundaries of professionalism itself, remain largely vague in the highly pluralistic world of healthcare delivery. Yet, like Supreme Court Justice Potter Stewart defining pornography as something that he knew when he saw it, a core consensus does exist surrounding what constitutes professional versus unprofessional conduct. The challenge for medical educators is devising a method for conveying this essence of professionalism, and a mechanism for evaluating the specific challenges of novel situations, to future providers. We propose a case and roleplay method for instilling professionalism and for establishing a theoretical framework through which young health care professionals can assess specific cases. The underlying goals of our presentation is to help students and house officers to 1) identify situations that require an assessment of professional duties; 2) recognize which of these situations fall under inflexible rules and which enable more discretion in the fulfillment of professional duties; and 3) in cases where discretion is permitted, determine which path of action is best for the systematic welfare of patients by harnessing the

trialanderror approach afforded by roleplaying with classmates and colleagues. This approach stands in contrast to much of the current education in professionalism and professional ethics that students and residents presently receive, in which an emphasis is placed upon abstract, inviolable rules, which the young providers have little opportunity to engage until they are actually confronted with a graves professional dilemmas. Much as one would never undertake a surgical procedure without first attempting it under careful supervision, after having studied similar cases, one should not have to confront challenges to professional boundaries without having first practiced confronting such dilemmas in the safe context that the combination of case study and roleplay provide.

WORKSHOP 38
SOCIAL MEDIA: A RISKY BUSINESS
American Association for Technology in Psychiatry
Chairperson.: Hsiung C Robert, M.D., 122 S. Michigan Ave. Suite 1025, Chicago, IL 60603
Presenter(s): Nicolas Terry, B.A., LL.M., Seth Powsner, M.D., Tracy Gunter, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Assess the potential risk of online disclosure of information about themselves and their patients; 2) Identify online evidence of online antisocial behavior; and 3) Evaluate the risk of participating in an online community.

SUMMARY:
The potential benefits of social media like Internet forums and Facebook include information, advice, sympathy, empathy, increased confidence, social identity, hope, and sense of community. Social media can also be a risky business. Psychiatrists can put themselves at risk by disclosing information about themselves, disclosing information about patients, and entering into peer relationships with patients. Distributed storage can increase that risk by making it difficult to know who really possesses disclosed information. Users who deceive, stalk, or bully may pose risks to others. The policies and procedures of online communities may increase or decrease the risks of participating. Dr. Powsner discusses the risks of cloud computing and other technologies that underlie social media. Mr. Terry discusses what psychiatrists can do to manage the risks of their use social media. Dr. Gunter discusses antisocial uses of social media and assessment of online evidence that may augment forensic evaluation. Dr. Hsiung discusses how to evaluate the risks of participating in an online community. Participants then suggest real world "cases" for the group to explore online and to discuss. A participant with questions about information they disclose online about themselves may show the group their Facebook profile. A participant with questions about antisocial behavior in an Internet forum, or about the risks of participating in an Internet forum, may show the group that forum. Internet access is provided. Time constraints preclude discussion of every "case". Cases are selected for their educational value. Patients should not be identified without their permission. The presenters do not provide medical or legal advice.

9:00 AM10:30 AM

WORKSHOP 39
IS SHE MAD OR BAD? WOMEN WHO PERPETRATE VIOLENCE
Chairperson.: Renee M Sorrentino, M.D., 1233 Hancock StRear, Quincy, MA 02169
Presenter(s): Susan Hatters Friedman, M.D., Gunter Lorberg, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify acute and dynamic risk factors for violence in women; 2) Develop a violence risk assessment, and 3) Describe empirically based violence risk reduction plans.

SUMMARY:
Society requires that mental health professionals opine about an individual's risk of danger to others or homicide. Common situations involving an assessment of dangerousness include emergency psychiatric evaluations, civil commitment, discharge from a psychiatric facility, and the evaluation of outpatients who make threats towards others. A competent opinion in this area requires an understanding of the research in this field. Evaluations of potentially violent women rely on an understanding of the gender specific differences in risk assessment. The purpose of this workshop to educate mental health professionals to conduct, evidence based, clinically informed risk assessments

for potentially violent women. The method utilized to achieve this purpose is a review of the literature examining risk factors for violence in women. The results from the literature reveal that psychiatric symptoms and psychosocial risk factors in women have a different impact on violent behavior in comparison to men. The data from the MacArthur Risk Assessment Study showed differences between men and women in the violence committed and substantial gender differences in the situational context of the violence committed. The workshop panel will discuss the relevance of applying common violence risk factors identified in men to women and the practice and management of violence risk assessment in women. The topic of maternal violence, including child murder by mothers, will be reviewed as an example of the gender differences in violent behavior. Participants will be asked to opine about dangerousness after watching videotaped vignettes of actual cases. In conclusion, participants will be able to perform evidenced based risk assessment of potentially violent women.

WORKSHOP 40
ADAPTING TOYOTA PRODUCTION SYSTEM (TPS OR "LEAN") METHODS TO BEHAVIORAL HEALTHCARE: THE SPIRIT PROJECT

Chairperson.: Robert P Roca, M.D., M.P.H., 6501 North Charles Street, Towson, MD 21204
Presenter(s): Steven Sharfstein, M.D., M.P.A., Robert Roca, M.D., M.P.H., Sunil Khushalani, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify ways in which a performance improvement methodology developed in manufacturing can be applied in a psychiatric hospital setting to improve the safety and quality of care.

SUMMARY:
Component 1: Toyota Production System (TPS or 'Lean') methods have long been used in manufacturing to eliminate waste, reduce cost, and improve quality and safety, thereby leading to better customer satisfaction. Jeffrey Liker has broken this methodology down to these four principles: 1) Long term thinking; 2) Right Process will produce the right result; 3) Challenge and facilitate the growth of people and partners; 4) Continuous performance improvement. Lean Methodology uses a lot of diagnostic and countermeasure tools for performance improvement and we will introduce some of them. In recent years, this approach has been adapted to general hospital settings and has been found to be effective in reducing the incidence of central line infections, improve patient flow in emergency rooms, and many other quality improvement efforts. Component 2: Lean Methods have rarely been used in behavioral healthcare settings. We will describe the implementation of lean methods in a free standing psychiatric hospital. We embarked upon SPIRIT (Sheppard Pratt Improvement Resources Inspired by Toyota) two years ago. We have utilized it so far to improve the following processes: 1) Discharge Planning; 2) Belongings Management ; 3) Food Tray Accuracy; 4) New Employee Orientation ; 5) Timely Availability of Keys to New Employees; 6) Increase Return Rate of Patient Satisfaction Surveys. We will demonstrate with these examples how lean principles were used in our behavioral health care setting. We will then introduce the participants to 8 types of waste as defined by Lean proponents. Component 3: Finally we would like for the participants to appreciate the fact that in complex healthcare environments, health care delivery is not provided with an emphasis on individual participation but rather with an emphasis on group effort by teams. It requires tremendous attention being paid to how individuals communicate with each other, how one relays information and products to each other (we are all customers and suppliers for each other), and how we need to strive to become highvelocity learning systems that improve with each successive cycle of work. Some examples of the lean tools that could help us along this process are: 1) Process Mapping 2) Brainstorming 3) A3 problemsolving. We will describe these tools briefly.

WORKSHOP 41
OPIOID TREATMENT OF CHRONIC PAIN: SKILLS FOR THE GENERAL PSYCHIATRIST

Chairperson.: Mark L. Willenbring, M.D., 1834 Hampshire Av, Saint Paul, MD 55116

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Differentiate addiction from effective opioid treatment for chronic pain; 2)

Calculate approximate equivalent doses among different opioids; 3) List at least 3 principles for effective opioid treatment for chronic pain; and 4) Evaluate the interaction of psychiatric disorders and pain.

SUMMARY:
Chronic pain is very common, and becoming more so as the population ages. Opioids are frequently necessary to control pain and improve function. However, controversy and confusion reign when it comes to chronic opioid treatment, and most psychiatrists receive little or no education in pain management. Nevertheless, psychiatrists are often called in to evaluate complex chronic pain patients for "psychological" factors that may contribute to pain. For that matter, patients with pain frequently have coexisting psychiatric disorders such as mood and anxiety disorders, insomnia, etc. In this workshop, participants will learn the characteristics and uses of various opioid medications, how to calculate approximate equianalgesic doses of different drugs, and how to transition from one to another. They will learn basic principles of prescribing opioids for chronic pain and how to differentiate true addiction to opioids from routine functional use or common aberrant behaviors. Finally, they will learn about the interaction of psychiatric disorders and pain and general principles for treating these complex patients. This workshop will use case studies as a way for participants to more fully understand the application of these principles. After completing the workshop, participants will have knowledge and skills that they can immediately apply in their practices.

WORKSHOP 42
TIME FOR TEAMWORK: A MULTIDISCIPLINARY APPROACH TO BEHAVIORAL MANAGEMENT FOR PATIENTS WITH DEMENTIA

Chairperson.: Amita R. Patel, M.D., 1435 Haven Hill Drive, Dayton, OH 45459
Presenter(s): Sanjay Gupta, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the origins and impact of behavioral symptoms of dementia; 2) Identify methods of communicating with and establishing treatment plans for patients with dementia; 3) Recognize the assessment of agitation and its triggers as well as nonpharmacological and pharmacological interventions to help alleviate symptoms; and 4) Communicate the importance of staff education in treatment of dementia patients.

SUMMARY:
This seminar will discuss the origins and impacts of behavioral problems, strategies for connecting with patients, nonpharmacological and pharmacological management of agitation, and the importance of staff training. Approximately 17% of the population in the United States over the age of 65 years is living in a skilled nursing facility. More than 70% of patients with dementia have psychological and behavioral symptoms of agitation and aggression, psychotic symptoms including paranoia, delusions, hallucinations, wandering, and anxiety. With adequate knowledge of the disease and commitment to care, the behaviors can be adequately managed to improve the quality of life for the patient. The origin of symptoms can be physiological, environmental, process related or comfort related – it is important to comprehensively assess each patient in order to prevent the potentially negative impact of the behaviors. Formulating a personalized treatment plan is found to be very effective. High staff turnover rate and varying levels of cognitive impairment are a few of the challenges which may be faced by staff member when trying to form a connection with the patient which is vital to provide care, however with adequate staff training, it can be achieved. Practice guidelines recommend use of nonpharmacological treatments as a first line treatment for behavioral and psychological symptoms of dementia. In practice pharmacological agents including antipsychotics, antidepressants and anxiolytics have been used. There should be attempts to taper and discontinue medications as FTag329 regulations suggest. Staff needs great knowledge of nonpharmacological strategies to be implemented in routine clinical practice. This would lead to a decreased use of unnecessary psychoactive medication and assist the nursing home in complying with the Ftag329 regulations. As the aging population continues to increase and occupy the long term care setting, more patients with dementia suffer from inadequate care. The behavioral symptoms and agitation associated with dementia can be effectively managed with proper staff training, understanding of the disease, analysis of behavioral triggers, and

a multidisciplinary treatment approach. It is the responsibility of the nursing facility to employ such methods in both preventative and interventional care. This seminar will also discuss these regulations, documentation guidelines, and assessment for continued use of medication.

WORKSHOP 43
THE SIXTH VITAL SIGN: ASSESSING COGNITIVE IMPAIRMENT IN HIV

Chairperson.: Marshall Forstein, M.D., 24 Olmsted St., Jamaica Plain, MA 02130
Presenter(s): Francine Cournos, M.D., Antoine Douaihy, M.D., Karl Goodkin, M.D., Ph.D., Stephen Ferrando, M.D., Kenneth Ashley, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the increased risk of cognitive impairment among HIV; 2) Discuss the signs and symptoms of cognitive decline; and 3) recognize the strategies for assessing and managing impairment.

SUMMARY:
HIV infection frequently results in cognitive impairment. The impact of cognitive impairment on HIVinfected individuals is related not only to their functional status but also to their adherence to the complex drug treatment regimens and medical care, their ability to cope and to work, their adherence to protective sexual practices, and their risk of mortality. Cognitive impairment can present as a spectrum of impairment severity and functional status impact ranging from mild subclinical impairment to severe dementia. Cognitive impairment can affect a variety of neuropsychological functions, including verbal memory, information processing speed, visuospatial ability, and executive functioning. Typically, changes in the language domain occur only in late stage disease, with the exception of verbal fluency. Each of these presentations has distinctive criteria defining the condition, along with specific excluding factors that must first be ruled out. Psychiatrists play a very important role in helping to identify and treat these conditions. This workshop is designed for practicing clinicians who diagnose, treat and manage patients with, or at risk for, HIV/AIDS. Faculty will discuss symptoms and signs of cognitive decline, identify the factors warranting exclusion of these disorders, and review the diagnostic issues and assessment criteria for HIVassociated cognitive disorders. Faculty will also discuss the therapeutic and pharmacological strategies for managing impairment. A combination of case studies, interactive audience participation, and lecture will be used for this workshop. A resource guide will be provided to participants.

WORKSHOP 44
PHARMACOLOGIC APPOACHES TO AUTISM SPECTRUM DISORDERS FOR CLINICIANS

Chairperson.: Christopher J. McDougle, M.D., Institute of Psychiatric Research, 791 Union Drive, Room 111, Indianapolis, IN 462024887

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Diagnose the subtypes of pervasive developmental disorders; 2) Identify the target symptoms associated with pervasive developmental disorders that may be amenable to pharmacologic treatment; and 3) Recognize the common adverse events of drugs used to treat target symptoms associated with pervasive developmental disorders.

SUMMARY:
Significant progress has been made in the pharmacologic treatment of autism spectrum disorders over the past two decades. In particular, efficacious treatments have been developed for irritability (aggression, selfinjury, mood swings, severe tantrums) and to some extent associated motor hyperactivity and inattention. Efficacious drug treatments for interfering repetitive, ritualistic behavior have yet to be developed. Moreover, controlled drug treatment studies have not identified a consistently effective agent for the core social and communication impairment of the autism spectrum disorders. This workshop will first review the diagnostic criteria for the five subtypes of pervasive developmental disorders. Controlled drug treatment trials for motor hyperactivity/inattention, interfering repetitive, ritualistic behavior, irritability, and the core social/communication impairment of the autism spectrum disorders will then be reviewed. The didactic portion of the workshop will conclude with a discussion of future directions in drug development for the autism spectrum disorders. The workshop will end with a 30 minute question and

answer session for the attendees.

WORKSHOP 45
CULTURE, *DSM-5*, MINORITY POPULATIONS, AND TRAINING IN PSYCHIATRY

CoChairperson(s): Vanessa T Bobb, M.D., Ph.D., 79 Carlton Ave, Apt 1, Brooklyn, NY 11205, Mandy Garber, M.D., M.P.H.
Presenter(s): Roberto LewisFernandez, M.D., Suzan Song, M.D., M.P.H., Nubia Lluberes, M.D., Hansen Hansen, M.D., Ph.D., Carl Bell, M.D., Francis Lu, M.D., Mona Jain, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the strengths and limitations of *DSM-5* in a crosscultural and international context; 2) Analyze and understand the concept of "culture bound syndrome"; and 3) Identify mechanisms to make psychiatric residency training more relevant and transportable to diverse populations in the U.S. and abroad.

SUMMARY:
DSM-5 aims to be a more comprehensive, culturally sensitive diagnostic manual for trainees in psychiatry. At the same time, the U.S. population is becoming more diverse, and our global village is increasingly smaller. How are psychiatry training programs preparing their trainees to effectively communicate with, diagnose, and treat patients from diverse cultural backgrounds? Will *DSM-5* effectively address this issue? How inclusive can and should the *DSM-5* be? What does inclusive mean? In this workshop, American Psychiatric Association Diversity Leadership Fellows will ask a panel of experts in the field of Cultural Psychiatry and *DSM-5*, to respond to a series of questions addressing this seminal issue. Members of the audience will also be able to ask questions of this panel and engage in lively discussion. Expert panelists include Carl Bell, Helena Hansen, Mona S. Jain, Roberto LewisFernandez, Francis Lu, Nubia Lluberes, and Suzan Song.

WORKSHOP 46
COLLEGE MENTAL HEALTH CASE CONFERENCE: PSYCHIATRISTS ROLE IN BUILDING ALLIANCES AND MANAGING STUDENT CRISES

CoChairperson(s): Ayesha Chaudhary, M.D., 214 Page Bldg, Box 90955, Duke University, Durham, NC 27708,
Doris M Iarovici, M.D.
Presenter(s): Doris M.Iarovici, M.D., Ayesha Chaudhary, M.D., Colleen Slipka, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) articulate rationale for building alliance and trust in the management of college aged patients, and importance of balancing this with risk management; 2) identify risk factors in college aged populations and understand diagnostic principles for this population; 3) develop awareness of key elements in campus culture that influence mental illness presentations; and 4) learn reallife strategies for interventions.

SUMMARY:
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 collegeaged students has tripled—from 9% in 1994 to 26% in 2008. By reviewing the unique challenges and opportunities for students needing acute mental health care, this workshop will prepare psychiatrists both within university centers and in private practice to more effectively approach students in crisis. Many college students will have their initial presentation in crisis, often during academically stressful times. While several universities have onsite counseling services, very often the students will need to access offsite services for psychiatric treatment. Students' unique living situations, relative absence of nearby family supports, exposure to potential triggers and risk factors on campus, and peerdependence can pose many pitfalls for management and disposition of students who are experiencing emotional crises. The psychiatrist's role in building an alliance with the student, their family/friends, and using university support systems can be confusing at times. The challenge often lies in balancing management of risk

vs. patient autonomy and therapeutic alliance. This workshop is designed to examine closely 2 clinical cases of students in crisis and an indepth discussion of balancing safety risks and treatment planning in each case.

WORKSHOP 47
THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL
CoChairperson(s): Robert Freedman, M.D., 13001 East 17th Place, Mail Stop E3251, Aurora, CO 88945, Joseph Cerimele, M.D.
Presenter(s): Sarah Fayad, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the manuscript preparation process, including writing, revising, reviewing, editing and publishing; 2) Identify the changes made to the Residents' Journal over the last 12 months; and 3) Identify the Journal's future directions.

SUMMARY:
The three participants will describe the changes made to the AJP Residents' Journal over the last academic year. Example changes to discuss include specific manuscript types and the peer review process. Past workshops on this topic have generated ideas for future directions, and have expanded interest in the AJP Residents' Journal among resident physicians.

WORKSHOP 48
TRAINING GLOBAL PSYCHIATRISTS: EXPLORING EDUCATIONAL OPPORTUNITIES FOR RESIDENTS IN GLOBAL MENTAL HEALTH
Chairperson.: Monica T Caselli, M.D., 1001 Potrero Avenue, San Francisco, CA 94110
Presenter(s): Tresha Gibbs, M.D., Emily Gastelum, M.D., Gina Clark, M.D., D.Phil., Alexis Armenakis, M.D.

EDUCATIONAL OBJECTIVES:
1) Understand the Global Burden of Disease Study and how its results may impact future residency training; 2) Appreciate the different models in which residents engage in global mental health and how these experiences have been incorporated into different residency programs; 3) Identify benefits and barriers to enhancing training in global mental health at participant's own program; 4) Develop at least one strategy for incorporating training in global mental health at participant's own program

SUMMARY:
Training in global mental health (GMH) during residency is not currently a required part of psychiatrists' educational experience. However, more and more psychiatry residents are seeking international experiences during their residency training. It is clear from the literature that residents across specialties who engage in international training opportunities not only highly value these experiences, but generally build better clinical knowledge and skills as a result. In addition, these residents develop a greater understanding of cultural issues, public health concerns, and the diversity of medical practice. Subsequently, residents who train abroad are much more likely to choose careers in primary care, public health, and underserved communities. In 2001, the World Health Organization published a world report on mental health, which highlighted the global burden of neuropsychiatric illness and predicted that in 2020 these illnesses would account for the majority of disability worldwide. The recommendations for addressing this public health challenge included developing human resources, such as training psychiatrists and psychiatric nurses, decreasing stigma through public education, and strengthening collaboration between institutions to promote best practices and scientific research. Currently, there is no formal direction by ACGME on how residents should be trained to meet these challenges. This workshop will focus on how residents at two different training programs (UCSF and Columbia University) have engaged in global mental health experiences, what the benefits and barriers to this type of training are, and finally, how training global mental health may be incorporated into every residency training program at some level. This workshop will attempt to engage participants to share their experiences at other programs and develop plans to try to incorporate GMH training into residency training curricula.

NOON - 1:30PM

WORKSHOP 49
PSYCHOPHARMACOLOGY

ALGORITHM FOR PTSD: FROM THE PSYCHOPHARMACOLOGY ALGORITHM PROJECT AT THE HARVARD SOUTH SHORE PROGRAM

Chairperson.: David N Osser, M.D., 150 Winding River Road, Needham, MA 02492
Presenter(s): Ana Ticlea, M.D., Robert Patterson, M.D., Laura Bajor, D.O., M.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Prescribe evidencesupported, targeted, optimal psychopharmacology for posttraumatic stress disorder taking into consideration the results of the latest clinical research.

SUMMARY:
This workshop focuses on the latest update of the algorithm for posttraumatic stress disorder from the Psychopharmacology Algorithm Project at the Harvard South Shore Program. A literature review was conducted focusing on new data since the last published version (1999). We evaluated studies of the response of prominent symptoms, response when there are comorbidities such as substance abuse, depression, psychosis, and response in treatmentresistant cases. We found that SSRIs and SNRIs are not as effective as previously thought. SSRIs may worsen the prominent sleep impairments in PTSD. New evidence suggests that prazosin is a very effective treatment for PTSDrelated nightmares, disturbed awakenings, and nocturnal hyperarousal, and can produce benefits in daytime PTSD symptoms as well. It is usually welltolerated. This suggests that targeting sleep problems with prazosin is a logical starting place for the algorithm. There is a possible role for early use of trazodone for sleep, but the supporting evidence is minimal. Other possible hypnotics are discussed but not encouraged, e.g. benzodiazepines, quetiapine. After this, if significant PTSD symptoms remain, an SSRI may be tried. If there is PTSDrelated psychosis, an antipsychotic may be added. Otherwise, 2 or 3 antidepressants may be used in sequence in resistant cases, e.g. other SSRIs, SNRIs, mirtazapine, or nefazodone. If there is partial improvement with residual symptomatology, augmentation may be tried: the best options are antipsychotics (e.g. quetiapine), clonidine, topiramate, and lamotrigine. The high placebo response rates in the studies of SSRIs and SNRIs suggest that clinicians in practice should expect to see partial improvements attributable to other aspects of the treatment: these should not automatically be "augmented" by adding more medications. The algorithm should not be understood as suggesting that medication is always indicted for PTSD: psychotherapy is a very effective treatment that in many cases could be firstline. Also, clinical experience may support other medications not mentioned in the algorithm and this experience could contribute to decisionmaking. One speaker will demonstrate how the algorithm flowchart and recommendations can be accessed on smart phones. Ample time will be provided for attendees to respond and interact with the presenters.

WORKSHOP 50
CONTROVERSIES IN DIAGNOSIS AND TREATMENT OF CONVERSION DISORDER, MOTOR SUBTYPE

Chairperson(s): Mateusz Zurowski, M.D., M.S., 399 Bathurst St., Toronto, M5T2S8 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify criteria used for the diagnosis of psychogenic movement disorder (PMD); 2) Develop an approach to initial communication of diagnosis to patients with PMD; and 3) Demonstrate awareness of various treatment options for patients with PMD.

SUMMARY:
Functional movement disorders (FMDs), referred to in the literature as psychogenic movement disorders, are a part of the spectrum of psychogenic neurological disorders. In DSM IVTR nosology they are classified as Conversion Disorder, motor subtype. The diagnosis of the psychogenic movement disorders is not one of exclusion. Patients can be classified as "documented", "clinically established" (these two have been combined as "clinically definite"), "probable" and "possible". FMDs account for 35% of consecutive patients seen in movement disorders practices and may be even more common in tertiary subspecialty clinics. Psychopathology in these patients varies considerably but anxiety and depression are most common. Since patients with Conversion Disorder are often unaware of the psychological nature of their pathology the general psychiatric interview often fails to define

the underlying psychopathology. The pathogenic mechanisms underlying FMDs are poorly understood. Imaging studies in other somatoform neurological disorders have demonstrated disturbances of brain function that appear to be reversible when symptoms resolve. It is possible that in predisposed individuals certain physical and emotional triggers result in "neuroplastic" changes in the nervous system that sustain the movement disorder. The management of these patients has been exceedingly difficult. Many patients continue to manifest FMDs for years with accompanying disability, work loss and family disruption. Patients with conversion disorders are known to respond to placebo and suggestion, including hypnosis. Although there has been debate about the use of such approaches in modern medical ethics, recent studies have demonstrated that prescribing placebo treatments is a common practice used by physicians in North America and the United Kingdom. Other treatments that have been used successfully are CBT, psychodynamic, and interpersonal therapies; inpatient and psychopharmacological interventions. During the course of this workshop participants will receive an update on developments in Conversion Disorder presented through brief case vignettes. Treatment will be a particular focus of the workshop as merits of various ways of communicating with patients about the illness will be discussed in group format.

MONDAY, MAY 16, 2011
7:00 AM - 8:30AM

WORKSHOP 51
CHARTING THE NEXT FRONTIER IN PSYCHIATRY: THE APPLICATIONS, BARRIERS, AND IMPACT OF TELEPSYCHIATRY ON MENTAL HEALTH CARE

CoChairperson(s): Sonya Lazarevic, M.D., M.S.W., 1090 Amsterdam Ave, 16th floor, New York, NY 10025, Steven E Hyler, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, practitioners will be able to: 1) Define telepsychiatry; 2) Identify the applications of telepsychiatry; 3) Analyze the barriers vs benefits associated with the implementation of telepsychiatry, using specific program/population examples via guest speakers; 4) Understand evidence based results on telepsychiatry; and 5) Identify resources for further education/training in telepsychiatry.

SUMMARY:
Technology is seamlessly integrated into routine personal, educational, military and commercial settings. As the general public embraces complex technologies like video chat along side other industries like banking and legal firms, medicine pursues this interest with a unique set of concerns specific to its field. Psychiatrists are faced with a technology which can have a great impact on the nature of the delivery of psychiatric services, the psychiatric interview, collaborative care with other health care provides and institutions and the public's overall access to mental health services. While psychiatry lends itself as an opportune specialty for live video assisted communication technology, the adoption process represents a great shift in thinking about the delivery of care and requires thoughtful evaluation along each step. This workshop will review the broad definition of telepsychiatry and focus on the application of video conferencing/ video chat in the clinical setting. The workshop will also address barriers to establishing telepsychiatry programs in terms of legal issues and cost, identify populations which have been successfully served and general results from clinical research. Guest speakers will represent a variety of current projects in the field of telepsychiatry; the workshop will be very interactive, with continuous open question & answer time for participants. Some data from a survey of all US psych residents will be included in this workshop, also a brief interactive video in which participants can role play will occur during this time as well. Conclusion will summarize the workshop and provide resources for further education and training in telepsychiatry.

WORKSHOP 52
APPROACHING ATTENTION DEFICIT DISORDER IN UNIVERSITY POPULATIONS: DOSING, DIAGNOSING (AND DETECTING THOSE JUST LOOKING FOR A BUZZ)

CoChairperson(s): Gordon D Strauss, M.D., 401 E Chestnut Street, Suite 610, Louisville, KY 40202, Beverly
Fauman,

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify at least three approaches to diagnosing ADD; 2) Utilize a dosing protocol designed to identify a patient's optimal stimulant dose; 3) Evaluate the legitimacy of requests for changes in stimulant doses; and 4) Identify and differentiate two subpopulations of medical students who present with ADD.

