



Syllabus and Proceedings



Advances in Psychiatry

Saturday, May 05, 2018

Harnessing the Perinatal Period for Women's and Their Families' Mental Health

Chair: Mary Claire Kimmel, M.D.

Presenter: Justine J Larson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review how the perinatal period is critical to women and their families' mental health; 2) Understand determinants of perinatal mental health; 3) Discuss the novel areas of research in epigenetics, the microbiome, and metabolomics applied to the perinatal period; 4) Discuss innovative interventions and treatments being employed for perinatal mental health that inform improvement of mental health; and 5) Apply knowledge gained from the perinatal period to develop future directions for research and models of care for mental health.

SUMMARY:

The perinatal period is a critical time for mother and baby biologically, socially and psychologically. Pregnancy and the first year postpartum are critical for the mother's health, how the relationship between mother and child will develop, how the relationships of all the family members will develop and adapt, and the child's development. Depression during pregnancy and postpartum affects 10-15% of women and has been associated with adverse pregnancy outcomes such as preterm birth and negative outcomes for the child's cognitive development. Risk factors for perinatal mood and anxiety disorders cross biologic, social and psychologic factors such as sensitivity to hormonal changes, immune and stress system changes, poor social support, stressful situations, and adapting to new roles. Because there are so many factors and likely for any woman there is a unique mix of factors, it has been difficult to diagnose, treat and prevent perinatal mood and anxiety episodes even when knowing a woman has risk factors. New areas of research including epigenetics, the microbiome, and metabolomics hold the promise of being able to better understand changes across a number of systems during the perinatal period for mom and

then the transmission of stress from mother to child. This talk will also look at some innovative treatments and interventions for postpartum depression capitalizing on what is known about hormonal changes and on improving access to care for mother-baby and her family. For example, University of North Carolina's Perinatal Psychiatry Inpatient Unit (PPIU) provides multidisciplinary care to help women with severe perinatal mental disorders. The PPIU has served as site for the study of brexanolone which capitalizes on what is known about allopregnanolone as a novel treatment for postpartum depression. In the outpatient setting, collaborative care models such a perinatal mental health clinic integrated in pediatrics has shown children get better well-child care compared to their siblings when the clinic did not exist. Participants will be asked to be engaged through survey questions to the participants and questions from the participants. The perinatal period is not only a critical time to intervene for the health of mother, baby and her family but also provides us unique opportunities to understand biologic, social and psychologic factors that impact women and their families across the lifespan. Focusing resources on this critical period can help us to develop future directions for research and models of health care for mental health.

Sunday, May 06, 2018

Dementia Care Update

Chair: George S. Alexopoulos, M.D.

Presenters: Davangere P. Devanand, M.D., M.B.B.S., Mary Sano, Ph.D., George S. Alexopoulos, M.D., Jeremy L. Koppel, M.D., Dimitris Kiosses, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The audience will be familiarized with most recent epidemiological findings, risk factors and prevention of dementia; 2) The lecture will provide information on the results of recent clinical trials of immunotherapy and other new agents aimed to improve cognitive symptoms and function in Alzheimer's disease; and 3) Attendees will learn about recent behavioral and pharmacological alternatives to antipsychotic agents in the treatment of neuropsychiatric symptoms and signs of demented patients.

SUMMARY:

5.5 million Americans have Alzheimer's disease (AD) with 5.3 million aged over 65 years. AD accounts for 60–70% of cases, other dementias such as Lewy body dementia (LBD), frontotemporal dementia (FTD), and vascular dementia (VD) for 15-30%, and reversible dementias for 2-5% of cases. The prevalence of dementia will rise as life expectancy increases but the incidence of dementia is declining in high income countries. Midlife vascular risk factors have been associated with late-life dementia and PET imaging suggests an association with increased brain amyloid. High blood glucose also increases the incidence of dementia in both diabetics and non-diabetics. Phase 3 trials failed to show a benefit of anti-amyloid immunotherapy in mild to moderate AD. The anti-A β monoclonal antibody bapineuzumab did not improve clinical outcomes in AD despite favorable change of biomarkers in APO ϵ 4 carriers. Solanezumab, a monoclonal antibody that preferentially binds soluble forms of amyloid did not improve cognition or function in AD. Passive immunotherapy with IVIg was of no clinical benefit. Oxidative stress contributes to dementia, but the only study of long-term antioxidant supplementation (vitamin E, selenium or both) showed no reduction in the incidence of dementia. Souvenaid (uridine, docosahexaenoic acid, eicosapentaenoic acid, choline, phospholipids, selenium and vitamins) was developed to support neuronal membranes and may have with a weak beneficial effect on cognition, function, and behavior. A 2-year FINGER trial of diet, exercise, cognitive training, and vascular risk monitoring was shown to prevent cognitive decline in older individuals at high-risk. The only FDA approved agents for AD are cholinesterase inhibitors (ChEI) for mild to moderate dementia and memantine for moderate to severe dementia. Only 15-20% of patients treated with ChEIs show some cognitive improvement but more experience a less steep cognitive decline. ChEIs may have a beneficial effect on cognition in LBD, Parkinson's dementia and VD but not in FTD. ChEI and memantine may be discontinued in patients with loss of speech, locomotion, and consciousness. Agitation and aggression occur in 60-90% of demented patients and depression in over 40%. Behavioral interventions should be favored when symptoms are

mild to moderate. WeCareAdvisor is a web-based platform developed for caregivers of AD patients. It provides education, guidance for symptom identification and management tips tailored to symptoms. PATH is a home-based treatment for depression of patients with mild to moderate dementia that integrates problem solving with environmental adaptations and caregiver participation. ChEIs may reduce behavioral symptoms of AD. Citalopram reduced agitation and caregiver distress in AD patients. Dextromethorphan/quinidine, scyllo-inositol, brexpiprazole, prazosin, cannabinoids, escitalopram, pimavanserin, and 5HT-6 receptor antagonists are under investigation for agitation of dementia.

Diagnosis and Treatment for Major Current Disorders

Chair: Herbert Pardes, M.D.

Presenters: Shannon M. Bennett, Ph.D., Adam M. Bisaga, M.D., David Alan Brent, M.D., Donald Charles Goff, M.D., Helen S. Mayberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The audience gets a state-of-the-art review regarding suicidal events, problems they pose when occurring at the beginning of treatment and use of Apps, games, and attempts to increase adherence; 2) Attendants will learn about some of the most exciting advances in our understanding of schizophrenia and our attempts to differentiate various aspects of the illness and the risk of the illness; 3) This panel will review innovative work on brain stimulation. Special focus will be on its use as an antidepressant and understanding mechanisms by which Deep Brain Stimulation is effective; and 4) Understanding of the development of anxiety disorders and concrete treatment information. Clinical research conducted by clinicians collaborating with researchers will offer concrete approaches.

SUMMARY:

There is a recent greater focus on psychiatric illness because of many developments including increased suicide, opioids use, widespread anxiety disorders, episodes of mass killing often by psychiatrically disturbed people as well as psychiatric problems

(e.g. Posttraumatic Stress Disorder [PTSD]) in Veterans and the recognition by the World Health Organization (WHO) of psychiatric disorders, particularly depression, as having the largest negative impact on the general health of the world population. Innovations including technological approaches and refined abilities to differentiate various kinds of problems from issues which do not represent psychiatric illness will be an important part of the presentation. The resurgence of focus on psychiatric illness is accompanied by dramatic, informing and innovative approaches to psychiatric illness. This panel will highlight some of the major challenges such as the explosion of opioids use, overdoses, and resultant deaths. It will include a presentation of evidence based treatment. It will also focus on the nationwide epidemic of anxiety disorders in youth and the best treatments available. We will also present new developments in biological models, biomarkers in schizophrenia and resultant new treatments. Exciting possibilities from brain stimulation in its relationship to neuropsychiatric illnesses – for example, resistance to depression will be discussed. We will also focus on assessing short-term risk of suicidal behavior in adolescents.

Monday, May 07, 2018

Advances in Understanding and Treating ADHD Beyond the DSM-5

Chair: Thomas E. Brown, Ph.D.

Presenters: Thomas E. Brown, Ph.D., Luis A. Rohde, M.D., C. Neill Epperson, M.D., Gregory Mattingly, M.D., Anthony Leon Rostain, M.D.

Discussant: Stephen Faraone, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe an updated model of ADHD as developmental impairments of executive functions of the brain involving not only attention, but also motivation, working memory, and emotion modulation; 2) Understand that ADHD often has onset in childhood, but also, for many, does not become apparent until adolescence or adulthood and may become more or less impairing over the course of the lifespan; 3) Recognize how presentation of ADHD impairments may differ in females, including mid-life initial onset of ADHD-like

symptoms in some menopausal women with no previous history of ADHD; 4) Identify differences among medications for ADHD and factors to be taken into account in tailoring ADHD medications to a particular patient, e.g. individual differences and variable task demands; and 5) Implement treatment plans for patients with ADHD which effectively utilize not only medication, where indicated, appropriate cognitive-behavioral or other psychosocial interventions.

SUMMARY:

Clinical and neuroscience research over the last decade has challenged many old assumptions about ADHD. This symposium will describe how understanding of ADHD has shifted from behavioral problems in little boys to developmental impairments of the brain's self-management system, its executive functions, extending in many cases from childhood through adulthood in both males and females. Recent research will be presented showing that ADHD often onsets in early childhood, but in other cases does not emerge until adolescence or adulthood. This new model explains that ADHD involves not only impairments of focus and attention, but also of motivation, working memory, planning, regulation of alertness, monitoring and inhibition of action, and modulation of emotions. Medication treatments for ADHD have been demonstrated effective for 70-80% of those affected; this symposium will emphasize that to be adequate treatment needs to be tailored to each patient because of individual differences and the frequent comorbidity of ADHD with other psychiatric disorders. Symposium presentations will also describe strategies for combining medication with cognitive- behavioral or other psychosocial interventions. Research on hormones and adult onset of ADHD-like impairments of executive functions in menopausal women will also be included as well as descriptions of new medications for ADHD recently approved or in the pipeline. Together these presentations will highlight the importance of recognizing the complexity of ADHD as it overlaps and is intertwined with multiple aspects of development and psychopathology.

BSNIP Biotypes in Psychosis

Chair: Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the case for conventional psychosis diagnoses; 2) Understand the usefulness of psychosis biomarkers; 3) See the power of large human data sets of individuals with psychosis; 4) See the power of computational clinical neuroscience in psychiatry; and 5) Understand the biological implications of BSNIP Biotypes.

SUMMARY:

Clinical psychiatry uses the same classification names for psychotic disorders as practitioners have used for 120 years, names which are based on phenomenology and clinical course; however, they are terms for which the specification of the clinical characteristics for each disorder is highly systematized. The Bipolar and Schizophrenia Network for Intermediate Phenotypes (B-SNIP), at the beginning, set out to find biomarkers for conventional psychosis diagnoses, including schizophrenia (SZ), schizoaffective disorder (SAD) and psychotic bipolar disorder (BDP). As such, B-SNIP reasoned, instead of divining diagnoses from a clinical interview and history, clinicians could gather critical facts and then order 'diagnostic tests' to achieve final certainty. To test this hypothesis, we collected 933 psychotic probands (397, SZ; 224, SAD; and 312, BDP), 1043 of their own first-degree family members and 435 healthy controls from 5 geographic sites and characterized them using the SCID, clinical symptom scales, cognitive tasks, oculomotor studies, structural brain imaging, evoked potentials and resting state EEG, and resting state fMRI (>50 biomarkers in all). After scoring and analyzing each biomarker within each diagnostic group, we found that no biomarker distributed differentially onto any diagnosis with enough power to make a diagnosis, suggesting that clinical diagnoses may not describe biologically homogeneous cases and could not be expected to represent distinct biologically-based disorders. The obvious, but rarely done, next step was to use only the biomarkers to partition the proband group, experimentally across psychosis diagnoses. It was a significant conceptual step that we could/should discard conventional diagnoses and reclassify. However, once stripped of diagnoses and analyzed

with forward looking computational approaches, the biomarker battery was able to segment the psychosis proband groups cleanly into 3 groups we called 'Biotypes', based only on biomarker characteristics (electrophysiology, cognition, imaging & oculomotor) and not on symptoms or clinical data. We will present what are the optimal biomarkers for such characterization; how the BSNIP Biotypes differ biologically from each other, and what implications these outcomes have for disease organization, possibilities for genetic definition and treatment forecasting as well as establishing the validity and stability of the Biotypes. This is an experimental approach not yet ready for implementation, but a putative model for the field with regard to moving toward biological models of diagnosis for serious mental illness.

Update on Managing the Adverse Effects of Psychotropic Drugs

Chair: Joseph F. Goldberg, M.D.

Presenters: Carrie L. Ernst, M.D., Rajnish Mago, M.D., Anita Louise Hammer Clayton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To identify techniques for shared decision-making when balancing risks and benefits of psychotropic drugs; 2) To recognize differences across psychotropic agents in their propensities to cause weight gain and metabolic dysregulation, alongside the management of these treatment complications; 3) To identify risk factors for, and collaborative management of, cardiac arrhythmias associated with psychotropic agents; 4) To recognize and understand how to utilize pharmacogenetic predictors of adverse effects of psychotropic medications; and 5) To describe current risk factors and management strategies for antidepressant- and antipsychotic-induced sexual dysfunction.

SUMMARY:

Adverse effects of psychotropic drugs continue to pose significant obstacles to patient care, treatment adherence, and optimal outcomes. The field has only fairly recently begun to address ways to better identify methods to recognize and manage adverse effects. New technologies have begun to emerge to

anticipate adverse effects (e.g., safety pharmacogenetics, statistical prediction models that incorporate patient propensities for undesired outcomes such as metabolic dysregulation or cardiovascular complications) alongside randomized trials of novel or existing medication strategies to counteract adverse drug effects. Rather than simply avoid otherwise efficacious medications that could potentially cause formidable side effects, clinicians and patients alike can make more confident and informed treatment decisions if they have greater knowledge about risk factors for adverse effects. This symposium will address both general and specific key issues in the contemporary management of adverse drug effects, with a focus on patient-centered care. Clinical characteristics will be described that render some patients more prone to develop adverse drug effects -- independent from pharmacodynamic factors -- including specific psychiatric diagnoses, outcome expectancies, past treatment experiences, and proclivities toward somatization. The concept of shared decision-making will be discussed when reviewing treatment risks and benefits with patients and gauging the likelihood, prevention, and manageability of potential adverse effects. Current knowledge will be reviewed concerning the use, and limitations, of pharmacogenetic testing to project risks for specific adverse drug effects. Specific examples will be discussed in greater detail regarding medication- and patient-specific risks for adverse metabolic, cardiac, and sexual effects of antidepressants, mood stabilizers, and antipsychotics across psychiatric diagnoses. We will review the strengths, limitations and rationales of known pharmacological strategies to counteract adverse weight/metabolic, cardiac/arrhythmogenic and sexual side effects of commonly used psychotropic drugs.

Advances in Transgender Mental Health Care

Chair: Eric Yarbrough, M.D.

Presenters: Sarah C. Noble, D.O., Amir K. Ahuja, M.D., Lisa Donohue, M.D., Christopher A. McIntosh, M.D., Hansel Arroyo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Introduce Clinicians to the Spectrum of Gender Identity; 2) Review the History

of the Gender Dysphoria Diagnosis in the DSM; 3) Identify Ways for Clinicians to Provide TGNC-Friendly Care; 4) Examine the Dynamic Process of Transitioning; and 5) Review Medical and Surgical Treatments Available to TGNC People.

SUMMARY:

Transgender and gender non-conforming people (TGNC) for better or worse are now in the midst of national political and social spotlights. For the first time in history, large portions of the world population are aware gender diverse people exist. Those who don't fit so neatly into the gender binary are marginalized and shunned from public society. Most cultures have little tolerance for those who don't follow general social gender norms. The growing number of gender diverse people in the world is something of a misconception. Gender diverse people have existed as long as people have existed. Greater society now being aware of them is mostly due to increasing safety and acceptance by communities. This was partly accomplished through advocacy organizations educating policy makers, research and scientific organizations educating clinicians, and to a greater extent the media of movies and television educating the general public. Regardless of the reason, gender diverse people are now feeling more comfortable to come out and express their gender identity. Now that so many people are aware of the TGNC population, they are having more reactions to being around those who are gender diverse. Seeing people who are not like ourselves makes us question our own sense of self. The presence of TGNC people have encouraged others to examine their own gender and the gender of others. Ideas about what is masculine and feminine are being called into question, and even those who do not necessarily identify as gender diverse are still bending gender with the way they dress, how they talk, and the activities they participate in. Society is being forced to look at the historical institution of gender now more than ever. Despite the growing presence of gender diverse people in the media, the medical and mental health communities' responses have been lacking. Gender clinics sparsely populate large urban areas and those tend to be over capacity with referrals of gender diverse people seeking care. The great majority of patients needing treatment either get poor

treatment from those who are not TGNC-competent, or they simply don't seek services out of frustration and an inability to connect with clinicians who work with and understand gender diversity. It is now time to train all mental health clinicians to understand and work with gender diverse people. By doing so, TGNC people will have access to trans-affirming mental health care. By offering specialized care, clinicians can work with TGNC people to focus on their mental health and create space for them to express themselves in a safe and supportive environment.

Tuesday, May 08, 2018

Advances in Psychotherapy for Personality Pathology: Treating Self and Interpersonal Functioning Across the Range of Severity

Chair: Eve Caligor, M.D.

Presenters: John Clarkin, Ph.D., Barry Stern, Ph.D., Eve Caligor, M.D., Frank Elton Yeomans, M.D., Otto F. Kernberg, M.D.

Discussant: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Apply recent developments in our understanding and classification of personality disorders to clinical practice; 2) Perform clinically meaningful assessment of personality functioning and pathology; 3) Understand the general clinical principles organizing psychodynamic therapy of personality disorders; 4) Establish a treatment frame and contract with patients presenting with personality pathology at different levels of severity; and 5) Understand the role of countertransference management in the treatment of patients with personality pathology at different levels of severity.

SUMMARY:

Recent developments in our understanding of personality disorders have emphasized the centrality of self and interpersonal functioning across personality disorders, with severity of impairment in self and interpersonal functioning emerging as a robust predictor of course and outcome. This symposium will introduce participants to a contemporary psychodynamic, object relations theory-based approach to personality pathology

based in this dimensional model of personality pathology. Presentations will provide an overview of a longer-term, flexible treatment package for personality disorders that focuses on pathology of self and interpersonal functioning. Presenters will cover the clinical objectives and core techniques that define the treatment approach, emphasizing how techniques are modified across the range of severity. Presentations focusing on specific elements of technique will also highlight their general clinical utility and accessibility for export to shorter-term, symptom-oriented treatments and acute treatment settings.

Case Conferences

Sunday, May 06, 2018

Challenges in the Diagnosis and Treatment of Prodromal and Early-Onset Psychosis in the Community Care Setting

Chairs: Gabrielle L. Shapiro, M.D., Tresha A. Gibbs, M.D.

Presenters: Colby Mykel Tyson, M.D., Caitlin Rose Costello, M.D.

Discussants: Ragy Girgis, M.D., Ilana R. Nossel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify challenges in the assessment and diagnosis of prodromal and first break psychosis in youth and young adults; 2) Identify challenges and recommendations for best practices for the community psychiatrist when engaging with and monitoring this population and their families; and 3) Describe community based interventions for patients with prodromal and early onset psychosis.

SUMMARY:

Approximately 100,000 young people in the United States experience first episode psychosis each year. Many individuals experience psychotic symptoms long before they engage in treatment. Studies have shown that duration of untreated psychosis can contribute to worsening prognosis and that psychotic disorders can interfere with youth and young adults meeting appropriate developmental milestones in regards to social, vocational and

academic skills. Extensive research is ongoing in identifying ways to increase clinical and functional recovery within this population. One major finding from the Recovery After an Initial Schizophrenia Episode (RAISE) program has been that comprehensive care for first-episode psychosis can be implemented in community clinics and improves functional and clinical outcomes with effects being more pronounced for those with shorter duration of untreated psychosis. This information stresses the importance of careful assessment and diagnosis, early treatment and monitoring, and the expansion of community-based care. However, there are many diagnostic challenges that arise while working with this population in a community based setting. The case conference will highlight three clinical presentations of psychotic illnesses in youth and young adults. Presenters will share details of each case including challenges faced and clinical questions related to diagnosis and community based interventions that arose over the course of treatment. A panel of child and adult psychiatrists will participate in discussion surrounding the issues presented and then open discussion up to the audience. This session aims to provide guidance for community psychiatrists who face the challenges of working with patients with prodromal and early onset psychosis. Handouts will be given on community programs and resources at conclusion of session.

Monday, May 07, 2018

When Treatment Fails: Clinical, Legal, and Ethical Considerations in a Case of Terminal Anorexia Nervosa

Chairs: Catherine C. Crone, M.D., Baiju S. Gandhi, M.D.

Presenters: Patricia Westmoreland, M.D., Yu Dong, M.D., Ph.D., James Lloyd Levenson, M.D., Stephen Clement, M.D., Joel Yager, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define terminal anorexia nervosa; 2) Discuss involuntary psychiatric hospitalization and coercive feeding in medical setting; 3) Discuss when to consider palliative care;

and 4) Explore the ethical conflicts inherent in this case.

SUMMARY:

Despite advances in medical technology and treatment approaches, the importance of recognizing the point at which treatment futility is reached and the need to refocus therapeutic goals is vital to prevent suffering and iatrogenic harm. While this concept is increasingly recognized within most fields of Medicine, it is still a foreign concept within Psychiatry. However, there may be times when psychiatrists need to be able to recognize when aggressive care is no longer possible or productive. With this idea in mind, we present a case of a patient with a 20-year history of intractable anorexia nervosa admitted repeatedly to two major medical centers who spurred serious clinical and ethical discussions, as well as outside consultations. The patient's assessment and management will be discussed from psychiatric, medical, forensic, ethical and pragmatic service delivery perspectives. Case: A young female with 20-year history of anorexia nervosa, restricting type. She kept BMI around 9-11, too low to be accepted by most eating disorder programs. She required several prolonged hospital stays for tube feeding. Despite professed wish to gain weight, her behavior spoke otherwise. Restrictive behavioral measures and 1:1 sitters failed to prevent manipulation of feeding tube, purging after bolus feeding, excess fluid intake, and establishment of adequate weight gain. Care was complicated by the medical staff being uncomfortable with implementing behavioral limit setting and countertransference. After repeated failed efforts at significant weight gain and no ability to have her accepted at an eating disorders program, palliative care was proposed. After discharge she was admitted to another hospital weeks later with new onset-congestive heart failure followed by aspiration pneumonia. A series of clinical, legal and ethical concerns were raised from this challenging case. First, how do we define and identify treatment refractory anorexia? Second, is tube feeding justified in a medically stable patient who only has a low BMI? Is tube feeding an involuntary treatment when patient's verbal consent is overridden by strong behavioral resistance? Does forced tube feeding cause more physical and psychological harm in a

refractory anorexic patient? Third, many medical providers are not comfortable engaging in ongoing battles with patients requiring forced tube feeding. What are the ethical principles behind forced feeding and principles behind considering transition to palliative and hospice care? What does palliative and hospice care entail for anorexic patients? How is this an option if patient, family and even medical providers are not accepting palliative care approach for eating disorder patients? What are the ethical principles behind forced feeding and principles behind transition to palliative and hospice care?

Tuesday, May 08, 2018

Death of a Physician-Patient by Suicide

Chair: Michael F. Myers, M.D.

Presenter: Michael Brog, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify key principles in the treatment of suicidal physicians; 2) Recognize common reactions to losing a patient to suicide; 3) Identify immediate and early ways of seeking assistance for oneself; 4) Reach out to grieving families and others with compassion and helpfulness; and 5) Recognize the centrality of postvention examination in advancing our knowledge of suicide and promoting resolution in the caregiver.

SUMMARY:

Suicides occur in clinical practice despite best efforts at risk assessment and treatment. It is estimated that fifty per cent of psychiatrists can expect to have at least one patient die by suicide, an experience that is considered an occupational hazard of treating mentally ill patients and may be one of the most difficult professional times in their careers. The latter can be compounded and even more wrenching when one's patient is a physician. The presenters will each give a brief case narrative of a physician patient whom they have lost to suicide. They will highlight the following issues: 1) critical features to keep in mind when treating a physician; 2) psychological reactions to patient suicide, including the myriad variables that characterize the doctor-patient relationship when both are physicians; 3) self-care

after losing a patient to suicide; 4) the clinician's roles and responsibilities after suicide, including outreach to survivors (family and significant others); 5) malpractice litigation after suicide – minimizing and dealing with lawsuits; and 6) postvention examination in the aftermath of suicide. Discussion with the presenters and attendees is an essential feature of this case conference (one half of the time will be protected). Those attending can expect to gain much new knowledge about treating suicidal physicians and become more comfortable with this very difficult dimension of professional life.

Lightning Strikes Twice: Anti-NMDAR Encephalitis in a 20-Year-Old Woman

Chair: Philip R. Muskin, M.D., M.A.

Presenters: Alejandro Ramirez, M.D., Ph.D.,

Susannah Cahalan, Sander Markx, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the risk factors for patients to develop anti-NMDAR encephalitis; 2) Explore the differential diagnosis for other conditions that should be considered in these patients; 3) Recognize the role of the psychiatrist in the diagnosis and management of patients with anti-NMDAR encephalitis; 4) Learn the impact of the encephalitis and the treatment on the recovering patient; and 5) Consider the potential outcome of untreated encephalitis as a route to chronic mental illness.

SUMMARY:

This case presentation will focus on a 20-year-old woman who presented with psychosis at age 10 following a viral infection. She was treated with psychotropics for Bipolar Disorder and remained well for 10 years until she was hospitalized for a new psychosis. Treatment for psychosis, followed by treatment for NMS was not successful. Her condition worsened, and she was transferred to our hospital. The presenters will explore establishing a diagnosis of anti-NMDAR ('limbic') encephalitis, including other differential diagnostic considerations that may confuse the diagnosis. Dr. Alejandro Ramirez will present the case history. Dr. Philip Muskin will discuss the role of the C-L psychiatrist in aiding the primary team to establish the diagnosis and the role

of the psychiatrist in managing the behavioral symptoms associated with limbic encephalitis while immunosuppressive treatment is employed. Dr. Sander Markx will give a presentation on the neurobiology of anti-NMDAR encephalitis as well as the potential for this disorder to aid in the understanding of other psychotic disorders. Finally, Susannah Cahalan, author of the book *Brain on Fire*, will discuss the experience of having been diagnosed with anti-NMDAR encephalitis and the process of recovery from this potentially life-threatening and debilitating illness.

Courses

Saturday, May 05, 2018

Evidence-Based Psychodynamic Therapy: A Pragmatic Clinician's Workshop

Director: Richard Fredric Summers, M.D.

Faculty: Jacques Barber, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Become aware of the substantial evidence base supporting psychodynamic psychotherapy; 2) Improve treatment selection by applying a contemporary and pragmatic framework for delivering psychodynamic therapy; 3) Diagnose core psychodynamic problems and develop a psychodynamic formulation for appropriate patients; and 4) Understand how to develop an effective therapeutic alliance and employ techniques for facilitating change.

SUMMARY:

This pragmatically oriented course will help clinicians provide focused and evidence-based psychodynamic therapy to a wide range of appropriate patients. By providing a clear and consistent model, connected to evidence and technique, we simplify and clarify the psychodynamic approach and help clinicians feel they are providing a contemporary and state-of-the-art treatment. Many video clips of therapy with participant discussion about technique, using interactive audience response technology and a group exercise on defining the core psychodynamic problem of a presented patient will make the course lively and participatory. The course follows the arc of

therapy by discussing the central concepts of therapeutic alliance, core psychodynamic problem, psychotherapy focus, and strategies for change. Presentation of the empirical evidence base is paired with the model and techniques to bolster the clinician's confidence in the effectiveness of the method.

Motivational Interviewing as a Core Communication Style for Psychiatrists

Director: Michael A. Flaum, M.D.

Faculty: Carla B. Marienfeld, M.D., Florence Chanut, M.D., Brian Hurley, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe what is meant by "the paradoxical effect of coercion" and why it is a central tenant of motivational interviewing; 2) Improve their ability to formulate simple and complex reflections; 3) Demonstrate at least three techniques to elicit change talk; 4) Explain the "elicit-provide-elicit" model of guiding a change plan; and 5) Describe how the spirit of MI relates to the core elements of mental health recovery.

SUMMARY:

Motivational interviewing (MI) is a method and style of interpersonal communication initially developed for the treatment of substance use disorders. Perhaps the key feature that distinguishes MI from other counseling styles is that with MI, the clinician intentionally tries to arrange the conversation so that it is the patient, rather than the clinician, who voices the argument for changing problematic behaviors. This actually proves to be a fairly radical departure from traditional helping conversations. Since its introduction in the early '80s, the utility and effectiveness of MI has been recognized and demonstrated in a wide variety of areas—both within health care and beyond—yet its utilization in psychiatry remains relatively limited to its application for patients with substance abuse problems. We feel its potential is markedly broader. Specifically, we suggest that the utilization of MI as a default communication style and way of being with patients is an ideal way to promote a "recovery-oriented" approach to mental health care. Additionally, MI can promote a "positive psychiatry"

approach across the full spectrum of patients. In this course, the core elements of both the technique and so called “spirit” of MI will be introduced, discussed, and demonstrated, as well as the rationale behind them. The course will include experiential learning, i.e., participants will actively practice core MI skills via simulations, role plays, and/or “real plays.” This will include practice aimed at improving reflective listening, strategies to elicit and reinforce “change talk” and respond to “sustain talk” and discord. We will also discuss, demonstrate and practice exchanging information and doing initial assessments and routine follow-up visits in an MI-consistent manner. The course is designed for learners of MI at all levels, including those who have had little to no exposure to MI.

The Clinical Assessment of Malingered Mental Illness

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Detect clues to malingered psychosis; 2) Identify factors that distinguish genuine from faked hallucinations and genuine and faked delusions; and 3) Be more skillful in detecting deception and malingering, especially in defendants pleading not guilty by reason of insanity.

SUMMARY:

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. The latest research on malingered hallucinations will be covered. Psychotic hallucinations will be distinguished from nonpsychotic hallucinations. Suspect auditory hallucinations are less likely to be associated with delusions. Persons faking auditory hallucinations may say they have no strategies to diminish malevolent voices and claim that all command hallucinations must be obeyed. Malingers are more likely to report extreme severity and intensity of their hallucinations. Suspect visual hallucinations are more likely to be reported in black and white rather than in color, be dramatic, and include miniature or giant figures. Resolution of genuine hallucinations and delusions with antipsychotic treatment will be delineated. Participants will learn 12 clues to detect malingered

psychosis and four clues to detect malingered insanity defenses. Videotapes of several defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned hallucinations.

Neuropsychiatric Masquerades: Medical and Neurological Disorders That Present With Psychiatric Symptoms

Director: Jose R. Maldonado, M.D.

Faculty: Andrea Ament, M.D., Filza Hussain, M.D., Yelizaveta Sher, M.D., Sheila Lahijani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should 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; 3) Understand the incidence, and clinical features of the most common metabolic disorders masquerading as psychiatric illness; 4) Understand the incidence, and clinical features of the most common Infectious disorders masquerading as psychiatric illness; and 5) Understand the incidence, and clinical features of the most common CNS disorders masquerading as psychiatric illness.

SUMMARY:

It is important for psychiatrists to recognize the variety of central nervous system (CNS) disorders that present with neuropsychiatric symptoms, thus masquerading as a mental illness. A high level of suspicion and the correct identification of the underlying process are paramount to initiate adequate treatment. This course will focus on the important differential of such disorders, common presentations, and guidelines for treatment. Psychiatric masquerades are medical and/or neurological conditions that present primarily with psychiatric or behavioral symptoms. The conditions included in this category range from endocrine disorders (e.g., thyroid, adrenal, parathyroid, pancreatic), to metabolic disorders (e.g., Wilson’s disease, hepatic encephalopathy, porphyria, nutritional deficiencies), to infectious diseases (e.g., syphilis, herpes, Lyme disease, PANDAS, HIV), to

autoimmune disorders (e.g., SLE, MS, fibromyalgia, paraneoplastic syndromes), to a variety of neurological disorders (e.g., epilepsy, NPH, dementia, Huntington's), to various toxins and substances our patients may be exposed to. In this course, we will discuss the presentation and symptoms of the most common endocrine, metabolic, infectious, autoimmune, and neurological disorders that can present with psychiatric symptoms. The presenters will focus on pearls for timely diagnosis and discuss potential management and treatment strategies. The proper workup and correct identification of the underlying process relies on accurate history taking, careful mental status examination, neurological exam, obtaining collateral information, and supporting laboratory and imaging data.

Sleep Medicine: A Review and Update for Psychiatrists

Directors: Thomas David Hurwitz, M.D., Imran S. Khawaja, M.D.

Faculty: Robert Auger, M.D., Elliott K. Lee, M.D., Ranji Varghese, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Become knowledgeable with the diagnostic features of the major sleep disorders; 2) Understand the meaning of data reported from sleep laboratory studies their patients undergo; 3) Become familiar with recommended evidence-based therapies for the major sleep disorders; 4) Recognize the importance of sleep disorders that are comorbid with psychiatric illnesses; and 5) Become confident in their abilities to propose sleep medicine consultation for patients who will benefit from specialist evaluation.

SUMMARY:

This course will present information about various sleep disorders important to practicing psychiatrists. The introduction will review basic principles of sleep-wake physiological regulation and a description of polysomnographic features of sleep stages. Clinical vignettes that could be seen in a psychiatric clinic will introduce presentations. Primary and comorbid insomnia will be discussed, as well as pharmacological and cognitive-behavioral

approaches to therapy. Restless legs syndrome will be dealt with additionally. Obstructive sleep apnea, a very prevalent disorder, will be presented as a major source of morbidity for psychiatric patients who are at additional risk because of weight gain associated with psychotropic drugs. Other hypersomnia conditions such as narcolepsy and idiopathic hypersomnia will be addressed to further assist participants to distinguish excessive daytime sleepiness from fatigue and apathy. Discussion of parasomnias will describe behavioral disorders of sleep that can be mistaken for nocturnal manifestations of psychiatric disorders. The course will close with a discussion of sleep disorders associated with various psychiatric disorders.

Disaster Psychiatry Review and Updates: Terrorist Mass Killing, Climate Change, and Ebola

Director: Joshua C. Morganstein, M.D.

Faculty: Frederick J. Stoddard, M.D., James Curtis West, M.D., Joseph C. Napoli, M.D., Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review contemporary critical principles in disaster psychiatry including behavioral and psychological responses, preparation and response, early interventions, crisis and risk communication; 2) Discuss the mental health effects of mass violence and disruption with special consideration of mass killings in "safe havens", such as churches, schools, and healthcare settings; 3) Describe the impacts of climate related disaster events on human health and how to apply critical principles in disaster psychiatry to enhance community preparedness and resilience; and 4) Understand unique psychological and behavioral responses to pandemics and important aspects of preparedness and response to these events using contemporary media content.

SUMMARY:

Understanding fundamental principles of disaster psychiatry and how to apply these principles enhances the ability of health care personnel to prepare and respond to disasters in a manner that reduces distress and enhances well-being of affected populations. Many individuals impacted by disasters

experience distress reactions, health risk behaviors, and psychiatric disorders, which produce significant morbidity and mortality. Critical interventions following disasters include effective health risk and crisis communication as well as individual and community biopsychosocial support utilizing the principles of psychological first aid. Certain populations are particularly vulnerable to adverse mental health effects of disasters and benefit from targeted behavioral health interventions. Behavioral health consultation and support to leaders who are managing the disaster will help sustain their effectiveness and optimize overall response and recovery efforts. Building on the fundamental principles of disaster psychiatry, optimal preparedness and response require an understanding of the unique psychological and behavioral effects of various natural and human-generated disasters. Mass killings, climate-related natural disasters, and pandemic infectious outbreaks represent increasingly significant global health threats. The shootings at the Route 91 concert in Las Vegas and First Baptist Church in Sutherland Springs, Texas, coordinated multisite attacks in Paris and Barcelona, and deadly vehicle crashes in Nice, France are among the growing list of mass killings around the globe. Mass killings are well-established elements of terrorism that result in particularly severe and lasting psychological effects. Climate-related natural disasters such as the severe hurricanes which impacted Texas, Florida, Puerto Rico and the Virgin Islands as well as floods in India, Nepal, and Bangladesh result in significant injury, death, and economic costs. These extreme weather events are occurring with increasing frequency and severity around the globe. Pandemics result in unique and extreme psychological and behavioral fear-based responses, which markedly exceed actual threat. Increased global mobility allows for more rapid and widespread transmission of infectious diseases. The requirement for isolation and quarantine associated with pandemics exacerbate mental health effects. Adverse psychological and behavioral responses to all types of disasters are amplified by excessive exposure to traditional news and social media. Enhanced preparedness and response efforts can significantly mitigate the adverse psychological and behavioral impact on individuals and communities affected by a broad

range of disasters. This course will begin with a review of fundamental principles in disaster psychiatry. Using case examples drawn from contemporary disaster events, attendees will be engaged in application of those principles within an active learning environment utilizing polling, panel discussions, and Q&A.

Emergency Psychiatry: The Basics and Beyond

Director: Kimberly D. Nordstrom, M.D., J.D.

Faculty: Scott L. Zeller, M.D., Seth M. Powsner, M.D., Jon Scott Berlin, M.D., Leslie Zun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the goals of emergency triage and medical assessment; 2) Learn practical ways of engaging patients in crisis; 3) Learn practical risk assessment and mitigation strategies; 4) Understand the thought process behind choosing between meds and when medications may not be appropriate; and 5) Learn practical de-escalation principles that will serve in any environment.

SUMMARY:

Emergency psychiatry, as a distinct practice, has existed since the mid-1950s and has grown exponentially with deinstitutionalization. Now there are many forms of services on and off of hospital campuses. No matter the type of environment in which you practice psychiatry, you will experience patients who are in crisis. Behavioral emergencies may occur in any setting—outpatient, inpatient, and emergency departments, as well as in the community. When psychiatric emergencies do occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes differentiating a clinical emergency from a social emergency. This course can serve as a primer or as an update for psychiatrists in the evaluation and management of psychiatric emergencies. The course faculty offer decades of experience in both emergency psychiatry and emergency medicine. The participants will learn about the role of medical and psychiatric evaluations and the use of risk assessment of patients in crisis. The course faculty will delve into when laboratory or

other studies may be necessary and note instances when this information does not change treatment course. Tools, such as protocols, to aid in collaboration with the emergency physician will be examined. The art of creating alliances and tools for engaging the crisis patient will be discussed. The participants will also learn about the management of agitation (de-escalation and medication use), and special emphasis will be given to psychopharmacological treatments in the emergency setting, including novel treatments such as ketamine. The course is divided into two parts; the first focuses on evaluation and the second on treatment. A combination of lectures and case discussion cover fundamental and pragmatic skills to identify, assess, triage, and manage a range of clinical crises. Course faculty includes emergency psychiatrists and an emergency medicine physician to help provide various viewpoints and allow for rich discussion. The course will close with the course director leading a debate with faculty over best treatments for specific case scenarios. This exercise serves to demonstrate that there is not one “right” answer and to exhibit the thought process behind treatment decisions.

Good Psychiatric Management for Borderline Personality Disorder

*Director: Brian Alan Palmer, M.D., M.P.H.
Faculty: John Gunder Gunderson, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Diagnose borderline personality disorder correctly, including differentiating from mood disorders and explaining the diagnosis to a patient; 2) Articulate principles for management of safety issues in patients with borderline personality disorder; 3) Describe the course and outcome of BPD and the impact of BPD on mood disorders and vice-versa; 4) Explain key principles and evidence in the pharmacological treatment of BPD; and 5) Understand the role of split treatments and family involvement in the treatment of BPD.

SUMMARY:

This course will teach psychiatrists the basics of what they need to know to become capable, and comfortable, in treating patients with borderline

personality disorder. The good psychiatric management taught in the course has been compared in a randomized study with dialectical behavioral therapy and performed equally well. Its contents have been developed as a handbook. The course begins with a focus on interpersonal hypersensitivity as a unifying feature of the disorder. Through interactive cases, video illustrations of principles, and ample time for questions and answers, participants will develop skills in diagnosing BPD, understanding its course and outcome, starting a treatment, applying principles of psychopharmacology, and effectively collaborating in multi-provider treatments. Basic information about the impact of BPD on other psychiatric and medical disorders (and vice versa) will help participants more effectively formulate care and treatment of patients with BPD and other disorders. Appropriate family involvement and key psychoeducational principles for families are included. Previous course participants have noted improvement in self-perceived skills in the treatment of BPD as they grow more confident in applying key principles in treatment.

Sunday, May 06, 2018

Cognitive Behavior Therapy for Severe Mental Disorders: Building Treatment Skills That Work

*Director: Jesse H. Wright, M.D.
Faculty: Douglas Turkington, M.D., David Kingdon, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify modifications of CBT for severe mental disorders; 2) Describe CBT methods for reducing suicide risk; 3) Detail CBT methods for treatment-resistant and severe depression; and 4) Recognize CBT methods for psychosis.

SUMMARY:

This course helps clinicians apply pragmatic CBT methods for severe mental disorders. Specific skills to be learned include using CBT for 1) suicide risk reduction; 2) chronic and severe depression; 3) delusions; and 4) hallucinations. Role plays, videos, and other demonstrations are used to illustrate key

strategies and methods. Participants are encouraged to discuss their own experiences in working with patients with severe mental disorders.

Sex Compulsivity and Addiction: Research, Diagnosis, and Treatment

Director: Kenneth Rosenberg, M.D.

Faculty: Patrick Carnes, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn the history, clinical instruments, diagnostic controversies, and diagnostic criteria associated with the diagnosis of sexual compulsivity; 2) Become familiar with the common terminologies and treatments particular to sexual addiction and compulsivity; 3) Use their skill set as psychiatrists to assess and initiate treatment for sexual addictions; 4) Distinguish between normal and pathological clinical presentations and discuss the differential diagnosis when compulsive sexual desire is a presenting complaint; and 5) Treat patients with compulsive sexual behaviors.

SUMMARY:

Most clinicians, even those trained in sexual disorders or addiction medicine, have little to no training in treating sexual compulsivity and cybersex addiction. This course presents historical context, proposed diagnostic criteria, evaluation protocols, comorbid disorders, speculations about the neuroscience, impact of compulsive infidelity on the family, and extensive treatment recommendations. Our discussion dates back to the 1812 book *Medical Inquiries and Observations Upon the Diseases of the Mind*, where Dr. Benjamin Rush recounted a case of a man whose “excessive” sexual appetite caused him psychological distress to the point of requesting that he be medically rendered impotent. In 1886, German psychiatrist Dr. Richard von Kraft-Ebbing argued that pathological sexuality was a bona fide psychiatric illness. We will review the more recent diagnostic approaches proposed by Ariel Goodman, M. D., Martin Kafka, Patrick Carnes, Ph.D., and others, who identified ten clinical signs of compulsive behavior: loss of control; unsuccessful efforts to stop; preoccupation; inability to fulfill obligations; continuation despite consequences; escalation; social, occupational, and recreational

losses; and withdrawal. This course delves into the research and will detail the diagnostic interview, testing, and instruments used to diagnosis sexual compulsivity. We will present a comprehensive treatment approach, with multimodal treatment, that is required to address the biopsychosocial aspects of the addiction. Adjunct therapies such as Twelve Step Facilitation will be discussed. We will review the patient’s arousal template and engaging the patient’s family and/or partner. We will discuss the various phases of short- and long-term recovery. As we will explain, there is no one-size-fits-all treatment approach, but rather, psychiatrists will be encouraged to practice good psychiatric, medical, and psychological care while focusing on the addictive cycle in order to restore the patient’s mental, physical, and sexual health.

Treating Narcissistic Personality Disorder: Transference-Focused Psychotherapy

Director: Frank Elton Yeomans, M.D.

Faculty: Otto F. Kernberg, M.D., Eve Caligor, M.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Achieve an understanding of the range of narcissistic pathology; 2) Diagnose the pathological grandiose self and understand its role at the center of narcissistic personality disorder; 3) Learn treatment techniques that address narcissistic resistances and help engage the patient in therapy; 4) Learn treatment techniques that help patient and therapist work with the anxieties beneath the grandiose self; and 5) Identify and work with the typical attachment styles of narcissistic patients.

SUMMARY:

Narcissistic disorders are prevalent and can be among the most difficult clinical problems to treat. Narcissistic patients tend to cling to a system of thought that interferes with establishing relations and successfully integrating into the world. Furthermore, these patients can engender powerful feelings in the therapist of being incompetent, bored, disparaged, and dismissed or, at the other extreme, massively and unnervingly idealized. This course will present a framework for conceptualizing, identifying, and treating individuals diagnosed with

narcissistic personality disorder (NPD) or with significant narcissistic features. Narcissism encompasses normative strivings for perfection, mastery, and wholeness as well as pathological and defensive distortions of these strivings. Such pathological distortions may present overtly in the form of grandiosity, exploitation of others, or retreat to omnipotence or denial of dependency, or covertly in the form of self-effacement; inhibition; and chronic, extreme narcissistic vulnerability. Adding to the difficulties in diagnosing and treating narcissistic disorders is the fact that they can manifest themselves in multiple presentations depending on the level of personality organization, subtype, or activated mental state. In this course, we will review the levels of narcissistic pathology. We will go on to discuss a specific theoretical and clinical formulation of narcissism and a manualized psychodynamic psychotherapy, transference-focused psychotherapy (TFP), that has been developed to treat patients with narcissistic disorders. We will review therapeutic techniques that can help clinicians connect with and treat patients with narcissistic pathology at different levels.

Assessment and Management of Autism and Associated Psychopathology

*Directors: Gagan Joshi, M.D., Roma Vasa, M.D.
Faculty: Shafali Jeste, M.D., Jeremy Veenstra-VanderWeele, M.D., Rebecca Ann Muhle, M.D., Ph.D., Lawrence Scahill, Ph.D., M.S.N., Bryan H. King, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide a review and update of the diagnostic and genetic workup and treatment perspectives for clinicians treating psychiatrically referred populations with ASD and associated psychopathology; 2) Review the diagnostic criteria for ASD and evaluation strategies for coming to an appropriate diagnosis; 3) Recognize the clinical presentation of frequently co-occurring psychiatric conditions in youth with ASD; 4) Appreciate the recent advances in the role of genetic workup for ASD in the clinical setting and the need for biomarkers in ASD to better understand the heterogeneity of the disorder; and 5) Gain an up-to-

date understanding of evidence-based pharmacotherapy in ASD.

SUMMARY:

This course provides a practical review and update on the assessment and diagnosis, with special focus on the genetic workup, and management of autism spectrum disorder (ASD) and frequently associated psychopathology in psychiatrically referred populations. This program was developed specifically for mental health providers who are providing diagnoses and ongoing treatment to psychiatrically referred populations with ASD. Clinicians will learn about common psychiatric disorders associated with ASD. Review of evidence-based psychopharmacological and behavioral interventions for ASD and commonly associated psychopathology will be provided. This course is broadly divided in two modules. Each module has presentations pertaining to the overarching theme, followed by panel discussion moderated by the course director in order to provide adequate time for the audience to address questions with presenters.

Mind-Body and Breath Techniques for Stress, Anxiety, Depression, PTSD, Military Trauma, and Mass Disasters: Lecture and Experiential

*Directors: Patricia Lynn Gerbarg, M.D., Richard Paul Brown, M.D.
Faculty: Richard Paul Brown, M.D., Patricia Lynn Gerbarg, M.D., Chris Conway Streeter, M.D., Amy Otzel, L.P.C., M.S., Beth P. Abrams, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe how increased heart rate variability and sympatho-vagal balance contribute to overall well-being and stress resilience; 2) Apply polyvagal theory to understanding how voluntarily regulated breathing practices (VRBPs) help shift the organism from states of defensive disconnection toward a state of safety and connectedness; 3) Discuss the vagal-GABA theory of inhibition and its potential relevance to treatment of stress, anxiety, and trauma-related disorders; 4) Experience coherent breathing for stress reduction and learn how VRBPs can be used to improve emotion regulation as well as reduce anxiety,

insomnia, and depression; and 5) Learn how to teach coherent breathing in clinical settings and access tools to increase this skill.

SUMMARY:

This update of last year's Mind-Body Techniques for Stress, Anxiety, Depression, PTSD, Military Trauma and Mass Disasters adds an expanded module on treatment of active duty military and veterans. **Neurophysiology, Research, Integration with Psychotherapy:** Breath-Body-Mind (BBM) uses simple practices, primarily voluntarily regulated breathing practices (VRBPs) with coordinated movements, mindfulness, and attention focus derived from yoga, qigong, martial arts, and neuroscience. Easily learned techniques provide rapid relief of stress, anxiety, depression, and PTSD; are accepted across diverse cultures; and can be modified for different settings—office, clinic, hospital, family and group therapy, school, military base, and disaster sites. Breath practices improve attention and cognitive functions. Models show how VRBPs may rapidly improve sympatho-vagal balance, emotion regulation, and symptom resolution in numerous disorders, including in children and adults. The evolving neurophysiological theory incorporates polyvagal theory (Stephen Porges), interception, interactions between the autonomic nervous system, gamma-aminobutyric acid (GABA) pathways, emotion regulatory circuits, neuroendocrine response, and social engagement networks. Physiological states characterized by increased vagal influence on heart rate variability (HRV) support social engagement/bonding and inhibit defensive limbic activity. Specific mind-body practices reduce fear and anger while restoring connectedness. Dr. Gerbarg updates evidence that VRBPs in combination with other practices lead to rapid improvements in psychological and physical symptoms in GAD, veteran PTSD, inflammatory bowel disease, and survivors of mass disasters: 2004 Southeast Asian tsunami, 9/11 World Trade Center attacks, war and slavery in Sudan, caregiver stress (gulf Horizon oil spill), and Middle Eastern refugees in Berlin. PTSD cases illustrate the use of VRBPs to enhance psychotherapy. Dr. Streeter presents a RCT in depressed patients showing effects of yoga plus coherent breathing on psychological measures, heart rate variability, and brain GABA levels (mass

resonance spectroscopy). **Experiential:** Dr. Brown leads rounds of movement with VRBPs, qigong movements, and open focus attention training. Gentle movements can be done standing or sitting. Awareness/mindfulness of breath and mental/physical state are cultivated. Group processes enhance learning. **Military Module:** Dr. Abrams reviews BBM VRBPs used at the Albany VA inpatient psychiatric unit, medical departments, and clinics. Dr. Gerbarg reviews a Breath-Body-Mind program in active duty troops. Amy Otzel, wounded warrior and military mental health specialist describes her use of VRBPs in recovery and in working with veterans.

Dialectical Behavior Therapy for Psychiatrists: A DBT Toolkit for Treating BPD

Directors: Beth Brodsky, Ph.D., Barbara Stanley, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn basic DBT theoretical principles and interventions; 2) Use DBT interventions to treat suicidal and self-harming behaviors; 3) Apply DBT interventions to their practice of psychopharmacology; and 4) Learn DBT approaches for enhancing treatment engagement with BPD patients.

SUMMARY:

Individuals with borderline personality disorder (BPD) present treatment challenges for even the most trained and dedicated clinicians. The BPD diagnosis is one of the most stigmatized of the mental illnesses, notorious for treatment resistance, high treatment utilization, and high drop-out rates, recurrent suicidal and non-suicidal self-injurious (NSSI) behaviors, and, consequently, clinician burnout. Dialectical behavior therapy (DBT) is an evidence-based psychosocial treatment with proven efficacy in decreasing suicidal, NSSI behaviors and treatment drop-out in BPD, yet few practicing psychiatrists have been exposed to DBT in their training. This half-day course will provide an overview of the DBT treatment approach and focus on teaching clinical psychiatrists and psychopharmacologists targeted DBT interventions that can enhance clinical management of the most

difficult behaviors presented by these patients, such as suicidal and NSSI behaviors, ideation, and communications; frequent help-seeking; interpersonal hostility; and medication and general treatment nonadherence. These interventions include validation strategies to enhance empathy and treatment engagement, commitment strategies to establish collaboration toward reaching behavioral goals and prioritizing treatment focus on life-threatening behaviors; use of a diary card to track mood, suicidality, medication adherence, and related symptoms; behavioral analysis of suicidal and dysregulated behaviors to enhance problem solving; a protocol for effective between-session contact; and distress tolerance skills for reducing impulsivity. Participants will leave the course with a DBT toolkit to incorporate into their clinical practice.

The National Neuroscience Curriculum Initiative (NNCI): Integrating Neuroscience Into the Clinical Practice of Psychiatry-a Practicum

Directors: Melissa R. Arbuckle, M.D., Ph.D., David A. Ross, M.D., Ph.D.

Faculty: Michael John Travis, M.B.B.S., Jane Louise Eisen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the value of incorporating a neuroscience framework into the everyday clinical practice of psychiatry; 2) Feel confident and empowered that, with or without a neuroscience background, they can integrate cutting-edge neuroscience knowledge in routine clinical settings; and 3) Access and use new and innovative methods to educate patients, relatives, and trainees about clinically relevant neuroscience findings.

SUMMARY:

Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry, yet most psychiatrists have relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of access to neuroscience teaching

faculty. In addition, neuroscience has generally not been taught in a way that is engaging and accessible. The focus of this session will be on strategies to incorporate a modern neuroscience perspective into clinical care and bring the bench to the bedside. Attendees will be exposed to new learning activities to further integrate neuroscience into their psychiatric practice in ways that are both accessible and engaging and which encourage lifelong learning. The session will include several workshops: 1) Basic Neuroscience: Understanding the major areas of the brain and their basic functions provides a necessary foundation for any neuroscience curriculum—in this session, participants will review the functional neuroanatomy of the brain through several interactive approaches intended to reinforce learning; 2) Clinical Neuroscience Conversations: This session is loosely modeled on the idea of the one minute preceptor—i.e., neuroscience teaching that can be done in the moment, with minimal preparation, and directly linked to a clinical case; 3) Neuroscience in the Media: In this session, a recent media psychiatric neuroscience article is reviewed, and structured format is used to critique the media coverage of the piece, find and appraise relevant literature, and then role play how one might communicate about this; 4) Talking Pathways to Patients: This session begins by reviewing the neurobiological underpinnings of a particular psychiatric disorder; participants then role play how they might discuss these findings with a patient, with an emphasis on understanding both symptoms and potential treatment options. Registered attendees should plan to bring a laptop or tablet and headphones to the course.

Monday, May 07, 2018

Mild Neurocognitive Disorders: Improving Detection, Diagnosis, and Early Interventions

Director: James Michael Ellison, M.D., M.P.H.

Faculty: Jennifer Rose Gatchel, M.D., Ph.D., David P. Olson, M.D., Ph.D., James Michael Ellison, M.D., M.P.H., Donald Davidoff, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Detect and assess *DSM-5* Mild Neurocognitive Disorder; 2) Understand the clinical

and prognostic significance of this syndrome, which lies between normal cognitive aging and major neurocognitive disorder; 3) Become familiar with evidence-based interventions that can delay or mitigate cognitive decline; 4) Understand the role of neuropsychological assessment in the evaluation of Mild Neurocognitive Disorder; and 5) Become acquainted with current and evolving neuroimaging techniques used in assessing Mild Neurocognitive Disorder.

SUMMARY:

This is an interdisciplinary course developed in order to help clinicians understand the detection, clinical significance, and current evidence-based interventions for people with *DSM-5* Mild Neurocognitive Disorder (MiND). Before current biomarker studies, mild cognitive symptoms were often attributed to depression or anxiety. Depression can be a prodrome of cognitive impairment, a risk factor for cognitive decline, a manifestation of a shared underlying etiology, or a reaction to progressive functional limitation. Identifying which of these paradigms applies can pave the way for effective intervention. Mild age-associated changes in cognition reflect aging of the brain, including changes in synaptic structure, neurotransmitter activity, integrity of white matter, and volume. Many older adults note mild changes in cognitive functions and express concern about progression. In “subjective cognitive impairment,” the earliest stage of cognitive symptoms to reach awareness, individuals complain of mildly compromised cognitive functioning that falls below the sensitivity of standardized screening tests. Subjective cognitive impairment may be a precursor to MiND. Concerns about memory or other cognitive faculties may lead an older adult to seek evaluation at this stage. MiND is a limited but significant functional impairment associated with an acquired decline in one or more of six cognitive domains: complex attention, memory, language, visuospatial, executive function, or social cognition. Compensatory behaviors are required to deal with a cognitive decline that is significant but not disabling. New dependence on cueing, reminders, lists, assistive technology such as GPS, or the help of others can signify the presence of mild neurocognitive disorder while allowing the affected

person to function with apparent independence. MiND can represent the prodromal stage of major neurocognitive disorder, whether associated with Alzheimer’s disease or another etiology. MiND is linked with biomarker changes including hippocampal and global brain volume loss, changes in regional glucose metabolism, amyloid deposition, and deposition of amyloid plaques. MiND and depression share a complex and reciprocal relationship. Cognitive symptoms accompany depression in many adults, and mood symptoms are frequently present in MiND, sometimes even in advance of clinically significant cognitive changes. Cognitive and mood disorders may share elements of pathophysiology; for example, they can reflect consequences of inflammation, and treatment interventions can therefore overlap. Vascular depression can be seen as a relative of MiND in which the mood symptoms clinically overshadow executive dysfunction or other cognitive changes. A growing focus in dementia care, now, is prevention. Thorough assessment of milder cognitive changes in older adults may in some cases help mitigate progression. Identifiable medical causes of cognitive symptoms such as dysregulation of glucose metabolism can sometimes be identified and addressed. Modification of physical activity, diet, cognitive stimulation, social engagement, and sleep quality have each been proposed to improve cognitive functioning or delay decline. While investigation of non-pharmacological interventions continues, the effect size of these lifestyle factors is being assessed in multiple trials. This course presents current best practices in assessment and intervention with people affected by MiND.

Risk Assessment for Violence

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Specify four types of paranoid delusions that can lead to homicide; 2) Identify the relative risk of violence in schizophrenia, bipolar disorder, and substance abuse; and 3) Indicate three factors that increase the likelihood that violent command hallucinations will be obeyed.

SUMMARY:

This course is designed to provide a practical map through the marshy minefield of uncertainty in risk assessment for violence. Recent research on the validity of psychiatric predictions of violence will be presented. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be reviewed. Dangerousness will be discussed in persons with psychosis, mania, depression, and substance abuse. Special attention will be given to persons with specific delusions, command hallucinations, premenstrual tension, and homosexual panic. Personality traits associated with violence will be discussed. Childhood antecedents of adult violence will be covered. Advice will be given on taking a history from potentially dangerous patients and countertransference feelings. Instruction will be given in the elucidation of violent threats, sexual assaults, and “perceived intentionality.”

Talking With and Listening to Your Patients About Marijuana: What Every Psychiatrist Should Know

Director: Henry Samuel Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review limitations on current scientific knowledge of marijuana; 2) Review history of marijuana in medicine; 3) Review biochemistry of exogenous and endogenous cannabinoids and their unique biological actions, receptors, approved cannabinoid preparations, metabolism, and routes of administration; 4) Review clinical research data on the effects of marijuana upon psychiatric and non psychiatric conditions and upon behaviors such as violence and its potential hazards; and 5) Discuss how to address providers’ legal/ethical/documentation and history-taking issues and patients’ questions, concerns, and educational needs regarding marijuana use.

SUMMARY:

Marijuana, according to NIDA, is “the most commonly used illicit substance.” However, according to state, not federal, laws, medical marijuana is legal in 28 states and D.C. Eight states have also legalized the recreational use of marijuana. As the legalization of marijuana grows, patients are turning to us, their doctors, for advice and

information regarding medical marijuana’s risks and benefits. As well, many patients with medical/psychiatric illness use marijuana recreationally, with little knowledge of its effects. Both groups deserve education from us based on scientifically derived data. However, despite research to the contrary, the U.S. government still considers marijuana a Schedule I substance “with no currently accepted medical use and a high potential for abuse.” The federal stance inhibits research on the science of marijuana and has promoted attitudes toward marijuana’s risks and benefits that are not objective or scientifically based. We need to be able to counsel and educate our patients based on objective, scientific data. Too much is said with authority about medical aspects of marijuana—pro and con—that is misleading and deceptive. This course will teach the practitioner to understand the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. The faculty will review the 4,750-year-long history of cannabis as medicine and the recent history of restrictions on research and use of cannabis in the U.S. We will discuss the cannabinoid system, CB1 and CB2 receptors, their distribution and function, as well as the endogenous cannabinoids. We will cover cannabis’ routes of administration, bioavailability, distribution and elimination, and the unique actions of various cannabinoids. We will then present clinical research and its limitations on the effects of cannabis in psychiatric conditions, including anxiety, depression, psychosis, PTSD and sleep, and its role in violence. We will also review clinical research on its effects in non-psychiatric medicine, including its actions in inflammation, pain, spastic diseases, appetite loss, nausea, epilepsy and HIV. We will present data on FDA-approved cannabinoids. The faculty will detail hazards of cannabis use, including use in pregnancy, addiction, accidents, psychosis, cognitive deficits, withdrawal, heart and lung illnesses, reproductive effects, and other symptoms. We will discuss synthetic cannabinoids. We will describe the malpractice risks, legal restrictions, and limitations on medical practitioners who may be asked by their patients to issue a ‘cannabis card.’ We will teach the practitioner to take a history relevant to the use of medical cannabis. We will discuss ways to listen to and talk with patients who consider using or are actively using cannabis for medical reasons, or

who are using cannabis recreationally while in treatment for a psychiatric or other medical disorder. We will not address screening for or treatment of addiction.

Acute Brain Failure: Pathophysiology, Diagnosis, Management, and Sequelae of Delirium

Director: Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; 2) Recognize the main risk factors for the development of delirium in the clinical setting; 3) Describe the evidence regarding the use of nonpharmacological techniques (e.g., light therapy, early mobilization) in delirium prevention and treatment; 4) Define the evidence behind the use of antipsychotic agents in the prevention and treatment of delirium; and 5) Recognize the evidence behind the use of non-conventional agents (e.g., α -2 agonist, melatonin, anticonvulsant agents) in the prevention and treatment of delirium.

SUMMARY:

Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity due to disturbances of systemic physiology. It is also the most common psychiatric syndrome found in the general hospital setting, causing widespread adverse impact to medically ill patients. Studies have demonstrated that the occurrence of delirium is associated with greater morbidity, mortality, and a number of short- and long-term problems. Short-term, patients suffering from delirium are at risk of harming themselves (e.g., falls, accidental extubation) and of accidentally injuring their caregivers due to confusion, agitation, and paranoia. Long-term, delirium has been associated with increased hospital-acquired complications (e.g., decubitus ulcers, aspiration pneumonia), a slower rate of physical recovery, prolonged hospital stays, and increased placement in specialized intermediate and long-term care facilities. Furthermore, delirium is associated with poor functional and cognitive recovery, an increased rate of cognitive impairment (including increasing rates of dementia), and

decreased quality of life. This course will review delirium's diagnostic criteria (including new *DSM-5* criteria), subtypes, clinical presentation and characteristics, and available diagnostic tools; the theories attempting to explain its pathogenesis; the reciprocal relationship between delirium and cognitive impairment; and a summary of behavioral and pharmacological evidence-based techniques associated with successful prevention and treatment techniques. We will also use delirium tremens (i.e., alcohol withdrawal delirium) as a way to better understand delirium's pathophysiology and discuss novel, benzodiazepine-sparing techniques in order to better control the syndrome and prevent its complications while avoiding the deliriogenic effects of benzodiazepine agents.

Working With Couples and Families When a Loved One Has Neurocognitive Impairment

Director: John Steven Rolland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand a comprehensive resilience-based family systems model for assessment and clinical intervention with individuals, couples, and families facing neurocognitive disorders; 2) Recognize the significance of life cycles, multigenerational themes, and belief systems in neurocognitive disorders; 3) Describe clinical approaches with common couple and family challenges with mild to severe cognitive impairment and progressive dementias; and 4) Understand guidelines for brief family-based interventions and other timely and cost-effective interventions with neurocognitive disorders.

SUMMARY:

Conditions involving neurocognitive impairment, such as Alzheimer's disease and traumatic brain injury, present heart-wrenching challenges to couples and families. Because they alter capacities for relational connection in varied ways, they can profoundly affect couple bonds and family life. Caregiving stresses over time can have serious health and mental health consequences and reverberate throughout the network of relationships. However, research and practice tend to focus narrowly on immediate issues for individual

caregivers and their dyadic relationship with the affected member. A broad family systems framework with attention to family processes over time is needed in training, practice, and research. In this course, Rolland's Family Systems Illness (FSI) model provides a guiding framework to consider the interaction of different psychosocial types of neurocognitive conditions and their evolution over time with individual, couple, and family life course development. The FSI model, developed for clinical practice and research with families dealing with major health conditions, provides a useful framework to apply with neurocognitive impairment. The FSI model distinguishes three dimensions of the illness experience over time: 1) "psychosocial types" of health conditions, based on the pattern of onset, course, outcome, disability, and level of uncertainty; 2) major developmental phases in their evolution over time (initial crisis, chronic, terminal), facilitating longitudinal thinking about chronic conditions as an ongoing process that families navigate with transitions and changing demands; and 3) key family system variables, including organization, communication, family (and individual members) life course development, multigenerational patterns/legacies related to illness and loss, and belief systems (meaning-making, influences of culture, ethnicity, spirituality, gender, and race). Drawing on his new book, Dr. Rolland provides a resilience-based practice approach and guidelines with case illustrations/video to maximize coping and adaptation over time. He will address key couple and family challenges with mild to severe cognitive impairment and progressive dementias, including communication issues, belief systems/meaning-making, multigenerational legacies, threatened future neurocognitive disability, ambiguous loss, decisional capacity, reaching limits, placement decisions, and issues for adult children and spousal caregivers. He will highlight core challenges for couples, such as intimacy, sexuality, and re-visioning hopes and dreams. Principles and guidelines are provided to help couples and families master these complex challenges, deepen bonds, and forge positive pathways ahead. We will discuss preventive screening, family consultation/assessment, treatment planning, and integration with other psychiatric approaches and in a range of health care settings.

Tuesday, May 08, 2018

Integrating Technology and Psychiatry

Director: John Luo, M.D.

Faculty: Carlyle Hung-Lun Chan, M.D., Steven Richard Chan, M.D., M.B.A., John Torous, M.D., Robert Kennedy

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Utilize online resources for lifelong learning, patient care, and collaboration; 2) Integrate electronic practice management tools in education, communication, documentation, screening, and evaluation; 3) Monitor and maintain professional identity and privacy; and 4) Assess novel technologies such as smartphone apps and predictive analytics to determine their role in patient care.

SUMMARY:

This is a newly revised course that addresses the important aspects of managing the information and technology that have become an integral 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. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system, participating in a social network as a career resource, using a smartphone or tablet to connect via email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in health care management, there are many ways and reasons to integrate technology in the practice of psychiatry. This course will review the technology trends, applications, gadgets, and other novel technologies in the future of patient interaction. We will explore the evolving role of tablets, smartphones, and social media as mediums for clinical practice. This course will explore many of the ways that clinicians can use technology to manage and improve their practice.

Psychiatrist as Expert Witness: The Ins and Outs of Being a Forensic Consultant

Director: Phillip Jacob Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Give more effective expert witness testimony; 2) Understand rules of evidence and courtroom privilege; and 3) Understand issues of power and control in the witness/cross-examiner relationship.

SUMMARY:

Trial procedure and rules of evidence governing fact and expert witnesses will be reviewed briefly. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre-trial conferences and depositions. Participants will learn to cope with cross-examiners who attack credentials, witness bias, adequacy of examination, and the validity of the expert's reasoning. Issues of power and control in the witness/cross-examiner relationship will be explored. Participants will learn how to answer questions about fees, pre-trial conferences, and 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 eight 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 suggestions for witnesses in depositions, 15 trick questions by attorneys, and over 50 suggestions for attorneys cross-examining psychiatrists.

Practical Psychodynamics to Enhance Outcomes in Pharmacological Treatment Resistance

Director: David L. Mintz, M.D.

Faculty: Heather Forouhar Graff, M.D., Barri Ann Belnap, M.D., Samar S. Habl, M.D., Erin Seery, M.D., David L. Mintz, M.D.

EDUCATIONAL OBJECTIVE:

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; 3) Understand how pharmacotherapy and the meanings of medications can either support or interfere with development; 4) Diagnose common psychodynamics underlying pharmacological treatment resistance; and 5) Use psychodynamic interventions in pharmacotherapy to ameliorate psychodynamic contributors to medication issues.

SUMMARY:

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 the systems within which psychiatrists are working often create pressures for doctors to adopt a symptom-focused, biologically reductionistic framework. In this context, the important impact of psychosocial factors in prescribing have been relatively neglected, leaving psychiatrists to work without some of our most potent tools.

Psychodynamic psychopharmacology is a psychodynamically informed, patient-centered approach to psychiatric patients that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacological treatment. While traditional objective-descriptive psychopharmacology provides guidance about what to prescribe, the techniques of psychodynamic psychopharmacology inform prescribers about how to prescribe to maximize outcomes, not only in terms of an absence of symptoms, but also in ways that support the patient's development, increase in the patient's personal authority, and foster general well-being. This course will review the evidence base connecting meaning, medications, and outcomes, and will review psychodynamic concepts relevant to the practice of psychopharmacology. Then, exploring faculty and participant cases, and with a more specific focus on treatment resistance, common psychodynamic sources of pharmacological treatment resistance will be elucidated. This is intended to help participants to be better able to recognize those situations where psychodynamic interventions are likely to be vital to enhance pharmacological outcomes. Faculty will outline

technical principles of psychodynamic psychopharmacology, providing participants with tools for working with psychodynamic resistances to and from psychiatric medications.

Eating Disorders and Obesity for the General Psychiatrist

*Directors: Evelyn Attia, M.D., B. Timothy Walsh, M.D.
Faculty: Deborah Glasofer, Ph.D., Katharine Loeb, Ph.D., Angela S. Guarda, M.D., Michael James Devlin, M.D., Janet Schebendach, Ph.D., Judith Korner, M.D., Ph.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the psychiatric and medical features of *DSM-5* feeding and eating disorders; 2) Learn the principles of evidence-based interventions for eating disorders, including psychosocial and pharmacological treatments; 3) Learn about the medical and psychological manifestations of obesity, especially as seen in psychiatric patients; 4) Learn about available bariatric surgery procedures, the psychological evaluations needed preoperatively, and the psychological changes commonly seen postsurgically; and 5) Learn about nutritional management of feeding and eating disorders.

SUMMARY:

Eating disorders are serious psychiatric illnesses associated with high rates of morbidity and mortality. They affect more than 10 million individuals in the U.S. and account for increasing rates of disability among adolescent and young adults worldwide, according to studies of the global burden of disease. Eating disorders are frequently associated with other psychiatric symptoms and syndromes, including mood, anxiety and substance use disorders. Psychiatrists and other mental health clinicians who may not specialize in eating disorder treatments will commonly identify eating and weight problems among their patients and may not know how best to manage these features. This course serves as an overview of eating disorders and obesity for the general psychiatrist. Following a brief introduction by Dr. B. Timothy Walsh, Dr. Evelyn Attia will review evidence-based medication treatments for eating disorders. Dr. Deborah

Glasofer will discuss psychological treatments for adults with eating disorders and will present clinically useful tools from manualized treatments such as cognitive behavioral therapy (CBT). Dr. Katharine Loeb will discuss issues specific to the identification and treatment of children and adolescents with eating disorders. Dr. Angela Guarda will discuss when to use higher levels of care in the treatment of eating disorders. Dr. Janet Schebendach will review nutritional principles for eating disorder treatments. Dr. Michael Devlin will discuss psychological assessment and treatment of the obese patient. Dr. Judith Korner will discuss medication management for obesity. Dr. Robyn Sysko will discuss pre-surgical psychiatric assessment and post-surgical management of the bariatric surgery patient.

Everything You Always Wanted to Know About Interpersonal Psychotherapy for Children and Adolescents and Never Had the Chance to Ask

*Directors: Laura Mufson, Ph.D., Jami Young, M.D.
Faculty: Laura Dietz, Ph.D., Gabrielle Anderson, Ph.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the basic principles of IPT-A; 2) Describe the key IPT-A techniques; 3) Understand how the principles and techniques have been modified for use as a preventive intervention; 4) Understand how the principles and techniques have been modified for use with preadolescents and their families; and 5) Utilize the techniques through role plays and discussion of case examples.

SUMMARY:

Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) was adapted from the adult model of IPT and is based on the premise that depression, regardless of its etiology, occurs in an interpersonal context. IPT-A is a 12–15-session treatment that focuses on improving depressive symptoms and interpersonal functioning. IPT-A has been adapted as a preventive intervention for adolescents at risk for depression and for preadolescents diagnosed with depression. This course will provide an introduction to the principles of IPT-A as adapted for adolescents as well as the prevention model, Interpersonal Psychotherapy–

Adolescent Skills Training (IPT-AST), and family-based IPT for preadolescents who suffer from depression. The course will include didactic lectures on the main principles and techniques of each treatment model, use of video illustration of particular techniques, opportunity for short experiential role playing, and brief case examples. IPT-A has been demonstrated to be an efficacious treatment for adolescent depression and is delineated in a published treatment manual. IPT-A meets the criteria of a “well-established treatment” for adolescent depression according to the American Psychological Association. This course will present the goals and phases of IPT-A, identified problem areas, primary components of IPT-A, and specific therapeutic techniques. IPT-AST is a group-based, preventive intervention for adolescent depression that can be delivered in a variety of settings. IPT-AST consists of one or two individual pre-group sessions, eight group sessions, and an individual mid-group session. Components of IPT-AST include psychoeducation regarding depression and the link between feelings and interpersonal events and interpersonal skill building to address interpersonal difficulties and prevent the development of depression. This course will provide a brief overview of the intervention, with a focus on specific strategies that are unique to the prevention model. Family-Based Interpersonal Psychotherapy (FB-IPT) is an effective treatment for depression in preadolescent children (ages 8–12). FB-IPT focuses on the family environment as a primary source of interpersonal stress for depressed preadolescents and provides a framework to address interpersonal impairment in depressed preadolescents and the family risk factors that may sustain their depressive symptoms. This course will outline the developmental modifications, structure, and clinical strategies for conducting FB-IPT. Participants who attend this course will gain a better understanding of IPT-A and its adaptations and how these models may be used in their own settings.

Wednesday, May 09, 2018

Conversion Disorder: Update on Evaluation and Management

Directors: Gaston C. Baslet, M.D., W. Curt LaFrance, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Perform a comprehensive assessment in patients with conversion disorder, incorporating input from test and exam results and other collaborating disciplines; 2) Communicate the diagnosis to the patient, his/her family, and the collaborating physician in a way that reinforces engagement in treatment; 3) Recommend, seek advice, and/or execute the most appropriate treatment plan based on the current evidence from the medical literature; and 4) Understand the complexity and heterogeneity of this patient population and recognize various modifiable risk factors that should be considered targets for treatment.