SUMMARY:
Attention Deficit Disorder (ADD) is a diagnosis surrounded with controversy no matter when in the life cycle it is encountered. For psychiatrists whose patients with ADD are students attending universities or colleges, there are a variety of important clinical questions, some of which depend upon factors such as whether there is a previous history of ADD diagnosis or treatment, how the diagnosis is documented, and where in the educational continuum from entering undergraduate to graduate or professional student (e.g., law, medicine or dentistry) the patient is located. This workshop will draw on the many years of experience in college and university student mental health of the cochairs and will focus on 1) what is needed to make the diagnosis of ADD; 2) picking an appropriate medication; 3) determining an optimal dose if a stimulant is chosen; 4) identifying two distinct subpopulations of medical students who present with ADD; 5) dealing with the risk of "sharing" stimulant medication and/or recreational use of prescribed stimulants by college or university students. While the cochairs will present some "content"—a brief review of ADD diagnostic instruments and testing, a protocol for determining optimal dose when initiating treatment with stimulants, etc.—onethird to onehalf of the workshop will be devoted to exploring clinical topics through role play scenarios and other interactive techniques. For example, audience members will be invited to role play student health psychiatrists while the cochairs role play students with both common and atypical ADD presentations in order to explore when to seek additional psychological testing, when to prescribe (or avoid) stimulants, or when to be concerned about tachyphylaxis. Whether due to increased incidence, decreased stigma or more effective diagnosis, more psychiatrists are treating college and university students with ADD. This workshop is designed to prepare those who attend to be more knowledgeable when working with this clinical population.

WORKSHOP 53
PSYCHIATRY AT A CROSSROADS: OUR CHANGING ROLE IN THE HOUSE OF MEDICINE
APA Council on Psychosomatic Medicine and Geriatric Psychiatry
Chairperson.: Christopher W Tjoa, M.D., B.S., 3535 Market St, 2nd Floor, Philadelphia, PA 19104
Presenter(s): Deyadira BaezSierra, M.D., Catherine Crone, M.D., Melissa Maitland, M.D., Mary Davis, M.D. Anique Forrester, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Analyze the relocation of psychiatric beds from general hospitals to offsite locations; 2) Identify factors that have led to these changes; 3) Recognize how changes will affect psychiatry, specifically psychosomatic medicine; 4) Review staffing issues that may result from these changes; and 5) Offer suggestions for how psychiatry can best navigate these changes to preserve quality clinical care and its role in the house of medicine.

SUMMARY:
Economic forces have shaped the hospital landscape. As these changes progress, psychiatry's role in the general hospital has changed. A notable change has seen the replacement of inpatient psychiatric units in general hospital settings with medical programs such as intensive care units with a higher dollar returns. These changes are not well publicized, but are important for psychiatrists to be aware of, as they are imminent. While psychiatry did not have a concerted role in preventing these closures, the field should be proactive in engineering the future of psychiatry in the hospital setting. Our interactive workshop will review the following: factors that have led to these changes, how the role of psychosomatic medicine will change, implications for psychiatric staffing, and potential opportunities for the growth of psychiatry's role in the hospital setting.

WORKSHOP 54
MOTIVATIONAL THERAPY FOR INDIVIDUALS WITH CONCURRENT DISORDERS
Chairperson.: Shimi Kang, M.D., Rm P4118Box 141,

4500 Oak Street, Vancouver, V6H 3N1 Canada,
Presenter(s): Shimi Kang, M.D., Marilyn Herie, Ph.D., SanchezSamper Ximena, M.D., Arvinder Grewal, M.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the evidence base of motivational therapy (MT) with regards to mental health (MH) and substance use disorders (SUD); 2) Demonstrate knowledge of the key principles of MT, including stages of change model; and 3) Demonstrate skills related to assessing and enhancing motivation in their clients.

SUMMARY:
In recent years, it has become evident that concurrent psychiatric disorders carry a high burden of disease in terms of medical and psychiatric disability, misdiagnosis, treatment delay, social instability and inefficient use of scarce services. An evidencebased, comprehensive and integrated approach is essential for treatment of this complex problem, and comprehensive treatment should include nonpharmacological approaches. One approach to managing concurrent disorders is by encouraging change through motivational therapy (MT). The purpose of this course is to provide clinicians with the concrete, practical tools of MT to apply in their own practices through a series of interactive exercises and roleplays. This MT course integrates the most current evidence with clinical expertise. A series of interactive discussions and breakout practice sessions provide participants with the foundational knowledge of MT. These discussions include a review of relevant research literature on using MT with clients with concurrent disorders, the key principles, stages of change, and goals and strategies to enhance motivation in their clients. The breakout sessions will allow participants to practice and demonstrate their skills via team activities and roleplays. Participants will also review case studies, which allow them to apply their new knowledge and skills towards real life clinical examples. Participants will benefit from the multidisciplinary team of cofacilitators and will be presented with immediate feedback on their progress when they fill out forms designed to test their knowledge and skills on MT before and after the course.

WORKSHOP 55

PART 1MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM I
For Residents Only
Chairperson.: Jonathan Amiel, M.D., 1051 Riverside Drive, #94, New York, NY 10032
Presenter(s): Anand Desai, M.D., Andrew Rosenfeld, M.D., Tresha Gibbs, M.D., Fumi Mitsuishi, M.D., M.S., Drake Christin, M.D., Filza Hussain, M.B.B.S

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Clearly define the Chief Resident role; 2) Identify effective strategies used in psychiatry residency programs to manage difficult issues and logistical problems; 3) Share their learning experiences with other participants; and 4) Build a network with Chief Residents from other programs to provide ongoing support and consultation.

SUMMARY:
This is Part I in a twopart 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 definitions 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 address the lack of information that often accompany this role. This will include presentations from outgoing Chief Residents 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 schedules, call coverage, retreats, (2) Dealing with difficult residency issues morale, supporting residents after patient suicide, supporting residents after violence, support residents with academic difficulties. Since 88.7% of Chief Residents in a recent study said their Chief experience has inspired

them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

WORKSHOP 56
PATIENT SUICIDE DURING PSYCHIATRY RESIDENCY: A WORKSHOP DISCUSSION

CoChairperson(s): Meredith A Kelly, M.D., 1051 Riverside Drive, New York, NY 10032, Emily Gastelum, M.D.
Presenter(s): Andrew Booty, M.D., Christina Mangurian, M.D., Peirce Johnston, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify feelings resident psychiatrists may have after a patient commits suicide; 2) Demonstrate better understanding of their experience of patient suicide; 3) Recognize common responses from colleagues and training programs that residents typically receive after a patient suicide; and 4) Make recommendations for their home institution to better support residents during this difficult time.

SUMMARY:
According to the Centers for Disease Control and Prevention (CDC), almost 31,000 people committed suicide in the US in 2001. Studies estimate that 2068% of psychiatrists will lose a patient to suicide in their career. A significant number of residents will experience the suicide of a patient during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents and their colleagues and supervisors after a patient commits suicide. It is the belief of this panel that this lack of discussion interferes with the use of positive coping strategies by residents during this incredibly difficult training experience. The workshop will begin with three psychiatry resident panelists sharing their feelings and experiences after their own patients committed suicide. Two senior attending panelists will then reflect on their experiences with patient suicide during training and later as supervisors. We will then open the discussion to the audience and invite members to share their own experiences as residents, supervisors, and training directors. The final portion of the session will be devoted to developing strategies that could be proposed to residency training programs to provide better support to residents who have a patient that commits suicide. These strategies may include (but are not limited to) discussions about how to maximize mentorship/supervision, facilitating senior staff members sharing their experiences, general education, peer discussions, case conferences and morbidity and mortality conferences. This workshop aims to 1) provide a safe place for residents to share the personal experience of having a patient who commits suicide, and 2) develop better ways to support residents through this experience in the future.

WORKSHOP 57
COLLATERAL DAMAGE: TEACHING RESIDENTS ABOUT THE IMPACT OF PATIENT SUICIDE

CoChairperson(s): Joan M Anzia, M.D., 1115 Forest Avenue, River Forest, IL 60305, Glen O Gabbard, M.D.
Presenter(s): Richard Balon, M.D., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate the emotional and cognitive impact of the experience of patient suicide on residents and attending psychiatrists; 2) Discuss a variety of ways to prepare trainees to deal with this experience; and 3) how the use of the film during residency training.

SUMMARY:
There has been an increased focus on the impact of patient suicide on psychiatrists, as well as an awareness of the frequency with which residents experience this event. Many educators have created helpful written curricular materials, including recommendations for preventive education, protocols, and "postvention" procedures. However, to our knowledge, there are no films or written narratives available to stimulate discussion about the emotional and cognitive impact of patient suicide. The presenters formed a small team of faculty psychiatrists and residents from programs around the U.S., and have created a film in which both senior clinicians and trainees tell their personal stories of patient suicide. The purpose of this film is to provide a springboard for smallgroup discussion for psychiatrists and psychiatry trainees. The film is currently the center of a pilot educational research

project at several psychiatry residency programs around the U.S. In this workshop, participants will view and discuss several segments of the film as well as some of the preliminary findings from the pilot project.

WORKSHOP 58
DYNAMIC THERAPY WITH SELFDESTRUCTIVE BORDERLINES: AN ALLIANCE BASED INTERVENTION FOR SUICIDE

Chairperson.: Eric M Plakun, M.D., Austen Riggs Center, 25 Main Street,, Stockbridge, MA 012620962
Presenter(s): Edward Shapiro, M.D., Eric Plakun, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to; 1)Understand converging approaches to treating selfdestructive patients from DBT and dynamic perspectives; 2) Enumerate principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of selfdestructive 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 selfdestructive 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 selfdestructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and selfdestructive behavior. The principles are: (1) Differentiate therapy from consultation, (2) Differentiate lethal from nonlethal selfdestructive 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) Nonpunitively 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 selfdestructive behavior, and (9) Provide 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.

8:00 AM - 9:30AM

WORKSHOP 59
THE WAR: UNDERSTANDING AND CONFRONTING SCIENTOLOGY'S EFFORTS TO DESTROY PSYCHIATRY

Chairperson.: Stephen R Wiseman, M.D., Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, V6Z1Y6 Canada,
Presenter(s): Stephen Wiseman, M.D., Nancy Many, B.S., C Lynn Partridge, M.D., Stephen Kent, M.A., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand Scientology's development and nature as a New Religion; 2) Appreciate the historical development of, and reasons for, Scientology's opposition to the practice of psychiatry; 3) Identify some of Scientology's current methods of opposing and stigmatizing psychiatric treatment; and 4) Appreciate the experience of mental illness and how it is handled from within Scientology.

SUMMARY:
L. Ron Hubbard published "Dianetics: The Modern Science of Mental Health" in 1950, prior to then developing Scientology and registering it as a religion in 19534. During this time, he referred to psychiatry as a potential rival but not an enemy to be demonized and destroyed. This suddenly changed

in 1955, however, and since this time, Scientology has been vociferously opposed to psychiatry to the degree of advocating for, and actively working towards, its entire destruction as a system of treatment. Today, both psychiatrists and the public alike are surprised by the degree of influence Scientology and its various affiliates have had, and continue to have, on antipsychiatry initiatives. Utilizing sophisticated propaganda techniques to disseminate apparentlylegitimate criticisms of psychiatric practice, Scientology has supported and paved the way for more comprehensive and damaging attacks on the profession using legal and political methods. Any understanding of the ongoing stigma against psychiatry, its practice, and by extension those in need of psychiatric treatment, is entirely incomplete without an appreciation of the major role Scientology has played over the years in its perpetuation. This workshop explores the relationship between Scientology and psychiatry by commencing with an academicallyoriented discussion of the nature and internal mechanisms of new religions and cults in general and Scientology in specific. A detailed history of Scientology's opposition to psychiatry, with specific ideas as to how and why this was triggered, is then presented. Thirdly, Scientology's current propaganda, legal, and political efforts to destroy psychiatry are reviewed, along with examples of how these have in fact had a stigmatizing influence. Finally, a personal testimony of Scientology's teachings, and a struggle against mental illness from within the Church, is presented by a prominent exmember who has also published her story in the book "My Billion Year Contract". This will be a controversial workshop, in that it will be the first presentation of its kind in North America to address this issue directly. Traditionally, the concern of legal action or even personal retribution against those who would speak out against Scientology's antipsychiatry practices has been enough to preclude any such workshop as this until now.

WORKSHOP 60
HIGHYIELD COGNITIVEBEHAVIOR THERAPY FOR BRIEF SESSIONS

Chairperson.: Jesse H Wright, M.D., Ph.D., Suite 610, 401 East Chestnut, Street, Louisville, KY 40202
Presenter(s): Donna Sudak, M.D., David Casey, M.D., Judith Beck, Ph.D., Jesse H Wright, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1)Identify CBT methods that can be delivered effectively in treatment sessions lasting less than 50 minutes; 2) Recognize strategies for enhancing the efficiency of CBT in brief sessions; and 3) Describe key methods of integrating CBT with pharmacotherapy in brief sessions.

SUMMARY:
In modern clinical practice, most psychiatrists spend the majority of their time with patients in sessions that are shorter than the traditional "50minute hour." Yet, traditional psychotherapy training emphasizes fulllength therapy sessions. In this workshop, methods are described and illustrated for drawing from the theories and strategies of CBT to enrich briefer sessions. Examples of specific interventions that are detailed include enhancing adherence to medication, using targeted behavioral strategies for anxiety disorders, cognitive restructuring in brief sessions, and CBT for insomnia. Participants will have the opportunity to discuss how they could implement CBT in brief sessions in their own practices. Methods: Didactic presentation, video and role play demonstrations, discussion.

9:00 AM - 10:30AM

WORKSHOP 61
GUARDIANSHIP AND ADVANCE DIRECTIVES IN PSYCHIATRY

Chairperson.: Renee M Sorrentino, M.D., 1233 Hancock StRear, Quincy, MA 02169
Presenter(s): Susan Hatters Friedman, M.D., Beesh Jain, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Define the different types of guardianship; 2) Identify and be familiar with the psychiatric assessment for guardianship and 3) Recognize situations in which advance directives are appropriate.

SUMMARY:
The determination of when a guardianship is appropriate is a legal determination. The legal system frequently relies on psychiatrists to evaluate

an individual's capacity to make decisions and to give informed consent. Psychiatrists who perform guardianship evaluations should be familiar with the specific criteria and the standard of proof regarding the creation of a guardianship. The psychiatrist's role in guardianship evaluations is twofold: first to perform a psychiatric assessment and second to communicate this opinion to the court. The foundation of the psychiatric assessment for a guardianship evaluation is the clinical interview including a comprehensive mental status. Some guardianship evaluations will require additional information such as neuropsychological testing or occupational therapy evaluations. In this workshop the panel will present four types of guardianship including testamentary guardian, guardian ad litem, limited guardian and general guardian. The panel will discuss the psychiatric assessment in guardianship evaluations and the role of psychometric testing. The question of whether the diagnoses of personality disorders and substance use disorders are sufficient diagnoses to warrant guardianship will be discussed. Alternatives to guardianship include social support services and advanced directives. Traditionally advance directives have not been widely utilized in the psychiatric population. However there has been substantial interest in psychiatric advance directives given the potential positive effect on communication between patients and providers. The panel will discuss the challenges of employing advance directives in the psychiatric population. In conclusion, the workshop will focus on report writing and expert testimony skills in guardianship evaluations. The panel will present clinical vignettes and invite the audience to opine about capacity and alternatives to guardianships.

WORKSHOP 62
BEHAVIORAL ADDICTIONS: NEW CATEGORY IN THE *DSM-5*

CoChairperson(s): Ken Rosenberg, M.D., 49 East 78th Street, 2A, New York, NY 10075, Charles O'Brien, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Demonstrate the fundamentals of diagnosing, evaluating and treating behavioral addictions, a diagnostic subcategory that will appear in the upcoming *DSM-5*; 2) Recognize research that supports this diagnostic category, and recognize the areas of controversy; and 3) Recommend pharmacologic, psychological and peersupport treatments for patients with behavioral addictions.

SUMMARY:
Recent advances will result in a new diagnostic category of Behavioral Addictions. Presentations from leading researchers will familiarize participants with the new diagnosis, research evidence, areas of controversies and treatment options. Dr. O'Brien, Chair of the American Psychiatric Association's *DSM* SubstanceAbuse Related Disorders Work Group, will discuss the basics of the diagnosis of behavioral addictions. Dr. O'Brien will address the specific diagnoses of internet and gambling addiction. 2. Dr. Carnes, EditorinChief, Journal of Sexual Addiction and Compulsivity, will discuss basics of the evaluation, diagnosis and treatment of the more controversial area of sexual addiction, specifically as it pertains to the area of internet addiction which will be included in the DSM. During the discussion, Dr. Carnes will address the unique aspects of treating sexual impulsivity. 3. Dr. Grant. EditorinChief, Journal of Gambling Studies, will summarize the clinical presentation, associated psychopathology, and neurobiology of pathological gambling. Dr. Grant will discuss the relationship of gambling addiction to chemical addictions and the research results of available treatment options. 4. Dr. Rosenberg will offer closing remarks and a perspective as an addiction psychiatrist practicing in the community.

WORKSHOP 63
GENDERSPECIFIC NEUROBIOLOGICAL, BEHAVIORAL AND SOCIAL INFLUENCE ON HUMAN DEVELOPMENT: IMPLICATIONS FOR HETEROSEXUAL RELATIONSHIPS AND COUPLES' THERAPY

Chairperson.: Scott D Haltzman, M.D., 147 County Road, Barrington, RI 2806

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Indentify 4 biological sexbased differences found in brain structure and development; 2) Recognize at least 2 ways that culture affects gender identity; 3) Apply knowledge about gender differences in communication to

couples' related issues in heterosexual couples; and 4) Appreciate other clinicians' points of view on the subject of how best to approach couples' education visavis genderspecific traits and styles

SUMMARY:
In recent years, a number of studies have uncovered genderspecific differences in the male and female brain functioning and behavior. Within the first hours of life, compared to girls, boys appear less focused on facial characteristics and less attuned to distress of other babies in the nursery. As babies grow, adults' and other children's perceptions of a child's sexual identity affect behavior toward that child. Differences in gross anatomy (such as a larger splenium of the female corpus callosum) and functional anatomy (as evidenced by more bilateral activity on listening tasks by females) point to gender specific brain differences in adult behavior. Additionally, hormonal activity shapes muscle, skeletal and nerve development, and also affects behavior, such as increases in sex drive and aggression associated with testosterone (typically higher in men compared to women) and bonding behaviors associated with oxytocin (typically higher in women compared to men). Research suggests that clinicians should be sensitive to gender as it affects response from everything to treatment for heart disease to treatment of depression with tricyclic agents. Clinicians who attend this workshop will be invited to share their experiences working with couples, and explore whether it is acceptable or even advisable to point out how gender affects the basics of relationships, such as sexuality, perception or communication skills. Genderbased couples' education could help couples to clarify and improve their dyadic interactions, or alternatively, might run the risk of perpetuating stereotypes and locking couples into roles imposed by society.

WORKSHOP 64
EXAMINING THE SOCIAL DETERMINANTS OF MENTAL HEALTH AMONG VARIOUS RACIAL/ETHNIC POPULATIONS

CoChairperson(s): Ruth S Shim, M.D., M.P.H., 720 Westview Drive, Atlanta, GA 30310, Monica TaylorDesir, M.D., M.P.H.
Presenter(s): Kaney Fedovskiy, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify and address the challenges and unique mental health needs of specific race/ethnicity groups; 2) Recognize the social determinants of mental health that contribute to Native American, African American and Latino populations; and 3) Develop strategies for improving mental health care for specific racial/ethnic populations.

SUMMARY:
The Social Determinants of Health have been closely examined and well documented in recent years; however, there continues to be limited research on the impact of Social Determinants on Mental Health. This workshop attempts to examine the impact of various social determinants of mental health on three unique racial/ethnic populations in the United States – Native Americans, Latino Immigrants, and African Americans. There are 563 native sovereign nations within the borders of the United States. Native Americans who reside on reservation land are not subject to state of local jurisdiction but are under their own tribal jurisdiction. There is a dearth of tribally operated inpatient hospitals for the mentally ill which presents a major barrier in seeking involuntary hospitalization for those Native American persons who are danger to themselves or others. One native sovereign nation in Arizona has developed a mental health code and intergovernmental agreement to assist their community members in securing mental health care. Latino immigrants have compromised access to and utilization of health care services, by virtue of being foreignborn. In addition, the physical and mental health status of Latinos deteriorates once they immigrate to the US. Lack of access to health care and health information may contribute to this decline in health status. Additional factors contributing to mental health care access barriers include: immigration status, lack of health insurance, low socioeconomic status, low English proficiency, and perceived discrimination. Mental health disparities in care are often seen when comparing African Americans to white populations; however, methodological limitations often make it difficult to determine the true role of neighborhood and environmental factors like poverty, unemployment, nutrition, discrimination, and chronic stress. The impact of these factors on the overall mental health within the African American

population is an important issue that needs more thoughtful examination and more methodologically rigorous research. This workshop aims to have a discussion on the role of psychiatrists in the ongoing management and treatment of these special populations, by highlighting personalized examples of strategies to improve access to and quality of mental health treatment among these populations, and by discussing new strategies to promote mental health within these communities.

WORKSHOP 65
PART 2 MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM II

For Residents Only
Chairperson.: Jonathan Amiel, M.D., 1051 Riverside Drive, #94, New York, NY 10032
Presenter(s): Anand Desai, M.D., Andrew Rosenfeld, M.D., Tresha Gibbs, M.D., Fumi Mitsuishi, M.D., M.S., Drake Christin, M.D., Filza Hussain, M.B.B.S

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Clearly define the Chief Resident role; 2) Identify effective strategies used in psychiatry residency programs to manage difficult issues and logistical problems; 3) Share their learning experiences with other participants; and 4) Build a network with Chief Residents from other programs to provide ongoing support and consultation.

SUMMARY:
This is Part II in a twopart 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 definitions 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 address the lack of information that often accompany this role. This will include presentations from outgoing Chief Residents 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 schedules, call coverage, retreats, (2) dealing with difficult residency issues morale, supporting residents after patient suicide, supporting residents after violence, support residents with academic difficulties. Since 88.7% of Chief Residents in a recent study said their Chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

WORKSHOP 66
PROFESSIONAL TRANSITIONS: THE PGY4 JOURNEY THROUGH TERMINATIONS AND GRADUATION TO "REAL LIFE"

Chairperson.: Joan M Anzia, M.D., 1115 Forest Avenue, River Forest, IL 60305
Presenter(s): Shannon Wagner, M.D., M.P.H., Kara Driscoll, B.A., M.D., Erin Stanton, M.D., Gaurava Agarwal, M.D., Elizabeth McIlduff, M.D., Mark Gindi, M.D., Deep Buch, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the variety of challenges faced by PGY4 residents; 2) Utilize new knowledge and skills for career planning, balancing work/life, financial planning postresidency; and 3) Plan for a thoughtful and safe termination with patients and program

SUMMARY:
The PGY4 resident faces numerous challenges during the last year of training; it is both an exciting and anxietyprovoking time. Tasks include career planning, job or fellowship searches, financial planning for postresidency, Board exams, and especially the emotionally demanding work of planning for terminations with many patients as well as saying goodbye to the program, fellow residents, faculty, mentors, and staff. Residents may also be moving to a different location or starting a family at this time. Without explicit guidance, resources, and support, all of these changes can seem overwhelming. This workshop is for senior residents

and program directors; it is based on a yearlong course given to PGY4 residents at Northwestern's Department of Psychiatry and Behavioral Sciences; this course has been tailored by residents over the years to meet their unique needs and interests. The workshop will begin with a brief overview of the common topics and themes covered by the seminar, with a special emphasis on the administrative, clinical, and personal(cognitive and emotional) aspects of termination. After a survey of workshop participants' learning needs and wishes, the eight presenterfacilitators (a program director and 7 PGY4 residents) will lead 35 small group discussions on the topics of participant choice. Participants will also receive a compilation of relevant resources for both graduating residents and program directors.

WORKSHOP 67
NIMH PSYCHOPHARMACOLOGY TRIALS: HOW THE RESULTS INFORM PRACTICE

Chairperson.: Adelaide S Robb, M.D., 111 Michigan Ave NW, Washington, DC 200102970
Presenter(s): Karen Wagner, M.D., Ph.D., Graham Emslie, M.D., John Walkup, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify benefits of switching antidepressant versus adding CBT in treatment resistant adolescent depression; 2) Recognize which pediatric anxiety disorders benefit from the combination of medication plus cognitive behavioral therapy; and 3) Prioritize the use of mood stabilizers for the treatment of pediatric bipolar disorder.

SUMMARY:
Objective: This workshop is designed to describe four of the most important large scale clinical trials for the treatment of pediatric mental illness funded by NIMH over the last decade. Studies included head to head comparisons, switching strategies, and cognitive behavioral therapy (CBT). Each large scale trial brought important information to the field about diagnosis and comorbidity, treatment paradigms, usefulness of CBT, and ordering medication options for the treatment of pediatric affective disorder. Method This workshop will review the TADS (Treatment for Adolescents with Depression Study), TORDIA (Treatment of SSRIResistant Depression in Adolescents), CAMS (Child/Adolescent Anxiety Multimodal Study), and TEAM (Treatment of Early Age Mania) studies. Each presenter will review the study design, 1° and 2° outcomes, treatment findings and recommendations to clinicians. In TADS 439 adolescents with DSMIV depression were randomized into one of four treatments, blinded placebo, blinded fluoxetine, CBT, and combination of CBT and fluoxetine. At 12 weeks improvement occurred in 71% of those on combination, 60.6% of those on placebo, and CBT and placebo were equivalent at 43 and 34.8%. TORDIA studied 334 teens who failed two months of an SSRI. They were given one of four treatments switch to a second SSRI, switch to venlafaxine, second SSRI plus CBT, or venlafaxine plus CBT. At 12 weeks venlafaxine had a 48% response rate compared to 47% in a second SSRI. Adding CBT to medication gave a 54.8% response rate compared with 40.5% on medication alone. CBT did not lower suicidality. CAMS treated social phobia, generalized anxiety disorder, and separation anxiety disorder. 488 717 yo had placebo, CBT, sertraline or a combination of sertraline and CBT. At 12 weeks, combination was superior to all groups with CBT and sertraline being equivalent and placebo being the least effective. Sertraline was well tolerated at final doses of 130140 mg daily, but younger children tended to have more adverse effects on the medication. TEAM is the first head to head comparison trial of three medications in the treatment of 379 children ages 616 with DSMIV bipolar disorder. The three treatment arms were lithium, valproate, and risperidone. Medications were titrated to high therapeutic levels on lithium.12±0.34 mEq/L, valproate 111.4±23.2 mEq/L or moderate doses on risperidone dose 2.67±1.30 mg. At 8 weeks, response occurred in risperidone (64.1%) versus lithium (27.0

10:00 AM - 11:30 AM

WORKSHOP 68
DOES THE BRAIN EVER RECOVER FROM DRUG ADDICTION?

U.S. National Institute on Drug Abuse
Chairperson.: Steven Grant, Ph.D., 6001 Executive Blvd.,, Bethesda, MD 20892
Presenter(s): Marc Potenza, M.D., Ph.D., Jay Nierenberg, M.D., Ph.D., George Fein, M.D., Diana Martinez, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize and understand the current knowledge regarding changes in the brain that contribute to or change during recover; 2) Identify specific brain regions and functional abnormalities that are predictive of or change during treatment; 3) Appreciate how understanding brain function during recovery can advance treatments for substance abuse; 4) Understand the limits of current knowledge and where future research is needed.

SUMMARY:
Although there is substantial evidence that drugs of abuse produce enduring changes in brain structure and function, a critical question is whether the brain recovers with treatment and abstinence, and if so, what is nature and time course of such recovery. This session will present the results of ongoing human brain imaging studies using MRI and PET that have addressed this question in stimulant abusers (cocaine and methamphetamine) and alcoholics. These speakers will address how the pretreatment state of brain structure and function in predicts treatment adherence and success; what is known about how the brain changes during the course of treatment; and how changes in the brain relate to clinical outcomes. Drs. Nierenberg, Potenza and Fein will present the results of MRI studies of treatmentrelated changes in brain structure and function of methamphetamine abusers, cocaine abusers, and alcoholics respectively, and the relationship of those measures to neuropsychological function. Dr. Martinez will present the results of PET studies of alterations in the dopamine neurotransmission how such changes are related to laboratory measures of the decision to take cocaine. In addition to presenting the results of their studies, the presenters will also address the issues of study design and implementation. Because this is an emerging area of research, a workshop format will facilitate discussion and interaction between researchers and practitioners.

WORKSHOP 69
COMPUTERASSISTED COGNITIVE BEHAVIOR THERAPY (CCBT): PRACTICAL IMPLICATIONS FOR EVERYDAY PRACTICE
CoChairperson(s): Amanda B Mackey, M.D., 501 East Broadway, Suite 340, Louisville, KY 40202, Sarah B Johnson, M.D., M.S.C.
Presenter(s): Joyce Spurgeon, M.D., Jesse H Wright, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Increase their awareness of CCBT applications available including multimedia programs, virtual reality and handheld devices; 2) Review evidencebased outcomes supporting the use of CCBT; and 3) Participate in an interactive discussion and demonstration of CCBT applications that can be utilized in daily practice.

SUMMARY:
There has been a recent acceleration in the development and testing of programs for computerassisted cognitivebehavior therapy (CCBT). Programs are now available for treatment of depression, anxiety disorders, and other psychiatric conditions. Technologies for delivery of CCBT include multimedia programs, virtual reality, and handheld devices. Research on CCBT has generally supported the efficacy of computerassisted therapy and has shown patient acceptance of computer tools for psychotherapy. Completion rates and treatment efficacy have typically been higher when clinicians prescribe and support the use of psychotherapeutic computer programs than when programs are delivered in a selfhelp format without clinician involvement. CCBT appears to have the potential to improve access to evidence based therapies while reducing the demand for clinician time. These applications can be especially useful to expand mental health services to underserved areas and patient populations.

WORKSHOP 70
CHALLENGES IN TREATING AND EVALUATING PHYSICIANS
Chairperson.: Glen O Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 770301316
Presenter(s): Glen O. Gabbard, M.D., Holly CrispHan, M.D., Gabrielle Hobday, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Identify the relevant medicolegal/forensic issues; 2) Recognize the specific concerns of physiciansintraining; and 3) Identify the typical countertransference themes involved in evaluating and treating physicians.

SUMMARY:
Clinicians have long experienced a specific set of challenges in the psychiatric evaluation and treatment of physicians. In this workshop we will provide an overview of those challenges and ways to address them. Dr. Hobday will outline the common medicolegal and forensic concerns confronted with physicians involving impairment, licensure, and confidentiality. Dr. CrispHan will then provide an overview of problems that arise when working with

medical students and house staff, including anxieties about how psychiatric treatment affects their chances of getting into the residency or fellowship of their choice and how a record of treatment influences licensing board decisions. Finally, Dr. Gabbard will address common countertransferences encountered when one is in a clinical relationship with a colleague.

NOON - 1:30 PM

WORKSHOP 71
DIAGNOSTIC ASSESSMENT IN *DSM-5*: APPROACHES AND EXAMPLES

American Psychiatric Institute for Research & Education
CoChairperson(s): David J Kupfer, M.D., Dept of Psychiatry, University of Pittsburgh School of Medicine, Western
Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213, Darrel A. Regier, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Explain how diagnostic assessment for DSM-5 is being proposed; 2) Describe how this session enhanced the participants' clinical understanding of the DSM-5 revision process; and 3) Apply independent diagnoses based on case examples.

SUMMARY:
The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*) is anticipated to include some significant revisions from the current *DSMIV*. This includes revised diagnostic criteria for select disorders, proposals to introduce new disorders not currently included in *DSMIV*, and proposals to remove current disorders or collapse multiple, similar disorders into a singular diagnosis. In order to facilitate better understanding of proposed revisions and to solicit input from the field on their potential clinical utility, this interactive workshop will provide audiences with an overview of select, significant proposed changes to *DSM-5*. This will include descriptions of diagnostic criteria as well as nondiagnosis specific changes, such as the introduction of assessments to dimensionalize diagnosis and more objectively capture diagnostic severity for tracking course of illness and informing treatment planning. Audiences will use electronic, handheld raters to respond to survey questions about proposed revisions as well as case examples, in which participants will individually apply diagnoses based on *DSM-5* criteria. Time will also be allotted at the end of this workshop for audience questions and discussion.

WORKSHOP 72
MENTAL HEALTH ISSUES AND THE LAW OF DEPORTATION

APA Council on Psychiatry & Law
Chairperson.: Patricia R Recupero, J.D., M.D., 345 Blackstone Blvd, Providence, RI 2906
Presenter(s): Eugenio Rothe, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the important issues associated with mental illness and proceedings before Immigration and Customs Enforcement (ICE).

SUMMARY:
A recent ACLU report: Deportation by Default – Mental Disability, Unfair Hearings and Indefinite Detention in the US Immigration System, details many of the difficulties people suffering from mental illness experience during INS proceedings. Occasionally, even citizens and legal residents are involved in these proceedings and do not have the ability to defend themselves because they are impaired by reason of a mental illness or disability. Currently there are no clear legal standards used to assess competency to proceed in civil cases including ICE proceedings. As a result people suffering from mental illness often face deportation without having the ability to fully represent themselves in the judicial system. This workshop will examine the role of competency to proceed in ICE proceedings by presenting and discussing the role of the psychiatrists in working with undocumented persons, legal residents, and other immigrants suffering from mental illness or disability In addition there will be discussion of issues related to deportations of persons suffering from PTSD to a homeland where the PTSD is likely to be reactivated or exacerbated. Suggestions will be made to provide added protections for persons with disability in INS proceedings.

WORKSHOP 73
PRIMARY CARE BEHAVIORAL HEALTH

INTEGRATION: ROLES OF THE KEY TEAM MEMBERS

Chairperson.: Lori Raney, M.D., 281 Sawyer Drive, Durango, CO 81303
Presenter(s): Lori Raney, M.D., Benjamin Miller, Psy.D., Frank Degruy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify and discuss the roles of the 3 members of a primary care behavioral health integration team; 2) Demonstrate basic knowledge of how to provide psychiatric consultation on an integrated care team; and 3) List the characteristics of psychiatrists most suited for this work.

SUMMARY:

Primary Care Behavioral Health (PCBH) Integration is an emerging research supported model for the identification and treatment of previously undiagnosed or undertreated mental illness in primary care settings and unrecognized chronic health conditions in mental health clinics. Due to its success, recent health care reform legislation provides additional funding for this model of care. Psychiatrists have had few training opportunities in this area even though they are valuable and highly sought after members of PCBH Integrated Care teams. The knowledge gap is significant and is hampering psychiatrists joining these teams in wellinformed and meaningful ways. The traditional PCBH integrated care team includes the Primary Care Provider (PCP), the Behavioral Health Provider (BHP) and the Psychiatric Provider all working together to provide the Patient with comprehensive care at the point of contact in the primary care setting. This workshop will provide an overview of PCBH Integration and offer an indepth exploration of the roles of each of the core team members and their working relationships to each other. The 3 speakers are representative of the makeup of these teams and will share their perspectives on the functions and training needs of each discipline. Dr. deGruy is a family practice physician who has extensive experience in PCBH integration. He will describe the unmet need for mental health treatment in primary care and the need for support by mental health professionals. Dr. Miller has trained Behavioral Health Providers for their roles in primary care settings and will describe the ideal BHP and the services they provide on the Integrated Care teams. Dr. Raney works as a team consultant psychiatrist in a variety of settings including a Federally Qualified Health Center, a Rural Health Center and a School Based Health Center. She will describe her experience in Integrated Care and offer psychiatrists concrete ways to prepare to be successful team members. She will focus on approaches psychiatrists can utilize to provide unprecedented support in primary care settings. A strong PCBH integrated care team requires a psychiatrist that is knowledgeable about not only their role on the team but also the workings of the PCBH integrated care system. This workshop strives to address the significant knowledge gap that currently exists for psychiatrists who desire to work in this developing subspecialty area.

WORKSHOP 74
THE OLDER ADULT DRIVER WITH DEMENTIA: SAFETY CONCERNS AND PHYSICIAN INTERVENTIONS *APA COUNCIL ON ADULT PSYCHIATRY*

Chairperson.: Helen H. Kyomen, M.D., M.S., 115 Mill Street, Belmont, MA 024789106
Presenter(s): Helen H. Kyomen, M.D., M.S., Robert Roca, M.D., M.P.H., David Casey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess the functional ability of the older adult driver with dementia; 2) Determine appropriate interventions for the older adult driver with dementia; 3) Counsel the older adult dementia patient who is no longer safe to drive; 4) Understand physician ethical and legal responsibilities regarding the older adult driver with dementia.

SUMMARY:

Among 6575 year olds, motor vehicle injuries are the main cause of injuryrelated deaths. Among 7584 year old persons, they are the second leading cause, after falls. Despite traffic safety programs which have reduced the fatality rate for younger drivers, the fatality rate for drivers over 65 years of age has remained consistently elevated. Dementia has a negative influence on driving skills which progressively worsen with increasing dementia severity. Psychiatrists are in a unique position to address this health issue by identifying and evaluating drivers at risk for motor vehicle accidents due to dementia, and intervening to enhance

driving safety and ameliorate the change to driving cessation when necessary. In this workshop, the participant will learn to assess the functional ability of the older adult driver with dementia, determine appropriate interventions, counsel the older adult dementia patient who is no longer safe to drive (and their caregivers), and understand ethical and legal responsibilities regarding the older adult driver with dementia.

WORKSHOP 75
MODELS FOR MAXIMIZING CLINICAL REVENUES AND SUPPORTING THE ACADEMIC MISSION: A JOINT

The AACDP and AAP
CoChairperson(s): Paul Summergrad, M.D., 800 Washington St. #1007, Boston, MA 02111, Radmila Bogdanich, M.A.
Presenter(s): Narriman Shahrokh, Other, Lindsey Dozanti, Other, Joseph Thomas, B.S., M.B.A., Stuart Munro, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session participants will be able to: 1) Identify which psychiatric services are profitable; 2) Recognize diversified funding streams; 3) Compare net collection rates for inpatient and outpatient care using various methodology; 4) Identify productivity benchmarking data for psychiatrists by specialty and also for psychiatric nurse practitioners, social workers, therapists, counselors and clinical psychologists; 5) How to design clinical services to maximize margin

SUMMARY:
Abstract: This workshop is a joint program submission of the American Association of Chairs of Departments of Psychiatry and the Administrators in Academic Psychiatry In this time of economic uncertainty and increased financial pressures, effective management of practice plan resources and clinical revenues is critical. Psychiatrists are being pressured to generate increased clinical revenues and yet it is difficult to find meaningful benchmarking data to plan clinical effort effectively. In the fall of 2010, a national benchmarking survey of 133 medical schools was conducted by the Administrators in Academic Psychiatry, in collaboration with the American Association of Chairs of Departments of Psychiatry. Data was gathered from academic departments across the country on a variety of topics including demographics, educational programs, research programs, organization of practice plans, and revenue generation and plan expenses of clinical practices plans. The information presented in this workshop will focus on clinical practice plans and allow the participants to identify a variety of practice plan structures, funding streams and recognize which clinical efforts are profitable. Productivity standards for adult inpatient and outpatient psychiatrists, child inpatient and outpatient psychiatrists, psychiatric nurse practitioners, social workers, therapists, counselor and clinical psychologists will be compared as well as net collection rates for both inpatient and outpatient care. Select profitable programs will be described. Discussions of how to balance the academic and clinical missions and challenges to improving the net margin of departments of psychiatry will be highlighted. Questions and answers from participants and the audience will be encouraged. Participants will be able to describe their current organizational structures and how the management of those services and resources can be modified to replicate successful strategies to enhance overall productivity, and improve their net margin in the service of academic goals.

WORKSHOP 76
GOING INTERNATIONAL: IMPROVING INTERNATIONAL MEDICAL GRADUATES' TRAINING EXPERIENCES DURING PSYCHIATRY RESIDENCY

Chairperson.: Sanjeev Sockalingam, M.D., 200 Elizabeth St. 8EN228, Toronto, M5G2C4 Canada,
Presenter(s): Ari Zaretsky, M.D., Susan E. Abbey, M.D., Sanjeev Sockalingam, M.D., Raed Hawa, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify common challenges facing IMGs during their transition into psychiatry residency training programs; 2) Evaluate IMGs' needs during their transition into psychiatry residency and to develop an educational plan to address potential challenges; and 3) Manage psychiatry IMG specific training issues and to recognize potential resources for IMGs.

SUMMARY:
With the increasing number of international medical graduates (IMGs) applying for psychiatry residency

in North America, improved IMG preparation is vital to facilitating a successful training experience. Although many IMGs in residency training programs are equipped with diverse language capabilities and sensitivity to caring for patients from other ethnic groups, some have proposed that transition to the North American medical environment may present IMG trainees with several challenges. During psychiatry residency, IMGs may experience "culture shock", communication difficulties, challenges in working with multidisciplinary teams and struggles with learning a new health care system. Although preparatory courses have historically been the primary educational resource for IMGs prior to residency, literature suggests that IMGs may also benefit from additional resources to assist with their transition and professional development during psychiatry residency. The following workshop will identify key challenges encountered by psychiatry IMGs and educators and will offer potential solutions to these training issues. Data from a multisite Canadian needs assessment of IMGs training needs during their transition into psychiatry residency will be used to facilitate an interactive discussion about potential solutions to these gaps in training. Cases from the presenters' experiences will be used to discuss common themes encountered during IMG training in psychiatry. The audience will be provided with an approach and resources for managing common IMG training concerns. Resources will include an innovative IMG Postgraduate Psychiatry training manual that will be utilized by postgraduate psychiatry programs across Canada. Moreover, the development and implementation of an IMG mentoring program and IMG Orientation to Psychiatry curriculum will be integrated into casebased discussions.

WORKSHOP 77
WHAT HAVE YOU DONE FOR ME LATELY: IDENTIFYING EARLY CAREER PSYCHIATRISTS'NEEDS AND RESOURCES WITHIN THE APA

APA *Membership Committee*
Chairperson.: Nioaka N Campbell, M.D., 15 Medical Park, Columbia, SC 29203
Presenter(s): Mark Townsend, M.D., M.S., Chetana Kulkarni, M.D., Emily Stein, M.D., Alan Schlechter, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the trends of Early Career Psychiatrists' membership within the APA; 2) Review the benefits and barriers for Early Career Psychiatrist members as they begin psychiatric practice; 3) Evaluate the needs of underrepresented and minority ECP members; and 4) Assess how interactions with Members in Training and Early Career Psychiatrists can enhance citizenship within the APA.

SUMMARY:
In a 2009 survey of first year medical students by Gillies et al., eight themes were identified in response to the question "Why pursue a career in medicine?" These included an expectation that a career in medicine would be intellectually and personally fulfilling, would be respected by the community, and would yield financial security. Conversely, a survey by Markwell and Wainer in 2009 revealed that 69% of young physicians finishing residency met the criteria for burnout. This was described as hopelessness and difficulty in effective job performance. Out of the respondents, 71% had lower than average levels of job satisfaction, and 38% indicated that they were not prepared for life as a physician. Entering into practice as an Early Career Psychiatrist, or ECP, poses continued stressors on young physicians. Balancing family, career, and other responsibilities can be a daunting task. In assessing Early Career Psychiatrists within our national organization, ECPs have comprised 1820% of our total APA membership over the past four years. During this time period, the percentage of total drops in membership pertaining to Early Career Psychiatrists has ranged from 2228%. In evaluating the reason for membership loss within our ECP members, we should first identify the internal and external stressors that are facing this population. The APA as an organization provides professional services, mentorship, and support to ECPs which are often underutilized or unrecognized. In this workshop we will discuss and evaluate the needs of ECPs, and the benefits that the APA can provide in the professional development of our young members. The needs of minority and underrepresented groups within the ECP membership who may have particular areas of interest that would be crucial in their professional careers will also be addressed. Finally, we will discuss

the transition of Members in Trainings to Early Career Psychiatrists, and how interaction between these groups may be effective for further endeavors. Providing a nurturing environment and needed support to ECPs in the early years of practice will benefit the field of psychiatry and promote citizenship and future leadership within the APA.

TUESDAY, MAY 17, 2011
7:00 AM - 8:30 AM

WORKSHOP 78
BRIDGING THE MENTAL HEALTH CARE CHASM: COLLABORATING WITH PEDIATRICIANS TO IMPROVE PSYCHIATRIC CARE FOR AMERICA'S CHILDREN

APA Council on Children, Adolescents & Their Families
Chairperson.: L. Charolette Lippolis, D.O., M.P.H.
Presenter(s): L. Charolette Lippolis, D.O., M.P.H., Michael Houston, M.D., Mary Dobbins, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants should be able to: 1) Identify administrative and economic barriers to collaboration between psychiatrists and pediatricians; 2) Describe collaborative care models for emergent and urgent psychiatric care for children and adolescents; and 3) Identify models of effective collaboration between pediatricians and psychiatrists in outpatient and community settings to improve mental health services for children and their families.

SUMMARY:
In 1999 the U. S. Surgeon General's Report on Mental Health stated that although nearly 1 in 5 children in America suffer from a diagnosable mental disorder, only 20% to 25% receive treatment. This report highlighted the challenges of gaining access to mental health services in a complex and often fragmented system of health care. The severe shortage of available child and adolescent psychiatrists places increased pressure on other health care providers, particularly pediatricians, to provide mental health services for children. Primary care providers have unique strengths, skills, and opportunities to identify and address the unmet mental health needs of children and adolescents; however, many administrative and financial barriers currently prevent them from fulfilling their potential: including discomfort with their knowledge and skills, time constraints, poor payment, limited access to mental health consultation and referral resources, and administrative barriers in insurance plans. In June, 2009, the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry published a joint position paper to help ensure the mental health and wellness of America's children and adolescents by addressing the administrative and financial barriers that primary care clinicians and children's mental health professionals face in providing behavioral and mental health services. This workshop will describe ways that collaboration between psychiatrists and pediatricians can increase access to mental health services for youth in a costeffective and clinically significant manner. Administrative and economic barriers to collaboration and recommendations for improvement will be explored. Collaborative care models for emergent and urgent psychiatric care for youth will be described. And finally, we will explore models of effective collaboration between pediatricians and psychiatrist in the outpatient and community settings.

WORKSHOP 79
ETHNOPSYCHOTHERAPY AND ETHNOPSYCHOPHARMALOGY

Chairperson.: Consuelo C Cagande, M.D., RWJMSCamden, Department of Psychiatry, 401 Haddon Ave,, Camden, NJ 8103
Presenter(s): Edmond Pi, M.D., Eugenio Rothe, M.D., R. Rao Gogineni, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Apply culturally sensitive psychotherapeutic techniques to be helpful to various ethnic groups; 2) Learn ethnic specific doctorpatient relationships, cognitions, transference reactions and design strategies to handle them; and 3) Determine the differences in responses to psychopharmacological agents among various ethnic groups and the reason for such variations

SUMMARY:
Purpose: 21st century brought in a changing face of ethnicity in United States. Various Latino, Asian groups became more prominent. NonHispanic whites will become a "minority". There has been rise

in multicultural consciousness. There has been an enormous increase in understanding of sociocultural, familial, psychological, intrapsychic/cognitive style differences in various ethnic groups. An increase in understanding of biological, metabolic, physiologic differences in psychopharmacogical agents' is increasing in various ethnic groups. It is important to consider these psychological, social, biological differences in practicing evidencebased psychiatry in various cultural groups Content: Some of the factors that influence ethnicity include race, racism, religion, social class, proficiency in English language, immigration, skin color, world view etc. The group's cultural attitudes towards therapy, what they perceive as problem, group's organization and group boundaries can influence the type of therapy, intervention one would prescribe. Learning about the family structure, generational differences contribute different family intervention "psychological mindedness", differences in individuation, child rearing, formation of "self", inter/intra ethnic transference/ counter transference reactions, cognitive style, world view etc. helps to design appropriate, useful psychotherapeutic interventions. Factors that influence pharmacological differences include pharmacokinetics (metabolism, protein biding, etc), pharmacodynamics (receptor specificity), attitudes towards medications etc. Methodology: Small group discussion with case based learning mixed in with didactics. Audience participation will be encouraged. Results and Importance: Help to prepare the clinicians to practice evidence-based, culturally sensitive, ethnically specific biopsychosocial interventions.

WORKSHOP 80
THE ANATOMY OF THE PAPERLESS PRACTICE: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW BEFORE GOING PAPERLESS

Chairperson.: Amy Berlin, M.D., 1032 Irving Street #707, San Francisco, CA 94122

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Describe basic functions of electronic health records (EHRs) for the psychiatry practice 2) Define "meaningful use" and understand eligibility criteria for federal government subsidies of EHR adoption; 3) Evaluate advantages and disadvantages of local versus remote software hosting; 4) Identify three basic security practices for EHR use; and 5) Outline a practicespecific strategy for EHR selection and implementation.

SUMMARY:
The advantages of a paperless practice are clear. Electronic charting, billing, prescriptions, and automated scheduling make us more efficient so we can focus on the work we love. But at what cost? How safe is it to completely abandon paper, pen, and appointment book? Given the pressure from the federal government for physicians to "go electronic," how do we decide if we are making the right choice of technology for our practice and our patients? In this workshop, we'll explore the nuts and bolts of developing a paperless practice, including: *Making sense of the American Recovery and Reinvestment Act's (ARRA's) subsidies for "meaningful use" of electronic health records (EHRs). This will include a review of the act's provisions, including plain language explanation of the criteria that qualify psychiatrists to receive federal subsidies for EHR adoption. *Workflow mapping 101. We will walk through the most common – and the most creative – uses of information technology in a psychiatric practice. Participants will learn how to "map" the flow of patients and information through their practice (or facility) to generate a customized technology "wish list." * How to select the right software – and exactly what to avoid so you don't end up overpaying. This will include an overview of two models for software hosting – local and remote – and what these choices represent for psychiatric practices of all sizes in terms of technological knowhow, infrastructure, and cost. Reallife EHR adoption scenarios will outline best practices for evaluating software vendors on everything from product stability to technical support. *Information security for dummies. Does paperlessness really compromise patient confidentiality? Workshop participants will explore their biases and fears from both sides of the digital divide. We will review critical security measures for the paperless practice from backups to policies on email correspondence with patients. If time permits, we'll also discuss the pros and cons of introducing computers to our sessions, be it for process notes, conducting literature searches for patients, or administrative purposes. Participants are encouraged to bring laptops for handson access to the interactive session handout.

WORKSHOP 81
IN OUR OWN WORDS: SUCCESSFUL AGING ACROSS THE LIFESPAN

Co-Chairpersons: Steve Koh, M.D., M.P.H., RTO 9116A, 9500 Gilman Dr, La Jolla, CA 92093, Laura F Marrone, M.D.
Presenter(s): Dilip Jeste, M.D., Sidney Zisook, M.D., James Henry, M.D., Daniel Sewell, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Acknowledge their assumptions about and personal definitions of successful aging; 2) Acquire a variety of perspectives about successful aging from those in different life stages; 3) Understand positive assets of aging and how this develops through life stages; and 4) Discuss effective ways in which to present the concept of successful aging to the public.

SUMMARY:
As our population ages, the concept of "successful aging" is undergoing its own maturation. Traditional models, which focus primarily on lack of disability, underestimate the number of older adults who selfreport as aging successfully (1, 2). Studies are bringing attention to the role of previously underappreciated factors, like spirituality and resilience (3). Despite this conceptual evolution, most medical school and residency programs have yet to integrate a multidimensional model of successful aging into their geriatric training. On the surface, it makes sense for medical trainees to focus primarily on the treatment of illness to promote healthy aging. The problem with this approach, however, becomes apparent when one considers the pervasiveness of ageism at various stages of training. Medical students already harbor negative attitudes toward older adults at the beginning of medical school (4). Awareness of the growing age gap has prompted many training programs to initiate geriatricspecific clinical rotations; even so, these rotations have no effect on negative attitudes unless they also include exposure to healthy older adults (5). There is evidence to suggest that these negative attitudes affect clinical decisionmaking and may even play a role in the low number of clinicians who pursue specialty training in geriatrics. In light of this persistent ageism, medical training programs are beginning to incorporate positive geriatrics into their curricula. Some pair medical students with "aging mentors"—independently living older adults without major medical problems—throughout the first two years of medical school. Pending completion of the program, medical student feedback demonstrated a new appreciation for the "vitality" and "courage" of older adults (6). Others have set up dialogues between medical students and a council of "well" elders; when paired with reflective writing exercises, this interaction led to an improvement on 7 items of the Geriatric Attitude Scale (7). The "Columbia Cooperative Aging Program" positively impacted attitudes of resident physicians towards older adults (8). Even so, fundamental questions remain to be answered—how should we choose exemplars of successful aging? Can we teach the elements of successful aging while tolerating this ambiguity? How does the definition of successful aging change over time? One possible attempt to answer these questions is to have aging experts interact with successfully aged individuals.

WORKSHOP 82
SCOPE OF PRACTICE EXPANSION: LESSONS LEARNED FROM THE ALOHA STATE

CoChairperson(s): Jerry L Halverson, M.D., 34700 Valley Rd, Oconomowoc, WI 53066, Claudia L Reardon, M.D.
Presenter(s): Art Walaszek, M.D., Jeffrey Akaka, M.D., Elaine Heiby, Ph.D.

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) Advocate for patient safety regarding scope of practice issues in psychiatry; 3)Understand the history of psychologist prescribing legislation in Hawaii; and 4) Appreciate the politics behind the Hawaii Psychologist Prescribing legislation.

SUMMARY:
Psychologists across the nation continue their push 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. No state knows this push better than Hawaii,

the location of this year's meeting. The national psychological association has targeted Hawaii for this scope of practice expansion for over 20 years without success. After an overview of the issues, we will examine the history of these attempted legislations, through the eyes of a Hawaiian psychiatrist, as well as a Hawaiian psychologist who disagrees with her national organization's push for prescribing privileges. We also plan to have a member of the Hawaiian legislature discuss the political aspects of this legislation (he has agreed to do it but was not able to get to his disclosure right now as he is running for reelection, so I will exchange him for Art when he is able to complete his disclosure). Through looking back at this history, we will discuss the arguments used to support this legislation. Included will be discussion of the Department of Defense pilot program to train military psychologists to prescribe. Then, 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. Finally, we talk about some of the innovative ways psychiatrists across the nation are helping to close the "access gap". 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.