SUMMARY:

Conversion disorder (also named functional neurological symptom disorder in the *DSM-5*) is diagnosed in a sizable proportion of patients seen in neurological practice. Treatment as usual involves referral to a mental health professional, including psychiatrists. During the last decade, there has been increased interest in the development of treatment options for this disorder, yet clear guidelines for the management of this complex population do not exist. This course will review the role of the psychiatrist during the diagnosis and management of patients with conversion disorder. We will provide an overview of our current understanding of the risk factors and pathogenic models of this disorder. These include biological and psychosocial etiologic factors. The course will focus on practical interventions, including guidelines for a comprehensive initial psychiatric evaluation. The effective communication of the diagnosis to patients, families, and collaborating providers is crucial. We will discuss the different stages of treatment, including engagement, evidence-based short-term interventions, and strategies for the long-term treatment of patients suffering from conversion disorders. The course will emphasize how to collaborate with the multitude of disciplines involved in the care of these patients. This will be facilitated by including faculty who possess a wealth of clinical experience in the evaluation and treatment of these patients. We will present

illustrative cases showcasing the complexity and heterogeneity of patients with conversion disorder. Participation from the audience will be encouraged, including discussion of their cases.

Interpersonal Psychotherapy (IPT) for Posttraumatic Stress Disorder

Director: John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain an understanding of how IPT has been adapted to treat PTSD; 2) Understand how to apply IPT to the treatment of PTSD; and 3) Gain appreciation for a non-exposure approach to PTSD treatment.

SUMMARY:

Exposure-based therapies have dominated the treatment research and clinical guidelines on posttraumatic stress disorder (PTSD); the Institute of Medicine deemed it the only treatment approach with sufficient evidence for their imprimatur. Research indeed shows that exposure treatments benefit many patients, yet they force patients to face their greatest fears, a grueling process that many patients and therapists are reluctant to undertake. Moreover, like all psychiatric treatments, exposure is no panacea; not all patients who are willing to try it improve, and some patients with high levels of dissociation may actually worsen with exposure. In 2015, we published results of a randomized controlled trial of 110 unmedicated patients with chronic PTSD in the *American Journal of Psychiatry*. This trial compared interpersonal psychotherapy (IPT), a non-exposure therapeutic approach; prolonged exposure, the best tested exposure-based treatment; and relaxation therapy, an active control condition. All three treatments showed large effect sizes for improvement. Contrary to the exposure dogma, IPT was non-inferior to prolonged exposure and had advantages for patients with comorbid major depression (half of patients who have PTSD) and for those with sexual trauma. Patients preferred IPT despite its then lack of a research base, and patients who responded to IPT generally remained well at three-month follow-up. Other research studies also suggest that IPT, a treatment with demonstrated efficacy for major

depression and eating disorders, also benefits patients with PTSD. This course will briefly review the evidence supporting the IPT approach, then focus on its clinical emphases. IPT is an affect-focused treatment that helps patients understand the connection between their feelings and their interpersonal environment. IPT for PTSD focuses not on reconstructing the trauma patients have experienced or on facing trauma reminders, but on the interpersonal consequences of having been traumatized. Adapting IPT for chronic PTSD involves emotional reattunement to address patient symptoms of numbness; acknowledging feelings as helpful indicators of interpersonal encounters, rather than as noxious; and role play to help patients master their interpersonal environments. If time permits, the course will also review cases of PTSD contributed by the audience and discuss IPT approaches to their treatment.

Sleep Disorders and Psychiatry: What Should Mental Health Care Provider Know for Patient Care

Director: Karim W. Ghobrial-Sedky, M.D., M.Sc.

Faculty: Andres Julio Pumariaga, M.D., Basant K. Pradhan, M.D., Gerd Naydock, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand and appreciate the importance of sleep disorders in patients with psychiatric disorders; 2) Demonstrate proficiency in knowledge about sleep disorders and its types; 3) Identify investigative and treatment methods to help patients; 4) Identify insomnia treatment methods and differences (advantages and disadvantages) between mindfulness therapy versus CBT-I for insomnia; and 5) Learn about new innovative treatments in the field of sleep medicine.

SUMMARY:

Sleep disorders are common in patients with psychiatric disorders. This includes insomnia, hypersomnia, sleep apnea, and restless legs syndrome. Narcolepsy, an unusual neuropsychiatric disorder, can sometimes be confused with psychosis due to its associated hallucination complaints. Thus, it is imperative for mental health care professionals to be educated about these different disorders and educate their patients about managing them. The

aim of this course is to discuss the prevalence of sleep disorders in patients with psychiatric disorders and the overlap between neurotransmitters implicated in both disorders. Restorative sleep protects human beings from the development of depression, mania, or even psychosis. Up to 60–90% of individuals with psychiatric disorders have comorbid sleep disorders. While there is sometimes significant overlap between these two disorders, treating one might lead to only partial remission. In a longitudinal meta-analytic review, presence of insomnia predicted the development of depression by an odds ratio of 2.6, highlighting the significant correlation. Similarly, in children, presence of sleep apnea was correlated to presence of depression and attention-deficit/hyperactivity symptoms, with improvements after treating the apnea. Thus, awareness of the methods to diagnose and treat sleep disorders becomes integral. A review of sleep questionnaire and hygiene, education about sleep studies, and laboratory tests required will be reviewed. In addition, synopsis about the use of mindfulness therapy—literature review, methodology of mindfulness, manual standardized for treating insomnia, and future work—will be discussed. This would be compared to the frequently used cognitive behavior therapy for insomnia, along with discussion about the preferred patient population in each with highlighting each modality's advantage of each.

Updates in Geriatric Psychiatry

Director: Rajesh R. Tampi, M.D., M.S.

Faculty: Shilpa Srinivasan, M.D., Aarti Gupta, M.D., Ilse R. Wiechers, M.D., M.H.S., M.P.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the epidemiology, neurobiology, assessment, and treatment of neurocognitive disorders among older adults; 2) Describe the epidemiology, and treatment of behavioral and psychological symptoms of dementia among older adults; 3) Enumerate the epidemiology, and treatment of mood and anxiety disorder among older adults; 4) Elaborate on the epidemiology, and treatment of psychotic disorders among older adults; and 5) Examine the epidemiology, and

treatment of substance use disorder among older adults.

SUMMARY:

The population of older adults is growing rapidly in the United States. Currently, 13% of the population of United States is 65 or older. The population of older adults is expected to double in the next four decades. Psychiatric disorders are not uncommon among older adults, with one in five older adults presenting with a diagnosable psychiatric disorder. Illnesses like neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders are frequently encountered among older adults. In this course, we will review the common psychiatric disorders among older adults, including neurocognitive disorders, psychotic disorders, and substance use disorders. We have designed this comprehensive review course for clinicians who want to gain expertise in caring for older adults with these psychiatric disorders. This course intends to be a one-stop shop for those who intend to receive the most up-to-date information on neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life. This course will be taught by award-winning geriatric psychiatrists who have expertise in the teaching courses in geriatric psychiatry.

Evaluation and Treatment of Sexual Dysfunctions

Director: Waquih W. Ishak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Acquire practical knowledge and skills in the evaluation of sexual dysfunctions; 2) Acquire practical knowledge and skills in treatment of sexual dysfunctions; and 3) Apply gained knowledge/skills to real-world examples of sexual dysfunctions in men and women.

SUMMARY:

This course is designed to meet the needs of psychiatrists who are interested in acquiring current knowledge about the evaluation and treatment of

sexual disorders in everyday psychiatric practice. The participants will acquire knowledge and skills in taking an adequate sexual history and diagnostic formulation. The epidemiology, diagnostic criteria, and treatment of different sexual disorders will be presented, including the impact of current psychiatric and nonpsychiatric medications on sexual functioning. Treatment of medication-induced sexual dysfunction (especially the management of SSRI-induced sexual dysfunction), as well as sexual disorders secondary to medical conditions, will be presented. Treatment interventions for sexual disorders will be discussed, including psychotherapeutic and pharmacological treatments. Major emphasis will be placed on women's sexual health and dysfunctions, including recent pharmacological and psychotherapeutic advances. Clinical application of presented material will be provided using real-world case examples brought by the presenter and participants. Methods of teaching will include lectures, clinical vignettes, and group discussions.

Psychiatric Disorders in Pregnant and Postpartum Women: An Update

*Directors: Shaila Misri, M.D., Deirdre M. Ryan, M.D.
Faculty: Barbara Shulman, Shari Isa Lusskin, M.D.,
Tricia A. Bowering, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify risk factors for perinatal depression and be familiar with individualized treatment intervention; 2) Understand the principles of pharmacotherapy in bipolar disorders I and II in perinatal women; 3) Understand how perinatal mood/anxiety disorders affect mothers, fathers, and children and to learn about nonpharmacological treatment interventions; 4) Recognize effects of anxiety on fetus/developing child and review clinical presentations and treatment options; and 5) Understand the impact of untreated maternal illness on fetus, child, and family and recognize evidence-based treatment guidelines.

SUMMARY:

This course provides a comprehensive overview of research updates and focuses on current clinical guidelines pertaining to treatment interventions in

major depressive disorders, bipolar disorders, anxiety disorders, posttraumatic stress disorder, and obsessive-compulsive disorder during pregnancy and the postpartum period. This course provides new research for perinatal pharmacotherapy in bipolar disorders, major depressive disorder, anxiety, and ADHD. Nonpharmacological treatments including psychotherapies such as cognitive behavior therapy (CBT), mindfulness-based CBT, interpersonal psychotherapy, light therapy, and alternative therapies will be discussed. Infant massage and mother-baby attachment issues will be explored. Information on postpartum mental illness in fathers, its effect on the growing baby, and the change in their family dynamics will be presented. This course is interactive; the audience is encouraged to bring forward their complex patient scenarios or case vignettes for discussion. The course handouts are specifically designed to update the audience on the cutting-edge knowledge in this subspecialty.

Rhythm and Blues: An Introduction to Interpersonal and Social Rhythm Therapy (IPSRT)

Director: Holly Swartz, M.D.

Faculty: John C. Markowitz, M.D., Debra Frankel

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide patients suffering from bipolar disorder with a rationale and set of strategies for improving their social rhythm stability; 2) Describe the link between stability of routines and mood; and 3) Use principles of chronobiology to help patients with bipolar disorder address mood symptoms.

SUMMARY:

Bipolar disorder (BP) is a highly disabling illness for which pharmacotherapy is only partially effective. Fewer than 50% of patients treated with pharmacotherapy alone recover and remain well for more than a year. In the last two decades, psychosocial interventions have emerged as valuable complements to medication in improving symptomatic and functional outcomes for individuals with bipolar disorder. Interpersonal and social rhythm therapy (IPSRT), based on interpersonal psychotherapy (IPT), is an evidence-based psychotherapy for adults and adolescents

suffering from bipolar disorder. Developed at the University of Pittsburgh, this treatment combines a behavioral approach to increasing the regularity of daily routines (social rhythms) with an interpersonal approach to coping with interpersonal life stress and social role problems. It has now been shown to be efficacious in preventing relapse of mania and depression and in treating acute episodes of bipolar depression when used in combination with pharmacotherapy. Studies also demonstrate its utility as a monotherapy for adults with bipolar II disorder and for adolescents with bipolar I or II illness. The IPSRT approach has now been expanded to include group therapy models for inpatient, intensive outpatient (day-hospital), and standard outpatient treatment. This course will explain the rationale for the treatment, present data on its efficacy in the treatment of bipolar disorder, and introduce participants to the strategies and techniques used in IPSRT. Coursework will focus on understanding and managing the sleep-wake cycle in the context of circadian biology changes related to bipolar disorder. Interactive components of the course will give participants the opportunity to practice basic IPSRT techniques such as assessment of social rhythm stability utilizing the Social Rhythm Metric. Participants who complete this course will have an increased understanding of the role of psychosocial interventions for the treatment of bipolar disorder and will be able to use components of IPSRT with their own patients suffering from bipolar disorder.

Focus Lives

Monday, May 07, 2018

FOCUS LIVE! Neurocognitive Disorders

Moderator: Mark H. Rapaport, M.D.

Presenter: William M. McDonald, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review information on the epidemiology, diagnosis, and treatment of neurocognitive disorders in geriatric psychiatry; 2) Apply increased understanding of neurocognitive disorders in geriatric psychiatry and be better able to contribute to the care of patients with these

disorders; and 3) Review current knowledge, recognize gaps in learning, and identify areas where more study is needed to enhance management of patients' treatment.

SUMMARY:

Cognitive function is a major determinant of an individual's quality of life. However, the number of individuals developing a neurocognitive disorder (NCD) is increasing as the population ages: the number of individuals with dementia is doubling every 20 years and will reach over 115 million worldwide by 2050. There is a need to identify vulnerable individuals early, understand the trajectory of their NCD, and intervene with effective treatments. The DSM-5 outlines criteria to identify patients with mild NCD and distinguish them from patients with major NCD. Identifying patients early in the course of a dementing disorder can improve the opportunity to develop effective interventions to change the course of the NCD. Research is needed to identify biomarkers and risk factors that indicate an individual's potential for developing an NCD. This FOCUS LIVE presentation will present multiple-choice questions based on information about the current status of our assessment and treatment approaches for neurocognitive disorders. This multiple-choice question based presentation will provide participants with an opportunity to test their knowledge about this disorder.

FOCUS LIVE! Anxiety Disorders

Moderator: Mark H. Rapaport, M.D.

Presenter: Andrew William Goddard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review multiple choice questions and test their knowledge of current trends in the diagnostic reconceptualization of anxiety disorders; 2) Apply increased understanding of anxiety disorders to clinical practice with the potential to improve recognition and treatment of these disorders; and 3) Review current knowledge, recognize gaps in learning, participate in a program of lifelong learning to identify areas where more study is needed.

SUMMARY:

Anxiety Disorders continue to be a major public health and clinical practice challenge due to their high prevalence, chronicity, and clinical comorbidities. It is striking that, despite the availability of modern psychiatric care, many patients still remain underrecognized and undertreated. Also striking is the fact that, in recent years, relatively few novel anti-anxiety treatments have been forthcoming. Our field is currently undergoing a remarkable time of change with regard to diagnostic reconceptualization, neuroscientific models of fear processing, and emerging treatment innovations. This FOCUS LIVE presentation will present multiple-choice questions based on information about the current status of our diagnostic and treatment approaches for anxiety, developmental aspects of anxiety disorders, explicating the need to adapt assessment and treatment strategies according to life phases. The presentation reviews diagnosis, epidemiology, etiology, and psychotherapy and pharmacotherapy recommendations and evidence. This multiple-choice question based presentation will provide participants with an opportunity to test their knowledge about diagnosis and treatment of this disorder.

Forums

Saturday, May 05, 2018

Partnering to Address Well-Being in Graduate Medical Education: A Call to Action for the Mental Health Community

Chair: Lyuba Konopasek, M.D.

Presenter: Christine Moutier, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the new Well-Being Common Program Requirements and the CLER Well-Being domain; 2) Identify stressors and supports in their own learning environment; 3) Describe tools to address primary, secondary, and tertiary prevention; and 4) Identify opportunities for collaboration with colleagues to address the ACGME CPRs and CLER Well-Being pathway in order help promote a healthy working and learning environment for all.

SUMMARY:

Physician stress, burnout, and depression are significant problems across the continuum of medical education. Medical students have been found to have increased rates of suicidal ideation and the prevalence of death by suicide among physicians is significantly higher than in the general population. It is critical that we think strategically about how to address resident wellbeing and mental health issues, targeting both individual and organizational factors, as well as primary, secondary, and tertiary prevention. The ACGME's new Common Program Requirements (CPRs) and Clinical Learning Environment Review (CLER) call for a systematic approach to address Well-Being in GME. This interactive forum will begin with a brief introduction of the new Well-Being CPRs and the CLER Well-Being domain. Next, participants will be encouraged to identify stressors and potential solutions to addressing these issues in their own environments. A demonstration of some tools used to address well-being and mental health will follow. Finally, participants will be challenged to discuss how they can partner with non-psychiatry colleagues to collaborate in creating a healthy working and learning environment and bring the expertise of the mental health community to help create a healthier work force.

Psychiatrists at the Helm of the Opioid Epidemic

Chairs: Elie Aoun, M.D., Lama Bazzi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explore the role of psychiatrists as providers of addiction treatment services and the application of specialized psychiatric training to improve patient outcomes; 2) Communicate effectively with other healthcare providers charged with diagnosing and treating patients with addictions, as well as making timely and appropriate referrals in complex cases; 3) Understand the role of psychiatrists in developing, overseeing, and implementing cost effective and efficient programs to educate law enforcement officials as the first responders to addiction related; 4) Understand the role of psychiatrists in assessing needs of defendants for addiction related treatments and providing

effective SUD treatments in correctional settings; and 5) Provide education to the public related to addiction as a major psychiatric disorder, the availability of effective treatments, and reducing stigma surrounding addiction as a disease.

SUMMARY:

Despite significant efforts to slow the opioid epidemic, drug overdose deaths continue to climb. More than two thirds of those deaths are attributed to opioids. Psychiatrists are uniquely equipped, as physicians specialized in mental health, to take the lead in providing cost effective, evidence based addiction treatment services. Using a framework for substance use disorders (SUD) as a mental disorder, psychiatrists ought to take the lead in providing addiction treatment services. They can offer distinctive expertise for screening, identifying and treating opioid use disorder (OUD) as well as co-occurring addictions and non-addictive co-occurring mental disorders using a compassionate patient centered approach. Indeed, addictions are within the "scope of practice of the general psychiatrist." We will discuss how psychiatrists are already equipped to be in charge of providing addiction treatment using models of care delivery such as the Vermont hub and spoke. We will explore psychiatrists as essential in a collaborative care approach to addiction treatments and as key educators of other physicians and healthcare providers in screening, identifying, and referring complex patients with co-occurring disorders to psychiatrists, when necessary. In such contexts, we will delineate models of working with teams with psychologists, social workers, other counselors and pharmacists to provide state of the art addiction treatment. We will explore the psychiatrist's role in educating emergency personnel as well as law enforcement on early engagement with high risk individuals with OUD, as well as identifying opioid intoxication, withdrawal and overdose and assisting in providing emergency treatments for opioid overdoses. We will discuss evidence based approaches to prescribing Medication Assisted Treatments and address barriers to access to MATs and how psychiatrists can help reform the system in order to overcome them. In the criminal justice systems, psychiatrists are needed to perform addiction treatment needs assessments and provide evidence based SUD

services in the correctional setting. This would increase the likelihood of implementing of systemized and personalized pre-release treatment planning for inmates with SUD. We will explore the role of the psychiatrist as an expert in diversion courts, and the need for psychiatrists to oversee treatment planning and assess effectiveness of programs defendants are referred to. Finally, we will discuss the psychiatrist's essential role in shaping addiction health care policy and driving reform through advocacy and increasing the public's awareness of addiction as a psychiatric disorder with effective treatments. In this context, with the psychiatrist serving as a liaison with the public at large to provide education about SUD as a major psychiatric disorder and the availability of effective psychiatric interventions that improve functionality, decrease rates of relapse and improve quality of life.

West Side Story: The Mind and Music of Leonard Bernstein

Chair: Philip R. Muskin, M.D., M.A.

Presenter: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the connection between hyperthymic temperament and bipolar disorder; 2) Understand music's role in alleviating depression and accessing ecstatic states; and 3) Appreciate the challenges involved in artistic collaboration.

SUMMARY:

Leonard Bernstein (1918-1990) was perhaps the most influential and versatile American musician of the 20th century. He was an outstanding conductor, an accomplished pianist, a renowned educator, and a composer who made significant contributions to Broadway, Hollywood, and the classical concert hall. Bernstein's best known work, the musical West Side Story, was the product of an extraordinary collaboration with lyricist Stephen Sondheim, choreographer Jerome Robbins, and playwright Arthur Laurents. The musical score of West Side Story is a remarkable blend of the most sophisticated techniques expressed in a manner which insured its universal popularity. Such duality is at the essence of Bernstein. Throughout his life he

sought to sustain the contradictions between elite and mass appeal, composing and performing, tradition and innovation, intellect and emotion. He experienced a similar contradiction in his personal life, as he attempted to navigate the conflict between homosexuality and a traditional heterosexual marriage. On the occasion of the centennial anniversary of Bernstein's birth, psychiatrist and pianist Dr. Richard Kogan will perform musical examples that illuminate the arc of Bernstein's career and intrapsychic struggles. There will be a focus on concepts of particular interest to mental health professionals - hyperthymic temperament, histrionic personality disorder, and music's role in relieving depression and accessing ecstatic states.

Sunday, May 06, 2018

Reducing the Risk of People With Serious Mental Illness Going to Jail

Chair: Fred Charles Osher, M.D.

Presenters: Michael K. Champion, M.D., Stephanie Le Melle, M.D., M.S., Deirdra Assey, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the Risk-Need-Responsivity (RNR) Model to address criminal thinking and behavior; 2) Understand how to identify people involved in the criminal justice and address their specific needs; and 3) Incorporate principles of RNR into treatment planning to support their clients in meeting their justice needs/goals.

SUMMARY:

People who have serious mental illnesses (SMIs) are increasingly overrepresented in the criminal justice system. At any given time, while only about 4 percent of the general U.S. adult population has an SMI, approximately 17 percent of adults booked into jails have an SMI. In addition, three-quarters of people in jail who have SMIs also have co-occurring substance use disorders. Further, 1 in 3 Americans has a criminal record. Considering these statistics, psychiatrists need to be aware that people who are in the criminal justice system or have a recent criminal justice history who have SMIs are very likely part of their patient population, and they are

uniquely positioned to help these patients avoid future involvement with the criminal justice system. Many community psychiatrists have not been adequately trained to identify and address the clinical and forensic needs associated with these patients' criminal behavior. Psychiatrists are rarely familiar with the Risk-Needs-Responsivity (RNR) principles that guide criminal justice professionals in identifying and targeting interventions that can help reduce recidivism for this population. Psychiatrists who recognize that people in the criminal justice system who have SMIs are a part of their patient population and understand the ways in which these patients' needs are informed by their criminal justice history are uniquely positioned to address these patients' complex needs. Psychiatrists who familiarize themselves with the principles of the RNR model and incorporate interventions that address these patients' criminogenic risks and needs into their treatment plans can help these patients achieve their recovery goals and reduce their likelihood of future contact with the criminal justice system. This workshop provides community psychiatrists with an overview of the RNR model, information on how to inquire about a person's criminal history, and ways they can help address the particular needs of this population.

Monday, May 07, 2018

Improving Access to Mental Health Care: Models for Working Collaboratively With Our Primary Care Colleagues in Pediatrics and Adult Medicine

Chair: Lawrence Wissow, M.D., M.P.H.

Presenters: Steven Alan Epstein, M.D., Barry David Sarvet, M.D., Matthew G. Biel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn the functions and processes of telephone mental health consultation to primary care; 2) Generate ideas for how telephone consultation can fit into participants' plans for integrated mental health care; 3) Learn how to conceptualize two-generational integrated care using early childhood as a model; and 4) Understand what types of interventions can best be supported with telephone consultation and how this may vary across the lifespan.

SUMMARY:

Telephone-based consultation programs aimed at building the child/youth mental health capacity of primary care providers exist in over 20 US states. These programs provide a mix of diagnostic and therapeutic advice, referral support, and training for primary care providers. The programs are designed to make primary care a more efficient gateway to mental health services as well as to increase the range and quality of mental health services delivered directly in primary care practices. Evaluations have found that consultation is well-received by primary care providers and changes attitudes about detecting and managing mental health problems commonly encountered in general practice. There is also accumulating evidence that programs have had a favorable impact on appropriate prescribing of psychopharmacologic medications. Telephone consultation is based on principles of collaborative care rooted in Wagner's Chronic Care Model (CCM). The CCM calls for increasing the expertise of front-lines clinicians and creating seamless pathways for increasing the intensity of diagnostic efforts and treatment in response to patient needs. Implementing telephone consultation involves many of the strategies required by other efforts to transform the roles and processes of primary care, including the establishment of medical homes. Consultation programs have also forced psychiatrists to learn new skills - particularly the ability to make assessments through the eyes of primary care providers and to propose interventions that can be practically delivered in the primary care setting. This forum will begin by looking at lessons from landmark adult collaborative care programs and some of the larger and oldest child telephone consultation programs. It will then discuss how child-focused integrated care has been evolving toward a two-generational model and talk about the opportunities and challenges involved in this change. The forum will conclude with a discussion of contrasts between adult and child integrated care and options for interventions that are practical in primary care. There will be ample time for questions and discussion.

Well-Being and Burnout Town Hall 2.0: Adapting and Thriving

Chair: Richard Fredric Summers, M.D.

Presenter: Anita Smith Everett, M.D.

Discussant: Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Assess your wellbeing and burnout as a psychiatrist; 2) Identify three possible interventions which could improve your wellbeing and decrease burnout; and 3) Recognize the shared concerns psychiatrists struggle with regarding wellbeing and burnout.

SUMMARY:

Professional burnout and mental health vulnerability are significant concerns affecting physicians-in-training and practicing physicians. Professional burnout can impact physicians' health and quality of life, the quality of care they provide, and their productivity and workforce participation. There is substantial evidence of burnout and vulnerability among psychiatrists. Opportunities exist to enhance psychiatrist wellbeing through research, education and intervention. The APA Workgroup on Psychiatrist Wellbeing and Burnout will present data on burnout among our members, and its recommendations to APA to support members' regarding burnout and depression. The panelists will lead an open discussion on members' responses to burnout and experience with strategies for promoting wellbeing and combating burnout.

Cutting-Edge Innovations to Provide Care

Chair: Erik Rudolph Vanderlip, M.D., M.P.H.

Presenters: Nina Vasan, M.D., Daniel Rollings Karlin, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify at least three aspects of innovation as they apply to psychiatric practice; 2) Apply concepts of design thinking to clinical medicine; 3) Challenge existing standards of care in light of emerging technologies; and 4) Understand a balance must exist between innovation and ideas of quality and safety.

SUMMARY:

Innovation is a word casually floated about today to

describe the myriad of ways in which clinical practice may be changed. Throughout the history of medicine, new technologies and advancements in the science of physiology and human behavior have uprooted professions and institutions from deeply entrenched dogma and power masked under the guise of safety and quality. Medicine in general, and psychiatry, in particular, are at the precipice of such upheaval now, though it is difficult to see where it will come from and what it will look like. This invited panel of early career psychiatrists will explore some of the thoughts behind these emerging technologies, challenge assumptions about current psychiatric practice, and work to apply the philosophies of design and empathy towards innovation and healing. This will be a guided and interactive panel discussion about the future of our practice, medicine, human behavior, and the role of the psychiatrist in the 21st Century.

Fact or Fiction? Antidepressants Aren't Safe in Pregnancy

Chair: Jennifer L. Payne, M.D.

Presenters: Krista Huybrechts, Ph.D., M.S., Samantha E. Meltzer-Brody, M.D.

Discussant: Lauren M. Osborne, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define the term “confounded by indication.”; 2) Define the difference between relative and absolute risk; 3) Quantify the risk of persistent pulmonary hypertension in antidepressant exposed newborns; and 4) Identify two risks of untreated psychiatric illness during pregnancy.

SUMMARY:

The literature regarding the safety of antidepressant medications during pregnancy is complex and there are many studies that are poorly controlled. This forum presentation will give an overview of the safety and risks of antidepressant medication use during pregnancy including the risks of untreated psychiatric illness during pregnancy using both lecture presentations and a panel discussion. Dr. Jennifer Payne, Chair, will present “In Utero Antidepressant Exposure: Problems with the Literature” which will detail the complexities and

misunderstandings of the literature in this area. This presentation will introduce the concepts of “confounding by indication” and the difference between absolute and relative risk. The presentation will also discuss potential underlying causes for the significant media hype surrounding the use of antidepressants in pregnancy, including stigma. Dr. Krista Huybrechts will then present an overview of her work in this area including the risks of cardiac defects and persistent pulmonary hypertension in antidepressant exposed infants. Dr. Samantha Meltzer-Brody will conclude the lecture portion of the forum with an overview of the risks of untreated psychiatric illness in pregnancy. A panel discussion will then be held with all three presenters and the addition of Dr. Lauren Osborne and audience members will be encouraged to join in the discussion.

Smartphone Apps and Digital Technology for the Busy Practicing Psychiatrist: Real-World Clinical Uses, Evaluations, and Clinical Considerations

Chair: Luis Sandoval, Ph.D.

Presenters: Matcheri S. Keshavan, M.D., John Torous, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Identify at least three areas where smartphone applications and wearable sensors can support the delivery of mental healthcare and psychiatric services; 2) 2.

Understand patient sentiment and interest in using smartphone applications and wearable sensors to monitor their own mental health; 3) 3.

Understand the difference between passive and active data, and identify how smartphones and sensors can collect data on self-reported symptoms, behaviors, and physiological measurements; 4) 4.

Recognize the potential of new research models using smartphones and wearable sensors and how such can inform clinical practice and patient care today; and 5) 5. Understand how to evaluate the role of mobile mental health technology in community clinical practice through accurately identifying the barriers, risk, and benefits to patients.

SUMMARY:

As interest in digital technologies like smartphone and sensors for psychiatric care continues to expand, it is important that psychiatrists remain educated and informed about the potential of these technologies, their current use cases, how to evaluate their risks/benefits, and finally how they may shape the future of the field. In this session, we will cover three core areas of direct interest to those providing psychiatric services: 1) using apps with patients as discussed in our team's American Journal of Psychiatry cover story from summer 2017, 2) evaluating smartphone apps using the American Psychiatric Association app evaluation framework, and 3) considering the implications of digital psychiatry for the future of the field.

Tuesday, May 08, 2018

Thriving Despite the Stress: Living a Smooth Sailing Life!

Chair: Linda Worley, M.D.

Presenter: Cynthia M. Stonnington, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1) Teach the Smooth Sailing Life Nautical Metaphor, a bio-psycho-social-spiritual framework to recognize the multifaceted etiologies and remedies for burnout; 2) 2) Complete a personal appraisal to identify areas in life in need of adjustment; 3) 3) Understand the evidence supporting interventions that bring about meaningful change, replenishment and rejuvenation; and 4) 4) Leave inspired with a sense of direction and hope for the future.

SUMMARY:

When you are filled with enthusiasm and satisfaction in your work, being highly productive, providing compassionate, high quality care to patients can feel effortless. Sustaining this level of wellbeing and engagement is easier said than done! The numbers of physicians acknowledging current symptoms of burn out is staggering. The path forward involves personal action by the individual, changes in the way we practice and a cultural shift within the house of medicine at large. This forum led by Dr. Linda Worley, APA 2018 Scientific Program Chair and originator of 'The Smooth Sailing Life Nautical

Metaphor' along with Dr. Cynthia Stonnington, Chair of the Department of Psychiatry and Psychology at Mayo Clinic Arizona and expert in evidence based interventions for burnout will provide participants with practical insights and solutions to thrive despite the stress. Dr. Worley will connect the multifactorial etiologies for burnout into a bio-psycho-social-spiritual Nautical Metaphor that provides an accessible, memorable tool for self-assessment and empowers meaningful change. Specifically, the metaphor can be a guide for physicians in how they navigate the drivers of burnout. The sailboat metaphor applies to each individual, their work "team," and to our profession. Dr. Stonnington will share evidence behind "well-being" interventions among medical professionals, including what works, what doesn't work, and areas ripe for further research. Using the sailboat metaphor as a framework, participants will apply the tool to their own lives to identify their own obstacles to "smooth sailing." The larger group will collectively tackle common obstacles to strategize workable solutions. Interdisciplinary audiences have found Dr. Worley's metaphor to be immediately instructive for identifying key problems and solutions to replenish and rejuvenate. You are in for a treat and will leave refreshed. Life is too short to suffer needlessly! Those individuals, practices, and organizations who recognize the need for and make adjustments along the way become the thriving, flourishing ones!

Religious Communities and Human Flourishing

Chair: Tyler VanderWeele, Ph.D.

Presenter: Stephen Post, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of religious community in shaping various human well-being outcomes; 2) Appreciate some of the methodological challenges in studying religious communities and well-being; and 3) Understand how various domains of human well-being are inter-related.

SUMMARY:

Participation in religious services is associated with numerous aspects of human flourishing including happiness and life satisfaction, mental and physical

health, meaning and purpose, character and virtue, and close social relationships. Evidence for these effects of religious communities on flourishing now comes from rigorous longitudinal study designs with extensive confounding control. The associations with flourishing are much stronger for communal religious participation than for spiritual-religious identity or for private practices. While the social support is an important mechanism relating religion to health, this only explains a small portion of the associations. Numerous other mechanisms appear to be operative as well. It may be the confluence of the religious values and practices, reinforced by social ties and norms, that give religious communities their powerful effects on so many aspects of human flourishing.

SAMHSA Priorities: The Opioid Epidemic and Serious Mental Illness

Chair: Elinore McCance-Katz, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Integrate knowledge of current psychiatry into discussions with patients; and 5) Identify barriers to care, including health service delivery issues.

SUMMARY:

Assistant Secretary Elinore McCance-Katz will review the current priorities and emerging programs at SAMHSA that focus on addressing our nations opiate epidemic as well as increasing access to treatment and recovery support services for persons with SMI/ISMIC, etc.

Learning Labs

Saturday, May 05, 2018

Leadership: A Boot Camp for Residents, Fellows, and Early Career Academic Psychiatrists

Presenter: Laura W. Roberts, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) identify the five missions of academic medicine; 2) identify where one's interests, strengths, and commitments fit in academic medicine; 3) learn practical habits to prepare for academic promotion; 4) learn strategies to meet the needs of colleagues, subordinates, and supervisors without losing sight of personal goals; and 5) engage in role-play of scenarios of difficult conversations to learn management and negotiation techniques.

SUMMARY:

This interactive session will promote academic growth, nurture leadership skills, enhance feedback, teach the basics of negotiation, and identify strategies for work-life balance. Using role plays, small group discussion, vignettes, and other techniques for audience engagement, Dr. Roberts will demonstrate models for effective communication while helping participants plan for their growth as leaders in academic medicine.

Theatrical Vignettes as an Educational Tool to Improve Communication in Asian-American Families

Chairs: Rona Hu, M.D., Eun Kyung Joanne Lee, M.D., M.S.

Presenter: Steven Sust, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Improve understanding of unique challenges faced by Asian-American families with adolescents, including possible impact of cultural expectations about success and mental health; 2) Learn about a unique method of community outreach and education involving mental health clinicians acting in theatrical vignettes; and 3) Recognize common challenges and concrete ways to improve parent-child communication about difficult emotional topics, including dating, self-harm behaviors, school performance, and acculturation.

SUMMARY:

Palo Alto, California (PA), is a Bay Area community that has experienced two separate suicide clusters—defined as a group of three or more suicides in close time or geographic proximity—since 2009. In a

community that is demographically 60% white and 27% Asian, Asian-American male adolescents have been disproportionately represented in these suicides. Following the second suicide cluster in 2014–15, the Stanford Department of Psychiatry and Behavioral Sciences conducted a set of focus groups to better understand the community's perception of current mental health needs and possible solutions. Participants included parents and adolescents of both Asian and non-Asian descent. Participants identified stigma against mental health as a significant barrier to accessing mental health services and voiced a need for more community education, resources, and support. Adolescents discussed feeling intense pressure from schools, parents, and peers to achieve personal and academic success. Asian adolescents additionally identified cultural expectations of success and cultural stigma against mental health as barriers to openly communicating with their parents and seeking help for their struggles. Among Asian participants, both parents and adolescents identified generational and cultural gaps in understanding mental health issues that affect youth. In subsequent workshops, parents identified difficulty discussing emotional topics with their adolescents and specifically requested a more "hands-on" way of learning alternative approaches to communicate with their adolescents. In response, Dr. Rona Hu, a Stanford psychiatry faculty and Chinese American, developed several vignettes as a tool for educating parents on effective communication. The vignettes, which will be performed in this workshop, simulate difficult, real-life scenarios that parents face, with specific emphasis on challenges that may arise in Asian-American households. These vignettes have been performed at several local schools and conferences in the past few years and have been produced into a TV series called *Parent Playbook*, now available on the web. Through unexpected media attention, lively and rich discussions have been generated among parents, school administrators, and mental health professionals in the region. As part of this learning lab, we will be discussing how the project may be replicated in different communities and will be high yield for clinicians at the APA who are looking for novel methods for outreach in their diverse communities.

Sunday, May 06, 2018

A Debate on Pharmacogenetic Testing: Does It Have a Role in Clinical Practice?

Moderators: Ron M. Winchel, M.D., Joel Asher Bernanke, M.D., M.Sc.

Discussants: Joseph F. Goldberg, M.D., Anil Malhotra, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The clinician will understand how some genetic tests seek to address the question of medication choice and likelihood of therapeutic effectiveness; 2) The clinician will understand that some genetic tests address variations in how individual patients metabolize various medications, and how that may affect safety and tolerance; 3) The clinician will understand the potential that available genetic profiles currently have - or do not have - for optimizing therapeutic outcomes; 4) The clinician will be equipped with information that will facilitate informed discussions with patients when the question of genetic testing arises or is presented to the clinician as a fait-accompli; and 5) The clinician will have an informed understanding of particular circumstances in which genetic testing can help avoid significant adverse side effects.

SUMMARY:

To what extent does genetic data inform prescribing? How much does it add to the clinical algorithms we use to help guide medication choice? Once a diagnosis is made, can we predict which in a class of drugs is more likely to help the patient? Which is less likely to cause harm? Which might be frankly dangerous? Such is the hope - and hype - of personalized medicine. But do currently available tools address the need? In this presentation, two leading psychopharmacologists will debate the pros and cons of genetic profile testing. Questions to be considered include: how is the tool of genetic testing to be used? What does genetic testing tell us about medication safety? Can genetic testing help choose a drug that is more likely to be efficacious? Or inform about which drugs are less likely to be effective? Under what circumstances should genetic testing be

considered? When should information about individual variations in medication metabolism be sought? Does information provided in commercially available profiles lead to more successful outcomes? Do we know enough about the implications of neurotransmitter-related polymorphisms to guide medication choice? Are there particular genetic tests that can help avoid various side effects? Can genetic profile testing mislead the clinician and diminish appropriate reliance on other clinical guidelines? What questions should the clinician ask himself before deciding to seek genetic testing? What should be considered when patients request such testing? What reasonable expectations can we have when considering genetic testing? Many articles have appeared in journals and other publications addressing the current utility or non-utility of genetic testing in psychiatry. This exploration of the issues is intended to help guide the clinician through the morass of data and opinions. In addition to hearing the debate, audience members will have an opportunity to submit questions through their devices to the experts.

Impact Lab: Social Determinants of Mental Health

Chair: Margaret E. Balfour, M.D., Ph.D.

Presenters: Ruth S. Shim, M.D., M.P.H., Glenda L. Wrenn, M.D., Chris Magnus

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Give examples how psychiatry intersects with various social justice issues; 2) List tools that can be used to advocate for change; and 3) Develop a plan to apply lessons learned in his/her own community.

SUMMARY:

Psychiatry intersects with a myriad of social justice issues. The population we serve often experiences poverty, disproportionate criminal justice involvement, health inequities, and increased mortality. Furthermore, social safety net programs such as Medicaid face an uncertain future in the current political landscape. Now more than ever, our collective impact is needed! This session is designed to give psychiatrists the tools to advocate for social justice. Impact leaders including Tucson Police Chief Chris Magnus, Black Lives Matter of

Greater New York President Hawk Newsome and the Senior Director of Behavioral Health at the Lesbian, Gay, Bisexual & Transgender Community Center in New York Antonio Ruberto, Jr. MS, LCSW-R, CASAC will give a rapid-fire overview of the issues. Breakout groups will then explore each topic in depth. APA Government Relations staff will provide guidance on how to effectively advocate with elected officials. Groups will also develop plans to stay connected and engaged via social media or other means. At the end of the session, each participant will leave with an actionable plan for making an impact in his or her own community.

Monday, May 07, 2018

You Are Human: Addressing Burnout Through Improv

Chair: Ashley Whitehurst

Presenter: Tristan Gorrindo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify major factors leading to burnout; 2) Understand the balance of physician needs and patient needs; 3) Utilize techniques from improv to combat burnout through better communication, self care, and personal connection; and 4) Let go and have a little fun.

SUMMARY:

Beep Bop Boop, guess what? You are not a robot that is expected to endure the same task over and over or expend all of your energy without release, recovery, and relaxation. Professional burnout can impact physicians' health, quality of life, quality of care they provide, and their productivity. There is substantial evidence of burnout and vulnerability among psychiatrists. The helpers and healers who treat those who need help are becoming more isolated, burnt out, and, more than ever, are at an increased risk of depersonalization, depression, and suicide. What can we do to address this alarming trend and bring wellness to psychiatrists? Improv. Improv? Yes! Improv! By applying the basic fundamentals of improv, we can move from isolation to more connection. We will learn to drop our barriers and guards and be comfortable with doing so. We will take care of ourselves so that we're

better equipped to take care of others. Using basic improv techniques allows every individual to overcome self judgement, drop pre-conceived notions to serve the situation/circumstances and not our own agenda, and be more comfortable about collaboration, communication, and connection with others.

Tuesday, May 08, 2018

Microaggressions, Macroeffects: Navigating Power and Privilege in Psychiatry

Chair: Kimberly A. Gordon-Achebe, M.D.

Presenters: Madeline B. Teisberg, D.O., Michaela Y. Beder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand microaggressions and implicit bias, and provide examples of how they affect patient care; 2) Identify the ways in which microaggressions and implicit bias influence both patients and clinicians; 3) Engage colleagues and patients with new communication skills after practicing exercises that teach techniques that can be incorporated into a clinician's daily routine; 4) Develop a self-awareness of our own privilege and/or oppression to better understand how we may impact others; and 5) Understand how racial and power dynamics intersect in complicated ways and can affect the quality of the psychiatric services our agencies provide.

SUMMARY:

Implicit bias and microaggressions affect all levels of medical care. Far from being subtle or small, an emerging literature suggests these phenomena can have big effects on access to care, care effectiveness, and even stigma. Manifestations can range widely, from assumptions about patient socioeconomic status or personality to recommending a different treatment depending on a patient's ethnicity, gender, or disability status, not to mention countless mental health-related disparities among racial and sexual minority and underrepresented groups that suggest these populations have worse prognoses. These injustices are not new and can have a significant impact on health, both physical and mental, at the individual

and population levels. They are among the forces that contribute to burnout and compassion fatigue among so many in the health professions. This can erode patient trust, undermine therapeutic alliances, discourage patients from seeking care, and potentially worsen outcomes. A recent study found that a black, working-class man would have to call 16 times as many therapists before finding care. This is unacceptable. Providers also experience these biases and microaggressions, which undermine their ability to provide excellent care. Interestingly, minority and underrepresented psychiatrists may self-select to work in underserved community clinics, and even there find discrimination from their peers and patients due to the subtle microaggressions of an oppressive health system. Experiences of discrimination based on gender, race, or identity may contribute to burnout and worsen provider well-being. Indeed, many academic institutions struggle to foster diversity at the highest levels of their organizations. An understanding of these factors is essential to increasing access to care, providing quality care, and fostering well-being among providers and patients. This highly interactive workshop will involve participants engaging in exercises to understand power, privilege, and microaggressions that occur on a daily basis in our offices, clinics, and hallways. A panel of facilitators will lead group discussion regarding the types of microaggressions, common reactions, and how they might affect our interpersonal interactions. Participants will be provided with resources to examine their own implicit biases, and we will conclude with strategies both individually and systemically to combat microaggressions and implicit biases in our daily practices and become allies with those who are oppressed. Questions and discussion will be encouraged.

Preventing a Crisis Before It Happens: Principles of Nonviolent Crisis Intervention

Chair: Moira Wertheimer, J.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how crisis situations evolve; 2) Gain experience delivering verbal messages in ways that can be beneficial or problematic in defusing a crisis; 3) Understand how

non-verbal communication may impact someone's behavior; 4) Understand the role empathic listening plays in diffusing a crisis; and 5) Understand how a crisis impacts both provider and patient.

SUMMARY:

Too often, in both the inpatient and outpatient settings, psychiatrists and staff are confronted with individuals demonstrating verbally and physically disruptive and violent behavior. Understanding how a potential crisis develops and learning responses designed to de-escalate a tense situation before it escalates can help improve overall communication patterns, reduce physical interventions, help improve problem-solving, build stronger staff confidence, and result in less injury, turnover, and liability. This learning lab, provided by risk management for the APA-endorsed liability carrier, will introduce the concepts and principles involved with non-violent crisis interventions. Participants will learn to recognize and respond to the stages of crisis development as well as recognize the behaviors that may indicate an escalation toward aggressive and violent behavior. Additionally, participants will begin to understand and appreciate how the various components of communication (verbal and non-verbal) can impact the role that communication plays in escalating/de-escalating a developing crisis. Participants will have the opportunity to demonstrate and practice verbal and non-verbal skills designed to defuse tense situations before they develop into a full-blown crisis.

Innovation and Design Thinking in Mental Health Care

Presenter: J. Andrew Chacko, M.D., M.S.E.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand what innovation and design thinking really are and what role they can play in the future of mental health care; 2) Understand some of the barriers to innovation in health care; and 3) Learn and practice some basic tools of design thinking and understand how it can greatly improve your patient engagement, transform your practice and reshape your personal life.

SUMMARY:

What is innovation? How is innovation in health care different? What is Design Thinking? Why is it important for us as psychiatrists to understand? We will answer all those questions and more. The word innovation is so overused that it seems to have lost all meaning. And yet, if you are an outsider, it can feel quite daunting--something to do with technology and apps and interoperability. In this session, we will dig through all the misconceptions to arrive at what it really means. The punchline: innovation is simply a novel way to solve a problem. The discussion will focus on three phases of Design Thinking and creative problem solving to enable you (the audience) to turn the same tools on the very problems that you are trying to answer. We will dissect cases that succinctly illustrate those principals. The format will be a lecture/workshop - the time will be very interactive, engaging and fun - because that is how we learn best, and because ... it's fun! My objective isn't to solve your problem for you, or wow you with some cool ideas that are fun but have little to no applicability to your world - it is to give you the tools to dramatically improve your ability to solve the problem yourself. In the process, we will delve into why innovation is critically important for us to understand and embrace. An inability to innovate and anticipate the future led to the collapse of titans of industry like Kodak and Blockbuster, while the opposite propelled young companies like Uber and AirBNB to the front of their respective packs. Interestingly, as physicians, we may feel secure in our field. Or are we? We will look at why we may not be. So how do we navigate this new world? Better still, how do we master it? This highly interactive workshop is designed to address just that. We will look at why it is not only natural but critical for Physicians to understand and embrace Design! We will look at how it can help us clinically, to design better treatment plans and increase patient engagement, to systemically - improve medicine as a whole. We will understand why, among clinicians, as psychiatrists, we are particularly well suited for the first and most critical step in design - and how that can put us at the helm, shaping the course not only of our discipline, but of medicine in general. At the end of the workshop we will have a chance to present our ideas about shaping our field to the some of the select APA leadership. Innovative thinking can not only reshape

your practice but can transform your life as well. And for a select few, whom these ideas ignite, it may radically alter your career.

Medical History Mystery Lab

Chair: Lawrence M. McGlynn, M.D.

Presenters: Francine Cournos, M.D., Jon Alan Levenson, M.D., Daena L. Petersen, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Use medical decision-making and problem-solving skills to solve a complex medical case; 2) Work collaborative to determine the complicated medical history of a patient; 3) Critically reflect on topics such as diagnosis, treatment, medical ethics and integrated care; and 4) Examine the role that mental health and psychiatry plays in patient care.

SUMMARY:

The Medical History Mystery Lab (MHML) is a medical education learning format that employs game-based learning and mechanics. MHML allows for high-level engagement and dynamic group discussion as participants work collaboratively to determine the medical history of a particular patient.

Lectures

Saturday, May 05, 2018

Dr. H. Anonymous and the Legacy of John E. Fryer, M.D.

Chair: Eric Yarbrough, M.D.

Lecturer: Jack Drescher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the history of psychiatric diagnosing of homosexuality; 2) Participants will be familiar with the social forces that played a role in the 1973 APA decision; and 3) Participants will be able to reflect upon the role of psychiatry in creating social change in the last half century.

SUMMARY:

In 1973, the American Psychiatric Association's Board of Trustees voted to remove the diagnosis of "homosexuality" per se from the second edition of the Diagnostic and Statistical Manual (DSM). Many mental health professionals and laypersons played a role in bringing about that historic decision. However, Dr. John Fryer's appearance as Dr. H Anonymous at the 1972 APA annual meeting was one of the most dramatic contributions to those events. To better understand the confluence of events that led to the changes in DSM, this presentation begins with a historical review of scientific theories and arguments that pathologized homosexuality and ultimately led to its placement in psychiatry's diagnostic manual. This is followed by a presentation of alternative, normalizing theories that eventually led to the diagnosis' removal. The presentation goes on to describe the events set in motion when, in 1970, gay activists disrupted APA's annual meeting and provoked a process of debate and exploration within the organization. Dr. Fryer's unique contribution to the 1972 annual meeting as a gay psychiatrist in disguise was an important part of that process. The 1974 membership referendum following the APA decision is reviewed and analyzed. Thanks to the work of Dr. Fryer and his many collaborators, there has been a widespread change in broader cultural beliefs about homosexuality and the place of LGBT people in society at large. The presentation goes on to review the social changes that eventually followed diagnostic removal. The presenter concludes with some lessons about science, sexuality and politics learned from the history of those events that played an important role in shaping his professional interests and identity.

How Is the Schizophrenia Brain Changing: Was Kraepelin Right?

Chair: Javier I Escobar, M.D.

Lecturer: Juan Bustillo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1) Understand the evidence of progressive brain changes in schizophrenia; 2) 2) Understand the NMDA hypofunction model of psychosis; and 3) 3) Understand the H-MRS evidence of glutamatergic abnormalities in schizophrenia.

SUMMARY:

The concept of dementia praecox, posited over 1 century ago that a significant proportion of young people suffering from impaired reality testing (delusions and hallucinations), would experience cognitive and functional deterioration and not return to their premorbid status. However, the technology available to Kraepelin and colleagues failed to detect progressive brain changes to support the striking clinical course of the syndrome. Over the last 20 years subtle but reliable, progressive brain tissue reductions have been documented with longitudinal MRI studies early in the course of schizophrenia. Though the mechanism and significance of these changes are far from clear, they highlight an opportunity to prevent the malignant course that still occurs in a large proportion of patients. Using proton magnetic resonance spectroscopy (1H-MRS), our group has been investigating a pathophysiological mechanism, NMDA hypofunction, that leads to a paradoxical increment in glutamatergic function and subsequent neuronal changes. Acute controlled NMDA blockade with ketamine in healthy volunteers resulted in increased glutamatergic brain concentrations in medial frontal cortex. We found similar increments in young, minimally treated schizophrenia patients. In the largest 1H-MRS schizophrenia study to date, we again found increased glutamatergic concentrations, in gray and white matter, regardless of age. Only later in the illness were changes in neuronal health detected, consistent with glutamatergic driven excitotoxicity. Furthermore, younger patients with a higher load of known schizophrenia risk-genes involved in brain glutamate metabolism, had higher levels of cortical glutamate, suggesting a genetic contribution to the 1H-MRS detected abnormalities. Conversely, short (6 weeks) and long-term (6 months) exposure to antipsychotic drugs in rats did not result in similar neurochemical changes. Though these studies have advanced our understanding of glutamate-related disease progression in schizophrenia, questions regarding the spatial distribution, timing and diagnostic specificity remain. We are now using a whole brain spectroscopic imaging approach to study first episode psychotic patients (schizophrenia and bipolar disorder), before and after antipsychotic treatment. Preliminary findings detect increased

glutamate in schizophrenia, but not in bipolar patients.

Principles and Practice of Forensic Psychiatry: Forensic Fundamentals and the Forensic Frontier

Chair: Debra A. Pinals, M.D.

Lecturers: Charles Leon Scott, M.D., Richard Rosner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. The audience participant will be able to apply the four-step conceptual framework important in the analysis of questions in forensic psychiatry; 2) 2. The audience participant will be able to cite current societal issues and case law relevant to the management of youth and adults involved in the criminal justice system; and 3) 3.

The audience participant will be able to appreciate the importance of evolving evidence-based assessments in a range of civil and criminal forensic evaluations.

SUMMARY:

In 1994, the First Edition of *Principles and Practice of Forensic Psychiatry*, edited by Richard Rosner, M. D., was published and became quickly recognized as the authoritative text in the field of forensic psychiatry. The contribution of a text covering the breadth of forensic psychiatry topics was particularly relevant in 1994 as the American Board of Psychiatry and Neurology (ABPN) formally recognized the subspecialty of forensic psychiatry with "Added Qualifications in Forensic Psychiatry" in the same year as this book's release. In the First Edition, Dr. Rosner developed and published his widely recognized "four step model" of forensic psychiatry. His model served as a conceptual framework for organizing and analyzing data in forensic psychiatry and was applied to a wide range of forensic psychiatric topics in the original edition of *Principles and Practice of Forensic Psychiatry*. Because of the success of this textbook and the need to update the rapidly advancing field of forensic psychiatry, the Second Edition of *Principles and Practice of Forensic Psychiatry* was published in 2003. This Second Edition, again edited by Dr. Richard Rosner, included 92 chapters and a diverse set of 105 author experts in forensic psychiatry.

Beyond Integration: Linking Mental Health, Physical Health, and Public Health

Chair: David Alan Pollack, M.D.

Lecturer: Benjamin G. Druss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To discuss the prevalence and causes of medical and mental health comorbidity; 2) To discuss the adverse public health consequences of medical and mental health comorbidity; and 3) To discuss a spectrum of population and public health approaches to addressing medical and mental health comorbidity.

SUMMARY:

Mental and medical health conditions commonly cooccur, resulting in poor quality of life and early death. Interventions will need to improve medical care, health behaviors, and the social determinates that underlie elevated risk in this population. A public health approach to the problem will address the problem across of a spectrum of prevention, early detection, and effective treatment.

We've Come a Part Way, Baby

Chair: Warachal E Faison, M.D.

Lecturer: Leslie Hartley Gise, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this presentation attendees will understand how and why an independent organization for women psychiatrists was formed; 2) At the conclusion of this presentation attendees will appreciate our knowledge about reproductive-related depressions in women and our challenges in research and treatment; 3) At the conclusion of this presentation attendees will learn about the focus on addiction in women as well as the forced detentions, incarcerations and treatment of pregnant women with SUDs; and 4) At the conclusion of this presentation attendees will know about the history of women in our military and our limited knowledge about the health, including mental health, of active duty service women.

SUMMARY:

An independent organization for women psychiatrists was formed in 1982 during the struggle to pass the Equal Rights Amendment. Women's health and mental health has traditionally been neglected but we have made some progress since the women's movement of the 1970s. Reproductive-related depressions in women have been studied but there are still gaps in our knowledge and deficiencies in our ability to carry our effective treatment. Until the 1990s addiction was considered a man's disease. We have learned some things about how substance use disorders in women differ from those in men but we continue to see forced detentions, incarcerations and treatment of women with substance use disorders who get pregnant. Since the founding of our country, women have made steady progress in the military but there is relatively very little recent data on the health, including the mental health, of active duty servicewomen. We have made some progress in promoting women's health and the advancement of women since the women's movement of the 1970s but there are still major challenges, backlash and deficiencies.

A Matter of Faith? The Role of Faith in the Experiences of Christians Living With Severe Mental Health Challenges

Chair: Clark Aist, Ph.D.

Lecturer: John Swinton, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To explore and re-think the relationship between the particularities of religious faith and the lived experiences of people living with severe mental health challenges; 2) To examine the critical tension between psychiatry and spiritual care; and 3) To open up space for fresh conversations between people living with mental health challenges, religious communities and professional mental health services.

SUMMARY:

What does it mean to live with a serious mental health challenge? With the current movement toward biological understandings of mental health challenges, there is a risk that the issue of the

meaning of such experiences can become occluded as the language of symptoms become the primary descriptor of people's experiences and biological intervention is assumed to be the primary response. Within such a worldview it is easy to overlook the fact that mental health challenges are first and foremost deeply meaningful experiences that occur within the lives of unique individuals whose life story and meaning making capacities are not wholly determined by their biology. One way in which meaning has been recovered within mental health care is through the "rediscovery" and reconstruction of the term "spirituality" as an aspect of our humanness. Such spirituality relates to such things as meaning, purpose, hope and value and for some people, God. Alongside of this recognition of the spiritual sits the scientific discoveries that seem to indicate that "religion can be good for our health." Such a recognition of the significance of religion and spirituality is to be welcomed. However, a good deal of the research has assumed religion and spirituality are generic categories, with the benefits to participants gauged primarily in relation to increased function and changes in behavior: "prayer helps coping," "community assists in alleviating isolation and preventing depression," "meditation leads to relaxation." To date relatively little attention has been paid to the significance of the ways in which people experience the particularities of their religion in the midst of their mental health experiences and how these experiences are processed and worked out in relation to specific religious traditions. The lecture will seek to speak into this knowledge gap by focusing on Prof Swinton's ongoing phenomenological research exploring the spiritual lives of Christians living with severe mental health challenges, namely: psychotic disorder, bipolar disorder and major depression. The lecture will draw on a series of qualitative interviews with Christians living with these conditions with a specific focus on the ways in which the particularities of this form of religion can significantly reframe standard accounts of how conditions are experienced and what kinds of responses might be considered authentic and spiritually healing in the light of this. The lecture will offer fresh insights into the nature of mental health and point toward the kinds of spiritual care that such experiences require.

Social Discrimination and Mental Illness Around the Globe

Chair: Nancy Diazgranados, M.D.

Lecturer: Dinesh Bhugra, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the differences between discrimination and stigma; 2) Attendees will be able to understand concepts of social justice in the context of modern clinical practice; 3) Delegates will be able to explore differences between various basic rights of people with mental illness; and 4) Attendees will understand Human Rights in various countries.

SUMMARY:

Social justice is defined as strengthening institutions so that every individual has equal rights irrespective of their disability or mental illness. Social justice reflects basic rights that all individuals have a right to live without experiencing discrimination and are accepted as and treated as equal without taking variations such as mental illness, gender, religion, sexual variation into account. There is no doubt that in spite of the United Nations' efforts, the human rights have evolved at different pace in different countries. The economic, legal and philosophical developments of human rights have emerged at different pace. There is no doubt that negative attitudes to mental disorder have led to stigma as well as discrimination both being strongly influenced by prevalent knowledge, religion and understanding of causative factors. Governments have a particular responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures but more importantly based on principles of equity. We set out to study the laws of member states of the United Nations as applied to people with mental illness in four areas: right to vote, right to marry, right to inherit property or make a will and right to employment. Of the 193 countries we were able to access the legal systems we found that wide spread discrimination against people with mental illness is prevalent. Thus there is a clear dissonance between the rhetoric and actual laws. It is better to tackle discrimination as changes in the law can lead to sustained changes in

improving services for people with mental illness in comparison with anti-stigma campaigns. In looking at human rights based parity across all health – be it physical or mental – clinicians must take the lead in advising policy makers to ensure right to a disability free life and to health is closely associated with the right to life, and these rights are indispensable for the exercise of most other human rights. Freedom from discrimination is at the core of all rights.

Sunday, May 06, 2018

The Future of Psychiatry

Chairs: Saul Levin, M.D., M.P.A., Michael Christopher Hann, M.D.

Lecturer: Norman Sartorius, M.D., D.P.M., Ph.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Better informed about the context in which psychiatry has to make progress; 2) Better able to understand the tendencies of growth and challenges which psychiatry has to face; 3) Better able to select topics of research whose findings will be useful to the growth of psychiatry and its usefulness; and 4) More competent in educating and informing others about ways by which they can contribute to enhancing the usefulness of psychiatry for overall country development.

SUMMARY:

The presentation will first present and discuss the major trends in the social and medical context of psychiatry. This will include a review the impact of globalization, urbanization, population explosion, commoditification and other major social changes or trends which have an impact on the practice of psychiatry and the organization of mental health services. This will be followed by a review of major changes and trends in medicine – including changes of requirements of medical ethics, changes of morbidity (with particular attention given to the rapid growth of comorbidity of mental and physical disorders) changes of organization of health services and other changes of medicine relevant to the development of psychiatry's future. The lecture will next discuss the basic paradigms of psychiatric care developed and accepted in the course of the

twentieth century and examine whether these paradigms are still valid or have become obsolete thus requiring significant changes. Among these paradigms will be those emphasizing the importance of community care, those seeing task shifting in psychiatric practice as a highly promising strategy of care, those outlining ways of rehabilitation of people with mental illness and those related to the prevention of mental illness and the promotion of mental health.

How the Digital World Is Changing the Way We Think and Feel

Chair: Eric R. Williams, M.D.

Lecturer: Susan Greenfield, C.B.E.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) understand and appreciate more fully the plasticity of the brain; 2) have a greater understanding of current research on the impact of digital technology on the mind; and 3) discuss constructively measures that need to be taken to enhance the potential and reduce the threats of the digital world.

SUMMARY:

Humans occupy more ecological niches than any other species on the planet because of the superlative ability of our brains, compared with those of any other animal, to adapt to the environment. Our brains become highly personalized post-natally by the development of unique configurations of connections between the brain cells that characterize the growth of the human brain after birth, personalizing it into a 'mind' that is in constant dialogue with the environment. Neuroscience can give valuable insights by offering a perspective at the level of the physical brain of how we might feel and think in unprecedented ways. We live in a world of concern for a global social networking profile, a world of instant views and thoughts read out in a virtual stream of consciousness. It's a two-dimensional world of only sight and sound yet offering instant information, connected identity, diminished privacy and here-and-now experiences so vivid they out-compete the real world of three dimensions and five senses. This new culture and way of life is unprecedented and as

such, is inevitably having an unprecedented affect on each individual human brain. Nowadays the digital technologies impact on every sector of our professional and private lives, encompassing goods and services, insurance and risk management, the media, leadership, education and ultimately most of domestic and international policy planning. However, social networking sites could be transforming the way we see our own identity and relations with others; video-games may be having an effect on attention, aggression, and even addictive behaviour patterns; search engines could be impacting on how we learn and differentiate information from knowledge. How will our culture and life-style adapt to a premium on the arguable features of a screen-based mentality, - such as a craving for sensation, short attention span and diminished frames of reference? My suggestion is that individual adaption will take the form of a more child-like scenario of literal and simplified events/characters/images where premium is based on direct and immediate experience. Then there's complementary question of how will culture and a new type of environment could develop a stronger sense of individual identity, reflective thought and the ability to make connections, - to join up the dots in a new way The digital world is arguably, for many, an end in itself, presenting a parallel life-style that over-rides that of the real world, and on which many will chose to spend their time and money. But how might this powerful digital environment be turned into a means to a much more fulfilling end? We need to be able to devise an environment and educational strategies for converting the fragments of isolated pieces of information of the screen into an interconnected system of knowledge. Only by joining up the dots into cohesive conceptual frameworks, will original thought and individual insight be able to emerge and flourish.

Mental Health Challenges Facing Patients and Providers of African Descent

Chair: Ayana Jordan, M.D., Ph.D.

Lecturer: Patricia Newton, M.D., M.A., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify the major challenges facing mental health

care delivery to African populations in the African Diaspora; 2) Participants will be able to understand the role of Black mental health providers in meeting the needs of underserved populations; and 3) Participants will have greater clarity as to why training in cultural competency is critical to improved outcomes in African patients.

SUMMARY:

This lecture will highlight disparities in mental health care for both providers and patients of African descent and its impact on health care costs, outcomes and delivery. The role that the creation of the Black Psychiatrists of America (BPA) has played in meeting this challenge will be explored. The historical relationship between the APA and BPA is highlighted and what the future holds for both organizations in meeting the needs of African patient populations will be addressed. The future of mental health relative to this population group will be highlighted with special emphasis on quality of life issues, eradicating provider bias, and psychiatric training issues in cultural competency will be discussed in terms of their relevance to mental health delivery.

Safe Patients and Staff: The Administration of Patient Safety in Psychiatry

Chair: John Elgin Wilkaitis, M.D., M.B.A.

Lecturer: Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand patient safety as it applies to psychiatry with emphasis on leadership and strategic planning; 2) Identify and mitigate risk factors for aggression/suicide; 3) Recognize systems-related factors that contribute to errors; 4) Identify error prone systems and points of vulnerability to avoid adverse events; and 5) Improve communication, training and transition care processes in your own system of care.

SUMMARY:

Patient safety is as a type of intervention, process or structure that reduces the probability of harm to patients or adverse events upon exposure to the health care system. How many of us have experienced negative results despite good care,

knowledge of medications, continuous education and attendance at meetings such as this? Why do we experience adverse events despite being good doctors? How do we recognize where we go wrong? Since the first patient safety committee of the American Psychiatric Association was established in 2002, we have had 16 years of experience in avoiding, preventing, and mitigating adverse outcomes stemming from treatment processes involving the examination of individuals and interactions in the care process. Today residents are required to be aware of and participate in safety practices. Administration of a safe system of care involves strategic planning, strong and committed leadership, establishing a safety culture, repeated training and communication across disciplines. Evidence of change requires research and review of results in a continuing manner. This lecture will showcase the recognition of pitfalls in psychiatric care, demonstrate how changes have been implemented over 2 decades in the psychiatric field to decrease suicides, avoid medication errors, improve outcomes from electroshock therapy, prevent aggression and diminish the use of seclusion and restraints, as well as other adverse events by providing both safe and courteous care.

The Burnout Crisis: Building a Resilient Clinician Workforce for the Future

Chair: Nancy Diazgranados, M.D.

Lecturer: Darrell G. Kirch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the causal factors of burnout within each of the three domains that influence clinician well-being; 2) Identify effective systemic and individual interventions to reduce burnout among physicians and other members of the clinical team; and 3) Recognize the role of psychiatrists in evaluating and improving clinical environments and promoting individual clinician well-being.

SUMMARY:

Clinician burnout in the U.S. is nearing public health crisis levels. Each year, 400 physicians commit suicide, a rate more than twice that of the general population. Nearly one-third of nurses are

emotionally exhausted. The traditional culture of health care—characterized by hierarchy, autonomy, competition, and individualism—has contributed to an environment that makes it difficult for physicians to ask for help or seek care when they experience burnout, depression, or suicidal ideation. The effects of this problem extend beyond the individual health care worker—burnout has been shown to lead to impaired professionalism, high staff turnover, a decrease in patient satisfaction, and an increase in medical errors. As psychiatrists, we can offer unique insight into this crisis—both its causes and potential systemic and individual interventions. Dr. Kirch will present a framework outlining the domains influencing clinician well-being, including the work environment, learning environment, and personal and professional factors. He will then delve into causal factors in each of these domains, including administrative and regulatory burdens, power differentials and mistreatment, and isolation and work-life imbalance. He will also examine the positive forces at work in each domain that promote wellness, social support, and group connectedness. Finally, Dr. Kirch will review the growing national momentum behind efforts to identify and implement evidence-based solutions to promoting clinician well-being and combating burnout, depression, and suicide among U.S. health care workers.

Computational Psychiatry

Chair: Philip R. Muskin, M.D., M.A.

Lecturer: Joshua A. Gordon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Foster an ongoing dialog between theoreticians and psychiatrists; 2) Accelerate knowledge and improve the lives of individuals with mental illnesses; 3) Test how dysfunction could create a progressive, chronic disorder by impacting neural development and plasticity; and 4) Understand how computational approaches can help take advantage of large data sets, categorizing brain dysfunction in a way that has the potential to lead to better diagnoses and improved biomarkers.

SUMMARY:

NIMH recognizes the key contributions computational and theoretical approaches can make to psychiatry, as well as the value of psychiatrists' expertise and insights with regard to the real-life problems that individuals with mental illnesses face on a daily basis. Psychiatry presents a set of real-world, clinically relevant problems, characterized by a particularly complex set of heterogeneous phenomena that are continually changing and responding to feedback that are ripe for the use of data and theory driven approaches. A principal factor is the complexity of the brain and the complexity of how neural systems produce behavior. It has proven incredibly challenging to connect knowledge gained at genetic, circuit, systems, and behavioral levels. Computational approaches allow us to describe and test how complex high-level phenomena emerge from interactions at smaller scale levels. Computational models of neural circuits that take into account differences in genetic makeup can put into explicit mathematical terms testable hypotheses regarding how alterations in genes might affect circuit function. Similarly, computational models of circuit dysfunction can test how such dysfunction could create a progressive, chronic disorder by impacting neural development and plasticity, and how that dysfunction could be revealed in neuroimaging findings and manifest in behavior. Finally, computational approaches can help take advantage of large data sets, categorizing brain dysfunction in a way that has the potential to lead to better diagnoses and improved biomarkers. By fostering an ongoing dialog between theoreticians and psychiatrists, NIMH hopes to accelerate knowledge and improve the lives of individuals with mental illnesses.

Monday, May 07, 2018

A "Circuits-First" Approach to Mental Illness

Chair: Godfrey David Pearlson, M.D.

Lecturer: Amit Etkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify brain circuit abnormalities characteristic of a variety of mental illnesses; 2) Understand neuroscientific insights about biologically-defined patient subgroups and

broader diagnostic classes; 3) Delineate ways in which neurostimulation can advance an understanding of psychopathology and development of novel treatments; and 4) Explain how adopting a brain circuit perspective can transform diagnosis and treatment in psychiatry.

SUMMARY:

Over the past two decades, neuroimaging studies have defined a set of distributed brain systems that contribute to cognition, emotion, mood and other mental processes. Perturbations in these circuits have been identified in different ways across psychiatric disorders. The challenge ahead of us is how to use these insights to: 1) understand the nature of neural circuit deficits in mental illnesses and their relevance for existing treatments, and 2) to develop novel circuit-based therapeutics. I will discuss work in the lab defining the neural circuit abnormalities associated with psychiatric disorders as a whole, as well as specific changes associated with particular mood and anxiety disorders (and subgroups within them). I will then examine the mechanisms of current medication, psychotherapy and brain stimulation treatments within the context of a circuit-based understanding. Finally, I will describe new methods for direct and non-invasive probing and manipulation of circuits and insights that this brings for the development of new circuit-targeting therapeutics. Together, these data suggest that we are now on the brink of innovations in "rational" circuit-based diagnosis and treatments for mental illness. Success down this path will take us beyond use of symptom checklists for diagnosis, and one-size-fits all treatment with the psychopharmacological and psychotherapeutic tools currently available.

Don Quixote and the IMG: A Mind State

Lecturer: Fructuoso Irigoyen-Rascon, M.D., P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn novel ways to interpret their own quixotic and sancho traits, particularly as international medical graduates; 2) Be introduced to Don Quixote and his psychiatric issues; 3) Be compelled to read or re-read Don Quixote de la Mancha; 4) Understand and appreciate better the

role of IMG's in American Psychiatry; and 5) Learn to use these concepts in their daily practice.

SUMMARY:

Don Quixote de la Mancha has been not only an immortal literary work of art but also the symbol of Spanish-speaking psychiatry. This lecture discusses Don Quixote relevance and validity in modern psychiatry and psychology not only as the image of a mentally ill individual but also in the characteristics of Don Quixote and Sancho Panza that we all, especially International Medical Graduates, have in our psyches and personality structures. The lecture has six sections: 1) Don Quixote which depicts some general data about the masterpiece and its iconographic representations; 2) Don Quixote's psychiatric issues; 3) Don Quixote and I, which describes the particular relationship of the presenter with Don Quixote; 4) Don Quixote and his diagnosis, discussing his historical and modern diagnosis up to DSM5; 5) Don Quixote and his legacy, which projects the Don Quixote peculiarities and evolution into Abraham Maslow's hierarchy of needs or motivations ending in self-transcendence; and 6) Don Quixote and the IMG, a state of mind, discussing parallelisms between Don Quixote/Sancho's psychology and the IMG's troubles and paradigms.

The Gatsby Wellcome Neuroscience Project

Chair: Jacqueline Maus Feldman, M.D.

Presenter: Wendy Burn

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Be aware of some of the recent advances in neuroscience; 2) Understand the way that Psychiatry training is structured and regulated in the UK; and 3) Understand the work that is being done in the UK to introduce more knowledge of neuroscience into the Psychiatry training curriculum.

SUMMARY:

This session will describe the work that the UK Royal College of Psychiatrists is doing with the help of a generous grant from the Gatsby Foundation and Wellcome Trust to introduce changes to the psychiatry training curriculum. The aim is to ensure that training focuses more on the exciting advances in basic and clinical neuroscience, so that trainees

are better equipped to provide mental health care in the future. We want trainees to be able to develop and deliver innovative biomedical approaches to the diagnosis and treatment of adult mental health, neurodevelopmental, and neurodegenerative disorders. Some of the recent advances in neuroscience will be described to illustrate how they will eventually change the practice of psychiatry.

From the River Pennar to the Hudson: Lessons Learned from the Personal Journey of an IMG Educator

Chair: Saul Levin, M.D., M.P.A.

Lecturer: Nyapati R. Rao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The complexity of educational background of IMGs and the challenges they face in the United States during psychiatry training; 2) The value of mentorship in career growth such as in scholarly work, research, and publication; 3) The differences between US medical education and foreign medical education systems; 4) How culture influences the training and professionalism of trainees; and 5) The obstacles face by IMGs in pursuit of leadership roles in organizational psychiatry; The role of psychodynamic psychotherapy training as an acculturation tool for IMGs.

SUMMARY:

In this presentation, Dr. Rao will focus on educational challenges faced by International Medical Graduates (IMGs) in psychiatry at various stages of their careers in the USA. As residents, the tasks that many IMGs confront are "learn a new subject, a new language and a new culture"- all within the four years of residency training. A tall order, indeed! However, the ubiquitous immigration and acculturation conflicts provide the common thread that runs through them, and how they are handled will determine the outcome of training for the individual IMG. In surveys that examined the educational needs of IMGs, it is reported that personal isolation brought on by immigration and lack of proficiency with English language are cited by IMGs as major obstacles to their success. Using his personal experiences, Dr. Rao will discuss the

cultural and educational challenges that he encountered in learning psychiatry, and his ongoing attempts to resolve them. In this context, he emphasizes the centrality of mentorship in all educational efforts. Also, he will address the critical importance of US faculty becoming familiar with the emotional toll of immigration on IMGs, and IMGs' discomfort in raising it in supervision because of heightened concerns caused by recent immigration restrictions. Furthermore, he will emphasize the significant role of psychodynamic psychotherapy training in helping IMGs to address psychological turmoil stirred up by immigration, to uphold their professionalism, and to affirm their identity as psychiatrists. He will conclude his talk by suggesting that the new tasks for the training director in this new era are to act as a caring friend, a culturally competent preceptor, an empathic guide and a philosopher for whom the IMG is not an anthropological curiosity but a young physician with great potential to succeed.

Some Thoughts on Our Search for Developing a Biopsychosocial Perspective for Psychiatry

Chair: Carol A. Tamminga, M.D.

Lecturer: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide a framework for assessing previous research on biopsychosocial models of depression; 2) Discuss the role of the hypothalamic pituitary adrenal axis in depression; and 3) Discuss more recent studies on other biological systems in depression.

SUMMARY:

The biopsychosocial perspective of depression has evolved particularly over the past 50 years with the original observations that monoaminergic activity was involved in the treatment response to new antidepressants as well as in the biology of the disorder. This talk in honor of research leading to receiving the Judd Marmor Award will review the progression of thinking in the area from the 1960's to current day with an emphasis on several systems that have particularly informed the field. The early studies on the monoamines did not emphasize the psychosocial aspect as much as the direct biological

and treatment significance. The move to a more biopsychosocial perspective occurred with the emphasis on stress systems such as the hypothalamic-pituitary-adrenal (HPA) axis where the biology of the stress response on the surface could be connected to an external stressor in animal models. This then led to applying understanding of stress biology to the development of phobic disorders as well as depression. Work in this area progressed further with hypotheses of how and why untoward stress responses could lead to psychotic thinking in depression as well as how early abuse could lead to increased risk for adult depression. Unfortunately, these systems' promise for leading to novel therapies has not been realized in clinical trials in part due to such issues as brain penetrance of compounds, receptor occupancy limitations, etc. In addition, we will discuss newer putative systems- such as growth factors-that may play a role in the biology and ultimately the treatment of depression. The quest for developing better biopsychosocial models for depression continues.