WORKSHOP 83
GROUP PROGRAM FOR TACKLING SMOKING CESSATION AND WEIGHT CONCERNS

Chairperson.: Rima Styra, M.D., M.Ed., 200 Elizabeth St., Toronto, M5G 2C4Canada,
Presenter(s): Rima Styra, M.D., M.Ed., Shobha Sawh, M.S.W.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant will be able to: 1) Identify factors that may negatively impact on smoking cessation attempts; 2) Use tools and strategies in a group environment to assist with smoking cessation and to address weight concerns; and 3) Provide a psychoeducational intervention to address the impact of smoking on medication.

SUMMARY:
Many believe that concerns about weight gain due to smoking cessation can impede quitting. A number of studies have demonstrated the efficacy of cognitive behavioral therapy in the treatment of smoking cessation as well as weight management. The conceptualization and combination of treatment for both these issues provides a more complex and inclusive approach to these patients. This is especially significant in patients who also have comorbid medical conditions and more aggressive treatment to address these issues is urgently required. Group cognitive behavioral therapy offers individuals the opportunity to learn behavioral techniques for smoking cessation, and to provide each other with mutual support. The literature states that efforts to avert weight gain while quitting smoking have been ineffective at best and a better approach to enhancing cessation is to minimize the smoker's concern about possible weight gain. The addition of a preventative weight gain component to the treatment allows identification and mitigation of fears and doubts about weight gain prior to the realization of these fears. We will outline the components that contribute to the effectiveness of the intervention starting with an evaluation of tools for the assessment of motivation and dependence. The steps utilized in selfmonitoring, the cognitive strategies directed at the link between smoking and weight gain, and the experiential strategies incorporated into the program will be reviewed. The experiential strategies are often the strongest factors that participants have identified as assisting in changing their core beliefs and behaviors. Tools and strategies which have been employed daily diaries, innovative group therapy environments, cooking/exercise participation, setting healthy goals and physiological measures (BMI, glucose, lipid profiles) will be reviewed. Patients with comorbid medical conditions who are in the group are usually concurrently being treated with medications to address their underlying disease. A psychoeducational component regarding medication metabolism with smoking cessation has therefore been incorporated and will be discussed.

WORKSHOP 84
FROM DR. KREIZLER TO HANNIBAL LECTER: FORENSIC PSYCHIATRISTS IN FICTION

CoChairperson(s): Sara G West, M.D., 10000 Brecksville Road, Cleveland, OH 44141, Cathleen A Cerny, M.D.
Presenter(s): Susan Hatters Friedman, M.D., Sherif Soliman, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate how psychiatrists and, more specifically, forensic psychiatrists are portrayed in fictional works; and 2) Identify changes in public policy based on the public's perception of forensic psychiatrists.

SUMMARY:
Fiction in all its forms abounds with examples of forensic psychiatrists. From The Alienist's wise and empathic Dr. Laszlo Kreizler to the cunning and diabolical Dr. Hannibal Lector, the public has been provided with a variety of vivid characters to mold their perceptions of our work. This presentation will start by exploring how psychiatrists, in general, have been portrayed in the mediums of popular culture. We will discuss the work of psychiatrist film scholars such as Glenn Gabbard and Irving Schneider. Next, we will narrow our focus to the field of forensic psychiatry and discuss fictional depictions of psychiatric experts. Numerous examples will be used to highlight the ways in which forensic experts have been criticized. We will link our fictional examples to public perception of forensic psychiatry. Finally, we will discuss how public perception influences political opinion, public policy and jury decision making. All of these objectives will be accomplished utilizing film, TV and audiobook clips.

WORKSHOP 85
HOW MAY MILITARY LEADERS OPTIMIZE MENTAL HEALTH OF SERVICE MEMBERS?
APA Lifers
CoChairperson(s): Sheila Hafter Gray, M.D., Box 40612 Palisades Station, Washington, DC 200160612, Stephen C Scheiber, M.D.
Presenter(s): Eugene Kim, M.D., Elspeth Ritchie, M.D., M.P.H., Christopher Perry, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to; 1) Identify stressors that occur during military service; 2) Differentiate roles of military and civilian psychiatrists; 3) Identify ways in which commanders may influence the mental health of their service members; and 4) Develop a model for consultation to military leadership to assure optimal mental health of service members.

SUMMARY:
In military culture, maintaining the health and welfare of service members, including their emotional wellbeing, is a duty of unit leaders. We shall explore some typical situations in which the attitude or behavior of commanders may be particularly influential on the mental health of individuals and of the unit, and show how psychiatrists may help them succeed in their mission. Ritchie will focus on the problem of sexual trauma in the military. The acute and long term clinical and forensic management of the issues raised when a service member has been assaulted may appropriately differ from those used in civilian practice. The role of command in mitigating the harm of the specific event and in reducing the overall incidence of sexual violence in a unit will be stressed. Combat stress is ubiquitous; but posttraumatic stress disorder is not. Military commanders know that experiences of helplessness and isolation during combat tend to eventuate in this mental disorder or in depression. Line officers are routinely educated and trained to lead in ways that help individual service members deal with unpleasant feelings and that maintain a cohesive functioning war fighting unit that mitigates isolation. They sometimes state wryly that there is no mental disorder in the military, only bad leadership. Perry will report on specific leadership skills that have proved effective, and on therapeutic interventions that are useful if the individual's experience of leadership was suboptimal. Division psychiatrists in Army combat units confront a set of challenges that are different from those encountered by their civilian counterparts in employee assistance programs. They are agents of command, implementing the requirement to maintain the health and welfare of service members, as well as psychiatrists for individuals. Kim will examine the tension of this dual agency, which is normative in military medicine, and describe some responses to the technical challenge to find a place where the interests of an individual soldier and that of command align harmoniously. He will show how achieving this balance sets an example of integrity and dedication that supports successful operations and individual well being.
DISCLAIMER: Opinions or assertions contained in this presentation are the private views of the speakers and are not to be construed as official or as reflecting the views or policies of the Department of Defense or any of its affiliated institutions.

WORKSHOP 86
REVISITING THE WAYWARD YOUTH
AAOL
Chairperson.: Nadia E Charguia, M.D., 114 Brookview Street, Durham, NC 27713
Presenter(s): Stephen Billick, M.D., Louis Kraus, M.D., William Arroyo, M.D., Peter Ash, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participants should be able to: 1) Understand past and recent developments within the Juvenile Justice System; 2) Identify conflicts around Adolescent Culpability and draw upon associations for clinical assessement, treatment and options of disposition; and 3) Appreciate implications of the current Juvenile Justice System as it affects minority and female adolescents.

SUMMARY:
As psychiatrists we continue to struggle to fully understand the adolescent stage of development, as this is a stage of such flux in emotional, hormonal, physical and ego development. More conflict and questions arise when this population suffers from mental health issues and delinquent behaviors. A persistent tension exists as we struggle to meet the needs of youth with mental health issues, desiring to educate, treat and rehabilitate delinquent behaviors. Yet this is juxtaposed with the additional necessity to determine accountability of juvenile delinquents for their behaviors as well as uphold a social mandate to protect and promote safety for all. This workshop intends to provide an overview of the Juvenile Justice System with a pertinent focus on the interface with adolescent psychiatry. Topics will center primarily on: 1) The history and recent areas of reform within the Juvenile Justice System, particularly looking at the impact of current research on public policy, with special focus on recent supreme court decisions around the death penalty and life without parole; 2) Exploring concepts of adolescent culpability, visiting legal aspects as well as clinical issues around assessment and practice; 3) Discussing topics around disproportionate minority contact and adolescent females in the Juvenile Justice System; 4) Assessing judicial options in disposition, with regards to treatment options for juvenile delinquents. The intended audience for this workshop is broad, as these topics pertain to all areas of practice within the field of psychiatry, including child and adolescent as well as forensic psychiatry. In addition, there are numerous social implications that affect us all. Time will be allotted after each topic as well as the end of the workshop for encouraged feedback and discussion regarding these important issues.

WORKSHOP 87
INNOVATIVE MODELS FOR INTEGRATING PSYCHIATRIC SERVICES INTO PRIMARY CARE AS HEALTH CARE REFORM MOVES TOWARD THE MEDICAL HOME
Chairperson.: Gregory W. Dalack, M.D., F6327, 1500 E. Medical Center Drive, Ann Arbor, MI 48109
Presenter(s): Radmila Bogdanich, M.A., Narriman Shahrokh, Other, Joseph Thomas, B.S., M.B.A., Lindsey Dozanti

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify alternative model programs to integrate psychiatric services into primary care settings; 2) Apply strategies that are critical to integrating psychiatric services into nontraditional settings; 3) Identify potential barriers to implementation; and 4) Utilize alternative models of financial management to increase revenue.

SUMMARY:
This workshop will describe four model programs for integrating psychiatric services into various primary care settings within public, private and academic health care systems and describe practice management tools to make the integration financially successful. Access to mental health services continues to be a problem for many patients. One way to approach this problem is through closer integration with primary care. While such integration promises to improve access and better coordination of overall care, implementation challenges remain. Some of the most vexing are allocation of practice costs, payment for mental health services, psychiatrist availability, delivering improved outcomes, reducing no show rates, and achieving greater patient satisfaction. Four academic health centers will present how they are tackling these issues through the use of improved patient interactive information systems, psychiatry friendly revenue sharing, practice expense mitigation, physician networking and physical integration of services. Workshop participants will learn to

apply critical strategies that allow integration of psychiatric services into nontraditional settings. Strategies include but are not limited to: planning and developing resources (including space and staffing), information sharing, patient consent, interdisciplinary consultation, appointment scheduling, insurance verification/precertification, billing, supervision, coordinated policy development, etc. Discussion will address how to: 1) identify and apply methods to build internal/external relationships, 2) recognize barriers including potential political road blocks, 3) utilize different financial models to optimize clinical revenues and funds flow to reinforce "onestop shopping" for patients.

WORKSHOP 88
CPT CODING AND DOCUMENTATION UPDATE
Chairperson.: Ronald M Burd, M.D., P.O. Box MC, Fargo, ND 581220390
Presenter(s): Tracy Gordy, M.D., Ronald Burd, M.D., Jeremy Musher, M.D., Allan Anderson, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be: 1) Knowledgeable about current Medicare and CPT coding changes; 2) Uptodate on Medicare reimbursement concerns; and 3) Have their individual questions about coding, documentation and reimbursement addressed.

SUMMARY:
The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding and current issues associated with documentation guidelines. This year's workshop will focus on 1) updating participants as to current issues related to CPT coding 2) a review of current Medicare reimbursement issues and concerns, and 3) discussion of documentation guidelines for psychiatric services as well as the evaluation and management service codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their own practices.

9:00 AM - 10:30 AM

WORKSHOP 89
MALPRACTICE DEFENSE: STRATEGIES FOR SUCCESS
CoChairperson(s): Abe M Rychik, J.D., 150 E. 77th St., New York, NY 10021, 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 3) Learn 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 the 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 viaavis 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. PostTrial 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.

WORKSHOP 90
MIND'ROIDS? PSYCHOTROPIC MEDICATIONS AS NEUROENHANCERS AND LIFESTYLE DRUGS: PSYCHIATRY AT THE ETHICAL, MORAL, AND LEGAL CROSSROADS
Chairperson: Damir Huremovic, M.D., M.P.P., Nassau University Medical Center, 2201 Hempstead Turnpike,

East Meadow, NY 11554
Presenter(s): Nyapati Rao, M.D., M.S., Carmela Olevsky, D.O., Guitelle St. Victor, M.D., Shabneet HiraBrar, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the growing public health issue of cognitive or mood enhancing drugs being used by healthy populations; 2) Identify ethical and legal challenges implicated in providing care and services for individual with such requests; and 3) Formulate opinion and position on how to address such issues in own practice.

SUMMARY:
The use of psychotropics for enhancement of cognitive performance represents a growing trend among college students and young adults struggling to meet increasingly complex educational and professional demands. One in five students internationally report taking psychotropic medications for nonmedical purposes, with a significant percentage of them using psychotropics consistently. Whilst use of psychotropics for nonprescribed (and often illegal) purposes is nothing new, their emerging use as neuroenhancers has so far been met with little social and professional scrutiny, implying tolerance if not outright acceptance. Possible explanation for this lies in the analogies with other lifestyle drugs (e.g. weight loss medications) or procedures (e.g. cosmetic surgery). Amidst growing demand by unimpaired individuals and supply by eager pharmaceutical companies, the use of psychotropics as neuroenhancers remains officially unsanctioned and unregulated. In the interim, stimulant medications prescribed by psychiatrists are shared or resold by one fifth of patients with legitimate diagnoses, with another significant subset of patients exaggerating or fabricating symptoms in order to obtain prescriptions for nonindicated purposes. With increasing prevalence of using existing medications as neuroenhancers and with the advent of new compounds aimed at boosting memory, mood, or cognitive skills, psychiatry as a profession will soon find itself at the crossroads, having to take a position on this issue. This workshop brings the issue of using psychotropics as neuroenhancers into the relevant forum and fosters an educated discussion by describing its trends and aspects, identifying associated ethical, legal, moral, and social challenges, and by outlining possible options to comprehensively addressing this issue, with special attention given to education of residents on this issue. Appropriate case examples will be used throughout the workshop to illustrate key points of this issue. Interactive participants' involvement is a key component of this workshop. Residents will be represented on the presenting panel.

WORKSHOP 91
QUALITY IMPROVEMENT IN PSYCHIATRY: WHY SHOULD I CARE?

CoChairperson(s): Claudia L Reardon, M.D., 6001 Research Park Boulevard, Madison, WI 53719, Jerry L Halverson, M.D.
Presenter(s): Robert Plovnick, M.D., M.S., Art Walaszek, M.D., John Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Describe the steps involved in a QI project in clinical psychiatric practice; 2) Understand the essential elements in developing a QI curriculum for psychiatry residents; 3) Explain the requirements involving QI that psychiatrists will need to meet in order to maintain certification; and 4) Understand how principles of QI are likely to influence psychiatric practice, including reimbursement.

SUMMARY:
Quality improvement (QI) in medicine involves a formal approach to the analysis of performance and systematic efforts to improve it. Psychiatry has lagged behind other specialties in quality improvement initiatives, in part because psychiatrists view their specialty as an art and not just a science and because they view their care as less amenable to outcomes measures. However, there are a number of reasons why psychiatrists should take the QI movement seriously, and this workshop utilizes a number of experts in the field to explain these myriad reasons. The Accreditation Council for Graduate Medical Education is increasingly mandating that residency programs provide education in QI to their trainees in order to maintain program accreditation. Dr. Claudia Reardon, Associate Residency Training Director in the University of Wisconsin Department of Psychiatry, has developed one of the first known

longitudinal QI curricula for U.S. psychiatry residents and will share essential elements in developing such a curriculum. Dr. Art Walaszek, Vice Chair for Education in the Department of Psychiatry at the University of Wisconsin and Director of Continuing Medical Education for the Wisconsin Psychiatric Association, will explain how the American Board of Psychiatry and Neurology's Maintenance of Certification Program contains a requirement for "Performance in Practice", in which ABPN diplomates will be required to participate in QI projects. Dr. John Oldham, APA PresidentElect and Past Chair of the APA Council on Quality Care, will provide an overview of the health care policy aspects of QI in psychiatry, including how reimbursement will increasingly depend on quality indicators. Dr. Jerry Halverson, a psychiatristadministrator at a large psychiatric hospital who has received extensive national training in QI, will conclude by sharing practical wisdom for incorporating QI into clinical practice. We will finish with plenty of time for audience discussion with a panel consisting of the above speakers together with Dr. Robert Plovnick, Director of the APA's Department of Quality Improvement and Psychiatric Services.

WORKSHOP 92
BULLYING: UNDERSTANDING ITS IMPACT AND ETIOLOGY *:*
APA AAOL
Chairperson.: Louis J Kraus, M.D., 910 Skokie Boulevard #230, Northbrook, IL 60062
Presenter(s): David Scasta, M.D., Debra Pinals, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the impact of bullying in schools, 2) Understand the group process of bullying, 3) Understand bullying and harassment of the LGBT individuals, and 4) Understand how to address the forensic and legal implications of bullying.

SUMMARY:
Bullying is typically a group process that can impact males and females. We most commonly see this in school age children. The process extends through adulthood. Perhaps more than any other school problem, bullying can affect a student's sense of well being both physically and emotionally. Schools are continuing to develop new techniques to decrease bullying, yet the problem continues. There are some that feel bullying is perhaps the most underrepresented safety problem in American school systems. These acts are intentional, they are malicious and they are typically repetitive. Bullying can include sexual harassment, ostracism, hazing, taunting, and physical assaults. Cyberbullying has also had an ongoing impact on children and adolescents. Many children that are bullied have underlying mental health and developmental issues which often leaves them with deficits in coping strategies. Tragically, over the past several years, there have been several suicides that were precipitated by bullying. In many cases of extreme violence, youth may experience a sense that they were bullied and pushed to a point where they needed to retaliate. Lesbian, gay, bisexual, and transsexual kids can be subjected to especially virulent and protracted bullying, especially by adolescent boys. Anxiety about sexual orientation can evoke classic psychodynamic projection and has been found to be at the root of some of the most violent crimes recorded. This workshop will focus on the impact that bullying has on individuals and families, and review the scope of individuals involved with bullying. This workshop will help to further understand the group process in bullying. We will further discuss the forensic and legal issues surrounding bullying, including risk assessment.

WORKSHOP 93
COGNITIVE THERAPY FOR PERSONALITY DISORDERS
Chairperson.: Judith S Beck, Ph.D., Suite 700, One Belmont Avenue Bala Cynwyd, Philadelphia, PA 190041610

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) Establish set goals and plan treatment for patients with character logical disturbance; 4) Enhance medication adherence; and 5) Describe and implement advanced cognitive and behavioral techniques.

SUMMARY:
Cognitive Therapy, a timelimited, structured,

problemsolving oriented psychotherapy, has been shown in over 500 trials to be effective in treating Axis I disorders. In the past 20 years Cognitive Therapy methods have been developed for Axis II disorders and research has verified the utility of this treatment approach. Cognitive Therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of developmental events. In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of Cognitive Therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and medication adherence. Role-plays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

WORKSHOP 94
ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE
APA Ethics Committee
Chairperson: Richard Malone, M.D., 120 Forest Ave, Rye, NY 10580
Presenter(s): Burton V. Reifler, M.D., Stephen Green, M.D., M.A., Wade Myers, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able t; 1) Recognize ethical dilemmas and common situations which may signal professional risk.

SUMMARY:
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.

WORKSHOP 95
CLINICAL DOCUMENTATION AFTER HITECH: IT'S BACK TO RISK MANAGEMENT BASICS *CoChairperson(s): Kristen M Lambert LICSW, J.D., M.S.W., 9 Farm Springs Rd, Farmington, CT 06032, Peter Imbert, Other*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the importance of formal policies and procedures for medical record documentation; 2) Establish and implement protocols for the security of protected health information; and 3) Minimize risk by adopting best practices to avoid professional liability claims.

SUMMARY:
While psychiatrists in all settings struggle on an ongoing basis to interpret emerging laws and regulations related to electronic record keeping, the success or failure of malpractice lawsuits more often turns on the quality rather than the method used for clinical documentation. This interactive risk management workshop will focus on identifying and implementing the fundamental best practices related to record keeping procedures – whether paper or electronic. Specific topics that will be discussed include: documenting consent for treatment, telephone conversations, consultation with other providers, prescriptions, as well as supervision of midlevel practitioners and students. In addition best practices to protect the privacy and security of patient information – whether paper or electronic – will be explored. Real life case examples from Allied World's psychiatry closed claims database will be provided in the form of case studies with audience participation in identifying the pitfalls and exploring risk mitigation and avoidance strategies.

WORKSHOP 96
OBESITY AND PSYCHIATRIC CARE: APPLICATION OF CURRENT EVIDENCE
Chairperson.: Valerie H Taylor, M.D., 100 West 5th Street, Hamilton, L8N 3K7 Canada,
Presenter(s): Brian Stonehocker, M.D., Arya Sharma, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the role played by psychiatric illness as both precipitating and perpetuating factors impacting weight regulation; 2) Accurately measure waist circumference and body mass index, and implement a Framingham risk score; 3 Calculate approximate caloric ranges for patients and use a food diary and a pedometer; and 4) Assess readiness to change and implement a behavioural plan for weight management to improve treatment.

SUMMARY:
Obesity is directly related to chronic conditions that are associated with early mortality and now has the dubious honour of having overtaken smoking as the health problem with the biggest impact on quality of life, mortality and morbidity. Despite this, the allocation of resources, research and treatment does not reflect the burden of illness. Individuals with mental illness are differentially affected by weight gain via mechanisms that both overlap with, and are distinct from, individuals in the general population. This obesity management workshop will use problembased learning to integrate the skills learned in the symposium, Obesity and Psychiatric Care: Current Evidence and Best Practice. Discussions will follow several structured cases, and will also review pharmacological management strategies. Participants will receive reference material and tools to take back to their practices.

WORKSHOP 97
PHYSICIAN HEAL THYSELF: THE WOUNDED HEALER, PSYCHIATRISTS' OWN PROFESSIONAL AND PERSONAL PAIN/STRESS/SUFFERING THE PATHS TO HEALING AND WHOLENESS *Chairperson.: James G Trantham, M.D., 402 South 333rd Street, Suite 100, Federal Way, WA 98003 Presenter(s): Ronald Hofeldt, M.D.*

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Evaluate the impact on themselves and their patient care of daily exposure to patient's pain, grief, and loss, as well as personal and family life experiences; 2) Gain experience in mindfulness practice and informal body scan as avenues for self care and self observation; 3) Appreciate and take control of their life balance to prevent burnout and adverse events in patient care.

SUMMARY:
A psychiatrist's health, self compassion, and healthy relatedness has a major impact on patient safety. As physicianpsychiatrists, we are in daily intimate contact with acute and chronic physical and psychic pain, grief, loss, sequelae of trauma, and violence. Chronic disease, disability, brain disease, dementia, and death have all been daily experiences. Encounters with psychotic depression, panic, mania, psychosis, substance related disorders, self mutilation, and suicide are routine. As human persons, we ourselves, like our patients, are subject to the pain, grief, loss, conflict, and emotional pain of living. How do we relate to and tend our own healing and wholeness in the intense, busy, often productivitydriven world of modern medicine? Do we remain aware of our own needs, met and unmet, our own dreams, losses, disappointments, pressures, missing parts of our lives and cut off parts of ourselves? In this program, we will seek to "remember" our "real self" behind the roles and personae that we live in. We will discuss the situations and events that may disconnect us from our real self as we strive to serve our patients, our families, our community, and comply with the political, legal, administrative entities that often seem to rule our lives. We will discuss the sources of our own stress, both from upbringing, school experiences, professional training in medical school, residency and the realities of professional practice. We will review some of the causes, symptoms, and results of unmet physician needs and unhealed personal and professional pain. We will practice a brief mindfulness exercise for ourselves as healers that can also be used for our patients. In group discussion, we will consider a "wheel of life" exercise to invite participants to evaluate their own needs, and consider individualized coping strategies. Psychiatrists will be invited to set one specific goal as an aid to reconnecting with their real self and moving toward healing and wholeness.

WORKSHOP 98
THE BURNING PLATFORM: TRANSFORMATION OF A BEHAVIORAL HEALTH SYSTEM IN CRISIS USING LEAN METHODOLOGY
Chairperson.: Joseph P Merlino, M.D., M.P.A., 205 East 78th Street, New York, NY 10075 Presenter(s): Kristen

Baumann, Ph.D., Joseph Merlino, M.D., M.P.A., Jill Bowen, Ph.D., Dimple Sodhi, M.D., M.S., Ellen Berkowitz, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Understand the basic philosophy and principles of Lean methodology; 2) Appreciate the various applications of Lean methodology in behavioral healthcare delivery. 3) Consider the use of Lean techniques in their own practice setting; and 4) Recognize that innovation is not only possible, but profitable and sustainable even in the current economic climate.

SUMMARY:
In June of 2008, international focus was brought to Kings County Hospital Center (KCHC) in Brooklyn, New York, as a result of the death of a psychiatric patient in the psychiatric emergency room. An investigation by the U.S. Department of Justice found systemic problems in the delivery of care. Recognizing the need to transform the system of behavioral health care at KCHC, an innovative model of care was initiated. The methodology utilized for this transformation was Lean. Lean is an approach to quality improvement which was originally pioneered in Japan. Core concepts of Lean are: continuous improvement, quality, safety, and efficiency without job elimination (Kearney & Dye, 2009). Established in 1831, KCHC, one of this country's four largest public hospitals, has been a pioneer in providing mental health services to New York City residents for nearly two centuries. KCHC is one of eleven hospitals run by the New York City Health and Hospitals Corporation (HHC). HHC is the largest urban health care agency in the United States and KCHC is the largest provider of inpatient behavioral healthcare (236 beds) in the borough of Brooklyn, as well as serving an average of 2000 active clients in its adult mental health clinic. Lean methodology was implemented across the continuum of care at KCHC – psychiatric emergency room, inpatient psychiatric services and outpatient clinic. Weeklong Rapid Improvement Events (RIEs) were conducted and "standard of work" were created. RIEs are data driven and focused on outcome measures. This workshop, through the presentation of successes and challenges in system transformation, will demonstrate how such innovations can be implemented in a variety of healthcare settings.

WORKSHOP 99
INTEGRATION OF CULTURE, TRADITIONAL HEALING AND WESTERN MEDICINE WITHIN INDIGENOUS AND IMMIGRANT POPULATIONS
Chairperson.: Jeffrey L Akaka, M.D., P.O. Box 11780, Honolulu, HI 968280780
Presenter(s): Daniel Dickerson, D.O., M.P.H., Jeffrey Akaka, M.D., Gerard Akaka, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1: Be aware and respect the traditional healing systems as part of culturally competent health and mental health care; 2) To review current successes in integrating indigenous medical and cultural traditions into Western health care delivery systems; and 3) Identify important issues with regard to policy development on the inclusion, legitimization and reimbursement of traditional healers in health care systems

SUMMARY:
Hawaii, with its rich, multicultural demographic, which includes indigenous populations and immigrant groups from around the world, has given rise to the awareness, acceptance and utilization of traditional healing practices in health and mental health care delivery. Clinicians are beginning to realize the importance of understanding, accepting and integrating traditional healing approaches as a part of culturally competent care. This workshop will explore how mental health and primary care practitioners are combining traditional healing practices and culturally appropriate methods with western medicine. Some examples that will be highlighted in this session include the concept of *aloha* and *ho'o pono pono* in providing individual and family therapy, integration of traditional healing and Jungian approaches, and the Strengthening Hawaii Families program. In addition, this session will include a discussion surrounding the need for policies related to the inclusion, legitimization and reimbursement of traditional healers in health care systems.

NOON - 1:30 PM

WORKSHOP 100

CURRENT REALITIES OF HISPANIC MENTAL HEALTH IN THE U.S.: THE NEED FOR CONVERGENT APPROACHES

CoChairperson(s): Renato D. Alarcon, M.D., 200 First Street, SW, Rochester, MN 55905, Robert Kohn, M.D. Presenter(s): Alex Kopelowicz, M.D., Renato Alarcon, M.D., M.P.H., Robert Kohn, M.D., Sergio AguilarGaxiola, Ph.D., M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize the cultural components of proposed models of *DSM-5* and ICD11 and their implications for Hispanic/Latino populations; 2) Refine knowledge about treatment tools and strategies for Latino patients with schizophrenia and other psychiatric diagnoses; and 3) Increase awareness about the disparities in mental health care for Hispanic populations and the need for a more coherent and consistent focus on their resolution.

SUMMARY:
The Hispanic or Latino community is the largest and fastest growing minority in the U.S. This Workshop will attempt to evaluate the current state of knowledge about several aspects of Hispanic mental health in the U.S., and discuss based on existing evidence, the nature, quality, problems, debates and solutions related to the provision of diagnostic and treatment services. The purpose is to ascertain ways to improve their mental health care on the basis of a concerted coordination of efforts by academic, administrative and policymaking agencies. Dr. Alarcon, will address the current process of development of APA's fifth version of the *DSM-5* and the WHO ICD11, with an emphasis on the implications of aspects of each nomenclature project on Hispanic populations. The cultural perspective is useful and controversial, in terms of the level of its acceptance by clinicians, administrators and even researchers. The impact of new suggestions about different diagnostic categories, the cultural variations among Hispanics and their effect on severity, pathogenic power, explanatory models, and management issues will be examined. Dr. Kohn, will review a number of treatment approaches to different clinical entities in Hispanic populations. His focus on issues such as clinical competence and its components, using *DSM-5*TR's Cultural Formulation, the work, benefits and limitations of interpreters in the clinical enterprise, and the need to acknowledge, accept and value clinical differences. Dr. Kopelowicz, will discuss treatment of Latino patients carrying the diagnosis of Schizophrenia. On the basis of well documented research studies, he will examine different modalities of treatment management, particularly Illness Management Skills Training and Family Psychoeducation as applied to Hispanic/Latino populations. Discussion to include the advantages/disadvantages, and actual results of these modalities with an emphasis on applicability to diverse settings (state institutions to community mental health centers). Dr. AguilarGaxiola will examine the disparities in the provision of mental health care to Latino patients as evidenced by a variety of epidemiological and clinical studies. Latino patients may be less likely to visit physicians as a first step in their helpseeking patterns however, those in the mental health field will be the last they seek. The fact that once in the mental health system, there are inequities.

WORKSHOP 101
TEACHING THE MANAGEMENT OF RACIAL/ETHNIC ISSUES IN PSYCHOTHERAPY

Chairperson.: Glen O Gabbard, M.D., 6655 Travis St Suite 500, Houston, TX 770301316
Presenter(s): Funmilayo Rachal, M.D., Valdesha Ball, M.D., Kimberlyn Leary, Ph.D., M.P.A., Glen Gabbard, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the major challenges in teaching how to manage racial and ethnic issues in psychotherapy; and 2) Recognize the strategies that are helpful to address those challenges.

SUMMARY:
Dr. Funmilayo Rachal will be the first presenter and will discuss the principal challenges educators face in trying to teach the management of racial/ethnic issues in dynamic therapy. Dr. Glen Gabbard will be the second presenter and will elucidate the psychodynamic underpinnings of racial prejudice and discuss the phenomenon of "white privilege." Dr. Valdesha Ball will be the third presenter and will outline strategies to deal with the challenges in the classroom. Dr. Kimberlyn Leary will be the fourth presenter and will serve as the discussant of the three

previous presentations. Each presentation will be 15 minutes, leaving 30 minutes for discussion with the audience.

WORKSHOP 102
A NEW FACE OF PSYCHIATRIC ILLNESS: NEUROPSYCHIATRY LESIONS IN PICTURES

CoChairperson(s): Niru Jani, M.D., 10810 Hickory Ridge Road, Columbia, MD 21044, Sushma Jani, M.D.
Presenter(s): Niru Jani, M.D., Sushma Jani, M.D., Suni Jani, M.P.H., Raja Jani, Other

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Distinguish comorbid Neuropsychiatric conditions and Psychiatric Disorders; 2) Learn to focus on visual details of "appearance" to identify comorbid conditions of Neuropsychiatric conditions and Psychiatric Disorders; 3) Enhance Visual recognition and documentation of evolving neuropsychiatric lesions; 4) Make supportive/working diagnosis of comorbid conditions; and 5) Improve coordinated care.

SUMMARY:
Clinical Neuropsychiatry is rapidly evolving and the 21st Century patient is well connected with internet and social media, which has contributed to their increased complication and sophistication. Clinicians are finding the increased complexity of documenting the 21st Century Patient both demanding and time consuming. To alleviate this burden of increasingly complex documentation, this session presents a visual alternative – showcasing photographs of patients that may be considered an alternative documentation approach for use during an initial psychiatric examination. This proposed approach helps reduce the time spent by the clinician when documenting the encounter. A picture is, after all, worth a thousand words. It is customary during the psychiatric interview to observe the patient's general appearance and comment on the patient's posture, grooming, clothing, and body habitus. When reporting this portion of the mental status examination, the interviewer may simply state that the patient's general appearance is within normal limits or may include specific mention of particular abnormalities. This presentation – provides a collage of pictures captured over a 20 year span. The use of these pictures support the ability of the clinician to identify the nature of the pathology, acute vs. chronic lesions, the number of lesions, and help consider the causal relationships of possible coexisting stressors and medical conditions. Pictures provide clarification of diagnosis and differential on Axis III of the DSM diagnostic tree. The highlight of this session is the review of the coordinated care of these realtime "connected" and sophisticated patients. The session culminates with a pictorial outcome (an outcome as measure) of the cases presented here. At the conclusion of this session the participants will be able to his recognize the nature of comorbid psychiatric disorders and neuropsychiatric illnesses; and will provide practical exposure specific to the collection of clinical data through photographs.

WORKSHOP 103
SEXUALITY: BIOLOGY AS A DESTINY

Chairperson: Ronald R Holt, D.O., M.P.A., 1200 El Camino Real, South San Francisco, CA 94080

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Compare and contrast the definitions of sexual orientation and sexual behavior; 2) Describe the spectrum of sexuality in the general population; 3) Identify that sexual orientation is not a choice; 4) Describe how genetics plays a role in sexuality; 5) List the current biological theories on causation of sexuality; and 6) Identify neuroanatomical differences between homosexual and heterosexual men.

SUMMARY:
This presentation brings together the latest scientific knowledge on the causation of human sexuality. Through the use of cutting edge technology, interactive feedback from media videos, and interactive questions, the audience is introduced to and taught the biology behind LGBT sexuality, including understanding the differences between sexual orientation versus behavior; describing the spectrum of sexuality; identify how sexuality is not a choice; describing how genetics and biology play a role in sexuality; and identifying neuroanatomical differences between homosexual and heterosexual men. The knowledge from this presentation will allow clinicians and others a better understanding of LGBT sexuality, which will enhance the ability to provide more culturally competent care to the

LGBT population within our membership.

WORKSHOP 104A
ABPN AND APA PERSPECTIVES ON MAINTENANCE OF CERTIFICATION
CoChairperson(s): Larry R Faulkner, M.D., 2150 E Lake Cook Road, #900, Buffalo Grove, IL 60089, Victor I Reus, M.D.
Presenter(s): Mark Rapaport, M.D., Deborah J.Hales, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to describe the ABPN's MOC requirements and the APA's programs for meeting those requirements.

SUMMARY:
The purpose of this workshop is to present information on the ABPN's evolving Maintenance of Certification (MOC) program and on the APA's related efforts on behalf of its members. As mandated by the American Board of Medical Specialties, the ABPN has developed an MOC program for specialists and subspecialists that has four components: professional standing (licensure); selfassessment and lifelong learning; cognitive expertise (computerized multiplechoice) examination; and assessment of performance in practice. The phasein schedule for the components and the options that are available for completing them will be presented. The computerized multiplechoice examinations will be described, as will examination results. Related issues such as maintenance of licensure will also be discussed. Representatives of the APA will outline the programs and services the organization has developed to meet the needs of psychiatrists participating in MOC.

WORKSHOP 104
VIOLENCE AGAINST MENTAL HEALTH PROFESSIONALS: WHEN THE TREATER BECOMES THE VICTIM
Chairperson.: Sara G West, M.D., 10000 Brecksville Road, Cleveland, OH 44141
Presenter(s): Ashleigh Biedrzycki, D.O.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify patients who are at greatest risk for behaving violently towards their providers; 2) Recognize the importance of reporting and receiving treatment for violent incidents involving patients; and 3) State various techniques that may be employed to prevent violence against mental health professionals.

SUMMARY:
On September 3, 2006 Wayne Fenton, a prominent schizophrenia expert was found dead in his office as a result of a tragic assault by his 19 year old schizophrenic patient. This left many mental health providers concerned about their own safety in dealing with psychotic patients. Some staff rationalize that violence is an occupational hazard and believe that they should be able to cope with it. Despite these beliefs, staff victims suffer from many of the same physical and psychological sequelae as victims of a natural disaster or street crime. This workshop will highlight findings in the literature regarding patients who assault mental health providers, including the frequency, outcome and treatment available for such incidents. This will be augmented by an audience driven discussion of film and media clips that show mental health care providers as victims of their patients. The participants will then divide up into small groups to discuss and formulate their responses to a clinical vignette. Finally, there will be time allotted for questions and the opportunity for providers to share their own experiences with patient violence.

WORKSHOP 105
CULTURAL CONSULTATION, REMOTE INDIGENOUS POPULATIONS AND TECHNOLOGY *Chairperson.: Linda B Nahulu, M.D., 1356 Lusitana St Fl 4, Honolulu, HI 968132421*
Presenter(s): Chad Koyanagi, M.D., Linda Nahulu, M.D., Daniel Alicata, M.D., Courtenay Matsu, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Increase awareness of how remote technology is used for direct psychiatric care as well as consultation with primary care practitioners in the evaluation and treatment of underserved indigenous populations and 2) To increase awareness of the therapeutic impact and challenges revolving around cultural issues as they pervade in-person versus technology-enhanced care.

SUMMARY:

Hawaii is among the states and U.S. territories that have a considerable percentage of people residing in rural and remote areas where specialty mental health services are in short supply. In order to bridge the clinical distance and gaps, technology has emerged with a solution: treatment and consultation via live videoconferencing, also known as telepsychiatry. This workshop will examine the utility of remote technology for direct psychiatric care as well as consultation with primary care practitioners in the evaluation and treatment of underserved indigenous populations in remote areas. Presenters will discuss the therapeutic impact and challenges revolving around cultural issues as they pervade in-person vs. technology-enhanced care.

WORKSHOP 106
PSYCHOTHERAPEUTIC STRATEGIES TO ENHANCE MEDICATION ADHERENCE *:*
For APA Members Only
CoChairperson(s): R. Rao Gogineni, M.D., One Bala Ave,Suite #118,, Bala Cynwyd, PA 19004, Amit Gupta, M.D.
Presenter(s): Donna Sudak, M.D., Nyapati Rao, M.D., M.S., R. Rao Gogineni, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify sources of noncompliance to medications in specific disorders and individual patients; 2) Treat the noncompliance anr poor adherence to medications by using brief cognitivebehavioral,Psychodynamic,educational ,supportive,family interventions; and 3) Identify methods to train residents and clinicians to use these psychotherapy techniques to improve compliance.

SUMMARY:
Purpose and background information: Multiple studies in adult and pediatric psychiatric disorders have shown compliance rate of 2070%, depending on the specific disorder. Outpatient antidepressant compliance is approximately 40%. Non compliance in schizophrenics is 74%. Three months after initiation only 50% of the patients take ADHD medications. Medication noncompliance leads to recurrence of symptoms and rehospitalizations. Poor understanding and misconceptions about illness and the need for medications, and comorbidity contribute noncompliance. Family dynamics, cultural and economic factors, cognitive distortions, psychodynamic factors and unrealistic expectations are sited as causative factors. Content: Psychoeducation is essential, but often insufficient to enhance compliance to medications. Cognitive skill training and cognitivebehavioral interventions focusing on patients' beliefs and attitudes about illness and medications are very useful in enhancing medication compliance, and have a substantial evidencebase. Psychodynamic aspects of resistance (denial of illness or pathological investment in symptom maintenance), or transference (medication as a threat to counterdependent stance in life) often impacts compliance. Psychodynamic etiologies can also involve projective identification from patients and countertransference in psychiatrists (narcissistic injury, guilt, anxiety, feelings of helplessness, and rage) can contribute to either over prescription or discontinuation of meds by treating psychiatrists. Family interventions and selfhelp groups are very helpful interventions in enhancing adherence. Recognition and management of nonadherence to psychopharmacological interventions and is an essential skill for psychiatry residents and physician extenders to learn. Methodology: Case based learning and small group discussion encouraging active participation by attendees in addition to presentation of EBM in this area. Results and Importance: Psychoeducation, enhancing strategies to improve doctorpatient treatment alliance, effective use of CBT techniques, and teaching trainees and allied professionals to enhance medication adherence and decrease recidivism and treatment failure.

WEDNESDAY, MAY 18, 2011
7:00 AM - 8:30 AM

WORKSHOP 107
ASSESSING AND TREATING ALCOHOL USE DISORDERS IN PSYCHIATRIC PRACTICE
CoChairperson(s): Mark L. Willenbring, M.D., 1834 Hampshire Av, Saint Paul, MD 55116, Robert Huebner, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Screen for atrisk and dependent drinking; 2) Diagnose alcohol dependence; 3) Conduct brief motivational counseling for atrisk drinking; and 4) Treat alcohol dependence using pharmacotherapy and behavioral support

SUMMARY:
Heavy drinking and alcohol dependence are common among psychiatric patients, yet few psychiatrists receive the training necessary to effectively manage them. Although standard practice is to refer patients with severe alcohol dependence to a rehab program, most patients will decline or will not have access, or will relapse after a period of abstinence. Fortunately, most patients who drink too much will respond to relatively brief nonintensive outpatient psychiatric management. In this workshop, participants will be introduced to the NIAAA Clinician's Guide: Helping Patients Who Drink Too Much, an evidencebased guide for nonaddiction specialists. They will develop skills in screening using a singlequestion, diagnosing and staging alcohol dependence, brief motivational counseling, treatment of alcohol dependence with medication and brief behavioral support and chronic care management for patients with severe recurrent dependence. This is a highly interactive workshop using stateoftheart video case studies and role play so as to maximize the immediate practice utility of this information.

WORKSHOP 108
PSYCHIATRIC INJURY AND THE LAW: PTSD GONE WILD?
CoChairperson(s): Landy F Sparr, M.D., M.A., 3181 SW Sam Jackson Pk. Rd., Portland, OR 97006, Charles Scott, M.D.
Presenter(s): William Newman, M.D., Nicholas Gannon, B.A., J.D., John Fergueson, B.S., D.Min.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Recognize that while PTSD continues to be popular in a variety of forensic settings its application is commonly misapplied.

SUMMARY:
Has posttraumatic stress disorder (PTSD) become a forensic growth stock? It is now well recognized that PTSD has had a dramatic impact on jurisprudence as it has entered the criminal and civil arenas in the form of litigant efforts to advance insanity, mens rea, and selfdefense defenses, or affirm stressbased tort, workers compensation and insurance claims. Psychiatrists may find themselves in the middle of victimization debates asked to give legitimacy to victims' claims in a variety of legal forums. Recent research has recognized emotional, behavioral, social, psychophysiologic and neuroendocrine aspects of PTSD. Yet, there are abundant vignettes of "absurd" stress claims. In reality, problems arise because there are essentially two concepts of stress: one medical, the other legal or moral. The *DSMIV* medical concept of stress begins with PTSD, a relatively discrete entity with specific criteria. PTSD refers to universal sequelae resulting from a stressor that produces intense fear and helplessness. In many instances, however, the decision as to whether or not a particular stressor is detrimental is not determined by clinical definition but, instead, on moral or legal grounds. In other words, if the individual can establish that he/she was treated unfairly (e.g., stressed), the experience may be said to have psychiatric or "mental" sequelae This inverse reasoning often neglects that fact that stress is a physiological fact of life and that dissatisfaction is not a psychiatric condition. Mental stress is subjective, and therefore, can only be measured by others (including psychiatrists and judges) by observing behavior. When behavior departs from the norm it may be defined as constituting a mental illness manifesting, for example, as an inability to function in the workplace and become the basis for a mental stress claim. A worker who is unfairly treated, unjustly terminated, or displeased with lack of promotion is not thereby mentally ill. Nor is a tort claimant who experiences a routine automobile accident or mild food poisoning. Many claims, however, represent "stress" disorders in this way, which explains the skepticism they arouse. The workshop panel will discuss some questionable PTSD claims, the assessment of malingered PTSD, the history of the *DSM* and PTSD with an emphasis on *DSMV*, and issues related to PTSD in the courtroom. Members of the audience will be encouraged to offer their own experiences.

WORKSHOP 109
SUCCESSFUL CAREER PLANNING FOR WOMEN
APA Womens Caucus
Chairperson.: Gail E Robinson, M.D., Toronto General Hospital8231 EN200 Elizabeth St., Ontario, Toronto, M4W 3M4
Canada
Presenter(s): Carol Nadelson, M.D., Gail Robinson, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify positive communication and negotiation skills; 2) Analyze employment offers; and 3) Evaluate potential career moves in order to make the most advantageous choices.

SUMMARY:
Women often have difficulties making successful career choices. They need to understand the value of mentorship and how to find and effectively use mentors. In evaluating a job proposal there are many things to consider such as: how does it fit with career, family and geographic needs; does it have advancement potential; is it a long or short term opportunity; what are the pros and cons, the advantages and tradeoffs; and what perks or benefits make it more or less worthwhile? Women are often hesitant to negotiate and may say yes or no to a position too quickly. Once in a position, they need to avoid communication pitfalls and learn how to speak up in a manner such that they will be heard at meetings. Women need to understand the importance of "selfpromotion" by letting others know about their successes. This workshop will provide tools and insights necessary for successful career planning.

WORKSHOP 110
DEVELOPING A CAREER IN CHILD PSYCHIATRY
Chairperson.: Ara Anspikian, M.D., 760 Westwood Plaza, Los Angeles, CA 90024
Presenter(s): Marcy Forgey, M.D., M.P.H., William Arroyo, M.D., Jayanthi Peters, M.D., Ledro Justice, M.D., Sheryl Kataoka, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Describe the nature and extent of the shortage and need for child psychiatrists; 2) Identify the different career paths and opportunities available to a child psychiatrist; 3) Identify challenges and opportunities within the field of child psychiatry; and 4) Be familiar with the general aspects of a career in private practice, community leadership, advocacy, fellowship and academia for a child psychiatrist.

SUMMARY:
A career in child and adolescent psychiatry presents as a very rewarding endeavor, especially considering the wide array of career trajectories starting from fellowship training and spanning academic settings, private practice, community leadership, advocacy and a variety of consultative and collaborative roles. The literature demonstrates a continuing and significant shortage of Child and Adolescent Psychiatrists, a wide breadth and depth of career paths and high ratings of career satisfaction compared to other medical specialties. A recent physician satisfaction survey indicates that child psychiatry finds itself in the top ten in regards to overall satisfaction from a total of 42 specialities surveyed. Despite high satisfaction rates the shortages in child psychiatrists especially in certain states is staggering. Ranging from 3.1 child and adolescent psychiatrists per 100,000 youth for Alaska up to 21.3 for Massachusetts. The United States as a whole was noted to have 8.67 child psychiatrists per 100,000 in 2001 as compared to 6.73 in 1990. This workshop is geared for medical students, general psychiatry residents, child psychiatry fellows and early career child psychiatrist who have an interest in child psychiatry training and career opportunities. The purpose of the workshop is to outline the types and benefits of training in child psychiatry and opportunities within the field. This talk will also describe what the range of available careers are in child psychiatry, including discussions of careers in academia, the community, government, leadership and private practice. The workshop aims to provide an interactive avenue to bring together leaders from the field of child psychiatry with those interested child psychiatry as a career and to discuss issues of relevance in regards to developing and pursuing a career in child psychiatry. After brief presentations by the speakers, the workshop will proceed to a small group and interactive format. If you have any interest in child psychiatry come join us for more information, new ideas, answers to questions and an opportunity for discussion, mentoring and networking.

WORKSHOP 111
THE ACCESSIBLE PSYCHIATRY PROJECT: THE PUBLIC FACE OF PSYCHIATRY IN NEW MEDIA
CoChairperson(s): Steven R Daviss, M.D., 301 Hospital Drive, Glen Burnie, MD 21061, Dinah Miller, M.D.
Presenter(s): Annette Hanson, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify three types of new social media with limited psychiatric representation; 2) Describe at least three risks and benefits for psychiatrists participating in these new media; and 3) Explain how public perception of and access to psychiatry can be affected by how we present ourselves in the new media.

SUMMARY:
The old media, relying on paper, celluloid, and public airwaves, include books, newspapers, radio, television, and film. The new media, relying on the internet as the principal distribution method, include email lists, blogs, podcasts, and wikis, as well as social media sites for microblogging (Twitter), videos (Youtube), pictures (Flickr), professional contacts (LinkedIn), and social contacts (Facebook). The field of psychiatry has had limited success in getting desired messages out to the public about mental illness and psychiatric treatment. Large portions of the public still maintain confusing and even scary images of psychiatry and psychiatrists, as exemplified by Schneider's three archetypes: dippy, darling, and dangerous. The old media was controlled by small numbers of people. The new media is controlled by no one. Anyone with an internet connection can broadcast their information. We now have much more control over the messages that the public are exposed to regarding our field, yet we have been slow to embrace this opportunity. The three presenters will describe their participation in what they've called the Accessible Psychiatry Project. By engaging in open discussion with patients, consumers, health care providers, and others, they have helped illuminate aspects of our field which have gone underrepresented in the old media. They will describe their experiences of participating in their Shrink Rap blog, My Three Shrinks podcast, and the other types of social media which everincreasing numbers of the public are engaging in. They will also discuss their experience of putting much of that experience to use in writing a book. As an example of how these new forms of education and communication can impact public perception, one of the presenters will discuss her experiences in this area regarding forensic psychiatry. Thirty minutes are reserved for questions and group discussion.

WORKSHOP 112
THE CUSTOMER IS ALWAYS WRONG: THE INVERSE CORRELATION BETWEEN PATIENT REQUESTS AND SERVICES DELIVERED IN EMERGENCY PSYCHIATRIC SERVICES

CoChairperson(s): Kenneth M Certa, M.D., 833 Chestnut St., Suite 210, Philadelphia, PA 19107, Jessica Mosier, M.D.
Presenter(s): Ellen Gluzman, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) List common reasons for seeking psychiatric services in emergency rooms; 2) Describe benefits and risks of providing care based on patient request; and 3) describe methods for reframing presenting complaints in a manner to enable greater likelihood of collaboration in recovery.

SUMMARY:
One of the more problematic parts of medicine is being unable to provide patients what they request and expect. In emergency psychiatry this often means a request for medication, or admission, or symptom relief by impossible or inadvisable means. Psychotic patients desire scans of their heads to identify and remove implanted transmitters but decline antipsychotic medication; patients with addictions insist "It's not the drugs" and demand other psychiatric services; homeless individuals claim suicidality to garner admission and refuse referral to shelters. It is remarkable how frequently the recommended disposition and services are not at all what the patient has come requesting. This disconnect is often troubling for trainees, other healthcare providers, and certainly patients and their families. The panel will present findings from a large data set looking at patient emergency room encounters, from presenting complaint to disposition, and describe characteristics which help predict more successful dispositions. In particular, they will present techniques for reframing patient complaints to more appropriately fit the dispositions indicated. Workshop participants will be solicited for other problematic cases and alternative approaches to patient management, including system redesign.

9:00 AM - 10:30 AM

WORKSHOP 113
DO YOU HEAR WHAT I HEAR? HOW TO UTILIZE TECHNOLOGY TO PROMOTE LIFELONG LEARNING

Chairperson: Peter S Martin, M.D., M.P.H., 395 Linwood Ave, Carriage House, Buffalo, NY 14209
Presenter(s): Peter Martin, M.D., M.P.H., Michael Scharf, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Review the evidence for different input methods of learning, 2) Explore the current state of professional audio media used in education; 3)Demonstrate the use of texttospeech and optical character recognition software for creation of unique audio learning materials; 4) Examine practical uses of mobile devices to maximize learning; and 5) Analyze how these technologies can be implemented within residency training and beyond.

SUMMARY:
The mainstay for generations of practitioners to broaden and update their learning has been the use of printed media. While technology has continued to advance our lives beyond paper, there are many methods of learning that have yet to be fully appreciated. The techniques in which people are typically taught (or selftaught) can be effective for most, yet there are significant gaps in the method of delivery of information that can be filled by the use of technology. In particular, in our increasingly mobile society, several forms of media (e.g. textbooks, interactive webbased learning, audio commentary) on the same topic can help maximize time efficiency and promote learning that may not occur otherwise. This workshop will review and demonstrate several forms of technology to help people at all stages of their career continue to keep up with the literature. It will begin with a brief review of the current knowledge base in regards to how people learn, emphasizing the benefits that multiple methods of learning to aid those who may be more visual, auditory, or a combination of each. Next, an exploration of alternative ways of learning by focusing of auditory media will be conducted. The strengths and weaknesses of the current professional auditory media will be done, with a demonstration for how attendees can access these resources. Then a discussion and demonstration of how one can convert visual references into audio form will be conducted, specifically through texttospeech and optical character recognition software. From here, a broader overview of how specific mobile devices such as smartphones and tablets can be used to enhance learning and teaching will be conducted. Lastly, an examination of how these ideas can be practically implemented into different forms of training will be shown. The workshop will conclude with an interactive discussion of how technology can promote learning both now and in the future.

WORKSHOP 114
COLLABORATING FOR CHANGE: DBT/ MBT PSYCHOEDUCATION CAN DEVELOP FAMILY MEMBERS OF PEOPLE WITH BORDERLINE PERSONALITY DISORDER AS CLINICAL ALLIES

CoChairperson(s): Valerie Porr, M.A., 23 Greene St, NYC, NV 10013, Linda A Dimeff, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participant should be able to: 1) Improve clinical practice through compassionate understanding of the BPD family experience; and 2) Incorporate biological explanations into their practice. Empiricallysupported coping behaviors such as talking about emotions, awareness of nonverbal communication, and validating experiences, derived from DBT and Mentalization, will provide new tools for improving family interactions and decreasing escalations.

SUMMARY:
As 70% of people with Borderline Personality Disorder, characterized by impulsive, self destructive behaviors, rapid mood changes and relationship difficulties, drop out of therapy, family members are left coping without skills. Clinician can help them become therapeutic parents by reinforcing effective behaviors, preventing escalations, raising awareness of environmental stressors, using effective skills and encouraging relationship repair. The workshop will present components of a DBT/ MBT psychoeducational program highlighting what families can do to "customize the environment to make it less stressful for the person with BPD." Through nonjudgmental, compassionate reframing of family experience; clinicians will understand

what it is like to live with someone with BPD. Presentation of the neurobiological underpinnings of BPD, research on brain systems in dysregulation and aversive feelings, (shame) underlying BPD responses will help dispel stigma, dissipate anger and cultivate compassion. Seeing the person with BPD as hypersensitive, hypervigilant, doing the best he can discourages viewing him as "manipulative" or hopeless. CBT concepts (reinforcement, shaping, extinction, consequences and punishment) will be presented with emphasis on why "tough love", contracts, "limits" and "boundaries" usually don't work. Explanation of Dialectical Behavior Therapy (DBT), a behavioral therapy teaching Mindfulness, emotion regulation, distress tolerance and interpersonal skills with emphasis on synthesis of opposites and balancing acceptance with change. Assuming family members lack skill discounts the effect of BPD on family dynamics. Validating, talking to the amygdala, responding emotionally to diffuse crises will be role played. Demonstration of how to radically accept BPD as a deficit or handicap that can be overcome and of a ritual acknowledging invalidated grief experienced by family members. Discussion of Mentalization including how awareness of body language, gestures, facial expressions, voice tones and differentiating between implicit and explicit communication can keep mentalization on line. Addressing relationship ruptures with humility, compassion and authenticity, "Columbo" questions, and reframing with alternate interpretations will be demonstrated.