Trauma, Culture, and Complex PTSD: Cambodian Genocide Survivors

Chairs: Dora-Linda Wang, M.D., Jesus Salvador Ligot, M.D.

Lecturer: Devon E. Hinton, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn a model of the cultural influence on trauma-related disorder; 2) Learn about culturally sensitive assessment; 3) Learn about complex trauma in cross-cultural perspective; 4) Learn about cultural influences on PTSD presentations of Southeast Asian Refugees; and 5) Learn about a unique cultural syndrome presentation among Cambodian refugees (khyâl attack, or "wind attack").

SUMMARY:

Culture profoundly shapes the experiencing of trauma. Trauma results in multiple symptoms that are then interpreted in terms of the local conceptions of the mind, body, and the spiritual. A model of how of how culture influences trauma experiencing is presented, showing how somatic symptoms and distress more generally are

generated among trauma survivors, a model that guides our culturally adapted CBT for trauma survivors. The talk will focus on Cambodian examples. Cambodian refugees are survivors of the Khmer Rouge genocide (1975-1979), one of the worst of the last century, during which ¼ of the population perished. As will be shown, cultural syndromes—such as “*khyâl* attack,” which is one of the cultural concepts of distress in DSM-5—profoundly pattern the interpretation of anxiety symptoms, including how patients go about treating those symptoms and the interpersonal course of symptoms. As other Cambodian examples, nightmares are interpreted according to spiritual beliefs (e.g., a visits by deceased relatives), and symptoms like orthostatic panic are a key part of the local trauma ontology.

Tuesday, May 08, 2018

Science as a Solution for the U.S. Opioid Crisis

Chair: Nancy Diazgranados, M.D.

Lecturer: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand addiction as a disease and how the environment can impact use; 2) Understand how the current opioid crisis was ignited by opioid over-prescribing and now includes serious problems from heroin and illicit fentanyl; and 3) Understand how research and development of medications for opioid use disorder and overdose can save lives and improve functional outcomes.

SUMMARY:

The current U.S. opioid crisis is an intersecting and overlapping set of issues related to both licit (i.e. prescription opioids) and illicit (i.e. heroin and fentanyl-related synthetics) substances. In addition to the increasing numbers of deaths related to these drugs, multiple other indicators of harms from opioid use have been increasing: infectious disease outbreaks (e.g. Hepatitis C and HIV), neonatal opioid withdrawal, need for addiction treatment, and non-fatal overdoses. Opioids are the major cause of harms but interactions with benzodiazepines and some antidepressants are implicated in morbidity and mortality as well. While the problems are

national in scope, different areas of the country have been impacted in distinct ways. Thus, efforts must be geared toward the specific issues facing particular communities (or regions). A notable issue is that prescription drug misuse can affect both patients to whom medications are dispensed as well as the broader network of persons interacting with these patients. The implication is that both patients and non-patients must be considered in developing policies and practices to address the opioid crisis. Key responses include primary prevention, reducing excess prescribing of opioids, saving lives acutely with naloxone, improved treatment of the underlying addiction, and research to inform prevention and treatment efforts. Fundamentally, prescription and illicit opioids are each elements of a larger epidemic of opioid-related disorders and death. Viewing them from a unified perspective is essential to improving public health. The perniciousness of these epidemics requires a multipronged interventional approach that engages all sectors of society.

Will Technology Transform Mental Health Care?

Chair: Steve Hyun Koh, M.D.

Lecturer: Thomas R. Insel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define digital phenotyping; 2) Explain the importance of measurement-based care; 3) Understand how technology is changing mental healthcare; and 4) Recognize the potential of machine learning for psychiatry.

SUMMARY:

Digital technologies are being developed to address a broad range of health challenges. Mental health challenges may seem particularly suited for digital solutions as many diagnostics and therapeutics can be delivered online. One diagnostic approach is digital phenotyping which uses smartphone sensor data, keyboard performance, and features of voice and speech to detect changes in mood, cognition, and behavior. In contrast to traditional assessments which are subjective, episodic, and clinic-based; digital phenotyping can deliver objective, continuous, and ecological assessments with the potential for early detection of relapse or remission.

Because the assessment is passive and the technology is ubiquitous, there is understandable enthusiasm about this new approach to measuring behavior and cognition. But will better measurement result in better outcomes? Better outcomes will require earlier detection and better assessment, but we will also need better interventions. Digital interventions, from peer support to crisis intervention, are becoming popular, with some companies claiming over a million users per month. The rapid growth and broad acceptance of on demand and anonymous online services can provide a critical adjunct to if not a replacement for the bricks and mortar mental healthcare system. Beyond the delivery of digital phenotyping and online interventions, technology can enhance the quality of care through better information, integration, and standardization. The vision is for a learning mental healthcare system based on deep data with point of care insights from machine learning. This lecture will explore the promise and problems of technology for mental health, arguing that better measurement will be fundamental to better management of mental disorders and that digital interventions and online care management can transform mental healthcare in both the developed and developing world. This transformation will need to be based on rigorous science and will only become possible if the technology ensures public trust.

Advances in Addiction Research

Chair: Godfrey David Pearlson, M.D.

Lecturer: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the utility of new imaging tools and molecular/genetic technologies for understanding the biological underpinnings of addictive disorders; 2) Understand the complex biological and environmental factors that underlie vulnerability and/or resilience to drug abuse and addiction; and 3) Understand the clinical implications of recent advances in addiction science for the development of effective interventions for drug abuse prevention and targeted strategies for treating addiction.

SUMMARY:

Research on drug abuse and addiction has allowed us to delineate some of the neurobiological processes that underlie the multi-faceted factors mediating substance use disorders (SUD). These include advances in our understanding of how genes that increase vulnerability for SUD influence the brain; why the adolescent brain is more susceptible to drug experimentation and addiction; why social stressors increase the vulnerability to SUD; and what changes in neuronal networks and brain circuits result in the loss of control and compulsive drug taking that characterizes addiction. These advances have helped to develop new interventions to prevent and treat substance use disorders. These include behavioral interventions to strengthen neuronal circuits whose dysfunction increases the vulnerability to SUD as well as strengthening (control and motivations circuits) or weakening (stress reactivity, conditioning) circuits that are disrupted in addiction; new medications to help reverse changes triggered by drugs as well as vaccines and immunotherapies to help prevent relapse. This presentation will highlight a number of recent findings in the science of addiction and their potential for translation into clinical practice.

Genetics of Therapeutic Response to Pharmacotherapy for Opioid Use Disorder

Lecturer: Wade Berrettini, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Attendees will understand the pharmacologic differences in opioid agonist treatment of opioid use disorder; 2) Attendees will be able to list the requirements for FDA-approval for pharmacogenetic testing; and 3) Attendees will know the potential for rs678849 to predict outcome for opioid use disorder agonist therapy.

SUMMARY:

Many patients with opioid use disorder do not have successful outcomes during treatment but the underlying reasons are not well understood. An OPRD1 variant (rs678849) was previously associated with methadone and buprenorphine efficacy in African-Americans with opioid use disorder. The objective of this study was to determine if the effect of rs678849 on opioid use disorder treatment

outcome could be replicated in an independent population. Participants were recruited from African-American patients who had participated in previous studies of methadone or buprenorphine treatment at the outpatient treatment research clinic of the NIDA Intramural Research Program in Baltimore, MD, USA between 2000 and 2017. Rs678849 was genotyped and genotypes were compared to urine drug screen results from the previous studies for opioids other than the one prescribed for treatment. Genotypes were available for 24 methadone patients and 55 buprenorphine patients. After controlling for demographics, the effect of rs678849 genotype was significant in the buprenorphine treatment group (RR = 1.69, 95% confidence interval (CI) 1.59-1.79, $p = 0.021$). Buprenorphine patients with the C/C genotype were more likely to have opioid-positive drug screens than individuals with the C/T or T/T genotypes, replicating the original pharmacogenetic finding. The effect of genotype was not significant in the methadone group ($p = 0.087$). Genotype at rs678849 is associated with buprenorphine efficacy in African-Americans being treated for opioid use disorder. This replication suggests that rs678849 genotype may be a valuable pharmacogenetic marker for deciding which opioid use disorder medication to prescribe in this population.

Subtyping Suicidal Behavior: A Blueprint for the Development of Biomarkers

Chair: Philip Wang, M.D.

Lecturer: Maria Antonia Oquendo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) ? Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:

Despite public health and research efforts to improve prevention, assessment and management

of suicidal behavior, suicide rates in the United States have remained stubbornly high. To the contrary, they have increased dramatically over the past 30 years. Suicidal thoughts and behaviors are transdiagnostic arising even in the absence of other diagnosable mental health disorders, but they are far from homogeneous. Genetic, neurobiological, and psychological factors are associated with suicidal behavior, but these risk factors have limited clinical utility and modest statistical power. Thus, suicidal behavior is more likely a final common pathway of multiple separate neuropathological processes. Developing distinct phenotypes of suicidal behavior that represent neurobiological subtypes may yield better strategies for identifying robust biomarkers to predict this tragic outcome.

Wednesday, May 09, 2018

Understanding Prejudice From Its Neural Foundations

Chair: Nasir H. Naqvi, M.D., Ph.D.

Lecturer: David Amodio, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the neural bases of intergroup prejudice and stereotyping; 2) Appreciate how race unconsciously influences how we perceive and act toward others; and 3) Gain insight on potential interventions.

SUMMARY:

How do implicit prejudices form and influence our behavior? And can they be reduced? Answers to these critical questions have long eluded behavioral scientists, but new evidence from neuroscience is beginning to illuminate the nature of implicit prejudice—what it is, how it forms, how it affects perceptions and actions, and how its effects may be mitigated. In this interactive session, I will discuss these advances, describing research from my lab and others, and address implications for intergroup relations, bias, and diversity in patient-client interactions and everyday life.

Master Courses

Saturday, May 05, 2018

Buprenorphine and Office-Based Treatment of Opioid Use Disorder

Director: Petros Levounis, M.D.

Faculty: John A. Renner, M.D., Andrew John Saxon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder; 2) Apply the pharmacological characteristics of opioids in clinical practice; 3) describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; 4) Describe the legislative and regulatory requirements of office-based opioid pharmacotherapy; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain.

SUMMARY:

This course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD) and review 1) *DSM-5* criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality rules related to treatment of substance use disorders; 3) Drug Enforcement Administration requirements for recordkeeping; 4) billing and common office procedures; 5) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, and ADHD and how to distinguish independent disorders from substance-induced psychiatric disorders; and 6) common clinical events associated with addictive behavior. Special treatment populations, including adolescents; pregnant addicts; and geriatric, HIV-positive, and chronic pain patients, will be addressed, and small-group case discussions will be used to reinforce learning.

Sunday, May 06, 2018

Pediatric Psychopharmacology

Director: Karen Dineen Wagner, M.D., Ph.D.

Faculty: John T. Walkup, M.D., Christopher

McDougle, M.D., Timothy Wilens, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders; 2) Identify practical clinical knowledge gained in the use of psychopharmacology and management of adverse effects; and 3) Utilize recent research on pharmacotherapy in common psychiatric disorders of childhood.

SUMMARY:

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. This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorder. 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. 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.

Monday, May 07, 2018

Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice

Directors: Richard A. Bermudes, M.D., Philip G. Janicak, M.D.

Faculty: Ian A. Cook, M.D., Karl I. Lanocha, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Explain the mechanism of action of TMS; 2) Identify appropriate patients for TMS; 3) Identify the risks and side effects of TMS; 4) Review the specifications of FDA-cleared TMS systems; and 5) Discuss innovations in TMS therapy.

SUMMARY:

Psychiatric disorders represent a significant and growing problem for society. While many patients are effectively treated with pharmacotherapy, psychotherapy or a combination of the two, up to 30% with mood and anxiety conditions (Bystritsky 2006; Rush et al. 2006) do not respond to these standard treatments. In October 2008, the first transcranial magnetic stimulation (TMS) system was cleared by the U.S. Food and Drug Administration (FDA) for the treatment of adult patients with major depression who had not responded to one antidepressant medication. This marked the beginning of the most important treatment development for psychiatry in the last decade. Now, patients have access to this ground-breaking form of neuromodulation at numerous centers in the United States and there is broadening clinical research as well as expansion in insurance coverage. Despite the growing availability of this innovative option, many psychiatrists are unsure about how to best utilize TMS. This course provides practitioners with a practical information for the management of patients who are candidates for TMS therapy. The course speakers are clinician-researchers with extensive knowledge about the clinical applications of TMS, as well as other forms of neuromodulation. The course reviews TMS mechanism of action, applications for depressed patients and other neuropsychiatric conditions, patient selection for the TMS, as well as a thorough review of the current FDA cleared TMS Therapy systems. Teaching techniques will include didactics, case discussion, device demonstration and panel discussion. Each attendee will receive a copy of Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice (Bermudes et al. 2018). In summary, this course provides both an update on the present clinical role of TMS and a road map to its potential future.

Tuesday, May 08, 2018

Essential Psychopharmacology

Director: Alan F. Schatzberg, M.D.

Faculty: Rona Hu, M.D., Charles Barnet Nemeroff, M.D., Ph.D., Manpreet Singh, M.D., Charles DeBattista, M.D., D.M.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide an update on recent advances in psychopharmacology for major disorders; 2) Discuss in detail approaches to the treatment of autism; 3) Review recent studies on the pharmacogenetics of antidepressant response; 4) Provide a rational basis for selection of medications for bipolar disorder; and 5) Discuss the efficacy and side effects of antipsychotic agents.

SUMMARY:

This master course in psychopharmacology will present new material on the pharmacological treatment of major psychiatric disorders. The course will involve presentation of data, Q&A, and case discussions.

Wednesday, May 09, 2018

Practical Cognitive Behavior Therapy

Director: Jesse H. Wright, M.D.

Faculty: Judith Beck, Ph.D., Michael Edward Thase, M.D., Donna Marie Sudak, M.D., Gregory Brown, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the core principles of cognitive behavior therapy (CBT); 2) Detail methods for structuring and pacing sessions to enhance the effectiveness of CBT; 3) Recognize CBT methods for spotting and changing dysfunctional automatic thoughts; 4) Describe behavioral strategies for depression and anxiety; and 5) Identify CBT methods for reducing suicide risk.

SUMMARY:

Cognitive behavior therapy (CBT) is the most heavily researched psychotherapy and is recommended in treatment guidelines for a wide range of disorders. This course will present the core principles of CBT with a focus on learning practical skills for clinical

practice. Using an interactive learning format, experts in CBT will explain and demonstrate some of the most useful methods of this approach. Specific skills will include how to structure and pace sessions, detect and modify dysfunctional automatic thoughts, use behavioral methods to treat low energy and difficulty completing tasks, perform effective exposure therapy and other CBT interventions for anxiety, detect and change maladaptive core beliefs, and employ cognitive and behavioral strategies for reducing suicide risk.

Media Workshops

Saturday, May 05, 2018

Children of Syria, Waves of Hope: Two Views of Trauma and Posttraumatic Stress Among the Syrian Refugees

Chair: Balkozar Seif Eldin Adam, M.D.

Presenters: Fatten Elkomy, Cheryl Lea Green, M.D., Ph.D., Magdoline Daas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand, in part by direct observation, some of the effects of war and immigration on children and their families; 2) To identify key characteristics of Syrian child and adolescent refugees and the potential impact of their religion, culture and immigration status on their mental health; 3) To recognize cultural and relationship stressors experienced by Syrian refugees; and 4) To discern from the experiences of four children key elements of resilience in the wake of trauma.

SUMMARY:

We present here details as to how the war in Syria began, details of its brutal course on three fronts, the depth of the religious and political divide between Shiites and Sunnis that it speaks to, and the millions of Syrian refugees that it has created. We will show two films – one documenting the struggles of a relatively well-off family, and one documenting the struggles of vast numbers of less wealthy Syrians who have escaped by boat – and then present additional factual material pertaining to the war itself, to the refugee crisis, and to possible solutions

for mitigating the suffering of those involved in this human translocation. Many die both in Syria and in the flight from Syria. However, those who survive the journey appear to demonstrate a remarkable degree of resilience. Conclusions: The war is terrible in scale and in the violence with which it impacts millions of Syrians; the journey out of Syria is also traumatizing and fraught with peril. However, for those who escape, there is substantial evidence that healing can occur and that psychiatry and psychiatrists can help.

Monsieur Ibrahim: A Movie About Adolescent Emancipation, Father-Son Relationships, and Promotion of Racial Harmony

Chairs: H. Steven Moffic, M.D., Karim W. Ghobrial-Sedky, M.D., M.Sc.

Presenters: Anum Bhatia, M.D., John Raymond Peteet, M.D.

Discussant: Yasmin Mohabbat, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of cross-generational attachment in adolescent identity formation; 2) Demonstrate the role spirituality/religion in the identity development of children and adolescents; 3) Identify the role of father and his absence in adolescent development; and 4) Demonstrate nuances of interfaith dialogue in healthy intergenerational, intra-generational and cross-gendered relationships.

SUMMARY:

Objective: Role of cross-cultural friendships in overcoming racial prejudice and understanding adolescent development Background: Historically, alliances were made within a similar caste, creed, race or background. As the world has become globalized, many of such restrictions have evaporated and people have formed kinship sans ethnicity. The interesting fact that remains stagnant is that a similar background is still the catalyst for a successful friendship. This movie explores how a fruitful relationship is formed between the two protagonists who have nothing in common. Monsieur Ibrahim is based on a novel by Eric-Emmanuel Schmitt. The movie revolves around two main characters: Moses Schmidt (Momo), a Jewish

youth and Ibrahim Demirci, an elderly Muslim shopkeeper. Momo's relationship with his father is conflicted. With frequent interactions, he develops a bond with Ibrahim who becomes his mentor/friend. They have varied discussions, one most intriguing to Momo is about Islam. One day Momo's father disappears and Ibrahim adopts Momo. Soon, they set on a journey to Ibrahim's hometown where Momo learns about Ibrahim's life before France. Later, Ibrahim dies in a car crash leaving a will behind which says "I, Ibrahim Demirdji, hereby leave all my goods to Moses Schmitt, my son Momo because he chose me as his father and because I've given him everything I've learned in this life." Momo returns to Paris to take over the shop. Methods: Discussion topics 1. Adolescent development and emancipation, particularly when one has a "distant" father, who eventually "disappears." Furthermore, how insecure attachments impact future relationships. 2. Interfaith/inter racial relationships in the background of current tumultuous racial issues in Europe and the rest of world. Racial stereotypes and prejudice inevitably color how different racial groups perceive each other, resulting in divisions that pose challenges to potential cross-cultural friendships. Forming cross-generational and inter-racial relationships as one is going through various stages of life can be a mechanism for overcoming prejudices. Results: Participants will gain understanding of the impact of a meaningful friendship between two individuals who have nothing in common. It will give us insight to expand our friend circle sans similar background, as this is the measure to diminish racism and stereotypes. Conclusions: Earlier it was believed that friends are made between people with even backgrounds or the very least similar mindsets. This has polarized the citizens in distinct sections where crossover is curtailed by societal pressure. This movie aims to show that fruitful friendships can arise from multiple different dimensions- race, sex, age. Once we are able to take away the primal notion of previous ingredients of friendships, we can cross bridges and provide an unified front to the subsequent minimized racism, sexism and ageism.

Warehousing—How Did We Get Here? Cutting Mass Incarceration in the United States—the Physician's Responsibility

Chair: Christopher James Hoffman, M.D.

Presenter: Nzinga Ajabu Harrison, M.D.

Discussants: Sarah Yvonne Vinson, M.D., Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review ways historians believe the United States restructured slavery through a constitutional loophole and conditioned the American view of "the criminal" by viewing the documentary film; 2) Discuss the impact of mass incarceration and the role of the criminal justice system as a social determinant of mental health, with emphasis on child and adolescence; 3) Evaluate changes in law-enforcement regulations leading to mass imprisonment and the criminalization of substance use disorders and mental illness; 4) Discuss the role of mental health care workers in past and future reformation of the justice system and in providing anticipatory guidance regarding justice system interaction with at risk youth; and 5) Discuss more effective justice system structures and the psychosocial, political, and systemic challenges in re-creating the judicial system in the US.

SUMMARY:

The latest Congressional Research report states that while the US population has increased by 43% since 1980, the prison population has increased over a staggering 400% and is now the largest in the world. After the legal end of slavery, entertainment, politics, and economics became major players in criminal justice policy while science and widely accepted social theories were sidelined. As a result, the criminal justice system's current policies and procedures are reflective of the racism permeating American society and, in turn, have criminalized Blacks at greater rates than any other race and given police freedom to act as militia with no favorable outcomes. In this media workshop, the documentary film, 13th, will serve to introduce race as the central theme that led to current policing and sentencing procedures in the U.S. and, subsequently, an exploding, racially disparate prison population. The panelists will discuss their views of the criminal justice system and its impact on mental health at both individual and community levels. There will also be explanation and analysis of improvement efforts

and the challenges of reforming problematic policies. We will also explore the roles mental health experts have historically played in order to inform a discussion regarding current and future roles of mental health experts in criminal justice reform.

Crazywise

Chair: Patricia Lynn Gerbarg, M.D.

Presenter: Phil Borges

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explore how the clinical diagnosis and description of psychotic symptoms can be restructured to emphasize hope, meaning and purpose for patients and their families; 2) Explore how the stigma, shame and isolation caused by diagnostic labels can be reduced and still be recognized by health insurance requirements; and 3) Question how peer support can be effectively used to facilitate the healing process in patients and enhance the work of mental health practitioners.

SUMMARY:

The film explores the relevance of indigenous perspectives and practices in modern mental health services and a growing movement of patients and mental health professionals who believe that a psychological crisis can be an opportunity for growth and transformation. -Indigenous and tribal cultures often view psychotic symptoms as an opportunity for positive transformation and spiritual growth. This positive reframing of the difficult and stigmatizing experience offers hope, meaning and purpose to mental suffering. -The World Health Organization has determined in three separate studies conducted in 1969, 1978 and 1997 that the recovery rate from a first episode psychological crisis is 1/3 more likely in a developing country than the US and Europe. Some possible explanations for these findings are the positive reframing of the mental illness, as well as means of support found in more traditional cultures including: 1) lifestyles that incorporate extended families and small intimate communities; 2) a strong physical and spiritual connection with nature; and 3) the use of 'wounded healers' to mentor the person through the crisis (peer support).

I Am Not Your Negro: Deconstructing Racial Politics

(and Implications for Psychiatry) Through the Psyche of James Baldwin

Chairs: Ruth S. Shim, M.D., M.P.H., Karinn A. Glover, M.D.

Presenters: Leesha M. Ellis-Cox, M.D., M.P.H., Anton Hart, Ph.D., Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the historical context of racism in the United States through the perspective of American author and activist James Baldwin; 2) Explore the lasting impact of race and identity on the mental health of both patients and providers; 3) Discuss and exchange therapeutic reflections on racism and racial trauma in the United States; 4) Identify best practices for deconstructing privilege and strengthening bonds of unity; and 5) Consider the role of psychiatrists and mental health providers in addressing racism in America.

SUMMARY:

In the Academy Award Nominated documentary film, *I Am Not Your Negro*, an unfinished James Baldwin manuscript about the assassinations of Medgar Evers, Malcolm X, and Martin Luther King, Jr. serves as a starting point for a deep dive into the history and present status of race relations in the United States, and into the unique mind of a genius. With this film, some 30 years after his death, a new generation has been reintroduced to the writer/activist James Baldwin, and his anguished, yet hopeful view of racial politics in America. Racism is rooted deep within the American psyche, and recent events have reopened long-festered wounds. Issues of racism and hatred have always been difficult to discuss openly in safe, non-judgmental spaces. Psychiatrists and other mental health professionals have a moral responsibility to increase their own comfort and confidence in addressing these issues, and may have a unique role in leading the charge to dismantle racism in our society. Following a screening of this brief, introspectively affecting film, a diverse panel of psychiatrists and psychologists (with expertise in child/adolescent psychiatry, psychoanalysis, cultural psychiatry, and community psychiatry) will lead a discussion, informed by themes that James Baldwin contemplates in his artistry. Areas of focus include the importance of

deconstructing privilege to effectively combat racism and discrimination, forming and strengthening bonds between privileged and discriminated populations, and analyzing the impact of racism on therapeutic relationships with patients. Recognizing that patient-provider relationships are microcosms of the broader society, participants will contemplate best practices to eradicate racism on a larger scale. Baldwin once said, "I imagine one of the reasons people cling to their hates so stubbornly is because they sense, once hate is gone, they will be forced to deal with pain." This workshop will contemplate the ways to make progress toward eliminating racism, will consider the multifactorial causes of its intractable nature, and will address the underlying pain that affects us all.

The 217 Boxes of Dr. Anonymous: Remembering Dr. John Fryer

Chair: Sarah C. Noble, D.O.

Presenters: Ain Gordon, Saul Levin, M.D., M.P.A., Roger Peele, M.D., Carolyn Reyes, Esq., M.S.W., Matthew Shurka

Discussant: David Lynn Scasta, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the historical significance of John Fryer in the LGBTQ equality movement following exposure to the material culture connected to Dr. John Fryer; 2) Identify the importance of the existence of the Association of LGBTQ Psychiatrists (ALGP) as an allied group of the APA upon learning its story from founding members; and 3) Identify ways in which equality continues to be a struggle by comparing experiences of the LGBTQ community in the 1970s and today.

SUMMARY:

In 1972 Dr. John Fryer stood before a group of psychiatrists at the APA meeting in Dallas, Texas and pronounced "I am a psychiatrist. I am a homosexual." This revolutionary statement paved the way for the removal of homosexuality from the DSM in 1973. 217 Boxes of Dr. Henry Anonymous is a play by Ain Gordon based on the personal effects of Dr. Fryer, which are stored at the Historical Society of Pennsylvania. By presenting excerpts of the play as well materials from Dr. Fryer's 217 Boxes we aim

to educate audience members about the context in which Dr. Fryer stood before his colleagues to fight for civil rights. 2018 marks the 40th anniversary of the AGLP, which formed as an allied organization of the APA once the DSM had been amended. Following the above presentation we will interview key members of the AGLP who participated in the founding of one of the first LGBT professional organizations in the country. We will then interview important participants in the current fight against conversion therapy for LGBTQ folks. In conducting the interviews, special attention will be paid to current events impacting the LGBTQ community such as milestones like the end of "Don't ask, Don't tell" and the supreme court decision in support of gay marriage. We will examine stressors facing the LGBTQ community such as the Orlando shooting and the continued fight against "religious freedom" bills and "bathroom" bills that threaten to roll back gains in rights and equality for LGBTQ people. The symposium will conclude with a period for questions and discussion by the participants.

Sunday, May 06, 2018

Cultural Depictions of Resilience in the Face of Inevitable Family Dissolution in the Films "Make Way for Tomorrow" and "Tokyo Story"

Chair: Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand cultural forms of resilience in the face of inevitable family dissolution as seen in the American film "Make Way for Tomorrow" and the Japanese film "Tokyo Story"; 2) Utilize a mindful method of film processing that includes silent reflection, journaling, dyadic sharing and large group discussion; and 3) Understand the value of compassion and serenity for fostering resilience as an aspect of wellbeing.

SUMMARY:

Elderly parents visit their grown children who are too busy with their own work and families to respect or care for them as they go from one to another and temporarily live separately. In contrast, either complete strangers or a more distant family member show compassion. Seeking solace through their love

for each other and recognizing their place in the larger world, the father and mother accept their fates and finally part poignantly for the last time. This media workshop will compare and contrast two film depictions—one American and one Japanese—of this common life scenario, making it evident that it is a universal story that challenges every culture's resilience as an aspect of wellbeing in the face of inevitable family dissolution. "Make Way for Tomorrow" is a 1937 Hollywood film by Leo McCarey that inspired both director Yasujiro Ozu and screenwriter Kogo Noda to create "Tokyo Story" in 1953. The former was a near-forgotten film that entered the U.S. National Film Registry in 2010, whereas the latter was ranked as the Greatest Film of All Time in the 2012 Directors' poll of Sight and Sound magazine conducted every 10 years. In the American film set in the Great Depression, the mother and father face the harshness of their situation with fond recollection of a happier time, whereas the Japanese film is suffused with the serene acceptance of the transience of life through the contemplative, compassionate love of the Eternal Now. The session will show extended clips from both films, provide the opportunity for participants to reflect on and share their own experience of the films and conclude with discussion by the Chair Francis Lu, MD.

Beyond 13 Reasons Why: Using Electronic Media to Promote Mental Well-Being

Chairs: Pallavi Joshi, D.O., M.A., Robert Rymowicz, D.O.

Presenter: Jose P. Vito, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the popularity and impact factor of social and electronic media on the public, especially adolescents; 2) Identify topical shows, websites, and social media trends that promote negative or dangerous messages on mental health; 3) Recognize ways in which social and electronic media can be used to positively influence users and promote mental wellbeing; and 4) Offer an appropriate example of a website, show, social media channel, or other electronic resource they would recommend to patients and families.

SUMMARY:

Electronic media use has exploded in recent years, particularly among adolescents. Teenagers mostly use the internet unsupervised, spending the majority of their time on social media sites such as Facebook and Instagram, and streaming sites such as YouTube and Netflix. The mental health implications of this social and electronic media use has been the topic of widespread debate since the release of the Netflix show "13 Reasons Why", a show about a high school student who commits suicide after a series of incidents involving certain individuals in her life. The program has been criticized for glamorizing the victim and the act of suicide in a way that glorifies both. Google searches for suicide were 19% higher for the 19 days following the release of "13 Reasons Why". While most queries were focused on suicidal ideation, public awareness indicative searches, such as "suicide prevention", were also elevated, highlighting the range of information on the internet. Social media sites have also been critiqued for their impact on mental wellbeing, with concerns ranging from cyber bullying to challenges that encourage self injury and suicidal behavior. If mental health professionals are made aware of negative messages on current media or dangerous trends, they could identify worrisome references by patients and potentially intervene earlier. This workshop will explore negative or dangerous messages on mental health in the media with video examples from "13 Reasons Why". We will also discuss websites and emerging social media trends that may be harmful. The Internet also has tremendous potential to promote mental wellbeing by enabling people to access services, find information and educational resources, and join an online community based on shared experiences. Several video bloggers have shared their own experiences with mental illness and coping strategies on YouTube. Mental health professionals can promote mental wellbeing by recommending such resources, and by having a professional online presence to advocate for patients and educate the public about mental health. In this workshop, we will share examples of mental health blogs and YouTube videos that positively influence their audience. We will discuss how mental health professionals can use their online presence to promote wellbeing. During the

workshop, participants will be asked to offer an appropriate example of an electronic media resource they would recommend to patients and families to promote mental wellbeing.

Experimenter

Chairs: Steven E. Hyler, M.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Determine whether, if a research study design can generate results important for the understanding of human nature, the experimenters can take liberties with the well being of the subjects; 2) Address the argument that “ordinary” American subjects resemble the population in Hitler’s Germany with respect to unquestionably following the direction of authority figures; and 3) Review current guidelines for informed consent of research subjects in light of the question whether an equivalent to the Milgram experiment ever be conducted again.

SUMMARY:

The 2015 Movie, “Experimenter” portrays the controversial social psychology experiments in compliance and conformity carried out by psychologist Dr. Stanley Milgram in the early 1960s at Yale. The study design tested individuals’ willingness to obey a white lab-coated experimenter who directed the study subjects to subject other subjects (actually confederates of the investigator) to what they thought were increasing painful (and purportedly dangerous) levels of electric shock. Much to the surprise of the investigators, they found that 65% of the subjects were willing to deliver what they were told were potentially fatal shocks when the authority figure requested that they continue with the study. The experiments generated a public outcry against the experimenter and the field of social psychology research. In this media workshop the movie will be played in its entirety and be followed by a discussion with the audience led by Dr. Paul Appelbaum, Columbia University Dept of Psychiatry, on the topic of research ethics and how lessons from the Milgram study apply to current research in Psychiatry and Psychology.

Monday, May 07, 2018

A Cultural Competency for Hate: Training International Medical Graduates to Convert Patient Racism to Data

Chair: Alexander C. L. Lerman, M.D.

Presenters: Alaa Elnajjar, M.B.B.Ch., Hameed Azeb Shahul, M.B.B.S.

Discussants: Kishan Nallapula, M.D., Jasra Ali Bhat, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the significance of cultural differences in the evaluation of psychiatric patients by International Medical Graduate (IMG); 2) Highlight salient challenges that arise in cross-cultural interactions, acknowledge their effect on the interviewer’s blind spots, and the barriers they pose to the development of a good clinical form; 3) Learn to use an innovative competency rating tool, to score the interviewer’s proficiency on various dimensions; e.g the capacity to use advanced interviewing techniques and the awareness of countertr; 4) Encourage participants' involvement in the development of other novel methods to highlight and redress the cross-cultural imbalance in psychiatric evaluation; and 5) Develop the skill of how to deal with first time exposure to racism by learning how to analyse the challenging data, and eventually be able to use this skill in a clinical setting.

SUMMARY:

Sensitivity to cultural factors in the assessment and care of psychiatric patients has long been recognized and cited repeatedly in the literature, but has not been matched effectively by development of specific competencies and training exercises. In this workshop presentation, we present a training module focused on a clinical situation nearly every (IMG) encounters: the task of evaluating a suspicious, and in some instances openly racist patient. The centerpiece of this workshop is a simulated patient training exercise in which psychiatry residents are confronted with the task of evaluating an actor who portrays an accomplished businessman brought to the ER after reportedly assaulting his wife and daughter, resulting in a

domestic abuse call. Ancillary documentation, including a police report, provide fairly conclusive evidence that the events occurred as described, but the patient denies this emphatically and repetitively. The interviewer is not aware that the actor is directed to patronize and denigrate the IMG interviewer, including repeatedly complaining about the interviewer's accent, making stereotyped comments about the interviewer's presumed background, and expressing support for contemporary anti-immigration politicians. Early career clinicians tend to rely excessively on the patient's subjective account in order to arrive at a coherent clinical formulation. This difficulty is more profound in a cross-cultural environment, when the clinician must rely on the patient, not only to provide a history and symptom index, but to serve as a guide and translator for a newcomer unfamiliar with local customs, idioms, and social cues. These challenges are compounded when an aggressive, suspicious, or devaluing patient aggressively mobilizes the discrepancies in the clinical situation. The challenge facing the early-career IMG is fundamentally the same as that all psychiatric trainees confront: the acquired skill of maintaining empathic contact with a patient, while simultaneously integrating data to generate a differential diagnosis and clinical formulation. A critical component of this skill is the capacity to differentiate empathy from sympathy. While viewing different residents' clips of the simulated interview, members of the audience will participate in interactive discussion about the interviewer's cultural competency; his/her capacity to be empathic and establish rapport; the use of advanced interview techniques such as confrontation and formula-driven interviewing, and the awareness of one's own emotional response or countertransference.

Psychological Exploration in Indie Horror: A Screening and Discussion of Larry Fessenden's IFC Film *Habit* With Mr. Fessenden and Steve Schlozman

Chairs: Steve Schlozman, M.D., Larry Fessenden

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To Appreciate the Unique Utility of Art House Cinema in Creating Authentic

Psychological Experiences for Viewers; 2) To Understand the Capacity for Independent Cinematic Horror to Reveal Fundamental Truths About the Human Condition; 3) To Foster Discussion of Young Adult Social Disconnection and Addiction Through the Use of Metaphor and Fantasy in Film; 4) To Question Whether Horror Themes Can Be Used as Appropriate Metaphors for Cultural and Psychological Trends; and 5) To Probe Whether the Depiction of Psychopathology in the Horror Genre is Protective or Damaging to the Ongoing Stigma Associated with Psychiatric Suffering.

SUMMARY:

Larry Fessenden's 1995 IFC movie "Habit" has been universally celebrated for its unsettling and yet sympathetic portrayal of the deprivation and interpersonal ravages of social isolation and co-existing substance abuse. This critical acclaim is perhaps even more remarkable because "Habit", at least on its surface, is a vampire film. It is of course no surprise that the myth of the vampire lends itself to themes of loneliness and craving, but "Habit" is made uncomfortably believable by the performance, writing and simultaneous directing talent of Mr. Fessenden himself. Roger Ebert wrote that Mr. Fessenden "is able to see himself with such objectivity" that "it is almost frightening...there is not a shred of ego in his performance." The movie is therefore a prime example of the unique narrative power that carefully crafted films employ to empathically and authentically depict psychological suffering within the horror genre. In a rare opportunity, this media workshop will feature a screening of "Habit" and a discussion with Larry Fessenden about the psychological effects that writing, directing and starring in "Habit" engendered. From there, we will move to a discussion of the utility of independent horror as a potent means of building sympathy and complex interpretations for complicated and not always immediately sympathetic protagonists. To this end, cinema in general and especially the horror genre can utilize displacement to discuss characteristics that might otherwise be dismissed as merely aberrant or evil. At the same time, even nuanced horror stories run the paradoxical and inherent risk of further stigmatizing behaviors that are consistent with psychopathology. "Habit" is a perfect film

around which to organize a careful exploration of these difficult topics. Fessenden's character is aimless, socially lost, and addicted to alcohol. The vampire who comes into his life helps him to appreciate the extent to which he is lost, even as he exchanges his addiction for hers, and as his own social disconnection melts in the presence of her ego-blurred merger. Author and child psychiatrist Steven Schlozman will join Mr. Fessenden and will address the psychiatric and neurodevelopmental themes that "Habit" brings to the screen. Ample time will be available for audience discussion and questions.

The Innocents: A Film Screening and Discussion

Chairs: Lloyd I. Sederer, M.D., Alan A. Stone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Illustrate a core conflict in human nature; 2) Demonstrate the horrors of war, including occupying forces; 3) Demonstrate how fundamental faiths can conflict; and 4) Show how a community/collective solution can work when individual solutions do not.

SUMMARY:

It is December of 1945 and the fields are draped white with snow, the roads mushy and the air a damp cold. We are in Poland after The War. The Russians have seized their plunder, namely this Eastern Bloc country that wanted no part of Nazi Germany, but was invaded and then what choice did they have? The story, recreated from actual events, takes place principally in two settings: a cloistered convent for nuns (Sisters or Soeurs since the film is largely in French, with English subtitles) and in the French Red Cross infirmary temporarily set up to care for those wounded in the war. Slowly, we discover that one, then another, then seven in all of the Sisters are near birth of children fostered by the ungodly rape perpetrated against them by the invading Russian soldiers. Not only have their vows of chastity been violated but their shame hangs over the monastery like a merciless winter that may never end. Their very lives, and that of the soon to be born, are also at risk given the lack of care they have received, the Spartan environment of the monastery

itself, and the complications and illnesses some of them face.

Tuesday, May 08, 2018

Wrestling With Identity: The Search for Self in *Dangal*, the Film

Chair: Sudha Prathikanti, M.D.

Presenters: Selena Chan, D.O., Ravi Chandra, M.D., Siya Mehtani, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define the concept of "tiger parenting" and its theoretical vs measured impacts on child achievement; 2) Identify similarities and differences in the role of mothers vs fathers in developing a daughter's sense of agency and power in a world where femaleness tends to be devalued; 3) Specify at least two ways in which increased participation of girls in sports may help promote gender equality; and 4) Identify at least two factors associated with resilience in children who face bullying for breaking gender norms.

SUMMARY:

This media session will examine the 2016 film *Dangal*, which has broken box office records in both India and China, and created a sensation in many Asian communities in the United States and around the world [1]. *Dangal* depicts the true story of a once-promising wrestler from rural India who pursues the gold medal he never won by coaching his daughters with single-minded ferocity to compete as world-class wrestlers in the Commonwealth Games. As the girls face social censure and ridicule for pursuing this male-dominated sport, they move through phases of fear, confusion, rebellion, and reconciliation in their search for agency and an authentic identity. In India and China, films such as *Dangal* may encourage greater participation of girls in sport [2,3], and the United Nations asserts such participation to be a vehicle for promoting gender equality [4]. Yet, the film has stirred passionate debate about whether it depicts female empowerment when the girls break out of gender stereotypes to wrestle [5,6], or whether it is actually a male-centric narrative in which the achievements of the obedient daughters

are not primarily their own, but a testament to their father's single-minded ambition and will [7,8]. A related debate focuses on whether the father's harsh "tiger parenting" is a form of emotional abuse that destroys the joys and imaginative self-exploration of childhood [9,10], or whether such parenting is integral to his daughters' ability to overcome gender barriers and self-doubt to become confident young women capable of success in both wrestling and a male-dominated world at large [11-13].

"Love Is All You Need?": LGBTQ Bullying and Suicide

Chairs: Beth M. Belkin, M.D., Ph.D., Richard Randall Pleak, M.D.

Presenters: Lauren Adela Teverbaugh, M.D., Myo Thwin Myint, M.D., Mary Lynn Dell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Attendees will be able to identify issues related to sexuality and gender; 2) Attendees will gain greater understanding of issues related to sexuality and gender; 3) Attendees will learn how lack of acceptance of LGBTQ youth by their families and society contributes to increased risk for depression and suicide; and 4) Attendees will gain greater appreciation of the special mental health needs of LGBTQ youth, their families, and community organizations of which they are members.

SUMMARY:

The presentation of "Love is All You Need?" is intended to foster clinical competence in those caring for individuals who are gay, lesbian, gender variant or transgender. Despite the fact that homosexuality is now recognized as a non pathological variant of human sexuality, intolerance is still widespread. As a group, members of sexual minorities experience stigma, prejudice and discrimination that are profoundly damaging to mental health. These individuals develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with the general population (1), "Love is All You Need?" is a theatrical feature-length version of an award-winning, critically acclaimed short film that explores bullying, racism, and prejudice in a way

never done before on the big screen. It is co-produced by the Gay, Lesbian & Straight Education Network (GLSEN), considered one of the most important anti-bullying organizations in this country. Co-written by director K. Rocco Shields with David Shields, the film explores what bullying would look like if heterosexuality was a "sin," something people fear and are disgusted by, and being gay was the norm. The film follows the life of an ordinary heterosexual college student who is bullied in a world where everyone is gay. Many of the situations in the film are true to life events that have happened either to Ms. Shields or to her writing partner, David, an openly gay man, or something she read about or heard in the news. There is a scene in the film where a character is getting hateful messages from peers and each of these messages is an actual message a person being bullied received before they killed themselves. The mission of the film is to use media for social change, as a springboard to represent minority cultures and bring them to public awareness. When these people are shown on cinema, they become less of an "other" and more just part of society. The film has been shown in cities across the United States in special screenings and events. The cities were chosen based on places where hate crimes were committed and locations that have a special connection to the pro-tolerance message of the film. Because it tells a classic love story in an upside-down world where same-sex couples are the norm and heterosexual couples are bullied, "Love is All You Need?" shocks and convicts its viewers who watch themselves get name-called, judged in the hallways and dragged down for being who they are. The film is masterfully effective in allowing everyone in the audience to understand the struggles that the LGBTQ community still faces. It drives home the point that suppressing someone's ability to love another person is inhumane and can cause them to break down. "Love is All You Need?" actively tries to make changes in its viewers, exhorting them to stand up to bullying, prejudice, and discrimination.

Wednesday, May 09, 2018

Black Swan: Teaching Psychiatry Through Innovative Media

Chair: Anthony Tobia

Presenters: Jayme Sack, Derek Rudge, Jason D. Mintz, M.D., Christine A. Annibali, M.D., Consuelo C. Cagande, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the widespread popularity and impact that visual media such as film provide to the general public and, therefore, medical students and residents; 2) Discuss the representation of mental illness in the film, *Black Swan* (2010); 3) Recognize how films such as < can provide learners with “consistent” characters who display common symptoms of mental disorders such as psychosis and dissociation; and 4) Appreciate the complexity of the fictional characters by discussing their development with writer/director Darren Aronofsky.

SUMMARY:

In our General Psychiatry Residency curriculum, first- and second-year residents attend a weekly psychopathology course that encompasses a broad range of mental illness. The course, *Reviewing [Mental] Disorders with a Reverent Understanding of the Macabre (REDRUM™)*, is taught through the use of horror movies and has been previously described. Our course’s primary goal is to reframe the film as a fictional case study thereby enhancing learning through creative discussion. Generally speaking, lecture content is primarily taken from the required text (Kaplan & Sadock’s *Synopsis of Psychiatry – 10th* edition) while the lecture topic is introduced through plot summary and character analysis from the selected work. In addition to reviewing the recommended chapter in the reference text, residents are encouraged to watch the selected film prior to the weekly PowerPoint presentation. The selected work (such as *Black Swan*) serves a metaphorical as well as factual role in the etiology, clinical presentation, course, and prognosis of the mental illness highlighted in our course syllabus. REDRUM™ is copyrighted as intellectual property and has been expanded to five levels of education at Rutgers University. For example, in separate courses, a) undergraduates, b) medical students, and c) teaching faculty congregate in a group to view a feature-length movie instead of watching the film independently. We propose a workshop that is a

hybrid of the two methods described above. Following a brief 10-minute introduction to set our workshop objectives, we will show 4-5 selected clips of *Black Swan*, each of which to be followed by a facilitated discussion with the audience that highlights a cited objective. Each objective will be addressed by our guest speaker; renowned director Darren Aronofsky who has agreed to attend our workshop and provide his insight into his characters’ development. For example, Mr. Aronofsky will provide his inspiration for creating the character, Nina; the depth of which can only be surmised by the audience. In this way, we’ll gain a unique understanding of what “motivates” Nina to act as she does.

Meet the Authors

Saturday, May 05, 2018

Addressing School Violence

Chair: Michael Brian Kelly, M.D.

Presenter: Anne Baden McBride, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) recognize the hallmark features of the hot and cold aggression; 2) summarize static and dynamic risk factors pertaining to school violence; 3) distinguish the salient features of structured professional judgment and actuarial violence risk assessment measures; and 4) characterize approaches to addressing school violence at the individual, school and community levels.

SUMMARY:

The topic of school violence garners a lot of attention in the media despite its overall decline in recent decades. High profile incidents of school violence, television shows, and movies have contributed to a typecasting of youth who commit violent acts at school. However, the general public’s perception of how school violence occurs often does not reflect reality. In general, predicting violence is a difficult task for mental health clinicians. Furthermore, the fact that many youth who perpetrate violence at school lack extensive histories of violent behavior makes attempts at predicting the

likelihood of school violence particularly difficult. This session is designed to familiarize mental health clinicians with current methods of identifying risk factors for school violence, assess its likelihood, intervene, and respond to school violence. We will begin with a review of adaptive and maladaptive forms of aggression followed by a discussion of risk factors for school violence. Next, participants will learn principles involved in the assessment of students' risk of violence and the utility of incorporating formal risk assessment tools when appropriate. Our discussion will conclude with a review of what schools can do to intervene and respond to school violence, including some case examples.

Co-Occurring Mental Illness and Substance Use Disorders: A Guide to Diagnosis and Treatment

Chairs: Jonathan Avery, M.D., John Warren Barnhill, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the interview and assessment of individuals with co-occurring disorders; 2) Understand treatment strategies for individuals with co-occurring disorders; and 3) Describe psychopharmacological and psychotherapeutic interventions for individuals with co-occurring disorders.

SUMMARY:

The editors of *Co-Occurring Mental Illness and Substance Use Disorders: A Guide to Diagnosis and Treatment* present an evidence-based approach to patients with at least two psychiatric disorders, one of which relates to substance use. Because co-occurring disorders are more the rule than the exception in psychiatry, the editors emphasize that patients should be carefully evaluated for a broad range of disorders, which should then be addressed clinically. The range of psychiatric disorders and the number of substances of abuse create complexity that can feel overwhelming to clinicians, and the editors will address this challenge by providing straightforward strategies for diagnosing and treating people with complicated presentations.

Tuesday, May 08, 2018

Narcissism and Its Discontents: Diagnostic Dilemmas and Treatment Strategies With Narcissistic Patients

Chair: Glen Owens Gabbard, M.D.

Presenter: Holly D. Crisp, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the subtypes of narcissistic personality disorder; 2) implement treatment plans for patients with narcissistic personality disorder; and 3) utilize strategies to manage challenges in psychotherapy of narcissistic patients.

SUMMARY:

The diagnosis of narcissistic personality disorder is complicated because of its pleomorphic nature. The clinical picture can change based on the emotional context of the patient. Moreover, there are three distinct subtypes that have been identified in research. NPD is also an entity that frequently has co-morbidities that may confuse the diagnostic picture. Treatment of NPD is complicated because of the difficulty many patients have in articulating what they want to change and because the therapist may feel controlled and criticized repeatedly. In this presentation, Dr. Glen Gabbard and Dr. Holly Crisp will outline strategies of treatment that tailor the therapeutic strategies to the specific characteristics of the patient.

Marijuana and Mental Health

Presenters: Michael T. Compton, M.D., M.P.H., Marc W. Manseau, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) list three associations between marijuana use with psychotic disorders; 2) describe the current treatment approach for cannabis use disorder; 3) describe recent trends in legalization of marijuana use; and 4) list five consequences of the use of synthetic cannabinoids.

SUMMARY:

American society is highly ambivalent about marijuana use. Some hold that marijuana is a

harmless substance that should be legalized; others believe that it may confer therapeutic benefit for patients with certain illnesses. Some view it as generally problematic with no health value, and yet others have serious concerns about the drug's potential for addiction and worsening of mental health. Despite our society's equivocal stance, many states have passed or are moving forward with legislation on medical marijuana programs, and some states have legalized marijuana outright, even though such state legislation conflicts with federal law. Media and lay interest around marijuana has grown exponentially in recent years. While the debate within society continues, controversy within the medical community persists as well. Nonetheless, accumulating evidence from psychiatry does implicate marijuana use, especially in adolescence, as a risk factor for poor educational achievement, cannabis use disorder and other substance use disorders, as well as schizophrenia and related psychotic disorders. This, in light of increasing marijuana use (not decreasing, as in the case of cigarette smoking and alcohol use) among middle and high school students, complicates the discourse on legalization. Evidence is mixed as to whether legalization (for either medical or recreational purposes) will increase the use of marijuana among adolescents. The relevance of this topic is further confirmed by recent trends in the use of synthetic cannabinoids, ongoing controversy over the "gateway drug" hypothesis, and many recent peer-reviewed articles on the effects of marijuana on mental health. This "Marijuana and Mental Health" session will provide a balanced overview, at a time when academics are redoubling efforts to understand the biology and consequences of marijuana use, and policy-makers are seeking guidance on questions of legalization. Speakers will address the following areas: (1) an overview of the complex connections between marijuana and mental health and mental illnesses, with a particular focus on psychotic disorders; (2) the latest treatment approaches for cannabis use disorder, including both proven and investigational pharmacological and psychosocial treatments; (3) recent, current, and proposed legislation in the U.S.—at the local, state, and federal, levels—pertaining to medical marijuana, as well as recreational marijuana; and (4) synthetic cannabinoids, including the biology, physiology,

epidemiology, and legislation pertaining to these novel substances of abuse, as well as their physical and psychiatric effects.

Psychodynamic Psychotherapeutic Approaches to Behavioral Change

Chair: Fredric N. Busch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the value of psychodynamic psychotherapy in identifying contributors to behavioral problems and promoting behavioral change; 2) Identify potential problems in targeting behavioral change that can be addressed with psychodynamic psychotherapy; 3) Learn specific techniques for targeting behavioral change that can be incorporated into psychodynamic psychotherapy; and 4) Identify the value of homework in promoting behavioral change in psychodynamic psychotherapy.

SUMMARY:

Psychoanalysts have avoided emphasizing or targeting behavioral change in psychoanalysis or psychoanalytic psychotherapies, believing such efforts can disrupt or derail effective treatment. Rather than being at odds with or disruptive to psychoanalytic treatments, the presenter demonstrates how efforts to change behavior can be part of the development and employment of a psychodynamic formulation and therapy. Indeed, psychoanalytic theory and techniques add several strategies for behavioral change to those employed in other treatments, and aid in addressing potential difficulties in the therapeutic relationship. The presenter has developed approaches for targeting behavioral change in psychodynamic psychotherapy. These approaches include identifying the context, feelings and thoughts preceding problematic behavior and developing a psychodynamic formulation that includes relevant fantasies, developmental factors, intrapsychic conflict, and defenses. This understanding and framework is then employed to identify strategies for behavioral change. Approaches include identification of alternative behaviors, followed by exploring factors that interfere with the performance of these actions. The therapist works with the impact of behavioral change on the patient's emotions and psychological

conflicts. Homework, such as a diary to monitor thoughts, feelings and circumstances preceding problematic behaviors, or the writing down of alternative scripts, can be useful for this treatment, despite its general exclusion from psychodynamic psychotherapy. The role of and approaches to trauma in the development of problematic behavior will be discussed.

Presidential Symposia

Saturday, May 05, 2018

Diversity Issues in Psychotherapy

Chair: David Leon Lopez, M.D.

Presenters: Allan Tasman, M.D., Sarah Oreck, M.D., M.S., Deborah Levine Cabaniss, M.D., Rachel Melissa Talley, M.D., Elise W. Snyder, M.D.

Discussant: Elizabeth Auchincloss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify and understand the issues that arise when Sociocultural Diversity (different backgrounds between psychotherapist and patient) is present; 2) Learn psychodynamic psychotherapy techniques that have improved treatment outcomes when there are sociocultural differences between psychotherapist and patient; and 3) Understand the learning processes and self-exploration that different psychotherapy experts have been through, as they have encountered Sociocultural Diversity.

SUMMARY:

For decades, psychiatrists who treated patients in psychodynamic psychotherapy assumed that all patients responded to classical technique in the same manner. Only recently have psychodynamic psychiatrists realized that Sociocultural Diversity requires the therapist to modify how information is processed and how it is conveyed to the patient. From the first contact on the telephone to how an interpretation is delivered, Diversity has taken an increasingly central role in establishing rapport and understanding the individual within his environment. The training process in psychodynamic psychotherapy includes developing a rapid, visceral ability to connect at an interpersonal emotional

level. This is done through intuitively identifying speech patterns and personal styles of communication that the therapist notices from the first contact. The therapist then uses these observations to best deliver information to the patient. For example, a psychotherapist quickly learns to be very precise with an obsessive patient, or to tolerate the self-importance of the narcissistic one. Only recently has the understanding of Diversity been included in the repertoire of the psychodynamic psychiatrist, since the sociocultural differences will make these patterns look differently depending on the patient's background. For a psychodynamic psychiatrist the modifications to the technique to be diverse-competent will seem obvious since these increase the interpersonal connection. The intense emotional bond between patient and therapist that occurs in psychodynamic psychotherapy allows the patient to realize when his therapist is not diverse-competent. Very often patients feel that therapists who are not diverse-competent only understand their problems partially. This can interfere with treatment and, in some instances it will derail it to the point of failure or abandonment. Therapists who become aware of this new area of study can now identify and correct it. Being diverse-competent does not mean understanding all cultures or social environments, but rather following an ongoing process. The first step is becoming aware of one's limitations in this area. Then, developing openness and interest for other sociocultural backgrounds. The final step is one of being willing to question one's biases related to other sociocultural backgrounds and accepting them without assigning subjective labels. As simple as this may seem, in practice this is a complex task since very often some of these diverse factors are intertwined with frank pathology. Being able to distinguish between diverse non-pathological factors and diverse pathological factors is the purview of the most seasoned psychodynamic psychiatrists. This symposium now provides the opportunity to update therapists in this new area of study with examples provided by experienced therapists, as well as therapists who come from other cultures.

Telepsychiatry and Mental Health Technologies

Chair: Peter M. Yellowlees, M.D.

Presenters: Robert Lee Caudill, M.D., James H. Shore,

M.D., Steven Richard Chan, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) learn about mechanisms developed to drive the universal implementation of telepsychiatry and demonstrate its value to patients, providers and payors; 2) learn how to modify and adapt their clinical processes to successfully treat patients using telepsychiatry in a range of clinical environments and models of care; 3) appreciate how developments in videoteleconferencing technology have impacted the evolution of telepsychiatry; and 4) learn about new and disruptive health technologies that will soon begin to change psychiatric practice.

SUMMARY:

Yellowlees. All health systems (independent of size and available resources) need to scale telepsychiatry programs and services to meet existing market needs and stakeholder demands and expectations. As the healthcare ecosystem continues to evolve, the combined power of telepsychiatry and other health technologies will have a profound impact on improving personal health as well as enhancing healthcare business efficiency and quality of patient care. These tools are being used to foster service innovation and increase value for all involved, just as value-based payment incentives are reshaping how we think about and practice healthcare. The session will focus on several national initiatives on telepsychiatry scalability, implementation and the demonstration of value currently being promoted by the American Telemedicine Association. Shore. This part of the presentation will focus on how to adapt clinically processes and styles for working with patients using telepsychiatry. Skills to be covered will include appropriate assessment and fit for patients with different telepsychiatry models of care, orienting and consenting patients, and adjusting clinical style and presentation for video conferencing. Emphasis will be given on how to build rapport and trust at a distance and manage a hybrid doctor-patient relationship (working with patients across technologies and settings). Important cultural issues that arise in the course of telepsychiatric treatment will be reviewed including not only issues related to the patient, but the organizational and

treatment environments in which care is occurring. We will review working in both individual settings but important process and management issues for team-based models of care (eg. Integrated care, residential treatment). Caudill. This discussion will provide a general review of the past, present, and future of telepsychiatry with an emphasis on implementation. While the advances in the treatment and understanding of psychiatric conditions have continued to advance, developments in technology have also been dramatic. Telepsychiatry sits at the intersection of these growing knowledge bases. This has allowed telepsychiatry to begin meeting some intransigent needs in the system of healthcare delivery. New technologies on the horizon stand ready to provide solutions to many challenges in disparities of care. Changes in care delivery systems lead to reviews of ethical and practice concerns. Chan. What information technologies and mobile apps can produce better outcomes for behavioral healthcare? How can virtual reality, augmented reality, and simulations produce better behavioral healthcare? What other new technologies are on the horizon, how can we critically evaluate them as leaders of behavioral health, and how can we bring about disruptive innovation rather than destructive innovation?

Bringing Light to Darkness: Seldom-Examined Topics in Forensic Psychiatry

Chair: Michael A. Norko, M.D.

Presenters: James Kimmel Jr., J.D., Michael Rowe, Ph.D., John M. W. Bradford, M.D., Alexander Simpson, M.B., Ch.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the perils of justice-seeking, and the “Nonjustice System” and early research of its effectiveness; 2) Explain the effects of vicarious trauma on forensic clinicians and the interventions available to minimize negative consequences or enhance functioning; 3) Assess the response of one forensic facility to evidence of patient abuse for its merit and potential utility in other facilities; and 4) Apply recovery principles to secure forensic treatment settings and protocols.

SUMMARY:

This symposium will explore topics in forensic psychiatry that are seldom discussed, each related to a darker aspect of the work that tends to elicit avoidance. In that avoidance may be found a lost opportunity for building well-being of one type or another. The panelists in this symposium will discuss various topics illustrating dark aspects of forensic work, their effects on participants in forensic processes, and the possibilities for innovative approaches to promote enhanced well-being for practitioners and service users alike. After many years of lawyering, Attorney James Kimmel, Jr. concluded that the pursuit of justice and the pursuit of happiness were irreconcilable, producing profound suffering. Seeking justice to avenge perceived wrongs, he argues, is the universal motive underlying most acts of aggression. Brain science has linked justice-seeking with the neural circuitry of addiction. This led him to develop his Nonjustice System – a nine-step process helping victims control the desire for justice. Attorney Kimmel will describe how he came to these conclusions and developed the Nonjustice System. Michael Rowe PhD will describe pilot studies of the effectiveness of this nonjustice methodology that have been conducted by members of Yale's Program for Recovery and Community Health (PRCH), and review the results of these studies and future directions for research. In 2013 John Bradford MBChB publicly disclosed his experiences of vicarious trauma as a forensic examiner to a news reporter for The Ottawa Citizen. Dr. Bradford will discuss the case that led to his personal experience of PTSD and depression. His public addresses have raised awareness about vicarious trauma as an occupational stress injury and opened avenues for assistance for judges, jury members, first responders and healthcare workers. He will focus on the latest research on treatment rehabilitation for this occupational hazard. Michael Norko MD will describe a disturbing case of patient abuse in an accredited and respected forensic treatment facility and its significant impact on patients and staff, and on the wider mental health system. He will focus on the multi-faceted response to the revelation of this abuse, and the initiatives that were begun to attempt to cope with trauma and re-build and enhance well-being and resilience

within the hospital community. Historically, the forensic treatment system has faced conceptual obstacles in responding to the growing recovery movement in mental health care, as recovery principles and the need for security and safety were seen as antithetical. Recent work, however, suggests that these goals need not be conflicting. AAPL has formed a new committee on Forensic Recovery, chaired by Alexander Simpson MBChB. Dr. Simpson will describe the literature and emerging interventions and research that can facilitate the union of recovery principles with forensic psychiatric treatment, including the use of forensic peer support specialists.

Sunday, May 06, 2018

From Bench to Buprenorphine: The Role of Psychiatry Residencies and Fellowships in Addiction Psychiatry Training

Chair: Art C. Walaszek, M.D.

Presenters: Carlos Blanco-Jerez, M.D., Ann C.

Schwartz, M.D., Andrew John Saxon, M.D., Justine Wittenauer Welsh, M.D., Jeremy Douglas Kidd, M.D., M.P.H., Tristan Gorrindo, M.D., Sandra M. DeJong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the basic science and public health aspects of substance use disorders that are relevant to psychiatric educators and learners; 2) Explain the state of residency and fellowship education in substance use disorders, including barriers to the effective transfer of knowledge and skills; 3) Appreciate the perspectives of learners and educators in addiction psychiatry; and 4) List the resources available via AADPRT and the APA to support the education of residents and psychiatrists in the care of patients with substance use disorders.

SUMMARY:

Substance use disorders have recently received unprecedented national and international attention. The opioid epidemic has alarmed the public and has led to calls for greater intervention, which will in turn lead to an increased need for psychiatrists skilled in the care of patients with substance use disorders. Furthermore, changing laws and social

mores with respect to the use of cannabis will pose new challenges to psychiatrists caring for patients with mental illness and comorbid substance use and for children and adolescents at risk for developing severe mental illness. The main setting for psychiatrists learning about substance use disorders is in psychiatry residency – the ACGME requires at least one month of addiction psychiatry training during residency. Some psychiatrists pursue fellowship training in addiction psychiatry, and others will keep up with advances in our understanding and treatment of substance use disorders via continuing medical education. Recognizing the importance of effectively training future psychiatrists to care for patients with substance use disorders, the American Association of Directors of Psychiatric Residency Training (AADPRT) has appointed an Addiction Psychiatry Task Force. The overarching goal of the task force is to identify methods and a strategic plan to enhance addictions training at general residencies and child and adolescent psychiatry fellowships across the U.S. During this Presidential Symposium, our speakers will present the latest advances in our understanding of the science of addictions relevant to psychiatric educators; will present the current state of residency education in addictions, based on the results of a survey of residency directors; will describe the role of addiction psychiatry fellowships in training specialists; will discuss the unique issues that arise when teaching clinicians how to care for children and adolescents with substance disorders; will present the state of addictions education from the perspective of an addiction psychiatry fellow; and will describe resources that the American Psychiatric Association and AADPRT have available to support addiction psychiatry training.

It's Not All in Your Mind: Diagnosis and Treatment of Sexual Dysfunction

Chair: Derek C. Polonsky, M.D.

Presenters: Bonnie R. Saks, M.D., Richard Carroll, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement

strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:

While a significant percentage of the population struggle with serious sexual difficulties, guidance regarding diagnosis and treatment is lacking in most medical school, residency and graduate programs. Too often, the assumption is, “if they have a problem, they will bring it up.” Sadly this is not the case. Shame and embarrassment often inhibit an individual’s raising it with a health care professional. The field of Human Sexuality has a solid foundation based on research and treatment approaches. When integrated with more traditional individual and couples therapy, the benefits to our patients are remarkable. This presentation will guide you in talking about sexuality with our patients. The nature of sexual difficulties, their diagnosis and treatment and an opportunity for Q and A will be the focus.

Monday, May 07, 2018

Different Faces of the Opioid Crisis in America

Chair: Ilse R. Wiechers, M.D., M.H.S., M.P.P.

Presenters: Karen Glaze Drexler, M.D., Nora D. Volkow, M.D., Melissa L. D. Christopher, Pharm.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss strategies employed to curtail the crisis, like overdose reversal & prevention, medications & novel treatment interventions, and safer, less addictive treatments for chronic pain; 2) Appreciate the importance of the medical community’s full awareness of and active engagement in efforts to curb this crisis; 3) Describe the impact of the opioid and alcohol use disorder epidemics across America, especially among America’s Veterans; 4) Describe the risks and benefits of medication-assisted treatment (MAT) for opioid and alcohol use disorders, including the mitigating impact on suicide risk; and 5) Identify the key components of recent initiatives launched by the

Veterans Health Administration to improve access to MAT for substance use disorders.

SUMMARY:

The misuse of and addiction to opioids has resulted in a national crisis requiring innovative scientific solutions. In response, the National Institutes of Health is employing a public private partnership approach to help accelerate therapeutic development in such areas as opioid overdose-reversal; improved opioid use disorder treatments; and safer treatments to manage chronic pain. There is an extensive literature supporting the use of Medication-assisted Treatment (MAT) for both opioid use disorder (OUD) and alcohol use disorder (AUD), yet many patients with these disorders never receive an evidence-based pharmacotherapy. Substance use disorders are independent risk factors for suicide, but successful treatment can mitigate these risks. In recognition of the importance of ensuring Veterans with OUD and AUD have access to high quality, evidence-based treatments and to prevent Veteran suicide, the Veterans Health Administration (VHA) has launched innovative initiatives focusing on increasing access to MAT. Our workshop will introduce participants to VHA programs that have combined clinical informatics, virtual learning collaboratives, and interprofessional partnerships to improve care for Veterans with substance use disorders. We will provide an overview of the Psychotropic Drug Safety Initiative (PDSI), a nationwide psychopharmacology quality improvement (QI) program that improves practices for prescribing medication based on evidence and clinical practice standards. Facilities chose an area of prescribing on which to focus from a menu of options of nationally-identified priorities. Since July 2017, those priorities have been increasing use of MAT for OUD and AUD. PDSI supports facility-level QI through: quarterly quality metrics, clinical decision support tools, technical assistance for QI strategic implementation, and a virtual learning collaborative. We will demonstrate the clinical decision support tools from PDSI, which provide daily updated actionable patient lists for every facility in the country down to the outpatient clinic and inpatient service level. Interprofessional collaboration across multiple program offices has been a cornerstone of PDSI since it began in 2013,

most critically the partnership with Pharmacy Benefits Management's Academic Detailing service. VA Academic Detailing is a one-to-one peer education program targeted to front-line providers. It gives specific information about a wide range of evidence-based prescribing practices and can compare the practice of an individual provider with that of their peers using clinical informatics tools. We will discuss the nature of our collaboration between PDSI and Academic Detailing and how these programs have combined efforts to target increasing access to MAT for OUD and AUD. We will also highlight innovative SUD care models that have been implemented in individual VA Medical Centers.

ECT in the Era of New Brain Stimulation

Treatments: Road Map of Future Enhancements

Chairs: Sarah H. Lisanby, M.D., David McMullen, M.D.

Presenters: Carlos Pena, Ph.D., Christopher Charles Abbott, M.D., Mustafa M. Husain, M.D., Zhi-De Deng, Ph.D.

Discussant: Matthew V. Rudorfer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learners will be able to describe the current indications for ECT in modern psychiatric practice; 2) Attendees will be able to identify modifications in ECT technique to improve the risk/benefit ratio; 3) Learners will be able to characterize emerging directions to refine ECT technique, such as magnetic stimulation and shaping the electric field; and 4) Participants will be able to describe up to date information about mechanisms of action of ECT, and how these are informing future directions to refine the therapy.

SUMMARY:

Electroconvulsive therapy (ECT) is the oldest somatic therapy in psychiatry. Given new developments in neuromodulation devices such as transcranial magnetic stimulation (TMS), what role does ECT play in today's practice? This panel will address this key question by showcasing what is new about this old treatment, and what role it plays today in the context of other brain stimulation devices. Dr. Lisanby will review the ways in which ECT practice has evolved since the early days of Cerlitti and Bini

through the modern era. Although ECT has been in continuous use since the mid 1930's, the way ECT is delivered has evolved since that time. Modern ECT practice now involves numerous options to tailor the dosage to the individual and to each clinical context. Large scale clinical trials provide an evidence basis to understand the impact of these treatment decisions on acute and long-term outcomes. Next, a representative of the US FDA will review the current regulatory status of ECT, how class determinations are made, and how these regulations interface with medical practice. Dr. Abbott, will present what neuroscience has taught us regarding mechanisms of action of ECT, and how this knowledge of regional specificity of the effects can inform modifications of the treatment to enhance efficacy and safety. He will report on his latest work supported by the NIH BRAIN Initiative to refine ECT procedures based on this mechanistic understanding. Dr. Husain will present the latest developments in Magnetic Seizure Therapy (MST), which was introduced as an investigational treatment to reduce the memory effects of ECT by using noninvasive magnetic fields that can be more precisely targeted to spare regions of the brain affecting memory. He will also report on the latest work of the National Network of Depression Centers to track cognitive outcomes following ECT. Dr. Deng will present new engineering advances to target the electric field in space (E-field shaping), to give better control over what parts of the brain are affected by the treatment, and thereby improve its safety. He will also demonstrate how engineering tools can be used to simulate and visualize the distribution of the electric field induced by ECT in the brain, to shed light on how variations in ECT technique can result in different clinical outcomes, and how this knowledge can be used to personalize the treatment. Dr. McMullen will briefly describe funding opportunities available through NIMH and the BRAIN Initiative to study ECT and related therapies. Finally, Dr. Rudorfer will serve as discussant, summing up the symposium and putting the presentations in to context for the practicing psychiatrist. In particular, Dr. Rudorfer will address the role of ECT in today's practice relative to other new neuromodulation treatments, where the research gaps are, and give a perspective on the future of ECT, informed by its historical context. ECT continues to play an important role in psychiatric

practice, and one that continues to evolve as technologies develop and as scientific understanding of its mechanisms advances.

State of the Art in Mood Disorder Diagnosis and Treatment: The View From Johns Hopkins

Chair: James B. Potash, M.D., M.P.H.

Presenters: Robert Lawrence Findling, M.D., M.B.A., Jennifer L. Payne, M.D., Irving M. Reti, M.D., Karen L. Swartz, M.D., Fernando S. Goes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learners will become familiar with the latest data on medication treatments for child and adolescent mood disorders; 2) Learners will understand the data on which the argument for pharmacogenetic testing in mood disorders rests; 3) Learners will become aware of the advantages and the challenges associated with using ketamine for depression; 4) Learners will become familiar with the comprehensive Johns Hopkins approach to history taking and formulation in mood disorders; and 5) Learners will become cognizant of the newest approaches to rTMS treatment for depression.

SUMMARY:

This Presidential Symposium is focused on state-of-the-art mood disorders diagnosis and treatment, as practiced at Johns Hopkins. Dr. Karen Swartz, the Clinical Director of the Johns Hopkins Mood Disorders Center, will discuss the Center's approach to comprehensive history taking and formulation, including methods to elicit subtle symptoms of depression, mania, hypomania and mixed states critical to diagnosis. A systematic approach for a range of mood disorders will be discussed including pharmacologic treatment guided by comprehensive review of past medication trials, identification and treatment of comorbid conditions, and potential psychotherapy approaches. Dr. Jennifer Payne will describe the prevalence of postpartum depression with a focus on women with pre-existing mood disorders. She will review evidence on the role of antidepressants in the prevention of postpartum depression and discuss current research identifying biomarkers of postpartum depression that, in the future, may be used to identify women at high risk and allow preventive strategies for this devastating

condition. Dr. Bob Findling is the founding editor of the APA's child and adolescent psychopharmacology text book. He will provide updates on psychiatric medication treatments for this population. Dr. James Potash's research has focused on the genetics of mood disorders. He will describe the pharmacogenetic tests currently in use for antidepressant selection in depression, and discuss the limited evidence base underlying their use. Dr. Irving Reti will present on the safety and efficacy of rTMS for the treatment of depression, as established by multiple randomized controlled trials over the last two decades. He will highlight recent and ongoing research efforts focused on predictors of outcome and treatment parameters aimed at optimizing application of this treatment both for the acute depressive phase and for relapse prevention. Dr. Fernando Goes will highlight the latest clinical research findings related to ketamine, an experimental novel antidepressant that is being used for treatment-resistant depression. The presentation will summarize available efficacy and safety data and discuss the clinical challenges concerning when to consider a referral for treatment with ketamine. A theme throughout this symposium is the dual emphasis in the Johns Hopkins Mood Disorders Center on intertwined aims: next-generation approaches to diagnosis and treatment that incorporate insights and advances at the molecular level, and strong-foundation approaches that preserve and enhance key features of the ancient art of healing such as getting to know our patients deeply and devoting ourselves to them fully.

Suicide, Self Harm, Overdose, and Addiction... and the Gray Areas in Between

Chair: Richard K. Ries, M.D.

Presenters: Christine E. Yuodelis-Flores, M.D., Hilary S. Connery, M.D., Ph.D., Sanchit Maruti, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Integrate the relationships and mechanisms of addictions in suicidal patients into clinical evaluations; 2) Evaluate self harm and its role in past or impending suicides; 3) Evaluate the potential role of suicide or self harm and prevention in the current opioid overdose epidemic; 4) Utilize better screening techniques for both suicide and the

role of addictions in suicide; and 5) Apply the knowledge of this symposium in case discussions with presenters.

SUMMARY:

Suicide is 10 to 15 times more common in persons with addiction compared to the USA general population. The workshop will be focused on suicide issues most relevant for AAAP members in their practices, with reference to the overlaps with addiction, accidental overdoses, psychiatric and medical co-morbidities. Etiology, prevalence, screening, and risks for suicidal behavior, as well as treatment planning will be discussed. Each of the 4 presenters will give a short talk of about 35 minutes. Dr Yuodelis-Flores will present on etiology, prevalence of suicidal behavior and completed suicide in patients with various addictions. Dr Connery will discuss the spectrum and role of self-harm in suicide and addictions. Dr. Ries will present on the opioid overdose epidemic and differentiation between accidental and deliberate overdoses. Dr Maruti will discuss screening techniques and evaluation. After these talks, 45 minutes will be spent with the full panel of presenters on case material and questions from the audience. Attendees should be thinking about cases to present to the panel in the discussion period.

Culture and Diversity in Geriatric Psychiatry Across the Clinical Continuum

Chairs: Iqbal Ahmed, M.D., Shilpa Srinivasan, M.D.

Presenters: Maria D. Llorente, M.D., Daniel D. Sewell, M.D., Ladson W. Hinton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the changing cultural landscape affecting the demographics of the aging US population; 2) Recognize the impact of culture and diversity on aging; 3) Review the cultural psychiatry curriculum components for healthcare providers working with older adults; 4) Discuss components of culturally sensitive care of LGBTQ older adults; and 5) Discuss innovative approaches incorporating families and caregivers of older adults.