WORKSHOP 115
STORIES FROM THE FRONT LINES: PSYCHIATRISTS' EXPERIENCES IN THE INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH

Chairperson: Ruth S Shim, M.D., M.P.H., 720 Westview Drive, Atlanta, GA 30310
Presenter(s): Lori Raney, M.D.

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) Discuss the importance of psychiatrists as leaders in advancing the integration of primary care and behavioral health; 3) Evaluate lessons learned from successful and unsuccessful attempts at integrating care; and 4) Consider common themes in successful integrated care models

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. 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. Evidence supports that effective management of mental illness can take place in integrated care settings. Furthermore, identification of "key leaders" during the transition and implementation of an integrated care program can be critical to the success of these programs. However, psychiatrists are often absent in the development and promotion of integrated care programs, which is unfortunate, because psychiatrists possess unique skill sets that make them ideally suited to serve as leaders in the field of integrating primary care and behavioral health. While there are clear examples of successfully integrated behavioral health and primary care models (Project IMPACT, RESPECTD, PROSPECT), many programs have attempted to integrate behavioral health and have been met with failure, or only partial success. By sharing "stories from the front lines" we can begin to identify themes of what leads to effective implementation, as well as discuss challenges and barriers in the implementation of integrated care programs. The role of the psychiatrist in integrated models of care is crucial to the effective implementation and practice of these programs. This workshop aims to examine various experiences in integrating primary care and behavioral health care, discuss ways that psychiatrists can serve as leaders in advancing integrated care, and brainstorm effective ways to implement integrated care in different clinical settings.

WORKSHOP 116
SUBSTANCE ABUSE AND HIV/AIDS: WOMEN'S PERSPECTIVE

CoChairperson(s): Michelle Primeau, M.D., 1120 NW 14th St, Miami, FL 33136, Pedro Ruiz, M.D.

Presenter(s): Annelle Primm, M.D., M.P.H., Michelle Primeau, M.D., Patricia Junquera, M.D., Rodrigo A. Munoz, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify issues pertaining to HIV/AIDS and substance abuse among women; 2) Understand the impact of HIV/AIDS and substance use on women's mental health; 3) Describe the relationship between substance abuse and HIV/AIDS among women; and 4) Analyze risk factors related to contraction of HIV/AIDS among substance abusing women.

SUMMARY:
Currently, HIV/AIDS affects approximately 1 million Americans; 27% of those affected are women, and women represent the most rapidly growing group infected with HIV/AIDS in the United States. Although Black and Hispanic women represent 25% of all US women, they account for 82% of HIV/AIDS infected women. In HIV (+) women, highrisk sexual contact accounts for 80% of new HIV infections. Risk factors for contraction of HIV have been identified among women; they include: being unaware of partner's risk factors, substance use, highrisk heterosexual behavior, socioeconomic and racial disparities. This workshop intends to highlight the psychosocial risk factors in women, so that mental health professionals can recognize disparities in women's mental health, and identify those women who are at increased risk of contracting HIV. Substance abuse has been shown to play a major role in HIV infection. In women, intravenous drug use and sharing contaminated needles leads to 29% of infections, while sexual contact with a known IV drug user contributes to 15%. Among AfricanAmerican women, having multiple sex partners is associated with alcohol, marijuana, crack and inconsistent condom use. Women are 5 times more likely to have multiple sex partners if they smoked crack in the past month. It has been speculated that the relationship may be mediated by intoxication leading to impaired judgment, disinhibition and reduced pain sensitivity. Drugseeking behavior may supersede a woman's concerns regarding safe sex. Highrisk sexual behavior has also been linked to other predictive factors. Childhood trauma and mistreatment have been associated with early sexual contact and sextrading, as well as having multiple partners. Childhood victimization has also been correlated with adult drinking behaviors and other substance use disorders. It is important to educate psychiatrists and other mental health professionals about the associations mediated by these risk factors. Proper assessment and treatment for women at risk allows an opportunity for prevention. By identifying and treating those children and adolescents who have been exposed to childhood sexual trauma, we may prevent the contraction of HIV, as well as mental health issues and substance use disorders in women.

WORKSHOP 117
A COLLABORATIVE APPROACH TO INTERDISCIPLINARY TREATMENT PLANNING

Chairperson.: Jaskanwar Batra, M.D., 103 S. Main Street, Waterbury, VT 05671
Presenter(s): Anne Jerman, M.S.N., Elliott Benay, M.A.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify the benefits of shared decision making; 2) Identify problems from patient's point of view and help identify patient's longterm goals; 3) Work with patient to create S.M.A.R.T. (specific, measurable, attainable, realistic, and timely) objectives; and 4) Write interventions that would allow the patient to understand each of the treatment team member's roles in their recovery.

SUMMARY:
A Treatment Plan can be conceived of as a road map to a person's treatment and recovery. Across various disciplines in medicine, the benefits of shared decisionmaking are showing promise in our patient's wellness. Similarly, there is recognition that an empowered patient, one who is informed, knowledgeable, and active in their mental health treatment, will yield better outcomes. The therapeutic alliance is the cornerstone of treatment of a person with mental illness; yet, it is often not reflected in the treatment plan. A treatment plan must be collaboration between the patient and professionals working with them, and not a mere collection of diagnoses or approaches being thrust on a patient. The plan must mimic the alliance that clinicians develop with the patient in helping them understand their disability and recommended treatment. While are several books and online

guidebooks that offer "cookiecutter" goals, objectives and interventions, that deliver a completed form, they do not foster optimum clinical care. We propose to discuss practical ways to transform the treatment planning meeting into a group effort, which includes the patient at every step of the plan, from collaborating in problem identification, discussing their long term goals as well as helping create "SMART" (specific, measureable, attainable, realistic and timely) shortterm goals that are meaningful to the patient and to treatment team. Interdisciplinary interventions that are precise, and specific to the person, such that the patient may look at their plan and know exactly what responsibilities they have and, what help they can expect to get and how proceed towards the next step in their recovery is essential. We believe that the best way to transition treatment providers towards a collaborative treatment plan is the same process that the clinicians use to ally with their patients. In turn, this process will help further a longlasting alliance. During this workshop we will discuss the transition of the treatment planning process at Vermont State Hospital and the challenges encountered and methods that helped to overcome hurdles as we evolved. The presentation demonstrates interdisciplinary points of view, with discussion by a nurse, psychologist as well as a psychiatrist. We propose to invite ideas from participants about their transformation process and discuss challenges and successes.

WORKSHOP 118
SOMATIZING: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW
Chairperson.: Jon JD Davine, M.D., 2757 King Street East,, Hamilton, L8G 5E4 Canada

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Appreciate the range of diagnoses that make up the somatoform disorders; 2) Understand the range of conscious and unconscious mechanisms involved in these disorders; and 3) Recognize treatment modalities for these disorders both psychopharmacologic and psychotherapeutic.

SUMMARY:
Somatizing and somatoform disorders commonly occur in all branches of medicine. Some studies have shown that 1030% of patients with somatic complaints who present to the doctor have no adequate physical cause to account for them. In this workshop, we define somatizing, and discuss an overview of somatoform illness using DSMIVTR criteria. We distinguish between conscious and unconscious processes involved in these categories. We discuss effective ways to make the "mindbody link" for patients, in ways that are seen as collaborative, and that engender alliance and cooperation on the part of those patients. We discuss the different presentations of somatizing, which include medically unexplained symptoms (MUS), distorted belief system about the body and its functioning, and comorbidity between somatizing and other primary psychiatric illnesses. We focus on treatment modalities, both psychopharmacologic and psychotherapeutic that are felt to be useful in the clinical situation. There will be didactic presentation, and then participants will be encouraged to present cases from their practice, with group discussion of these cases. Prepared cases will be available for group discussion as well.

11:00 AM - 12:30PM
WORKSHOP 119
ADDRESSING DIABETES AND CARDIOMETABOLIC RISK IN LOWRESOURCE COMMUNITY PSYCHIATRY SETTINGS: TOOLS TO TAP INTO MOTIVATION
CoChairperson(s): Jeanie Tse, M.D., 40 Rector St, 8th Floor, New York, NY 10006, Elisa Chow, Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: 1) Identify factors contributing to increased cardiometabolic mortality and morbidity for people with serious mental illness (schizophrenia, bipolar disorder, major depression); 2) Use evidencebased best practices, including motivational interviewing, to enhance health literacy, improve health outcomes and potentially reduce costs in lowresource community psychiatry settings.

SUMMARY:
People with serious mental illness (schizophrenia, bipolar disorder, major depression) have increased mortality related to higher rates of cardiometabolic disorders, including diabetes. Poor health literacy and access to care are among multiple factors contributing to increased risk. Psychoeducational

tools that focus on patients' values and motivation can be used to improve health outcomes in lowresource community psychiatric settings, and may even lead to health care costs savings. A Diabetes SelfManagement Toolkit and a Healthy Living Toolkit were piloted in 81 New York City housing, case management and clinic programs. Both Toolkits were structured around workbooks enabling paraprofessionals to use motivational interviewing to promote health literacy and treatment adherence for patients with serious mental illness. Significant pre to postintervention improvements in HbA1c levels, access to recommended diabetes monitoring interventions, selfreported diabetes selfmanagement behaviors, and inpatient and emergency utilization were found for participants using the Diabetes SelfManagement Toolkit (n=204). Significant improvements on the SF8 Health Outcomes Questionnaire and in selfreported health knowledge and behaviors were found for participants using the Healthy Living Toolkit (n=1351). Workshop participants will be introduced to the approach, structure and content of these Toolkits. They will review the basics of motivational interviewing and participate in exercises to develop skills including reflective listening. Volunteer participants will be asked to role play interactions using Toolkit materials at different stages of patients' change readiness, with support and problemsolving from the presenters and audience. The process and challenges encountered in implementing and evaluating the Toolkits in New York will be discussed, with exploration of potential steps and barriers to implementation in participants' communities.

WORKSHOP 121
PROMOTING IMPROVED INTEGRATION: AN EXAMINATION OF COLLABORATIVE HEALTH CARE MODELS

APA Council on Advocacy & Government Relations
Chairperson.: Peter S Martin, M.D., M.P.H., 395 Linwood Ave, Carriage House, Buffalo, NY 14209
Presenter(s): Marilyn Griffin, M.D., Peter Martin, M.D., M.P.H., Christina Mangurian, M.D.

EDUCATIONAL OBJECTIVES:
The participant should be able to 1) Describe the current system of health care and how this leads to difficulties in integrating primary care with mental health needs; 2) Identify different models of integrative health care; 3) Explore the concept of the medical home; 4) Distinguish between the integrative models when applied to adult compared to pediatric populations; and 5) Discuss health care coordination models in different countries and cultures.

SUMMARY:
The current system of health care provides many challenges to the integration of general medical and mental health concerns. With time pressures, increasing levels of paperwork, complicated schedules, and the everexpanding perplexity of health care, it can be challenging for practitioners to provide the ideal level of care that many would desire. In order for this to change, changes on a systemic level are required to bring about optimal care. This workshop will examine the various models that have been devised to improve the collaboration of health care. It will begin with a brief discussion of the current system of health care and how this can lead to marked challenges with integrating care. Next, a review of different models that have been devised and researched will be examined, showing how specific models may be useful for certain patient populations. The role of the medical home model will specifically be explored to highlight how this may act as an overall framework for various collaborative approaches. From here, exploration of how these models can be applied throughout the lifespan will be emphasized. Lastly, a review of different cultural considerations when addressing collaboration will be done. The workshop will conclude with an interactive discussion on the individual providers' experiences with collaborative care models.

WORKSHOP 122
THE ROLE OF PSYCHIATRISTS SUPPORTING THE U.S. EMBASSY EMPLOYEES DURING THE HAITI EARTH QUAKE:PERSPECTIVES FROM DEPT OF STATE MENTAL HEALTH SERVICES

Chairperson.: Panakkal David, M.D., 2401 E Street NW, L218, Washington, DC 20037
Presenter(s): David Johnson, M.D., M.P.H., Mark Vanelli, M.D.

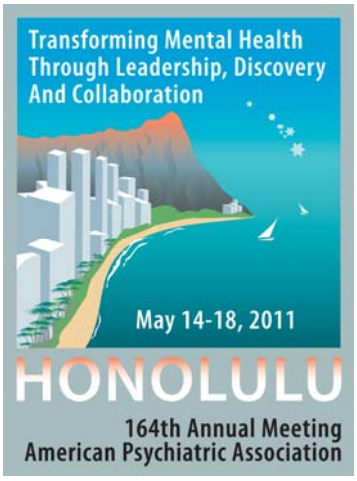
EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to 1) Understand the role of a clinical

psychiatrist during the initial phase of the response to earthquake working with in the constraints of a federal civilian organization; and 2) Apply lessons learned at a future critical event.

SUMMARY:

January 12, 2010 earth quake in Haiti produced massive destruction in Port au Prince and plunged the nation into chaos with multitudes of people dead and or injured. The United States Embassy remained essentially intact with self generated power and water supply and became a haven for thousands of people seeking medical care, shelter, and expedited entry visas to US. Employees of our mission also suffered both personal and property losses but remained on duty to assist the local population. The US mission became the triage and surgical operating site and our medical team collaborated with deployed military medical assets and saved countless lives. Many of local employees who lost their families still showed up for work. We evacuated family members of the diplomatic corps including nonessential personnel. The core employees worked and lived in their offices to provide essential services. They processed over 14,000 visas and ran convoys to the airport and accompanied orphaned children. Department of State office of Medical Services mobilized resources to assist in the relief effort and deployed a clinical psychiatrist along with other medical assets to work with Foreign Service officers, locally employed staff, and the embassy leadership. As expected adjustment disorders and or Acute Stress Disorders were evident among the employees who witnessed the carnage. The mental health services continued to station psychiatrists for 4 weeks and monthly afterwards. The review of the visits reiterated the need for a psychiatrist to be deployed in the initial phase and demonstrated the improved resiliency and resolution of acute stress disorders within the ranks of the employees.

2011 CME Courses



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.

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

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA provides 4-8 **AMA PRA Category 1 Credits™** per course for this live activity. Physicians should claim credit commensurate with the extent of their participation in the activity.

EVALUATION

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.

COURSE MATERIALS AND CERTIFICATES

Course materials will be provided in a hard copy and on a CD-ROM. Advanced registrants will be able to access the course materials prior to the meeting. A course certificate specific to the course attended will be provided at the conclusion of the course.

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, 59 Continuing Medical Education Courses will be offered at the Annual Meeting in Honolulu, HI ; five (5) Master Courses of which four (4) are repeating and one (1) offered for the first time. Thirteen (13) courses will be offered for the first time. Forty-one (41) 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 Hilton Hawaiian Village Hotel, Honolulu and the Hawaii 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.)	$135
Full-day (6 hrs.)	$200
Full-day (8 hrs.)	$240
Master Courses	$310

	Advance	On-Site
Half-day (4 hrs.)	$155	$180
Full-day (6 hrs.)	$230	$260
Full-day (8 hrs.)	$285	$325
Master Courses	$335	$365

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).**

COURSE CANCELLATION FEES:

On or before January 3, 2011-No fee
January 4,-April 22, 2011- $100 fee
After April 22, 2011 -No refunds granted

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 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 08, 2011. 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 Hawaii Convention Center.

Course enrollment hours are:
Fri., May 13: 12:00 p.m.-6:00 p.m.
(*Exclusive Members only Registration from 11:00 a.m.-12:00 p.m.*)
Sat., May 14: 6:30 a.m.-3:00 p.m.
Sun., May 15: 6:30 a.m.-3:00 p.m.
Mon., May 16: 6:30 a.m.-3:00 p.m.
Tue., May 17: 6:30 a.m.-3:00 p.m.
Wed., May 18: 6:30 a.m.-1:00 p.m.

REFUNDS

After April 22 absolutely no refunds will be granted or changes in course selections permitted.

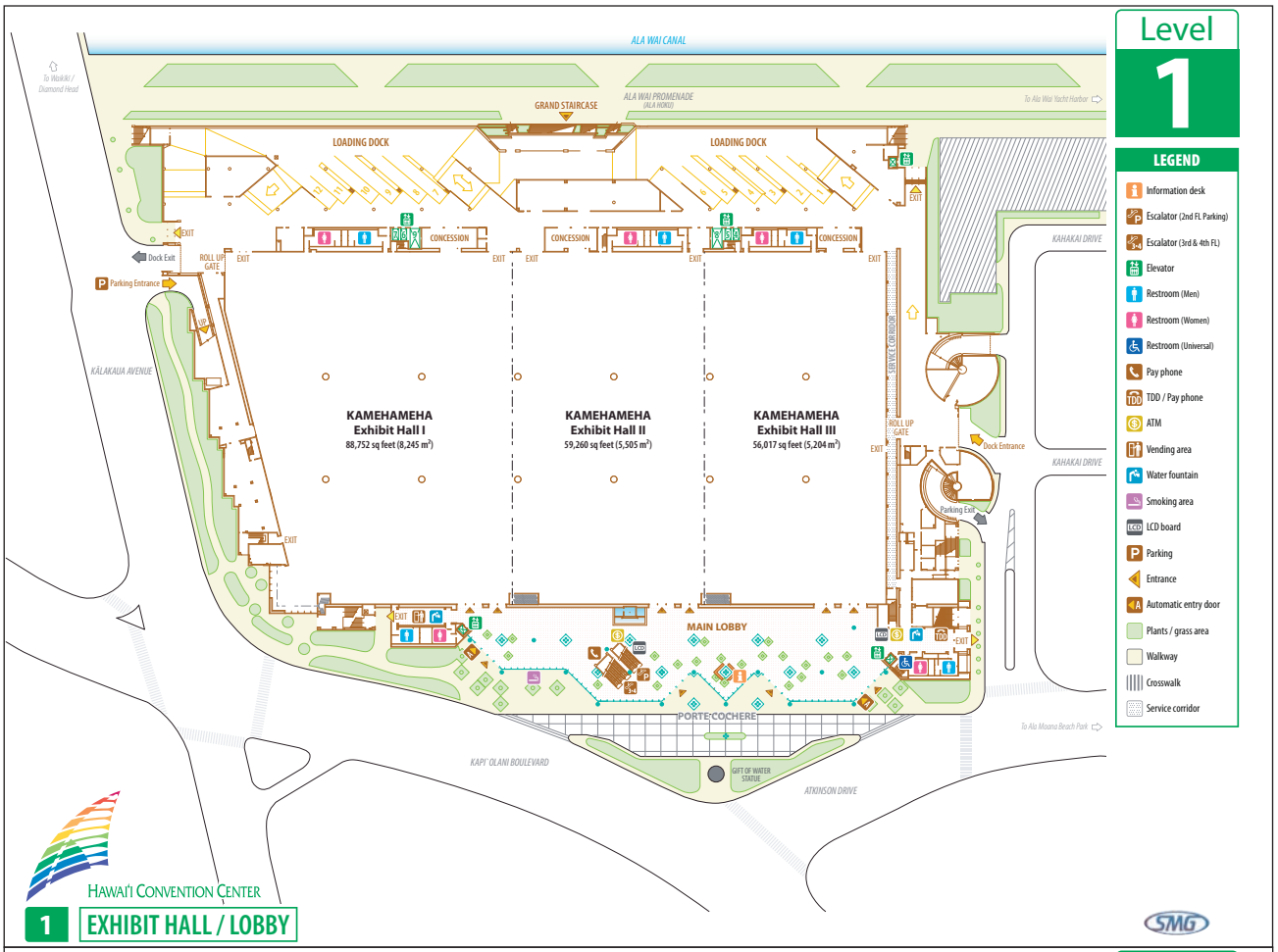
We'd hate for you to miss the meeting, but if you must all cancellation requests must be received in writing to the APA office by April 22, 2011. A confirmation will be sent once the request has been processed. Fees will be refunded in the manner that it was received. Please see registration form for the cancellation fees that will be assessed. **Refunds will not be granted after April 22, 2011** There will be no exceptions to the refund policy.

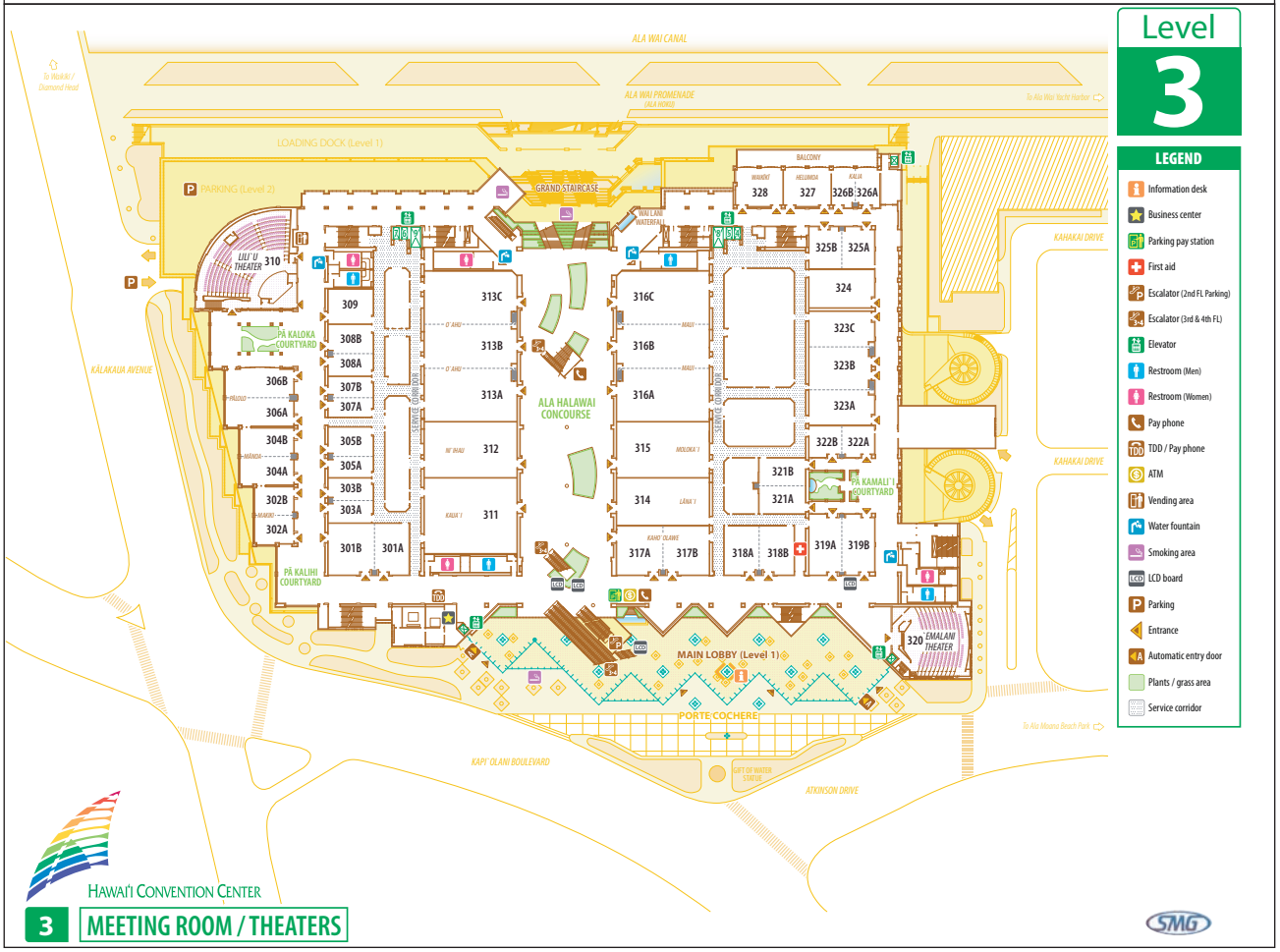
These written notifications should be addressed to:

Jolene McNeil
Associate 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

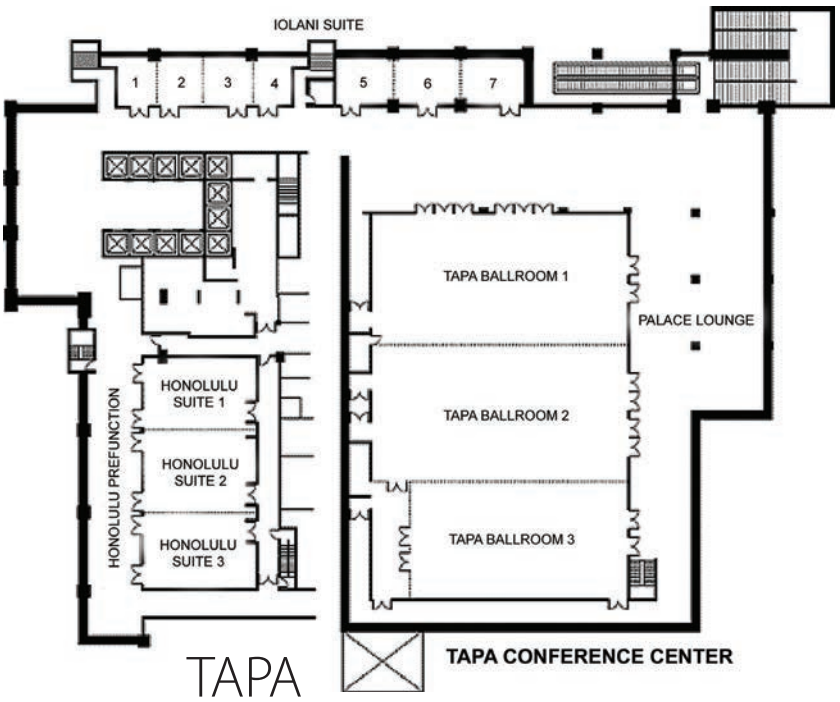
Publication Designed by D. Dustin Stitely
Cover Illustration: D. Dustin Stitely

DDS


Level
1
LEGEND
Information desk
Escalator (2nd FL Parking)
Escalator (3rd & 4th FL)
Elevator
Restroom (Men)
Restroom (Women)
Restroom (Universal)
Pay phone
TDD / Pay phone
ATM
Vending area
Water fountain
Smoking area
LCD board
Parking
Entrance
Automatic entry door
Plants / grass area
Walkway
Crosswalk
Service corridor
ALA WAI CANAL
ALA WAI PROMENADE
GRAND STAIRCASE
LOADING DOCK
LOADING DOCK
CONCESSION
CONCESSION
CONCESSION
KAHAKAI DRIVE
KĀLAKAUA AVENUE
Parking Entrance
Dock Exit
ROLL UP GATE
KAMEHAMEHA
Exhibit Hall I
88,752 sq feet (8,245 m²)
KAMEHAMEHA
Exhibit Hall II
59,260 sq feet (5,505 m²)
KAMEHAMEHA
Exhibit Hall III
56,017 sq feet (5,204 m²)
SERVICE CORRIDOR
Dock Entrance
Parking Exit
MAIN LOBBY
PORTE COCHERE
KAPI'OLANI BOULEVARD
GIFT OF WATER STATUE
ATKINSON DRIVE
To Ala Moana Beach Park
HAWAI'I CONVENTION CENTER
1
EXHIBIT HALL / LOBBY
SMG