SUMMARY:

The population of the United States is aging and

growing increasingly diverse, creating a demographic imperative to address diversity among older adults. Diversity encompasses ethnicity, cultural background, gender, sexual orientation, sexual identity, and immigration status. Currently, 13% of the population is over the age of 65. This number is projected to increase to over 80 million by 2050, with an accompanying increase in racial and ethnic diversity. The United States is also projected to become a majority-minority nation by this time. Ethnic elderly age 85 and above comprise the most rapidly growing segment of the U.S population. Culture and ethnicity impact aging both developmentally as well as in terms of psychopathology leading to differences in prevalence, presentation, and etiology of symptoms. Culture can also affect therapeutic relationships, attitudes towards treatment, and can contribute towards stigma. Cultural and ethnic differences between patients and healthcare providers can exacerbate disparities in healthcare. A framework for culturally informed, aware, and culturally competent care is therefore a critical component of meeting the mental healthcare needs of the diverse aging population. The American Association for Geriatric Psychiatry (AAGP), a national leader in the care of older adults with psychiatric illness, is promoting the use of culturally sensitive approaches across the continuum of clinical care, teaching, and research. In this symposium, we will first present an overview of culture and diversity in aging. We will review the role of cultural psychiatry education and curriculum in training the healthcare workforce to meet the needs of minority elderly. Next, we will discuss culturally sensitive clinical care of LGBTQ older adults. Lastly, innovative and culturally-sensitive approaches incorporating families and caregivers will be discussed

Learning Health Care Systems: Clinical Registries and Networks in Psychiatry

*Chairs: Philip Wang, M.D., J. Raymond DePaulo, M.D.
Presenter: John Francis Greden, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) How, to reverse the burdens of mental illness, the profession must implement network collaborations, data-sharing, large samples,

and learning health care models; 2) How APA's national mental health registry (PsychPRO) and the National Network of Depression Centers (NNDC) are engaged in collaborative efforts to implement such transformative programs; and 3) How registries and learning health models can be adopted, as well as support psychiatrists in their delivery of clinical care.

SUMMARY:

The increasing focus on population health reporting and the spread of electronic health records particularly in the U.S. has provided a rationale the mechanisms for establishing clinical registries for monitoring care (i.e., for quality improvement and reporting purposes) and a mechanism for longitudinal clinical studies. These include the testing of potential predictors of important health and functional outcomes, as well as responses to different treatments. In this symposium, we will feature the American Psychiatric Association's development of its quality reporting focused registry (PsychPRO) and the National Network of Depression Center's (NNDC) Mood Outcomes Program registry, developed over the last 3 years for clinical monitoring as well as clinical, translational, and implementation research. The progress and the collaboration opportunities between these and other registry types will be discussed by leaders from the NNDC and APA.

The Life of a New York City Ballet Principal: A Sports Psychiatric View Through the Opera Glass

*Chairs: Wendy M. Whelan, Antonia L. Baum, M.D.
Presenters: David Oliver Conant-Norville, M.D., Claire Twark, M.D., Antonia L. Baum, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the developmental (both individual and family) dynamics and psychiatric predilections in an athlete training intensively in a single sport in order to perform as a professional athlete; 2) Understand eating disorder in the dance world; 3) Recognize the spectrum of psychiatric sequelae in the injured athlete; 4) Have an appreciation for the impact of retirement on one whose livelihood and identity have been in the professional athletic arena; and 5) Conceptualize treatment of the above entities --burnout, eating

disorder, injury and retirement incorporating a biopsychosocial approach.

SUMMARY:

The life cycle of the professional athlete is unique. Through the lens of a formidable, former NYC Ballet principal, Wendy Whelan--featured in a recent documentary "Restless Creature" nominated for best documentary in the 2017 Miami Film Festival--this symposium will illustrate formative points in the life cycle of a professional athlete. The singular focus and intensive training usually required from a young age in order to achieve the status of a professional in the athletic arena has a great impact on the family of origin and evolving nuclear family as an athlete develops. It may take an extreme of personality organization to achieve in this highly competitive world. Once in the professional athletic life, the finely tuned instrument of the body is central to the athlete's sense of self and to their success in life. Eating disorder is but one manifestation of an obsessive focus on one's primary instrument. Injury may have profound consequences in an athlete's career, and there is the potential for significant psychiatric sequelae, including major depression and suicide. Retirement --which may follow on the heels of a career ending injury--or the often limited lifespan of the professional athlete in general due to the demands of sport on the body--may leave the professional athlete without direction at a relatively young age. This too may precipitate despair and psychopathology. It behooves the sports psychiatrist to be cognizant of these aspects of the life of the professional athlete, so that problems may be identified and treated in a timely manner. The capacity for reinvention at the point of retirement is a watershed moment in the life of the athlete, The distinguishing characteristics that may make some more successful in this process are explored.

Tiping Point: The Critical Decline in Psychiatric Hospital Beds

Chair: Steven Samuel Sharfstein, M.D.

Presenters: Tarun Bastiampillai, M.B.B.S., Richard O'Reilly, Brian Matthew Hepburn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide an overview of the

critical decline in the U.S. supply of psychiatric beds; 2) Understand the full range of administrative and clinical problems associated with this shortage of psychiatric beds; 3) Examine the experiences with shortages of psychiatric beds in similar countries--the U.S., U.K., Canada and Australia; 4) Describe criteria for estimating "safe minimum" numbers of psychiatric beds needed for acute and longer-term care; and 5) Discuss national strategies to restore an adequate US psychiatric bed base.

SUMMARY:

The U.S. mental health system has reached a tipping point, due to our extremely low access to inpatient psychiatric care. Back in 1991, we had an adequate supply of hospital-based psychiatric beds (a total of 153,517 public and private psychiatric beds representing 61 psychiatric beds per 100,000 population). This figure is comparable to the current Organisation for Economic Cooperation and Development (OECD) average of 71 beds per 100,000 population. By 2014, only 67,717 beds (21 beds per 100,000 population remained). Just three of the 35 OECD countries are placed lower in the rankings than the US. The most proximal signs of the lack of beds are seen in our hospitals: patients boarding in overcrowded emergency rooms for days and even for weeks whilst awaiting admission, hospital occupancy rates constantly over 100% and ultra-short psychiatric lengths of stay. Negative clinical consequences such as homelessness, incarceration, and suicidal behavior are affected by many variables but lack of beds is an important one. Currently 383,000 people with a serious mental illness are incarcerated in U.S. prisons:10 times the number in state funded hospitals. The symposium will explore not only the consequences, but also the reasons behind the extraordinary decrease in psychiatric beds, which is driven by a powerful, and up to this point, prevailing alliance between ideology and economics. Finally we will discuss national strategies aimed at restoring adequate supplies of acute and long-term psychiatric beds.

Tuesday, May 08, 2018

Global Mental Health Research and the Fogarty International Center's 50th Anniversary

Chairs: Beverly Pringle, Ph.D., Kathleen Michels,

Ph.D.

Presenters: Milton Leonard Wainberg, M.D., Vishwajit Nimgaonkar, M.D., Ph.D., Mary McKay, Ph.D., M.S.W., Lauren Haack, Ph.D., Muthoni Anna Mathai, Ph.D., MB.Ch.B., M.Med., Brandon Alan Kohrt, M.D., Ph.D.

Discussants: Joshua A. Gordon, M.D., Ph.D., Roger I. Glass, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about unique opportunities to extend the frontiers of research around the world with a particular emphasis on low- and middle-income countries; 2) Identify unique research questions that can best be addressed by conducting research abroad, and how international experience can contribute to reduce mental health treatment gap; and 3) Appreciate the potential impact of training the next generation of researchers in Global Mental Health for the 21st century to address the major barriers globally to accessing mental healthcare.

SUMMARY:

In the 20th century, global health research focused primarily on HIV and other infectious diseases. In the 21st century, as life expectancy has increased globally, non-communicable disease (NCDs), including mental, neurological, and, addictions disorders, have become priorities to add years to life and boost the quality of life during years lived. The risk and protective factors for mental illness, and the quality, effectiveness, and delivery of preventive and treatment interventions need more study in low- and middle-income countries (LMICs). Research on these topics in LMICs has seen considerable growth over the past several decades. Also growing is realization that human biological and environmental diversity across the globe can enrich the research enterprise; understanding of mental, neurological, and, addictions disorders; and the value of research in helping people around the world as well as at home. This research can best be accomplished through multi-disciplinary research partnerships. The Strategic Plan of the Fogarty International Center (FIC) focuses on training the next generation of researchers in Global Health for the 21st century. The United States needs investigators able to work

internationally to extend the frontiers of research around the world with a particular emphasis on LMICs, which have the fewest investigators. The FIC also aims to provide outstanding foreign scientists with opportunities to train with US research teams. FIC has a long-standing partnership with the National Institute of Mental Health (NIMH). Throughout this partnership, FIC and NIMH have collaborated to provide a seamless, comprehensive experience for researchers. Currently, research is being supported to develop innovative, collaborative research projects between U.S. and LMIC scientists, on brain and mental disorders throughout life, relevant to LMICs; and to develop or adapt innovative mobile health (mHealth) technology specifically suited for LMICs to address mental health treatment gap. The goal of the Symposium will be to encourage young trainees in academic settings to learn about unique opportunities to extend the frontiers of research on mental, neurological, and, addictions disorders around the world, with a particular emphasis on LMICs. We will discuss the unique research questions that can best be addressed by conducting research across national boundaries, and how international experience can help to reduce the mental health treatment gap around the world as well as in U.S. We will also discuss the relevant partnership between FIC and NIMH. Ultimately, we believe that research anywhere will help people everywhere. Senior recent grantees will present research where international collaborations have led to new discoveries. Fogarty and NIMH grantees will then discuss how Fogarty and NIMH support have launched their academic careers in Global Mental Health Research.

Cannabis Use in Europe and the U.S.

Chairs: Francois C. Petitjean, M.D., John A. Talbott, M.D.

Presenters: Alain Dervaux, M.D., Ph.D., Amine Benyamina, M.D., Georges Brousse, Frances Rudnick Levin, M.D., Meg Haney, M.D., Gregory Bunt, M.D.

Discussant: Richard Joseph Frances, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand basic issues about the epidemiology of cannabis use in Europe and the US; 2) Understand the major comorbidities

associated with cannabis use; and 3) Better understand issues about decriminalization/legalisation of cannabis use.

SUMMARY:

This session will present data on cannabis use in Europe(mainly France) and the US. Differences and similarities between the US and Europe concerning the epidemiology of cannabis use will be presented by A Dervaux The issue of decriminalization will be adressed, as the situation is quite different on both sides of the Atlantic, with presentation by A Benyamina (France) and G Bunt (USA). Finally data concerning comorbidities will be presented and M Haney (USA) G Brousse (France) and F.Levin will talk about medical indications for cannabis: evidence or lack of?

Frontiers in Research on the Neurobiology of Early Psychosis and Implications for Clinical Practice

Chairs: Tresha A. Gibbs, M.D., Saurabh Somvanshi, M.D.

Presenters: Scott Small, M.D., Michael B. First, M.D., Tyrone Cannon, Ph.D.

Discussants: Jeffrey Alan Lieberman, M.D., Sarah H. Lisanby, M.D., Steven N. Adelsheim, M.D., Ragy Girgis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain an understanding of the contemporary glutamate-based theories on the neurobiology of incipient psychosis; 2) Describe the symptoms and diagnostic conceptualization of attenuated psychosis and controversies regarding its incorporation into the DSM; 3) Gain an understanding of the clinical assessment and available evidence for interventions with individuals with attenuated psychotic symptoms; and 4) Discuss the practical implications for general psychiatrists treating adolescents and young adults presenting with symptoms of early psychosis.

SUMMARY:

This symposium aims to provide general psychiatrists with an update on the topic of early psychosis and the psychosis prodrome. This will include an overview of the innovative and exciting research evidence for measurable markers of pre-

psychotic brain changes including the progression from neurochemical to structural abnormalities. In particular, speakers will present the concept of being at clinical high risk for psychosis and, in particular, attenuated psychosis. We will explore the implications for our diagnostic and classification system and in particular discuss considerations for whether attenuated psychosis meets the threshold for classification as a disorder. Attendees will then hear about front line community work being conducted in clinics serving individuals at clinical high risk of psychosis, with an emphasis on educating general psychiatrists on the assessment of these individuals, common differential diagnosis, and the treatment and monitoring interventions supported by the evidence. Lastly, a panel of clinicians and researchers will discuss issues raised in the presentations. Lastly, a panel of clinicians and researchers will discuss issues raised in the presentations. Panelists will discuss the clinical and public health implications, including efforts to improve early identification through research, outreach and community education.

Psychiatric Services Gold Star Paper: The Path to Sustainable Implementation for Digital Mental Health

Chair: Lisa Dixon, M.D.

Presenters: Madelyn Gould, M.D., Ph.D., Dror Ben-Zeev, Ph.D., John Torous, M.D., Andrew Bertagnolli, Ph.D., David Mohr, Ph.D., Anthony Pisani, Ph.D., Bob Filbin, Fred Muench, Ph.D., Shairi Turner, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Participants will be able to describe some of the ways in which digital mental health implementations in healthcare settings have failed; 2) 1. Participants will be able to describe the user-centered philosophy of Crisis Text Line and at least one reason for its success; 3) 1.

Participants will be able to articulate 3 features or mechanisms that promote user persistence in digital mental health interventions; and 4) Participants will be able to articulate at least one privacy challenge for patients, and one privacy challenge for healthcare providing organizations.

SUMMARY:

Digital Mental Health (DMH) interventions, which use commonly available digital technologies such as the computer and mobile phones to deliver psychological treatments for mental health conditions, hold great promise to extend cost effective treatments, virtually any time and any place. More than 100 randomized controlled trials have demonstrated the efficacy of DMH interventions, particularly when they are supported with some coaching or support via telephone or messaging. Yet to date, despite repeated attempts, there has not been a single successful, sustainable implementation within a healthcare setting. The aim of this symposium will be to explore the challenges that have led to this research-to-practice gap, as well as potential solutions. Dr. Mohr will describe the background and the framework for this discussion, based on his column published in *Psychiatric Services*, "Three Problems With Current Digital Mental Health Research...and Three Things We Can Do About Them." Dr. Bertagnolli will describe a number of implementation attempts within healthcare delivery organizations, the results of these attempts, and reasons for these failures. Dr. Pisani, Dr. Gould and Robert Filbin will share data and experiences from the Crisis Text Line, a not-for-profit company that provides crisis counseling via text messaging to almost half a million individuals per year, with further growth expected. In conversation with other panelists they will draw lessons from Crisis Text Line's success that might be applied to developing of sustainable implementations within healthcare settings. Dr. Muench will discuss the features and mechanisms of DMH interventions that promote persistence in engagement among patients. Dr. Torous will discuss the security and privacy issues related to DMH that are critical for acceptance both by patients and care systems. Finally, Dr. Ben-Zeev, Editor of the *Technology in Mental Health* column in *Psychiatric Services*, will highlight the points from each of these talks that illuminate the path towards sustainable implementation in healthcare settings.

Update on Childhood Psychiatric Disorders

Chair: Karen Dineen Wagner, M.D., Ph.D.

Presenters: Karen Dineen Wagner, M.D., Ph.D., John

T. Walkup, M.D., Jeremy Veenstra-VanderWeele, M.D., Gabrielle A. Carlson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the age of onset of depression and anxiety in children and adolescents; 2) Discuss the importance of screening for and the consequences of untreated depression and anxiety in children and adolescents; 3) Discuss treatment options for depression, anxiety, autism spectrum disorder, and disruptive mood dysregulation disorder in children and adolescents; 4) Articulate the differential diagnosis of children with outbursts/mood dysregulation; and 5) Explain the process of taking neurobiological hypotheses from the bench to the clinic.

SUMMARY:

This symposium gives updates on the latest advances in treatment for depression, anxiety, autism spectrum disorder (ASD), and disruptive mood dysregulation disorder (DMDD). Dr. Karen Dineen Wagner begins by reviewing age of onset of depression in children and adolescents and discussing screening for this disorder in youth. The consequences of untreated depression in youth such as impaired school performance, poor peer relationships, disruptive family functioning, and suicidality are discussed, in addition to treatment options for depression in children and adolescents. Dr. John T. Walkup follows by reviewing the ages of onset of the various anxiety disorders and their clinical presentations across the lifespan. There are a myriad of reasons why childhood anxiety is not identified and treated which include confusion regarding healthy anxiety and pathological anxiety, lack of awareness and advocacy as compared to other childhood conditions, and the perception that anxiety disorders are not severe or as impairing as other psychiatric disorders. As a result children with untreated anxiety are at risk to develop problems with adaptation and coping and maladaptive behaviors including substance use disorders, suicidal behavior, and nonsuicidal self-injury as they move from childhood to adolescence and young adulthood. The presentation concludes with guidance regarding identifying and treating anxiety disorder symptoms. Jeremy M. Veenstra-

VanderWeele reviews the current evidence base for behavioral and medication treatments in ASD. To date, all evidence-based interventions in ASD are based upon either empirical findings (e.g., risperidone) or basic behavioral principles (e.g., ABA). In contrast, the presentation describes initial forays into autism spectrum disorder treatment studies based upon neurobiology, highlighting both the advantages of mechanistic hypotheses and the challenges of studies targeting the core symptoms of ASD. Although emerging research promises that we are on the cusp of rational therapeutics, also outlined are some of the challenges of translating hypotheses from the bench (or the cage) to the bedside. Finally, integration of treatment using a blend of precision medicine, empirical treatment, and the symptom-based approach most frequently practiced in psychiatry is described. Finally, Dr. Gabrielle A. Carlson reviews DMDD, a condition defined by frequent explosive outbursts occurring within the context of chronic, pervasive irritability, beginning in early childhood though not diagnosable until age 6. Circumstantial evidence classifies this condition as a mood disorder which is where it resides in the most recent DSM. This lecture reviews how the condition evolved and speculates that although it originated ostensibly as a response to the overdiagnosis of bipolar disorder in children, the overdiagnosis of bipolar disorder occurred because of the absence of a good diagnostic home for explosive outbursts.

Wednesday, May 09, 2018

**Mythbusters: Consultation-Liaison Doctors
Separate Medical Fact From Fiction**

Chair: Robert Joseph Boland, M.D.

Presenters: Peter A. Shapiro, M.D., Sparsha Reddy, M.D., Sejal Shah, M.D., David F. Gitlin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the process by which individual experiences become incorporated as “truths”; 2) Identify examples of such myth building in the way we evaluate and treat our patients; and 3) Develop a plan to minimize the biases that contribute these myths.

SUMMARY:

As doctors, most of us come to realize at some point in our training that many of the “facts” we are taught are just anecdotes, which, through repetition have evolved from “rules of thumb” to “accepted truth.” We create a mythology in our field to help us understand what is not yet known. This is true in all of medicine, however Consultation-Liaison Psychiatrists, given the collaborative relationship with many fields of medicine, seem to encounter a great number and variety of these myths. This myth creation is unavoidable as it is part of human nature, as well as part of our profession: we must often make diagnostic and treatment decisions using inadequate information, as our patients cannot wait for the definitive study to receive our help. However, we should not confuse myths for fact, lest we become too rigid in our decision making. To illustrate his point, the speakers will discuss several examples of myths within psychiatry. These will range from diagnostic to treatment choices, many of which we learn as students or residents as part of the canon of psychiatry, that are in fact based on little or questionable research. The purpose of this is not to be nihilistic: we are not suggesting that medicine in general, or psychiatry in particular is built on foundations of sand. Instead, we are reminding ourselves that ours is an evolving field with varying degrees of evidence and we should remain open to the growth and change that is a natural part of our field.

Special Sessions

Saturday, May 05, 2018

Applying the Collaborative Care Approach: Practical Skills for the Psychiatric Consultant

Director: John Sheldon Kern, M.D.

Faculty: Lorin Michael Scher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting

psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations.

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at three sessions during the Annual Meeting.

Sunday, May 06, 2018

Applying the Collaborative Care Approach: Practical Skills for the Psychiatric Consultant

Director: Anna Ratzliff, M.D., Ph.D.

Faculty: Hsiang Huang, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations.

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington.

This training is supported as part of that project. The same training will be offered at three sessions during the Annual Meeting.

Monday, May 07, 2018

Management of Cardiometabolic Risk in the Psychiatric Patient

Chairs: Jeffrey T. Rado, M.D., Aniyizhai Annamalai, M.D.

Presenters: Martha Craig Ward, M.D., Jaesu Han, M.D., Robert M. McCarron, D.O., Alyson Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss lifestyle modifications that are useful; 2) Improve current state of the art knowledge in treating diabetes, hypertension and dyslipidemias; 3) Develop skills in understanding the use of treatment algorithms for prevalent chronic illnesses in the SMI population; 4) Increase comfort in using screening guidelines for early identification of common diseases; and 5) Understand key concepts in prevention and treatment related to obesity, tobacco use and vaccinations.

SUMMARY:

Patients with mental illness, including those with serious mental illness (SMI), experience disproportionately high rates of tobacco use, obesity, hypertension, hyperlipidemia and disturbances in glucose metabolism. This is often partially the result of treatment with psychiatric medications. This population suffers from suboptimal access to quality medical care, lower rates of screening for common medical conditions and suboptimal treatment of known medical disorders such as hypertension, hyperlipidemia and nicotine dependence. Poor exercise habits, sedentary lifestyles and poor dietary choices also contribute to excessive morbidity. As a result, mortality in those with mental illness is significantly increased relative to the general population, and there is evidence that this gap in mortality is growing over the past decades. Because of their unique background as physicians, psychiatrists have a particularly important role in the clinical care,

advocacy and teaching related to improving the medical care of their patients. As part of the broader medical neighborhood of specialist and primary care providers, psychiatrists may have a role in the principal care management and care coordination of some of their clients because of the chronicity and severity of their illnesses, similar to other medical specialists (nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer). The APA recently (July, 2015) approved a formal Position Statement calling on psychiatrists to embrace physical health management of chronic conditions in certain circumstances. Ensuring adequate access to training is an essential aspect of this new call to action. There is a growing need to provide educational opportunities to psychiatrists regarding the evaluation and management of the leading cardiovascular risk factors for their clients. This course provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors which contribute heavily to the primary cause of death of most persons suffering with SMI, and allows for the profession of psychiatry to begin to manage some of the leading determinants of mortality and morbidity in patient populations frequently encountered in psychiatric settings.

Applying the Collaborative Care Approach: Practical Skills for the Psychiatric Consultant

Director: John Sheldon Kern, M.D.

Faculty: Lori E. Raney, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Discuss principles of integrated behavioral health care; 3) Describe the roles for a primary care consulting psychiatrist in an integrated care team; and 4) Apply a primary care-oriented approach to psychiatric consultation for common behavioral health presentations.

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health is

delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model—the integrated care approach with the strongest evidence base. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded \$2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at three sessions during the Annual Meeting.

Tuesday, May 08, 2018

Applying the Integrated Care Approach 201: The Advanced Course in Collaborative Care

Chairs: John Sheldon Kern, M.D., Anna Ratzliff, M.D., Ph.D.

Presenters: Patricia Ellen Ryan, M.D., Amy K. Anderson, M.D., Janet Howe, M.D., Kristyn Spangler, L.M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the most important tasks required for successful implementation of a collaborative care program; 2) Describe the use of

collaborative care payment codes; and 3) Demonstrate registry data evaluation and use in collaborative care.

SUMMARY:

In the last two years, the APA/AIMS Center Support and Alignment Network (SAN) project has trained over 1600 psychiatrists in the Collaborative Care model to provide behavioral health services in the primary care setting. Most of these psychiatrists received their training in in-person presentations at live District Brand or APA meetings. Many of the psychiatrists have gone on to be involved in successful implementations of the Collaborative Care model, and many more are preparing to do so. So far there have been 10 completed SAN learning collaboratives, an advanced online training activity. There continues to be strong interest among participating psychiatrists in ongoing support and training in Collaborative Care, and this workshop will present the opportunity for exposure to advanced topics in Collaborative Care. We will discuss a number of areas crucial to the successful implementation of Collaborative Care programs, including an up to date review of the new CMS payment codes for Collaborative Care, and a thorough introduction to the APA/AIMS Center Financial Modeling Tool, that has been assisting organizations with making credible financial plans for Collaborative Care implementation. There will also be a review of the use of data gleaned from a Collaborative Care registry, and a presentation on how to meaningfully evaluate this data for purposes of program improvement. Two organizations who have successfully implemented Collaborative Care programs will present their experiences, with a focus on those issues most critical to successful roll-out. Finally, there will be a review of techniques and strategies for efficiently training members of the Collaborative Care team, including care managers and PCPs. There will be opportunity for participants to engage with panel members in order to reflect the diverse real-life experiences of building and implementing a Collaborative Care program.

Symposia

Saturday, May 05, 2018

Body-Behavior-Brain Interactions in Psychosis

Chairs: Sophia Frangou, M.D., Matcheri S. Keshavan, M.D.

Presenters: Christoph U. Correll, M.D., Swaran Singh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the type of metabolic abnormalities (i.e., lipids, body mass index, glucemic control) that are present in psychosis; 2) Understand the association between metabolic abnormalities and cognitive dysfunction in psychosis; 3) Understand the association between metabolic abnormalities and brain alteration in psychosis; 4) Describe the relevance of metabolic dysregulation to treatment planning and treatment response; and 5) Increase awareness of the high prevalence of metabolic problems in psychotic patients.

SUMMARY:

Schizophrenia and bipolar disorder are among the 10 major causes of years lost to disability. These disorders are often associated with medical comorbidities particularly increased incidence of cardiovascular disease and diabetes. The prevalence of obesity, metabolic syndrome and poor glycemic control are substantially higher in individuals with psychosis compared to the general population. Although factors such as medication, especially atypical antipsychotics, dietary habits, and lifestyle play an important role, there is evidence that metabolic abnormalities may be an integral dimension of the pathophysiology of psychosis. It is therefore important to identify the dynamic relationship and potential synergistic pathways linking metabolic disturbances to the cognitive processes and brain structural and functional measures that are often impaired in psychosis. In this symposium we begin by summarize the current knowledge about the nature and prevalence of metabolic and glycemic dysregulation in psychosis and the key risk factors. We then focus on the association between psychosis and genetic variants linked to poor metabolic and glycemic control. We will also describe the multivariate association between metabolic, behavioral and lifestyle factors, cognitive processes and neuroimaging phenotypes both in the general population and in individuals

with psychosis. We will then discuss the complex influence of antipsychotic treatment on metabolic control which has been shown to increase cardiovascular risk but may have a potentially beneficial effect on psychotic symptoms. Finally, we will focus on clinical care pathways and we will present models of care that can effectively address the physical health care needs of patients with psychosis

Common Challenges in Assessing and Treating Body Dysmorphic Disorder

Chairs: Katharine Phillips, M.D., Evan Rieder, M.D.

Presenters: Sabine Wilhelm, Ph.D., Fugen Neziroglu, Ph.D., Jamie D. Feusner, M.D.

Discussant: Helen Blair Simpson, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify assessment and treatment challenges that clinicians commonly encounter when treating patients with body dysmorphic disorder; 2) Implement strategies to overcome these assessment and treatment challenges; 3) Identify abnormalities in perception, information processing, and neurocognition in patients with body dysmorphic disorder; 4) Identify effective treatments, both pharmacologic and psychosocial, for body dysmorphic disorder; and 5) Understand the relevance of strategies for these assessment and treatment challenges to other psychiatric disorders.

SUMMARY:

Body dysmorphic disorder – distressing or impairing preoccupations with nonexistent or slight defects in appearance (for example, a “huge” nose or perceived “balding”) -- is a common disorder, affecting 2-3% of the general population. Classified as an obsessive-compulsive and related disorder, BDD is often severe and challenging to treat. For example, most patients have poor or absent BDD-related insight, believing that their view of their perceived defects is probably or definitely accurate. Thus, they may be reluctant to accept the diagnosis and psychiatric treatment, believing that cosmetic treatment is the solution to their suffering. Indeed, about three-quarters of those with BDD seek, and two-thirds receive, cosmetic treatment (e.g.,

dermatologic, surgical) for BDD concerns, which appears to almost never be effective. Another challenge is frequent comorbidity with substance use disorders, including potentially risky anabolic steroid abuse among those with the muscle dysmorphia form of BDD. Recent studies indicate that the most often endorsed motive for both alcohol and drug use is coping with distress; more than half of those with BDD report drinking sometimes, often, or almost always/always to forget their body image concerns, with similar findings for illicit drug use. Furthermore, suicidality commonly occurs in BDD, which often appears secondary to BDD-engendered distress. Although effective treatment is available, these and other challenges can interfere with patient engagement and participation in treatment; many seek treatment at the behest of others. This symposium will incorporate recent research findings with clinical experience to help clinicians successfully engage and treat these patients. Dr. Phillips will give an overview of assessment and treatment challenges, and will discuss strategies for comorbid substance abuse, suicidality, and reluctance to take medication. Dr. Feusner will present recent data on abnormalities in visual processing in BDD and anorexia nervosa, as well as information processing and neurocognitive deficits, and how clinicians can use this information to help engage patients in treatment. Dr. Wilhelm will present findings from a recently completed study of cognitive-behavioral therapy for BDD versus therapist-delivered supportive psychotherapy; this study is the first to compare these treatments and the largest treatment study of BDD. Her presentation will include data on BDD-related insight as a predictor of treatment response and change in insight with treatment. Dr. Neziroglu will discuss additional cognitive-behavioral strategies for engaging reluctant patients in treatment. Dr. Rieder will present data on cosmetic treatment for BDD and strategies to help patients disengage from such treatment and participate in psychiatric treatment. Dr. Simpson will discuss these presentations and their relevance to other disorders, such as anorexia nervosa and other obsessive-compulsive and related disorders.

**Cultural Issues on Suicide, Sociopathy, and Opioids:
An International Latino Perspective**

Chair: Bernardo Ng, M.D.

Presenters: Pedro Ruiz, M.D., Maria Antonia Oquendo, M.D., Ph.D., Nicolas Martinez, M.D.

Discussant: Alvaro Camacho, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) • Understand the importance of culture in the mental health of Latinos; 2) • Appreciate the benefit of keeping culture in diagnostic and therapeutic actions with Latino patients; 3) • Understand the interaction between culture, suicide, substance use disorders and sociopathy; and 4) • Demonstrate ability to recognize the role of culture in mental health and mental illness.

SUMMARY:

Culture plays a major role in the mental health perspectives of Latino populations in the United States (US) and abroad. Family traditions, religion, gender, educational level, community support, migratory status, exposure to trauma, place of residence (i.e. urban vs. rural), and other cultural factors impact the lives of Latinos in general and in their mental health in particular. Cultural factors influence the way Latinos manifest and recover from psychiatric illnesses (i.e. suicide attempts), the treatments they choose (i.e. methadone replacement therapy), factors that prevent treatment adherence (i.e. personality disorders), and factors that prevent recurrences (i.e. reinsertion to the workforce). This symposium presents a Latin American perspective with data from different countries, on how to identify cultural factors and incorporate them to prevent mental illness and favor mental health. 1. Suicide and suicidal behavior, exhibit features peculiar to Latino populations that may vary within the ethnic group according to age, gender, religion and other factors. This symposium presents scientific evidence to support sound clinical models that help identify Latino patients at risk of suicide, prevent the different manifestations of suicide attempts, and suicide deaths. These models can be used with Latinos in the US and abroad. 2. Sociopathy and antisocial personality share clinical features. Most studies include prison samples; in stead, our team at the National Institute of Psychiatry in Mexico City, one of the most populated

cities in the world, has worked with a clinical sample (n=80) against a sample of controls paired in age and gender. Thorough evaluation to screen clinical features such as callous unemotional traits, substance use, childhood disorders (i.e. ADHD, conduct disorder), and active comorbidities is presented. 3. Latinos are not the exception among victims of the opioid epidemic. The substance and form of consumption have evolved from intravenous to smoked heroin, and most recently to oral narcotics. A sample of active patients (N=357), treated at a substance abuse clinic in rural California is presented to identify cultural and clinical factors that influence treatment success, treatment barriers, and prognosis. These clinical services (i.e. methadone replacement, drug counseling) exist in this underserved community (i.e. Imperial County) for almost 3 decades, and the patients served are highly represented by the poor, unemployed, and uneducated Latino. The symposium will close highlighting how individual cultural factors that shape the manifestation and perception of mental health and illness in Latinos, may not be unique to this population. Even though they may be present in other populations (i.e. Africans, Anglos, Asians), it is the understanding of how these factors interplay, what gives us the opportunity to have a positive influence in the prevention and recovery from mental illness among Latin

Hikikomori: Recent Findings and Their Relevance to American Psychiatry

Chairs: Tsuyoshi Akiyama, M.D., Ph.D., Takahiro Kato, M.D., Ph.D.

Presenters: Takahiro Kato, M.D., Ph.D., Tsuyoshi Akiyama, M.D., Ph.D., Alan R. Teo, M.D., Michael B. First, M.D., Tae Young Choi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The audience will learn about overview of hikikomori (severe social withdrawal); 2) The audience will learn about hikikomori and interventions to hikikomori in East Asia; 3) The audience will learn about the relevance of hikikomori to American psychiatry; 4) The audience will learn about nosological significance of hikikomori; and 5) The audience will learn about

culture bound and cultural general aspects about hikikomori.

SUMMARY:

The appearance of people in Japan, especially young men, who stopped going to school or the workplace and spent most of the time withdrawn into their homes for months or years, came to be seen as an increasing social phenomenon called Shakaiteki hikikomori (social withdrawal) by the late 1990s. A community-based survey published in 2010 reported that the prevalence of hikikomori was approximately 1.2% of the Japanese population, and in 2016 a Japanese cabinet report estimated people with hikikomori to be about 541,000 within the age range of 15-39. Hikikomori-like cases have been reported in other countries of varying sociocultural and economic backgrounds such as Hong Kong, Oman and Spain, and structured interviews have revealed the existence of hikikomori in India, South Korea and the US. Thus, hikikomori now crosses the limits of a culture-bound phenomenon and should be seen as an increasingly prevalent international condition. Our pilot study using the SCID-I&II has found that most cases with hikikomori are comorbid with various psychiatric disorders including avoidant personality, social anxiety disorder and major depression. In addition, autistic spectrum disorders and latent or prodromal states of schizophrenia may have some overlapping symptomatology with hikikomori. Thus, hikikomori has links to several mental illnesses, and we hypothesize that some common psychopathological mechanisms may exist in the act of “shutting-in” regardless of psychiatric diagnosis. To facilitate international researches, a novel assessment system of hikikomori has been created. As for intervention, there are more than fifty government-funded community support centers for hikikomori located throughout the prefectures of Japan, providing services such as telephone consultations for family members, the creation of “meeting spaces” for affected people, and job placement support. Family intervention has been provided to identified Hikikomori cases in South Korea as well. In this symposium, the overview and recent findings of Hikikomori, reports from Japan (Kato) and Korea (Choi), introduction of a novel assessment tool of hikikomori, discussion on the relevance of hikikomori to American psychiatry

(Teo), discussion on nosological significance of hikikomori (First), discussion on culture bound and culture general aspects of hikikomori (Akiyama) and commentary (Kanba) will be presented. At the end of the symposium, the audience will learn that hikikomori is in most parts culture general psychopathology and has a significant relevance to American psychiatry.

Lithium: The Old New Wonder Drug

Chair: Crystal T. Clark, M.D.

Presenters: Crystal T. Clark, M.D., Melvin McInnis, M.D., James W. Murrough, M.D., James H. Kocsis, M.D.

Discussant: James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) By the end of the symposium, participants will be able to describe long term renal and neurocognitive risks; 2) Participants will be able to explain how lithium prevents Alzheimer's disease; 3) Participants will be able to demonstrate an understanding of pharmacokinetics across pregnancy and the effect on lithium concentration monitoring and dosing; 4) Participants will be able to identify the genetic variants that are associated with lithium responders versus non responders; and 5) Participants will be able to describe the mechanistic features of lithium for bipolar disorder.

SUMMARY:

Bipolar Disorder (BD) is characterized by chronic remitting and relapsing episodes of depression, hypomania, and mania. Lithium treatment for mood disorder was first described in 1949 and it remains the gold standard of treatment for BD despite a number of alternative pharmacotherapies, such as anticonvulsants and atypical antipsychotics. Lithium is the drug of choice for BD because of its effectiveness and its unique function in reduction of the population-level risk of completed suicides. Although lithium is an old drug, new and emerging clinical indications and treatment approaches have made this drug new again. This symposium will 1) review the history of lithium treatment of bipolar disorder, information about new and emerging clinical indications such as prevention of Alzheimer's, present new data on the long-term renal and

neurocognitive risks of lithium treatment including methods for reduction of risk, and will review the results of recent comparable effectiveness studies of lithium versus antiepileptic drugs and atypical antipsychotic drugs in bipolar disorder. During the symposium data will be presented on 2) the benefit of lithium treatment to extend the effects of ketamine treatment for major depressive disorder and 3) pharmacokinetics of lithium concentration across pregnancy and postpartum and how to effectively dose lithium across pregnancy. Data on the mechanism of action of bipolar disorder shows that cellular model neurons using induced pluripotent stem cells (iPSC) derived from bipolar patients and compared with control subjects show significantly increased excitability (amplitude and transient of the action potential) compared health controls. Co-culturing bipolar neurons with physiological levels of lithium normalizes the excitability. Lithium also has an effect on the developmental patterning of the neuronal cultures derived from bipolar iPSC. Lithium increases the amount of dorsal cellular markers, suggesting that it has an effect on neuronal cell plasticity. Finally, we will present data on 4) the mechanism of lithium pharmacotherapy and the latest on how pharmacogenomics may be used to distinguish lithium responders from non-responders.

To Treat or Not to Treat Perinatal Mood and Anxiety Disorders: Both Options Carry Risks!

Chair: Teri Pearlstein, M.D.

Presenters: Carmen V. Monzon, M.D., Joanna V. Maclean, M.D., Elizabeth Ellen Flynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the potential negative effects on the fetus and infant of untreated depression as well as antidepressant medications during pregnancy and the postpartum period; 2) Describe the course of anxiety disorders through pregnancy and the postpartum period and the treatment options; and 3) Recognize the increased risks of bipolar and psychotic episodes during pregnancy and the postpartum period, and the risks associated with mood stabilizers and antipsychotic medications.

SUMMARY:

Women with current psychiatric disorders face difficult treatment dilemmas when they conceive. Studies report potential negative effects of untreated psychiatric symptoms on fetal growth, birth outcomes, and early infant development. Studies also confirm potential negative effects of psychotropic medications on fetal development, birth outcomes and early child development. This symposium will present up-to-date knowledge about the risks of untreated psychiatric disorders and the risks of medications. The first speaker will discuss depression during pregnancy. Antidepressants have been associated with potential increased risk of miscarriage, congenital cardiac malformations, persistent pulmonary hypertension of the newborn, low birth weight, preterm delivery, and neonatal adaptation symptoms. The growing mixed literature about antidepressant exposure and risk of autism will be reviewed. Since the possible increases in absolute risks are small, a pregnant woman's choices of medication treatment versus no treatment must be carefully weighed. Psychotherapeutic and alternative treatments are options that patients should consider in their decision making. The second speaker will discuss the risks of postpartum depression. Non-pharmacological treatment options for postpartum depression, including psychotherapy, will be discussed. The small number of controlled antidepressant and hormone therapy trials in postpartum depression will be reviewed. Current recommendations for psychotropic medication use with breast feeding will be presented. The third speaker will review the epidemiology, birth outcomes and treatment of anxiety disorders during pregnancy and postpartum. Panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, fear of childbirth, PTSD and traumatic delivery will be discussed. The fourth speaker will discuss bipolar disorder during pregnancy and postpartum and postpartum psychosis. The increased risks of a having a bipolar or psychotic episode during pregnancy and the postpartum period will be discussed. The existent data will be summarized about the risks of prenatal exposure to lithium, mood stabilizers and antipsychotics. The current recommendations about mood stabilizers and antipsychotic medications with breast feeding will be presented. This symposium will present case vignettes and encourage audience participation.

Addressing the Challenges to Treatment Engagement of Individuals With Serious Mental Illness: New York State Initiatives

Chairs: Neal Cohen, M.D., Ann Marie T. Sullivan, M.D.

Presenters: Marc W. Manseau, M.D., M.P.H., Iruma Bello, Ph.D., Molly T. Finnerty, M.D., Merrill Richard Rotter, M.D., John Allen

Discussant: Lisa Dixon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the significance of engagement in bringing about good treatment outcomes and enhancing recovery; 2) Describe a number of systemic and provider-level obstacles to good engagement with persons with serious mental illnesses; and 3) Apply the principles of engagement toward practical and implementable actions in treatment settings and the behavioral health system.

SUMMARY:

Participating in mental health care is a critical part of recovery for individuals with serious mental illness (SMI). However, many people with SMI fail to engage or drop out of treatment. Data from the U.S. National Comorbidity Survey Replication find that nearly one half of individuals with a serious mental illness had not received mental health treatment in the prior year (1) while over 70% drop out do so after their first or second visits (2). Furthermore, poor engagement can lead to worse outcomes, including but not limited to symptom relapse and re-hospitalization. Certain populations may be particularly challenging to engage, including people who have experienced a first episode of psychosis, individuals experiencing homelessness, persons with co-occurring SMI and substance use disorders (SUDs), and people with a history of involvement with the criminal justice system. To better understand engagement challenges and opportunities in the New York City (NYC) public mental health system, the New York State Office of Mental Health (NYS OMH) convened a summit on engagement on May 11, 2017. In attendance were leaders from dozens of key stakeholder organizations, representing local (NYS and NYC) government, mental health treatment providers, community support service providers, and

housing/shelter providers. Following the summit and drawing upon the challenges and principles of engagement identified at the summit, the NYS OMH has prioritized principles of engagement as an overarching approach—even a culture—within organizations and systems, rather than any one process or program. The symposium examines NYS OMH efforts to transform these themes into practical and implementable projects to improve the ability of providers across the system to effectively engage challenging populations including young adults with first episode psychosis; a web-based platform for supporting shared decision-making with both consumer-facing and provider-facing portals; and, efforts to re-engage those SMI individuals who have dropped out of treatment. Discussants will provide perspectives on the challenges of engagement with individuals diagnosed with SMI from both the consumer and provider perspectives underscoring the importance of promoting recovery-oriented skills and attitudes to enhance engagement (3).

Beyond Beds: The Vital Role of the Psychiatric Continuum of Care

Chair: Debra A. Pinals, M.D.

Presenters: Doris Fuller, Brian Matthew Hepburn, M.D., Ted Lutterman, David Covington, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe current data related to psychiatric beds across public and private sector settings and trends in that data; 2) Discuss the array of crisis response options available and needed in psychiatric services; 3) Describe national policy recommendations related to the need for a continuum of care and how to get there; 4) Delineate lessons learned with personal and professional experiences working across states and systems; and 5) Describe the critical importance of psychiatric treatment for persons with mental illness as part of the continuum of care.

SUMMARY:

Psychiatric bed access is a topic of national conversation. State public mental health systems are often a major focus of the conversation given the historic role of state hospitals. However, today

psychiatric beds are found in many venues beyond state public mental health hospitals. In fact, the meaning and definition of psychiatric beds, even public psychiatric beds, can vary and can mean many different things in different contexts. The imperative to look beyond beds to support the needs of persons with mental illness has become an increasingly recognized public health priority. Just like in medical contexts where inpatient care represents only one level across many needs of chronic illness management, in psychiatric care, inpatient settings are no longer the only proper level for all psychiatric care. This shift toward the concept of a robust continuum of care means that communities must examine local and state treatment needs and resources to help fill in any gaps in services to address the various needs. A continuum of crisis responses, crisis stabilization units, respite as a step up and step down option, and inpatient beds are among the levels of care necessary to meet individual clinical needs when and where they occur. Yet, definitions remain elusive and data related to public and private psychiatric beds has been hard to come by. In this symposium, we will present newly compiled data related to the national landscape regarding psychiatric beds and needs. We will describe the interplay between crisis services, police response, and jail diversion across the sequential intercept model, and personal and professional experiences across states and systems. Public mental health leaders will take the opportunity to present to American psychiatrists a vantage point that relates health policy, treatment needs, and exciting opportunities of great growth in psychiatric treatment at a time of program development. Individuals with serious mental illness deserve and require strong psychiatric services and the psychiatrists working in public mental health systems can be important advocates for patients and their needs in the national conversation. This symposium will begin with an overview from the national association of state mental health program directors regarding why a continuum of care is critical, followed by a review of newly compiled data on psychiatric beds, an overview of approaches to crisis services, a personal account of the journey through the public mental health system by a family member, and a review of ten key policy recommendations newly developed and

promulgated. Audience participation will be encouraged.

Choosing the Right Treatment for Substance Use Disorders

Chairs: Herbert David Kleber, M.D., Edward Vernon Nunes, M.D.

Presenters: John J. Mariani, M.D., Adam M. Bisaga, M.D., Elias Dakwar, M.D., Frances Rudnick Levin, M.D., Edward Vernon Nunes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize clinical signs/symptoms of abuse of sedative-hypnotic or stimulant medications, understand strategies to manage patients, and recognize risks/benefits of prescribing these medications; 2) Be familiar with medication-assisted treatments for opioid dependence, new approaches to medication induction and discontinuation, and strategies for transitioning patients between treatments; 3) Be familiar with research findings on the use of pharmacotherapies in combination with behavioral interventions for the treatment of problematic non-prescription stimulant use; 4) Understand impact of increased marijuana potency and availability and the subsequent need for improved treatments and become aware of treatments trials of pharmacological and psychological approaches; and 5) Understand major empirically supported behavioral treatments for substance use disorders, potential for combining behavioral and pharmacologic approaches, and obstacles in delivering these treatments.

SUMMARY:

Substance use disorders remain a major public health problem with financial costs and implications for health and criminal justice systems. Shifts continue to occur in cost, purity, and geographic spread of various agents. The fastest growing problem is the rise in heroin use (eg., in New York City, the heroin overdose death rate is the highest that it has been since 2003). In addition, cocaine use remains endemic, methamphetamine use has decreased, marijuana has a higher potency and greater availability, and marijuana use has lower age of onset. The symposium combines current scientific

knowledge with discussion of the most effective treatments for all of these agents. Emphasis is on office-based, and presentations include discussion of both pharmacological and psychological treatment methods. The speakers are nationally recognized experts in substance use disorders and will discuss practical and cutting edge treatments.

Digitally Driven Integrated Primary Care and Behavioral Health: How Technology Can Expand Access to Effective Treatment

Chair: Lori E. Raney, M.D.

Presenters: John Torous, M.D., Matthew S. Duncan, M.D., Michael Hasselberg, Ph.D., M.S., James H. Shore, M.D., Kristen M. Lambert, Esq., L.I.C.S.W., M.S.W.

Discussant: Peter M. Yellowlees, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe a continuum of models and accompanying technologies that can expand capacity to treat mild to moderate mental illness in the primary care setting; 2) Discuss the role of the psychiatrist in each of the technology solutions; 3) Explain how two or more models could be used in combination; 4) Understand liability issues that arise in situations of indirect consultation; and 5) List the key tasks of integrated care that are adaptable to technology.

SUMMARY:

There is a marked shortage of psychiatrists and other behavioral health providers which leads to reduced access to care, poor outcomes, and increased cost of overall care. Integrating primary care and behavioral health with the collaborative care model is an example of an approach that allows psychiatrists to leverage their expertise to help build the capacity to treat mild to moderate behavioral health disorders in the primary care setting and utilize direct evaluation for more complex patients. There are many tasks for the psychiatrist, primary care provider and behavioral care manager on the team that are required in delivering effective integrated care and workforce shortages limit the number of staff to do this. In addition to collaborative care, other solutions to treating mild to moderate behavioral health conditions in the primary case

setting have been developed over the past several years and can serve as adjuncts integration efforts. This symposium will focus on strategies that use various technologies to treat behavioral health conditions in primary care settings including eConsult, Project ECHO, apps and text messaging, telepsychiatry and telehubs. In addition, an inside perspective on the growing development of behavioral health technology nationwide will be presented. This symposium will describe a range of approaches using technology and new models to build capacity in the primary care setting, going upstream from telepsychiatry to include other solutions. Lori Raney, MD who chairs the APA Committee on Integrated Care will discuss core tasks of effective integrated care and the key tasks adaptable to technology, Matthew Duncan MD from Dartmouth will describe eConsult, Michael Hasselberg, PhD, APRN from the University of Rochester will discuss PSYCH Project ECHO (Extension of Community Healthcare Outcomes), Jay Shore, MD from the University of Colorado will discuss telepsychiatry and “tele-teaming” with primary care practices and John Torous, MD, who heads the APAs task force on mobile apps will discuss the use of behavioral health apps. David Bergman, former Director of Operations of a tech start-up, will give an industry perspective and Peter Yellowlees, MD, current president of the American Telemedicine Association will serve as the Discussant. Following individual presentations the speakers and audience will be asked to consider ways each of these approaches could be utilized not only as stand-alone models but also used in combination with each other, and will engage the audience in a discussion of how they could apply these models in their locations. Audience experience will be important as these are emerging approaches with developing evidence bases and sharing stories of success and challenges will be vital to the discussion.

Harnessing Technology for Clinical Research and Practice

Chair: Joel Sherrill, Ph.D.

Presenters: Rosalind Picard, Sc.D., Stephen Matthew Schueller, Ph.D., Colin Depp, Ph.D., Benjamin G. Druss, M.D.

Discussant: David Mohr, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how sensor-based and other technology-assisted assessment is being used to advance understanding of risk factors and illness trajectories; 2) Identify how mobile assessment can be used to improve the efficiency, timeliness, and accuracy of clinical and functional assessments; 3) Describe how mobile technology can be used to deliver interventions that are matched to individual needs and preferences; and 4) Identify opportunities for using technology, in conjunction with health record data, to support providers in delivering measurement-based care and quality monitoring/quality improvement efforts.

SUMMARY:

Rapidly advancing technology offers opportunities for improving assessment and detection of mental health conditions and new possibilities for prevention, treatment, and service delivery. This set of presentations will highlight programs of research that illustrate the potential of technology, not only for accelerating research, but also for improving the accuracy and efficiency of clinical assessment and for extending the efficiency, reach, and quality of mental health interventions and services. Technology-assisted assessment presents unprecedented opportunities for real-time, low-burden collection of behavior in natural environments that can be used to identify biomarkers and behavioral phenotypes, to understand and predict illness trajectories, and ultimately, to identify at-risk individuals for prevention or early intervention. The current presentations will illustrate applications of sensor-based, passive monitoring of individuals' autonomic state, activity level, location and social/environmental context, paired with other data collection (e.g., ecological momentary assessment) and computational approaches (artificial intelligence), for assessing and predicting mood and other health states and characterizing real-world functioning. Applications of technology for launching and conducting clinical trials and for supporting the delivery of interventions will also be presented, including approaches for rapidly refining interventions to improve their potency and

efficiency, for identifying and deploying more prescriptive treatment (e.g., using machine learning or other approaches to match individuals to research-informed approaches based on their needs and preferences), and for pushing out “just-in-time” interventions (e.g., sending information, prompts, or recommendations in real-time based on the individual’s current state and circumstances). Finally, the presentations will also highlight how technology can be harnessed to support providers in their use of measurement-based care, to enable patient-provider communication, to encourage the use of research-informed strategies (e.g., to facilitate guideline-concordant medication algorithms or promote fidelity in the delivery of evidence-based psychosocial interventions), to encourage patient adherence to medication and health-promoting behaviors, and to facilitate quality monitoring and quality-improvement efforts, in general. The discussion will address new opportunities and challenges associated with increasingly large streams of data collected via these various approaches and computational approaches that are being used to mine and analyze these data. Panel and audience discussion will also consider current applications of technology and potential opportunities for integrating technology-assisted approaches into to clinical practice and service delivery.

Immunotherapies in Schizophrenia and Bipolar Disorder

Chair: Robert Yolken, M.D.

Presenters: Mark Weiser, M.D., Faith Dickerson, Ph.D., M.P.H., Ragy Girgis, M.D., Mikhail Pletnikov, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of discussion the participants will be able to understand the rationale behind the immune hypothesis of schizophrenia and bipolar disorder; 2) At the conclusion of discussion the participants will have an understanding of the many groups of compounds that have been studied in schizophrenia and bipolar disorder; and 3) At the conclusion of discussion the participants will have an understanding of future directions of immune treatments in psychiatry.

SUMMARY:

The hypothesis that at least a sub-set of patients with schizophrenia and bipolar disorder the illness have an immunological, perhaps infectious etiology, has gained much attention over the years. Many treatment trials have been and are being performed, focusing on different components of the immune system. This symposium will review the scientific rationale of this hypothesis, review the studies that have been performed, and give an overview of present and future trials. Dr. Weiser will give an over-view of the theoretical basis of the topic and the clinical trials performed on compounds such as anti-biotics, anti-virals, NSAIDS and anti-oxidants, some positive and other not, including several meta-analyses. He will describe ongoing studies funded by the Stanley Medical Research Institute on monoclonal antibodies, prednisone and other compounds. Dr. Pletnikov will present infectious and genetic animal models on the effects of probiotic treatment on affective behaviors and cognition. Regional and cell-type specific gene expression signatures of various probiotics will be described. The role of neuro-immune-gut interplay in mediating behavioral and brain effects of probiotic treatment will be discussed. Dr. Dickerson will present results from a recently completed randomized controlled trial administering probiotics to patients with acute mania, showing that treatment with the probiotic compound resulted in a 2.5 fold reduction in the rate of re-hospitalization in the 6 month period following hospital discharge. Dr. Girgis will present data from a recently completed study on tocilizumab, a monoclonal antibody which binds IL-6. The study included 36 clinically stable, moderately symptomatic (PANSS > 60) individuals with schizophrenia who were administered 3 monthly infusions of 8mg/kg tocilizumab or placebo. No clinical effect was identified, however patients receiving tocilizumab had an increase on IL-6 and IL-8, and decreased CRP levels. Dr. Howes will present new data on the role of microglia in schizophrenia, showing that a marker expressed on activated microglia is altered in schizophrenia, and is linked to symptoms and structural brain changes seen in the disorder. He will present data on the effect of a drug that binds to a protein expressed by activated microglia on markers in schizophrenia. He will then

discuss an on-going trial of a monoclonal antibody designed to target aspects of inflammation in schizophrenia.

International Perspectives: How Government Policies Influence the Practice of Psychiatrists and the Rights of Their Patients

Chair: Saul Levin, M.D., M.P.A.

Presenters: Kym Jenkins, MB.Ch.B., Wendy Burn, Albert Bernard Janse van Rensburg

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Consider information on action to engage with the protecting of human rights of mental health and psychiatric care users in different parts of the world; 2) Appreciate the challenges of having to effectively engage as health and mental health advocate; 3) Refer to examples of plans, programs, guides and action taken by professional bodies in this regard in the UK, Australia and New Zealand, and South Africa; 4) Understand how government policies influence the practice of psychiatry and delivery of mental health services; and 5) Understand how psychiatrists can take a leadership role in influencing government policy.

SUMMARY:

In recent years examples have occurred of psychiatrists and psychiatric bodies involving themselves with local processes of reconciliation as well as in advocacy for the rights of mental health and psychiatric care users. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) seeks to position psychiatrists as experts in mental health and strives for the RANZCP to be a principal influencer of mental health policy. The RANZCP endeavours to enhance the profile of psychiatrists and psychiatry generally by developing and maintaining relationships and partnerships with governments and departments. It has been suggested that Medicine's and Psychiatry's relationship with society should be seen as a social contract. However, when having to effectively engage in care and human rights issues as health and mental health advocates, mental health care staff are often conflicted in terms of a dual loyalty to service management or funders. The RCPsych's Professional Practice and Ethics Committee has developed a

guide for psychiatrists. The Royal College of Psychiatrists is also working with the UK government to change mental health policies in order to improve the rights of mental health patients. In South Africa, issues of human rights abuses in mental health and psychiatry historically dates back to the Apartheid years and the time where other professional bodies such as the APA and the RCPsych called for the expulsion from the WPA of the then Society of Psychiatrists of South Africa (SPSA). Importantly, the South African Society of Psychiatrists (SASOP) has recently been required to find effective ways to advocate for human rights of mental health care users, compelled by the experience where more than 140 deaths of ex-Life Esidimeni long-term psychiatric patients were confirmed during 2016 and 2017 after their poorly planned transfer by a provincial Department of Health to ill-equipped and unlicensed NGOs. Presentations in this symposium will address psychiatrists' and Psychiatry's role and responsibility in the process of preventing and engaging with current, as well as remembering and reconciling past human rights abuses in mental health and in the community.

New Guideline Recommendations for Strengthening Psychiatric Practice

Chair: Michael J. Vergare, M.D.

Presenters: Laura J. Fochtmann, M.D., Catherine C. Crone, M.D., George Alan Keepers, M.D., Victor Ivar Reus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe potential benefits of using evidence-based guidelines in clinical psychiatric practice; 2) Discuss the ways in which the amount and quality of relevant research evidence shapes the development of clinical practice guideline recommendations; and 3) Name at least 1 APA practice guideline recommendation and discuss the balance between the benefits and harms of the recommendation.

SUMMARY:

Practice guidelines act as a vehicle for bringing state-of-the-art evidence, including new innovations in care, to the attention of clinicians, with the ultimate goals of improving quality of care and patient well-

being. Practice guidelines are of increasing value to psychiatrists by synthesizing advances in research and providing consensus-based guidance when research evidence is unavailable. With the shift to quality based payment methodologies, practice guidelines will take on even greater importance. This presentation will provide an overview of APA's practice guidelines program including current and planned guidelines relating to the treatment of alcohol use disorders, eating disorders, schizophrenia, and bipolar disorder. For each guideline, we will describe evidence that underlies key recommendations. In addition, we will discuss some of the challenges that arise in developing practice guidelines as well as approaches to implementing guideline recommendations in psychiatric settings. The program will foster an exchange with attendees about the recommendations and barriers to guideline use. Attendees will be encouraged to give examples of successes and challenges of adopting practice guideline recommendations in their own practices. They will be asked to share their preferences for accessing guidelines (e.g., web, textbooks, pocket cards, phone apps) and offer suggestions for making guidelines more useful in their daily practice. Plans for future guideline topics will also be discussed.

Online Psychotherapy Clinic: A New Method in Overcoming Treatment Barriers

Chair: Nazanin Alavi, M.D.

Presenters: Mohsen Omrani, M.D., Ph.D., Taras Romanovyc Reshetukha, M.D., Archana Patel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Compare traditional notions of mental health delivery with recent technological advances; 2) Learn techniques to use online psychotherapy in the treatment of patients with mental health problems; and 3) Use an online clinic for assessment and treatment of patients with mental health problems.

SUMMARY:

Introduction: Psychotherapy is one of the most widely investigated and practiced forms of treatment used to treat mental health problems. However, there are some barriers in delivering this

treatment, including long waiting lists, therapist shortage, and lack of access in remote areas. With internet use ever rising, it makes sense to explore alternative methods to overcome these barriers. This session presents a variety of studies that examine the efficacy of delivering psychotherapy (CBT & DBT) through an online clinic. Method: We have developed a revolutionizing Online Psychotherapy Tool (OPTT). OPTT is an online clinic that is designed to provide guided and secure therapy such as Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT). The division of psychiatry at Queen's University and University of Toronto provides different psychotherapy groups for individuals suffering from a variety of mental health problems. Applicants were offered the opportunity to choose the online clinic or live group sessions. All the patients participating in live groups or using the online clinic were assessed by different questionnaires for evaluation of the efficacy of the treatment. Results: Statistical analysis showed that this method of delivering psychotherapy significantly reduced patients' symptoms, decreased the number of people on waiting lists and increased the compliance of patients participating in psychotherapy. Conclusion: Despite the proven short and long-term efficacy of psychotherapy, there are significant barriers to delivering this treatment including limited access, stigma, and high cost. OPTT breaks these barriers and could impact therapy delivery in psychiatric practices across the nation.

Positive Psychiatry, Positive Psychology, and Positive Psychotherapy: Sociocultural, Clinical, and Global Perspectives

Chairs: Consuelo C. Cagande, M.D., Erick L. Messias, M.D.

Presenters: Consuelo C. Cagande, M.D., Shridhar Sharma, M.D., R. Rao Gogineni, M.D., Frank Aguilar, M.D.

Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand principles of positive psychiatry, positive psychology of making use of hope, wisdom, creativity, future mindedness, courage, spirituality, responsibility and perseverance; 2) Be familiar with sports psychology

focusing on virtues such as courage, optimism, honesty, perseverance and success; 3) Demonstrate positive psychodynamic, cognitive-behavioral, client-centered approaches using positive cognitions, life events and schema; 4) Describe principles and resiliency enhancing treatments for children and their families; and 5) Provide interventions using positive features of hope, responsibility and perseverance.

SUMMARY:

The Greek philosopher Aristotle's (384-322 BC) *Nicomachean Ethics* describes how to achieve *eudaimonia* – translated as happiness, flourishing, the good life, or contentment. Positive seeks to understand and promote well-being through assessment and interventions involving positive psychosocial characteristics (PPCs) in people who suffer from or are at high risk of developing mental or physical illnesses. Positive psychiatry has 4 main components: (1) positive mental health outcomes (eg, well-being), (2) PPCs that comprise psychological traits (resilience, optimism, personal mastery and coping self-efficacy, social engagement, spirituality and religiosity, and wisdom-including compassion) and environmental factors (family dynamics, social support, and other environmental determinants of overall health), (3) biology of positive psychiatry constructs, and (4) positive psychiatry interventions including preventive ones. There are promising empirical data to suggest that positive traits may be improved through psychosocial and biological interventions. (Jeste, Palmer and Boardman). Martin Seligman developed the *Foundations of Positive Psychology*. It focuses on optimism, life's worthiness of living, hope, wisdom, creativity, future mindedness, courage, spirituality, responsibility, and perseverance contribute to transformations of negatives and contribute to enhancement of happiness, autonomy, self-regulation and creativity. Positive Psychotherapy (PPT) is based on a resource-oriented and humanistic conception and focuses on "positive" perspective in their function to react with inner conflicts. Resiliency enhancing treatments focus on positive cognitions, positive projective identifications, positive schema and strength based approaches that can be useful in psychotherapy. Resilience in children and adolescents can be greatly enhanced by attention to the value of culture,

sporting and other activities, sensitive mentoring to build self-esteem, strengthening mental health and opening new social relationships. Outcome studies have shown positive psychology concepts to be promising in pediatric oncology, sexual health and HIV/STD, pregnancy, and unprotected sex. Positive religious and spiritual approaches can address some major existential problems that one faces in life and in addressing some "resistances" in treatment. In Sports Psychology and Psychiatry focus on virtues such as courage, optimism, honesty, perseverance, and success are fundamental tenants. Athletes are perhaps already accomplished "positive psychologists". For the most part elite athletes focus on their strengths and abilities and seek to realize their potential. Athletes use positive self talk and visualization of success. The symposium presenters will outline a framework for a science of positive psychiatry, positive psychology, positive psychotherapy and point to gaps in our knowledge that allows provision of more effective interventions.

Reigniting the Fire: Creativity in the Practice of Psychiatry

Chair: Vineeth John, M.D., M.B.A.

Presenters: Marsal Sanches, M.D., Ph.D., Stanley Lyndon, M.D., Antolin Trinidad, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Construct a working and practical definition of creativity; 2) 2. Learn how to examine our best creative moments in the light of circumstances which made them happen; 3) 3. Understand the principles of linguistic innovations and narrative creativity; 4) 4. List factors which led to serendipitous discoveries in Psychiatry; and 5) 5. Acknowledge the crucial need for embedding convergence sciences into Clinical Psychiatry.

SUMMARY:

Once considered the product of genius or divine inspiration, creativity — the ability to spot problems and devise smart solutions — is now recognized as a prized and teachable skill. Study of creativity is unfortunately not part of the formal curricular instruction in most academic medical settings. Despite significant breakthroughs in the neuroscience of insight, creativity is often an ignored

theme in academic medicine. Creativity moves beyond mere synthesis and evaluation, and is indeed the missing “higher order skill.” While traditional academic disciplines continue to be relevant and pertinent, it becomes increasingly important to develop creative strategies to reframe challenges and extrapolate and transform information, and to accept and deal with ambiguity. Creativity positively impacts clinical care, teaching effectiveness, and breakthroughs in research. Serendipity is a critical complement to creative mind set. It represents the ability to capitalize on the potential of accidental encounters. The field of Psychopharmacology owes its origin to many serendipitous discoveries. However, time constraints, limited opportunities for fresh observations and emotional exhaustion seem to have restricted our ability to cultivate serendipity in our chore filled and task oriented lives. Yet, opportunities abound to tap into the narrative creativity of our daily clinical encounters and thus deploy linguistic innovations to create meaningful experiences for both the physician and the patient. Creativity thus becomes a valuable survival tool to navigate the challenges of being a 21st century Psychiatrist. Being creative helps us build sacred spaces for reflection, and unleash the power of metaphor and analogy in our discourses. The symposium proposes to examine our current understanding of innovation and creativity, exploring the neuro-biological underpinnings of creativity, especially the fascinating research paradigms examining insight, default mode network, and top-down control. In addition, we will be introducing a case study detailing the discovery of *Helicobacter pylori* by two relatively unknown Australian physicians, Drs. Robin Warren and Barry Marshall, so as to highlight the various individual and institutional factors that promote creative breakthroughs including the power of serendipity. We would present two clinical cases which highlight the healing power of narrative creativity in our daily clinical practice. Finally, the symposium explores various insights from the field of convergence sciences in psychiatry resulting in innovations in both clinical and non-clinical realms.

Research to Practice Partnerships to Decrease Mental Health Treatment and Research Gaps

Chairs: Milton Leonard Wainberg, M.D., Ilana Pinsky

Presenters: Cristiane Duarte, Ph.D., M.P.H., Maria Lídia Chaúque Gouveia

Discussants: Maria Antonia Oquendo, M.D., Ph.D., Chris Smithers

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the global mental health treatment and research gaps in low- and middle-income countries and low resource settings in the US; 2) Understand how research capacity building can decrease both the global mental health treatment and research gaps; 3) Describe implementation research studies that can decrease the global mental health treatment gap; and 4) Understand how implementation science can inform policies to decrease the global mental health treatment gap.

SUMMARY:

The Global Burden of Disease Study 2010 not only corroborated findings from 1990 about the significant burden of mental and substance use disorders, but it also identified that the burden of these disorders had worsened. Mental and substance use disorders are now the leading cause of years lived with disability globally. Lack of human resources, poor to no financing, weak governance, and mental illness illiteracy and stigma all contribute to the global mental health treatment gap, which in comparison to high-income countries is worse in low- and middle-income countries and in low-resource settings of high-income countries. The goal to vastly spread access to care in low-resource settings requires multiple strategies to increase resources and capacity building to implement and scale-up effective interventions for the prevention and treatment of mental and substance use disorders. In spite of this well-documented global burden of mental illness, both inherent risks for and devastating impact on other comorbidities, including communicable and non-communicable diseases, efforts to address the global mental health treatment gap have been sparse in comparison to the well-funded (non-mental health) global health programs. Concerns about the low research to practice and policy yield are far worse in the mental health field, even in high-income countries. The global mental health treatment gap requires

investing in implementation science with participatory approaches and practice-based production of research in low-resource settings of high-income countries as well as in low- and middle-income countries. This Symposia will discuss methods to address the global mental health research and treatment gap.

The IMG and a Successful Career in Psychiatry

Chair: Rajesh R. Tampi, M.D., M.S.

Presenters: Antony Fernandez, M.D., Juan Joseph Young, M.D., Silpa Balachandran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the process of obtaining a competitive psychiatry residency position of your choice in the US; 2) Discuss methods of succeeding in a competitive residency program in the US; 3) Enumerate a plan to obtain a competitive psychiatry subspecialty fellowship position of your choice in the US; 4) Elaborate on methods to have a successful career in psychiatry in the US; and 5) Define important rules for IMGs to follow when in leadership positions.

SUMMARY:

International Medical Graduates (IMGs) constitute about 30% of the psychiatrists in the United States. The IMGs also constitute 25% of the members of the APA. The IMGs have had successful career as clinicians, educators, academics and researchers in psychiatry. In this symposium we will discuss how IMGs can obtain competitive psychiatric residency position in the US. We will also review ideas on how an IMG can be successful in these competitive residency position. In addition, we will describe methods of obtaining competitive subspecialty fellowship positions in psychiatry. We will then review data on how IMGs can have a successful career in psychiatry. We will then conclude by discussing important rules for IMGs to follow to be successful leaders in psychiatry. This symposium is intended to be a one stop shop where IMGs can learn about having a successful career in psychiatry in the United States.

Sunday, May 06, 2018

A Staggered Edge: Ethical, Legal, and Practical Challenges in End-of-Life Care for Patients With Serious Mental Illness

Chairs: Daniel Shalev, M.D., Philip R. Muskin, M.D., M.A.

Presenters: Jon Alan Levenson, M.D., Steven Z. Mostofsky, A.J.S.C., Jean-Marie E. Alves-Bradford, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate gaps in end-of-life and palliative care experienced by patients with comorbid serious mental illness and life-limiting medical illness; 2) Understand the unique ethicolegal challenges arising in the end-of-life care of patients with serious mental illness with respect to issues such as capacity, competence, and physician-assisted death; 3) Recognize the role of the longitudinal and consulting mental health teams and of the legal system in improving the end-of-life care of patients with serious mental illness; and 4) Develop a basic repertoire of innovative approaches to challenging ethical and legal situations arising in the care of patients with comorbid serious mental illness and life-limiting medical illness.

SUMMARY:

Approximately six percent of the population suffers from serious mental illness (SMI): mental illness that is chronic or recurrent, requires ongoing intensive psychiatric treatment, and significantly impairs function (1). People living with SMI die prematurely, primarily due to medical illnesses such as heart disease, cancer, chronic lung disease, and dementia (1–4). Despite the high chronic disease burden among people living with SMI, data suggest that people with SMI have less access to and receive lower quality end-of-life care. The gap in end-of-life care for people living with SMI is multifactorial. Among the many contributors are limited training for psychiatrists in palliative care, systems-level deficits in provision of concurrent psychiatric and end-of-life care, and stigma among medical providers towards patients with SMI (5). Many of the ethicolegal challenges arising regularly in the context of end-of-life care are exceptionally complex for patients with SMI. There is a scant literature providing guidance for the provision of high quality,

ethical end-of-life care for patients with SMI. Standards for end-of-life and chronic illness care are improving as palliative and supportive care services become increasingly integrated into our health system, but patients with mental illness risk exclusion from the benefits of such care without innovative strategies of care. In this presentation, we review what data exist on the care of patients with SMI at the end of life, and discuss the ethical, legal, and practical challenges of the end-of-life care of patients with SMI. We utilize both individual presentations and case-based panel discussion in order to convey both a conceptual and practical framework for caring for such patients. We begin by a brief review of the data and exploration of the common ethical challenges arising in end-of-life care for patients with SMI with a focus on conflicts between autonomy and beneficence in the provision of palliative interventions. We will then examine the ethics of physician-assisted death for patients with comorbid SMI and life-limiting medical illness given the current significance of this topic in medical, political, and public discourse. From there, we will discuss special challenges encountered by inpatient consultation-liaison and outpatient longitudinal mental health providers when patients with SMI develop severe medical illnesses. We then discuss legal challenges in the context of geriatric and medically ill patients with serious mental illness and/or dementia from the perspective of a mental hygiene judge. Finally, we will engage in a case-based panel discussion of a challenging case of a chronically psychotic patient with advanced cancer; speakers will comment on innovative approaches to the care of such a patient.

Empirical Evidence for Reducing Personality Pathology

Chair: James Harry Reich, M.D.

Presenters: Harold Warren Koenigsberg, M.D., James Harry Reich, M.D., Emil Frank Coccaro, M.D., Rona Hu, M.D., David Mark Allen, M.D.

Discussant: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The participant will better understand how emotional regulation in borderline personality disorder is related to neural networks

and cognitive control; 2) The participant will better understand natural variations in personality pathology and how this can be of use in the clinical setting; 3) The participant will better understand biases that may get in the way of interpreting literature on personality pathology; 4) The participant will better understand the relationship between impulsivity and violent behavior; and 5) The participant will better understand the relationship between psychosis and violence.

SUMMARY:

This symposium will focus on various approaches to reducing disability in patients with personality pathology. The first topic will be whether we can train borderline patients to improve emotion regulation by better engaging the neural networks implicated in cognitive control. Emotional instability is a key feature of borderline personality disorder and is associated with many of the behavioral and interpersonal symptoms. It has been shown that when borderline patients attempt to employ the highly adaptive emotion regulation strategy of cognitive reappraisal, they are unable to engage prefrontal regions as healthy individuals do. This talk examines whether guided practice in cognitive reappraisal can enable borderline patients to engage these regions as healthy subjects do. The effect of guided practice in borderline patients, avoidant personality disorder patients and healthy controls will be presented. The durability of these effects over several weeks will be presented. A second topic will be natural variations in personality symptoms and how that affects treatment. Although once conceptualized as something that started early in life and was largely unchangeable, it has gradually been recognized that personality pathology is much more flexible and nuanced. Personality pathology can change over the long term, have variations from time to time and may be exacerbated by stress. Methods of reducing exacerbations of personality pathology due to the stress of a syndrome disorder will be discussed. The third topic is the area of impulsive and violent behavior. It will focus on the relationship on biological, endocrine and environmental factors related to violent and impulsive acts. Impulsive aggression is common among those with personality disorders. Though significant histories of impulsive aggression are more

likely observed in those with borderline, antisocial, paranoid, narcissistic, and compulsive personality disorders. Although impulsivity is complex and multifactorial treatment with pharmacologic agents or with CBT appears to reduce impulsive aggressive behavior regardless of the specific personality disorder diagnosis. The fourth topic is the relationship of psychosis to violence. The talk will cover the association of psychosis and violence and variables that influence that association. In addition practical suggestions for dealing with the possibility of violent behavior in psychotic patients. Finally a speaker will examine False a priori Assumptions in Research Regarding Reducing Personality Pathology. These are the hidden, and perhaps not always valid, assumptions in personality disorders research. They include the: fundamental attribution error; ignorance of error management theory; confusion of performance and ability; ignorance regarding subtext and historical development in attachment relationships; confusion of abnormality with difference on fMRI scans; inherent problems with self-report data; and ecological fallacy.

Innovative Methods for Addressing Substance Use in Pregnancy

Chair: Kimberly Ann Yonkers, M.D.

Presenters: Constance Guille, M.D., Grace Chang, M.D., M.P.H., Ariadna Forray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge on the prevalence and consequences of substance use in pregnancy; 2) Understand the benefits and limitations of several screening instruments that may be used to detect substance use in pregnancy; 3) Appreciate new tools that may be used to help pregnant women change patterns of or reduce substance use in pregnancy; and 4) Summarize the outcomes of novel treatment interventions that have been tailored for women with substance use in pregnancy.

SUMMARY:

In 2013, there were over 3.9 million births in the US. 1 The National Survey on Drug Use and Health found that among pregnant women that year, ~5% used illicit substances, 9% consumed alcohol and 15%

smoked nicotine cigarettes.² Maternal opiate use in pregnancy has risen more than five-fold since 2000.³ Substance use in pregnancy compromises mother's health.⁴ It can also lead to a variety of adverse birth outcomes depending upon the substance used, including delivery of infants who are low birth weight, preterm or have malformations. 5-7 Recognition of substance use in pregnancy and engagement in treatment can be facilitated by innovative methods such as use of electronic interventions and provision of behavioral health care for addiction on site in reproductive health settings. In this symposium, Dr. Grace Chang will present results from a study funded by the Centers of Disease Control that recruited over 1200 pregnant women from three centers (Yale University, Wayne State and Massachusetts General Hospital) to determine the optimal screening measure to detect hazardous substance use in pregnancy. Women participating in this study were administered five substance-use screening questionnaires (NIDA quick screen, Wayne State Indirect Drug Use Screener, CRAFT, 4 Ps and Substance Use Risk Profile- Pregnancy) in counterbalanced order and a urine sample for substances was collected. Performance metrics of the questionnaires were compared and questions from all screeners were subjected to recursive partitioning analysis to build a new questionnaire for the detection of hazardous substance use in pregnancy. Dr. Kimberly Yonkers will present results from a NIH trial that screened women for substance use and provided a motivational interview to help participants reduce substance misuse (Screening, Brief Intervention and Referral to Treatment; SBIRT). The behavioral intervention was delivered either by a clinician or via a computerized avatar and was compared to usual care. Findings on the impact of the SBIRT intervention on substance misuse, compared to usual care, will be presented. Dr. Constance Guille will present results from a NIDA and Duke Endowment sponsored trial delivering in-person vs. telemedicine cognitive behavioral therapy and shared-decision making program to address prescription opioid use, misuse and abuse in pregnancy. The program was delivered in-person or via telemedicine to pregnant women presenting to an obstetrics practice for perinatal care. Between group (in-person vs. telemedicine) and within group

(pre-post program) outcomes related to substance use, misuse and abuse as well as pain, functioning, depression and anxiety will be presented. Dr. Ariadna Forray will present results from a trial that used smartphones to undo the attentional bias that perinatal women who smoked have toward smoking-related cues as a postpartum relapse prevention intervention.

Suicide Prevention in Medical Settings

Chair: James Churchill, Ph.D.

Presenters: John McCarthy, Ph.D., Gregory Edward Simon, M.D., Edwin Boudreaux, Ph.D., Cheryl King, Ph.D.

Discussant: Mark Olfson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the importance of systematically screening for elevated suicide risk in both general medical and emergency department (ED) settings; 2) Describe how screening offers opportunities to both augment clinical decision making and focus limited resources to enhance evidence-based service delivery; 3) Understand the implications and differences in computational approaches that calculate risk focused on population data versus models focused on risk following a specific medical visit; 4) Demonstrate a basic understanding of some of the approaches for identifying adults and teens presenting in EDs with elevated risks for suicidal behaviors; and 5) Understand how health-care data are being leveraged to inform clinical practice regarding suicide risk, decision making, as well as benefits regarding suicide risk identification and treatment.

SUMMARY:

In 2015, more than 44,000 Americans died by suicide; a figure that exceeds traffic accident deaths and doubles homicide deaths. This symposium will review innovative initiatives to improve risk identification in adults and youth presenting to emergency departments and other medical settings. Early results suggest practical opportunities for making progress of identifying and reducing suicide risk. One approach adopted by the Mental Health Research Network (MHRN) uses population-level health records to develop algorithms to identify

individuals with substantially elevated near-term suicide risk. These risk prediction models hold promise of immediate practical use by providing a powerful tool to augment clinical assessment and by guiding prevention strategies. Similarly, the Veterans Health Administration's (VHA) predictive model is based on patient clinical and demographic characteristics. Using this approach, the 0.1% of Veterans at highest calculated risk have a 30-40-fold increase in suicide rates over the next month and the 5% at highest calculated risk accounted for almost 25% of all suicides over one year. REACH VET was launched as a research-informed program in which patients in the highest calculated risk stratum are being contacted for appraisal of their current status, and reevaluation of treatment plans. Recognizing individuals seeking treatment for self-harm injury or expressing intent often visit EDs, research focused on screening for elevated risk and providing systematic treatment are discussed. Data from the ED Safety Assessment and Follow-up Evaluation (ED SAFE) study indicate that use of a brief, universal screening approach with all adults in the ED doubles the rate of suicide risk detection (from 3% to 6%). Using a stepped wedge service delivery implementation strategy, early lessons about screening and safety planning are emerging. Identification of risk in adolescent populations is particularly challenging and recent evidence suggests that fidelity of screening for youth is likely to be improved through computerized adaptive screening approaches. The ED Screen for Teens At Risk for Suicide (ED-STARS) study is examining ways to identify a minimal set of screening items with high sensitivity and specificity for youth. Importantly, considerations regarding the use of data that dynamically incorporate screening data for clinical triage discussions are considered. A growing body of evidence supports screening as a critical to identifying individuals with elevated suicide risk and in helping focus limited resources. General medical settings, and EDs specifically, provide a platform where quick, systematic screening of risk followed by targeted clinical assessment and brief interventions such as collaborative safety planning and post-discharge follow-up offers hope for reducing later suicidal behavior. Computational approaches offer opportunities to augment clinical

decision making and enhancing evidence-based service delivery.

Training Psychiatrists of the New Millennium

Chair: Andrea Fiorillo, M.D., Ph.D.

Presenters: Sheldon Benjamin, M.D., Dinesh Bhugra, M.D., Donald M. Hilty, M.D.

Discussant: Allan Tasman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the evolving target of psychiatry, changing from the treatment of the “insane” to the management of mental health problems, which is having an impact on training curricula of young gener; 2) To describe obstacles, limits and solutions of training in academic skills in psychiatry; 3) To highlight the importance of integrating neuroscience in the core curriculum of residents in psychiatry; and 4) To understand that educating psychiatrists of the new millennium is a challenging task, requiring a continuous adaptation of educators to the evolving requests of the society at large.

SUMMARY:

The context within which psychiatry is practiced is rapidly changing, with a significant impact on educational and training activities. The need to adapt training curricula to the new needs of modern residents and early career psychiatrists has been repeatedly claimed. Traditionally, the core of postgraduate training has consisted in a combination of clinical rotations in a variety of specialized services; nowadays, there is the need to include training on leadership skills, economic management, dealing with mass-media, managing conflicts of interest and training on academic skills. In particular, it has been reported a shortage of recruitment in psychiatry by young medical doctors, due to the misconception that psychiatry is an unscientific discipline and it is considered a waste of time compared to other medical disciplines. This bad image of our discipline negatively impacts on the decision to choose an academic career in psychiatry. Choosing an academic career is not an easy task since it is a highly demanding, time-consuming, and challenging activity. For this reason, mentors, senior researchers and professors should take care of the

subset of young psychiatrists who wish to develop a clinical academic career. In particular, nurturing the career development of trainees and young psychiatrists may be the key to strengthen psychiatry as discipline. Moreover, training the psychiatrists of the new millennium include the provision of training on topics such as neuroscience or neuropsychiatric skills, which have been neglected for a long time in psychiatric curricula. The integration of neuroscience with traditional psychiatric knowledge would improve diagnosis, treatment and prognosis of mental disorders, while positioning practitioners to utilize findings from emerging brain research. In particular, psychiatry traditionally is focused on helping individuals to construct meaningful life narratives and this must be integrated with the understanding of brain functioning, which represents one of the fundamental determinants of individuality. In conclusion, in this symposium we aim to describe that training the psychiatrists of the 21st century is a challenging task, which requires a continuous adaptation to the modern society in which we live.

When the Disaster Is Slow-Moving: Implications of Climate Change for Psychiatry

Chair: Lise Conway Van Susteren, M.D.

Presenters: Janet Lisa Lewis, M.D., Elizabeth Haase, M.D., Lise Conway Van Susteren, M.D., Carissa Caban-Aleman, M.D.

Discussant: H. Steven Moffic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Understand a tripartite framework of psychiatry’s relationship to climate change- understanding and addressing difficult realities, mitigation, and adaptation/resilience work; 2) 2. Appreciate psychiatric understandings of the mind relevant to climate change response and consider political and ethical demands on psychiatry in responding to this challenge; 3) 3.

Understand interventions to create sustainability in mental health care systems, addressing carbon footprint and the impacts of heat, sea level rise, and extreme weather; and 4) 4.

Be familiar with programs to promote “transformational resilience” to unavoidable climate risks at community and individual levels.

SUMMARY:

Understanding the interface of climate change and psychiatry depends both upon our understanding of psychiatric roles and upon our acceptance and understanding of climate change. The latter is like a slow moving disaster. Climate change brings an increased frequency and severity of disasters such as storms, floods, droughts, heat waves, outbreaks of disease, and forced migrations. Psychiatry has responded to acute disasters. However, in addition, because of the slow moving and progressive nature of climate change, this disaster brings with it a foretaste of our future, with consequent opportunities and responsibilities to engage in innovative mitigation and adaptation. The extent to which we accept a responsibility to engage in mitigation and adaptation work will depend upon how we conceptualize climate change. Human destabilization of the climate is a scientifically supported fact that, like other areas of science in the past, has been politicized. If climate change is seen as primarily political, then psychiatrists will be wary of professionally engaging it. However when climate change is recognized as a profound clinical and public health issue, as it has been by the American Psychiatric Association, then our obligations to vigorously engage in mitigation and adaptation efforts become clearer. This symposium will explore a tripartite relationship of psychiatry with climate. The first facet involves our clinical understanding of engaging with a difficult, brutal reality and of coming to better understand that reality. Overcoming denial and disavowal are processes well-known to clinicians. Climate change requires us to work with individuals and families affected by current realities and future implications of climate change. Psychiatry may also be required to contribute this understanding on a more comprehensive scale to promote public health goals. Particular realities we must understand as psychiatrists, because they affect our patients, include the emotional responses to rapid and extreme environmental changes, emotional responses to a threatened future, and the ethical issues for organized psychiatry in our responding on clinical and societal levels. The second facet of psychiatry's relationship to climate involves our responsibility to transform mental health care systems into environmental sustainability. This is

psychiatry's part in the mitigation effort. Mental health care has a substantial carbon footprint. The carbon footprint of different parts of mental health care have been assessed in Great Britain. The applicability of this data to our healthcare system and a vision of sustainability will be explored. The third focus is the contribution mental health professions can make to psychosocial adaptation and resilience. Climate change is now ongoing and our patients must adapt to risks which cannot be avoided. Innovative programs aiming to train communities and individuals in "Transformational Resilience" will be reviewed and discussed.

Women's Mental Health: Where Are We Now?

Chairs: Gail Erlick Robinson, M.D., Malkah T. Notman, M.D.

Presenters: Carol C. Nadelson, M.D., Gisele Apter, M.D., Ph.D., Nada Logan Stotland, M.D., M.P.H., Helen E. Herrman, M.D., M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how cultural attitudes, expectations and limitations continue to affect the mental health of women around the world; 2) Understand the relationship between women's reproductive health and their mental health; 3) Learn about the impact of violence on women's mental health; and 4) Assess the World Psychiatric Association's initiative to address women's mental health.

SUMMARY:

Although women's mental health is receiving attention around the world, how far have we come in moderating the factors that impact women's well-being? Governments make laws which not only often fail to protect women but can perpetuate systems that put women at risk for physical and mental harm. International data reveals women often lack education and access to resources including health care. Women's reproductive lives have a major impact on their mental health. Women's mental health during pregnancy and the peripartum remains underassessed, stigmatized and in desperate need of expert care. Peripartum illness frequently goes unrecognized. Even when diagnosed, women are often undertreated because fetal and infant welfare

come first. This belief ignores the importance of maternal well-being on infant development and prevention of impaired cognitive, behavioral, and emotional development during childhood and adolescence. Even in the United States, the availability and stability of access to mental health care for women is inadequate. Laws in several American states send pregnant women to prison when they are suicidal, or suffer from alcohol or substance use disorders, sometimes even as they seek treatment. Other laws grievously intrude into the doctor-patient relationship by requiring doctors to give patients inaccurate information about the mental health effects of induced abortion. Violence also has a major impact on women's mental health, resulting in depression, anxiety, PTSD, substance abuse, helplessness and hopelessness and suicide. A World Health Organization's study of 24 countries found that 20-50 % of women suffered physical abuse from their partners. In North America, a woman is more likely to be sexually assaulted, beaten or killed by a partner or former partner than any stranger. Women who escape from a violent relationship are at high risk of being stalked by their ex-partner. With immigration, honor killing and female genital mutilation have also been seen in North America. Laws, public and cultural attitudes, and lack of resources interfere with women's coming forward to complain or receive help for the psychological consequences of violence. The World Psychiatric Association's priority for action in 2017-2020 is the mental health of women and girls, particularly those living in adversity including women and girls living in poverty, displaced by conflict and natural disasters and those who experience violence and human rights abuse. Mental health is a neglected priority in health, child development and economic development. It is integral to women's overall health, and connected closely with the health and function of their families and communities. The goal is to understand the interconnected needs of women and men and contribute to interventions that work across genders as well as those that are gender specific. Cultural attitudes, expectations and limitations continue to affect the mental health of women around the world.

WPA Position Statement in Religion, Spirituality, and Psychiatry: Practical Implications

Chairs: Alexander Moreira-Almeida, M.D., John Raymond Peteet, M.D.

Presenters: Alexander Moreira-Almeida, M.D., Peter Verhagen, M.D., Christopher Cook, M.D., Ph.D., John Raymond Peteet, M.D.

Discussant: James Welton Lomax, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To know the guidelines proposed by the WPA Position Statement on Spirituality & Religion in Psychiatry; 2) To understand the challenges for the practical implementation of the Position Statement; 3) To recognize what has been implemented in North America and what is still needed; and 4) To be able to apply in clinical practice an spiritually sensitive approach.

SUMMARY:

Recently WPA approved a Position Statement (PS) on Spirituality and Religion in Psychiatry, that was a consequence of the increasing public and academic awareness of the relevance of spirituality and religion to health issues. It is an important step towards improving clinical practice in psychiatry and ensuring that the spiritual, as well as biopsychosocial, needs of mental health service users are met during the course of their treatment. A large number of empirical studies have been shown that values, beliefs and practices related to religion/spirituality (R/S) remain relevant to most of the world population and they have significant implications for prevalence, diagnosis, treatment, outcomes and prevention, as well as for quality of life and wellbeing. However, few medical schools or specialist curricula provide any formal training for psychiatrists to learn about the evidence available, or how to properly address R/S in research and clinical practice. This symposium will present the PS and its practical implications for research, education and clinical practice. In addition, it will discuss the ways in which psychiatry have (or have not) adopted policies in line with the WPA statement, and to consider the ways in which individual psychiatrists might be influenced by it in practice. The PS puts psychiatrists up to serious questions with regard to a professional attitude. Psychiatrists and all mental health professionals should be aware of the meaning of their own personal history, tradition and current

preferences with regard to religion and spirituality. The participants will get a clear picture of the consequences of this statement with regard to professional attitude. It will also discuss the seven proposals made in the Paper with respect to how they are currently being implemented in the North American context, and to what further work is still needed. Areas for consideration of religion/spirituality include: inclusion in history taking, diagnosis, and treatment; broadly based, especially clinical research; ethical considerations; cooperation with faith communities; vocational and professional implications; and recognition of its potential benefits and harms. Delegates will be invited to contribute their own responses and to share examples of the impact that the PS has had on clinical practice.

70 Years of Lithium: From Serendipity to Gold Standard in the Treatment of Bipolar Disorders

Chair: Michael Jay Gitlin, M.D.

Presenters: Michael Bauer, Lars Kessing, Thomas G. Schulze

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Know the efficacy of lithium for both treatment of acute mood episodes and for prevention of mood episodes; 2) Be aware of the potential effect of lithium in preventing dementia; and 3) Prescribe lithium skillfully, minimizing side effect burden and avoiding toxic effects.

SUMMARY:

More than 66 years from the breakthrough of identifying lithium salts as having antimanic and prophylactic efficacy, modern research serves to further substantiate lithium's position at the front-line in the treatment of bipolar disorder. When used correctly, lithium unquestionably produces the most dramatic benefits of any medication in psychopharmacology. Two recent meta-analyses confirmed its efficacy regarding the prevention of overall mood episodes, manic episodes, depressive episodes (dependent on the type of analyses performed) and acceptability (completion of study). The first talk will review lithium's efficacy both for acute mood episodes and in bipolar episode prevention. The second talk will present recent data

on the association of lithium in drinking water with the incidence of dementia from Denmark. These results suggest that long-term increased lithium exposure in drinking water may be associated with a lower incidence of dementia in a nonlinear way; however, confounding from other factors associated with municipality of residence cannot be excluded. The third talk will present the latest genomic analyses of lithium response from the international Consortium on Lithium Genetics (www.conligen.org). These will include state-of-the-art polygenic burden analyses, innovative explorations of the phenotypic space of lithium response, and circadian gene enrichment analyses. Finally, using select samples from the US, Israel, and Germany, the presentation will cover the latest transcriptomic profiling approaches to lithium response studies. Our last talk focuses on the optimal management of lithium side effects since these may underlie lithium's decreased utilization. Common side effects-nausea, tremor, polyuria can be managed. Potential toxicities-renal, thyroid and parathyroid- are also major sources of concern and proper management and treatment strategies will be discussed.

Addressing the Social Determinants of Mental Health Disparities

Chair: Denise Leung, M.D.

Presenters: Adriana E. Rego, M.D., Melina Sevlever, Ph.D., Grace Cortijo, L.C.S.W., Pantea Farahmand, M.D., Carolina Velez-Grau, L.C.S.W.

Discussant: Tami D. Benton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the mechanisms by which social determinants, health care systems, the community, the provider, and the individual can create disparities in mental health care; 2) Identify interventions that can be used to reduce the mental health disparities at the levels of the health care system, community, provider, and the individual; 3) Discuss various strategies to empower youth and families in their mental health treatment; and 4) Demonstrate an increased understanding of how increasing the awareness of provider views towards mental health disparities can improve quality and access to treatment.

SUMMARY:

There is an increasing awareness that the social determinants of mental health and resulting disparities – such as socioeconomic status (SES), social supports, access to health care services, and stigma – must be addressed in order to promote engagement in behavioral health services and subsequently improve the quality of life of those we serve. Mechanisms of disparities can occur at several different levels: regulation of federal and state policy, the health care system, the community, the provider, and the individual. To address health disparities, the Surgeon General report has recommended: 1) to increase cultural competence and communication of health care providers; 2) train and hire more qualified staff from underrepresented racial and ethnic minorities and people with disabilities, and 3) to enhance care coordination and quality of care. Our presentation addresses each of these efforts by focusing on the effect of mental health disparities in various populations to continue the dialogue on further educating clinicians to become more aware of the disparities faced by their patients and to enhance their quality of care. We will begin with an overview of the social determinants that affect mental health care of youth and their families. We will then present a program developed at an urban community child and adolescent psychiatry service to educate staff on mental health disparities and the resulting effects of the program for staff to provide culturally informed care, increase mentorship of minority trainees, and support clinicians in their efforts to increase quality of care to minority patients. We will then discuss how the use of a structured Psychosocial Assessment Tool (PAT) to assess a family's risks and resiliency and subsequent implementation of targeted case management services led to improved engagement in behavioral health services. The presenters will then address the effect of stigma on populations that commonly require mental health services and interventions to promote wellbeing. To address mental health disparities among patients with intellectual disabilities, we will review the currently available literature, discuss international recommendations, and provide a guideline for treating patients with intellectual disabilities on inpatient psychiatric units. With a specific focus on

substance use disorders, we will examine factors that may dissuade families from seeking care for their children – thus creating further health disparities – and interventions to engage these families in care. Finally, we will present a Photovoice Project, which is a Community-Based Participatory Research (CBPR) method that allows youth to voice and document their experiences through photographs. We will discuss the conditions that surround adolescents' daily lives in the context of mental health, their perceptions of behavioral health treatment, and response to Photovoice approach among adolescents at risk.

Climbing Out of Quicksand: Adapting the Critical Time Intervention (CTI) to High Utilizers of Psychiatric Emergency Room Services

Chairs: Anna Kostrzewski Costakis, M.D., Rachel Melissa Talley, M.D.

Presenters: Brian Youngblood, Heather Straccia, M.D., Mary Hanrahan

Discussant: Robert R. Moon

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the unique behavioral health needs of individuals in New York State based on recent needs assessments; 2) Describe the structure of the Critical Time Intervention (CTI) model, the history of its development, and prior research supporting its effectiveness; 3) Understand how the CTI model was modified to meet the needs of high utilizers of psychiatric emergency room services in the New York Presbyterian model, and the rationale; 4) Appreciate the impact this model has had on mental health and social services outcomes for the target patient population; and 5) Consider future directions for expansion of the CTI model to address the needs of other mental health patient populations at critical transition points in care.

SUMMARY:

Originally developed to address homelessness among individuals in New York with mental illness, the Critical Time Intervention (CTI) is a time-limited, evidence-based practice specifically focused on facilitating continuity of care for vulnerable populations at periods of transition. Seeing a

promising opportunity to leverage this intervention to address the needs of vulnerable individuals who frequent psychiatric emergency services, New York Presbyterian/Columbia University Irving Medical Center (NYP/CUIMC) proposed an innovative behavioral health crisis intervention based on the CTI model and implemented this intervention through the Delivery System Reform Incentive Payment (DSRIP) Program, a mechanism by which New York State is re-investing Medicaid dollars with a goal of reducing avoidable hospital use. In this presentation, we will demonstrate how NYP/CUIMC successfully adapted the CTI model to address the needs of patients who frequently use psychiatric emergency services. Often in flux, this population presents unique difficulties related to being in the midst of acute illness episodes and has not previously been a focus for CTI intervention. We will begin by characterizing the issue of high utilization of psychiatric emergency services in New York State, specifically describing a subset of the patient population at NYP/CUIMC as an example of this phenomenon. We will then describe the basic structure of the original CTI model and the history of the CTI's development. This will include a summary of prior data supporting this model's effectiveness, including outcomes of reducing homelessness among individuals with mental illness and cost effectiveness as compared to usual intervention. Next, we will introduce the structure of the NYP/CUIMC CTI team. We will specifically highlight how the basic CTI model was modified to incorporate a more diverse array of professionals and expanded into an inter-agency model collaborating with community organizations in order to holistically addressing an array of mental health and psychosocial needs for our target population. Finally, we will present the initial outcomes from implementation of this model, including impacts extending beyond reduced ER utilization such as improvement in mental health symptoms and improved access to social services. We will also present a series of case examples demonstrating specific psychosocial challenges that our model has addressed for our patients. In presenting these findings, we will demonstrate that the CTI model has potential for success in arenas beyond its original intent of addressing homelessness in individuals with severe mental illness, and can bridge crucial gaps in

a variety of realms related to critical transition points in behavioral healthcare. Our discussant will represent the perspective of the Office of Mental Health New York Field Office in considering future directions for this intervention.

Clinical Considerations From the APA Council on Consultation-Liaison Psychiatry Workgroup on QTc Prolongation and Psychotropic Medications

Chair: Margo Chrstiane Funk, M.D., M.A.

Presenters: Jolene Bostwick, Pharm.D., Abhisek Chandan Khandai, M.D., M.S., Richard J. Kovacs, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) List clinical risk factors for Torsades de Pointes; 2) Describe the approach to TdP risk assessment when prescribing psychotropic medications; 3) Describe clinical scenarios where it is appropriate to consult cardiology; and 4) Describe the limitations of medication databases to predict risk of TdP.

SUMMARY:

Over the past decade, there has been increasing attention by the medical community on the role of QTc monitoring in the prescription of psychotropic medications. There is a paucity of strong evidence to guide clinicians in best-practice prescription and monitoring of psychotropic medications that may increase the risk of Torsades de Pointes (TdP). To date there are no practice guidelines endorsed by the American Psychiatric Association (APA) or the American College of Cardiology (ACC) to address this concern. The APA Council on Consultation-Liaison Psychiatry, in collaboration with the ACC, convened a workgroup of experts to review the current literature and create a set of clinical considerations for the practicing clinician. In the first 120 minutes of this symposium, members of the workgroup will present clinical considerations as related to QTc prolongation and psychotropic medications. Dr. Chandan Khandai will present an introduction to TdP and QTc. Dr. Jolene Bostwick will discuss psychotropic medication classes and risk of QTc prolongation. Dr. Anand Panderangi will discuss the approach to TdP risk assessment. Dr. Richard Kovacs will discuss the approach to the electrocardiogram

(ECG), when to consult cardiology, and the role of pacemakers and implantable cardioverter defibrillators. Dr. Margo Funk will discuss special considerations for different clinical settings, including the intensive care unit and resource-poor settings. In the next 30 minutes, workgroup members will present a series of challenging clinical cases to encourage audience discussion and segue into the final 30 minutes of open question and answers with the panel of workgroup members.

Colton and Manderscheid a Decade Later: Are We Moving the Dial on the Mortality Gap?

Chair: Lori E. Raney, M.D.

Presenters: Benjamin G. Druss, M.D., Joseph John Parks, M.D., Ron Manderscheid, Ph.D.

Discussant: Elinore McCance-Katz, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the causes of premature mortality in the population with SMI; 2) List models of integration that have been successful in treating common medical conditions; 3) Understand the importance of care management and the role it plays in effective care; and 4) Describe the psychiatrists' role in oversight of chronic medical conditions.

SUMMARY:

In April 2006, a landmark study by Craig Colton PhD and Ron Manderscheid PhD revealed an alarming 10 year increase in the mortality gap for persons with serious mental illness (SMI) that occurred between 1991 and 1995. The conclusion was this health disparity now stood at 25 years of lost life for this population of patients and that natural causes such as cardiovascular disease were at the root of the problem. This finding was followed in October that same year by a report from Joe Parks MD and colleagues from the National Association of State Mental Health Program Directors (NASMHPD) describing approaches to begin the difficult task of unraveling the problem and proposing solutions based on the delivery models in the field of psychiatry at that time. In particular the report called for greater integration of primary care and behavioral health although no approaches with an evidence base in this population were available at

this time. The idea of “reverse” or bidirectional integration was in its infancy and the field was ripe for innovation. Much has happened since 2006 including SAMHSA awarding 187 Primary Care and Behavioral Health Integration (PBHCI) grants, Ben Druss MD publishing his Primary Care Access and Referral and Evaluation (PCARE) and Health Outcomes Management and Evaluation (HOME) studies, the Affordable Care Act including provisions for behavioral health settings to become 2703 State Plan Amendment (SPA) health homes, the American Psychiatric Association passing a position statement on the psychiatrists’ role in the overall health of patients with behavioral health conditions and a new white paper by the APA updating the field on the results of the above programs. In addition SAMHSA has awarded 8 states pilot grants to create Certified Community Behavioral Health Centers and the 21st Century Cures Act directed the development of an Interdepartmental Serious Mental Illness Coordinating Committee (ISMIC) that is also looking at the health disparities in this group. It has been over a decade now since the Colton and Manderscheid study was published and the question for this symposium is do we have proof any of these efforts are actually working and if not where do we go from here to address what has been called the “scandal of premature mortality”? This symposium brings together major players in the field including Drs. Manderscheid, Parks and Druss who have been instrumental in the initiatives around this issue as well as Lori Raney MD who chairs the APA Committee on Integrated Care whose group developed the APA position statement. Ellie McCance-Katz MD, the Assistant Secretary of Mental Health and Substance Use will be the Discussant and give a government perspective of where interventions are occurring at the national level.

Come on, If You Were Suffering From Dissociative Identity Disorder I’d Have Noticed Something: Cross-Cultural Trauma-Informed Diagnosis and Treatment

Chair: Richard Joseph Loewenstein, M.D.

Presenters: Roberto Lewis-Fernandez, M.D., Vedat Sar, M.D., Bethany Brand, Ph.D.

Discussant: Steven Samuel Sharfstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand that the clinical phenomenology of DID is different than media stereotypes; 2) Identify the salient differences as well as similarities between pathological possession forms of DID and non-possession forms; 3) Learn to apply the principles of phasic, trauma-informed/dissociation-informed treatment for DID; and 4) Develop greater cultural competence in working with severely traumatized populations in both Western/secular and non-Western/non-secular populations.

SUMMARY:

Dissociative Identity Disorder (DID) is a severe, chronic psychiatric disorder that, based on international studies, may affect 1-3.5 % of the general population, and, when screened psychometrically, is frequently found among psychiatric inpatients, outpatients, partial hospital and substance abuse patients, and patients in psychiatric emergency departments. DID patients have high rates of severe co-morbidities such as PTSD, Major Depressive Disorder, and Substance Abuse. DID patients have high rates of suicidal and severe self-destructive behaviors, as well as reports of completed suicide. In epidemiological studies in the US and Europe, these patients show significant psychosocial impairment. Unfortunately, most mental health providers get their training in DID from the media. Thus, these patients are commonly misdiagnosed, averaging 5-12 years in the mental health system, and 3-4 other psychiatric diagnoses, before correct diagnosis. DID patients are often found among patients labeled “treatment resistant” – for other disorders. DID patients have very high rates of repeated childhood maltreatment and adversity, usually beginning before the age of 6, as well as very high rates of repeated sexual assault, intimate partner violence, and other forms of victimization in later life. Data strongly suggest that DID is a complex, posttraumatic developmental disorder. This is a profoundly traumatized, underserved population, that is subject to severe forms of stigma due to highly inaccurate media depictions of the disorder. The DSM-5 Work Group identified a pathological possession form of DID in non-Western/non-secular cultures, also associated with higher rates of childhood and adult trauma

compared with controls. Cost-efficacy and outcome studies of DID treatment consistently show major cost reductions and positive outcome if appropriate trauma-informed/dissociation-informed treatment is provided. In this presentation, we review basic information on differential diagnosis, epidemiology, psychological structure, neurobiology, and genetic data on DID. We then review the data on pathological possession forms of DID that led to the DSM-5 definition of DID, as well conceptualizations of this and related dissociative disorders in ICD-11. We then review extensive data on DID from Turkey where patient presentations vary among pathological possession, conversion disorder, Western/secular, and mixed presentations. Finally, we review outcome data from the large, international, prospective, longitudinal Treatment of Dissociative Disorders (TOPDD) Study. The overarching goal of this symposium is to help with better case-finding of these patients; promulgation of evidence-based, trauma-informed/dissociation-informed treatment methods; reduction of stigma; and development of cultural competence in working with both Western/secular and pathological possession forms of DID.

Conceptualizing and Promoting Human Flourishing: What Are the Implications for Psychiatry?

Chair: John Raymond Peteet, M.D.

Presenters: Tyler VanderWeele, Ph.D., Claude Robert Cloninger, M.D., Dilip V. Jeste, M.D., Gerrit Glas, M.D., John Raymond Peteet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the empirical basis for a broad conception of human flourishing; 2) Identify the determinants of human well being supported by psychiatric research; 3) Relate objective, subjective and dynamic conceptualizations of human flourishing; and 4) Recognize the role of psychotherapy in promoting virtues involved in recovery.

SUMMARY:

Psychiatrists treat disease but also promote well being. Yet defining human flourishing in measurable ways remains challenging. A 2017 paper in the Proceedings of the National Academy of Sciences by

Tyler VanderWeele suggested that research into human flourishing include not only the domains of physical and mental health, but happiness and life satisfaction, meaning and purpose, character and virtue, and close social relationships. This symposium explores the implications of this conceptualization for psychiatric research, theory and practice. Dr. VanderWeele of Harvard's School of Public Health will review the empirical literature in an effort to identify major determinants of well being, propose ways of measuring human flourishing and discuss the implications of this understanding of flourishing for future research. Dr. Robert Cloninger, a research psychiatrist from Washington University in St. Louis will discuss the determinants of mature personality development and well being, including evidence for the importance of self transcendence, altruism and spirituality. Dr. Dilip Jeste, a professor of psychiatry at the University of California, San Diego, and co-editor of *Positive Psychiatry: A Clinical Handbook* will discuss his research on positive traits across the adult life span, with a particular focus on wisdom. His work suggests that wisdom is a complex trait useful to the individual and society. Its components include prosocial behaviors like compassion and empathy, emotional regulation, self-reflection, social decision making, value relativism, and spirituality. A putative neurocircuitry of wisdom involving prefrontal cortex and amygdala is the basis for a new scale for measuring wisdom. Dr. Gerrit Glas, a psychiatry residency training director and Professor of Philosophy of Neuroscience at the University of Amsterdam will review how divergent concepts of quality and quantity of life are used in the medicine. There are subjective definitions (i.e. from the perspective of the person experiencing 'flourishing' or quality); there are attempts to make lists of empirically verifiable criteria of flourishing (quality). And there are attempts to transcend this split between subjective and objective definitions, capturing flourishing in more dynamic and dispositional terms: as someone's inner nature that expresses itself authentically under certain favorable circumstances; or as 'flow'; or 'balance', or (inner) peace, or optimal development. Finally, Dr. John Peteet, a C/L psychiatrist at Harvard will consider the role of psychotherapy in promoting virtues. Individuals with personality disorders or depression may need to develop certain self and

other regarding virtues as therapeutic goals, while the process of working through problems in psychotherapy may involve the cultivation of certain virtues such as responsibility. Psychodynamic, cognitive behavioral and mentalization based approaches can all promote ethical growth.

Cooperation Between American Psychiatrists and Colleagues in Developing and Emerging Countries

Chair: Uriel Halbreich, M.D.

Presenters: Eliot Sorel, M.D., Dinesh Bhugra, M.D., Helen E. Herrman, M.D., M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) to understand common denominators in International Psychiatry and appreciate cultural sensitivities as well as differences among populations in need; 2) To be familiar with some of the procedures and means for effective International collaborations; 3) To highlight the APA Global Mental Health initiatives and capabilities; 4) To understand barriers and obstacles for collaborations and think creatively on solutions; and 5) To identify and appreciate the merits of care-integration, its International collaborating potential, its contribution to enhancing health systems performance, access, quality and sustainability of care.

SUMMARY:

The facts and problems Psychiatrists and allied Mental Health Professionals in most countries around the Globe share similar issues. Preeminent sources of distress of communities and individuals are: shaken sense of individual safety and stability, waves of immigrants and refugees with cultural, religious and socio-economic backgrounds that clash with their targeted refuge society. Waves of populations' shifts within countries—mostly from rural areas to urban industrial centers. These contribute to increased social disparities and potential unrest. In most, if not all countries, the Human capital of Psychiatrists and their available resources are not adequate for optimal solutions. Statistics on magnitude of the problems are compiled annually by the WHO, The Gallup survey and other UN, NGOs and Governments as well as commercial agencies. Their presentations provide

for multitudes of concerns. Attempts to overcome the problems vary from country to country. The APA Global Integrated Care survey currently conducted by the APA Council on International Psychiatry is expected to provide opinionated descriptions of partnerships of Psychiatrists in many countries with their colleagues from other disciplines--in construction of Integrative Care. WPA-and WHO-led efforts are future –oriented documentations. Drawing The roadmap for solutions The WPA, which is an Association of most National Psychiatric Societies, targets in it`s 2017-2020 work plan people who face adversity and disadvantage. Partnerships to respond to ongoing processes as well as conflicts and humanitarian emergencies-are formed. Psychiatrists in many countries are looking for American Psychiatry as a model for diagnosis, treatment and management of Mental Disorders. The APA is the largest National Association. The USA has some of the most established prestigious clinical and research Institutes. Presumably it commands the best resources, although probably there are differences between the few centers of excellence and most community services. Being a magnet for professionals from all over the World, America is blessed with diversity of Psychiatrists with multitude of cultural backgrounds and sensitivities. In a multi-cultural World, multi-cultural open-minded group of Psychiatrists as is the CGP, forms a bridge between the USA and the rest of the World, between the” Haves and Have-not” ,Realizing that in our current world there are no isolated local problems—They are problems for all of us.

Flourishing in the Community Through Recovery-Oriented Cognitive Therapy

Chair: Paul Grant, Ph.D.

Presenters: Aaron Brinen, Psy.D., Irene Hurford, M.D., Ellen Inverso, Psy.D.

Discussant: Lawrence Alan Real, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how an evidence-based approach (recovery-oriented cognitive therapy) operationalizes recovery and resiliency; 2) Identify three research findings supporting the recovery-oriented cognitive therapy approach; 3) Name three interventions to access the adaptive

mode; 4) Identify ways recovery-oriented cognitive therapy efforts aid first episode teams successfully coordinate their efforts; and 5) Identify signs that Recovery-Oriented Cognitive Therapy promotes a culture change.

SUMMARY:

This symposium will focus on recovery-oriented cognitive therapy (CT-R) for serious mental illness, an empirically-supported treatment that operationalizes recovery and resiliency in a person-centered, strength-based way. CT-R applies across the range of severity, and includes a way to understand the challenges (low energy, disorganization, grandiosity, hallucinations, aggression, self-injury, etc.) that can keep them from engaging and getting the life of their choosing, along with strategies for action to promote that life to its fullest. The basic science of CT-R is rooted in the cognitive model of schizophrenia: the self is weak, vulnerable, ineffective, and worthless; others are controlling, dangerous, and rejecting; the future is uncertain and forbidding. A series of research studies will be presented that support the role of dysfunctional beliefs and negative self-concept in negative and positive symptoms and impoverished functioning. This science will then be translated into practice. CT-R is active. Beliefs are corrected experientially through productive and enjoyable interactions with others (i.e., staff and other individuals). Engagement by therapists and staff, collaborative goal setting, and galvanizing action plans prime motivation, thus alleviating social avoidance and inertia; the process leads to a series of powerful success experiences that activate underlying adaptive beliefs while deactivating stultifying dysfunctional beliefs. The approach will be illustrated with case examples. Evidence supporting the efficacy of CT-R will be presented next. Results from a randomized controlled trial with blind evaluations showed superiority of CT-R at end of treatment and at follow-up. Additionally, belief change correlated with the improvement in outcomes across the trial. CT-R is readily teachable and has been implemented in a variety of settings. The seminar will next focus on how CT-R can be successfully introduced to realize the potential of early episode teams. The approach provides an opportunity for coordinating team members' efforts.

The humanistic core of CT-R empowers the emerging adult to be the expert in his or her own resiliency and recovery, supported by the team. This will be illustrated with case examples and outcome measures. Next, the seminar will focus on adaptations of CT-R to multidisciplinary team-based service delivery settings (forensic and civil inpatient units, Assertive Community Treatment teams, community residences). The approach energizes the therapeutic milieu, transforms treatment planning, enlivens action-oriented therapy, and promotes continuity of care across the network of service delivery. Particular attention will be paid to the culture change generated within organizations by the training. Outcomes will also be presented for implementation in large mental health systems.

Innovations in Psychosomatic Medicine: Promoting Well-Being in the Medically Ill

Chair: Andrew J. Roth, M.D.

Presenters: Janna S. Gordon-Elliott, M.D., Yesne Alici, M.D., Andrew Edelstein, M.D., William Breitbart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Become familiar with the importance of meaning, as a component of spiritual well-being, and its relationship to depression, hopelessness and desire for hastened death; 2) Become familiar with a structured, didactic and experiential 8 session intervention for advanced cancer patients aimed at sustaining or enhancing a sense of meaning in the face of terminal illness; 3) Recognize clinical scenarios where mind-body medicine practices are useful and feasible for patients in medical settings; 4) Become familiar with the assessment and management of cognitive changes following cancer and cancer treatments; and 5) Recognize that while mental health needs of the palliative care population is paramount, integration of a psychiatrist could be highly effective.

SUMMARY:

The care of the medically ill presents a unique challenge for psychiatrists. The high prevalence of depression, anxiety, and cognitive changes in the medically ill require psychiatrists to be well equipped. This symposium will provide an overview

of innovations in psychosomatic medicine that promote well-being. The first presentation will provide an overview of existential issues in end of life care, with an emphasis of the important role of “meaning”. A novel counseling intervention for patients with advanced cancer, entitled “Meaning Centered Psychotherapy (MCP)” will be described. A detailed description of the manualized intervention will be provided. The results of randomized controlled studies with MCP intervention will be presented which demonstrate that MCP enhances spiritual well being and meaning, improves quality of life, decreases depression, anxiety, hopelessness and desire for hastened death. In addition, adaptations of Meaning-Centered Psychotherapy will be described. The second presentation will discuss mind-body medicine (MBM) practices. MBM practices have been shown to bring symptomatic benefit for a range of physical and emotional symptoms, and may be particularly useful in the management of medically ill patients for whom standard treatments have limited feasibility. This presentation will provide an overview of common MBM practices, including review of mechanism of action and utility, and application of these techniques for medically ill patients at the bedside. Audience members will be led in a brief experiential component. The third presentation will review a highly prevalent challenge encountered in cancer patients, commonly referred to as “chemobrain”. This presentation will provide an overview of cancer and cancer-treatment related cognitive changes. Innovations in the assessment and management of this challenge facing cancer survivors will be described from nonpharmacological therapies to different pharmacological options, and neuromodulation strategies such as transcranial direct current stimulation. The fourth presentation will present an innovative collaborative care model in palliative care settings. The collaborative care model provides opportunities to offer behavioral healthcare to underserved populations. This is particularly relevant in the palliative care settings given the high prevalence of depression, anxiety, suicidal ideation, and delirium. This presentation will describe a collaborative care model of integrating psychooncology into palliative care through a multidisciplinary patient conference, communication skills teaching, didactic program, and selective

supervision of cases. This talk will also outline areas of collaborative research, including use of ketamine to treat comorbid pain and mood symptoms, tracking and treating serotonin syndrome, and establishing pain treatment guidelines for patients with history of substance use disorders.

Innovations in Psychotherapy for PTSD: Beyond Exposure

Chair: John C. Markowitz, M.D.

Presenters: Marylene Cloitre, Ph.D., Barbara Milrod, M.D., Janice Krupnick, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will gain a broadened perspective on the range of available treatments for PTSD; 2) Participants will learn the empirical support for a range of psychotherapies for PTSD; and 3) Participants will appreciate the importance of affect as an alternative and complement to exposure in treating PTSD.

SUMMARY:

Psychotherapy is the key to treating posttraumatic stress disorder (PTSD). Psychotherapy of posttraumatic stress disorder (PTSD) has long been dominated by exposure-based therapies, which have a strong evidence base both in clinical trials and in an animal fear-extinction model. The weight of evidence for exposure treatments has led some treatment guidelines to recommend them to the exclusion of alternatives. Nonetheless, exposure therapies (like all psychiatric treatments) are not panaceas: not all patients benefit from them. Many patients and some therapists find exposure-based therapies grueling and refuse to undertake them. It therefore benefits patients and therapists to have an array of available, efficacious psychotherapeutic treatments for complex conditions like chronic PTSD. In this symposium, psychotherapy experts will present a range of affect- and relationship-focused alternatives to exposure-based approaches and the growing evidence base supporting them. Dr. Marylene Cloitre will present her development and testing of Skills Training in Affect and Interpersonal Regulation (STAIR), a modular treatment effective in reducing PTSD and improving functioning that can be used alone or in combination with exposure

therapies. Dr. Barbara Milrod, an expert in Panic-Focused Psychodynamic Psychotherapy (PFPP), which she has demonstrated is an efficacious treatment for panic disorder, will describe its adaptation and feasibility testing in an ongoing study of veterans with PTSD at three VA hospitals. Dr. Jan Krupnick will describe her work with Interpersonal Psychotherapy (IPT) as a treatment for veterans with PTSD in a large, two-site VA study. Dr. John Markowitz will present results from a randomized trial comparing individual IPT to Prolonged Exposure and Relaxation Therapy, including a new finding of sexual trauma as a moderator of differential outcome. The presenters will then conduct a panel discussion of the role of affect -- as an alternative to fear extinction -- in the treatment of PTSD. Audience discussion will follow.

Issues and Controversies Around Marijuana Use: What's the Buzz?

Chair: Godfrey David Pearlson, M.D.

Presenters: William Iacono, Ph.D., Sue A. Sisley, M.D., Michael Stevens, Ph.D., Deborah Hasin, Ph.D., Deepak D'Souza, M.D.

Discussant: Godfrey David Pearlson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of recent findings in a number of key areas, from investigations into effects of recreational and medical marijuana; 2) Learn how this evidence either supports (or fails to support) frequently-made claims regarding both beneficial and detrimental effects of marijuana use; 3) Appreciate that many important questions regarding marijuana's effects still remain to be answered; and 4) Update knowledge on marijuana's putative risks and benefits in the psychiatric arena.

SUMMARY:

Nearly all psychiatrists have strong opinions regarding beneficial and/or detrimental effects of recreational and medical marijuana use, but there remain many misconceptions about the drug's effects and associated risks. This symposium assembles experts who have conducted some of the recent key research on these issues, to focus on some of these controversial topics, with the aim of

summarizing available evidence and educating the audience broadly on themes where many psychiatrists have clinically-relevant questions. For example, there is apparent widespread agreement that frequent, high-dose cannabis exposure during the teen years may result in permanent declines in intellectual functioning, but the extent of any causal relationship is still a point of contention (Iacono). Nobody would argue that acute marijuana smoking improves on-road driving ability, but exactly what relevant abilities are impaired, exactly how long after drug use such impairment persists and how it can be reliably detected by law enforcement in routine roadside testing are all largely unexplored (Stevens). Medical marijuana has been recommended by some clinicians to reduce anxiety and as being therapeutic for cases of PTSD. However, some individuals experience increased anxiety or panic attacks as a result of using the drug. What's the evidence from recent clinical trials in identifying which individuals with PTSD might benefit from treatment with medical marijuana, and under what circumstances? (Sisley). Prevalence estimates of cannabis use disorders vary, and it's important to address who might be at particular risk, and the relationship of the number of cases in the community to passage of medical marijuana laws and recreational cannabis legalization/decriminalization (Hasin). Finally, the relationship between cannabis and psychosis risk is frequently debated. Who are the individuals who might be at particular risk and how are they identifiable? What is the evidence for putative genetic risk markers? Is marijuana precipitating psychosis only in individuals who are already at high risk for developing the condition, but eliciting the illness at an earlier time point – and if not, why are incidence rates of schizophrenia apparently not rising? (D'Souza).

Maternal Mental Health: New Advances in Research to Help Women Now

Chairs: Catherine Monk, Ph.D., Samantha E. Meltzer-Brody, M.D.

Presenters: Nancy Byatt, D.O., M.B.A., M.S., Katherine Leah Wisner, M.D., Camille Hoffman-Shuler, M.D., M.Sc., Myrna M. Weissman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this symposium, each participant will understand the high rates of maternal mental illness as well as the lethality of these conditions; 2) At the conclusion of this symposium, each participant will be able to describe barriers to mental health care during the reproductive period and new treatment approaches that overcome them; and 3) At the conclusion of this symposium, each participant will demonstrate knowledge of risk factors for maternal depression and the different subtypes that are emerging in research.

SUMMARY:

Nearly 4 million mothers deliver live births each year in the United States, ~14% will develop major or minor depression within the first four months postpartum and similar numbers (10%) will experience depression in pregnancy. These numbers dwarf prevalence rates for gestational diabetes (2-5%) and are comparable to preterm birth (11.4%). Importantly, maternal mental illness can be lethal. In developed countries, suicide is a leading cause of death during pregnancy and the first year postpartum when the rate is between 2-3 women per 100,000 live births in the US, Canada, and the UK; ~1/19 maternal deaths stem from behavioral health issues. This symposium brings together leading clinical researchers to address the current knowledge of maternal mental illness and new treatments to help women now. Presentation #1 will discuss data from a large scale, international consortium that empirically identified for the first time three clinically relevant phenotypic subtypes of perinatal depression. This work characterized these subtypes by time of symptom onset and severity within pregnancy and three postpartum periods as a mechanism for tailoring treatment on the basis of subtype. Presentation #2 addresses the nine common causes of maternal death categorized as behavioral or self harm, suicide, accidental drug overdose, homicide, and trauma-related deaths from interpersonal violence, and utilizes a systematic review of clinical and public data to ascertain known psychiatric diagnoses and assess discontinuance of therapies related to these deaths. Presentations #3-5 describe novel interventions. #3 reviews results from a highly successful statewide

program, the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms) that impacts >80% of deliveries by addressing known treatment gaps as follows: 1) provider trainings and toolkits on evidence-based guidelines for screening, assessment and treatment of perinatal mental illness; 2) access to real-time telephonic psychiatric consultation for providers serving pregnant and postpartum women; and, 3) care coordination. #4 Introduces a new treatment model, Interpersonal Counseling, based on Interpersonal Psychotherapy, designed to work in primary care to address the World Health Organization's request to develop psychological interventions that are simplified and can be easily delivered by both specialized and non-specialized professionals. #5 describes promising data from a novel, OB-embedded intervention, Practical Resources for Effective Postpartum Parenting (PREPP), to prevent postpartum depression (PPD) based on the conceptualization of PPD as a potential disorder of the mother-infant dyad, and one that can be approached through psychological and behavioral changes in the mother, commencing before birth, that affect her and the child. A world-leader in perinatal psychiatry will discuss tractable next steps to making significant change in women's peripartum mental health.

Novel Approaches in Assessing, Monitoring, Preventing, and Treating Suicidality

Chairs: David V. Sheehan, M.D., M.B.A., Jennifer Giddens

Presenters: Greg Hudnall, Steven Eliason, Jenna Heise

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of peer relationships in youth suicide prevention; 2) Understand the value of legislative initiatives in the prevention of suicidality; 3) Understand the process of implementing a state-wide program of suicidality assessment; 4) To be aware of the medications being used or studied for the treatment of suicidality; and 5) Understand the importance of the graphic display of quantitative suicidality data (S-Plots), their use to identify patients at higher risk, & provide a method to monitor their status.

SUMMARY:

1. A Review of Utah's Approach to Successful Suicide Prevention in Schools Dr. Gregory Hudnall: Founder Hope4Utah Dr. Hudnall will share the "hope squad" model: a school based peer to peer suicide prevention program that helped reduce youth death by suicide by 25% in Utah. 2. A Review of Novel Legislative Approaches to Successful Suicide Prevention in Utah Utah State & Representative Steve Eliason Participants will hear from State Legislator Steve Eliason on how Utah has a multi-dimensional, legislative approach to suicide prevention. 3. Zero Suicide in Texas: Creating a Statewide Suicide Safer Care System Jenna Heise MA, BC-DMT, NCC, Texas State Suicide Prevention Coordinator This presentation discusses the process by which the "Zero Suicide" initiative was implemented in the state of Texas. It provides an overview of the 7 basic components of the "Zero Suicide" initiative and summarizes the tools and resources available for this comprehensive approach. 4. The Pharmacological Treatment of Suicidality Dr. David V. Sheehan, MD, MBA, Distinguished University Health Professor Emeritus at University of South Florida College of Medicine There is increasing evidence that suicidality has a genetic component that can be transmitted independently of transmission of depression and other psychiatric disorders. Suicidality may be a group of separate Axis I disorders, that need separate pharmacologic treatments. The presentation will provide a phenotypic classification of suicidality disorders and will overview recent advances in specific anti-suicidality medication treatments. 5. The Graphic Display of Quantitative Suicidality Data: S-Plots Jennifer M. Giddens, University of South Florida College of Arts and Sciences Regulatory agencies, pharmaceutical companies, clinical research organizations, data safety monitoring boards, medical directors of health care organizations, and medical safety officers are challenged with the difficulty of summarizing the suicidality status of patients under their care in a simple, clear manner. This presentation provides an overview of several methods of graphically displaying quantitative suicidality data captured from the S-STs. These S-Plots (for Suicidality Plots) display the data both for

groups of patients and individual patients over time. The presenter will review the interpretation of these S-Plots, to identify patients at higher risk, and provide a method to monitor the status of these patients over time. 6. Panel Discussion: Questions and Answers Symposium Schedule: 3 Hour Symposium 10 minutes Introduction 25 minutes for each presentation 45 minutes for Panel Discussion.

Optimizing Treatment of Major Depression After the Initial Treatment Falls Short

Chair: Sidney Zisook, M.D.

Presenters: Somaia Mohamed, Ph.D., Lori Lynne Davis, M.D., Paul B. Hicks, M.D., Ph.D., John William Kasckow, M.D., Ph.D.

Discussant: A. John Rush, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand pros and cons of common switching and combination strategies for treatment resistant depression; 2) Appreciate differences in treatment outcome both during and after the acute treatment phase; 3) Identify the importance of co-occurring conditions, including PTSD, anxious and mixed features, and medical comorbidity on treatment outcome; 4) Recognize the patterns and meanings of different trajectories of response; and 5) Grasp the effects of different treatment approaches on increases or decreases in suicidal ideation for patients with treatment resistant MDD.

SUMMARY:

The VA Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) study was a 35-site Veterans Affairs (VA) Cooperative Study designed to determine the relative effectiveness, safety and tolerability of three commonly used “next-step” approaches for 1522 Veterans with nonpsychotic MDD who previously failed to achieve an optimal outcome after at least one well-delivered trial with their clinician’s choice of antidepressant(s): switching to bupropion-SR (SWI-BUP), combining the index antidepressant with bupropion-SR (COM-BUP) or augmenting the index antidepressant with aripiprazole (AUG-ARI). These Veterans had been severely depressed for many years, often on and off and often persistently; often were unmarried and

unemployed; had considerable anxiety, substance use, PTSD, mixed or hypomanic symptoms and general health issues; often were untreated or undertreated for years; had histories of considerable childhood adversity; had experienced losses of loved ones that may have related to their depressions’ onset or persistence; had had several previous medication trials; had current suicidal thoughts and often had made one or more attempts at taking their own lives; were impaired in multiple domains of their lives; and had extremely negative images of their self-worth. At the 2017 Annual Meeting, we presented the overall results. Remission rates were higher with AUG-ARI than SWI-BUP, but no different between COM-BUP and SWI-BUP or between COM-BUP and AUG-ARI. Response rates were greater with AUG-ARI than with either of the other treatments. BUP had more treatment emergent anxiety than ARI while ARI was associated with more somnolence, extrapyramidal effects and weight gain. In this presentation, we will focus on longer-term results, the effects of comorbidity, and changes in suicidal thoughts and behaviors. First, we will describe treatment outcomes after the first 12 weeks of treatment, examining differences between groups on both relapse and emergent remission during continuation treatment. Next, we will examine whether co-occurring PTSD, anxious features, mixed features or general medical conditions affect overall treatment outcome and/or response to specific interventions. After that we will describe distinct antidepressant response trajectories and associated clinical prognostic factors. Finally, we will cover the all-important topic of suicide risk. We will answer 3 related questions: 1) is there an identifiable subset of patients who experience new or worsening suicidal ideation with any of these treatments? 2) do patients who enter the study with ideation improve? And 3) are their differences in suicide risk:benefit between treatments? At the end of the symposium, participants will be better armed to make informed choices regarding “next-step” interventions for outpatients with major depressive disorder.

Promoting Sustainable Mental Health Systems After Humanitarian Disasters: “Building Back Better” Strategies in Global Mental Health

Chair: Brandon Alan Kohrt, M.D., Ph.D.

Presenters: Suzan Song, M.D., Ph.D., M.P.H., Amir

Arsalan Afkhami, M.D., Ph.D., James Lamont Griffith, M.D., Brandon Alan Kohrt, M.D., Ph.D., Allen R. Dyer, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Distinguish between acute and chronic mental health needs in humanitarian emergency settings; 2) Identify common elements of “Building Back Better” strategies from case studies of responses in Burundi, Greece, Iraq, Jordan, and Nepal; 3) Prepare capacity building plans for mental health services and research for local actors to lead mental health responses in humanitarian settings; 4) Apply the World Health Organization “Building Back Better” framework to design and implementation of mental health responses in humanitarian settings; and 5) Apply the World Health Organization “Mental Health Gap Action Programme—Humanitarian Intervention Guide” to train primary care workers in mental health services for disaster-affected populations.

SUMMARY:

Each year more than 100 million people are affected by humanitarian emergencies. War, terrorism, environmental disasters, and industrial disasters threaten mortality and produce a range of long term physical and mental health sequelae. Resources for humanitarian emergencies are often mobilized in the immediate aftermath of disasters, and short-term physical and mental health services are provided in the weeks and months following the crises. However, psychiatric health problems can persist or emerge months or years following a disaster. Moreover, humanitarian emergencies disproportionately impact countries and regions with limited or non-existent mental health care infrastructure, and these populations have long-term mental health needs in addition to acute distress associated with disasters. The World Health Organization, the Inter-Agency Standing Committee, and non-governmental organizations increasingly advocate strategies for “Building Back Better” in which emergency responses are expected to create the human, technological, and physical capital for sustainable mental health services. In this symposium, we provide case studies of humanitarian responses describing the needs, facilitators, and

barriers related to sustainable mental health care in emergency-affected populations. We provide case studies including care for child soldiers in Burundi and inter-generational mental health needs, training and professional capacity building for mental health professionals in Iraq, resilience-building for both Syrian refugees and care providers on Greek islands, preventing demoralization in the context of chronic instability after humanitarian disasters,, and iterative cycles of policy, research, and training advances in response to repeated disasters from a decade-long civil war to earthquakes to devastating floods in Nepal. We highlight common themes across emergencies including training and research capacity among national stakeholders, the need for policy changes following disasters to prepare for future disasters, and the need for standardized national approaches in contrast to externally imposed donor-driven approaches, which vary widely by emergency context and donor-specific agendas. Strong national capital developed through “Building Back Better” approaches increases the likelihood of both effective responses to disasters and sustainable services for mental health care beyond emergencies.

Psychiatrists in Recovery: What Should I Say? What Should Be Done? Disclosing Our Experience With Mental Illness and Emotional Suffering

*Chairs: Robert S. Marin, M.D., H. Steven Moffic, M.D.
Presenters: Tamar C. Carmel, M.D., Claire MaChere Cohen, M.D., Frank A. Clark, M.D., Michelle Georges, M.D., Raymond M. Reyes, M.D.
Discussant: Michael F. Myers, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Present personal narratives that illustrate psychiatrists’ experience of mental illness and emotional suffering, and their relationship to burn-out, racism, and sexism; 2) Characterize the way self-disclosure and self-identification contribute to our work as clinicians, teachers, scholars, and leaders; 3) Explore psychiatrists’ sources of resilience, including strategies for enhancing the contributions they make to psychiatrists’ recovery and to reducing the risk of suicide, disability and addiction; 4) Present specific recommendations for using self-disclosure to promote system transformation, including their

value in patient care, team work, teaching, and scholarship; and 5) Illustrate the diversity of psychosocial and cultural factors that influence the meaning and potential value of self-disclosure in recovery oriented system transformation.

SUMMARY:

This symposium will explore the ways in which mental illness and emotional suffering create problems and opportunities for psychiatrists in their personal and professional lives. The hope is that talking openly about self-identifying and self-disclosure will foster opportunities for personal growth and professional effectiveness and at the same time generate a sense of community that is welcoming to psychiatrists and to others. All attendees are welcome: since all behavioral health providers are directly and indirectly affected by the systemic meanings of mental illness, the symposium is intended for conference attendees who do not have mental illness, not just those who do. Presenters will offer personal and clinical narratives of their journeys with mental illness and emotional suffering. We will relate the experience of mental illness or emotional suffering to personal and social dimensions of identity, including its impact on our personal lives and careers. Narratives will underscore the fact that perceived need for treatment may reflect social and professional conventions, in particular the recognition of subclinical or unrecognized conditions such as burn-out and grief. The narratives will be personal and clinical and at the same time practical and recovery oriented: each presenter will describe sources of resilience that contribute to their lives and offer proposals that can benefit practitioners, service users and our system of care. The thesis of the symposium is that self-disclosure and self-identification are transformative resources in human growth and in society. Psychiatrists are susceptible to the same forms of mental suffering as their patients. Stigma, which embodies the personal and social meanings of mental illness and emotional suffering, presents psychiatrists with much the same challenges, risks, and distress as their patients. It is ironic in this recovery-oriented era that psychiatrists' reluctance to self-disclose may reinforces stigma and deprive others of the benefits of self-identifying. Thus, the "recovery of psychiatry" is intimately

intertwined with our ability to be "psychiatrists in recovery." The symposium will offer extensive opportunity for attendees to present questions and suggestions and to share their own experience with mental illness and suffering.

Psychiatrists' Emotional Responses to Suicidal Patients: Effects on Treatment Process and Potential Intervention

Chair: Igor I. Galynker, M.D., Ph.D.

Presenters: Shira Barzilay, Ph.D., Zimri Yaseen, M.D., Karina Høyen, M.Sc., Mariah Hawes, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the complexity of clinicians' emotional responses to patients at risk for suicide; 2) Understand the relationship between clinicians' countertransference reactions to high-risk patients and their treatment decisions concerning those patients; and 3) Appreciate how clinicians' emotional responses to suicidal inpatients could help in the assessment short-term suicide risk.

SUMMARY:

Approximately one-third of suicide decedents had contact with mental health care in the weeks and months before death (Luoma, 2002; Ribeiro, 2017), emphasizing clinicians' pivotal role in suicide prevention. However, interactions with acutely suicidal patients are emotionally challenging for clinicians resulting in complex emotional reactions, which may enter into their clinical judgment (Hendin, 2006; Levi, 2017, Galynker, 2017). In general, clinicians' negative emotional responses to patients have been shown to associate with poorer treatment outcomes in global functioning, symptom reduction, and patient's subjective report of treatment gains. The symposium will present first reports on the potential mechanisms by which clinicians' negative emotional responses may affect patients' suicidal ideation and behaviors in the critical context of suicide risk assessment and suicide prevention. The first speaker will examine to what extent the perceived suicide risk of potential patients in the outpatient setting in Israel may influence the therapists' willingness to accept them for treatment. He will also discuss therapists' personal and professional characteristics that may

contribute to their levels of willingness to treat. The second speaker will examine to what extent clinicians' emotional responses to patients are related to the patients' trait characteristics and to their acute suicidal state-related symptoms. The third speaker will discuss how clinicians' initial emotional response to high-risk psychiatric inpatients in Norway may be associated with these patients' willingness to reveal their suicidal ideation or intent. She will further explore how clinicians' emotional responses could be used to identify patients at risk of imminent suicide. The fourth speaker will present her findings on how, in the outpatient setting in a large urban area in the United States, clinicians' prediction of near-term suicidal ideation and behaviors may be impacted by their emotional responses and by their assessment of the traditional risk factors. The final presenter will discuss the impact clinicians' ability for emotional self-regulation may have on their emotional reactions to patients at high risk for suicidal behavior and their clinical judgment when treating such patients. Together this panel will provide a well-rounded and evidence-based description of how emotional and rational factors may impact clinical judgment when working with suicidal patients, pointing to emotional awareness and regulation as a promising area of research and training. Understanding how clinicians emotional responses and judgment may associate with suicide risk during heightened risk time periods may be critical for efforts to reduce suicide risk and prevent suicide.

Quality of Child Mental Health Care: Can Measurement Drive Improvement?

Chair: Bonnie T. Zima, M.D., M.P.H.

Presenters: Molly T. Finnerty, M.D., Sarah Scholle, M.P.H., Philip Wang, M.D.

Discussant: Harold Alan Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To identify select national quality measures related to child and adolescent mental health care; 2) To become familiar with two statewide initiatives to improve the quality of care for children; and 3) To describe APA's national registry (PsychPRO) and uses for quality improvement and research.

SUMMARY:

Multiple national reports have identified improving the quality of child mental health care as a national priority, yet the quality of care for children served in Medicaid-funded programs is often poor, fragmented, and inefficient. In one of the nation's largest managed Medicaid programs, child clinical outcomes for children receiving ADHD care did not improve and were similar to those of children who dropped out of care, even after adjusting for clinical severity. According to the National Quality Strategy, key levers to drive improving the quality of care include use of standardized measures and public reporting; mechanisms that are increasingly incentivized by shifts to Medicaid pay for performance programs. In this symposium, we will begin with an overview of national child mental health quality measures developed and used by the National Committee for Quality Assurance. This presentation will be followed by a description of two statewide initiatives: 1) a multiple managed care plan quality improvement collaborative to improve antipsychotic medication prescribing among children receiving Medicaid-funded services in New York; and 2) systematic identification of a child clinical outcome measure for use in a state-mandated performance measurement system in California. The final presentation will describe the American Psychiatric Association's (APA) national mental health registry (PsychPRO), which includes children and adolescents. In addition to a description of PsychPRO, the presentation will discuss the implications for how use of the registry can inform development of quality measures as well as improvement interventions, and provide a rich data source for clinical researchers. Together, findings from these presentations will be synthesized by a national leader in quality of care research and member of APA's Council on Quality Care to stimulate discussion about quality measurement for childhood onset psychiatric disorders and its implications for practice and policy.

Shelter From the Storm: Understanding and Treating the Refugee Patient

Chairs: Eugenio M. Rothe, M.D., Aidaspahic S. Mihajlovic, M.D.

Presenters: Holly Ackerman, Ph.D., Catherine Stuart

May, M.D., Andres Julio Pumariaga, M.D., Eugenio M. Rothe, M.D.

Discussant: Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1) Learn about the psychopathology, diagnosis and treatment interventions with refugee patients; 2) 2) Learn about the socio-economic and political issues motivating the global refugee crisis and the governmental policies that are in place to address the immigrant flow; 3) 3) Learn how national narratives shape group behavior towards the refugees and how narratives can also be used as a psychodynamic-therapeutic tool to treat refugee patients; 4) and 5) Learn about the long term sequelae and acculturation issues faced by refugees after arrival in the receiving communities; 5) 4) Learn about the differences between the American and European perspective of threatening refugees.

SUMMARY:

The number of forcibly displaced people worldwide reached 59.5 million in 2014, the highest since World War II. This was followed by the European Migrant Crisis that began in 2105. Refugees are often exposed to experiences of war, persecution, violence, torture, killings, disrupted attachments, and emotional losses which increase the risk for psychological distress and may contribute to the risk of their developing psychiatric disorders. These refugees may undergo a series of very stressful experiences prior to arriving to the host country that fit within the three phases of the refugees' experience: pre-flight, flight, and resettlement. Once refugees resettle in the new host country they need to undergo a process of acculturation which brings about inherent stressors. Psychiatric symptoms and mental health difficulties in refugees have been found to persist over many years and the mental health literature has framed the problems that result from these experiences under the diagnosis of Post-traumatic stress disorder (PTSD) and its treatment, which now constitutes a separate field of investigation. Narratives are the stories that humans use to understand their lives and the world around them, and to plan and justify their actions. The

sudden increase in refugees worldwide often results in nationalistic-xenophobic narratives that present refugees as unwanted, dangerous and undesirable. These narratives exert powerful influences on group behavior and become engrained in the social subconscious, are reinforced through social interactions, get reflected in government policies and eventually these narratives shape national identity. The creation of narratives can also be used as a psychodynamic-therapeutic tool in the treatment of patients who are refugees. In dealing with sudden refugee crises, the receiving community may find itself besieged by their massive arrival, which may overwhelm the available mental health infrastructure. This symposium will present an analysis of the socio-economic, political issues that are responsible for the current global refugee crisis and the government policies affecting the sea migrations in Europe and the American Continent. It will analyze the different national narratives created about the refugees, as well as the use of narrative as a psychodynamic-therapeutic tool to treat refugee patients and in addition, it will present the current treatment interventions with Syrian refugees in Europe, and the mental health issues and treatment interventions with refugees arriving in the U.S. In closing, this symposium will present the viewpoint of a senior discussant who will expand on the role of the psychiatrist in treating these patients and will invite audience participation.

Telepsychiatry Best Practices: Joint American Psychiatric Association and American Telemedicine Association Committee Recommendations

Chair: James H. Shore, M.D.

Presenters: Carolyn Turvey, Ph.D., M.A., M.S., Robert Lee Caudill, M.D., Matt Mishkind, Ph.D., Donald M. Hilty, M.D.

Discussant: Peter M. Yellowlees, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about the evidence base for telepsychiatry and the evolution of the joint best practices document; 2) Identify key areas of concern for the responsible practice of telepsychiatry; 3) Understand recommendations regarding interjurisdictional practice in telepsychiatry; 4) Learn recommended privacy and security practices when

using videoconferencing technology to provide care; and 5) Learn best practices for managing patients with potential for self or other harm in telepsychiatry.

SUMMARY:

Telepsychiatry practice, delivery of psychiatric services through videoconferencing technology, has grown exponentially with the proliferation of high quality desktop and mobile videoconferencing technologies - and with financial incentives for behavioral health management through new health care payment models. The expansion of telepsychiatry has surpassed the development of clear best practice guidelines. Such guidelines are critical in light of the potential for questionable practice in areas such as jurisdictional issues related to licensure, prescription of controlled substances via technology, and risk management using remote technologies when working with patients at risk to harm themselves or others. The American Psychiatric Association has joined with the American Telemedicine Association to develop a guide for best practices that will educate and inform practitioners how best to make use of the evolving sophistication in videoconferencing technology. The best practice recommendations will help practitioners improve access to care without compromising the quality or integrity of their clinical practice. This symposium will include presentation from the leadership and authors of this joint endeavor. Dr. Jay Shore, the chair of the committee will introduce the general framework of the best practice recommendations including a brief summary of the research supporting telepsychiatry and the key areas addressed within the document. Co presenters will address recommendations regarding interjurisdictional practice when providing care across state boundaries; prescribing recommendations in the context of telepsychiatry including prescription of controlled substances, privacy and security issues to take into consideration when evaluating technologies, optimal room and equipment specifications, and management of high risk patients through videoconferencing. The presentation will conclude with discussion with participants about their key concerns and experiences with using technology to deliver care with expert

recommendation from panel members who have many years experience in telepsychiatry.

Telepsychiatry: The Evolving Landscape of Mental Health Treatment

Chair: Hossam M. Mahmoud, M.D., M.P.H.

Presenters: Hossam M. Mahmoud, M.D., M.P.H., Marianne W. Tateosian, D.O., Jose Antonio Ribas Roca, M.D.

Discussant: Hossam M. Mahmoud, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the applicability of telepsychiatry across different clinical settings; 2) Assess the advantages and limitations of telepsychiatry vs in-person practice; 3) Understand the application of different telepsychiatry care models; 4) Realize the applicability of telepsychiatry with children and adolescents; and 5) Recognize the opportunities and barriers regarding international telepsychiatry.

SUMMARY:

The societal burden of mental illness is significant and measurable, with enormous costs related to suicide, decreased productivity, absenteeism, and co-morbidity. Yet, an astonishing number of people with mental illness are unable to access care. The most common barriers include cost, lack of insurance, time and cost of travel, patient mobility issues, unequal geographic distribution of psychiatrists and an overall shortage of mental health professionals. As the need and demand for psychiatric services continue to rise, psychiatrists and healthcare facilities are increasingly considering telepsychiatry as a means to enhancing access to care. Over six decades of evidence have demonstrated the feasibility, acceptability, reliability and effectiveness of telepsychiatry. However, significant concerns remain about the limitations regarding the application of telepsychiatric services in certain healthcare settings. This symposium will discuss the applicability, acceptability, effectiveness and limitations of telepsychiatric services across a wide range of clinical settings, patient populations and geographical locations. From a healthcare delivery perspective, we discuss the application of the integrated-care model as an alternative to the

“just-in-time” models. We examine the practice of “virtually staffing” psychiatrists within healthcare facilities, as an approach to enhancing collaborative care, continuity of care and higher patient engagement. From a patient care perspective, we discuss the impact of telepsychiatry on enhancing access to hard-to-reach adult, adolescent and pediatric patient populations, across different settings, including emergency room and consultation liaison services. We focus not only on the advantages but also the limitations associated with psychiatric care performed via videoconferencing. Finally, we move our discussion beyond the United States, to discuss the use of telepsychiatry at the international level, with applications in war zones, with refugees and other displaced persons, with an emphasis on connecting patients with culturally and linguistically competent providers in different parts of the world where performing in-person treatment might be impossible. With the increasingly widespread use of telehealth, psychiatry has become a leader in the field, and as the technology continues to develop and its application continues to expand, it is our responsibility to continuously scrutinize and re-examine our telepsychiatry practices to ensure that we adhere to the highest standards of care that patients deserve.

The Adolescent Brain Cognitive Development (ABCD) Study: Overview and Emerging Mental Health, Substance Use, and Imaging Data

Chair: Gayathri Dowling, Ph.D.

Presenters: Terry Jernigan, Ph.D., Hugh Garavan, Ph.D., Deanna Barch, Ph.D., Mary Heitzeg, Ph.D., B. J. Casey, Ph.D.

Discussant: Gayathri Dowling, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand and appreciate the value of school-based recruitment and the open science model in a multi-site study aimed at identifying the trajectories of child and adolescent development; 2) Understand the assessment procedures being used by ABCD and the resulting data available for the scientific community; 3) Describe preliminary substance use and mental health data for a diverse sample of youth and how it may be combined with other data to understand

factors that influence developmental trajectories; and 4) Appreciate the comprehensive nature of this longitudinal study using measures of developmental psychology, neuroimaging, cognitive neuroscience, genetics, epidemiology, bioassays & bioinformatics.

SUMMARY:

The Adolescent Brain Cognitive Development (ABCD) study is a large multi-site longitudinal study supported by the National Institutes of Health and the Center for Disease Control and Prevention to increase our understanding of brain, cognitive, and social/emotional development. Children and adolescents are exposed to myriad internal and external influences that interact with their changing biology, and genetic and environmental vulnerabilities to affect brain maturation, and behavioral, health, and psychological outcomes. The ABCD study launched in 2015 and data collection began in the fall of 2016. The study is combining measures of developmental psychology, neuroimaging, cognitive neuroscience, genetics, and epidemiology with advanced techniques in bioassays, bioinformatics, and mobile assessment to follow ~11,500 9-10 year olds recruited at 21 sites around the country. This symposium brings together representatives from the ABCD Research Consortium leadership to present the goals of the study and its design, a description of the demographic characteristics of the emerging cohort, and a first look at baseline data on the first 4500+ children recruited, including measures of: 1) mental health, including assessments of early emerging psychopathology from both the child and parent perspective, measures of impulsivity and behavioral inhibition/activation, the prevalence and correlates of suicidal ideation in this age range, and initial assessment of psychosis prior to onset of substance use; 2) substance use and cultural and environmental risk and protective factors; and 3) brain imaging measures, with a particular focus on resting state fMRI measurements and early findings from task related activation measures of reward, emotion and cognitive control. Preliminary findings on mental health indicate that approximately 2% of children have current or past suicidal ideation, with up to 6% experiencing current or past thoughts of wishing they were dead. In addition, we find that between 5-10% of children report psychotic like

experience associated with distress. These experiences are more likely among children with a family history of schizophrenia, but not among those with a family history of depression or mania. Further, psychotic like experiences are significantly associated with both verbal IQ deficits and working memory impairments. The majority of youth in the sample to date endorsed having heard of alcohol, tobacco, and to a lesser extent marijuana yet few participants have begun to use any substances of abuse. Additional preliminary analyses will focus on the association between peer, family, neighborhood and school environmental factors and experimentation with substances. Ultimately linking these mental health and substance use findings with environmental factors and the multimodal brain imaging measures will help to inform how childhood experiences and changing biology affect brain development and wellbeing.

The Delusion Dilemma: Defining the Line Between Delusions and Other Beliefs

Chair: Brian James Holoyda, M.D., M.B.A., M.P.H.

Presenters: Michael Caton, M.D., Ryan Colt

Wagoner, M.D., Brianna M. Newman, M.D., William J. Newman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the history of the definition of “delusion” and the conceptualization of the delusion as a psychiatric symptom since the 19th century; 2) Delineate modern neuroscientific theories regarding the formation and maintenance of delusions; 3) Understand other types of beliefs that are commonly conflated with delusions, including beliefs held by cults, extremist religious organizations, and members of cultural movements; 4) Define important clinical issues when working with patients with religious delusions; and 5) Provide practical guidelines for the evaluation of individuals with delusions or beliefs that may be conflated with delusions, specifically in cases involving civil commitment or forensic evaluation.