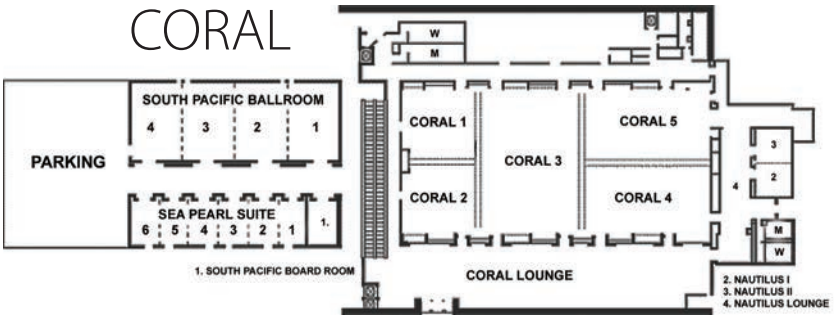

Level
3
LEGEND
Information desk
Business center
Parking pay station
First aid
Escalator (2nd FL Parking)
Escalator (3rd & 4th FL)
Elevator
Restroom (Men)
Restroom (Women)
Pay phone
TDD / Pay phone
ATM
Vending area
Water fountain
Smoking area
LCD board
Parking
Entrance
Automatic entry door
Plants / grass area
Service corridor
ALA WAI CANAL
ALA WAI PROMENADE
LOADING DOCK (Level 1)
PARKING (Level 2)
GRAND STAIRCASE
BALCONY
KAHAKAI DRIVE
KĀLAKAUA AVENUE
LILI'U THEATER
310
PĀ KALOKA COURTYARD
PĀ KALIHI COURTYARD
PĀ KAMALI'I COURTYARD
ALA HALAWAI CONCOURSE
MAIN LOBBY (Level 1)
EMALANI THEATER
320
PORTE COCHERE
KAPI'OLANI BOULEVARD
GIFT OF WATER STATUE
ATKINSON DRIVE
To Ala Moana Beach Park
HAWAI'I CONVENTION CENTER
3
MEETING ROOM / THEATERS
SMG


KALIA ROAD
ALA MOANA BLVD.
KALIA TOWER
KALIA CONFERENCE CENTER (2ND FLOOR)
KALIA TOWER POOL (4TH FLOOR)
PARKING ENTRANCE
MID-PACIFIC CONFERENCE CENTER
GRAND WAIKIKIAN
RAINBOW BAZAAR
RAINBOW DRIVE
ATM
TAPA TOWER
TAPA CONFERENCE CENTER (2ND FLOOR)
BUS AND TOUR TRANSPORTATION
PAOA ROAD
AMERICAN EXPRESS
US POST OFFICE
XEROX BUSINESS CENTER
TAPA POOL
DIAMOND HEAD TOWER
ATM
AMERICAN EXPRESS
VILLAGE GREEN
FRONT DESK
MAIN LOBBY
LAGOON DRIVE
ALI'I TOWER
POOL
ATLANTIS SUBMARINE TICKET DESK
LAGOON TOWER
GREAT LAWN
SUPER POOL
PARADISE POOL
RAINBOW TOWER
RAINBOW SUITE AND PATIO
DUKE KAHANAMOKU LAGOON
PORT HILTON



TAPA

CORAL



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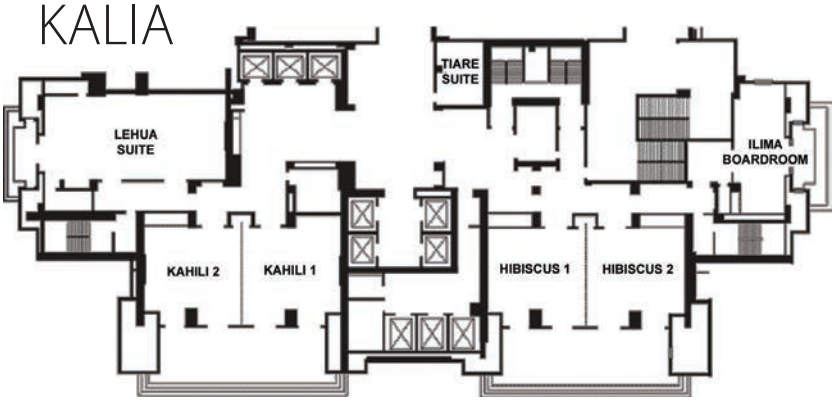

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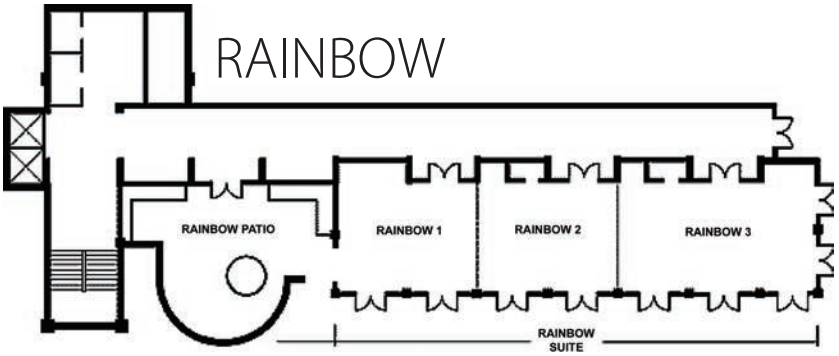

Contents

SATURDAY, May 14, 2011
7 AM - 2 PM

Master Course 1 - Update on Pediatric Psychopharmacology

Topic: Child & Adolescent Psychiatry
Director: Christopher J. Kratochvil, M.D.
Faculty: Karen D. Wagner, M.D., Christopher J. McDougle, M.D., John T.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, attentiondeficit/hyperactivity disorder (ADHD), 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. **The price includes a copy of *Clinical Manual of Child and Adolescent Psychopharmacology*.**

Course Level: Intermediate
Format: Lecture

Saturday, May 14, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Convention Center; Early Bird $310.00; Advance $335.00; OnSite $365.00; Spaces Available: 150
Sunday May 15, 2011, 7:00 am -2:00 pm:

SUNDAY, May 15, 2011
7 AM - 3 PM

Master Course 2 - ABPN 2011 APPI Board Review Course

Topic: Psychiatric Education
Director: James A. Bourgeois, O.D., M.D.
Faculty: Charles Scott, M.D., Jessica Ferranti, M.D., Jason G. Roof, M.D., James A. Bourgeois, O.D., M.D., Andreea L. Seritan, M.D., Alan Koike, M.D., Mark Servis, M.D., Matthew Soulier, M.D., Jaesu Han, M.D., Glen L. Xiong, M.D., Robert McCarron, D.O.

Educational Objectives At the conclusion of this session, the participant should be able to: 1) Identify gaps in knowledge in psychiatry and neurology in preparation for board examinations; 2. Analyze multiple choice questions pertinent to clinical topics; 3) Identify preparation strategies for board examinations; 4) Be able to search the clinical literature to prepare for board examinations; and 5) Demonstrate a working knowledge of the various topical areas likely to be encountered on board examinations.

Description: Faculty members will lead audience members in question-based presentations of various clinical topics. Detailed review of questions representative of each topic will be accompanied by discussions by faculty members. Each topic will be covered in 30 minutes, with the exception of neurology, which will be covered in 60 minutes. The clinical topics are depression, bipolar disorders; psychotic disorders; substance abuse; cognitive disorders/geriatric psychiatry; anxiety disorders; personality disorders; child and adolescent psychiatry; forensic psychiatry and ethics; somatoform disorders, impulse control disorders, and paraphilias; and neurology. Audience members will use and audience response system to respond to the multiple choice format before correct answers and full explanations and references will be covered. **The price includes a copy of *The American Psychiatric Publishing Board Review Guide for Psychiatry*.**

Course Level: Basic
Format: Lecture

Sunday, May 15, 2011, 7:00 am - 3:00 pm; Full Day 6 hours; Convention Center; Early Bird $310.00; Advance $335.00; OnSite $365.00; Spaces Available: 150

Master Course 3 - Practical Cognitive Behavior Therapy

Topic: Behavior & Cognitive Therapies
Director: Jesse H. Wright, M.D., Ph.D.
Faculty: Donna M. Sudak, M.D., Robert Goisman, M.D., Judith S. Beck, Ph.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, problemoriented 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.**The price includes a copy of *Learning Cognitive-Behavior Therapy: An Illustrated Guide*.**

Course Level: Basic
Format: Didactic presentations, Video illustrations, Role plays, and Interactive learning exercises.

Sunday, May 15, 2011, 7:00 am 2:00 pm; Full Day 6 hours; Hilton; Early Bird $310.00; Advance $335.00; On-Site $365.00; Spaces Available: 150

MONDAY, May 16, 2011
7 AM - 2 PM

Master Course 4 - Assessment and Treatment of Bipolar Disorders

Director: Terence A. Ketter, M.D.
Co-Director: Po W. Wang, M.D.
Faculty: Kiki D. Chang, M.D., Mytilee Vemuri, M.D., M.B.A., John O. Brooks, III, Ph.D., M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Assess patients with diverse presentations of bipolar disorders; 2) Demonstrate knowledge of evidence-based state-of-the-art pharmacotherapy for patients with bipolar disorders across all phases of the illness; and 3) Diagnostic and therapeutic implications of bipolar disorder occurring in children and adolescents, pregnant women, and older adults.

Description: Assessment and treatment of bipolar disorders is rapidly evolving. The development of *DSM-5* is raising important diagnostic issues related to bipolar disorder, including using dimensional as well as categorical approaches as well as classification of: mood and behavioral problems in children and adolescents, mixed symptoms and depression accompanied by anxiety symptoms in adults, and premenstrual dysphoria in women. Current FDA-approved treatments include mood stabilizers (lithium, divalproex, carbamazepine, and lamotrigine) and second-generation antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, and asenapine) with robust evidence supporting their differential efficacy across illness phases, and varying adverse effect profiles. There is also currently 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 course includes presentations of diagnostic advances as well as NNT and NNH analyses of approved pharmacotherapies for various phases (acute mania, acute depression, and maintenance) of bipolar disorder, to facilitate assessments of not only diagnoses but also of risks and benefits of treatments in individual patients. In addition, there are presentations regarding the substantive specific differences in the assessment and treatment of bipolar disorder in children and adolescents, women, and older adults. Taken together, the information in this course should facilitate clinicians' efforts to perform more accurate assessments and to translate the latest advances in research into evidence-based personalized state-of-the-art care for patients with bipolar disorder. **The price includes a copy of *Handbook of Diagnosis and Treatment of Bipolar Disorders*.**

Course Level: Intermediate
Format: Lectures and small group Discussion

Monday, May 16, 2011, 7:00 am 2:00 pm; Full Day 6 hours; Hilton; Early Bird $310.00; Advance $335.00; On-Site $365.00; Spaces Available: 150

TUESDAY, May 17, 2011
7 AM - 2 PM

Master Course 5 - Essential Psychopharmacology: Staying on the Cutting Edge of Advances in Clinical Psychopharmacology

Topic: Psychopharmacology
Director: Alan F. Schatzberg, M.D.,
CoDirector: Charles DeBattista, M.D.
Faculty: Ira D. Glick, M.D., Natalie L. Rasgon, M.D., Kiki Chang, M.D., Terence A. Ketter, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) 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 disorder, child/adolescent disorders, women's health disorders and treatment, and 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 smallgroup breakup session of 30 minutes. **The price includes a copy of *Manual of Clinical Psychopharmacology, Seventh Edition***

Course Level: Intermediate
Format: Lectures and smallgroup Discussion

Tuesday, May 17, 2011, 7:00 am -2:00 pm; Full Day 6 hours; Hilton; Early Bird $310.00; Advance $335.00; On-Site $365.00; Spaces Available: 150

SATURDAY
May 14, 2011
7 AM - 11 AM

Course 1 - Motivation and Change: The Theory and Practice of Motivational Interviewing

Topic: Behavior & Cognitive Therapies
APA Council on Adult Psychiatry
Director: Petros Levounis, M.D.
Co-Director: Bachaar Arnaout, M.D.
Faculty: Stephen Ross, M.D., Edward Nunes, M.D., Christopher Welsh, M.D., Paul J. Rinaldi, Ph.D., Ramon Solhkhah, M.D., Marianne T. Guschwan, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Discuss the fundamental concepts of Motivational Interviewing (MI) as a supportive yet directive approach to addiction treatment; 2) Use specific MI approaches to help patients move through the stages of change; 3) Apply MI principles to a number of clinical and non-clinical settings from treating dually-diagnosed patients to helping an entire health-care system change its culture.

Description: This 4-hour course provides the busy clinician with the fundamentals of the theory and practice of Motivational Interviewing. With a special focus on substance use disorders and addiction, this course equips its participants with a full understanding of the Motivational Interviewing approach-an understanding that clinicians can flexibly apply to address patients' issues of motivation and change even beyond substance use. The course; Is built on the main theoretical platforms of two ground-breaking innovations in addiction treatment: 1) Prochaska and DiClemente's transtheoretical or stages of change model and 2) Miller and Rollnick's Motivational Interviewing; Provides actual case studies presented by psychiatrists working directly with patients with substance use disorders; Explores the fundamentals of motivation and change, the stages of those changes, and how to treat patients at various stages of change; Reviews the intersection of motivational work with other interventions from psychopharmacology to Alcoholics Anonymous; Details the unique challenges of treating patients throughout the life cycle, including adolescents and older adults. Our audience is primarily the general psychiatrist. However, we expect that this course will also be helpful to family practitioners, internists, pediatricians, medical students, allied professionals, and anyone else who may be interested in issues of motivation and change. The course is offered at a level that can be understood by clinicians who have an interest in this area but who do not have specialized knowledge or expertise in addiction treatment.

Course Level: Basic
Format: Lectures, role-play, interactive small-group discussions
The price includes a copy of *Handbook of Motivation and Change: A Practical Guide for Clinicians*.

Saturday, May 14, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hawaii Convention Center; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 55

SATURDAY
May 14, 2011
7 AM - 2 PM

Course 2 - Mindfulness: Practical Applications for Psychiatry

Topic: Stress
Director: Susan E. 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 sum-

marized. 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

Saturday, May 14, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hawaii Convention Center; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 50

Course 3 - Adult Sexual Love and Infidelity

Topic: Couple & Family Therapies
Director: Stephen B. 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 love's ideals and how they deal with their disappointments.

Course Level: Intermediate
Format: Lecture, case histories and discussion.

Saturday, May 14, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hawaii Convention Center; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 100

Course 4 - 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. Note, there is some overlap in the review of the scientific materials in the early part of this course with the course on "Kundalini Yoga Meditation Techniques for Schizophrenia, the Personality Disorders, and Autism." However, the majority of the meditation techniques are different and the protocols are also completely different.

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.

Saturday, May 14, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Convention Center; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 75

SUNDAY
May 15, 2011
7 AM - 11 AM

Course 5 - Comprehensive, Multimodal Treatment for Obsessive Compulsive Disorder (OCD) and Compulsive Hoarding: Current Trends

Topic: Anxiety Disorders
Director: Barbara L. Van Noppen, Ph.D.
Faculty: Michele T. Pato, M.D., Sanjaya Saxena, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able: 1) To have a solid understanding of the diagnosis and phenomenology of OCD and Compulsive Hoarding; 2) To know the psychopharmacology for OCD and Compulsive Hoarding; 3) To be able to assess OCD and Compulsive Hoarding symptoms and implement CBT; 4) To understand family factors in maintaining OCD and a multifamily application of CBT; and 5) To understand the treatment of Compulsive Hoarding.

Description: This course will equip clinicians with a comprehensive, multimodal treatment approach that includes assessment methods and gold standard treatment intervention techniques for both OCD and Compulsive Hoarding. Current pharmacotherapy and neurobiological interventions will be discussed for both OCD and Compulsive Hoarding. Using lecture, DVD observation, role-play, and experiential exercises, participants will be offered a unique opportunity to learn to initiate CBT for OCD in individual, group and multifamily group formats. In addition, the role that family members play in facilitating the symptoms, family accommodation, and how to best intervene, underscores the integration among biopsychosocial treatment modalities. Compulsive Hoarding is under consideration as a distinct diagnosis for *DSM-V*; cutting edge neuropsychiatric findings and CBT treatment strategies will be presented, also with consideration for the role of the family. Throughout the course, participants will receive packets of assessment instruments and treatment worksheets for clinical use.

Course Level: Intermediate
Format: Methods will include informal lecture with PowerPoint slides, role pay, small group exercises, videotaped (DVD) clinical examples and discussion. A fair amount of interactive, experiential learning exercises will be used so that the participants will have a better understanding of how to implement the techniques taught during the course. This has been very successful in previous courses and well received by particpants.

Sunday, May 15 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 6 - Mood Disorders in Later Life

Topic: Geriatric Psychiatry
Director: James M. Ellison, M.D., M.P.H.
Co-Director: Yusuf Sivrioglu, M.D.
Faculty: Patricia A. Arean, Ph.D., Donald Davidoff, Ph.D., Brent P. Forester, M.D., James M. Ellison, M.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 15, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 80

Course 7 - Melatonin and Light Treatment of SAD, Sleep and Other Body Clock Disorders

Topic: Mood Disorders
Director: Alfred J. Lewy, M.D., Ph.D

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) 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 as well other melatonergic drugs in this newest class of antidepressants.

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 of light treatment will also be reviewed, as well as the most recent research findings. The use of melatonin and the other melatonergic drugs in this newest class of antidepressants will be explained in detail.

Course Level: Basic
Format: Lecture

Sunday, May 15, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 11 - Therapeutic Interventions in Eating Disorders: Basic Principles

Topic: Eating Disorders
Director: David C. Jimerson, M.D.
Faculty: Joel Yager, 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 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 an overview of short-term psychotherapy, and detailed discussion of 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.

Sunday, May 15, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00;Spaces Available: 65

SUNDAY
May 15, 2011
7 AM - 2 PM

Course 8 - Davanloo's Intensive Short-Term Dynamic Psychotherapy in Clinical Practice

Topic: Individual Psychotherapies

Director: James Q. Schubmehl, M.D.
Co-Director: Alan R. Beeber, 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.

Sunday, May 15, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 20

Course 9 - Essentials of Assessing and Treating Attention Deficit Hyperactivity Disorder in Adults and Children

Topic: Attention Spectrum Disorders
Director: Thomas E. Brown, Ph.D.
Faculty: Anthony L. Rostain, M.D., Jefferson B. Prince, 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 15, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 85

Course 10 - 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 improve-

ment 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. 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 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.

Sunday, May 15, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 65

Course 12 - Narrative Hypnosis for Psychiatry: Emphasis on Pain Management

Topic: Individual Psychotherapies
Director: Lewis Mehl-Madrona, M.D., Ph.D.
Faculty: Barbara J. Mainguy, M.A.

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) Be able to 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

Sunday, May 15, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 100

SUNDAY
May 15, 2011
6:30 AM - 3:30 PM

Course 13 - Office-Based Buprenorphine Treatment of Opioid-Dependent Patients

Topic: Addiction Psychiatry/Substance Use Disorder
Director: Petros Levounis, M.D.
Faculty: John A. Renner, M.D., Andrew J. Saxon, 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; 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. **The price includes a copy of Handbook of *Office-Based Buprenorphine Treatment of Opioid Dependence*.**

Course Level: Advanced
Format: Lecture and small-group discussions.

Sunday, May 15, 2011, 6:30 am - 3:30pm; Full Day 8 hours; Hilton Hawaiian Village Hotel; Early Bird $240.00; Advance $285.00; On-Site $325.00; Spaces Available: 150

SUNDAY
May 15, 2011
11:30 AM - 3:30 PM

Course 14 - Neuroanatomy of Emotions

Topic: Biological Psychiatry & Neuroscience
Director: Ricardo M. 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 their trajectories, and their specific targets; 3) Describe how each limbic structure contributes to the specific expression of emotions and attachment behavior; and 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 15, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 15 - Psychiatric Pharmacogenomics

Topic: Genetics
Director: David Mrazek, M.D.
Faculty: Daniel K. Hall-Flavin, M.D., Renato D. Alacrcon, M.D., M.P.H.

Educational Objectives: At the conclusion of this presentation, the participant should be able to: 1) Understand the basic principles of medical genomics including the identification of key genes associated with disease management; 2) Learn how therapeutic interventions can be enhanced through using pharmacogenomic testing; 3) Learn how to interpret genetic test results and communicate these findings to patients and their families; and 4) Understand the relevance and utility of genetic testing to optimize outcomes.

Description: This course is designed to provide a succinct overview of the rapidly developing area of psychiatric pharma-

cogenomics. It will begin with a basic review of recent advances in molecular genetics 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 both inpatient and outpatient testing will be reviewed and specific cases discussed. This course is designed to provide participants with basic information during the review of molecular genetics in order to prepare clinicians for the discussion of clinical pharmacogenomic testing results with their patients.

Course Level: Intermediate
Format: Lecture and questions and answers

Sunday, May 15, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 80

Course 16 - 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 1) 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 18th 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 15, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 17 - Short-Term Psychodynamic Supportive Psychotherapy for Depression

Topic: Individual Psychotherapies
Director: Henricus Van, M.D.
Co-Director: Frans F. De Jonghe, M.D.
Faculty: Annemieke A. Noteboom, M.S.C., Simone S. Kool, Ph.D., Anne van Broekhuyzen, 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; 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

Sunday, May 15, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 45

MONDAY
May 16, 2011
7 AM - 11 AM

Course 18 - ECT Practice Update for the General Psychiatrist

Topic: Other Somatic Therapies
Director: Laurie M. McCormick, M.D.
Faculty: Andrew Krystal, M.D., Peter B. Rosenquist, M.D., Laurie Mccormick, M.D., Charles Kellner, M.D., Donald P. Eknoyan, 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 vs. 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. There will be special mention of 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 question and answer sessions.

Monday, May 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 19 - Street Drugs and Mental Disorders: Overview and Treatment of Dual Diagnosis Patients

Topic: Addiction Psychiatry/Substance Use Disorders
Director: John W. Tsuang, M.D.
Faculty: Reef Karim, M.D., Larissa Mooney, M.D., Timothy W Fong, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the issues relating to the treatment of dual diagnosis patients; 2) Popular street drugs and club drugs will be discussed; 3) The available pharmacological agents for treatment of dual diagnosis patients will be covered; 4) 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 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 20 - The Detection of Malingered Mental Illness

Topic: Forensic Psychiatry
Director: Phillip J. Resnick, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) 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 and psychological testing 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 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 21 - Current Procedural Terminology Coding and Documentation

Topic: Practice Management
Director: Ronald M. Burd, M.D.
Faculty: Tracy R. Gordy, M.D., Ronald M. Burd, M.D., David K. Nace, M.D., Allan A. 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, question and answer

Monday, May 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 30

Course 22 - Exploring Technologies in Psychiatry

Topic: Computers, Technology, Internet & Related
American Association for Technology in Psychiatry
Director: Robert S. Kennedy, M.D.
Co-Director: John Luo, M.D.
Faculty: Carlyle H. 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 as well 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 vs 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 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 23 - Internal Medicine Update: What Psychiatrists Need to Know

Topic: Other Somatic Therapies
Director: Monique V. Yohanan, M.D., M.P.H.
Co-Director: Michele T. 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 in people with mental health conditions; 2) Summarize diagnostic and treatment options for conditions that increase cardiovascular risk: hypertension, diabetes, and hyperlipidemia; 3) Assess cardiovascular treatment options appropriate to psychiatric patients receiving antidepressants, antipsychotics, and/or mood stabilizers; and (4) Apply behavioral interventions to this patient population

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. 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

Monday, May 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 150

Course 24 - Mentalization Based Treatment (MBT) for Borderline Personality Disorder (BPD): Introduction to Clinical Practice

Topic: Personality Disorders
Director: Anthony W. 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 recognise non-mentalizing interventions.

Course Level: Basic
Format: Lecture, role plays, video tapes and large group discussion.

Monday, May 16, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 60

MONDAY
May 16, 2011
7 AM - 2 PM

Course 25 -Yoga of the East and West: Integrating Breath Work and Meditation Into Clinical Practice

Topic: Stress
Director: Patricia L. Gerbarg, M.D.
Co-Director: Richard P. Brown, M.D.
Faculty: Richard Brown, M.D., Patricia L. Gerbarg, M.D., Martin Katzman, M.D., Monica Vermani, M.A.

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. Adaptation of mind/body programs for disaster relief will be discussed in relation to the Southeast Asian tsunami, the September 11th World Trade Center attacks, the 2010 earthquake in Haiti, and for survivors of mass trauma, war and genocide in Rwanda and Sudan.This course is suitable for novices as well as experienced practitioners.

Course Level: Basic
Format: Lecture, Experiential teaching, Coaching in mind/body practices, Small-group discussion

Monday, May 16, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 65

Course 26 - A Practical Approach to Risk Assessment

Topic: Forensic Psychiatry
Director: William H. Campbell, M.D.

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, workshop with presentation exercises and group discussion.

Monday, May 16, 2011, 7:00 am - 2:00 pm; Full Day 6 Hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 80

Course 27 - Autism Spectrum Disorders: Diagnostic Classification, Neurobiology, Biopsychosocial Interventions and Pharmacologic Management

Topic: Child & Adolescent Psychiatry
Director: Kimberly A. Stigler, M.D.
Co-Director: Alice R. Mao, M.D.
Faculty: Mathew Brams, M.D., Eric Courchesne, Ph.D., James Sutcliffe, Ph.D., Stephanie Hamarman, 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; 5) Review the psychopharmacology of ASDs; and 6) Describe educational 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

Monday, May 16, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 110

Course 28 -Psychodynamic Psychopharmacology: Applying Practical Psychodynamics to Improve Pharmacologic Outcomes with Treatment Resistant Patients

Topic: Combined Pharmacotherapy & Psychotherapy
Director: David L. Mintz, M.D.
Faculty: Barri Belnap, M.D., David Flynn, M.D., Samar Habl, 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; 2) Construct an integrated biopsychosocial treatment frame; recognize common psychodynamics of pharmacologic treatment resistance; 3) Use psychodynamic interventions to address psychodynamic sources of resistance to medications; and 4) 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. This course is designed to help clinicians who prescribe 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.

Monday, May 16, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 65

Course 29-Trauma-Informed Care: Principles and Implementation

Topic: Violence, Trauma & Victimization
Director: Sylvia Atdjian, M.D.
Faculty: Tonier Cain, Lyndra Bills, M.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 on

symptom formation and behavioral manifestations in individuals with psychiatric illness; 3) Recognize the importance of creating environments that facilitate self-soothing in the healing of trauma survivors; 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 implementation and outcomes of trauma-informed services in different mental health settings.

Course Level: Basic
Format: Lecture, videotape and discussion.

Monday, May 16, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 45

MONDAY
May 16, 2011
11:30 AM - 3:30 PM

Course 30 - Advanced Assessment and Treatment of Attention Deficit Hyperactivity Disorder

Topic: Attention Spectrum Disorders
Director: Thomas E. Brown, Ph.D.
Faculty: Anthony L. Rostain, M.D., Jefferson B. Prince, 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 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 31- The Psychiatrist as Expert Witness

Topic: Forensic Psychiatry
Director: Phillip J. Resnick, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify ways that psychiatrists give more effective expert witness testimony; 2) Recognize and understand the rules of evidence and courtroom privilege; 3) Identify and understand issues of power and control in the witness/cross examiner relationship.

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 the 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, pre-trial conferences, questions from textbooks. 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 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

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., Camille Dieterle, O.T., Ali Nemat, M.D., Faye M. 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; 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

Monday, May 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 30

Course 33 - Culturally Appropriate Assessment Made Incredibly Clear: A Skills-Based Course With Hands-On Experiences

Topic: Cross-Cultural & Minority Issues
Director: Russell F. Lim, M.D.
Faculty: Puja Chadha, M.D., Russell F. Lim, M.D., Francis Lu, 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; 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 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

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: Deirdre Ryan, M.D., Shari I. Lusskin, 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.