SUMMARY:

Among psychiatric symptoms, delusions present multiple theoretical and clinical challenges. When first described in Germany in the early 1800’s, the

concept of being “deluded” referred to the deprivation of an individual’s sense and brightness. Psychiatrists at the time questioned whether delusions were a disease entity unto themselves – a “monomania” – or the end result of a different illness. In the late 1800’s Swiss psychiatrist and philosopher Karl Jaspers pointed out the complexities of defining and understanding delusions because of the difficulty inherent in experiencing someone else’s reality. Modern definitions of delusional belief have not developed substantially beyond Jaspers’ descriptions and remain unsatisfactory for multiple reasons. First, in a multicultural, socially dynamic world it is difficult to maintain a consistent standard for what is considered to be “culturally appropriate” belief. Second, healthy humans commonly form differing beliefs based on the same information. Though neuroscientists have not yet developed an adequate neurocognitive model of belief formation in health, some competing models of pathological belief formation have been proposed. Our knowledge of delusions remains limited, which impacts clinicians’ ability to reliably assess them. Despite the lack of a clear method by which to distinguish delusions from other types of belief, clinicians are charged with evaluating and treating both individuals who harbor genuine delusions and those whose beliefs that could be conflated with delusions. For example, distinguishing between an individual’s religious experience and delusions with religious content can present many challenges for clinicians. Many common religious practices involve experiences and beliefs that, if taken out of context, could be perceived as psychotic. Individuals who adhere to beliefs held by other fringe groups such as cults, politicoreligious terrorist organizations, and cultural movements like the “sovereign citizens” in the United States further blur the line between delusions and other beliefs. In this symposium we will trace the history of the concept of “delusion” from its origins. We will describe modern neuroscientific theories regarding the formation and maintenance of delusional belief. We will review challenges associated with treating certain types of delusions, including religious delusions. We will describe various types of extreme beliefs and organizations that espouse such beliefs, including cults, cultural movements, and politicoreligious

terrorist organizations. We will delineate practical methods by which the clinician can distinguish between delusional beliefs and non-delusional extreme belief, as well as effectively communicate with judges about patients' beliefs in the setting of civil commitment.

The Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders

Chair: Michael B. First, M.D.

Presenters: John M. Oldham, M.D., Donna S. Bender, Ph.D., Andrew E. Skodol, M.D., Michael B. First, M.D.

Discussant: Benjamin Hummelen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) participant will understand the essentials of the DSM-5 alternative model for personality disorders; 2) participant will understand how the components of the DSM-5 alternative model have been implemented in the SCID-AMPD; and 3) participant will understand the procedures and conventions for administering the SCID-AMPD using case materia.

SUMMARY:

The Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD) is a semi-structured diagnostic interview to guide clinicians in the assessment of the three essential parts of the Alternative Model for Personality Disorders (AMPD), published in DSM-5 Section III "Emerging Measures and Models": 1) the level of impairment in personality functioning, 2) pathological personality traits, and 3) six categorical personality disorders (PDs) – Antisocial PD, Avoidant PD, Borderline PD, Narcissistic PD, Obsessive-Compulsive PD and Schizotypal PD – defined according to criteria based on specific impairments in personality functioning and particular configurations of pathological personality traits, plus Personality Disorder – Trait Specified (PD-TS) for presentations that do not meet the criteria for the six specific PDs. Accordingly, the SCID-5-AMPD is divided into three modules. Module I guides assessment of the Level of Personality Functioning Scale (LPFS), a 5 point severity scale summarizing impairment in the four domains of personality functioning included in the model (Identity, Self-

direction, Empathy, Intimacy). Module II provides ratings for the AMPD's 25 individual personality trait facets, and combines them to provide dimensional ratings for the five DSM-5 trait domains (Negative Affectivity, Detachment, Antagonism, Disinhibition, Psychoticism). Module III provides a semi-structured interview for the categorical component of the AMPD, namely the six specific PDs in the hybrid dimensional/categorical model. For each disorder, the interviewer starts first with ratings of the "criterion A" items (i.e., ratings for the disorder-specific personality functioning domains), then continues with criterion B trait ratings that cover both disorder-specific traits as well as ratings for the general trait definitions in order to allow for a diagnosis of PD-TS. The goal of this symposium is to familiarize participants with the various components of the SCID-5-AMPD. The symposium will begin with an overview of the DSM-5 Alternative Model, as well as of the SCID-5-AMPD, presented by John M. Oldham, M.D., who will also briefly present a clinical case which raises issues of personality and personality pathology and will be used in the subsequent presentations to demonstrate how the various SCID-5-AMPD modules are used in assessment and diagnosis. The next three presentations (Donna S. Bender, Ph.D. for Module I, Andrew E. Skodol, M.D. for Module II, and Michael B. First, M.D. for Module III) will address how to administer each of the three modules using the clinical case as an illustration. Finally, a discussant (Benjamin Hummelen Ph.D., M.D.) who has had extensive experience administering the SCID-5-AMPD in a clinical research setting will comment on the presentations and on his research team's experiences.

Toward Hispanic-American Well-Being: Understanding Cultural Concepts of Distress, Responses to Stress/Trauma, and Adaptation of Services

Chairs: Esperanza Diaz, M.D., Jose E. De La Gandara, M.D.

Presenters: Alvaro Camacho, M.D., M.P.H., Ruby C. Castilla Puentes, M.D., Carlos Fernandez, M.D., Pamela Carolina Montano, M.D.

Discussant: Bernardo Ng, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand cognitive characteristics of Hispanic adults; 2) Understand Hispanic children's responses to trauma; 3) Provide reasons to educate the Hispanic community about children's mental disorders; 4) Identify challenges implementing mental health interventions targeting Hispanic Immigrants; and 5) Understand specific effective mental health services for monolingual Hispanics and ways to sustain them.

SUMMARY:

How do Hispanic patients with anxiety, and depression respond to medical treatments and mental health services? What helps, and what does not? The presenters will shed light on Hispanics' unique responses to stress, cultural concepts of distress and mental disorders and then what we should consider when providing and developing mental health services. 1. An examination of the association between verbal learning fluency and processing speed with anxious depression symptomatology in Hispanics found significant inverse associations between moderate and high anxious depression with neurocognitive measures. Results suggest that increased anxious depression symptoms are associated with decreased neurocognitive function among Hispanics. 2. The psychological long-term effects of a mass shooting incident in Belen, Boyacá, Colombia are examined. This prospective longitudinal study examined children at the park and children who were not in the park at 1 month and 10 years after the event. Intrusive recollections and startle reflex were the most prevalent symptoms. After 10 years the directly affected had a higher prevalence of PTSD than those indirectly affected. 3. A grassroots community academic partnership addressing stigma, clarification of mental misconceptions and development of positive attitudes towards children mental health is studied in a pilot project in a population with 52% Hispanics. Results illuminate important influences in reducing barriers to mental health services, reducing stigma and elimination of health disparities leading to early prevention intervention and treatment of children. 4. A review of current literature regarding psychotherapy for Latino populations and its limitations will set the stage for outcome results of different psychotherapy

modalities targeting a Latino population in a NYC clinic including an intervention for undocumented minorities. 5. A culturally informed community-academic collaboration is described highlighting the factors sustaining eight years of services to a monolingual Hispanic population. The approach has two main priorities: increase access and workforce development. 6. Our discussant will examine the common threads to understand Hispanic needs and how to address them. This symposium is in collaboration with the American Society for Hispanic Psychiatry.

Treatment in Transition: The Mental Health Provider's Role in the Integrative Health Care of Transgender and Gender Non-Conforming Populations

Chair: Matthew Lee Dominguez, M.D., M.P.H.

Presenters: Max Alan Lichtenstein, M.D., Hansel Arroyo, M.D., Elizabeth Berk, Ph.D.

Discussant: Zil Goldstein, N.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explain the complexities of sexual identity and the importance of a psychosexual health survey; 2) Review the history and evolution of transgender medicine and mental health care; 3) Describe minority stress, systemic and its role in the health disparities of TG-GNC populations; 4) Understand the current standards of care in the treatment of gender dysphoria and the importance of utilizing an integrated health care model in TG-GNC populations; and 5) Discuss challenges to treatment from hormone side effects, to insurance issues, capacity evaluations, medication, and therapy.

SUMMARY:

Despite the increasing visibility of transgender (TG) and gender non-conforming (GNC) populations and the promotion of cultural competence as a core skill for mental health providers, few clinicians are given opportunities to work with these communities during their training. This deficit in education leaves providers unprepared to deliver culturally appropriate treatment to TG-GNC patients and prevents them from meeting the standards of care for those struggling with gender dysphoria. For

decades it has been observed that TG-GNC populations are at increased risk of trauma exposure, substance abuse, and suicidal behaviors, with lack of access to appropriate health care services only increasing these disparities. In addition to experiencing social prejudice in regards to sexual orientation and gender identity, TG-GNC populations face obstacles when attempting to obtain not only gender affirming services but also basic preventive health care. In order to address these issues, we will review the checkered history of transgender medicine and mental health care, with emphasis on the evolution of sexual identity theory. We will then utilize modern tools for exploring these identities with patients during evaluation and treatment. We will review minority stress theory in order to enhance our understanding of the development of mental illness and health risk behaviors, with focus on the risk of diminishing health care utilization when TG-GNC populations are met with microaggressions in the very systems they turn to for help. We will examine how these systems may be improved upon by reviewing the groundbreaking work of gender clinics across the country, as well as, introducing the nation's first Transgender Psychiatry Fellowship Program. Finally, through case examples, we consider a wide array of challenges faced by both providers and patients when navigating the system of TG-GNC health care.

Monday, May 07, 2018

Advancing the Integration of Behavioral Health Into Primary Care for Small Practices

Chairs: Henry Chung, M.D., Matthew Louis Goldman, M.D., M.S.

Presenters: Joseph G. Squitieri, M.D., Katy Smali, Greg Burke, M.P.A.

Discussant: Harold Alan Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate the utility of a newly developed continuum-based framework for behavioral health integration into primary care; 2) Appreciate the qualitative findings that describe the successes and challenges of integrating behavioral health into primary care; and 3) Present unique insight into the quality measurement and health

policy mechanisms that support successful behavioral health integration.

SUMMARY:

Addressing behavioral health issues in primary care requires significant changes to bring about meaningful improvement at the level of the provider, practice, and health system. Adaptations of integrated care models will often vary according to the size, location, and resources of a primary care practice. In particular, the roles of psychiatrists and other mental health providers can vary depending on the practice characteristics and goals. With these realities in mind, a framework for integrated care was recently created in New York State with input from multiple stakeholders in order to support key statewide policy initiatives promoting integration. The framework is based on evidence and is structured on a continuum that can be used as a roadmap while allowing flexibility for implementation and advancement of integration. This is a departure from previous frameworks, which tend to be more categorical. Now, to test and improve the framework, the participants in this symposium are using grant awards from the New York State Health Foundation and United Hospital Fund to help ten small practices achieve evidence-based behavioral health integration through the use of the framework and monthly technical assistance webinars. Speakers will present the framework and describe its use in clinical practice from the perspectives of a clinician participating in the program as well as from the results of 6- and 12-month qualitative evaluations. The framework is intended to aid in the assessment of the current state of practice integration across a range of integration domains (including case finding, screening and referral to care, ongoing care management, and culturally adapted self-management support) and to provide specific guidance for moving forward along the integration continuum, with achievable goals at each step along a domain. The continuum structure recognizes that achieving the most advanced state of each domain and its components will not necessarily be the ultimate target for every primary care practice. This symposium will provide attendees with unique insights into the effectiveness of an innovative framework, the lessons learned among behavioral

health professionals collaborating with small primary care practices motivated to better deliver behavioral health services, and the urgent need for behavioral health system improvements from the perspective of grant-maker and policy experts.

At Risk: Undocumented Immigrant Mental Health in the Current Political Climate

Chairs: Pamela Carolina Montano, M.D., Divya Chhabra, M.D.

Presenters: Victor M. Fornari, M.D., Ateaya Ali Lima, M.D., Andres Julio Pumariaga, M.D., Tahia Haque, M.D., Pamela Carolina Montano, M.D., Alma Valverde Campos

Discussants: Francis G. Lu, M.D., Esperanza Diaz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the link between the current sociopolitical debate on immigration, the shifting status of undocumented immigrants, and mental health challenges including access to care; 2) Understand the intersection between undocumented immigrants, the legal system, immigration reform, and patient care from firsthand DACA recipients; 3) Recognize examples of culturally-specific concepts of distress as well as normative cultural factors that may influence symptom presentation, diagnosis, and treatment; 4) Understand the prevalence of various mental illnesses among undocumented citizens including trauma, how to screen for trauma, and examples of practicing trauma-informed care; and 5) Understand the importance of and how to coordinate interdisciplinary care, social supports/support groups, and community resources for the well-being and recovery of undocumented adults and children.

SUMMARY:

The USA is home to approximately 40 million immigrants and 35 million children whose parents are foreign born. Within this group, 11.4 million are undocumented immigrants, half of whom are of Latino origin. Little research has been done on the mental health of undocumented versus documented immigrants, despite the growing size of this population, their risk factors for mental health disorders, and the current changing sociopolitical

climate. Mental health professionals in various settings are likely to make contact with these populations and often may be one of very few contacts for them. This provides the mental health community with a unique opportunity to make a difference in this population's lives for which clinicians must be prepared. Undocumented immigrants, whether children or adults, undergo specific stressors across the various stages of the immigration process: pre-migration (trauma in country of origin, sense of failure), in-transit trauma (including violence, environmental hazards, abandonment, witnessing death) as well as trauma after migration (limited resources, intra- and interpersonal conflict, acculturative stress, limited resources, exploitability, fear of deportation, and discrimination). When exposed to the aforementioned stressors, undocumented immigrants are associated with a higher risk for depression, PTSD, and substance use. In one study, 82% of undocumented immigrants, who were evaluated at their point of entry endorsed a history of trauma, which is in alignment with research indicating that escape from violence and financial issues are the leading factors of illegal entrance. Studies have shown that immigrants use mental health services at lower rates than nonimmigrants, despite an equal or greater need. Not all undocumented immigrants suffer from mental health disorders, and this is often a result from protective factors such as social support. Research on DACA recipients shows greater social integration, self-efficacy, and decreased fear of deportation; unfortunately, the September 2017 changes made for DACA recipients leave them in a more precarious state. We will introduce participants to the limited research that has been conducted on undocumented immigrants to promote awareness on risk factors, prevalence of mental illness, protective factors, and mental health treatments. We will also focus on how the current political climate affects them and their care from a legal standpoint and how we can help patients utilize their rights. Lastly, the symposium will help participants understand specific interdisciplinary treatment techniques (trauma-informed care, culturally-informed care, community support, accessing resources) that should be utilized with this population to better outcomes. A PowerPoint presentation, presentations (including a

DACA recipient and immigrant rights advocate), and clinical cases of undocumented immigrants various settings and backgrounds will be incorporated. We will also have time for an interactive discussion with various experts in the field. The current political climate has engrained a sense of fear in undocumented immigrants, preventing many from being able to advocate for themselves. It is vital that we support and advocate for UIs - through marches, community resources, advocacy, and informed, compassionate mental health treatment.

Autism Spectrum Disorder: Essentials of Practical Management and Cutting-Edge Treatments

Chair: Eric Hollander, M.D.

Presenters: Deborah Fein, Ph.D., Robert Lee Hendren, D.O., Stefano Pallanti, M.D., Ph.D., Naomi Fineberg, M.B.B.S., Randi Hagerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To highlight the role of the psychiatrist in the optimal assessment and treatment of ASD; 2) To describe the cognitive assessment of infants and toddlers with ASD, and to describe patients with optimal outcome; 3) To elucidate how symptoms overlap between ASD and obsessive compulsive personality disorder and OCD related disorders; 4) To discuss new targeted treatments for fragile-X syndrome and syndromal ASD based on molecular mechanisms; and 5) To review new data and procedures on transcranial magnetic stimulation treatment in ASD.

SUMMARY:

Autism Spectrum Disorders (ASD) are common and complex neurodevelopmental disorders which may present at different stages with different target symptoms (Hollander E, Fein D, Hagerman R, 2017). This symposium will help educate the psychiatrist to optimally participate in the assessment and treatment of ASD. It will raise awareness and expertise in both the practical management of ASD and new cutting edge treatments. A review of evidence based treatments for various target symptoms of ASD will be presented (Hollander E, Kolevzon A, Coyle J., 2011). The role of comorbidity in treatment selection will be highlighted. Comprehensive cognitive assessment of infants and

toddlers will be described, and the implication of these findings on educational, behavioral, and speech and language treatments will be discussed. Long term follow up studies describe patients who have optimal outcomes of ASD. The repetitive behavior domain in ASD, OCPD and OCD related disorders will be evaluated and implications for common underlying mechanisms discussed. New targeted treatments for fragile-X syndrome and other genetically homogenous syndromal forms of ASD based on molecular mechanisms will be highlighted. Families often utilize complementary and integrative treatments for ASD and the evidence for such use, and risks and benefits of these treatments are discussed (Hollander E, Anagnostou E, 2007). Non-invasive brain stimulation techniques such as transcranial magnetic stimulation (TMS) have been studied for the treatment of core and associated symptom domains, and the promise and pitfalls of such treatment discussed.

Biopsychosocial Psychiatry: 21st Century Psychiatry or Empty Slogan?

Chairs: J. Pierre Loebel, M.D., John Wynn, M.D.

Presenters: John Wynn, M.D., Charles Barnet Nemeroff, M.D., Ph.D., Will Davies, D.Phil., Eliot Sorel, M.D., Marc Avery, M.D., Nassir Ghaemi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn the historical origins of and philosophical considerations pertaining to the biopsychosocial concept; 2) Understand current neuroscience grounding the biopsychosocial approach; and 3) Appreciate that all three levels, biological, psychological and social, must be taken into account in every health care task.

SUMMARY:

The Symposium's aim is to elaborate and clarify the power of the biopsychosocial model to furnish a coherent conceptual foundation for modern psychiatry. Psychiatry lacks a widely accepted theoretical framework. "The student (of psychiatry) is more likely to encounter a heterogeneous collection of teachers propounding a bewildering variety of incompatible dogmas and precepts." But Psychiatry has never completely forgotten that human beings function in biological, psychological

and social domains, even as the ^{DSM} fails to practically address their interconnectedness. In this Symposium, speakers will introduce the core concepts and history of the biopsychosocial model in Medicine in general and Psychiatry in particular. Speakers will provide a philosophical reassessment of the model, buttressed by recent contributions of neuroscience to psychiatry and a review of the Integrated Care and Collaborative Care initiatives launched by the APA Assembly. These insights are generating new modes of application in clinical practice, training, research and related areas. Clinical cases followed in the Mental Health Integration Program will be described as an example of emerging applications and challenges. In conclusion a discussant will review earlier presentations and moderate a discussion with the audience.

Brief Therapy Skills for Everyday Practice

Chair: Mantosh Dewan, M.D.

Presenters: Roger Greenberg, Ph.D., Judith Beck, Ph.D., Seth Gillihan, Ph.D., Brett Steenbarger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) apply common factor skills; 2) practice some key cognitive- behavioral therapy skills; 3) apply some key solution- focused therapy skills; and 4) conduct prolonged exposure.

SUMMARY:

Brief therapies are evidence based, applicable to an ever-growing range of disorders, and eminently learnable. This symposium presents concepts and skills from four brief therapies that are main-stream and representative of the richness of brief approaches: 1) the skills that form the basis for all therapies and are therefore considered “common factors”; 2) the key skills of cognitive behavioral therapies, which are applicable to a wide range of disorders; 3) the specific skills of prolonged exposure, which is effective for the treatment of trauma eg rape victims; 4) the concepts and skills that make solution focused therapy ultra-brief (often 1-2 sessions) and particularly suitable for college mental health settings. Each presentation aims to transfer practical, immediately usable skills, which are illustrated by the liberal use of clinical vignettes and video. Although presented as ‘pure’ models of

brief therapy, the skills and techniques can be meaningfully integrated into all brief and long term work. Participant interaction is encouraged, with time for questions and a panel discussion.

Building Resilience Through Applied Positive Psychiatry

Chairs: Keri-Leigh Cassidy, M.D., Kiran Rabheru

Presenters: Olga Yashchuk, M.D., Prasad Rao Gundugurti, M.B.B.S.

Discussant: Roy Abraham Kallivayalil, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) to discuss resilience building measures; 2) To understand resilience as a concept for interventions across psychiatric disorders; and 3) To understand resilience and its role in stress response.

SUMMARY:

Revolutionary advances in understanding mental disorders and in providing novel treatments have enhanced the expectations of patients and relatives. There is a growing demand on newer research in providing interventions that allow patients to live a normal life. Of late concept of the illness itself has undergone significant change. It is now proposed that expected outcome from treatment of mental disorder is to achieve a state of “wellness” Positive psychiatry is a new approach in health sciences and psychological medicine. Recent studies have shown that Personal and psychosocial characteristics play an important role in pathogenesis, intervention and health outcomes. So far there has been over emphasis in understanding mental disorders from an external perspective. Personal characteristics of an individual which effectively deals with psychosocial stressors can change severity, course, pharmacotherapy and outcomes. Positive psychiatry also explains differences in inter and intra-cultural variations among individuals with mental disorders. Positive psychosocial characteristics (PPCs) e.g. Resilience, spirituality, optimism. Personal mastery wisdom and social engagement. Absence of satisfactory PPCs can reduce outcome and their treatment can increase outcome. The Fountain of Health (FoH) initiative in Canada is an example of the principles of Positive Psychiatry in action. Two

projects – one on Age-Friendly Communities and another one on community based peer led education groups will be explored to highlight current efforts to bridge the gap between theory and practice and to bring Positive Psychiatry's principles to the forefront of clinical practice. The FoH is the first global initiative to optimize aging by reducing negative stereotypes and promoting healthy aging through five scientific, evidence-based, measurable strategies: 1) physical activity, 2) social activity, 3) engaging in lifelong learning, 4) taking care of our mental health, 5) changing how we think about aging. The FoH aims to create and disseminate user-friendly tools to affect positive change as primary, secondary, and tertiary strategies. These can be disseminated through strategic partnerships connecting populations, clinicians, governments, industry, and policy makers. CBT offers evidence-based approaches for clinicians to use to promote resilience cognitive restructuring and behavioural activation for primary and secondary illness prevention. FoH's tools adapt CBT techniques to promote health behaviour change in 10 minute contacts in the course of usual care. A short educational video, and on-line and paper based materials to support clinicians' integration of positive psychiatry into standard practice will be provided. The evidence for the FoH Clinician materials will also be reviewed. We propose this symposium in which presenters will discuss a number of issues related with interventions.

Coordinated Specialty Care for First-Episode Psychosis (FEP): Science-to-Service Updates

Chairs: Robert Heinssen, Ph.D., Lisa Dixon, M.D.

Presenters: Michael L. Birnbaum, M.D., Vinod Srihari, M.D., Delbert Robinson, M.D., David Penn, Ph.D.

Discussant: Patrick McGorry, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the rationale for early detection, multimodal intervention, and ongoing personalized care for persons experiencing a first episode of psychosis (FEP); 2) Recognize the six components of Coordinated Specialty Care for FEP, including the psychiatrist's responsibilities as a CSC team member; 3) Describe strategies for implementing Coordinated Specialty Care in

community clinics, including staff training, treatment fidelity, and measuring FEP symptomatic and functional outcomes; 4) Appreciate how online and social media resources can be used to reduce the duration of untreated psychosis and engage youth with early stage psychotic disorders in care; and 5) Explain FEP-specific medication guidelines and how computerized decision support can improve the quality and effectiveness of FEP pharmacotherapy in community settings.

SUMMARY:

Coordinated Specialty Care (CSC) is a team-based, multi-element treatment for first episode psychosis (FEP) that integrates medical, psychosocial, and rehabilitative interventions in a recovery-oriented, collaborative approach to care. Component interventions include low doses of select antipsychotic agents, recovery-oriented cognitive and behavioral psychotherapy, supported employment and education services, family education and support, and coordination with primary care. Recent research supports the feasibility and effectiveness of CSC in community mental health clinics in the United States. Findings from two randomized controlled trials (Kane, Robinson, Schooler, et al., 2016; Srihari, Tek, Kucukgoncu, et al., 2015) illustrate that compared to usual care, CSC promotes better outcomes for FEP in the domains of psychopathology, work and school functioning, overall quality of life, and cost-effectiveness of treatment. Complementary dissemination and implementation research has identified strategies for implementing CSC broadly in U.S. community clinics (Dixon, Goldman, Bennett, et al., 2015). Together, these studies have accelerated adoption of CSC in 37 States (74%), with over 130 clinics nationwide now offering evidence-based care for FEP. This symposium presents cutting-edge research that informs broader adoption of CSC in U.S. settings, including (1) community psychiatry approaches that support wider-scale FEP intervention; (2) strategies to proactively encourage early help seeking among FEP patients via online and social media based resources; (3) applied research to reduce the duration of untreated psychosis in areas served by CSC programs; (4) computer decision support for evidence-based FEP pharmacotherapy; and (5) a moderated on online platform that extends

CSC services beyond the period of initial care, with the goal of enhancing long-term functional recovery. Professor McGorry's discussion will provide an international context, relating recent U.S. initiatives to similar FEP intervention efforts in Australia, Europe, and elsewhere.

Creating Wellness and Balance for Ourselves and the People We Serve: An Experiential Program of Innovative Techniques to Promote Self-Care

Chair: Beth P. Abrams, M.D.

Presenters: Janice Putrino, L.C.S.W., Mary DeSario

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand basic knowledge about how breathing practices impact physiology and emotions; 2) Experience how gentle grounding practices, regulated breathing and music can be utilized to impact mood and energy; 3) Understand how to increase self-awareness and express emotions through the use of journaling/therapeutic writing; and 4) Understand a model for integrating & creating wellness activities for individuals and groups.

SUMMARY:

Mental health providers and healthcare recipients face significant challenges in the current healthcare climate. Research has documented high levels of workplace stress, burnout and compassion fatigue for providers. Consumers' healthcare reviews indicate that conventional treatment often does not address the holistic, complex & unique needs & preferences of individuals. Mind-Body & Creative/Therapeutic Arts-based Practices have been introduced in various medical and mental health care settings to expand holistic approaches & improve outcome and satisfaction through multi-levels of impact. On a personal level, these practices can improve mental focus, physical energy and promote calmness & confidence. On a professional level, these practices can help staff & colleagues manage job-related stress, improve frustration tolerance, reduce compassion fatigue & burnout and enhance staff wellness-all of which improves systemic functioning and benefits any milieu. For the individuals we serve, developing these skills can help them manage psychosocial stressors, mental health

challenges, chronic pain and medical conditions that are exacerbated by the physiologic stress response. In the Mind-Body segment of this symposium, participants will learn didactic aspects and experience practical elements of Mind-Body practices using Breath-Body-Mind techniques. In the Journaling segment, participants will learn about how writing techniques have been used in educational & clinical settings as a means of processing trauma, providing insight and documenting history for therapeutic gains. Participants will learn specific techniques that build in structure, pacing and containment in their writing. The integration of reflective processing can empower individuals & promote healing, self-awareness and self-directed change. Mental Health professionals who use therapeutic writing can reduce stress, burnout and compassion fatigue. Clinicians can also use therapeutic writing with their clients to advanced therapeutic goals. In the segment on Creating Wellness for All- using examples the VA Whole Health Initiative & A Women's Veterans Wellness Workshop, participants will learn about a model for holistic approaches to wellness, health and healing in the context of a creative arts & mind body practice workshop that was developed for Women Veterans. Descriptions of the program, implementation methods and responses of participants & staff can serve as an inspiration & template for symposium attendees to create such initiatives in their own practice and institutions.

Eating Disorders in Obesity and Bariatric Surgery: Assessment, Treatment, and Prevention

Chairs: Sanjeev Sockalingam, M.D., Raed Hawa, M.D.

Presenters: Weronika A. Micula-Gondek, M.D., Wynne Lundblad, M.D., Stephanie Cassin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To use evidence-based tools and assessment approaches to identifying eating psychopathology in patients with obesity; 2) To describe the role that psychiatrists have in bariatric surgery care, specifically treating and preventing obesity-related eating psychopathology; and 3) To apply pharmacology protocols and brief

psychological interventions that improve psychiatric care during obesity management.

SUMMARY:

The World Health Organization (WHO) has reported that we are in the grip of a global obesity epidemic. Due to the prevalence of obesity in the population and bi-directional relationship between obesity and mental illness, psychiatrists are now considered integral to the management of severe obesity in hospital and community based settings. DSM 5 has also increased awareness of obesity related eating disorders through the introduction of binge eating disorder as a formal diagnosis, which has resulted in increased interest in psychological and pharmacology interventions for eating psychopathology in the context of obesity care. As a result of the confluence of developments in obesity-related eating disorders, psychiatrists are an integral component to obesity care. The effectiveness of bariatric surgery, the most durable treatment for severe obesity, can be improved through psychiatrists involvement in pre-screening and bariatric surgery after care psychiatric interventions. A recently approved APA Resource Document on Bariatric Surgery and Psychiatric Care developed by the presenters and the Council on Psychosomatic Medicine outlines psychiatrists' role in managing psychiatric comorbidity, including eating psychopathology pre- and post-surgery to mitigate weight regain and psychiatric sequelae (Amer J Psychiatry 2017). This symposium aims to improve psychiatrists' awareness, confidence and skills in managing common eating psychopathology in obesity care. Dr. Raed Hawa will provide an overview of the prevalence of eating disorders and psychopathology in obesity and discuss specific screening questions, differential diagnoses and practical tools to assess obesity-related eating psychopathology in clinical care. Dr. Micula-Gondek will provide an update on the evidence base for eating psychopathology as it relates to bariatric surgery outcomes including specific risk factors. Dr. Lundblad will provide a comprehensive review of post-bariatric surgery eating psychopathology, including de novo eating disorders and the spectrum of binge eating after surgery loss of control over eating and binge eating. Dr. Sockalingam will discuss a stepped care approach to eating psychopathology

in severe obesity. This model will summarize pharmacological approaches to eating psychopathology and the evidence for emerging treatments of refractory binge eating, such as neurostimulation. Lastly, Dr. Cassin will present data on the role of motivational interviewing and cognitive behavioural therapy for eating psychopathology during obesity treatment. Data from these studies will be linked to practical office based interventions that can be used by symposium attendees to manage common eating behaviours and support obesity management. The symposium will include presenters' original research, illustrative cases, practical assessment tools and audience polling to engage learners and provide feedback during the session.

Emerging Ethical Considerations in a Globalized Psychiatry

Chair: Anish Ranjan Dube, M.D.

Presenters: Allen R. Dyer, M.D., Ph.D., Samuel Osifo Okpaku, M.D., Ph.D., Christopher Cho, M.D., Michael Liebrez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the unique ethical considerations of working with disaster affected communities; 2) Identify potential conflicts and ethical issues arising from work sponsored by International Aid and how to reduce potential challenges; 3) Understand non-American perspectives to the intersection of psychiatry and society; and 4) Learn of moments in history when psychiatry was used for political aims.

SUMMARY:

Whereas the modern practice of psychiatry mirrors the larger trends towards globalization characteristic of society and of medicine throughout the world, by its very nature, psychiatry simultaneously concerns itself with the local, that is the tension between the self in relation to the other. When considering an assessment of 'global mental health' and then intervening upon such, the space between the self and the other lends itself to a unique set of ethical challenges deserving of careful consideration and caution. In this symposium we examine ethical concerns that arise out of direct clinical care

provided to vulnerable populations, such as with the use of international aid in implementing interventions or when working with disaster affected communities, by the panelists' own personal experiences in international work and their research on the subject. Specifically, the relationship between the donor and the recipient is explored for its asymmetry and remedies offered through the use of standard questions in planning and evaluation stages. The second part of our symposium shifts in its focus to explore the broader role of the psychiatrist in society and how culture influences the ethical principles we come to espouse. Given the recent enthusiastic reporting in American media about the American Psychiatric Association's long established 'Goldwater Rule' and whether extreme political circumstances warrant a departure (and as some may suggest, an ethical obligation) from the aforementioned practice, we briefly revisit the origins of the 'Goldwater Rule' and comment on (the relative lack of) similar prohibitions in other parts of the world, such as in European Psychiatry. This is followed by a historical review of the implicit and explicit uses of psychiatry and psychiatrists in political processes, for example in reifying notions of race and inferiority in the age of European colonialism or in the justification used by authoritarian regimes' to imprison political opponents and inspire virulent nationalism (such as in Nazi Germany or the Soviet Union). Finally, we invite the audience to participate in the dialogue and debate on whether a more universal application of psychiatrists' restraint should be considered in the political sphere.

**Healing the Body in Psychiatric Practice:
Innovations in Psychosomatic Care**

Chair: Alla Landa, Ph.D.

Presenters: Alla Landa, Ph.D., Philip R. Muskin, M.D., M.A., Brian A. Fallon, M.D., Robert Eric Feinstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) . Understand distinctions and overlaps of somatic symptom disorders, illness anxiety, and personality/Axis I psychopathology affecting medical conditions; 2) Know about the most current evidence on treatments for somatic

symptom disorders, and personality/Axis I psychopathology interacting with medical conditions; 3) Know about the most innovative current approaches to organizing the diagnosis, treatment facilitation and treatment for psychosomatic problems at different levels of care; 4) Appreciate the role of integrative multidisciplinary care in the diagnosis and treatment of psychosomatic problems and be familiar with the cutting edge models of integrative care; and 5) Use evidence from translational neuroscience to engage patients with psychosomatic presentations in appropriate treatments.

SUMMARY:

In this presentation, Dr. Rao will focus on educational challenges faced by International Medical Graduates (IMGs) in psychiatry at various stages of their careers in the USA. As residents, the tasks that many IMGs confront are "learn a new subject, a new language and a new culture"- all within the four years of residency training. A tall order, indeed! However, the ubiquitous immigration and acculturation conflicts provide the common thread that runs through them, and how they are handled will determine the outcome of training for the individual IMG. In surveys that examined the educational needs of IMGs, it is reported that personal isolation brought on by immigration and lack of proficiency with English language are cited by IMGs as major obstacles to their success. Using his personal experiences, Dr. Rao will discuss the cultural and educational challenges that he encountered in learning psychiatry, and his ongoing attempts to resolve them. In this context, he emphasizes the centrality of mentorship in all educational efforts. Also, he will address the critical importance of US faculty becoming familiar with the emotional toll of immigration on IMGs, and IMGs' discomfort in raising it in supervision because of heightened concerns caused by recent immigration restrictions. Furthermore, he will emphasize the significant role of psychodynamic psychotherapy training in helping IMGs to address psychological turmoil stirred up by immigration, to uphold their professionalism, and to affirm their identity as psychiatrists. He will conclude his talk by suggesting that the new tasks for the training director in this new era are to act as a caring friend, a culturally

competent preceptor, an empathic guide and a philosopher for whom the IMG is not an anthropological curiosity but a young physician with great potential to succeed.

HIV/AIDS as a Chronic Disease: The Role of Psychiatrists Across Cultures

Chairs: Milton Leonard Wainberg, M.D., Francine Cournos, M.D.

Presenters: Andre Malbergier, Jordi Blanch, M.D., Ph.D., Adriana Carvalhal, M.D., Ph.D., M.Sc., Yiu Kee Warren Ng, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the most frequent psychiatric disorders among HIV-infected individuals; 2) Appreciate the role of psychiatrists and other mental health providers in HIV/AIDS patients' comprehensive care across cultures; and 3) Understand current state-of-the-art treatments for psychiatric disorders in the HIV/AIDS population.

SUMMARY:

Since the advent of effective combination antiretroviral treatment, the course of HIV/AIDS has changed dramatically. HIV infection is now a chronic and treatable illness and patients are encouraged to live a normal life with few restrictions. This impressive change has brought new challenges for patients and their health care teams, especially for psychiatrists and other mental health professionals. Throughout the world, people with HIV infection and AIDS have higher rates of depression, anxiety, stress, alcohol and drug use, pain, sexual problems and cognitive disorders than the general population. Besides psychiatric symptoms, HIV-infected individuals have to cope with complex psychological and social issues such as stigma, occupational problems, social exclusion, disclosure issues, and sexual/marital relationship difficulties. Psychiatrists and other mental health professionals are therefore essential members of HIV/AIDS health care teams. Aging is another challenge that HIV-infected people will face. HIV seems to exacerbate age-associated cognitive decline. Many middle-aged HIV-infected people are experiencing cognitive decline similar to that found among much older adults. Children and adolescents living with HIV infection

are another difficult population to be treated. Clinicians have to make a great effort to keep them adherent to their treatment, especially in the long term. Disclosure of infection, sexuality, parental loss or rejection, and other social issues are also important. Trends in HIV/AIDS prevalence demonstrate the disproportionate burden of HIV infection among racial minorities, especially among youth. Diagnosing and treating psychiatric disorders among HIV-infected people increases antiretroviral therapy adherence, diminishes the likelihood of virologic failure, and decreases morbidity and mortality. This symposium will gather a panel of US and international experts to discuss state-of-the-art psychiatric care for this population across cultures. The topics that will be discussed are: global approaches to HIV/AIDS related mental health problems across countries, sexuality across cultures among people living with HIV, alcohol and drug use and its impact on the HIV care continuum, cognitive disorders among HIV/AIDS-infected individuals, and the special needs of HIV-infected adolescents.

Innovative Quality Improvement Initiatives: International Perspective

Chair: John S. McIntyre, M.D.

Presenters: Wolfgang Gaebel, M.D., Michelle B. Riba, M.D., M.S., J. Richard Ciccone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize quality indicators that have been developed in Germany and other European countries; 2) Recognize quality measures on treatment of Major Depressive Disorder; 3) Understand some of the strategies on medical inpatient units that can drive improved quality and decrease readmission rates; and 4) Identify risk factors that lead to restraint deaths in children and adults.

SUMMARY:

This symposium will present 4 quality improvement projects, one from Europe and the other three from the United States. This symposium is organized by the Section on Quality Assurance of the World Psychiatric Association. The first presentation focuses on the current status of development and use of Quality Indicators. Quality indicators are used

to assess in a systematic fashion evidence-based processes and outcomes. They can be used on the micro, meso and macro level of the health care delivery system. The presentation from Europe will describe the process of development of Quality Indicators, using as an example the German initiative of developing Quality Indicators for schizophrenia. The instrument QUALIFY which measures the relevance, reliability, validity, and feasibility of QIs will be described. Measures are mechanisms that enable the user to quantify the quality of a selected aspect of care by comparing it to an evidence-based criterion. In the United States one of the leading organizations for the development, specification and testing of Quality Measures is PCPI (formerly Physician Consortium on Performance Improvement.) PCPI has developed 350 measure sets including one on Major Depressive Disorder in Adults. In the second presentation the 10 measures in this measure set will be described as well as a review of the structure and processes of measure development by PCPI. Another component of PCPI, the National Quality Registry Network, will be described and current initiatives to increase interoperability will be reviewed. The importance of registries in Quality Improvement activities will be discussed. Because of the high rate of re-hospitalization (33% of Medicare beneficiaries within 90 days) a number of Quality Improvement projects have been instituted to decrease this number. Approximately 25% of these readmissions are viewed as preventable. Depression has been shown to significantly increase the readmission rate. The third presentation in this symposium will describe the strategies in a project to improve depression care in the hospital with one of the goals to decrease readmission rates. The fourth presentation will focus on a national study of death in restraints. State patient advocacy organizations provided information about deaths that resulted from restraints along with all available records. Data concerning the 62 deaths that were included in the study will be reviewed including the site of the restraint (most frequently in general hospital medical units), characteristics of the persons placed in restraints, the type of restraints, the techniques used in applying the restraints and the nature of the observation after the person was placed in

restraints. Based on this data recommended principles, protocols and techniques are outlined.

Middle Eastern Arab Psychiatry: Innovative Initiatives in Clinical Service, Policy, Education, and Research

Chairs: Ossama Tawakol Osman, M.D., Abdel F. Amin, M.D., M.P.H.

Presenters: Ammar Albanna, M.D., Ossama Tawakol Osman, M.D., Hisham Ramy, M.D., Ahmed Elkashef, M.D., Ghanem Ali Al Hassani, M.B.B.S.

Discussant: David V. Sheehan, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the nature of challenges to Arab mental health in the Middle East; 2) Review wellbeing needs of Arab Psychiatric Populations; 3) Identify new innovations in Arab Mental health services, education and research; 4) Discuss origins and current state of Arab Mental health policies and laws and future directions; and 5) Learn about innovative progress in addiction services in the United Arab Emirates.

SUMMARY:

There had been an exponential and impressive efforts in Middle Eastern Arab countries to meet the needs of its populations especially with continuing stressful regional conflicts there. Many impressive initiatives are underway to improve population mental health and wellbeing in that region. This symposium will discuss examples of this effort from representative Arab countries. These efforts span clinical services, psychiatric education, legislations and research. Egypt for example had one of the oldest systems that took care of people with mental illness. The roots of the system can be traced back to an ancient era. The system had evolved over time and was influenced by several great civilizations including Greek, Roman, Islamic and the western civilizations. All had influenced the system of care and the services available in Egypt and beyond in other Middle Eastern Arab countries. Currently, mental health services in Egypt are expanding and moving towards integration in Primary Health Care Services with greater emphasis on community care. In the Arab Gulf region, mental health and addiction services have greatly advanced during the past

decade. Many modern addiction treatment and rehabilitation facilities were opened to serve an increasing demands for services in the Gulf states. The National Rehabilitation Center in Abu Dhabi is an example of a governmental center for treatment and rehabilitation in the United Arab Emirates (UAE). It has developed Through multiple international (UNIODC, WHO, Harvard Maclean Hospital) and national collaborations and has evolved as a regional center of excellence aspiring to become a WHO regional collaborative center. The criminal justice system has also witnessed a progress in the interest of wellbeing and mental health of the population with innovative community outreach initiatives in the Emirate of Abu Dhabi. Mental Health service for children and adolescents have also become a priority in many Arab countries. In the UAE as an example, legislations passed in 2016 include the first child protection law and is being implemented across the country. Many Innovative collaborative models to address pertinent mental health issues are being implemented. Al Jalila Children's Speciality Hospital is the first stand-alone tertiary care hospital in the UAE and includes a dedicated center for child and adolescent mental health aiming to promote excellence in clinical care, research and education. Innovations there include a comprehensive system of care for autism across different sectors, using collaborative approaches. Research projects include a randomized trial of a tele-mental health model. Dubai is steadily nurturing wellbeing and is advancing clinical, research and education services there. Presenters in this symposium will address these initiatives and will interact with the audience in discussion of new ideas hoping to seek further potential fruitful international collaborations.

Multimodal Predictors and Moderators of Treatment Response in Major Depression: First Results From the EMBARC Study

Chairs: Myrna M. Weissman, Ph.D., Maria Antonia Oquendo, M.D., Ph.D.

Presenters: Madhukar H. Trivedi, M.D., Mary L. Phillips, M.D., Ph.D., Ramin V. Parsey, M.D., Ph.D. Discussant: Conor Liston, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn first results of EMBARC, a

multisite placebo-controlled randomized clinical trial of sertraline, examining clinical and biological moderators and predictors of treatment response; 2) Appreciate how biosignatures may potentially optimize treatment selection for depressed patients; and 3) Understand new methods for precision psychiatric treatment using multimodal approaches.

SUMMARY:

Remission rates for major depressive disorder (MDD) are low and unpredictable for any given treatment. No one biological or clinical marker has demonstrated sufficient precision in the selection of treatment. It is unlikely that a single biomarker based on genetic, neuroimaging, electrophysiology, or clinical presentation will successfully guide treatment selection. Biosignatures that harness combined predictive value from various measures may be needed. The first findings of a multi-site clinical trial, Establishing Moderators and Biosignatures of Antidepressant Response in Clinical Care (EMBARC) will be presented. EMBARC is a randomized, placebo-controlled trial of a serotonin selective reuptake inhibitor (SSRI), sertraline, in approximately 300 depressed patients. The study was designed to systematically explore promising clinical and biological markers of antidepressant treatment outcome. Participating centers include the University of Texas Southwestern Medical Center (Coordinating Center), Columbia University/Stony Brook (Data Center), Massachusetts General Hospital, University of Michigan, University of Pittsburgh, and McLean Hospital. We will present results on depressive symptom change over 8 weeks, using clinical, cognitive/behavioral, electrophysiological and neuroimaging moderators. We will show the strong moderation of the patients' baseline clinical severity on symptom change. Previous studies showed impaired reward processing and aberrant reward circuitry (especially ventral striatal) activity during receipt of award in individuals with MDD. We show that changes from baseline to week 1 in ventral striatal activity to reward receipt are associated with differential treatment response to sertraline vs. placebo. Using MRI and DTI, we found that early cortical thickening with sertraline and early cortical thinning with placebo were associated with greater symptom improvement, suggesting potential subtypes. Using

EEG, we demonstrate that increased pre-treatment rostral anterior cingulate theta activity at baseline and week 1 is a non-specific predictor associated with greater improvement in depressive symptoms to both sertraline and placebo, accounting for 40% of the symptom change when combined with demographic and clinical data previously linked to treatment response. In contrast, baseline cognitive control and neuroticism differentially predict response to sertraline. The findings will be discussed in comparison to other biomarker studies. These preliminary analyses demonstrate the potential of multimodal exploration to lead the way to precision psychiatry. These data will become available to the scientific community. A panel of presenters will answer questions about next steps.

National and State Clinical Efforts to Move Toward Zero Suicide

Chair: Molly T. Finnerty, M.D.

Presenters: Michael Hogan, Ph.D., Jay Carruthers, M.D., Prabu Vasan, L.C.S.W., Deborah Layman, Christa Labouliere, Ph.D.

Discussant: Mark Olfson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand suicide as a critical public health issue as well as the current national and state suicide prevention efforts; 2) Describe the nation's largest quality improvement project to reduce suicide incidents among clinical populations and determine the most effective quality improvement strategies for mental health clinic; 3) Examine the validation of an organizational self-study (modified zero suicide self-study) and baseline description of suicide care practices across 193 mental health clinics; 4) Identify service utilization patterns received by Medicaid enrollees prior to a suicide attempt or episode of intentional self-harm; and 5) Review baseline ratings of knowledge, attitudes, and behaviors of clinicians regarding suicide clinical practices.

SUMMARY:

Most individuals who die by suicide accessed the health care system in the year prior to their death and almost half had contact with their provider in the past four weeks. Because behavioral health

clinicians see their patients more often and for longer periods of time than practitioners in other clinical settings, and mental health patients are at substantially increased risk for suicide, approaches to reducing suicide of mental health clinic patients have the potential for saving lives. However, many behavioral health clinicians receive only minimal training in suicide risk assessment and care. Strengthening suicide safer care practices has become a national priority with a particular emphasis on models such as Zero Suicide to better identify and treat individuals at highest risk. We will begin the symposium with an overview of the Zero-Suicide Prevention model and implementation efforts nationally followed by a review of New York State's efforts to reduce suicide and apply the Zero-Suicide model across diverse health settings. Then, we will review a large-scale suicide prevention quality improvement collaborative initiative, with over 160 participating mental health outpatient clinics. The fourth presentation will focus on how mental health clinics (n=193) describe their organizational infrastructure and suicide prevention clinical practices, based on the Zero Suicide Organizational Self-Study, and review psychometric testing results for this fidelity scale, including the relationship between the Zero-Suicide practices at participating clinics and suicide incidents among their patients. This presentation will also report new findings regarding the distribution of demographics, service history, and diagnoses in the year before a suicide attempt for Medicaid enrollees. We conclude with findings of a large-scale workforce survey of 2,045 mental health clinic staff in 172 participating clinics focusing on the experience, training, knowledge, attitudes, and behaviors of mental health clinicians regarding suicide prevention. Throughout the symposium, we will address how innovative quality improvement practices and implementation of data-driven clinical practices can support clinicians in screening and managing their patients who are at high risk for suicide.

Novel Approaches to Treatment in Bipolar Disorder: Algorithms, Controversies, and Special Populations

Chair: Michael Jay Gitlin, M.D.

Presenters: David J. Miklowitz, Ph.D., Christopher D. Schneck, M.D., Katherine Burdick, Ph.D.

Discussant: Robert Morton Post, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Know the potential of treatment algorithm in treating in at risk youth; 2) Be knowledgeable about the utility of family involvement in high risk children/youths; 3) Be familiar with the recent data on antidepressants in bipolar disorder, and especially for bipolar II depression; and 4) Understand the relationship between cognitive deficits and inflammatory markers in bipolar disorder.

SUMMARY:

In this symposium, we will review recent data on a series of topics related to bipolar disorder. The first topic will present new data on the creation of a pharmacologic treatment algorithm for youth at high risk for bipolar disorder. Given the paucity of data to guide treatment in this population, an algorithmic approach to medication interventions may aid in the treatment of such patients. These data suggest that an algorithmic approach to pharmacologic interventions may aid in the management of youth at high risk for bipolar disorder. Our second talk will describe a psychosocial treatment as early intervention for children at high risk for bipolar disorder. We will review targeted psychosocial treatments that can improve outcomes for young patients with high risk conditions – those with early signs of depression or hypomania, evidence of psychosocial impairment, and a family history of bipolar disorder. Because bipolar disorder affects family members as well as patients, and because children and adolescents often live with and are dependent on their parents, the patient's family should usually be included in treatment. Our most recent trial conducted in three sites indicates that children at high risk who receive 4 months of family-focused treatment have longer times to depressive recurrence and less severe manic symptoms than those who receive 4 months of psychoeducation and support. Our next talk will review issues surrounding the prescription of antidepressants for bipolar disorder. Despite concerns that antidepressants are either ineffective and/or provoke mood instability or manic/hypomanic episodes, recent data suggest relative safety and efficacy of antidepressants in treating bipolar depression. Most controversial is the

use of antidepressants as monotherapy in bipolar II depression. Here too, a number of recent studies have provided evidence of both safety and efficacy for antidepressant monotherapy in bipolar II depression. We will review these recent, interesting and surprising data. Our last talk will review the relationship between inflammatory markers and cognitive deficits in bipolar disorder. Though most studies show a normalization of many cytokines during euthymia, there appears to be a cumulative burden over time, with patients in the late 'stage' of BD showing persistently elevated inflammation. This presentation will focus on preliminary results from the first 40 subjects on measures of general cognition, emotional processing, and reward processing with inflammatory markers. Results from this study will help to elucidate how peripheral inflammatory markers affect brain function and advance our understanding of the pathophysiology of cognitive and emotion processing dysfunction in BD.

Psychiatric Genetics in Society: Hopes and Challenges Ahead

Chairs: Maya Sabatello, Ph.D., LL.B., Paul S.

Appelbaum, M.D.

Presenters: Dolores Malaspina, M.D., Caroline Demro, M.A., Lawrence Yang, Ph.D.

Discussant: Erik Parens, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Establish the scientific landscape of psychiatric genetics: recent findings, hopes arising from large scale genomic research; 2) Discuss emerging uses of genetic data to promote health practices and behaviors among individuals at risk for psychiatric disorders; 3) Consider the impact of stigma associated with psychiatric genetics on social and mental health recovery across cultures; and 4) Identify ethical, legal, and social issues arising from the use of psychiatric genetics in daily life settings, including genetic attributions for behavior and use of such genetic data in schools.

SUMMARY:

Advances in psychiatric genetics have complex implications for issues of broad concern to society. The exponential growth in genomic research and the

emerging knowledge of genetic influences on psychiatric and behavioral disorders raise hopes for improved care and prevention. However, the ability to translate psychiatric genetic research findings into social benefits hinges on societal views and values. Moreover, the “geneticization” of society—the process whereby genetic explanations are increasingly ascribed to behaviors and invoked to account for differences among individuals and groups—raises unique ethical, legal, and social issues for psychiatry. These include: conveying the limitations of scientific findings about behavioral and psychiatric genetics; public (mis)understanding of psychiatric genetic risk and willingness to act on such data; the heightened stigma that genetic findings may bring to psychiatric conditions; and the increasing tendency to expand the uses of psychiatric genetics beyond clinical settings to non-clinical, daily-life behaviors and environments. In this symposium, we explore the complex relationship between society and the emerging knowledge of psychiatric genetics. We begin by describing the scientific landscape of psychiatric genetics: historical developments, hopes arising from ongoing psychiatric genetic research, and limitations of emerging findings. We then discuss the extent to which genetic knowledge can promote health practices and behaviors among individuals who may be at risk for developing psychiatric disorders. Next, we consider the ways in which stigma associated with psychiatric genetics can impede social integration and recovery from mental disorders across cultures, and propose some measures to address this challenge. Finally, we discuss the ethical, legal, and social issues arising from growing availability of psychiatric genetic data in non-clinical settings. These include: the impact of genetic attributions of “good” and “bad” behaviors on public responses to such behaviors, and the possible uses—and misuses—of psychiatric genetic data in school settings. A discussant will comment on the presentations and identify questions and areas for further development.

Reshuffling the Deck: Revising Sexual and Gender Diagnoses in ICD-11

Chairs: Jack Drescher, M.D., Geoffrey Reed

Presenters: Richard Bohn Krueger, M.D., Shane Kraus, Ph.D., Jack Drescher, M.D., Geoffrey Reed

Discussant: Meg Kaplan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify and understand that changes from ICD-10 to ICD-11 in the section concerned with paraphilic disorders; 2) Participants will be able to distinguish and understand diagnostic guidelines being proposed for compulsive sexual behaviors for possible inclusion in ICD-11; 3) Participants will be able to explain the ICD-11 revision process of sexual orientation and gender identity diagnoses; and 4) Participants will be able to articulate at least three scientific and policy arguments for the reclassification of sexual and gender diagnoses in the ICD-11.

SUMMARY:

Since Krafft-Ebing’s *Psychopathia Sexualis* in the 19th Century, psychiatrists have been diagnosing atypical presentations of sexuality and gender as mental disorders. In 1973, gay activists challenged the prevailing psychiatric dogma and persuaded APA to remove homosexuality from the DSM. The World Health Organization later followed suit, removing homosexuality per se from ICD-10 in 1990. Yet controversies have persisted in the wider world regarding ICD-10 diagnoses pertaining to gender identity disorders (F64), disorders of sexual preference (F65), and psychological and behavioural disorders associated with sexual development and orientation (F66). Consequently, changes have been incorporated into ICD-11 based on advances in research and clinical practice, and major shifts in social attitudes and in relevant policies, laws, and human rights standards. All F66 disorder categories specifically related to sexual orientation have been removed in ICD-11. Gender identity disorders in ICD-10 have been reconceptualized as Gender Incongruence and moved to the new chapter on sexual health. The ICD-11 classification of Paraphilic disorders distinguishes between conditions relevant to public health and clinical psychopathology and those that merely reflect private behavior. There has also been controversy regarding whether classifications of mental and behavioral disorders should contain diagnoses related to compulsive sexual behavior. The decision was to include such a

category in a grouping of Impulse Control Disorders in ICD-11, emphasizing its commonality with other disorders involving the failure to control impulses or urges resulting in significant distress or functional impairment. The panel of presenters, all involved in differing aspects of development of ICD-11, discuss the history of controversies surrounding these diagnoses, the role of advocacy groups, the rationale and evidence for changes, key differences from DSM-5, and the forthcoming ICD-11 diagnostic guidelines. Evidence from field studies and from legal and policy analyses conducted around the world will be presented.

Terrorism: Radicalization and Rehabilitation

Chair: Zebulon C. Taintor, M.D.

Presenters: Phil Gurski, Ricardo Guinea, M.D., Alberto Fergusson, M.D., Feriha Peracha, Ph.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) describe the process of cognitive narrowing and identification leading to the choice of violent extremism; 2) explain the national contexts that have led to different expressions of violent extremism; 3) explain how violent extremists can be reintegrated into mainstream society; and 4) work toward individual and organizational involvement to counter violent extremism.

SUMMARY:

Psychiatry is uniquely challenged as a medical specialty by those who try to produce a severe symptom we try to treat. This symposium will describe how the choices of violent extremism are evolving in Canada, Pakistan, Spain, the United Kingdom and the United States. Different societal, technological, economic, political, and religious factors work along divisive, unifying, authoritarian, democratizing lines to confront individuals with many choices. Many individual factors, such as anger, powerlessness, a sense of victimhood, intolerance of ambiguity, a desire for purity, seeking adventure, etc. may operate to create a personal narrative that can produce a lone wolf or group identification. In most countries the population most at risk for turning to violent extremism is male, 18-21 years old. Recruiters seek the vulnerable,

isolated, those seeking meaning for their lives, and cautions against recruiting those whose religious identity is well formed, i.e., those who may know too much about their religion to accept authoritarian directives to kill others. Social media have been a boon to recruiters, enabling them to operate over vast distances and use multiple identities, but the technique is traditional: a) first being very interested in knowing the candidate; b) establishing a nonthreatening friendship relationship; c) offering to supply what the candidate seeks as part of getting involved with a movement that is defined slowly as tolerated; d) assignment of a role the candidate wants (consistent with personal values, morality and taste), rewarding success when the tasks are carried out. Once a candidate is placed in the organization's environment, a status hierarchy is revealed and the candidate is tasked with working his way up. Considering the macho culture of most terrorist groups, girls have been recruited fairly well, either for traditional female roles or on the promise of equality with men. Programs that reverse the process of radicalization are not so much deradicalization as they are rehabilitation. They address the whole person, not just the terrorist identity. While reversing cognitive distortions and examining moral principles underlie the programs, success depends on personal contact and experience, emotional involvement and motivation. Feelings about family and siblings, often neglected in the process of radicalization, can be brought into play with impressive force. Open discussions and questions on any topic are encouraged. Political questions generally are discussed only as questions, not answers. While recruitment can be seen as identity narrowing to the terrorist purpose, rehabilitation can be seen as a widening to multiple identities, purposes, and affiliations. Powerless is overcome through education, formal and vocational, and praise for jobs well done. The discussion will consider organizing Section on Terrorism within the World Psychiatric Association.

Why Are Women Physicians at Higher Risk for Burnout? Empowering the Next Generation to Do It Better (Than We Have)!

Chair: Cynthia M. Stonnington, M.D.

Presenters: Elena Volfson, M.D., Judith Carol Engelman, M.D., Julia Files, M.D., Jewel Kling, M.D.,

M.P.H., Suniya Luthar, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the strengths that women physicians bring to the field of medicine; 2) Describe the biopsychosocial vulnerabilities, e.g., unconscious bias, risk for depression and addiction, hormonal influences, child-care responsibilities, challenges in self-advocacy and limit-setting; 3) Recognize appropriate times to use menopausal hormone therapy; and 4) Discuss a variety of solutions that can be implemented individually, organizationally, and culturally to increase resilience and prevent burnout.

SUMMARY:

Women physicians are in demand for good reasons. In general, they listen to their patients, spend extra time when needed, adhere to clinical guidelines, and thoughtfully apply clinical reasoning to patient concerns. And yet, their risk for stress-related problems, burnout, and depression exceeds that of their male counterparts. Given the growing numbers of women entering medical school, the healthcare system will benefit from leveraging the many assets that women bring while meaningfully addressing associated vulnerabilities. In this symposium, we will focus on solutions geared to preventing burnout among women physicians and how to foster a culture that reinforces their strengths and resilience by acknowledging vulnerabilities in order to enable healthy behaviors and mutual support.

Why Play Therapy? A Look at Play as the Premier Psychodynamic Treatment for Young Children

Chair: Pamela Meersand, Ph.D.

Presenters: Christine Anzieu-Premmereur, M.D., Ph.D., Maria Master, M.D., J.D., Talia Hatzor, Ph.D., Alexander D. Kalogerakis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) This symposium will demonstrate the application of psychodynamic concepts to the treatment of young children; 2) Participants will gain knowledge about the potential role of play therapy in supporting developmental progression; and 3) The symposium will provide

exposure to play therapy techniques across a range of clinical situations.

SUMMARY:

This symposium seeks to provide a basic primer on the use of psychodynamic principles in the treatment of young children. Imaginative play, a normative growth-promoting capacity that emerges during the third or fourth year of life, represents the main mode of treatment to establish a therapeutic relationship, gain a window into the child's private conflicts, wishes and fantasies, and help restore the forward progression of development in children who are struggling to meet age salient tasks. In play therapy, disavowed affects and unwanted roles are assigned to the therapist who animates them via her participation in and elaboration of the child's narratives. Overwhelming feelings and unacceptable impulses are named and explored, giving rise to the child's greater tolerance for and understanding of uncomfortable inner states. The three components of this symposium will present play from different vantage points: 1. the first segment will provide a discussion of the theoretical aspects of play, using brief vignettes to illustrate how play functions as a normative developmental capacity as well as a therapeutic tool; 2. the second segment will delve into the process of play, using process material from two children's play therapies in order to illustrate typical treatment dilemmas and challenges, including establishing a positive therapeutic relationship, managing aggressive behavior, and working with parents; and 3. the final segment will provide a discussion of play therapy with very young, insecurely attached children and use process material in order to demonstrate how play therapy is used to strengthen the parent-child relationship.

13 Reasons Why Not: Approaches to Treatment-Resistant Adolescent Depression and Suicidality

Chairs: Jennifer Buenzle Dwyer, M.D., Ph.D., Manpreet Singh, M.D.

Presenters: David Alan Brent, M.D., Andrew J. Gerber, M.D., Ph.D., Mark Olfson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Develop greater comfort and confidence treating adolescent patients with

treatment-resistant depression and suicidality; 2) Understand risk factors for adolescent suicide and develop approaches to stratify risk; 3) Appreciate multiple clinical lenses through which to view adolescent depression and use these to tailor treatment planning; and 4) Understand the evidence base for current and novel treatments for adolescent treatment-resistant depression and suicidality.

SUMMARY:

Major depressive disorder is a significant health problem in child psychiatry, with nearly one in four adolescents meeting criteria by the end of this developmental period¹. While many children improve with first-line treatments, a significant portion remains depressed despite multiple trials of psychotherapy and pharmacotherapy, categorized as treatment-resistant depression (TRD). Suicide, a tragic complication of untreated or inadequately treated depression, is the second leading cause of death in 10-34 year olds in the United States². A media spotlight has recently been cast on this issue with television series such as “13 Reasons Why” creating discussion in both lay and professional circles, and unfortunately also coinciding with a sharp increase in internet searches related to suicide, sparking worries about contagion³. Many clinicians feel ill-equipped to care for children and adolescents with TRD and suicidality. Psychiatric providers face challenges in formulating adolescent patient’s difficulties in a developmental context, assessing and stratifying risk for self-harm and suicide, developing treatment plans with confidence, and evaluating when to refer to more specialized treatments. This symposium aims to address these clinical challenges in order to make participants more comfortable treating this population. Experts will discuss adolescent TRD and suicidality from multiple vantage points, focusing on suicide prediction and risk stratification, intensive psychotherapeutic approaches to TRD, pharmacologic approaches to TRD, and the current evidence base for the novel treatment, ketamine, in this population. There will be time for questions and discussion with this multi-disciplinary panel to enrich our understanding of these adolescent patients and to develop strategies of how best to approach difficult cases.

Advances in Ketamine Research and Clinical Practice: Need for Evidence-Based Practice Guidelines

Chair: Steven Taylor Szabo, M.D., Ph.D.

Presenters: Gerard Sanacora, M.D., Ph.D., Sanjay J. Mathew, M.D., James W. Murrough, M.D., Ashwin Anand Patkar, M.D., Prakash S. Masand, M.D.

Discussant: Carlos A. Zarate, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Translate the mechanism of action of subanesthetic doses of ketamine to clinical practice; 2) Understand the role of ketamine in the treatment of various mental illnesses; 3) Identify several types of ketamine treatment algorithms in management of mood, anxiety, and chronic pain; 4) Appreciate the potential impact of ketamine in mental health and the need to develop guidelines ; and 5) Research registry approaches to evaluating safety and optimization of ketamine treatment.

SUMMARY:

Clinical appreciation and use of ketamine in the treatment of patients with mental illness has significantly increased over the past decade. Research continues to indicate various mechanisms by which subanesthetic doses of ketamine exert neurobiological effects to ameliorate psychiatric symptoms. Clinical trials using ketamine has demonstrated prominent effects in symptom reduction in patients with mood and anxiety spectrum disorders (i.e., bipolar depression, major depressive disorder, posttraumatic stress disorder, and obsessive compulsive disorder), as well as in the management of chronic pain. However, there is a lack of consensus and uniformity in the clinical protocols that clinicians are employing. In this presentation, we overview evidence based practices as derived from clinical research findings. We will then discuss potential regulatory changes which are needed for use of ketamine in clinics as based on the available scientific data. Finally, we will hear about one initiative that involves a consortium of research clinics to standardize the treatment of subanesthetic doses of ketamine in patients with mental illness using a data registry approach. Safety issues

including potential abuse liability of ketamine will be also discussed.

Complementary and Integrative Treatments in Psychiatric Practice

Chairs: Philip R. Muskin, M.D., M.A., Patricia Lynn Gerbarg, M.D.

Presenters: Richard Paul Brown, M.D., Jerome Sarris, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify herbal treatments that can be useful in the treatment of anxiety, depression, and other psychiatric disorders; 2) Integrate S-adenosylmethionine (SAMe) into treatment of patients with depression; 3) Discuss the effects of voluntarily regulated breathing practices on sympatho-vagal balance, stress response, and social engagement systems; and 4) Access information and tools to develop skills in the use of voluntarily regulated breathing and other mind-body approaches as adjunctive therapies in psychiatric practice.

SUMMARY:

International experts who authored chapters in *Complementary and Integrative Treatments in Psychiatric Practice* by the American Psychiatric Association Publishing (2017), discuss the evidence base, treatment issues, safety, efficacy, and future directions for Complementary and Integrative Medicine (CAIM) in psychiatry. Guidelines for decision making, combining CAIM approaches, and integration with conventional treatments are provided. This sampling of treatments covered in the book is based upon therapeutic potential, evidence base, safety, clinical experience, geographical and cultural diversity, and public interest. Dr. Philip Muskin opens the symposium by putting CAIM in the context of 21st century practice of psychiatry. Issues to be addressed include the importance of learning about CAIM, the doctor-patient relationship, how to introduce CAIM to patients, ethical issues, liability issues, developing competencies in integration of herbs, nutrients and mind-body practices with conventional treatments, and future directions. Jerome Sarris presents data from a newly completed large multicenter randomized controlled trial (RCT)

of a combination nutraceutical approach to treat depression, and on individual nutrients including S-adenosylmethionine (SAMe) and omega-3. He will also present new RCT data on Kava for the treatment of anxiety (including pharmacogenomic and neuroimaging data). He provides research updates of other medicinal plants, including Rhodiola and Saffron. Patricia Gerbarg updates the evidence for safety and efficacy of mind-body interventions in neuropsychiatric disorders, potential neurobiological mechanisms, neurophysiological theories and clinical studies of breathing practices in treatment of anxiety, depression, and traumatic stress-related disorders. She discusses response to Breath-Body-Mind interventions by adult and child refugees from the Middle East living in shelters in Berlin as well as South Sudanese survivors of war and slavery. Dr. Gerbarg describes potential beneficial effects of mind-body treatments, particularly therapeutic breathing practices, on stress response, trauma resolution, empathy, and connectedness. Questions from attendees will be addressed by a panel comprised of the presenters. Dr. Brown leads participants to experience some of the therapeutic movement, breathing, and Open Focus Attention practices he has used in treating psychiatric patients, individuals with serious medical illness, veterans, and survivors of mass disasters in the US, South Sudan and Berlin. Clinicians will acquire valuable insights into complementary and integrative practices for self-care, patient care, community resiliency, and disaster response.

Eroticism: Denial and Recovery

Chair: Otto F. Kernberg, M.D.

Presenters: Susan Carole Vaughan, M.D., Robert Michels, M.D., Otto F. Kernberg, M.D.

Discussant: Eve Caligor, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Trace the origin and development of the affective system of eroticism, from sexual excitement to passionate love; 2) Assess the extent to which patients have achieved a mature sexual identity, or present inhibition or pathology in their sexual life; 3) Diagnose and manage typical difficulties in the intimate sexual experiences of borderline and narcissistic patients; and 4) Access

and manage the transference and countertransference complications typical for the treatment of erotic pathology.

SUMMARY:

This symposium will explore the erotic inhibitions and pathology in the sexual life of patients with severe personality disorders. It will outline normal development of eroticism, from sexual excitement to passionate sexual love, and outline typical difficulties in the love life of borderline and narcissistic personality disorders. The expression and therapeutic management of these difficulties in the transference and countertransference of psychodynamic psychotherapies will be explored as an important aspect of psychotherapeutic approaches to these patients. The therapists' alertness to different sensibilities, cultural variations and sexual identities of patients will complete this overview.

Innovation Gone Wrong: What We Can Learn From Psychiatrists' Involvement in Eugenics and the Holocaust

Chair: Bruce Alan Hershfield, M.D.

Presenter: Mark Stephen Komrad, M.D.

Discussants: James Henry Scully, M.D., Glenn J.

Treisman, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) State 2 present-day parallels between physician-assisted suicide/medical euthanasia, or the opiate epidemic, and the US eugenics movement/Nazi T4 program; 2) List 3 safeguards that exist in Psychiatry now that decrease the likelihood of a repetition of these tragedies; and 3) Name 3 signs that suggest present-day "innovations" can end tragically.

SUMMARY:

Mark Komrad, MD, Ethicist in Chief at Sheppard Pratt Health System: "The Role of Psychiatrists in the US Eugenics Movement and the Nazi Holocaust": While assisted suicide and voluntary euthanasia, even of psychiatric patients, becomes more common, it is important to look at how Psychiatry lost its ethical moorings in the past. The eugenics movement in the US led to forced sterilization of the

mentally ill and developmentally disabled. It occurred in some of the major psychiatric centers and was promoted by leaders of Psychiatry, who believed they were acting most humanely, to move Society forward. The step of proposing euthanasia for the mentally ill was left to the T4 program in Germany, which systematically murdered mentally ill and developmentally disabled people, utilizing techniques that were later used in the camps. The most prominent German psychiatrists were key organizers and participants. These are important lessons for Psychiatry now, since social pressures in some countries have led psychiatrists to euthanize some suicidal patients who requested it. This is a version of a talk given last August to the Southern Psychiatric Association. The response was sufficient to encourage opportunities for more commentary. James H. Scully, Jr., MD, University of South Carolina and former Medical Director of the APA, will speak and will serve as a Discussant: "How Psychiatry has Changed So that We Can Better Recognize and Eliminate Mistakes": Since World War II, Psychiatry has developed as an important part of Medicine. A strong APA with an Ethics Committee and a democratically elected Board and Assembly, and international societies such as the WPA, are now in place to prevent repetition of these kinds of tragedies. He will give examples of "innovations" that the profession was able to identify as destructive and to eliminate. Glenn Treisman, MD, PhD, the Eugene Meyer Professor of Medicine and Psychiatry at Johns Hopkins, will also serve as a Discussant, speaking on "Protecting & Advocating for Vulnerable People in Health Care". He will give examples of medical system problems that can lead to misuse of patients, and discuss mechanisms such as DNR orders and advanced directives that may become part of the process. He will talk about impaired autonomy and how Psychiatry can avoid misdirecting treatment, so that patients are not hurt. He will also describe the opiate epidemic in the US and how it relates to eugenics. Bruce Hershfield, MD, Johns Hopkins University, will act as Chair.

Innovations in Global Psychiatric Education

Chairs: Saul Levin, M.D., M.P.A., Roger Man Kin Ng, M.D.

Presenters: Nada Logan Stotland, M.D., M.P.H., Dinesh Bhugra, M.D., Marc H. M. Hermans, M.D.,

Mahesh Jayaram, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) understand about the variation of psychiatric education around the globe; 2) learn about innovative training methods to benefit mental health professionals with limited access to high quality training; and 3) Online training is a promising approach given the ready access to internet in many countries.

SUMMARY:

The worldwide survey of training provisions for psychiatrists in WPA member societies revealed that the member societies belonging to the low and middle income country group (LMIC group) have a significantly shorter duration of psychiatric training and fewer chances of rotation to different psychiatric subspecialties than those in the high income countries (HIC). What is of major concern is that around 20% of member societies, all belonging to LMIC group, have less than 36 months of psychiatric training. Over 40% of member societies do not include medical leadership as a didactic teaching topic in the psychiatric training curriculum. Dr Ng will first highlight the significant findings of the survey and the strategic direction of WPA in addressing the shortfall of education in the LMIC. Given the increasing availability of internet access, transfer of knowledge and skills through online platform becomes a reality. Dr Mahesh Jayaram will provide an overview of the development, content and delivery of the new online WPA Diploma of International Psychiatry which is jointly developed by WPA and University of Melbourne, Australia. Although online training provides a good medium of learning, effective education should also involve additional training methods. Dr Marc Hermans will share some innovations of psychiatric education being developed in Europe to harmonise the standard of psychiatrists in Europe, so as to ensure free movement of EU doctors across the continent but also guarantee an optimal standard of mental health care to patients. Dr Nada Stotland will also share her experiences about the role of senior psychiatrists in HIC group in supporting education and training of psychiatrists in LMIC. This is a relatively untapped resource which can be further

developed to enhance psychiatric education to psychiatrists and mental health professionals in LMIC. Last but not least, Prof Dinesh Bhugra will address the importance of medical leadership training in basic psychiatric curriculum given that psychiatrists in the current era should play multiple key roles in mental health field.

Innovative Approaches to Quelling the Opioid Epidemic: From Plants to Implants

Chairs: Sandra Comer, Ph.D., Eric Strain, M.D.

Presenters: Wilson M. Compton, M.D., Sharon Walsh, Ph.D., Paul Pentel, M.D., Andrew Kruegel

Discussant: Beatriz de A. Rocha, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the scope of the opioid epidemic and its impact on society; 2) Understand the use and limitations of rescue medications to treat opioid overdose; 3) Understand new and emerging approaches using buprenorphine as a medication assisted treatment (MAT) for opioid use disorders; 4) Understand the principles underlying vaccines used to treat opioid use disorders; and 5) Describe evidence for the utility of natural products such as kratom to treat opioid use disorders.

SUMMARY:

The widespread abuse of prescription opioids and dramatic increase in the availability of illicit opioids, including heroin and fentanyl, has created what is commonly referred to as “the opioid epidemic.” The scope of this epidemic is nothing less than startling: about 4% of the adult U.S. population misuse prescription opioids, and in 2015, 33,000 deaths and more than 1.25 million hospital visits were attributable to overdose with licit and illicit opioids. Recently, President Trump declared the opioid epidemic a public health emergency. Increasing both the availability and efficacy of medication-assisted treatments (MATs) is an essential component of an integrated/coordinated approach to quell this epidemic. The speakers in this symposium will discuss innovative approaches to treating opioid use disorders (OUDs). The use and limitations of naloxone, an FDA-approved medication to treat opioid overdose, will be described together with the

potential for developing more effective rescue medications. Oral and buccal buprenorphine has been a mainstay of MATs to treat OUDs. The development of both long-lasting (6 month) buprenorphine implants and sustained-release injections that produce therapeutic levels of buprenorphine from 1-4 weeks will be described. The concept of developing vaccines to target abused opioids (e.g., heroin, oxycodone, fentanyl) raises the possibility that a patient can be immunized against these compounds while receiving another MAT such as buprenorphine, methadone, or naltrexone. The challenges of 'tricking' the immune system to recognize a small molecule (opioid) and raise antibodies against it will be described. Finally, data will be presented suggesting that natural products, such as kratom, may be useful for the treatment of opioid withdrawal symptoms. The regulatory hurdles associated with the development of each of these types of medications will be discussed.

Innovative Models of Collaborative/Integrated Care: Training Child Psychiatrists and Pediatricians for the Future

Chair: Justin W. Mohatt, M.D.

Presenters: Sandra Fritsch, M.D., Cori Green, M.D., M.Sc., Benjamin Miller, Psy.D., Elise Michelle Fallucco, M.D.

Discussant: Elizabeth McCauley

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss innovative collaborative approaches to improve access and care of children with mental health needs; 2) Understand the training needs for pediatricians to provide mental health care themselves and in a collaborative approach; 3) Understand the training needs for mental health professionals to provide support and work in collaborative care settings with primary care physicians; 4) Describe training needs and models for future collaboration between primary care physicians and mental health professionals; and 5) Understand how to implement different models of collaborative and integrated care for children with mental health needs.

SUMMARY:

The disparity between the number of available child

mental health (MH) clinicians and the number of children in need of their services is well known and requires us to think about novel care delivery models that take advantage of the full range of potential mental health providers and partners in communities. At the same time pediatricians are seeing larger percentages of their patients in need of MH services. Innovative models for integrating MH services, enhancing collaboration between pediatricians and MH clinicians, and training a new generation of both pediatricians and psychiatrists to work in these models is crucial to solving these access issues. Pediatricians are well suited to manage certain MH concerns given the shortage of MH specialists, stigma associated with MH, and longitudinal relationships pediatricians develop with their patients and families. However, the majority of pediatricians do not feel prepared to do so since residency training does not prepare them to provide this care. National efforts to improve training have existed for decades, but the American Board of Pediatrics recently put out a call to action in order to move efforts forward. However, how to better prepare future pediatricians is debated, especially since their pediatric preceptors and mentors were not trained to do so. Training programs have increasingly started to collaborate with their MH departments and a third of pediatric programs have reported having on-site MH services. Data suggests practicing in new models of integrated care has influenced trainees' confidence, skills, and knowledge. At the same time psychiatrists must be trained to practice in these new models, which require a different skill set than traditional individual practice models. There are currently no evidence-based recommendations in implementing or adapting integrated models for practicing pediatricians or for residency training programs in either pediatrics or child psychiatry. Innovative efforts at both the state and training program level exist and show promise. We will hear from some of the innovators in this field. First we will hear from a pediatrician who has studied the current and ideal state of MH training in pediatric residency and how that led to an integrated model for their training clinic. Second, we will hear about how one child psychiatrist engaged pediatricians through the North Florida Collaborative Care Initiative. Next, we will hear about a model of integrating the training

experience of both psychiatric and pediatric residents using a novel “Buddy” system that pairs residents in both fields. Lastly, that we will hear how experts in the field in Colorado created evidence-based competencies for Behavioral Health clinicians to work in primary care.

Mental Health in All Policies: How to Partner With Lawmakers to Improve Mental Health Outcomes

Chair: Ruth S. Shim, M.D., M.P.H.

Presenters: Marc W. Manseau, M.D., M.P.H., Kevin Maclair Simon, M.D., Joshua Berezin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the “Health in All Policies” approach and apply it to a mental health framework; 2) Learn how to critically evaluate and screen bills for mental health policy implications; 3) Interact with local governmental officials (including legislators, staffers, and activists) to advance sound mental health policy; and 4) Develop tools for actively improving mental health policy at the local government level.

SUMMARY:

The social determinants of mental health (those factors stemming from where we grow, live, work, learn, and age that impact upon our overall mental health and well-being) are responsible for many of the disparities and inequities we see in mental health outcomes in our society. These social determinants are shaped by public policies and social norms; therefore, they are modifiable through social and public policy interventions. Significant progress in addressing the social determinants of health has been made by adopting a “Health in All Policies” approach, which incorporates health into decision making across various sectors and policy arenas. This Symposium expands the Health in All Policies initiative to consider “Mental Health in All Policies” and equips mental health professionals with the tools to effectively engage and interact with local governments to shape public policies. Few mental health providers feel adequately prepared to interact with legislators and other policy influencers in their local governments, despite the fact that these relationships can prove most effective in directly addressing the social determinants of

mental health. Presenters will discuss how to establish relationships with lawmakers, learn techniques for examining bills for mental health policy implications, and will discuss effective ways to influence and educate legislators and their staff. Local lawmakers will participate in the discussion and provide personal perspectives for building and maintaining positive collaborative relationships.

Neuroscience-Based Nomenclature (NbN) for Psychotropic Drugs: Progress Report and Future Plans

Chair: Maria Antonia Oquendo, M.D., Ph.D.

Presenters: Stephen Michael Stahl, M.D., Ph.D., Joseph Zohar, Deborah A. Bilder, M.D.

Discussant: Michael John Travis, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the current problems with the existing nomenclature; 2) Understand the new nomenclature that is based on pharmacology and mode of action; 3) Examine avenues for dissemination and training of MD’s and other mental health professionals; and 4) Get perspective on its international adoption.

SUMMARY:

This session should provide a clear framework how the Neuroscience Based Nomenclature (NbN) can be used to improve our understanding of psychiatric drugs and how such a new language will benefit translational neuroscience and provide an asset for new treatments for brain disorders. The approach taken by the NbN has several advantages including: 1) a much better reflection of basic and clinical neuroscience, 2) greater precision arising from a nomenclature based on pharmacology and modes of action as opposed to disease based naming which is derived from the initial approval of the compound, 3) reduced stigma associated with taking a compound that does not match with its use (giving ‘antidepressant’ to patients who suffer from anxiety or ‘antipsychotic’ to depressed patients who do not suffer from psychosis), and 4) greater ease in educating professionals, patients and their families about psychopharmacology. Furthermore, the availability of a free of charge informational app that is revised periodically by expert consultation can

facilitate overall dissemination and rapid adoption by scientific journals editors, reviewers, and those who are contributing to the scientific literature. The endorsement of the five international organizations and of more than 25 leading scientific journals are indicators of the scientific “weight” and relevance of NbN. The dissemination efforts include presentations to a variety of research and clinical audiences, trainees, and other mental health professionals. Moreover, the area of child and adolescent psychopharmacology is being pursued actively. This symposium will begin with a brief introduction to the present NbN app (J. Zohar), to be followed by a presentation by M. Travis on the implications for residency education. D. Bilder will then discuss the application of the NbN to the treatment of children and adolescents. S. Stahl will discuss the implications for the major psychiatric disorders. Finally, M. Travis will serve as discussant of the above presentations.

Rebuilding Our Bridges: Using Quality Improvement and the Systems-Based Practice Model to Address Systems and Physician Burnout

Chair: Carisa Maureen Kymissis, M.D.

Presenters: Stephanie Le Melle, M.D., M.S., Renu Maria Culas, M.B.B.S., Alexander Kane, Sarah Kauffman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the signs and manifestations of burnout within individuals, teams, clinics, and systems; 2) Demonstrate ways to help prevent burnout and improve patient care by incorporating a culture of Quality Improvement as part of routine clinical practice, training, and patient safety; 3) Enhance models for resident training in public psychiatry by incorporating a Systems-Based Learning approach and Quality Improvement projects; 4) Apply the Systems Based Practice model to management of high needs community psychiatry patients and identifying missing components of clinical care; and 5) Raise awareness of both clinician burnout and systems burnout in managing complex/high needs patients and populations.

SUMMARY:

Effective delivery of behavioral health services in the

community requires a conceptual framework or a system of care. One clinical approach to delivering care to high needs community patients is to incorporate a systems based practice (SBP) approach, one of six core competencies required by the Accreditation Council of Graduate Medical Education (ACGME). The ACGME Milestones for SBP was modeled in part by the Four Factor Model of Systems Based Practice. One training program demonstrating successful implementation of the Four Factor Model of SBP approach suggests organizing the psychiatrist role into four components: patient care advocate, team member, information integrator, and resource manager. This model can provide an effective teaching approach to help residents conceptualize community patients with complex psychopathology, medical co-morbidities, and extensive psychosocial service needs. In managing patients collaboratively as a team member in the hospital system and in the community, residents learn to partner with other team members improving patient engagement in a system of care, and in turn reducing clinician burnout by organizing a patient’s care amongst a larger system of care with multiple teammates. The model also addresses optimal use of limited resources including time management which is a crucial contributor to clinician burnout. We demonstrate how this SBP approach may be useful in identifying key components of patient support that are missing from the system and leading to suboptimal patient outcomes, clinician burnout, and ‘systems’ failures. Our team’s use of this model helped to facilitate our practice of Quality Improvement (QI) by providing an organized approach to integrating a complex set of information associated with a high needs patient. Of note, studies show that involving trainees in QI projects early in their career positively influences patient care and provides opportunities for trainees to gain valuable leadership and administrative experience. ACGME expectations are that residents learn to “systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement”. With training and clinic QI missions in mind, and in working to address systems gaps to more effectively treat our community patients, our resident-attending clinic team developed a systems-level QI

case conference to engage the larger hospital system in exploring ways to fill the patient care gaps that we identified in assessing our patient's care. In this symposium, we aim to present an SBP model as practiced in our clinical service to ground listeners to this patient care approach, illustrate application of these concepts through a clinical case vignette, highlight how this model alerted us to system deficits associated with this patient's care, and discuss gains in mitigating clinician and systems burnout through a system-wide QI case conference format.

Suicide and Suicide Risk Assessment: A Core Competence

Chair: Liza Hannah Gold, M.D.

Presenters: Richard Lesesne Frierson, M.D., Cheryl D. Wills, M.D., Kaustubh G. Joshi, M.D., Donna Vanderpool, J.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the basic principles of suicide risk assessment; 2) To appreciate the importance of suicide risk assessments in reducing the risk of suicide; 3) To improve skills in conducting suicide risk assessments in general and with special populations; and 4) To understand and mitigate liability issues in the context of suicide and suicide risk assessments.

SUMMARY:

A wise psychiatrist once observed that there are only two kinds of psychiatrists: those who have had a patient commit suicide and those who will have a patient commit suicide. Suicide is the tenth leading cause of death in the United States, the third leading cause of death among individuals between the ages of 10 and 14, and the second leading cause of death among individuals between the ages of 15 and 34. In 2015, there were more than twice as many suicides (44,193) in the United States as there were homicides (17,793) and the total suicide rate has increased 24% from 10.5 to 13.0 per 100,000 over the past 15 years. In addition, It is estimated that for every suicide there are at least 6 survivors. Based on this estimate, approximately 6 million Americans became survivors of suicide in the last 25 years. Beyond these horrific associated emotional losses,

the economic toll of suicide is staggering: the CDC estimated that in 2013, the medical and work-loss costs of suicide associated were \$50.8 billion, 24% of the total costs associated with all fatal injuries. One of only two interventions demonstrated to decrease the risk of suicide is accessing mental health treatment. Suicide risk assessment is the gateway to treatment. Yet research has shown that psychiatrists often report that they lack adequate training in conducting suicide risk assessments. This symposium will review the principles of suicide risk assessment and adaptations needed for different populations such as inpatients, outpatients, teens, and veterans. We will also review the liability issues associated with patient suicide and how adequate suicide risk assessments can mitigate potential liability in the unfortunate event of a patient suicide. Ongoing suicide risk assessment is a necessary part of the treatment process with patients at risk of suicide. Attendees can expect to gain increased understanding of the suicide risk assessment process and improved skills in conducting these potentially life-saving evaluations. This symposium will review of the need for systematic review of factors that increase risk or mitigate risk, and the need to conduct multiple assessments, particularly at times of change in treatment interventions, such as decreasing frequency of outpatient treatment or discharge from inpatient hospitalization. Psychiatrists are in a unique position to address the public health issues that suicide presents. This symposium will help improve their skills in doing so.

The New Frontier in Bipolar Disorder Research: Clinical Implications

Chair: Iria Grande, M.D., Ph.D.

Presenters: Eduard Vieta, M.D., Ph.D., Katherine Burdick, Ph.D., Terence Ketter, M.D., Roy H. Perlis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Update knowledge on management of bipolar disorder; 2) Know the impact of bipolar disorder in functioning and well-being; 3) Be aware of the cognitive impairment associated with bipolar disorder; 4) Learn how to assess and manage mixed state in bipolar disorder; and 5)

Assess the possible use of biomarkers in bipolar disorder.

SUMMARY:

This symposium aims to give an update on relevant issue on the management of bipolar disorder regarding the most cutting-edge research on the moment. Dr. Vieta will focus on functioning of patients with bipolar disorder and their well-being, while Katherine Burdick will describe the current knowledge on cognition in this disorder, Terence Ketter will address the controversial issue of mixed states in bipolar disorder, and Roy Perlis the possible utility of biomarkers in bipolar disorder.

Using Neurobiology to Inform the Development of Novel Interventions for Depression

Chair: George S. Alexopoulos, M.D.

Presenters: Francis Lee, M.D., Ph.D., Conor Liston, M.D., Ph.D., Marc J. Dubin, M.D., Ph.D., Faith Gunning, Ph.D., Jennifer N. Bress, Ph.D.

Discussant: Sarah H. Lisanby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Impart information on network abnormalities in depression; 2) Familiarize the audience with genetic and neurophysiological subtypes of depressive syndromes; 3) Convey information of network dysfunction interfering with response to antidepressants; and 4) Present findings on novel, neurobiologically-informed interventions for depression.

SUMMARY:

The presenters of this symposium have worked together to produce findings and concepts that can led to novel interventions for depression. Their work is based on the assumption that targeting neurobiological abnormalities of depressive syndromes can decrease the complexity of interventions and improve their efficacy. One of the barriers to treatment development has been the genetic and neurophysiological heterogeneity of anxiety and depressive syndromes. F. Lee, MD, PhD will present data on genetic variations that influence neuroplasticity in fear related brain circuitry and can be used in the development of targeted treatments. C. Liston, MD, PhD will present results of an effort to

test whether depressed patients could be subdivided into neurophysiological subtypes defined by distinct patterns of dysfunctional connectivity in limbic and frontostriatal networks. He and his colleagues discovered four connectivity-based subtypes associated with differing clinical symptom profiles that predicted differential responsiveness to transcranial magnetic stimulation therapy. He will discuss on-going efforts to further optimize these methods and apply them to related diagnoses. M. Dubin, MD, PhD will report on Low Field Magnetic Stimulation (LFMS), an experimental treatment that has shown promise for efficacy in both unipolar and bipolar depression. He will present findings on the effects of LFMS on resting state functional connectivity, which is known to be abnormal in depression. F. Gunning, PhD will report findings suggesting that abnormal activation and functional connectivity of the cognitive control network predict poor response of late-life depression to antidepressant drugs. Based on patterns of functional connectivity, she will describe subtypes of patients that correspond to different behavioral expressions of abnormal cognitive control and reward-related behaviors. G. Alexopoulos, MD will report findings on efficacy and target engagement of “Engage”, a streamlined behavioral intervention for late-life depression. “Engage” is based on findings suggesting that dysfunction in reward networks is fundamental to the pathogenesis of late-life depression and uses “reward exposure” to reignite the uncton of these networks. If patients fail to utilize “reward exposure”, therapists seek to identify and address barriers to reward exposure (i.e. negativity bias, apathy, or emotional dysregulation related to negative valence, arousal, and cognitive control system dysfunctions respectively) so that “reward exposure” can proceed unimpeded. J. Bress, PhD will report on electrophysiological abnormalities of reward systems in depression. She will discuss the utility of reward positivity (RewP) and of the late positive potential (LPP) in assessing engagement of the reward systems targeted by “Engage” therapy. SH Lisanby, MD of the NIMH will serve as the discussant.

What Is “Medically Clear” for “the Psychiatric Patient” in the ED?

Chair: Yad M. Jabbarpour, M.D.

Presenters: Yad M. Jabbarpour, M.D., Leslie Zun, M.D., Rachel Lipson Glick, M.D., Richard J. Bonnie, LL.B., Christopher McStay
Discussant: Marvin Stanley Swartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the crucial role of clinical assessment in serving patients presenting with changes in behavior, cognition and emotion to rule-out underlying medical conditions; 2) Recognize the role of emergency medicine physicians and psychiatrists – as well as integration and collaboration - in the medical screening of psychiatric patients in the emergency department; 3) Apply the legal components, ranging from EMTALA to commitment laws, to serving psychiatric patients in the emergency department and supporting level of care decisions; and 4) Identify the barriers associated with medical screening of psychiatric patients in the emergency department and strategies to overcome those barriers to safety and quality care.

SUMMARY:

Patients present with disturbances of affect, behavior, and cognition in Emergency Departments (ED's). Some of the patients referred for inpatient psychiatric hospitalization actually have underlying medical issues causing their problems for which medical treatment is indicated; not psychiatric hospitalization. Simultaneously persons with severe mental illnesses are experiencing comorbid medical issues, which might require emergent assessment and treatment. In addition, emergency departments are increasingly burdened with serving persons presenting with psychiatric problems in a health care system that is reported to be underfunded, not integrated, and experiencing an ever dwindling number of psychiatric beds. ED's and patients become burdened with boarding. Patients, their families and clinicians must navigate a complex labyrinth of fragmented services with varying state, insurance and healthcare regulations in the process of emergency assessment, diagnosis, triage, treatment and placement. In a setting of supporting psychiatric patients in need of inpatient psychiatric services getting a timely inpatient treatment, what medical screening should occur for patients

presenting with psychiatric symptoms and signs? What is Medically Clear for "The Psychiatric Patient" in the ED? The first and most crucial step in the evaluation process is to eliminate possible medical causes for patients' presenting psychiatric symptoms and signs. As there are a number of rapidly lethal medical conditions that may manifest common psychiatric symptoms, the ability to identify these conditions and make appropriate early interventions is a core skill. A wide range of medical conditions and treatments may result in abnormal behavior, and many medical disorders may produce or exacerbate psychiatric symptoms in patients with pre-existing mental illness. In addition, some experts in the field of emergency medicine state that the use of the term "medical clearance" is imprecise and should not be utilized. The term implies that the patient has been cleared of all medical conditions. Risk management issues exist; in addition to potential human rights violations: Failure to detect and diagnose underlying medical disorders may result in significant and unnecessary morbidity and mortality, invasion of an individual's life and constitutionally guaranteed liberties and liability to community systems and transferring physicians. Transfer of patients with acute or unstable medical conditions from an emergency department may constitute a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA); however, clinicians are also balancing risk management issues and mental health commitment laws. Guidelines based upon evidence-base can support the medical screening of psychiatric patients. These best practices can support clinical decision-making so that the right patient gets to the right place in the right time.

What Psychiatrists Should Know About the Legalization of Cannabis and Its Implications for Adolescents and Young Adults

Chair: Stephan M. Carlson, M.D.

Presenter: Jason E. Hershberger, M.D.

Discussants: Jose P. Vito, M.D., Manuel Lopez-Leon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss why a public mental health framework is imperative for cannabis legalization; 2) Describe the endocannabinoid

system, its functions, and therapeutic potential; 3) Describe the potential long-term brain changes of heavy cannabis use prior to brain maturation; and 4) Discuss the epidemiology of cannabis use disorder in adolescents and young adults.

SUMMARY:

Dr. Hershberger, the first discussant, will discuss the landscape of decriminalization of recreational and legalization of medicinal cannabis and the rapid changes in policy, culture and research relating to cannabis in the U.S. While cannabis remains a Schedule I drug, more than half of states have legalized it. Although these state laws decriminalizing cannabis, for the most part, have not targeted adolescents, they have created an environment in which marijuana is perceived as safe, non-addictive and therapeutic. As society is confronted with these new trends in cannabis consumption, Dr. Hershberger will set the stage for growing concerns that psychiatrists should understand -- including the potential risks of these increasingly accessible products to adolescents and young adults. He will discuss the dynamic marijuana policy environment and the expanding marijuana industry. Legalized markets open opportunities for a lucrative market in which corporations will seek to maximize consumption to maximize profits through innovations product design and marketing. To counter these inevitable pressures, Dr. Hershberger will discuss why a public mental health framework is needed for marijuana. In this framework, the policy environment would develop a marijuana prevention and control program aimed at the general population and produce public education campaigns modeled on successful tobacco control. Dr. Carlson, the second discussant, will review the fascinating discovery of the endocannabinoid (eCB) system -- which helps us to understand the normal physiological functions of this system. He will then highlight how researchers are exploring the modulation of the activities of the eCB to harness new therapeutic interventions in several diseases. This system can also be hijacked by phytocannabinoids -- especially those strains with high THC and low cannabidiol content. Dr. Carlson will review phytocannabinoid pharmacology including the strains, the potency, and the different products. Dr. Lopez-Leon, the third discussant, will

then review the research on whether cannabis use during adolescence can cause any functional or structural changes to the developing brain. He will review evidence of impaired neurological development and cognitive decline, diminished school performance and lifetime achievement. Finally, in the fourth presentation, Dr. Vito will review the epidemiology of cannabis use by adolescents in the United States. He will review studies looking at whether cannabis use in this age group is linked to cannabis use disorder and whether it is associated with increased emergency room visits or hospitalizations in the states that have legalized either medicinal and/or recreational cannabis. He will also review the question of whether cannabis is a gateway drug leading to other substance use disorders, such as the initiation and maintenance of tobacco smoking, alcohol use and opioids.

Tuesday, May 08, 2018

Collaborative Care in Comorbid Depression and Chronic Disease: Effects, Costs and Implementation

Chair: Christina M. Van der Feltz, M.D., Ph.D.

Presenters: Cees Rijnders, M.D., Ph.D., Maria Panagioti, Ph.D., Christina M. Van der Feltz, M.D., Ph.D., Anna Ratzliff, M.D., Ph.D.

Discussant: Aartjan Beekman, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discern physical and depressive outcomes of CC in comorbid major depression and chronic disease; 2) Describe the effect of CC on suicidal ideation in major depression with or without comorbid chronic disease; 3) Comprehend cost-utility of CC in comorbid major depression and chronic disease; and 4) Adjust implementation strategies for collaborative care for his practice setting.

SUMMARY:

Collaborative care (CC) has been evaluated in research and implemented in health care in the USA and Europe, and implementation is still expanding. It is a protocolled multi-disciplinary chronic care treatment for depressive and anxiety disorders, originally developed in general health care in the 1970s, which involves a nurse care manager (CM), a

primary care doctor(PCP) and a consultant psychiatrist (CLP) working with a patient. CC is effective compared to Care As Usual (CAU) in depressive disorders. It is recommended as the treatment of choice in case of comorbid depressive disorder and chronic disease, as this comorbidity can easily lead to disability and to high health care costs. However, so far research exploring the impact of CC on physical outcomes has been scanty. Also, the influence of CC on suicidal ideation has not been explored, although it is known that suicidal ideation is a common occurrence in depressive disorder and in chronic disease, especially in case of chronic pain or low quality of life. CC was mostly provided in primary care but as a new model also has been introduced in the outpatient general hospital setting, which may be especially relevant in patients with this comorbidity. Hence, in this symposium, collaborative care for comorbid depressive disorder and chronic disease will be the subject of our attention. We will explore several avenues. 1) What effect CC has on illness burden and physical outcomes in this patient group? A systematic review and meta-analysis were performed to answer this question and to give an estimate of the effect size. 2) If CC is effective against suicidal ideation in depressed patients, with and without chronic disease. This will be explored in an IPD analysis of more than 10 collaborative care trials in depressed patients. 3) Whether collaborative care in this patient group is associated with more somatic diagnostic and treatment interventions, with better effect on health outcomes, and for what costs. This question will be discussed based on the outcomes of an RCT from the Netherlands. 4) Whether a collaborative care model applied in the general hospital outpatient setting would be better suited for this patient group than CC in primary care. 5) If psychiatrists want to implement CC, what strategies they can follow. The APA has sponsored learning collaboratives to support the implementation of Collaborative Care as part of the Transforming Clinical Practice Initiative which has trained over 1500 psychiatrists to date. Strategies and best practices from this experience will be reviewed to help attendees take the ideas shared in this session and start using them in their own practice. The results and these questions will be discussed with the audience.

Diverse Career Pathways to Leadership in Psychiatry

Chairs: Tobias Diamond Wasser, M.D., Manish Sapra, M.D.

Presenters: Lawrence Goldberg, M.D., Sy Atezaz Saeed, M.D., M.S., David Nace, M.D., Barry Keith Herman, M.D.

Discussant: Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Weigh the benefits and challenges of assuming leadership roles in psychiatry; 2) Identify multiple pathways to and types of leadership roles within in psychiatry; and 3) Consider opportunities to begin attaining leadership experience during training and/or their early career.

SUMMARY:

For psychiatry trainees and early career psychiatrists, identifying administrative and leadership opportunities can be challenging. Most residency programs do not have an identified “leadership” or “administrative” track for their trainees. Thus, it often takes significant time and effort for a trainee to recognize such opportunities. Further, finding the time during an already busy residency and/or fellowship training to participate in such extracurricular activities can be quite challenging. The Accreditation Council for Graduate Medical Education (ACGME) has recognized the importance of Systems-Based Practice and incorporated this into their developmental milestones for residents, but has not fully embraced the need for programs to provide residents specific education and experience serving in administrative roles. However, it will be important for future psychiatrists to have administrative skills and experience, particularly with increasing emphasis on integrated and managed care. This trend toward increased integration of care requires psychiatrists to have a greater understanding of how to serve as consultants and leaders in guiding our partners in physical healthcare in collaborative care models. In addition, in both private and public healthcare settings, psychiatrists early in their practice have been and continue to be called upon to serve as clinical and administrative leaders within healthcare organizations. Thus, it is

imperative that psychiatrists begin to develop this skillset to prepare for these experiences. In this symposium, the presenters will highlight opportunities to gain such leadership experiences during training or early in their career to assist residents, fellows and early career psychiatrists in preparing for these future administrative roles. Presenters, all leaders in diverse components of the mental health field (including academia, pharmaceutical industry, managed care organizations, healthcare technology and large healthcare systems), will describe their career trajectory and pathway to their current leadership/administrative role. These personal narratives will be used as illustrative examples to guide participants through the seemingly ominous path from trainee to leader in the field. Ample time will be allotted for questions and interactive discussion with the audience.

**Innovations in Interpersonal Psychotherapy (IPT):
Across a Diagnostic Range**

Chair: John C. Markowitz, M.D.

Presenters: Holly Swartz, M.D., Andrea Feijo-Mello, M.D., Ph.D., Frenk Peeters, M.D., Ph.D.

Discussant: Myrna M. Weissman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will gain understanding of how IPT has been adapted to treat disorders other than major depression; 2) Participants will discover new empirical data supporting IPT for differing disorders; and 3) Participants will gain a broader understanding of the range of available treatments for multiple DSM disorders.

SUMMARY:

Over the past forty years, a succession of studies has now demonstrated the efficacy of Interpersonal Psychotherapy (IPT) for major depression. IPT is a manualized, time-limited, diagnosis-focused treatment that focuses on affect, life events, social functioning, and their interaction. After a slow start, the dissemination of IPT is catching up with its research achievements: more and more clinicians in the United States and worldwide are training and practicing IPT. In the meantime, IPT has branched

out from major depression. A series of randomized controlled trials have demonstrated its benefits for patients with a range of mood, anxiety, eating, and personality disorders, as well as its limitations in treating patients with substance use disorders. This symposium assembles an international team of expert researchers who will present their findings in testing IPT for a range of common psychiatric disorders: bipolar and unipolar depression, and posttraumatic stress disorder. Holly Swartz, M.D. from the University of Pittsburgh will present results from her randomized controlled trial of IPSRT (interpersonal and social rhythms therapy) for bipolar II disorder. Frenk Peters, M.D. from the University of Maastricht will present data including two year follow-up from a randomized trial of IPT and CBT in the Netherlands. Andrea de Mello, M.D. will present results of a trial adapting IPT for sexually assaulted women with PTSD in Brazil, while John Markowitz, M.D. will present related findings from a randomized trial in New York. Myrna Weissman, Ph.D., the co-inventor of IPT, will discuss the material before welcoming audience participation.

Model-Based Classification in Mental Health

Chair: Bruce Cuthbert, Ph.D.

Presenters: Martin Paulus, M.D., Deanna Barch, Ph.D., Roy H. Perlis, M.D., Michael Frank, Ph.D.

Discussant: John H. Krystal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand new class of analytic procedures that employ formal computational modeling; 2) Explain integration of multiple data sources of varying types; and 3) illustrate how different modeling paradigms can be implemented.

SUMMARY:

This session will bring together four experts to present representative concepts and research about a new class of analytic procedures that employ formal computational modeling to identify new ways of classifying patients for assessment and treatment based upon integration of multiple data sources of varying types. The presentations will reflect diverse research perspectives that include a focus both on new analytical models, and on the application of

new models to various types of data. The speakers will illustrate how different modeling paradigms can be implemented, and reflect the variety of different types of data that can provide input to innovative classification efforts that can be valuable for applied clinical use. Dr. John Krystal, editor of *Biological Psychiatry*, will serve as a discussant to outline the salient points of each talk and their overall potential for new ways to advance classification and resultant innovations in diagnosis, treatment, and prevention.

Readmission and Reimbursement in a Time of Cutbacks

Chair: Wendol A. Williams, M.D.

Presenters: Jon Scott Berlin, M.D., John S. Rozel, M.D., Leslie Zun, M.D.

Discussant: Anita Smith Everett, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the impact of repeat users on EDs, and their health care providers; 2) Analyze the financial impact of increased hospital HRR; 3) Examine whether Hospital Readmission Rates (HRR) affect clinical diagnosis and bias; and 4) Examine cultural dimensions of providing services in this changing environment.

SUMMARY:

Readmission to acute psychiatric hospitals is problematic. State budget cuts have introduced budgetary pressures on an over-burdened MHC system. These pressures affect EDs, acute inpatient (IP) units, and outpatient (OP) services. How should hospital readmissions and revolving door admission policies be understood in a larger social and financial context? A broad conceptualization encompassing IP clinical stabilization, and highly integrated social support services, is needed. Without close coordination of OP and social support networks, the successful management of patients from OP to ED to IP to OP care, will fail, leading to higher readmission rates (HRR), and poorer clinical outcomes. Readmission rates are a leading quality indicator for all healthcare programs and are rapidly emerging as one of the most important measures that behavioral health programs are held accountable for. External stakeholders, reviewers, and third party payers are applying increased scrutiny to this issue. Effectively

managing clinical care to enhance wellbeing and minimize readmissions requires commitment and collaboration from all elements of the health system. In the past, some private general hospitals have maintained a commitment to mental health care, even to vulnerable patients, and made it a service priority. Historically, ready-access to IP and OP services has been an implicit part of that commitment. This symposium will assess the impact that HRR has had on financial stability and clinical integrity of acute IPs.

The Management of Refractory Anxiety Disorders, OCD, and PTSD: An Update

Chair: Michael Van Ameringen, M.D.

Presenters: Charles Barnet Nemeroff, M.D., Ph.D., Mark H. Pollack, M.D., Helen Blair Simpson, M.D., Ph.D., Giampaolo Perna, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To obtain an overview of the clinical management of refractory anxiety and related disorders; 2) To review the evidence-based literature on the treatment of refractory anxiety and related disorders; and 3) To discuss future directions of research into treatment resistance.

SUMMARY:

At least one third of the general population will meet diagnostic criteria for an anxiety disorder, obsessive compulsive disorder (OCD) or posttraumatic stress disorder (PTSD) at some point in their lifetime. These disorders are associated with significant social and occupational dysfunction as well as costs to afflicted individuals, their families and society. Standard first-line treatments for these disorders include antidepressants such as serotonin reuptake inhibitors (SRIs) as well as cognitive behavioural therapy (CBT). Unfortunately, treatment response rates to these standard treatments are less than optimal, with 40-60% of patients continuing to have residual (and impairing) symptoms with pharmacotherapy, and 23% with CBT. Although, there is a small, emerging body of randomized controlled trials (RCTs) in refractory anxiety and related disorders, these studies are comparably sparse when compared to the literature associated with other refractory mental disorders (i.e.

schizophrenia, bipolar disorder or depression). There is limited information on next-step treatments which has presented a significant problem for patients, clinicians and researchers. Clinicians have typically relied upon the refractory depression literature to guide treatments, however this strategy has not always resulted in improved outcomes for refractory anxiety patients. While no drug has been approved for use in treatment resistance, a variety of pharmacological and psychological strategies have been recommended in treatment guidelines, supported by evidence from randomized controlled (RCT) and open label trials. In cases of treatment resistance, clinicians generally adopt one of several strategies, including SRI augmentation with other class agents, with CBT or switching to another treatment. Meta-analyses of refractory anxiety and related disorder RCTs, have generally supported the superiority of pharmacological augmentation compared to placebo; there is also meta-analytic support for switching to CBT in pharmacotherapy-resistant cases. This presentation will present an update on the management of the following refractory disorders: generalized anxiety disorder, social anxiety disorder, panic disorder, obsessive compulsive disorder and posttraumatic stress disorder. Each of the five presenters will critically evaluate the literature published over the past 1 to 3 years, emphasizing interesting and important new findings. Presenters will report on any clinical pearls they may have and offer opinions on controversial findings in this literature.

Transformative Partnerships for the Mental Health of Young People

Chairs: Saul Levin, M.D., M.P.A., Helen E. Herrman, M.D., M.B.B.S.

Presenters: Moitreyee Sinha, Ph.D., Lian Zeitz, Nicholas Allen, Ph.D., Patrick McGorry, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. At the conclusion of this session, the participant will be able to discuss historical and contemporary challenges related to improving mental health and access to mental health care of young people; 2) 2. At the conclusion of this session, the participant will be able to consider various approaches to working with

primary health care practitioners to improve access to primary health care; 3) 3. At the conclusion of this session, the participant will be able to understand the role of a multi-stakeholder initiative to driving change in mental health in communities; 4) 4. At the conclusion of this session, the participant will be able to review the role of digital technology in promoting mental health, and preventing and treating mental illnesses; and 5) 5.

At the conclusion of this session, the participant will be able to work with youth leaders across disciplines including digital health, mental health, child development, gender, and education.

SUMMARY:

There are more young people today than ever before, totalling nearly 3 billion or almost half of the world's population. Most people under the age of 25 live in cities. Young people have enormous potential to drive social change and care for their community. Unlike other illnesses, mental illnesses are diseases of the young, with over 75% manifesting by age 24. In recognition of the magnitude of both the opportunities and the problem, a dramatic evolution has begun in the field of mental health, leading to the creation of a multi-stakeholder initiative, citiesRISE, to catalyze action to improve mental health in cities and beyond. A resilient, secure, empowered and thriving youth population is critical to the future of all communities. In order to achieve the Sustainable Development Goals (SDGs), diverse partners and key institutions from public and private sectors (including Grand Challenges Canada, BasicNeeds, the World Psychiatric Association – WPA, King's College London, Harvard University, World Bank, Johnson & Johnson, Verily) have come together with international thought leaders and leadership in several cities including Seattle, Chennai, and Nairobi to develop new partnerships to achieve meaningful, lasting improvements in young people's mental health globally. They have come together on the citiesRISE platform that sets the foundation for a broader, more significant effort to mobilize youth as beneficiaries and drivers of a mental health movement. This presentation will discuss: • local and global partnerships that are transforming the systems in which young people grow up; • how to build new ways for young people to access services and support, through integrated

health systems and through innovative technologies and community based-interventions that provide additional and complementary options to improve mental health and wellbeing; • the role of youth leadership and of health practitioner groups in policy and practice; • global indicators, targets, and research priorities in young people’s mental health and well-being; • innovative funding structures and financing mechanisms for supporting young people’s mental health and well-being. This presentation will describe the ideas, evidence, design and the planned outcomes of the citiesRISE initiative and its work with WPA and other partners to transform policy and practice related to young people’s mental health and well-being. Drawing on lessons from international and national projects such as The Center for Digital Mental Health, Headspace, Headstrong, ThriveNYC, and the work of associations such as WPA and the International Association of Youth Mental Health, the audience will be provided tangible examples and case-studies of evidence-based practices in the field of young people’s mental health and well-being. The insights shared will encourage professionals to consider broad approaches to supporting youth mental health through community and health service development.

Trauma, Delinquency, and Antisocial Personality Disorder: Connecting the Dots

Chairs: Lara J. Cox, M.D., Bipin Raj Subedi, M.D.

Presenters: Akeem N. Marsh, M.D., Jennifer Cabrera, M.D., Jessica Linick, Ph.D.

Discussant: Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand risk factors for, and the impacts of, trauma and disrupted attachment on social-emotional development, including behavioral similarities between complex trauma and Conduct Disorder; 2) Discuss the overlap in the epidemiology and phenomenology of trauma-related symptoms, Conduct Disorder, and Antisocial Personality Disorder; 3) Describe changes observed in neurobiology with trauma exposure and in those with symptoms of Conduct Disorder or Antisocial Personality Disorder; 4) Review the evolution of Conduct Disorder and Antisocial Personality Disorder

as diagnostic constructs in the context of historical, socioeconomic, and politico-legal factors; and 5) Explore the utility and limitations of diagnosing Conduct Disorder and Antisocial Personality Disorder, and the impact of diagnosis on treatment and prognosis.

SUMMARY:

The field of psychiatry is increasingly recognizing the significance of exposure to trauma and other adverse experiences, as evidenced by the extensive revision of the Post-Traumatic Stress Disorder diagnosis and the creation of a Trauma- and Stressor-Related Disorders section for the DSM-5. The diagnosis of Conduct Disorder (CD) has also undergone an important clinical modification for the 21st century, with the addition of the specifier “with limited prosocial emotions.” Progression to Antisocial Personality Disorder (ASPD) is often viewed as the inevitable outcome of CD; however, the diagnosis has questionable inter-rater reliability and is of unclear utility in the clinical setting. The diagnoses of CD and ASPD are based almost entirely on behavior alone, without consideration of that behavior’s context and etiology. The relationship of trauma to the continuum of antisocial behaviors is complex, and includes various biological, economic, and sociological confounding factors. A nuanced understanding of these relationships is often challenging in treatment settings. This symposium aims to demonstrate, through use of a case study and review of the literature, that thoughtful consideration of developmental and sociological factors is necessary to fully understand youth and adults with antisocial behaviors and guide their treatment. Attendees will be encouraged to consider and reflect on how they can incorporate knowledge related to the nexus of attachment, trauma, and disruptive behavior disorders into their clinical practice, and will be provided with practical tools to both conceptualize and work with individuals presenting with these potentially challenging behaviors. The authors will identify risk factors associated with exposure to trauma and adverse experiences, and the connections between such experiences and incarceration. This will segue into a discussion of the impact of early trauma and attachment disruption on social-emotional development. We will review the characteristics of

antisocial behavior in youth and adults, with particular consideration given to various sociological phenomena, including the school-to-prison pipeline and mass incarceration. The commonalities in the epidemiology, phenomenology, and neurobiology of trauma, Conduct Disorder and Antisocial Personality Disorder will be explored. We will illustrate the consequences of failing to address adverse life experiences when diagnosing and treating individuals who would often be given diagnoses of Conduct Disorder and Antisocial Personality Disorder. The symposium will utilize clinical examples, historical context, and a review of the literature to address the themes above.

A Successful Approach to Reduce Seclusion and Restraint: The High and Intensive Care Unit

*Chairs: Tom van Mierlo, Joris Hendrickx, M.D., M.B.A.
Presenters: Bram Berkvens, Miranda de Weijer-Dupuis, M.Sc., Alexandra Vos, M.D., Rama Kamal, M.D., Ph.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the mechanisms of the High and intensive care model; 2) Identify and apply key factors in reducing coercion en seclusion; 3) Appreciate the proven benefits of improving rehabilitation by applying this model; and 4) Understand the importance of multi-disciplinary cooperation in order to prevent restraint and seclusion successfully.

SUMMARY:

At present it is, or at least it should be, common knowledge that the use of seclusion or restraint for people with psychiatric disorders has a profound risk of inducing mental and physical trauma, the effects of which can last for years. Yet the use of coercive methods is still very common. Research shows that in the United States of America or in Europe up to one third of patients being admitted on an acute psychiatric ward are subjected to coercive measures, including seclusion and (chemical) restraint. There is a lack of evidence-based interventions which provide sustainable and successful reduction of coercive measures, despite many reports of naturalistic studies showing reduction in the use of seclusion and restraint by one method or another. In the

Netherlands, the High and Intensive Care (HIC) model has been developed. The HIC model combines successful evidence-, and practice-based interventions as well as healing environment concepts to reduce the use of seclusion and restraint. Its aim is to provide optimal psychiatric crisis-intervention and improving the wellbeing of patients by emphasizing the concept of recovery in combination with the medical model. During the symposium, first we start with a presentation about the specifics of the HIC model, and we present the first findings on specific hospital wards about the results on number and duration of seclusions and duration of admission. Next we will present the importance of introducing the recovery principles on acute wards. We go on with a presentation about the different roles and responsibilities of the multidisciplinary team, and present the possibilities in which technical innovations can improve team collaboration and patient outcome. Further on we will demonstrate the importance of the care chain and will consider the challenges of implementing this kind of care. Finally, we present the HIC monitor, which was developed to assess HIC model fidelity. We studied the psychometric characteristics of the HIC monitor (which were satisfactory), and its associations with use of coercion and patient satisfaction. Higher HIC monitor scores were associated with the use of less coercive measures. Results pertaining to the association of HIC model fidelity and patient satisfaction will be presented during the conference.

Addressing Physician Burnout and Depression: An Opportunity for Psychiatrists to Lead

Chairs: Laurel Mayer, M.D., Matthew Louis Goldman, M.D., M.S.

Presenters: Laurel Mayer, M.D., Matthew Louis Goldman, M.D., M.S., Christine Moutier, M.D., Maria Antonia Oquendo, M.D., Ph.D., Dennis S. Charney, M.D.

Discussant: Carol Ann Bernstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how rising levels of physician burnout and depression impact the professional development of today's medical trainees; 2) Apply the current evidence on suicide

screening to the physician population; and 3) Understand the key elements of physician resilience.

SUMMARY:

The mental health effects of medical training and practice are becoming increasingly well documented, with high rates of burnout, depression and suicide among residents, fellows, and physicians in practice. Awareness of physician burnout and depression has recently taken center stage within the medical profession. As the ever-shifting landscape of the healthcare system continues to demand more from both trainees and faculty, many physicians feel that action must be taken now. Several national groups have dedicated a new focus on these issues, with the APA Board of Trustees convening an Ad Hoc Workgroup on Physician Well-Being and Burnout, the ACGME introducing new Common Program Requirements focusing on trainee mental health and wellness, and the National Academy of Medicine establishing its Action Collaborative on Clinician Well-Being and Resilience. The primary goals for comprehensive intervention programs are to promote well-being and resilience among the physician workforce while simultaneously preventing, screening, and treating burnout and depression, as well as their negative sequelae. Striving for wellness during medical training and adopting methods to maintain wellness can help trainees to learn lifelong strategies for maintaining satisfaction and joy in their careers. We will begin this presentation with the description of the growth and development of a House Staff Mental Health Service at a major academic institution, highlighting the unique internal and external barriers that limit physician access to mental health treatment. We will then introduce a framework for developing a successful well-being plan for your institution built on six key elements, and introduce a new Toolkit for psychiatrists to serve as local Wellness Ambassadors. Screening for burnout, depression and/or suicide risk has been recommended as a suicide prevention strategy among resident physicians, and we will discuss the benefits and limitations of screening for mental illness and suicide risk in medical trainees, followed by a research update on physician suicide, including data on suicide during medical training. This evidence-based review will be followed by personal reflections from a clinician-scientist whose

research career was built on studying resilience and who will share with us his “Resilience Prescription.” We will close with a discussion extending the conversation towards how psychiatrists are taking the lead with initiatives being implemented at the national level to promote resilience during training and improve physician mental health.

Biomarkers in Psychiatry: Current Status and Development

Chairs: Linda L. Carpenter, M.D., Carolyn Rodriguez, M.D., Ph.D.

Presenters: Ned Henry Kalin, M.D., Charles Barnett Nemeroff, M.D., Ph.D., Alik Sunil Widge, M.D., Ph.D., Carolyn Rodriguez, M.D., Ph.D., Conor Liston, M.D., Ph.D.

Discussant: Linda L. Carpenter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the characteristics of a validated biomarker; 2) Demonstrate knowledge of current challenges to biomarker development in psychiatry; and 3) Understand the advances in inflammatory, EEG, and neuroimaging biomarker development.

SUMMARY:

Validated diagnostic and treatment biomarkers would facilitate drug development and personalized treatments for mental illnesses. This panel will review the characteristics important for validation of a biomarker. Challenges to identifying translatable biomarkers relevant to psychiatry include the use of a symptom-based diagnostic system, methodological limits of existing studies, and lack of a full understanding of the pathophysiology underlying mental disorders. Consistent with the National Institute of Mental Health (NIMH)’s Research Domain Criteria (RDoc), panelists will describe how biomarkers that examine biotypes (underlying biological constructs) that transcend diagnostic categories can be used to move towards objective (rather than symptom-based) assessment. Progress and challenges in biomarker development in mood and anxiety disorders will be highlighted across topics ranging from inflammatory, EEG, and neuroimaging biomarkers.

Crossing Borders Between Obsessive Compulsive Spectrum Disorders and Tic Disorders: From Clinical Characterization to Therapeutic Interventions

Chairs: Bernardo Dell'Osso, M.D., Eric Hollander, M.D.

Presenters: Eric Hollander, M.D., James Frederick Leckman, M.D., Maria C. Rosario, M.D., Bernardo Dell'Osso, M.D., Joseph Zohar, Mauro Porta

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Acquire further insight on the DSM-5 tic-related obsessive compulsive disorder; 2) Examine immunologic and neuroinflammatory patterns of tic-related obsessive compulsive disorder; 3) Analyze epidemiology, psychopathology, clinical presentation and course of tic-related obsessive compulsive disorder; and 4) Review therapeutic approaches from integrated treatments to brain stimulation.

SUMMARY:

Obsessive-Compulsive Disorder (OCD) and Tic Disorder (TD) are highly disabling, frequently comorbid, often chronic and difficult-to-treat conditions, affecting child, adolescent and adult patients, and responsible for a substantial socio-economic burden for affected individuals, related families, caregivers and community. Of note, in the 5th Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* OCD has been allocated into a newly defined chapter of OC and related disorders, with the introduction of a new 'tic-related' specifier. Comorbidity between OCD/Obsessive Compulsive symptoms/Obsessive Compulsive behaviors and TD/tics is so frequent in specific subgroups of patients that many experts in the field believe that the two disorders' dimensions are deeply interconnected and ultimately represent a specific subtype of illness. Available literature indicates that specific symptoms, comorbid patterns and course characteristics may be of more frequent observation in patients with tic-related OCD. Treatment and overall management of OCD and TD have significantly progressed over the last decade with meta-analyses, consensus and international guidelines available. Nonetheless, affected patients have been traditionally considered poor-responder

to standard treatments, when not completely treatment-refractory. Pharmacological first-line treatments often bring only partial benefit, so that combined therapies represent the rule rather than the exception for these patients. Aim of the proposed symposium is to provide the state of the art in the field of tic-related OCD from different perspectives (classification, psychobiology, clinical characterization and therapeutics) by International experts with research and clinical expertise with adolescent and adult patients suffering from these disabling conditions.

Long-Term Medication for Axis I Disorders: Lifetime Treatment or Not?

Chair: Ira David Glick, M.D.

Presenters: Robert Morton Post, M.D., Madhukar H. Trivedi, M.D., Carl Salzman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Be aware of benefits and risk of long term treatment of major depressive disorder; 2) Be aware of benefits and risk of long term treatment of anxiety disorders; 3) Be aware of benefits and risk of long term treatment of bipolar disorder; and 4) Be aware of benefits and risk of long term treatment of schizophrenia.

SUMMARY:

Introduction While there is extensive evidence supporting efficacy of medications for major depressive disorder (MDD), bipolar disorder (BD), anxiety disorder (AD) and schizophrenia, the question of how long to stay on medication after an acute episode continues to be debated. This panel will present the long-term outcome data to speak to that question. Methods Global outcome, symptoms, and functional data from long-term (>10 years) studies of patients with the above four disorders will be presented by Dr. Post (BD), Dr. Trivedi (MDD), Dr. Salzman (anxiety disorders), and Dr. Glick (schizophrenia) on data on effects of discontinuation as well as large-scale, real-world trials will be presented. Results All studies show a strong effect of a positive correlation of adequate medication adherence and improving outcomes. Lack of medications almost always resulted in poor outcomes, often disastrous. The data are strongest

that repeated drug discontinuations and associated relapses can drive treatment refractoriness. We will discuss the utility of direct recommendations for long-term, vs indefinite, vs lifetime treatment. We will also discuss predictors of long-term outcome to assist clinical decision making. Summary and Conclusion Results strongly suggest, not prove, better outcome is strongly associated with higher medication adherence. Such therapeutic approaches are readily accepted in the treatment of hypertension, diabetes mellitus, etc, but often not accepted or recommended in psychiatric illness. The strength of the database and rationale for the recommendation across the different illnesses will be discussed.

New Frontiers for Artificial Intelligence in Psychiatry: From Personalized Health to Community Care

Chair: Niall Boyce

Presenters: Becky Inkster, M.D., John Pestian, Ph.D., M.B.A., Desmond Patton

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about the latest on AI and its current and potential impact in psychiatry; 2) Gain hands-on skills using AI technology, such as through chatbots and predictive algorithms; and 3) Gain opportunities to become involved in research at the frontier of AI in psychiatry.

SUMMARY:

Artificial intelligence (AI) has paved the way for innovation in many areas of modern society. Leveraging AI in psychiatry has enormous potential as it may allow for practitioners to operate more efficiently, for services to run more cost-effectively and for patients to receive more personalised and community-connected care. This symposium will provide practitioners with the latest information on how AI can be leveraged to support mental healthcare from multiple viewpoints covering 3 main questions: (1) What can machines learn from psychiatric data? Increasingly, healthcare innovations are following the availability of analyzable data. Innovations that require data about patient 'thought markers' like words, acoustics, or facial features have not been analyzable until now.

Speaker 1, Professor John Pestian, will examine how AI and computational algorithms can be used to inform decisions. The speaker will discuss how optimal machine learning methods can be converted into smart-phone based apps to conduct real time analyses for mental illness classifications. He will examine questions such as how can algorithms improve the accuracy of making psychiatric diagnoses? How can passive sensing identify risk? (2) How can AI directly interact with patients and practitioners? AI has the potential to go beyond passive sensing and predictive behavioural modelling. It can offer interactive care. Speaker 2, Dr Becky Inkster, will discuss concepts such as AI-assisted coaching platforms, leveraging user data to support customised care pathways, providing direct chatbot-based psychosocial support, driving engagement, and encouraging adherence to treatment plans. The speaker will discuss ideas around AI supporting task shifting in mental health professional networks, reducing face-to-face time for 'low intensity' treatments, addressing some of the demands of high staff turnover rates and training requirements etc. (3) How can AI support community care and address the access divide? Speaker 3, Assistant Professor Desmond Patton, will examine how to leverage community experts to provide insights in the development of AI in preventing and intervening in gun violence in urban areas, focusing on New York City, USA. The speaker will share his team's work and future plans to evaluate the effectiveness of the natural language processing (NLP) systems as an enhancement to firearm violence prevention efforts, in partnership with an international violence prevention organization. The work will allow violence outreach workers to use social media as a tool to detect and interrupt potentially violent events and to disseminate targeted public messaging aimed at changing attitudes, behaviors, and norms that perpetuate violence. As questions regarding the ethics of AI approaches become increasingly urgent, our symposium will also underscore key ethical issues.

Pastoral Counseling and Psychiatry: What Can We Learn From Each Other?

Chair: Rachel Yehuda, Ph.D.

Presenters: Pamela Cooper-White, Ph.D., Asma

*Mobin-Uddin, M.D., LaTonya Heyward, L.M.S.W.
Discussant: Michelle E. Friedman, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify similarities and differences between clergy and mental health in their approaches to different types of clinical problems; 2) Understand the psychological training offered in pastoral programs in various faith traditions so that the mental health provider can recognize potential gaps in service; and 3) Consider how mental health professionals and clergy can better collaborate to improve client care.

SUMMARY:

People in psychiatric distress seek help from multiple sources. Chief among these are mental health professionals and clergy. In fact, clergy are often de facto front line professionals following critical life events, or when initial episodes of mental illness are apparent since their services are often free of charge. Furthermore, persons of faith are likely to trust spiritual leaders. It is important to have candid discussion within psychiatry regarding how the values, methods and goals of these two disciplines similar and different. In this symposium the speakers will address the issue of how persons in roles of spiritual authority (priests, rabbis, ministers, imams, etc.) understand and fulfill the pastoral counseling component of their vocations. A panel of diverse spiritual leaders will describe how each religious faith is taught to understand and respond to signs and symptoms of psychiatric disturbance. This will be done by articulating the type of training received and discussing overlap, or lack thereof, with training received by mental health professionals. The speakers in this panel function as both licensed mental health providers in health care systems and elders in their various religious communities and are in a unique position to reflect on these important issues. We plan to use several clinical cases as a reference points. The vignettes will be introduced in the introduction, and various speakers will compare and contrast outlooks regarding the cases, and provide clear discourse on the nature of intervention from a mental health and spiritual perspective.

Positive Psychiatry International

*Chairs: Dilip V. Jeste, M.D., Keri-Leigh Cassidy, M.D.
Presenters: Nina Timmerby, M.D., Vihang Nalinkant
Vahia, M.D., Orestes Forlenza
Discussant: Dinesh Bhugra, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the empirical basis for Positive Psychiatry; 2) Assess the outcomes of combining psychotherapeutic and pharmacologic treatments; 3) Use mind-body interventions such as yoga and meditation to promote well-being; and 4) Develop community-based interventions to promote healthy living.

SUMMARY:

Positive Psychiatry is an emerging area within psychiatry, which focuses on promotion of health and well-being in individuals by applying positive psychological, behavioral, and biological interventions. It aims to enhance the practice of psychiatry beyond symptom reduction and relapse prevention, to promotion of well-being. This symposium will explore the implications of the conceptualization of Positive Psychiatry for psychiatric practice, research, and training. The symposium includes experts from the US, Canada, Denmark, UK, Brazil, and India, sharing their latest work and goals for the future of this evolving field. Dilip Jeste, MD, from University of California San Diego, US, focused on Positive Psychiatry as his APA Presidential theme in 2012-13. Since then there have been a number of papers and presentations as well as formation of an APA Caucus and a World Psychiatric Association Section on Positive Psychiatry. Dr. Jeste will describe the evolution of this field from basic research to clinical practice and training. Keri-Leigh Cassidy, MD, from Dalhousie University, Canada, will describe the Fountain of Health Initiative for Optimal Aging, a leading movement in Positive Psychiatry in Canada. It offers unique research and frontline knowledge translation tools in positive psychosocial living, including a website, a Facebook page, educational videos, research publications, presentations, and clinical materials. Nina Timmerby, MD, PhD, from University of Copenhagen, Denmark, will discuss the pharmaco-psycho-metric triangle, an important element in measuring outcomes in clinical trials within the

umbrella of Positive Psychiatry. Using brief and psychometrically valid outcome scales in measurement-based care helps establish a collaborative relationship between therapist and patient. Vihang Vahia, MD, from University of Bombay, India, will describe history of and research in the use of positive behavioral interventions that originated in oriental cultures – e.g., meditation and yoga, both as a part of healthy lifestyle as well as treatment for mental and physical illnesses. Orestes Forlenza, MD, PhD, from University of Sao Paulo, Brazil, will discuss neuroprotective strategies, specifically lithium. He will present basic research (GSK3 inhibition) as well as a recent randomized controlled trial indicating that long-term lithium treatment may attenuate cognitive and functional decline in older adults with amnesic mild cognitive impairment, and modify Alzheimer’s disease related biomarkers. Dinesh Bhugra, MD, from King’s College, London, UK, is the President of the World Psychiatric Association and the British Medical Society. He will tie the different presentations to present a holistic and global perspective on Positive Psychiatry.

Quick Fix or Road to Recovery? Concepts, Courts, and Clinical Concerns With Civil Commitment for Substance Use Disorders

Chair: Abhishek Jain, M.D.

Presenters: Paul P. Christopher, M.D., Paul S.

Appelbaum, M.D., Carl Erik Fisher, M.D.

Discussant: Debra A. Pinals, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define civil commitment for substance use disorders; 2) Recognize the historical background and ethical underpinnings of involuntary treatment for substance use disorders; 3) Summarize the variability in content and utilization of laws authorizing civil commitment for substance use disorders in the U.S; 4) Discuss empirical evidence and clinical outcomes, including effectiveness and limitations, related to civil commitment for substance use disorders; and 5) Describe provider experiences with the legal system when seeking civil commitment for substance use disorders.

SUMMARY:

About 85% of the people in the U.S. who need

specialized treatment for a substance use disorder do not receive it and do not recognize the need for it. This striking figure, which includes more than 17 million American adults, supports the notion that many clinical interventions are likely ineffective for those who do not have adequate insight into their substance use disorder and simply refuse services. In this presentation, we focus on one particular strategy to mandate treatment that has been gaining interest: civil commitment for substance use disorders. This is a legal mechanism that allows civil courts to require that individuals comply with substance use treatment – which is separate from drug courts or other court-ordered treatments that only apply when individuals have criminal charges. As of 2015, 32 states and the District of Columbia had statutes on the books permitting civil commitment of an adult for substance use treatment, but in many jurisdictions these laws are not used or underutilized. Now, especially with the rising rate of overdose deaths (at least 142 daily on average) - mostly attributed to opioids and heroin – more states, such as Pennsylvania and Washington, are considering enacting these laws. This symposium will explore the origins and history of civil commitment for substance use disorders in the United States, which can be traced back to the middle of the 19th century. We will summarize the current legal landscape, including the variability in the content of the laws, how they are applied, and how often they are utilized. Next, we will discuss the ethical underpinnings of these laws, including issues such as autonomy, beneficence, capacity to make medical decisions, and fundamental questions about the degree to which substance use disorders are considered a “disease” in law and philosophy. That will be followed by a review and appraisal of the evidence for and against involuntary treatment strategies relevant to civil commitment. Finally, a leader in forensic psychiatry, who has directly been involved with civil commitment for substance use disorders in one of the few states that frequently implements this type of compulsory treatment, will describe her experiences and lead a discussion with pertinent case examples. Throughout the presentation, we will highlight areas for further research.

Wednesday, May 09, 2018

Advancing Diagnostic Biological Markers for PTSD: Findings From DOD Systems Biology

Chairs: Charles R. Marmar, M.D., Marti Jett-Tilton
Presenters: Kerry Ressler, M.D., Ph.D., Rasha Hammamieh, Janine Flory, Synthia Mellon, Burook Misganaw

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The learner will be able to describe new research related to the genetic underpinnings of trauma and stress-related disorders, as well as the neurobiology of PTSD; 2) Understand the blood molecular etiology and diagnosis of PTSD and determine the molecular events associated with PTSD co-morbidities; 3) Describe how neurocognitive functioning is associated with PTSD in OEF/OIF veterans at differing levels of IQ; 4) Understand the metabolic, metabolism, and inflammation markers related to PTSD; and 5) Interpret the multi-omic signals of PTSD and explore causes of incorrect predictions.

SUMMARY:

Posttraumatic Stress Disorder (PTSD) accounts for about half the mental health burden in OIF/OEF veterans. Management of PTSD is complicated by the overlapping symptoms of its comorbidities, the diagnostic reliance on self-report and time consuming psychological evaluation process. The purpose of this research is to facilitate an objective method of diagnosis, and advance development of experimental therapeutics. This symposium will present updated findings from DOD funded case-control studies of biological markers of PTSD. Study participants included male and female veterans deployed to Iraq or Afghanistan post-9/11 with and without PTSD, based on the Clinician Administered PTSD Scale for DSM-IV. Study procedures included a fasting blood draw (pre and post-dexamethasone), 24-hour urine collection, and self-report questionnaires. We compared 83 PTSD positive male cases (based on the Clinician Administered PTSD Scale for DSM-IV) with 83 PTSD negative male controls matched by age and ethnicity. We also included a validation cohort with 29 PTSD positive male cases and 40 male controls and a female cohort of 20 PTSD positive female cases and 21 controls.

This symposium will present updated findings from DOD funded case-control studies of biological markers of PTSD. We will first discuss our approaches to understanding mechanisms by which genetic heritability increases risk for Posttraumatic Stress Disorder (PTSD) following trauma exposure. We review the status of genome-wide association study (GWAS) approaches to PTSD, and then present specific findings from the Systems Biology Biomarker cohort. Next we will present findings of hypermethylated genes and their implications for behavior, immune response, nervous system development, and relevant PTSD co-morbidities. The third presentation will focus on the effects of IQ as related to neurocognitive functioning. The penultimate presentation will discuss findings on metabolism, inflammation, and metabolomic markers in combat-exposed OEF/OIF men and women with and without PTSD. The final presentation will focus on integrating multi-omic signals of PTSD. We will present multi-omic panels of candidate diagnostic markers of PTSD combining anthropometric body measurements, clinical laboratory values, genomic, epigenomic, miRNA, metabolomic, and proteomic data.

At Gunpoint: Firearm Violence From a Forensic Psychiatrist Perspective

Chair: Rahn K. Bailey, M.D.

Presenters: Margaret R. Rukstalis, M.D., Patrick H. Harmon, M.D., M.A., Richard C. Blanks, M.D., Richard Patrick Smith, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define Firearm Violence as a Public Health Crisis in America; 2) Understand how individual firearm ownership adversely affects our community, including LEO's efforts protect our citizens; 3) Understand how Firearm Violence plays a role in Domestic Abuse; 4) Understand the disastrous impact of firearms on America's youth; and 5) Understand that firearm violence and mental illness are not inextricably linked.

SUMMARY:

Firearm violence is a public health epidemic today. This issue straddles all races, socioeconomic classes, and genders. A public health epidemic can be

defined as a complex state of health affairs that has a significant impact on community health, mortality, and economy, resulting from disease, industrial processes, or poor policy. (1) This panel attempts to de-politicize the narrative on firearm violence in America, exploring the issue as a public health epidemic instead of a partisan political issue. We discuss notion that more stringent firearm control will decrease communal firearm violence across the United States. We emphasize that firearm violence is a universal issue rather than one confined to minorities, mentally ill, or lower socioeconomic classes. Those individuals victimized by firearm violence are disenfranchised. Their voices are seldom heard. High-ranking NRA officials and lawmakers in Washington are only peripherally affected by these issues, yet they hold the largest stake in how the rest of the community will be exposed to this menace. Those ravaged by firearm violence in America are not just primary victims of guns, but also secondary and tertiary victims such as family, friends, and neighbors. Firearm violence is a problem that permeates the very fabric of our society, disseminating across gender, class, race, and creed. The issue warrants a change in cultural attitudes followed by legislative reform before we progress as a nation towards a firearm violence- free future.

Big Data in Mental Health

Chair: Michele Ferrante, Ph.D.

Presenters: Bing Brunton, Ph.D., Leanne Williams, Ph.D., Justin Taylor Baker, M.D., Ph.D., Raquel E. Gur, M.D., Ph.D.

Discussant: Alik Sunil Widge, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the main challenges and opportunities in dealing with large, complex, and dynamic psychiatric datasets; 2) Realize the potential of applying rigorous computational approaches to big datasets related to Mental Health; and 3) Identify key translational research priorities related to the unbiased identification of neurobehavioral factors associated with psychiatric risk and progression.

SUMMARY:

Our unprecedented ability to collect big datasets from large cohorts in naturalistic settings will pave the way for closed-loop illness detection systems using adaptive neurobiological sampling strategies. Affective and psychiatric patients often experience profound changes in mood and cognition over time, and over relatively short periods (e.g., psychiatric hospitalization). Prodromes of many neuropsychiatric disorders may be present in youth. But the complex dynamics and comorbidity of these signals require rigorous deep phenotyping of large samples to explain the relationships between symptoms, neurocognitive functioning, and underlying brain parameters. These projects and computational methods could transform how we deal with precision medicine in psychiatry. We will present four cutting-edge studies that combine temporally dense multimodal phenotyping in large samples with sophisticated computational approaches (e.g., model-driven, latent factor models, exploratory and confirmatory factor analysis, semi-supervised, and/or unsupervised methods in machine learning and pattern recognition) to identify: 1) Diagnostic sub-types clustering psychiatric symptoms and behavioral signatures in large and rich psychiatric datasets reveals previously unseen structures that may be informative about efficacy of treatments. 2) Biotypes and temporal trajectories describing relationship and interactions between imaging of large-scale brain circuits mapping on symptoms and behavior across mood and anxiety diagnoses. These biotypes (reproducible across large datasets) can predict whether a patient is likely to remit with more than 75% cross-validated precision, improving on the current chance-level for common first-line treatment choices. 3) Robust and reproducible predictors capturing how mood and cognitive fluctuations vary from individual to individual and from episode to episode in affective and psychotic illnesses. 4) Longitudinal data: revealing the emergence of psychosis and identifying factors related to risk and resilience in youth (on the subthreshold psychosis spectrum). The Philadelphia Neurodevelopmental Cohort is a diverse sample of ~9,500 genotyped youths (11-21yo), who underwent clinical assessment (with categorical and dimensional phenotypes), computerized neurocognitive evaluation (testing Executive, Memory, Cognition,

Social and Sensorimotor functions), and multimodal neuroimaging (in a subsample of 1,600). Dimensionality reduction subdivided symptomatology in four domains (Anxious-Misery, Fear, Externalizing, and Psychosis) that differed by sex, in relation to each other, and to brain structure and function. Taken together these studies show how integrative and systematic approaches can advance translational research in psychiatry with opportunities for early detections and interventions.

Compulsivity and Addiction: Where Do We Draw the Line? New Insights and Novel Therapeutic Approaches

*Chairs: Joseph Zohar, Marc N. Potenza, M.D., Ph.D.
Presenters: Eric Hollander, M.D., Lior Carmi, Jon E. Grant, M.D., M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the interplay between compulsivity and behavioural addiction; 2) To identify and diagnose OCD, OCRD and behavioral addiction (including PIU) in patients; 3) To implement relevant therapeutic approaches in patient with OCD and behavioral addiction (including PIU); and 4) To be informed with the deep TMS technology as an optional tool in the treatment of OCD and OCRD.

SUMMARY:

Representing the tendency to perform repetitive, unwanted, inflexible and time consuming acts, compulsivity is increasingly recognized as a contributory factor in the loss of personal control over a broad range of human behaviours. It is associated with widespread adverse health and social consequences, and underpins a variety of chronic, costly, functionally disabling disorders. Introducing the Obsessive Compulsive and Related Disorders (OCRD) chapter in DSM-5 along with the Research Domain Criteria (RDoC) initiative have paved the way for a new approach to compulsivity. In this symposium the compulsivity domain will be discussed across disorders, specifically addressing the Compulsivity – Behavioural addiction interplay. Starting with an introduction of Impulsivity-Compulsivity spectrum concept in general and its dimensions in OCD related disorders in particular,

the first lecture will review the diagnostic implications as expressed in DSM-5. In the second lecture, both the prevalence (of OCRD) and the digital presentation of OCD will be presented in relation to the increasing usage of Internet: As OCD symptoms are usually embedded within a specific cultural setting, in the 21st century it is often assimilated with the penetration of the Internet and smartphones to our daily life. Problematic Internet Use (PIU) as a new presentation of compulsivity (or addiction) will be explored. Finally results from studies utilizing the novel approach namely deep TMS in treating compulsivity and behavioural addiction will be presented including a multi center FDA regulated study, interfering with the Cortico-Striatal-Talamic circuitry attributed to OCD and a pilot study of smoking cessation. The discussant will summarize the main take home message and point out the new exciting diagnostic and therapeutic perspectives of the cross road new (dimensional) concepts and contemporary environmental changes (internet).

Innovations in the Treatment of Persons With ID and Psychiatric/Behavioral Disorders? Point Versus Counterpoint

*Chairs: Robert Joseph Pary, M.D., Janice L. Forster, M.D.
Presenters: Dorcas O. Adaramola, M.D., Jeffrey I. Bennett, M.D., Shizhen Jia, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) By the end of the presentation, the participant will be able to describe innovative technologies to assist in the treatment of persons with ID and psychiatric/behavioral disorders; 2) By the end of the presentation, the participant will be able to discuss whether aspects of psychotherapy is or is not innovative for persons with I.D; 3) By the end of the presentation, the participant will be able to discuss what, if any innovative psychotropic treatment exists for persons with ID and psychiatric disorders; and 4) By the end of the presentation, the participant will be able to discuss ways to utilize environmental change in management of persons with I.D.

SUMMARY:

Persons with intellectual disability are among the most medicated individuals in society. Unfortunately, for many persons this has not resulted optimal outcomes. There is a need for innovative care. What innovations have occurred during the past twenty years in treating persons with intellectual disability (I.D.) and psychiatric and/or behavioral disorders? Have design flaws in pharmacologic research in persons with I.D. impacted advances (1)? Mental retardation is no longer an acceptable term; Intellectual developmental disorder is used worldwide (2) and DSM5 utilizes the term I.D. While the importance of replacing the term, “mental retardation” cannot be overestimated, have there been significant innovations in treatment? Has the use of environmental change been ignored too often in the management of behavioral problems in persons with I.D.? Is telepsychiatry truly innovative for the treatment of psychiatric disorders in persons with ID, when Menolascino and Osborne published an article on it nearly 50 years ago (3)? Is supportive psychotherapy limited to only persons with mild I.D. or can persons with moderate I.D. also benefit (4)? The presentations and subsequent panel discussions will offer point/counterpoint arguments about innovations in the treatment of psychiatric/behavioral disorders in persons with I.D. Audience discussion/disagreement/debate is encouraged.

Iraq on the Ground (Part II): Mental Health in Conflict Zones

Chair: Allen R. Dyer, M.D., Ph.D.

Presenters: Anita Smith Everett, M.D., Amir Arsalan Afkhami, M.D., Ph.D., Catherine Stuart May, M.D., Mohammed al Uzri, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the health and mental health impact of war and political conflict on citizen populations; 2) To understand the psychophysiological relationship between mind and body in face of adverse traumatic experiences; 3) To understand the emerging narcotics problem in a regional context; 4) To see the world’s current refugee crisis as a continuation of both internal and external displacements from home; and 5) To

appreciate the role of the psychiatrist in mitigating trauma and distress.

SUMMARY:

At the 2008 APA, in the midst of the war in Iraq, this team presented a symposium on Iraq, “The View through the Psychiatrist’s Lens”. A decade later it is time to take another look at mental health in Iraq. While Iraqi civilians, families, communities have faced enormous trauma, they have also shown enormous resilience. Throughout the war, British and American teams have worked closely with Iraqi mental health professionals and government officials to improve health and mental health care. Though the aftermath continues, the improvements have been impressive.

Novel Approaches and New Directions in the Treatment of Borderline Personality Disorder

Chair: Marianne Seligson Goodman, M.D.

Presenters: Mary Zanarini, Donald W. Black, M.D., Stephanie Stepp, Sarah Kathryn Fineberg, M.D., Ph.D.

Discussant: Frank Elton Yeomans, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify ways that psychoeducation about the BPD disorder can decrease BPD symptom severity; 2) Highlight how treatment of maternal dysregulation in BPD can positively impact offspring psychopathology; 3) Integrate group approaches to current treatment efforts for BPD symptomatology and to lessen suicide risk; and 4) Expand knowledge base on the safety and potential efficacy of Ketamine in BPD populations.

SUMMARY:

North American Society for the Study of Personality Disorders Submission: Borderline Personality Disorder (BPD) is a disabling disorder characterized by poor affect regulation, impulse dyscontrol, impaired interpersonal relationships and maladaptive behavioral patterns, including anger, aggression and self-destructive behaviors. The disorder remains notoriously difficult to treat, with many patients responding poorly or partially even to the most widely accepted treatment strategies

leaving many clinicians and patients frustrated with suboptimal outcome. This symposium consists of 5 presentations highlighting several new treatment approaches including on-line psychoeducation, two novel group treatments, transmission of maternal emotion regulation skill training to preschooler offspring, and ketamine. Dr. Mary Zanarini will begin with a description of a randomized controlled trial (RCT) of psychoeducation for BPD that was conducted using the Internet in 80 females with the disorder. Half of the subjects received an on-line curriculum teaching about BPD in a comprehensive manner, which resulted in greater reductions in the symptom severity of BPD for periods up to one year. Dr. Don Black will present on Systems Training for Emotional Predictability and Problem Solving (STEPPS); an evidence-based group treatment program for persons with BPD. Using two data sets, one collected in Iowa's correctional system, and another at an academic medical center, he will examine the effect of race and age on treatment response, suicidal behaviors, disciplinary infractions (in prisoners), and patient satisfaction. Dr. Stephanie Stepp will then present an overview of an early intervention for preschoolers that targets maternal emotion dysregulation in mothers with BPD. An RCT of dialectical behavior therapy (DBT) skills training will be used to test the impact of maternal emotion dysregulation on developing emotion dysregulation during the preschool period. Dr. Marianne Goodman will describe "Project Life Force" (PLF), a novel suicide safety planning group intervention to target high-risk suicidal behavior. PLF, a 10-session, group intervention, combines cognitive behavior therapy (CBT)/ DBT skill based and psychoeducational approaches, to maximize suicide safety planning development and implementation. Preliminary feasibility and effectiveness data will be presented. Lastly, Dr. Sarah Fineberg will discuss the use of Ketamine in BPD. Given Ketamine's rapid and robust reduction of depressive symptoms and suicidal ideation in people with depression, there has been growing interest in the use of ketamine in people with BPD. Questions about the safety, tolerability, and efficacy of ketamine in BPD will be discussed along with preliminary data from a clinical trial of ketamine in this setting. The symposium will conclude with a synthesis of the 5 presentations by

Dr. Frank Yeomans who will share his thoughts about treatment advances in BPD.

Patient Suicide in Residency Training: The Ripple Effect

Chairs: Daphne Collado Ferrer, M.D., Joan M. Anzia, M.D.

Presenters: Marina Bayeva, M.D., Ph.D., Priti Ojha, M.D., James Welton Lomax, M.D., Alexis A. Seegan, M.D., Stefana B. Morgan, M.D.

Discussants: Deepak Prabhakar, M.D., M.P.H., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify challenges in educating psychiatry residency trainees about the impact of patient suicide; 2) Discuss strategies for improving supports for resident trainees at their home programs; and 3) Provide an open platform for sharing experiences with patient suicide.

SUMMARY:

According to the Centers for Disease Control and Prevention, in 2014 suicide was ranked as the tenth leading cause of death, accounting for 42,773 deaths. Studies estimate that 20-68% of psychiatrists will lose a patient to suicide in their career. A significant number of residents will experience patient suicide during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the available literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents, their colleagues, and supervisors after a patient dies by suicide. This lack of discussion interferes with the use of positive coping strategies by residents, and highlights that residency training programs need improvement in supporting residents through this difficult experience, and preparing them for the likelihood of losing a patient to suicide in their career. The symposium will begin with a discussion from residency program directors examining the challenges in educating trainees about the impact of patient suicide, illustrated through a video titled "Collateral Damage: The Impact of Patient Suicide on the Psychiatrist". This video was developed as a discussion stimulus for

residents, faculty, and private practitioners in psychiatry to help them with the experience of having a patient die by suicide. Data from a study by Prabhakar et al examining the role and development of support systems including educational curricula within psychiatry residency training programs, has demonstrated an increased awareness of issues related to patient suicide, and promise as a useful program in residency training. Psychiatry residents from various training programs across the United States will then share their individual experiences of patient death by suicide. Small group discussions led by panelists will follow, allowing an open platform for sharing of experiences with patient suicide among audience participants. The symposium will end with a large group discussion of strategies for improving supports for residents, and close with final comments and a forum for questions from the audience.