Monday, May 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 150

Course 35- Can't Work or Won't Work? Psychiatric Disability Evaluations

Topic: Forensic Psychiatry
Director: Liza H. Gold, M.D.
Faculty: Donna Vanderpool, J.D., William J. Stejskal, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Analyze the relationship between psychiatric disorders, impairment, and disability; 2) Identify all relevant psychiatric and nonpsychiatric factors; 3) Utilize a "work capacity" model to develop a disability case formulation and answer most frequently requested Questions; 4) Identify appropriate uses of psychological testing; and 5) Understand and develop tools to manage risk and liability associated with disability evaluation.

Description: This course will review the complex relationship between psychiatric impairment and work disability in competitive employment contexts through presentations by a multidisciplinary faculty utilizing case examples and interactive discussion. Psychiatrists often provide disability evaluations for their patients or for third parties such as insurance companies, attorneys, or administrative agencies. Legal or administrative disability decisions regarding awards of public or private insurance benefits, legal damages, ADA accommodations, and fitness for duty may depend on psychiatric opinions and may have profound implications for the evaluee's psychological, social, financial, and employment status. The presence of a psychiatric diagnosis does not automatically imply functional impairments, and functional impairment does not necessarily result in work disability. Some individuals with relatively mild symptoms may have severe impairments and disability; others with severe symptoms may have no work disability at all. Our faculty will review the most common diagnoses associated with disability claims in competitive employment contexts. Comprehensive disability evaluations should also consider personal, social, economic, and workplace factors or circumstances that may influence a disability claim or status. We will discuss what information is needed to provide opinions regarding impairments and associated dysfunction, and the correlation of impairments and dysfunction with specific job requirements and work skills. We will present an innovative "work capacity" model that facilitates consideration of these factors and the development of case formulations. We will review the most frequently asked questions psychiatric disability examinations are asked to answer. We will demonstrate how to utilize the "work capacity" model and a case formulation to assist psychiatrists in providing the opinions to the frequently asked questions in disability evaluations, including causation, motivation, and malingering. We will also review the only professionally endorsed guidelines for psychiatric disability assessment, and discuss practical application. Finally, we will discuss and review relevant psychological testing and testing related issues, HIPAA issues, legal liability in the provision of disability evaluations, and risk management of these important practical aspects of disability evaluations.

Course Level: Basic
Format: Lecture, interactive audience discussion of case example throughout presentations based on lecture content
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Monday, May 16, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

TUESDAY
May 17, 2011
7 AM - 11 AM

Course 36 - Motivational Enhancement for Individuals with Concurrent Disorders

Topic: Behavior & Cognitive Therapies

Director: Shimi Kang, M.D.
Faculty: Shimi Kang, M.D., Marilyn Herie, Ph.D., Ximena Sanchez-Samper, M.D., Arvinder K. Grewal, M.A.

Educational Objectives: At the conclusion of this session, the participant should be able to 1) Understand the evidence base of motivational therapy (MT) with regards to mental health (MH) and substance use disorders (SUD); 2) Demonstrate knowledge of the key principles of MT, including stages of change model; and 3) Demonstrate skills related to assessing and enhancing motivation in their clients.

Description: In recent years, it has become evident that concurrent psychiatric disorders carry a high burden of disease in terms of medical and psychiatric disability, misdiagnosis, treatment delay, social instability and inefficient use of scarce services. An evidence-based, comprehensive and integrated approach is essential for treatment of this complex problem, and comprehensive treatment should include nonpharmacological approaches. One approach to managing concurrent disorders is by encouraging change through motivational therapy (MT). The purpose of this course is to provide clinicians with the concrete, practical tools of MT to apply in their own practices through a series of interactive exercises and role-plays. This MT course integrates the most current evidence with clinical expertise. A series of interactive discussions and break-out practice sessions provide participants with the foundational knowledge of MT. These discussions include a review of relevant research literature on using MT with clients with concurrent disorders, the key principles, stages of change, and goals and strategies to enhance motivation in their clients. The breakout sessions will allow participants to practice and demonstrate their skills via team activities and role-plays. Participants will also review case studies, which allow them to apply their new knowledge and skills towards real life clinical examples. Participants will benefit from the multidisciplinary team of co-facilitators and will be presented with immediate feedback on their progress when they fill out forms designed to test their knowledge and skills on MT before and after the course.

Course Level: Basic
Format: The methods used to teach will involve lecture, role play, video tapes, interactive discussions, and small-group discussions.

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 37 - Brain Stimulation Therapies in Psychiatry

Topic: Other Somatic Therapies
Director: Ziad H. Nahas, M.D.
Faculty: Linda L. Carpenter, M.D., Darin D. 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

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 38 - Disaster Psychiatry

Topic: Violence, Trauma & Victimization
APA Committee on Psychiatric Dimensions of Disasters
Director: Anand Pandya, M.D.
Co-Director: Frederick J. Stoddard, M.D.
Faculty: David M. Benedek, M.D., Kristina Jones, M.D.

Educational Objectives: At the conclusion of this course, participants should be able to: 1) Adapt the standard psychiatric evaluation to assess common post-disaster problems; 2) Describe evidence-based interventions for acute psychiatric problems after a disaster; 3) Describe the psychological impacts of disasters on children and interventions to mitigate this impact; and 4)Describe the systems issues that affect post-disaster psychiatric practice.

Description: Attention to disaster psychiatry continues to expand tremendously since the September 11th attacks, the Indian Ocean Tsunami, Hurricane Katrina, and the earthquake in Haiti. Recent studies and reports chart the range of post-disaster psychiatric problems and the opportunities for assisting response teams and survivors. Today, psychiatrists who wish to serve in disasters need to gain an understanding of risk communication and psychological first aid, fields barely known a decade ago. This course will review these topics and other core clinical areas and will use interactive scenarios to give participants a vivid sense of the systems issues and the treatment environment confronting disaster psychiatrists. Participants will learn who is at risk for psychiatric problems and a broad range of post-disaster interventions from experienced faculty who have edited and authored a variety of books in the field including the new APPI Clinical Manual of Disaster Psychiatry which will be included with the course as an enduring resource for all participants. **The price includes a copy of *Disaster Psychiatry: Readiness, Evaluation, and Treatment*.**

Course Level: Basic
Format: Lecture Role-Play

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 39 - ADHD in Adults - From Clinical Research to Clinical Practice

Topic: Attention Spectrum Disorders
Director: Craig Surman, M.D.
Faculty: Paul Hammerness, M.D.

Educational Objectives: Participants should be able to 1) Identify the evidence basis that informs assessment and treatment of ADHD in adulthood; 2) Demonstrate efficient methods for assessing ADHD symptoms and impairment; 3) Develop a personalized treatment plan for adults with ADHD; 4) Optimize pharmacologic management of the condition;and 5) Implement cognitive-behavioral and other therapies for adults with ADHD.

Description: Purpose: In the last decade the body of research on Attention Deficit Hyperactivity Disorder in adulthood has grown dramatically. Consumers frequently present to clinicians with the condition, but most practicing clinicians have not had formal training in its management. This course will catch participants up on the extent, including limits, of the science of ADHD, and train participants in evidence-informed approaches to identifying and managing ADHD in clinical practice. Course Format: The faculty are practicing clinicians who have contributed to approximately 50 studies of ADHD in the past decade, including studies of the association between ADHD and sleep and eating disorders, novel pharmacotherapies, and a cognitive-behavioral therapy technique recently published in the Journal of the American Medical Association. Up-to-date scientific findings will serve as context for practical, step-by-step training in the art of in-office clinical decision making. Attendees will participate in a virtual patient encounter, learn to identify ADHD symptoms, and practice applying medication and non-medication treatments to virtual cases. Learning Goals: Participants will learn 1) when ADHD is and is not a clinically significant diagnosis; 2) efficient methods for assessing ADHD symptoms and impairment; 3) what ADHD symptoms respond, and which do not, to pharmacologic therapies; 4) step-by-step instruction on personalizing treatment for ADHD patients, including optimal pharmacologic and non-pharmacologic supports; 4) evidence based-cognitive behavioral therapy strategies; 5) principles for managing common complex presentations, including patients with non-attention executive function deficits, mood disorders, anxiety disorders, and substance abuse disorders Summary: This course offers participants practical and effective techniques to appropriately diagnose and treat ADHD in adults, developed from extensive recent research.

Course Level: Basic
Format: Lecture, video, and interactive polling/discussion with the audience will be utilized. The program will didactically present up-to-date academic findings, and introduce their clinical application through patient-centered, case-based teaching. Presentation is scalable-if space allows we will split into smaller groups for discussion of symptom rating and treatment decisions, but this is not required for effective learning so one room is sufficient.

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 80

Course 40 - Sexual Compulsivity and Addiction: Diagnosis, Evaluation and Treatment Issues

Topic: Addiction Psychiatry/Substance Use Disorders
Director: Kenneth Rosenberg, M.D.
Faculty: Patrick Carnes, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Recognize the diagnostic categories of sexual disturbances; 2) Become familiar with the common terminologies and treatments particular to sexual addiction and compulsivity; and 3) Be able to use their pre-existing skill set as psychiatrists to initiate treatment for sexual addictions and make appropriate recommendations.

Description: Patrick Carnes, PhD, Executive Director, Gentle Path Healing program at Pine Grove Behavioral Health and Editor-in-Chief of the Journal of Sexual Addiction and Compulsivity and Kenneth Paul Rosenberg, MD, Associate Clini-

cal Professor of Psychiatry at the Weill Cornell Medical College and Contributing Editor of the Journal of Sex and Marital Therapy will introduce psychiatrists to the diagnosis, evaluation and treatment of sexual compulsivity and addiction. In the *DSM-V*, the diagnosis of Substance Abuse Disorders may be replaced with term Addiction and Related Disorders, which will include a sub-category of Behavioral Addictions, with a further subcategories of Pathological Gambling and Internet Addiction which will include Cybersex Addiction. The change in phenomenology is the result of clinical experience, research and current theories which put greater emphasis on the reward, control and memory systems responsible for addictions. In light of these changes, psychiatrists can expect to see more patients with complaints such as cybersex and sexual compulsivity. This course will teach participants the basics of evaluating and treating these patients, as well as highlighting the controversies and neurobiological supportive evidence. Session Objectives:Discuss proposals for *DSM-V* diagnoses related to sexual compulsivity and addiction. To understand the evolution and research of the Sexual Addiction Screening Test-Revised (SAST-R);To utilize the SAST-R in a clinical setting; To describe the PATHOS, a sexual addiction screening test being developed for physician use;To introduce the Sexual Dependency Inventory Revised (SDI-R)To describe gender differences and co-occurring patterns of sexual aversion;To provide overview of Cybersex and Internet pornography;To provide overview of sex addiction treatment;To describe evidenced-based data about recovery;To introduce the concept of task-centered therapy;To specify the research and conceptual foundations of a task centered approach to therapy;To understand task one including performables and therapist competencies; Review the theoretical neurobiology.

Course Level: Basic
Format: Dr. Carnes will discuss the diagnosis and treatment of sex addiction as a primary diagnosis with and without co-morbid substance abuse. Dr. Carnes will discuss, in detail, the paradigm that he has developed in the evaluation and treatment of sex-related disorders. Dr. Rosenberg will discuss changes in the DSM V as they may pertain to sexual compulsivity and addiction, discuss neurobiological and theoretical considerations, and present videotaped cases for course participants to discuss.

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 41 - Neuropsychiatric Masquerades: Medical and Neurological Disorders That Present With Psychiatric Symptoms

Topic: Psychosomatic Medicine
Academy of Psychosomatic Medicine
Director: Jose R. Maldonado, M.D.

Educational Objectives: At the end of the talk, participants will be able to 1) Recognize the most common clues of presentation suggesting an organic cause for psychiatric symptoms; 2) Understand the incidence, epidemiology and clinical features of the most common endocrine disorders masquerading as psychiatric illness; and 3) Understand the incidence, epidemiology and clinical features of the most common metabolic disorders masquerading as psychiatric illness.

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.

Course Level: Intermediate
Format: Lecture; Q&A Sessions; Interactive Discussions

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 150

Course 42 - Risk Assessment for Violence

Topic: Violence, Trauma & Victimization
Director: Phillip J. 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. 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 paranoid 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. 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 preven-

tion plan for a man who planned to kill his boss.

Course Level: Basic
Format: lecture and videotapes.

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 43 - Psychiatric Consultation in Long-Term Care: Advanced Course

Topic: Geriatric Psychiatry
Director: Abhilash K. Desai, M.D.
Co-Director: George T. 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 in individuals 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 question and answer sessions.

Tuesday, May 17, 2011, 7:00 am - 11:00 am; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 45

Course 44 - Child and Adolescent Psychiatry for the General Psychiatrist

Topic: Child & Adolescent Psychiatry
Director: Robert L. 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; and 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 question and answers

Tuesday, May 17, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 50

Course 45 - A Developmental Approach to Contemporary Issues in Psychotherapy with Gay Men

Topic: Lesbian/Gay/Bisexual/Transgender Issues
Director: Robert M. Kertzner, M.D.

Co-Director: Marshall Forstein, M.D.
Faculty: Stewart L. Adelson, M.D.

Educational Objectives: At the conclusion of this course, the participant should be able to: 1) Identify major developmental issues facing gay men; 2) Identify how early life issues related to a sense of being different affect mental health; and 3) Identify transference/countertransference issues.

Description: The formation of a sexual minority identity (based on sexual orientation) requires additional developmental tasks in the lives of gay men. Beginning in childhood with the experience of being different, gay males experience stigmatization of deeply felt, personal aspirations for attachment, intimacy and sexual expression. In addition to the effect of stigmatization of a sexual minority identity, self-identification and expression of being gay in the areas of play, work and love are influenced throughout the life of gay men by geography, culture, religion, family, and legal status. Gay men who are of racial and/or ethnic/or fundamental religious groups negotiate multiple minority identities. Gay men are thus challenged to integrate these multiple sources of identity with a sexual minority identity. In addition, rapidly evolving historical change such as "gay liberation", the HIV pandemic, and the evolution of civil rights including the legal recognition of marriage affect psychological development. Despite an improving climate of social and legal acceptance, a significant number of gay men are characterized by social and psychological vulnerabilities that increase the risk for mental health disorders that have the potential to disrupt normative developmental growth; for other gay men, the different social context in which developmental tasks are realized creates developmental pathways that may differ from their heterosexual counterparts. Using a developmental model, this course will address some common issues that gay men experience and may bring to the therapeutic experience. Particular issues for gay men that may impede the realization of normative male development will be highlighted in childhood, young adulthood, midlife and late adult life. Clinicians working with gay men must frame a developmental dynamic formulation of each personal history in the context of the social milieu in which each individual grows. Transference and counter-transference issues present great challenges to both gay and non-gay therapists.

Course Level: Intermediate
Format: Lectures with powerpoint presentations, discussion of case vignettes, small-group discussion

Tuesday, May 17, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 65

Course 46 - A Psychodynamic Approach to Treatment Resistant Mood Disorders: Breaking Through Treatment Resistance by Focusing on Comorbidity and Axis II

Topic: Individual Psychotherapies
Director: Eric M. Plakun, M.D.
Faculty: Edward R. Shapiro, M.D., David L. Mintz, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to 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. 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.

Tuesday, May 17, 2011, 7:00 am - 2:00 pm; Full Day 6 hours; Hilton Hawaiian Village Hotel; Early Bird $200.00; Advance $230.00; On-Site $260.00; Spaces Available: 65

TUESDAY
May 17, 2011
11:30 AM - 3:30 PM

Course 47 - Lifting the Fog: Complicated Grief and Its Treatment

Topic: Treatment Techniques & Outcome Studies

Director: Katherine Shear, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Describe the syndrome of complicated grief (CG); 2) Use assessment tools to screen, diagnose and monitor the severity of CG; 3) Use principles, strategies and procedures used in a short term, proven efficacious treatment for CG; and 4) Know efficacy of CGT with and without concomitant antidepressant medication.

Description: This workshop will introduce participants to complicated grief and its treatment. We will discuss principles and procedures used in a treatment for complicated grief that has been shown to be efficacious in a randomized controlled trial, as well as discuss a possible role for antidepressant medication. The presentation includes a review of criteria being considered for inclusion in DSM-5 and the data supporting it. CG is conceptualized as a condition that results when the natural instinctive process of adjustment to loss of a close relationship is impeded. Attachment loss is viewed as a form of psychological trauma that triggers an instinctive response in attachment, caregiving and exploratory systems. Adjustment is thought to progress best through a process working on loss-related and restoration-related issues in tandem, and by a balanced oscillation toward and away from emotional pain. Adaptive adjustment to an important loss entails a variable period of acute grief that progresses erratically as the finality and consequences of the loss are integrated and a sense of satisfaction in life is restored. CG occurs when integration is blocked by maladaptive thoughts, behaviors, dysregulated emotion or external problems. The workshop will explain in detail the core components of complicated grief treatment (CGT), an intervention that has been manualized and tested in a study comparing outcome of CGT to Interpersonal Psychotherapy. Workshop content includes an approach to screening, diagnosis and monitoring of CG symptoms, a description of the model and principles that underlie the treatment, examples of a treatment formulation and video demonstration of core strategies and procedures.

Course Level: Intermediate
Format: lecture videotapes and demonstration small group discussions role-play

Tuesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 48 - Neuroscientific Understandings in Psychotherapy

Topic: Neuropsychiatry
Director: Gaston Baslet, M.D.
Faculty: Ellen Fletcher-Astrachan, Ph.D.

Educational Objectives: At the conclusion of this session, the participant should be able to; 1) Recognize and describe the neuroscientific foundations that explain clinical scenarios commonly seen in psychotherapy; 2) Identify components of the psychotherapeutic encounter that can be reformulated from a neurobiological perspective; 3) When appropriate and feasible, allow this understanding to generate new therapeutic opportunities; and 4) Distinguish which aspects of these concepts are inferential versus evidence-based.

Description: Purpose: The purpose of this course is to expand the participants' knowledge of basic neuroscience concepts pertaining to psychotherapeutic situations and help them apply such concepts in a clinical context and, when possible, therapeutically. Methodology: The course will be divided in modules. Each module will consist of a didactic portion addressing a relevant neuroscience concept (emotion processing, social cognition and attachment, memory systems, psychotherapeutic change) and a discussion on its psychotherapeutic application with brief clinical examples from faculty and participants. Importance of the course: With current advances in psychiatry and with psychotherapy gaining a stronger biological foundation, a renewed focus is necessary to help therapists and patients embrace this treatment modality from a perspective that incorporates evidence-based neuroscientific findings. This redefined understanding will enhance patients' acceptance of psychotherapeutic indications and could help clinicians expand therapeutic opportunities. While psychotherapy and neuroscience are recognized as separate disciplines, it is their mutual interaction that will enrich and advance each other. Clinicians understanding this interaction will have a particular advantage as they will be able to make use of growing scientific knowledge for their patients' therapeutic benefit.

Course Level: Basic
Format: The course will be divided in modules. Each module will consist of a didactic portion addressing a relevant neuroscience concept (lecture) followed by an interactive discussion between faculty and participants on pertinent clinical cases or scenarios.
Tuesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 65

Course 49 - Motivational Interviewing for Routine Psychiatric Practice

Director: Steven Cole, M.D.
Topic: Behavior & Cognitive Therapies

Educational Objectives: At the conclusion of this program, participants will be able to: 1) Describe 3 questions and 4 skills of Brief Action Planning (B.A.P.); 2) Explain how B.A.P. aligns with the Spirit of Motivational Interviewing; 3) Discuss 13 advanced communication and MI skills for persistent unhealthy behavior (PUB); 4) Use B.A.P. and 20 skills of Comprehensive Motivational Interventions (CMI) in routine practice; and 5) Teach B.A.P. to trainees, team members or colleagues.

Description: Motivational Interviewing (MI) is 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 behavior including substance abuse, smoking, obesity, and medication non-adherence as well as improved outcomes when combined with cognitive-behavioral or other psychotherapies. New data reinforces its relevance for psychiatrists: life-expectancy of patients with severe mental illness is 32 years less than age and sex-matched controls and the risk of death from cardiovascular disease is 2-3x higher than controls. Despite this evidence and its compelling relevance, most psychiatrists still have little appreciation of the principles and practice of MI. Using interactive lectures, high-definition annotated video demonstrations, and role-play, this course offers the opportunity to learn core concepts of MI and practice basic and advanced MI skills. The course introduces participants to an innovative motivational tool, "Brief Action Planning (B.A.P.)," developed by the course director (who is a member of MINT: Motivational Interviewing Network of Trainers). Research on B.A.P. was presented at the First International Conference on MI (Interlaken, 2008) and the Institute of Psychiatric Services (2009). The B.A.P. Checklist was published by the AMA, by the Patient-Centered Primary Care Collaborative (www.pcpcc.org) in its book, Transforming Patient Engagement, and by the Commonwealth Fund in its tool-kit for the Patient-Centered Medical Home. The B.A.P. Checklist has been disseminated by programs of the CDC, HRSA, the VA, the Indian Health Service, and the Robert Wood Johnson Foundation. Participants will learn how to utilize the 3 core questions and 4 associated skills of B.A.P. in a manner consistent with the "spirit of motivational interviewing"These 7 skills comprise a set of basic "Comprehensive Motivational Interventions (CMI)," appropriate for all patients at all levels of readiness for change. In a stepped-care approach to change, for those patients with complex, refractory and persistent unhealthy behaviors ("PUB"), attendees will also have the opportunity to observe and practice 13 higher-order evidence-based interventions from the repertoire of MI and Dr. Cole's textbook on medical communication: The Medical Interview: The Three Function Approach. These 13 additional skills represent the skill set of "advanced" CMI. Though designed as an introductory course for psychiatrists, 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 utilize B.A.P. in routine care for improved clinical outcomes and/or for training purposes.

Course Level: Basic
Format: Lectures, High Definition Annotated Video Demonstrations, Role-Play Demonstrations, Role-Play Practice, Interactive Discussions,and Small Group Feedback and Discussion

Tuesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85

Course 50 - Assessment and Management of Behavioral Disturbances in Dementias: Now That They Are Admitted as my Patient, What Do I Do?

Topic: Cognitive Disorders (Delirium, Dementia)
Director: Maureen Nash, M.D.
Faculty: Sarah E. Foidel, B.S., Maureen Nash, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to; 1) Have a framework for conceptualizing, diagnosing and treating significant behavior disturbances in the most common types of dementia with both behavioral and pharmacological interventions; 2) Identify and understand cognitive and functional assessments leading to accurate diagnosis of people with dementia; and 3) Recognize and encourage use of appropriate interventions to improve quality of life in people with dementia.

Description: This course is designed for all clincians - psychiatrists, primary care providers and advanced practice nurses - who desire to learn about how to assess and manage behavioral disturbances in dementia. The course has 4 sections. Management for both inpatient and outpatient situations will be covered; however, emphasis will be on the most difficult situations - typically inpatients on adult psychiatric or geriatric units. The first part will be an overview of the topic and determining the proper diagnosis. Determining the type of dementia is emphasized for proper management. Part II explores the non-pharmacological strategies for managing behavioral disturbances. Part III will delve into the pharmocological management of behavioral disturbances in dementia. Part IV will include many case examples. Cases of Alzheimer's, Lewy Body, Fronto-temporal lobe and other dementias will be used to highlight aspects of successful management of the behavioral disturbances unique to each disease. Audience participation in Part IV will highlight the learning experience.

Course Level: Basic
Format: Lecture and multiple case vignettes

T**uesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 85**

Course 51 - Mindfulness-Based Cognitive Therapy for Depression

Topic: Treatment Techniques & Outcome Studies
Director: Stuart Eisendrath, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Understand the differences

between Minfdulness-Based Cognitive Therapy and traditional CBT; 2) Utilize mindfulness concepts in treating patients with prevention; and 3) Have an understanding of how MBCT can be used for the prevention and treatment of depression.

Description: Mindfulness-Based Cognitive Therapy (MBCT) is a new form of psychotherapy that blends mindfulness meditation with elements of cognitive therapy. The course will describe the development of MBCT initially as a depression relapse prevention technique. Several randomized controlled trials have demonstrated its effectiveness in reducing relapse with efficacy rivaling maintenance antidepressants. MBCT is appealing to patients as it promotes self-efficacy and emotion regulation. MBCT use has also been extended as a therapy for active depression, particularly as an augmentation strategy for medication-resistant patients. Although its psychological mechanisms are not completely clear, MBCT appears to reduce rumination, enhance self compassion, decrease experiential avoidance, and increase mindfulness. In addition, because of studies demonstrating mindfulness meditation's effects on brain function, MBCT may have direct impact on neural pathways involved in depression. The course will examine the research literature supporting MBCT's broadening use and theoretical psychological and neural mechanisms. The course will have an experiential component, allowing participants to become directly familiar with several features of MBCT training. This component will be interactive and focus on mindfulness meditation techniques and their application for the depressed patient. This first-hand knowledge will give participants the opportunity to learn how MBCT teaches individuals to gain a metacognitive perspective on their thoughts, feelings and sensations. The course will contrast MBCT's approach with traditional cognitive behavioral techniques.

Course Level: Basic
Format: lecture, small group discussion, experiential exercises

Tuesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 80

Course 52 - Foundations of Disaster Mental Health Abbreviated Training

Topic: Violence, Trauma Victimization
Director: Kenneth W. Lee, M.S.W.
Co-Director: Leslie H. Gise, M.D.

Educational Objectives: At the conclusion of this session, the participant should be able to: 1) Identify American Red Cross mission, disaster services structure, and settings where mental health professionals work; 2) Describe culturally appropriate interventions by Red Cross mental health workers with disaster survivors and relief workers; 3) Apply evidence-based risk factor triage system to prioritize disaster mental health resources; and 4) Describe legal and ethical implications of disaster mental health work.

Description: This course will provide basic level Disaster Services training to prepare licensed mental health professionals to provide for and respond to the psychological needs of people across the continuum of disaster preparedness, response, and recovery. Information will include the American Red Cross mission, disaster services structure, and settings where mental health professionals work; description of culturally appropriate interventions by Red Cross mental health workers with disaster survivors and relief workers; psychological impact of disaster response and recovery and the context within which disaster services are provided; application of evidence-based risk factor triage system to prioritize disaster mental health resources; discussion of legal and ethical implications of disaster mental health work including licensing, HIPPA regulations, confidentiality and professional ethics; and opportunities for becoming involved with American Red Cross Disaster Mental Health through local chapters. 1)Participants must be a mental health professional with a current state license to include Counselor, Marriage and Family Therapist, Psychologist, Social Worker and Psychiatrist. Registered nurse with psychiatric nursing experience and training beyond rotation the normal rotation required for RN. 2)Participants must complete the brief online ARC course "Introduction to Disaster Services" at http://www.redcross.org/flash/course01_v01.

Course Level: Basic
Format: This course consists of a series of presentations, interactive discussions and table group activities designed to support participants learning the key concepts, knowledge, and skills required of Red Cross Disaster Mental Health (DMH)volunteers. This course allows participants to apply their learning to real-world examples that reflect the work-related challenges experienced by DMH in roles including part of Disaster Action Teams and larger disaster relief operations.

Tuesday, May 17, 2011, 11:30 am 3:30 pm; Half Day 4 hours; Hilton; Early Bird $135.00; Advance $155.00; On Site $180.00; Spaces Available: 65

Course 53 - Pain and Palliative Care in Psychogeriatrics

Topic: Geriatric Psychiatry
Director: Abhilash K. Desai, M.D.
Faculty: George T. 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 psychosocial 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 and question and answer sessions.

Tuesday, May 17, 2011, 11:30 am - 3:30 pm; Half Day 4 hours; Hilton Hawaiian Village Hotel; Early Bird $135.00; Advance $155.00; On-Site $180.00; Spaces Available: 45