Psychiatry in the Hot Seat: Excelling at Direct and Cross Examination

Chair: Stephen Noffsinger, M.D.

Presenters: Jennifer L. Piel, M.D., J.D., James Lyle Knoll, M.D., Ashley VanDercar, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of the psychiatrist in providing expert witness testimony in civil and criminal matters; 2) Describe 10 techniques for delivering effective direct expert witness testimony; 3) Understand how trial attorneys prepare to cross examine the psychiatric expert witness, and 10 commonly used cross examination techniques; 4) Understand and demonstrate 10 techniques for avoiding cross examination pitfalls and for successfully remedying cross examination techniques; and 5) Write forensic reports that minimize the potential for cross-examination.

SUMMARY:

Psychiatrists may be called upon to testify in legal settings such as depositions, hearings and civil and criminal trials. Civil commitment, involuntary treatment, disability and guardianship hearings frequently require psychiatric expert testimony, as do criminal and civil hearings and trials involving trial competency, the insanity defense, medical

malpractice, emotional damages and other medical-legal disputes. Live testimony before a judge or jury poses both opportunities and risks for experts. Direct testimony allows the psychiatric expert the unique opportunity to provide the judge or jury with their opinions and rationale underlying their opinions, and to instruct the judge or jury about the psychiatric issues in dispute. When an expert's report is not admitted into evidence or is not read by judge or jury, live testimony is often the only vehicle for conveying the experts' opinion. However, live testimony also creates the risk of having the expert's opinion distorted or discredited by rigorous cross examination, especially when the cross examination is conducted by an attorney who is a skilled cross examiner. The cross-examining attorney's goal is to undermine the expert's opinion by challenging the expert's qualifications, methodology, reasoning and objectivity. While psychiatrists routinely receive little-to-no training in how to deliver effective testimony, the skilled cross examiner may have undertaken several law school courses on trial advocacy and have honed their cross examination skills through years of courtroom experience. This presentation will explain how psychiatrists can: 1. Write reports that serve as templates for future testimony; 2. Undertake pre-trial planning with retaining attorneys to script effective direct testimony; 3. Provide direct testimony that teaches the judge and/or jury about the pertinent issues; 4. Deal with overtly or subtly hostile cross examination, including challenges to professional credentials, overcoming adverse spin and distortion of one's expert opinion, portrayal of the expert as biased, and manage stress. Audience participation will be achieved by the speakers presenting a number of written and/or video vignettes illustrating commonly used attorney cross examination techniques. The audience will be asked to identify the types of cross examination technique being illustrated, and will suggest potential solutions to counter the cross examination techniques. Additionally, audience members will participate in mock cross examination.

Religion and Suicidality: Risk or Resilience?

Chairs: Connie Svob, Ph.D., Myrna M. Weissman, Ph.D.

Presenters: Tyler VanderWeele, Ph.D., Ryan Edward Lawrence, M.D., Clayton McClintock, M.S., Steven

Hoffman

Discussant: Maria Antonia Oquendo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To learn empirical findings related to both risk and resilience factors associated with religion and suicidality; 2) To better understand the theoretical context for engaging in discussions concerning the association between religiosity and suicidality; and 3) To identify different ways religiosity can be conceived in potential interventions of suicidality.

SUMMARY:

The relationship between religiosity and suicidality has been described for over 100 years (Durkheim, 1897). The actual role of religion in risk and resilience for suicidality remains little understood and controversial. With the upsurge of interest in interventions for suicidality, religiosity has been regaining attention as a potential protective mechanism. In this symposium, we present various perspectives and data related to both risk and resilience in the association between religion and suicide. We will present empirical findings from several studies and will provide theoretical contexts in which to interpret the results. We will present data on the association between religious service attendance and lower suicide rates in a long term prospective U.S. study of nurses (N=89,708), and will consider similar protective findings of religious attendance against suicidal ideation in a group of adolescents from Central Mexico. We will then extend the findings of these protective effects by examining them intergenerationally. That is, we will present data that suggest a parent's religiosity (religious service attendance and religious importance) can be protective for children against suicide ideation and attempts. In addition to presenting data on the protective effects of religion, we will also present data on religion as a potential risk factor for suicidality. For example, we will outline data that implicate religion as a risk factor for suicide attempts and ideation among depressed patients. We will demonstrate that the topic of religion and suicidality requires a more complex and nuanced discussion than simply asking, "Is religion protective?" Rather, we will suggest that future

research should ask, "What does it mean for this person to be religious, and how does that affect their interpersonal context and their struggles with mental illness?" To end, we will consider ways the construct of religiosity can be expanded and be made applicable to varying groups of individuals by approaching the dialogue from the perspective of spirituality, rather than religiosity. We will present data on global spirituality factors that have replicated across three international samples (N=5,512) – USA, India, and China – and consider them in relation to suicidality. Taken together, the symposium will be both empirically and theoretically relevant to psychiatry and the endeavor to harness religiosity as a potentially protective intervention against suicidality.

Repetitive Transcranial Magnetic Stimulation and Addiction: A New Scenario

Chairs: Giovanni Martinotti, M.D., Antonello Bonci, M.D.

Presenters: Lorenzo Leggio, M.D., Primavera Spagnolo, M.D., Sarah H. Lisanby, M.D., Colleen A. Hanlon, Ph.D., Giovanni Martinotti, M.D., Mauro Pettoruso, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) to describe the state of the art with regards to the use of rTMS in addiction psychiatry; 2) to report the first promising data about rTMS in the treatment of cocaine addiction; and 3) to evaluate and discuss the potential of brain stimulation techniques in other form of addiction, including gambling disorder.

SUMMARY:

Addiction disorders are a major public health concern, associated with high relapse rates, significant disability and substantial mortality. Chronic use of these psychoactive substances may cause relevant brain damage, including changes in the prefrontal cortex, which plays a critical role in the addictive cycle. Repetitive Transcranial Magnetic Stimulation (rTMS) is a non-invasive brain stimulation technique that has been employed with promising results in a variety of neuropsychiatric disorders. Experimental studies suggest that there is indeed a dopaminergic dysfunction of the

mesolimbic systems in addicts. According to some authors, symptoms of addiction could be alleviated by “boosting” dopaminergic transmission which may be achieved via TMS. Because of their deep brain localisation, dopaminergic neurons are indirectly stimulated during rTMS, through their more superficial projections, especially in the dorso-lateral prefrontal cortex (DLPFC). The DLPFC is involved in cognitive control and the physiopathology of impulse control disorders, such as addiction. rTMS applied to the DLPFC may therefore indirectly modulate dopaminergic pathways and may consequently have an impact on the symptoms of addiction: cognitive control could be improved and cravings could be reduced. In this symposium the possible applications of rTMS in addiction will be presented and discussed. Pilot data about the successful treatment of cocaine use disorders with different rTMS techniques will be reported. Moreover, new scenarios, and possible translational applications, including gambling and other behavioral addictions will be reported.

Research Advances in the Pharmacotherapies for Opioid Use Disorders

Chairs: Geetha Subramaniam, M.D., Ivan Montoya, M.D.

Presenters: Michelle R. Lofwall, M.D., Eric Strain, M.D., Aidan Hampson, Ph.D., Elias Dakwar, M.D., Joshua Lee, M.D.

Discussant: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about the results of 2 Phase III studies examining different long-acting injectable formulations of buprenorphine; 2) Become familiar with the role of lofexidine in the management of opioid withdrawal; 3) Learn about advances in the rapid initiation of extended-release naltrexone in active opioid users; and 4) learn about the comparative effectiveness of sublingual buprenorphine vs. injectable naltrexone in the management of OUD patients.

SUMMARY:

Opioid misuse and opioid use disorders have risen to epidemic proportions, in recent years. Psychiatrists are uniquely positioned to apply these cutting-edge

strategies to treat patients with opioid use disorders (OUD), as many present with chronic-co-occurring psychiatric conditions. Several pharmacological agents such as sublingual and implantable buprenorphine and injectable extended-release naltrexone formulations are currently available for the management of OUD. However, new medications and new extended-release formulations of existing agents are being developed (with some pending FDA approval) that address limitations of daily dosing, acceptance/tolerability of existing preparations. This symposium is designed to provide research updates on several aspects of OUD management. Specifically, five presentations will highlight the results of recently completed clinical trials: two phase 3 trials comparing two different weekly and monthly injectable formulations of buprenorphine to sublingual buprenorphine; efficacy of lofexidine in the management of opioid withdrawal; preliminary findings from ketamine-supported opioid withdrawal; and a recently completed multisite trial comparing the effectiveness of sublingual buprenorphine and injectable naltrexone. The discussant will summarize, critique and offer their perspective on the state of the science and new directions in research in this area.

Stress Among Medical Students, Residents, and Physicians: A Global Perspective

Chair: Fahad Dakheel Alosaimi, M.D.

Presenter: Ahmad N. Alhadi, M.D.

Discussant: Sanjeev Sockalingam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the evidence on stress for learners in psychiatry and medicine in general; 2) Contrast unique global contexts and their influence on student burnout and stress; 3) Identify patterns of Stress and stress-coping strategies among practicing physicians, including psychiatrists; and 4) Learn possible interventions and resources to manage the challenges facing international medical graduates (IMG) especially psychiatric trainees during postgraduate training in North America.

SUMMARY:

In the past few decades, compared to other

professional groups, physician wellness has diminished in every aspect of professional life. However, stress starts in early career. Medical education itself can have significant negative effects on the well-being of medical students. A recent review found the prevalence of depression or depressive symptoms among medical students to reach 27.2% and that of suicidal ideation was 11.1%. In the other hand, residency training is also a difficult and stressful stage of development in a professional career. Residents are often subject to prolonged working hours, sleep deprivation, uncontrolled schedules, high job demands, and inadequate personal time. Additionally, residency may impact the residents' quality of life and cause them to experience sleep disorders, family problems, and even psychiatric disorders. Chronic stress may affect the relationship of physicians with their patients and can lead to negative clinical consequences, such as compassion fatigue, unprofessionalism, and clinical errors. Chronic stress can also affect a physician's personal life and result in negative outcomes, such as fatigue, substance abuse, psychiatric morbidity, and suicidal ideation. Work-related stressors include less autonomy because of the widespread adoption of evidence-based practice protocols, working in larger groups, and being subjected to scrutiny regarding their intervention. Moreover, physicians are concerned about increasing the number of complaints, the costs of liability insurance and the development of the judicialization of care. Psychiatrists are in good position to make physicians' mental health as a necessary part of any discussion of the health-care system—and of health-care reform. This symposium tackles this important and prevalent issue of stress in medical training and provides a unique international perspective regarding interventions to address this issue and lessons learned. Dr. AlHadi will begin by reviewing and discussing the available studies about stress and studying medicine in Saudi Arabia and compare it to other countries. Dr. Alosaimi will discuss novel research on the perceived stress and stress-coping strategies among residents in Saudi Arabia and compare these data to similar international studies. Dr. Sockalingam will discuss distress in the challenges facing international medical graduates (IMG) during postgraduate training in North America based on two studies. He will also share possible

interventions and Canadian resources aimed at supporting psychiatry residents' transition into Canadian residency and fellowship programs. Lastly, Dr. Alosaimi will discuss patterns of Stress and stress-coping strategies among practicing physicians in Saudi Arabia and compare distress prevalence and interventions with other countries. The presenters will use case studies and large group discussion to integrate the findings into their own programs and practices.

Cornell ALACRITY Center: Implementing Neurobiologically Based Interventions for Mid- and Late-Life Depression in the Community

Chair: George S. Alexopoulos, M.D.

Presenters: Dimitris Kiosses, Ph.D., Jo Anne Sirey, Patricia Marino, Mark Matthews, Samprit Banerjee

Discussant: Richard Alan Friedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn how neurobiological concepts can be used to identify behavioral targets that can be addressed by streamlined behavioral interventions; 2) Become familiar with three neurobiologically informed behavioral interventions for community-treated depressed middle aged and older adults; 3) Learn about the process for developing smartphone apps that can augment behavioral interventions for depression at the assessment, the intervention, and the adherence monitoring levels; and 4) Learn how the use of "big data" can be mined and used to identify populations in need of specialized interventions.

SUMMARY:

We will present a novel model of deployment-based behavioral interventions streamlined based on neurobiology models and augmented by mobile technology. Our model: 1) Develops its interventions jointly with community partners and uses neurobiological concepts as a "simplification rule" for streamlining behavioral interventions so that they can be used by community clinicians; 2) integrates mobile technology to community interventions at the assessment, the intervention, and the adherence monitoring levels; and 3) tests its interventions at community sites using community clinicians to shorten the way to sustainability. Dr. D.

Kiosses will discuss the theoretical and clinical framework of “Relief”, a brief intervention for depressed middle-aged and older adults suffering from chronic pain designed to be administered by licensed social workers and nurse practitioners in primary care practices. “Relief” is a psychosocial intervention targeting symptoms of depressed, pain patients originating from dysfunction of the reward, salience, and cognitive control networks. Dr. J. Sirey will describe the development of PROTECT, a psychosocial intervention for elder mistreatment victims who comprise up to 10% of older adults and of whom 30% have depressive symptoms. PROTECT targets symptoms of depressed victims stemming from dysfunction of the cognitive control and the reward networks and is designed to work in synergy with mistreatment resolution services that provide safety planning, support services, and links to legal services. Dr. P. Marino will present the theoretical and aspects of REDS, an 8-week group therapy intervention that is based on a stepped-care model streamlined to use “reward exposure”. REDS is based on the assumption that dysfunction of the reward networks is central to the pathogenesis of depression. This intervention is administered by licensed social workers in NY City senior centers. Dr. S. Banerjee will describe methods by which “Big” databases, e.g. electronic health records and claims databases, can be mined with machine learning methods to identify populations in need of specialized interventions. He will discuss how advanced statistical methods such as joint modelling of multiple correlated outcomes can increase information yield from clinical studies. Finally, Dr. Banerjee will describe the logic of methods to analyze “small” data generated from smartphones used to augment treatment with daily monitoring apps. Dr. RA Friedman will serve as the discussant.

Defining Core Competencies for Dealing With Spirituality and Religion in Psychiatry

Chairs: John Raymond Peteet, M.D., Wai Lun Alan Fung, M.D.

Presenters: Cassandra Vieten, Mary Lynn Dell, M.D., Francis G. Lu, M.D., Alexander Moreira-Almeida, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Understand the history and current extent of psychiatric training in R/S; 2) Appreciate the need to identify core competencies in this area; 3) Identify principles underlying the selection of core competencies in R/S; 4) Articulate competencies in R/S in child and adolescent psychiatry; and 5) Cite evidence-based guidelines for curricula in R/S.

SUMMARY:

The complex relationship between spirituality and religion (S/R) and mental health has been recognized for centuries, and in recent decades has been validated through a growing body of research. Most studies show a positive relationship between S/R and measures of health and wellbeing, but S/R can also be a source of harm (e.g., treatment refusal, intolerance, and negative religious coping). Position statements on spirituality and religion in psychiatry published by the Royal College of Psychiatrists (UK) in 2013 and by the World Psychiatric Association in 2016 emphasize the importance of psychiatrists’ competence in dealing with religion/spirituality. The American College of Graduate Medical Education now mandates that residents demonstrate “sensitivity and responsiveness to a diverse patient population, including... diversity in ...religion.” Additionally, residents “must demonstrate proficiency in their knowledge of... religious / spiritual...factors that significantly influence physical and psychological development throughout the life cycle.” The number of American psychiatry residency programs offering courses in S/R increased from 39 to 84 (of about 200) from 1998 to 2006, and a 2003 study found that 14 of the 16 Canadian psychiatry residency programs provided at least some S/R training. Despite increasing recognition of the importance of training for competence in S/R, no consensus exists about what competencies in this area are most important to acquire and teach. Establishing such a consensus is a critical first step in identifying learning objectives for each stage of training, and what strategies for achieving them are most effective. Presenters in this symposium will address this question from complementary perspectives: Dr. Cassandra Vieten will discuss her recently published research on competencies for psychologists in the domains of religion and spirituality. Dr. Alan Fung will review the existing

literature regarding training in psychiatry in S/R. Dr. Francis Lu will examine the place of S/R in the ACGME Milestones for psychiatric residency education, and the DSM-5 Cultural Formulation interview, which he helped to develop. Dr. Mary Lynn Dell will discuss R/S competencies as they relate to child and adolescent psychiatry, using a developmental perspective. Finally, Dr. Alexander Moreira-Almeida, Chair of the Section on Religion, Spirituality and Psychiatry of the World Psychiatric Association will present evidence-based guidelines for curriculum on R/S.

Schizophrenia Care Pathways by Health Quality Ontario

Chair: Jen Pikard

Presenters: Tariq Allauddin Munshi, M.D., Anees Bahji, M.D., Jen Pikard, Farooq Naeem, M.B.B.S.

Discussant: Farooq Naeem, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) "At the conclusion of this session, the participant will be able to be familiar with the care pathways for Schizophrenia by Health Quality Ontario; 2) "At the conclusion of this session, the participant will be able to understand background of the endeavors of health quality ontario in the province; 3) "At the conclusion of this session, the participant will be able to understand the fundamentals of Cognitive Behavioral Therapy for Psychosis; 4) At the conclusion of this session, the participant will be able to be familiar with the current diagnostic criteria and management of Schizophrenia; and 5) "At the conclusion of this session, the participant will be able to have an identify the potential areas of the gaps in the services.

SUMMARY:

Quality Standards are a new form of evidence-based guidance developed by Health Quality Ontario in topics that are identified as high priority areas for quality improvement in Ontario. Quality Standards are intended to support health care professionals in providing the best care possible, and to help patients, caregivers and the public know what kind of care they should expect. It is with time we have realized that a more comprehensive approach is

required to improve the care of those with psychosis. Currently, there is an emphasis on developing and testing care pathways in health. These pathways map the journey of a person with psychosis through the care system. The aim of a care pathway is to enhance the quality of care across the continuum by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources." Recently the Health Quality Ontario has taken the initiative to come up with care pathways for individuals with Schizophrenia in attempt to standardize care across the province. There are 11 Quality Standards in this pathway which range from providing comprehensive physical health assessment to discharge planning on the continuum. There are gaps within the services which also vary from one area to the area in terms on the resources. Our aim is to identify those gaps and therefore start an attempt to address them. The primary example of it is the lack of trained therapists in Cognitive Behavioral Therapy for Psychosis.

Struggling With Burnout in Residency Training: The Causes, the Consequences, and Coping With It

Chair: Louis Belzie

Presenters: Adeel Anwar, M.D., Milania Dela Cruz, M.D., M.P.H., Surya Nethikunta, Nidhi Karingula

Discussant: Sanila Rehmatullah

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) • At the conclusion of this session, the participant will understand laws and regulations on residency training hours and also recognize stressors for burnout; 2) •

Understanding the analysis of a research study we conducted on burnout of residents in a busy inner-city hospital in Brooklyn, NY; 3) • Increase awareness of the consequences of burnout on residents including depression, substance abuse, anxiety, and suicide and its effect on patient safety; 4) • To discuss different interventions already implemented in residency programs promoting resident wellness and exploring whether residents are aware of these interventions; and 5) • At the end of this conclusion, the participant will be able to balance "work and play" and be aware of any

innovative social/technological forms of combating burnout.

SUMMARY:

Residency training can be a stressful, overwhelming period where residents and fellows work long hours and have tremendous responsibilities in the workplace for utmost and superior delivery of patient care yet may lack autonomy in regards to work schedules and medical decision-making. This can set the stage for ongoing stress ultimately leading to residents' burnout. There has been significant attention whether residents' psychosocial distress has any immediate or long-term consequences in patient care or for the physicians themselves. As per the nature and intensity of the training, some stress seems inevitable or even favorable. Yet scattered studies suggest that residents experience high rates of burnout causing a severe stress reaction and that burnout could lead to adverse mental health and work performance. Research has shown that resident fatigue and extended work hours can adversely affect patient care. Consequences of burnout are multifactorial and can include dramatic increases in the rates of depression, anxiety, and drug use among residents throughout their training with resultant increase in cynicism, decreased empathy, and poor performance. In a recent study from the United States, 45.8% of physicians reported having at least one symptom of burnout. We conducted an IRB-approved study on resident burnout in an inner city hospital using the Maslach Burnout Scale (MBI). Majority of the resident population who participated in this study were comprised of international medical graduates. In one of the study conducted in 2011, burnout was found to be less among international medical graduates than among US medical graduates in a multivariate analysis. (45.1% vs 58.7%; odds ratio, 0.70 [99% CI, 0.63-0.77]; $P < .001$). Experience of international medical graduates in US training programs is poorly understood. Our data suggested a very different resident population as compared to an average US program (80 % IMG). Therefore, we will look at specific issues related to each residency group and have a comparison about major common issues faced by most training programs at Brookdale. We also would like to openly discuss already implemented interventions that

promote resident wellness. It would also be included to discuss evidence-based interventions and their effectiveness. If residents are provided opportunities to develop self-care practices to help cope with the stress of the medical profession, it may mitigate more severe mental dysfunction and burnout later. Increased wellness may also reduce high-risk behaviors such as smoking, alcohol, and substance use.

The Role of the General Psychiatrist in the Management of Patients With Pain

Chairs: Carlos Blanco-Jerez, M.D., Geetha Subramaniam, M.D.

Presenters: Edward Vernon Nunes, M.D., Sharlene Wedin, Psy.D., Alla Landa, Ph.D., Ivan Montoya, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the end of the presentation the audience will better understand the role of the general psychiatrist in managing pain; 2) The audience will be familiar with the most common pharmacological and non-pharmacological approaches to pain; and 3) The audience will be aware of the benefits and risks of using opioids to treat pain.

SUMMARY:

The goal of this symposium will be to teach the general psychiatrist (i.e., the non-pain expert) how to recognize pain in their patients and help them decide when to treat and when to refer. It will also provide information on how to avoid common pitfalls in the management of pain. Pain is a highly prevalent condition, with recent estimates suggesting that chronic pain affects approximately one third of the US population and constitutes one of the most common symptoms for which patients seek medical attention. It is associated with intense personal suffering, high rates of disability, and an economic burden surpassing half a trillion dollars per year due to the cost of medical treatment and productivity losses. Concerns about undertreatment of pain have led to rapid growth in the rates of prescription opioids and a dramatic increase in the prevalence of prescription opioid use disorders, which themselves pose risks of premature mortality. Psychiatrists often see patients with pain, yet most

psychiatrists feel uncertain about their role in the treatment of pain. The role of this symposium will be to present a variety of treatments for pain, including pharmacological, non-pharmacological and multimodal approaches to pain. At the end of the symposium, the audience should feel more comfortable with the recognition and assessment of pain, as well as have a general framework to decide what and when to treat, and when to refer to the pain specialist.

Trending Issues in Geriatric Forensic Psychiatry

Chair: Jacob Chaim Holzer, M.D.

Presenters: Robert Kohn, M.D., Carolina Jimenez Madiedo, M.D., Barry W. Wall, M.D., Patricia Ryan Recupero, M.D., J.D.

Discussant: James Michael Ellison, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand that as the geriatric population increases a greater understanding of forensic psychiatry is needed; 2) Identify the role of the psychiatrist in working with the elderly in the forensic setting; 3) Understand how the psychiatrist working with geriatric patients can reduce liability while improving patient outcome; 4) Identify forensic psychiatry issues specific to elderly patients; and 5) Describe the relationship of the judicial system with the forensic geriatric consultant specialist.

SUMMARY:

Geriatric forensic psychiatry is an evolving field that requires knowledge of forensic psychiatry and geriatric psychiatry. Consistent with the growing elderly population there will be increasing attention to the forensic psychiatry needs of the elderly in clinical, judicial, and correctional settings. The clinician working with the geriatric population may encounter a wide range of forensic issues from prevention of bad outcomes that could create risk management issues to working with elderly defendants and the legal profession. Elderly individuals are aging into or becoming increasingly involved with the judicial system. The growing number of individuals with cognitive impairment may pose an increase in frequency of situations that create ethical and forensic issues that the clinician

will encounter, beyond that of assessing for capacity. We review that the elderly population presents unique challenges to safe management, including the risks of medical comorbidity, polypharmacy, cognitive impairment, and reduced sensory input and physical functioning. Understanding the reasons for increased risk in the geriatric population will help clinicians design strategies to lower these risks and reduce the potential for harm. We then examine two of the more common forensic geriatric psychiatric issues encountered in the clinical setting, elder abuse and suicide. Elder abuse frequently goes undetected and under-reported despite that it increases mortality, emergency room visits, hospitalizations, and skilled nursing home placement. The probability of death from a suicidal act increases exponentially with age; yet few guidelines for prevention of suicide and reduction of clinician liability have been developed. The challenges of working with the working with the judicial system and the elderly defendant will be examined. The clinician working with the elderly defendant should be aware how law enforcement and court personnel may interact with the elderly population. In working with attorneys, psychiatrists will find it helpful to gain a basic understanding of different aspects of elder law and the ethical obligations of attorneys. Understanding the roles of laws, regulations, and legal professionals is important to the successful practice of geriatric forensic psychiatry, as geriatric psychiatrists may be among the first clinicians to recognize an elderly person's need for legal assistance. Issues in geriatric forensic psychiatry span across all clinical settings including long-term care and into the judicial system, and not only directly involves the patient, but also may directly impact the clinician.

Workshops

Saturday, May 05, 2018

Eating Disorders in Adolescents: Diagnosis, Treatment, and Research Update

Chair: Matthew Shear, M.D.

Presenters: Victor M. Fornari, M.D., Sean Kerrigan, M.D., Joanna E. Steinglass, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role and significance of a continuum of care in the treatment of adolescents with eating disorders; 2) Understand the clinical implications of newly created diagnostic categories for adolescents with eating disorders; and 3) Develop an understanding of the current research regarding the neurobiology of eating behaviors in anorexia nervosa.

SUMMARY:

Eating disorders are severe and life-threatening psychiatric conditions that are often first diagnosed during adolescence. Early identification and intervention have been associated with improved outcomes. This workshop, with presentations focusing on diagnosis, evidence-based treatments, and recent research will discuss several issues of significance to psychiatrists who work with young patients with eating disorders. Dr. Sean Kerrigan, an attending psychiatrist at a specialized eating disorders inpatient program at New York-Presbyterian Hospital, will discuss new diagnostic categories described in DSM-5, including Avoidant/Restrictive Food Intake Disorder (ARFID), Pica, and Rumination Disorder, which commonly present early in life. Dr. Victor Fornari, Director of the Division of Child and Adolescent Psychiatry at Long Island Jewish Medical Center, will discuss the development, function, and essential role of a continuum of care for adolescents with eating disorders. Dr. Joanna Steinglass, Director of Translational Research in Eating Disorders at Columbia University Medical Center, will provide an update on current research examining the neurobiology of food choice in anorexia nervosa.

EEG in Psychiatric Practice

Chair: Oliver Pogarell, M.D.

Presenters: Nashaat Nessim Boutros, M.D., Oliver Pogarell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) to recognize the clinical EEG as auxiliary diagnostic tool in psychiatry; 2) to decide whether a clinical EEG is indicated for a particular patient; 3) to identify EEG abnormalities and clinical consequences; and 4) to appreciate the possible

impact on diagnosing and managing psychiatric patients.

SUMMARY:

Standard electroencephalography (EEG) remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this workshop, clinicians will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns. Specific clinical indicators (“red flags”) for EEG assessment will be stressed. More detailed coverage of selected areas will include: (1) EEG in psychiatric assessments in the emergency department; (2) EEG in the assessment of ADHD, panic and borderline patients; (3) the value of EEG in clinical presentations where diagnostic blurring occurs (i.e. differential diagnosis of dementia, differential diagnosis of the agitated and disorganized psychotic patient, and psychiatric manifestations of non-convulsive status epilepticus). Specific flow charts for EEG evaluations with neuropsychiatric patients will be provided. Numerous illustrated clinical vignettes will emphasize points being made. This workshop is designed to enable the practicing clinician to utilize EEG effectively (i.e. avoid over- or under-utilization), to help with differential diagnostic questions and to be able to determine when an EEG test was adequately (technically) performed. At the conclusion of this workshop, participants should be able to understand the limitations of EEG and broad categories of pathophysiology that produce EEG abnormalities. Participants will have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG, including monitoring ECT and pharmacotherapy. The workshop is intended for the practicing clinician in psychiatry.

Expanding Access to Medication-Assisted Treatment for Opioid Use Disorders to Patients in the Hospital

Chair: Christopher J. Welsh, M.D.

Presenters: Eric Weintraub, M.D., Danae Nicole DiRocco, M.D., Jamie Spitzer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the current epidemiology related to opioid use disorders in the U.S; 2) Understand the long term benefits of medication assisted treatment for opioid use disorder; 3) Describe some of the acute benefits to managing opioid withdrawal in the hospital setting; 4) Describe the federal regulations that allow for the use of buprenorphine and methadone in the hospital setting; and 5) Describe the role of educating residents in the management of Opioid Use Disorders in the hospital setting.

SUMMARY:

According to the Center for Disease Control and Prevention, drug overdose deaths in the United States increased by about 20% from 2015 to 2016, accounting for approximately 64,000 total deaths with over 20,000 attributed to illicitly manufactured fentanyl and its analogues, 15,400 to heroin and 14,400 to prescription opioids. Emergency room visits, general hospital admissions and psychiatric admissions involving individuals with opioid use disorders have all increased in many parts of the country over the past 5-10 years. A great deal of evidence shows that proper treatment of opioid use disorders helps reduce opioid misuse and opioid-related overdose. Medication-assisted treatment (MAT), Opioid Maintenance Treatment (OMT) or Opioid Substitution Therapy (OST) are common terms used to refer to the use of methadone or buprenorphine for ongoing treatment. Although their use has been hampered by various federal and local policies/regulations, as well as negative attitudes held by the general public, patients, medical providers and many clinicians who work in the substance abuse treatment field, the support of various government agencies (CDC, ONDCP) and reforms in insurance coverage (Affordable Care Act; state Medicaid expansion) appear to be helping increase their availability. Psychiatrists can play an important role in the expansion of the use of methadone, buprenorphine and naltrexone in various areas of the hospital including the general emergency department (ED), psychiatric emergency

services (PES), general medical/surgical units through consult-liaison (CL) and in-patient psychiatric units. Often, psychiatrists and other physicians believe that they are not able to start patients on these medications in the emergency department or hospital because of federal regulations. Many are not aware of provisions in the Controlled Substances Act that allow for the administration of buprenorphine and methadone to patients in the hospital or ED. Several studies have demonstrated the increased initiation of treatment in substance abuse and primary care settings after being started on MAT in the hospital prior to being referred to out-patient treatment. The workshop will discuss the epidemiology of opioid misuse, use disorders and overdose in the United States. It will then briefly review the literature highlighting the efficacy of MAT for reducing illicit opioid use and the consequences of use. The federal regulations that dictate how MAT is provided on an out-patient basis will be presented as well as the exceptions to these regulations that allow for MAT to be used in the ED and in-patient settings. Lastly, the importance of student and resident training in the management of opioid use disorders in the hospital will be discussed. Case vignettes will be used to highlight various aspects of this issue and differences in the regulations that apply in the ED versus in-patient settings. Audience participation and case material will be encourag

IMG: I Care and Need to Be Cared for

Chair: Kishan Nallapula, M.D.

Presenters: Jennifer Severe, M.D., Maria Mirabela Bodic, M.D., Sasidhar Gunturu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The audience will appreciate the burden of IMG physicians in the US; 2) The audience will have a basic understanding of the immigration process for physicians to practice in the US; 3) The audience will appreciate the acculturation process and stress associated with it for an IMG; 4) The audience will engage in role-playing scenarios with IMG colleagues; and 5) The audience will engage in strategies to assess burn out in residency training.

SUMMARY:

An estimate of actively licensed physicians in the US in 2014 showed 75% are graduates of US medical schools, 22.7% are International Medical Graduates (IMG) and 2.3% are unknown. In the recent years, more US citizens are graduating from a foreign medical school. The cultural transition of IMGs to medical learning and practices goes through different shade and shape contingent on personal and interpersonal challenges as well as availability of surrounding buffers. IMGs need to be cognizant of those risks factors and able to harness the protective ones to adapt in alien environments. The path to become a fully licensed physician for a foreigner includes navigating the complex US immigration system in addition to the USMLE exams and residency training. The restrictions based on the immigrant status of a foreign physician forces the physician to compromise on their professional goals, starting with the choice of a residency program and as they progress along with their careers. This factor has many times been a rate limiting step for IMG's in different aspects - time line for job search, geographic, kind of practice, hours you want to practice and on international travel. A foreign-born physician faces unique challenges on a personal/social level. These include clothing, language, social interactions, diet, dating, family values, weather, financial etc. Studies in general population consistently show that immigrants have poorer health outcomes. Although this may not be generalizable to immigrant physicians, acculturative stress can be the unspoken "elephant in the room", which extorts a lot of mental energy from the physician. The fourfold model classifies acculturation strategies into assimilation, separation, integration and marginalization. Peer support and mentoring processes can help the physician acculturate, thereby reducing the stress experienced. During our workshop, we will encourage participants and presenters to engage in self-disclosure about their journeys to the US. We will give opportunities to native-born US physicians to engage in empathic social interactions with their foreign colleagues and vice-versa. Psychiatrists as a group are potentially more vulnerable to burnout than other physician groups due to exposure to violence, suicide, and limited resources, stigma towards our patients as

well as internalized stigma about reaching out for help ourselves. For IMGs, acculturation is added to the mix, especially at the beginning of one's training, increasing the risk for early burnout. A small quality improvement project in a psychiatric emergency service in Brooklyn, with primarily IMG psychiatry residents showed significantly higher degree of burnout in PGY1s compared to PGY4s, and begs the question: are we doing enough to support our IMGs in training? In this workshop, we propose some strategies to assess burnout in training and engage the audience in discussing ways to facilitate the acculturation of IMGs early in their career.

In the Classroom and on the Field: Improving Mental Health Care for Collegiate Student Athletes

Chair: Bettina U. Bohle-Frankel, M.D.

Presenters: Courtney Albinson, Ph.D., Mehak Chopra, D.O., Julie Sutcliffe, Psy.D., Douglas Noordsy, M.D., Francesco Dandekar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand how the athletic culture and the drive to perform affects student athletes and their mental health; 2) Know what supports are available to student athletes including sports medicine and academic advising; 3) Collaborate with the sport medicine team to optimize care, i.e. moving to a higher level of care; 4) Take the athletic culture and the impact of the sports' season into consideration when prescribing medications; and 5) Demonstrate knowledge of the NCAA rules regarding prescribing medications to collegiate student athletes.

SUMMARY:

According to the NCAA there are more than 460,000 collegiate student athletes in the US. They are constantly juggling academic and athletic demands. Although they are no more likely to suffer from mental illness than other students, athletes face unique challenges: a culture that expects problems be "fixed" quickly, stigma regarding mental illness and "being weak", NCAA rules, and team/coach dynamics. Athletes are supported and monitored closely by sports medicine physicians and athletic trainers who often see them daily and receive third party information from teammates and coaches.

Close cooperation with sports medicine can facilitate referral to mental health care and help with compliance and monitoring. Athletes are often motivated to receive care in order to improve performance. This creates an opening to address the mental health issues that frequently are at the root of poor performance. In 2016, the NCAA published a consensus statement for best practices in mental health care recognizing the crucial importance for athletes' well-being. This focus on mental health has led to universities creating different models of mental health care and the creation of new positions for sport psychologists. A higher demand for psychiatrists with expertise in the field, either in university positions or in private practice, will likely follow. This workshop will describe innovative health care models developed at Northwestern and Stanford universities to improve athletes' mental health and overall wellbeing. We will start by reviewing stressors for this population such as coping with academic and athletic demands, injuries, performance struggles, and poor sleep and nutrition. Using clinical cases, common disorders will be discussed including post-concussion syndrome, ADHD, and eating disorders. There will be a focus on how to collaborate with sports medicine in order to improve compliance and to facilitate a higher level of care when needed. We will consider how different interventions affect the athlete's eligibility for sports participation, such as medical leave of absence, red-shirting and the reduction of the student's course load. Specific aspects of medication use in this population will be examined such as the impact of side effects on performance, required documentation for the NCAA, and timing with regards to being "in season" for the athlete's sport. Finally, participants will work on vignettes to illustrate the complicated interchange between sports psychologists, psychiatrists, athletic trainers, sports medicine physicians and sports dietitians. Presenters will include two college sport psychologists, including the current president of the Society for Sport, Exercise & Performance Psychology of the American Psychological Association, a fellow in college mental health, a resident, a sports psychiatrist, and a college psychiatrist.

Integrating Suicide Risk Screening Tools Into

Practice: When Research and Clinical Reality Come Together

Chairs: Adriana E. Foster, M.D., Igor I. Galynker, M.D., Ph.D.

Presenters: Jaclyn Schwartz, Ph.D., Shira Barzilay, Ph.D., Zimri Yaseen, M.D., Daniel Castellanos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) List validated instruments for suicide risk screening; 2) Evaluate existing evidence on validated suicide screening and measurement tools; and 3) Plan the implementation of standardized suicide risk measurement tools in a clinical practice or educational program.

SUMMARY:

Suicide is the 10th leading cause of death in the US. In 2013, 3.9% of the population (9.3 million adults) reported suicidal thoughts, 1.1% made plans of suicide, and 0.6% made suicide attempts. Worldwide, people with suicidal ideation have a 12-month prevalence of suicide risk of 15% vs. 2% prevalence in general population. Identifying people with suicidal thoughts and plans can help intervene and save lives. American Psychiatric Association guidelines for psychiatric evaluation of adults recommend assessing, estimating, and documenting suicide risk. Furthermore, accreditation agencies require systematic measurement and tracking of care outcomes, particularly tracking attempted and completed suicides. Individual physicians or institutional procedures determine whether the assessment of suicidality is completed through clinical observation, judgement, or with the aid of validated measures. If a validated suicide risk assessment tool is integrated into the practice, the physicians and institutions must blend the tool into the "natural flow" of the clinical evaluation, medical record documentation and quality improvement processes. Furthermore, for teaching institutions, these possible tools must be part of medical students' and residents' training and evaluation. This workshop will address the challenges and successes of selecting and incorporating such measures in psychiatric practice. We will present the results of prospective and retrospective research that reflects integration of such measures in various settings, involving a variety of patient populations

(outpatient, inpatient, emergency room, adult and adolescent patients), and findings on the contribution of such measures, as well as other factors that contribute to clinicians' naturalistic judgement of suicide risk level. We will discuss the role of validated suicide risk assessment tools in identifying specific characteristics, environmental features and clinically meaningful points at which an individual may be at risk for suicide attempt. Participants will be given the opportunity to describe situations they encounter in their practice or academic settings and will receive feedback from the workshop presenters and the audience. The session's presenters are clinicians, researchers and educators who work in academic, community-based and private practice settings and whose research interests include suicide and adherence with treatment in mental health.

Multidisciplinary Medical Forensics in U.S. Asylum Cases: How to Start Your Own Asylum Clinic and Why Psychological Evaluations Are Key

Chair: Jon Wesley Boyd, M.D., Ph.D.

Presenters: Nikhil "Sunny" Patel, M.D., M.P.H., Nina Evelyn Sreshta, M.D., Katherine Peeler, M.D., Robert P. Marlin, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the process of offering and performing asylum evaluations and the significance of a psychological evaluation in the outcome of an asylum case; 2) Describe how asylum-seekers with mental illness face disadvantages with respect to credibility determinations in U.S. immigration courts; and 3) Articulate and brainstorm ways of creating and implementing an asylum clinic within one's own department of psychiatry.

SUMMARY:

Asylum has become a germane topic given concerns about migration issues driven by the humanitarian crisis produced by the Syrian civil war, ongoing violence in Latin America and Africa, and by the nascent US administration's approach to immigration. Refugees have significant trauma exposure and are at high risk for developing post-traumatic stress disorder. Psychiatrists can assist asylum-seekers and immigration courts by

performing evaluations, acting as expert witnesses, and providing corroborating evidence of trauma. Additionally, psychiatrists can present information about how trauma can create difficulties in recalling events accurately or ability to speak about traumatic events, which is important given that asylum seekers are expected to testify about their experiences. The overall success rates of asylum seekers in gaining legal status is about 30%, but when a psychological evaluation is performed to support the client, 90% of cases are successful. The presenters, which include attending physicians who developed an asylum clinic at their hospital and medical school, and resident trainees who have participated in these evaluations, will discuss nuances of working with this population and offer ways of creating and implementing asylum clinics within a department of psychiatry. Given both the drastic increase in traumatized refugee populations and the current political climate in the US, this information is both topical and important.

No Poster, No Publication, No Problem: A Step-by-Step Guide to Get You Started in the Scholarly Activity Process!

Chairs: Rashi Aggarwal, M.D., Nicole A. Guanci, M.D.
Presenters: Cristina Montalvo, M.D., Robert Rymowicz, D.O., Senthil Vel Rajan Rajaram Manoharan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Help participants identify barriers to productivity in the scholarly activity process; 2) Provide concrete steps towards choosing a topic for an abstract; and 3) Provide guidelines for undertaking a literature search and steps for writing.

SUMMARY:

Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, many residents lack the necessary skills for choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. According to a study, only 30% of residents had national presentations with 54% having no publications. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. The goal

of this workshop is to assist participants with scholarly activity at the beginner level –whether medical student, resident, fellow, or practicing physician. We aim to facilitate the scholarly activity process by identifying barriers to lack of productivity and delineating specific techniques for tackling these barriers. We will provide concrete guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. These guidelines are not only helpful for potential writers, but are also useful for residency program directors and clerkship coordinators wanting to create an academic environment that fosters scholarly activity. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports. During this workshop, we will offer examples of scholarly activities by residents in our own program. Our residents have had over 100 presentations at national meetings and over 50 publications in the past 5 years. This is in comparison to a previous precedent of only a few posters presented per year, which highlights the utility of our proposed tips. Our workshop will be highly interactive and the process of taking a rough idea and then narrowing it into a research question will be demonstrated by role-play. Participants will be able to discuss some of their own research ideas or ideal patients for case reports and will be guided through the process in order to be more prepared to tackle their first poster or first publication. By the end of this workshop, participants will be better equipped with practical knowledge of progressing from the inception of an idea to completing a scholarly activity.

Outpatient Violence Risk Assessment: What Clinicians Need to Know

Chair: Ryan C. Hall, M.D.

Presenters: Susan J. Hatters-Friedman, M.D., Renee M. Sorrentino, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to understand

the implications of some new case law regarding outpatient violence risk assessment, such as the Volk v. DeMeerleer; 2) At the conclusion of this session, the participant will be able to discuss the APA resource document on Violence Risk Assessment and The APA Practice Guidelines for the Psychiatric Evaluation; 3) At the conclusion of this session, the participant will be able to appreciate the multiple factors and difficulties inherent in assessing outpatient risk; and 4) At the conclusion of this session, the participant will be able to discuss some of the various structured interments and approaches for assessing multiple types of risk.

SUMMARY:

Although the notion of duty to protect has been with the therapeutic community for over 40 years, new and ever-changing case law impacts how the field must think about risk. This was recently highlighted by the Washington state’s Supreme Court ruling in the case of Volk v. DeMeerleer in which the court allowed a lawsuit to continue against an outpatient psychiatrist whose patient was involved in a homicide multiple months after the last patient contact. The court noted, “Both statutorily and through common sense, society relies on mental health professionals to identify and control such risks. The mental health community therefore has a broad responsibility to protect society against the dangers associated with mental illness. This responsibility is analogous to the duty imposed on health care providers to warn others of their patients’ contagious or infectious diseases . . . The obligation imposed by this court, therefore, is similar to that already borne by the medical profession in another context.” This panel will review aspect of risk assessment, particularly for the outpatient provider who usually has limited time for screening, limited resources (e.g. may not have access to a psychologist to perform in-depth neuropsychiatric testing, or to a forensic colleague for a second opinion), and less control over a patient than available in an emergency or inpatient setting. Pros and cons regarding the contagion model of violence prevention will be discussed. APA guidance and advice will be reviewed such the 2012 Resource Document on Psychiatric Violence Risk Assessment and the 2016 Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition. Standardized

approaches to screen for multiple types of potential violence, such as for general violence, self-harm, domestic violence, and sexual violence, will be reviewed. In addition, how to document violence risk whether or not a standardized instrument is used will be discussed. Audience members will be encouraged to participate through asking questions and engaging in brief discussions about their own experiences of their own experiences.

Personal Injuries: Updates on the Impact of Intimate Partner Violence

Chair: Shawna Newman, M.D.

Presenters: Nadya V. Friedman, M.D., Mayumi Okuda, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the characteristics, prevalence and frequency of Intimate Partner Violence (IPV); 2) Describe the increased risk of IPV for Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) individuals; 3) Recognize the impact and implications for children exposed to IPV; 4) Describe the underlying psychodynamic and psychoanalytic implications for victims of IPV as well as the effects on clinicians who provide treatment; and 5) Gain an understanding of current IPV research, including the neurobiological impact of IPV on the physical and mental health of its victims.

SUMMARY:

Intimate Partner Violence (IPV) remains a serious public health issue in the United States. This workshop will focus on understanding characteristics of IPV and its persistence in our society. Presentations will address current IPV related research as well as assessment of IPV including screening, interventions and goals for prevention. Our workshop will include a discussion of the impact of exposure to IPV for children as well as the risks of IPV for lesbian, gay, bisexual, transgender and queer individuals. Psychodynamic and psychoanalytic conceptualization of the relationships between victim and abuser will be discussed as well as effects of IPV on clinicians. Data from a large nationally representative study in the United States and large cohort of individuals in the UK will be presented, highlighting the association of IPV and the onset of

psychiatric issues including mood, anxiety, substance abuse, and psychotic spectrum disorders. Finally, the workshop will provide a platform for discussion of our understanding of IPV and its effects on society.

Perspectives on Professionalism: Millennials to Boomers

Chairs: David Allan Casey, M.D., Brian Andrew Casey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The participant will understand the differences between millennials and boomers on career and professionalism; 2) The participant will learn how the generations view one another; and 3) The participant will understand how the generations view work-life balance, technology, psychotherapy.

SUMMARY:

The presenters, a father-son team of a boomer psychiatrist and a millennial psychiatric resident, have conducted a series of wide-ranging interviews of practicing psychiatrists and residents of varying ages and stages of professional life. The interviews were unstructured but all covered certain basic topics of professionalism, work-life balance, views on technology, employment plans and preferences and others. This is an ongoing project with approximately 25 interviews conducted to date. The authors also surveyed the somewhat scant literature on this topic as well as on topics of intergenerational work relationships, how generations form a particular point of view, and evolution of generational viewpoints over time. The authors presented an early version of this work at the annual meeting of the Southern Psychiatric Association, provoking intense audience response, discussion and interaction. Some results included that millennials are far more dedicated to work-life balance and are willing to set limits on work. They are “digital natives” and fully expect to use technology in all aspects of practice. They expect to be employed physicians and to change employers at intervals through life. They view themselves as equally dedicated as their predecessors. They expect to be promoted a cute their skill set rather than through seniority and are generally critical of hierarchy. However, neither they nor boomers perceive a “generation gap”, finding

more similarities than differences. Many boomers are somewhat critical of the limits that millennials set on work, yet many admire and envy their dedication to work-life balance. Neither boomers nor millennials are happy with current EHRs, seeing them as cumbersome, awkward and not user friendly. However, many boomers, with notable exceptions, regard this type of technology as contributing to burnout and early retirement. Boomers expect employment to be a long term mutual commitment and many are comfortable with small-scale private practice. It remains to be seen how millennial attitudes will evolve over time.

Schizophrenia Dissection by Five Anxiety and Depressive Subtype Comorbidities: Clinical Implications and Evolutionary Perspective

Chair: Jeffrey Paul Kahn, M.D.

Presenters: Michael Hwang, M.D., Jeffrey Paul Kahn, M.D., Andre Barciela Veras, M.D.

Discussant: Dolores Malaspina, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review psychiatric co-morbidity with psychoses; 2) Consider known and proposed comorbidity psychosis subtypes; 3) Understand an evolutionary theory positing five core non-psychotic anxiety & depression subtypes; and 4) Learn comorbidity treatment strategies that lead to improved clinical outcome.

SUMMARY:

Can psychosis be dissected into discrete diagnostic subtypes? The hodgepodge of psychosis associated comorbidities have long been thought of as unsurprising consequences of psychosis itself. But, what if it were the other way around? Actually, comorbidities usually precede psychosis onset: and then become psychotic symptoms. For a long time, unsuccessful efforts have tried to sort schizophrenia into distinct, definable and treatable subtypes. Just maybe, the comorbidities actually denote the very clinical subtypes that we have been seeking. One published evolutionary theory posits five core anxiety & depressive subtypes, each one evolved from a primeval social instinct: social anxiety (social hierarchy for group organization), panic anxiety (separation anxiety for group cohesion & thus

safety), OCD (behaviors for healthy, wealthy & wise groups), atypical depression (rejection sensitivity for inoffensiveness & thus social harmony), and melancholic depression (fatal illness or severe loss lead to death and thus group resource preservation). Now consider applying some known theories of psychogenesis to these subtypes: reduced conscious modulation of instinct in people with prefrontal cortex hypofrontality, & greater salience of instinct in people with increased dopaminergic activity. These mechanisms may help generate intense psychosis from comorbidities. Comorbidity researchers will discuss five psychosis subtypes and their associated comorbidities: - psychotic depression (melancholic depression) - delusional disorder (social anxiety) - mania (a phase shift of atypical depression) - schizo-obsessive disorder (proposed; OCD) - panic psychosis (proposed; panic anxiety) These subtype associated comorbidities are supported by research. Panic psychosis may look like paranoid schizophrenia with voices. Newly published research replicates the finding of simultaneous paroxysmal onset of voices and panic and suggest that the five subtypes may account for most of functional psychosis. Moreover, comorbidity dissection of psychosis may significantly improve clinical outcomes by adding specific comorbidity treatments and increase understanding of specific psychotic symptom origins. The chair will briefly review psychosis subtyping and treatment, and evolutionary theory behind the five subtypes. Speakers on three specific subtype pairs will describe: near-psychotic features of non-psychotic anxiety and depressive subtypes, diagnostic difficulty in psychotic patients, phenomenological similarities of the non-psychotic/psychotic pairs, echoes of the non-psychotic diagnosis in specific psychotic symptoms, psychosis subtype treatment approaches and improved clinical response. The co-chair will present a new pilot study suggesting that most schizophrenia patients fit into the five subtypes. Finally, a leading psychosis researcher will consider strengths and weaknesses of this approach.

The American Society of Clinical Psychopharmacology Curriculum for Psychiatry Residency Programs: How to Get the Most Out of Your Teaching

Chair: Ira David Glick, M.D.

*Presenters: Jose Manuel Rubio-Lorente, M.D.,
Mujeeb Uddin Shad, M.D., M.S., Matthew Brian
Wasser, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Familiarize the audience with the structure and content of the ASCP Model Psychopharmacology Curriculum for Psychiatric Residency Programs; 2) 2. Identify what gaps in the residency curriculum may be covered by the pre-designed lectures from the ASCP Model Psychopharmacology Curriculum for Psychiatric Residency Programs; and 3) 3. Help non-expert teachers to prepare lectures using the ASCP model curriculum content and structure to maximize their teaching potential.

SUMMARY:

Psychopharmacology is an ever-expanding field which is essential for the training of psychiatry residents. Because of the rapid development of the field, it is challenging to produce and maintain a psychopharmacology residency curriculum that is updated, comprehensive and detailed. The lack of locally available expertise in a particular area of interest may limit the training in a specific area in a residency program. To cover this gap, the American Society of Clinical Psychopharmacology (ASCP) has developed a Model Psychopharmacology Curriculum for Psychiatric Residency Programs. This initiative aims to help the dissemination of the knowledge generated by the expert members of the society to psychiatry trainees. This didactic material covers a wide range of topics in psychopharmacology at the level of a general psychiatry resident. In the 9th edition, recently published in 2016, it contains 101 power point presentations designed by renowned experts in each specific area. Furthermore, these slides are constantly updated with feedback from residents and instructors in order to facilitate their use. For each selected topic, there is a set of slides designed to be taught by a non-expert in an interactive fashion in 1 hour sessions. While this material can be of great help to teach the content in the curriculum for which there is no local expertise, it can be challenging to teach using material developed by others in a topic in which the instructor is not an expert. This may represent a

challenge to the routine use of the ASCP curriculum in various sites. In order to address these challenges, in this workshop we will practice presentation skills and facilitation of group discussions related to the topics covered in the slide sets.

The Color of My Face: Race, Discrimination, and the Psychiatrist

Chair: Annie Sze Yan Li, M.D.

Presenters: Khadijah B. Watkins, M.D., Angel A. Caraballo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Become aware of the prevalence in which physicians are subjected to acts of racial discrimination from patients; 2) Understand the ethical and legal conflicts associated to a patient's request for a race-specific provider, especially when such requests stem from prejudice; and 3) Begin to Identify ways to address racial discrimination from patients in the workplace.

SUMMARY:

Objective: The purpose of this workshop is to provide a forum for APA members to have a healthy dialogue on racial discrimination, and how it may impact their professional identity and everyday practice. APA members are encourage to share their experiences with the goal of promoting collegiality, peer support, and mentorship to collectively rise above patient-driven racial discrimination. Abstract: Physicians hold a high degree of professionalism to meet the needs of their patients, to reduce health disparities across racial groups, to practice in a culturally competent manner and to uphold standards of care for all patients. At times, patients may request for a physician to be of a certain racial or ethnic background. When the request creates a concordant relationship optimizing patient care, physicians do honor such requests. Yet, what happens when those requests are driven by bigotry, ignorance and hate? Dr. Sachin Jain recounted his experience in the Annals of Internal Medicine in 2013 of a patient making the comment "Why don't you go back to India?" In October 2016, Dr. Tamika Cross, a black female physician, posted on social media her anecdote of Delta flight attendants declining her offer to provide medical assistance for

a sick passenger when her appearance did not fit her claimed credentials as a physician. Law professor Kimani Paul-Emile describes it as “an open secret,” where it is a common phenomenon for many physicians to experience racism from their patients, though it is something not candidly talked about. For psychiatrists, specific issues arise on this topic, including workforce shortage in remote settings where referral to another psychiatrist is not feasible, or when it’s patient’s family members (ie parents, adult-children) who are being racially discriminatory. With much literature available on health disparities as it pertains to disorders, mental health care access and treatment responses across racial groups, our literature and data on how race impacts the professional identity and everyday practice of psychiatrist are limited. Our current political and social climate is filled with strong rhetorics about race and it is likely that psychiatrists will continue to encounter scenarios countering an agenda of equality. Talking about race, discrimination from patients and how it impacts our professional identity in a workshop is a good way for us to recognize this issue. Knowing the legal and ethics rules can best guide our responses in clinical setting. More importantly, developing a network of peer support and mentorship can help psychiatrists collectively address and manage acts of racial discrimination, find ways to serve the best interest of our patients, while ensuring that our integrity, both professional and personal, are not compromised.

The Pratt Street Gorge: A Lean Analysis of the Transition From Psychiatric Inpatient to Outpatient and How It Can Be Improved

Chair: E. Jane Richardson, M.D.

Presenters: Ann L. Hackman, M.D., Michael S.

Peroski, D.O., Emily Haas, M.D.

Discussant: Christopher William Teixeira Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the scope of the problem getting newly discharged patients engaged in outpatient treatment; 2) List some of the barriers to follow up face by patients; and 3) Perform a Lean analysis of the inpatient-to-outpatient transition process at the participant's home institution.

SUMMARY:

Every day, urban emergency rooms are filled with psychiatric patients requiring immediate assistance but not meeting criteria for inpatient hospitalizations. Every day, inpatient psychiatric facilities discharge chronically mentally ill patients with limited means back to the community with outpatient appointments scheduled in the near future. Every day, intake slots at community clinics are filled with “no-shows.” And every day, inpatient psychiatrists are questioned by hospital administrators about why their recently discharged patients were readmitted in under 30 days. There is one block separating the University of Maryland Medical Center’s (UMMC) psychiatric emergency room (PES) and general adult and geriatric inpatient psychiatric units from the Walter P. Carter Community Clinics, but getting patients to cross Pratt Street for an intake appointment, let alone a follow up, often seems all but impossible. The result is “frequent fliers” in the emergency room who create extra work and resentment in already-stressed ER physicians, and re-admissions which cost the hospital money. We will present a Lean quality improvement analysis of the process a patient with severe mental illness (SMI) goes through between being discharged from UMMC to making it to his first appointment with our community mental health center, and changes that may improve engagement in outpatient care and reduce re-admissions to inpatient psychiatric units. We will then discuss with the audience ways this analysis would be different at other hospitals, and how the results can be generalized on a broader scale.

Adult ADHD: An Evidence-Based Psychopharmacology Treatment Algorithm

Chair: David Neal Osser, M.D.

Presenter: Bushra Awidi, M.D.

Discussant: Robert D. Patterson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand and identify the signs and symptoms of adult ADHD based on the updated DSM-5 criteria; 2) Learn about the psychopharmacologic studies conducted on adult populations with ADHD; 3) Apply a stepwise

psychopharmacology approach to treating patients with adult ADHD based on the latest scientific evidence; and 4) Demonstrate ability to modify selected medication choices based on various medical and psychiatric comorbidities.

SUMMARY:

ADHD is a neurodevelopmental disorder with a worldwide rate of approximately 3-10% in school-age children. It often continues to show manifestations in adults, with up to 4% of adults carrying this diagnosis worldwide. These patients suffer from a multitude of functional impairments with overall negative impacts on their quality of life. In response to the growing need for a treatment guide to clinicians when choosing medications for adult ADHD, we have created a medication algorithm for adult ADHD using systematic literature search to identify relevant studies and key findings in adult ADHD pharmacological management. The algorithm recommendations may be briefly summarized as follows. After an accurate diagnosis of adult ADHD and after accounting for any medical contraindications, initiate treatment with a low dose (5 mg) of immediate release methylphenidate (MPH) or amphetamine and titrate the dose every 3 days until effectiveness occurs or until side effects develop, with the usual efficacious dose being 1-1.3 mg/kg for MPH and 0.6-0.9 mg/kg for amphetamines. Non-stimulants such as atomoxetine may be tried after failure of two adequate trials with stimulants. However, no evidence supports positive effects if stimulants have failed. Note that atomoxetine needs ~10 weeks before it takes full effect. The role of other non-stimulants such as bupropion, modafinil, guanfacine, and clonidine will be discussed. In adults with ADHD and co-morbid cocaine use disorder: after establishing a period of sobriety, we recommend considering using extended-release formulations of stimulants (MPH or amphetamines). In adults with comorbid ADHD and bipolar disorder: it safe to give stimulants but only after the patient's bipolar disorder is stabilized on a mood stabilizer. In this workshop, the authors will present attendees with the evidence-based reasoning justifying the sequence of recommended treatments for adult ADHD while taking into consideration how comorbidity with other psychiatric or medical conditions changes the

recommendations as well as accounting for safety and long-term tolerability of these medications. There will be ample time for attendees to respond and interact with the presenters through a panel discussion.

Bringing *Lived Lives* to "Swift's Asylum": How Science-Arts Collaboration Can Impact Suicide Research

Chair: Kevin Malone, M.D.

Presenter: Seamus McGuinness, Ph.D.

Discussant: James Lucey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the mechanisms and potential value of science-arts interdisciplinary research methods in suicide research; 2) Recognize how utilizing and harnessing durational community engagement in interdisciplinary suicide research can impact national prevention strategies; 3) Identify how marginalized and at-risk communities such as indigenous ethnic minorities and those in psychiatric institutions can be safely engaged through science-arts research methods; and 4) Understand science-arts research in action through engaging with the physical *Lived Lives* artworks.

SUMMARY:

Suicide is a significant public health concern, associated with stigma, which impacts on health outcomes. Few suicide intervention and prevention studies have included mixed methods and fewer still have considered interdisciplinary approaches to obtain new knowledge and understanding around suicide and its aftermath. *Lived Lives* is a novel science-arts project combining a psychobiographical and visual arts autopsy for studying suicide and its impact on surviving family and friends. Participating families donated material belongings, stories and images pertaining to 104 young Irish lives lost to suicide, from which the *Lived Lives* artworks and subsequent mediated *Lived Lives* exhibitions were created. The project has been installed and documented in urban and rural community settings, as well as most recently in Ireland's oldest and largest psychiatric institution (St. Patrick's University Hospital founded by writer and scholar Johnathan Swift in 1746), and has been incorporated as part of

Ireland's National Suicide Prevention Strategy. Through the lens of the *Lived Lives* project, our workshop will provide participants with information about the mechanisms, value and impacts of sciences-arts interdisciplinary suicide research. Participants will be shown movie documentation of key moments of participating family and community engagements with the project. These video clips will illustrate how science-arts methods can engage young people, marginalized communities, indigenous ethnic minorities, psychiatrists, psychiatric patients, and policy makers in shaping community suicide intervention initiatives through facilitating dialogue and response. We will provide an artist/scientist -mediated interactive tactile tutorial, where participants will have an opportunity to physically engage with some of the *Lived Lives* artworks. An interactive panel discussion will follow with clinical psychiatry researchers, visual art researchers and workshop participants about how the research methods, impacts and relevance of *Lived Lives* may transcend national and cultural boundaries and traditional clinical disciplines. The panel will also discuss the impacts of science-arts collaborations for suicide and other areas of mental health research that deal with feelings of loss, and where identity and validation are overlooked or eclipsed by the silence of stigma.

Cinderella Redeemed: Teaching and Supervising Supportive Psychotherapy

Chair: Randon Scott Welton, M.D.

Presenters: Erin Crocker, M.D., Marie Rueve, M.D., Priyanka Badhwar, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the data supporting the use of Supportive Psychotherapy; 2) Contrast the goals and techniques of Supportive Psychotherapy with those of other common psychotherapies; 3) Design a training program to teach the fundamentals of Supportive Psychotherapy; and 4) Assess the quality of Supportive Psychotherapy provided to patients using a variety of tools.

SUMMARY:

Supportive Psychotherapy has long been devalued within psychiatry. It is often described as the

"Cinderella of Psychotherapies" which does most of the work but possesses none of the glamour of other psychotherapies. This workshop will provide attendees with a comprehensive structure for understanding, teaching, and evaluating Supportive Psychotherapy. Attendees will participate in developing a definition and conceptualization of Supportive Psychotherapy that emphasizes its potential to help the majority of our patients. We will review evidence demonstrating its efficacy in a wide variety of serious, common mental illnesses. Supportive Psychotherapy's flexibility enables its use in fast-paced psychiatric services including inpatient units, medication management clinics, and Consultation/Liaison teams. All too frequently Supportive Psychotherapy is relegated to a simplistic desire to be friendly and "support" the patient in an ill-defined way. The seminar will define an approach to Supportive Psychotherapy that rests on the common elements of psychotherapy, a strong emphasis on the therapeutic alliance, and a variety of specific interventions organized with the acronym "HOPE" - Hear, understand, and reflect the patient's feelings and emotions; Organize the patient's narrative and experience; Promote adaptive psychological functioning; and Effect change to reduce stressors and increase support. Attendees will engage in interactive discussions of how to design training experiences enabling learners to master these techniques. Objectively evaluating the quality of psychotherapy provided by a trainee has long challenged training programs, but careful observation and standardized assessments are crucial for providing formative feedback. Attendees will be introduced to tools developed by organizations such as the American Association of Directors of Psychiatry Residency Training's Psychotherapy Committee to more objectively assess the quality of Supportive Psychotherapy provided by residents. These tools allow the trainee and supervisor to engage in focused improvement of the learner's psychotherapy skills. These tools were developed for use following live therapist-patient interactions or videos. To gain familiarity with these tools attendees will watch a series of training videos and use the tools to assess the Supportive Psychotherapy being provided. Attendees will be asked to describe the challenges they will face in implementing more formal training and evaluation

of Supportive Psychotherapy in their workplaces and will collaboratively develop solutions to those challenges.

Creating a New Type of Telepsychiatry Team: An Innovation Pilot Grant in the Berkshires

Chair: Alex Nicholas Sabo, M.D.

Presenters: Brenda Bahnson, L.I.C.S.W., Venkata D. Sugnanam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the roles of the telepsychiatry, teleconferencing and community health workers; 2) Provide a simple patient-friendly clinical measure that helps engage patients in their treatment; 3) Understand the three salutary effects of the yoga-mindfulness patient groups; 4) Understand how to implement a psychopharmacology adjunctive practice to the group work; and 5) Understand the provider and patient satisfaction with the telepsychiatry and teleconferencing services.

SUMMARY:

In the summer of 2016 the Massachusetts Health Policy Commission awarded an Innovation Grant to Berkshire Medical Center to use Telepsychiatry, Psychiatric Residents, Care Management, Community Health Workers, and integrative therapies including yoga-mindfulness and CBT groups to integrate behavioral health into six primary care practices serving 50,000 patients. This innovation grant has been designed to support primary care and to address serious gaps in timely access to needed behavioral health services. The breakdown of access and fragmentation within the service delivery system in Berkshire County, inappropriate use of the emergency room and unnecessary hospitalizations are major costs resulting from a lack of access to less restrictive, less expensive and more effective community health services. Most important, this represents sub-optimal care for the region's adults with addiction disorders and mental illness. Berkshire County suffered 23 suicides in 2013 and had the highest rate of suicide of any County in Massachusetts (Suicide in MA in 2013: Data Report, 12-31-2015, p. 7). Approximately 45% of those who suicide visit their

primary care provider within one month of their death and that number reaches 58% for those aged 55 and older (Luoma JB et al: 2002). Improved screening for depression and suicide in primary care settings (through care navigators in this proposal) is imperative. Mental health disorders and alcohol/drug abuse are the second and eighth leading causes leading to hospitalization for the county. Both mental health and alcohol abuse exceed the state's average for hospitalization. An estimated 15% of Berkshire jail inmates have an SMI or Axis I diagnosis; 38% are on psychotropic medication. An estimated 10-30% of police calls involve mental illness. There have been 1,333 involuntary commitments from 2009-2013. When the grant is completed in 2018, 1,500 patients with high-risk conditions will have been engaged. This workshop reports the system design, the implementation mid-point data (clinical outcomes, utilization, patient and provider satisfaction) and illustrative case vignettes that highlight how the telepsychiatry and integration is occurring. Successes and barriers are identified. Workshop participants are invited to share their own experience using innovation, telepsychiatry, integrative health, residents, care managers and community health workers to achieve behavioral health integration in primary care.

Culture Matters: The Impact of Culture and Bias on the Assessment and Treatment of First-Episode Psychosis

Chairs: Danielle Hairston, M.D., Tresha A. Gibbs, M.D.

Presenter: Robert Daniel La Bril, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain an understanding of the role of race/ethnicity in schizophrenia diagnosis particularly in African Americans; 2) Gain an understanding of the risk of suicide after diagnosis of first episode psychosis, particularly post hospitalization; 3) Review a clinical case presentation where psychosis presentation overshadowed the cultural presentation leading to an incomplete assessment of risk and mood symptoms; 4) Discuss role of clinician bias in the working alliance, diagnosis, treatment plan and prognosis of patient

with first episode psychosis; and 5) Understand, define, and discuss implicit and explicit biases.

SUMMARY:

Clinician's attitudes and biases, both implicit and explicit, contribute to disparities in psychiatric care. Biases impact assessment and treatment at many levels, including diagnoses, medication dosing and choices, use of restraints, level of care, involuntary commitment. Racial bias is considered "explicit" when the belief or attitude is overt and conscious on the part of the clinician. Implicit bias results from the subconscious association of stereotypical attributes with particular racial groups. These biases may differ from an individual's self report of explicit bias. Initial psychotic episodes are difficult to understand and are challenging for patients, families, and clinicians. This experience can be even more difficult and challenging when cultural stigma and bias exist. Preconceived stereotypes and biases, whether implicit or explicit, can greatly impact the assessment and course of treatment for patients experiencing a brief psychotic episode. Since the 1970s, researchers have found that African American patients with affective disorders are at higher risk than white patients of being misdiagnosed with a psychotic disorder. Clinician bias can emerge during the clinical consideration of psychotic symptoms. The overvaluing of psychotic symptoms and under appreciation of mood symptoms in African American patients has been highlighted in multiple studies. During the course of clinical assessment of African American patients, psychotic symptoms may more frequently be conceptualized as isolated and independent of affective illness, and prematurely attributed to an underlying psychotic disorder. In the course of weighing symptoms and competing diagnostic possibilities, racial biases in underemphasizing affective symptoms and over attributing symptoms to schizophrenia may intercede. Although first-rank psychotic symptoms are common in primary psychotic disorders, they are not pathognomonic for psychotic disorders and are often present in mood disorders. Failure to recognize the impact of bias and culture on the assessment and treatment of patients can lead to missed diagnoses, incomplete risk assessments, and incorrect choices for level of care. The case(s) discussed will provide insight into the importance of

addressing biases clinically. This workshop will identify evidence of biases and discuss strategies for avoiding common pitfalls that negatively impact the care of racial minorities, particularly for adolescents and young adults experiencing a first episode of psychosis.

Getting Better Together: Addressing Trauma and Staff Wellness as Part of a Metric-Driven Quality Improvement Program at an Inner City Hospital

Chair: Renuka Ananthamoorthy, M.D.

Presenters: Farah R. Herbert, M.D., Donna Leno Gordon, M.P.A., M.S., R.N., Jennifer Morrison-Diallo, Ph.D., Christine Pyo

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the impact of trauma in acute care settings for both patients and staff; 2) Understand the components of a wellness response for staff dealing with vicarious trauma; 3) Identify techniques to help staff when managing crises in acute care settings; 4) Name brief interventions for improving patient experience in an acute care hospital; and 5) Recognize the challenges of administering these complimentary interventions to complicated, high needs populations.

SUMMARY:

As the expectations for hospital reimbursement shift to include measures of the quality of care delivered, clinicians and administrators must review and adapt the framework for delivering care. In mental health this involves recognizing that some unique experiences influence patients' hospital experience while mitigating how being maintained in a restricted facility, often against their will, is handled. In exploring strategies to improve the Patient Experience by developing strategies to listen and respond to concerns in real-time it became evident that past traumas played a significant role in shaping the view of the hospital experience. While developing a Trauma-Informed Care Setting it was evident that how moments of crisis are contained defined the experience of the patient and was influenced by staff perceptions of safety and their ability to provide empathetic responses. Our interdisciplinary team examined factors contributing to patient satisfaction to develop a novel, integrated

approach to improve patient and staff experience. The Getting Better Together initiative includes four components: a) Patient Experience, b) Staff Wellness, c) Zero Assaults, and d) Trauma-Informed Care. The team implemented brief interventions for monitoring and addressing concerns during the admission to form the Patient Experience Initiative. A staff training initiative in trauma was instituted with changes to the treatment milieu reflecting recognition of triggers and planning care to consider this in order to develop a Trauma-Informed Milieu. Annual training in Preventing and Managing Crisis Situations was augmented by a vision to achieve Zero Assaults by providing regular practice situations in which unit teams utilized each other, their skills and knowledge of an identified patient in impending crisis to de-escalate the situation. Beyond training staff, preventing burnout and fostering strong teams that share the institutional vision is critical to developing a sustained culture change. Wellness Programs were prioritized and expanded to address staff morale and satisfaction. Finally, engaging managers and directors to obtain real-time observations of the challenges staff were experiencing to provide immediate, targeted support developed into Proactive Rounding to identify high risk situations in order to implement informed care solutions supported by leadership. This workshop will educate participants about the components described above using de-identified case presentations to describe how each works individually and how they support each other. Outcome data including measures of incidents of aggression, Press Ganey Patient Satisfaction scores and staff safety and satisfaction metrics will be presented with comparisons before and after the interventions were implemented. Through discussions with participants the challenges, future directions and strategies for applying these interventions in different care settings will be explored.

How Should I Prescribe Exercise and Physical Activity Augmentation Treatment for Patients With Depressive Disorders?

Chair: Rohul Amin, M.D.

Presenters: Rachel Snell, Adam Lee Hunzeker, M.D., Courtney E. Kandler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Describe evidence for the use of exercise augmentation in depressive disorders; 2) 2. Demonstrate goal-based prescription of physical activity and exercise to your patient with depression; and 3) 3. Demonstrate follow-up assessment, adherence, and motivational enhancement of your patient with depression who is prescribed exercise and physical activity.

SUMMARY:

Depression is a common presentation in all psychiatric practices. Various modalities are available to the psychiatrists including first-line medications and psychotherapies. Unfortunately, only 40% of patients respond to the first intervention. Patients with depression require subsequent changes and/or augmentations to treatment. The addition of medications put patients at risk for poly-pharmacy and associated risks of side-effects. Exercise is a potential augmentation strategy among appropriate patient populations. According to clinical guidelines, offering exercise as adjunct treatment is recommended to patients with depression. There is ample evidence that shows the positive effects of exercise in depressed patients. Along with antidepressants and lithium, exercise is known to increase brain-derived neurotrophic factor (BDNF), a factor associated with treatment response in patients with depression. Exercise and physical activity also improves other protective factors associated with depression including reduction in cortisol, increased relaxation, and enhanced self-esteem. Despite these positive findings from controlled trials, many psychiatry residents and practicing psychiatrists do not have the knowledge and skills to prescribe exercise and physical activity to their patients. We aim to help close this knowledge and skill gap by providing the learners the current evidence and guidelines for the use of exercise and physical activity in depressive disorders. Following enhancing their knowledge, we plan to have the learners apply this knowledge in small groups using clinical vignettes. We will also discuss motivational interviewing techniques to enhance adherence and address relative contraindications to exercise and physical activity. Our team includes

psychiatrists, physical therapist and primary care physicians.

IMGs as Psychiatrists: Training Director and Resident Perspectives

Chairs: Vikas Gupta, M.D., M.P.H., Roopma Wadhwa, M.D., M.H.A.

Presenters: Rajesh R. Tampi, M.D., M.S., Vineeth John, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Highlight the significance of successful integration of IMGs into U.S. psychiatry; 2) Highlight the trends of IMGs matching to U.S. psychiatry residency positions for past 5 years; 3) Identify challenges unique to IMG residency applicants, residents and psychiatrists in academia and practice; and 4) Understand faculty and resident perspectives on how IMGs can successfully integrate into training and psychiatric practice.

SUMMARY:

IMGs comprise more than 30% of U.S. psychiatrists. In 2017, of the 1495 psychiatry residency positions offered, over 20% were filled by IMGs. Psychiatry Match data for IMGs- 2013-2017 Year 2017 2016 2015 2014 2013 Total positions 1,491 1,373 1,339 1,291 1,282 Total positions filled by IMGs 303 294 342 387 394 Percentage of Total positions 20.3 21.4 25.5 29.97 30.7 IMGs care for several disadvantaged patients in many underserved settings disproportionately more than U.S. medical graduates. Some states heavily rely on IMGs to provide psychiatric care to their populations. [4] There are several challenges which IMGs may encounter including exposure to psychiatry may be limited due to shorter psychiatric rotations as often psychiatry is treated as a subspecialty of internal medicine. Often times, there are no standardized evaluations in Psychiatry in medical school including written or clinical examination in psychiatry. Clinical training is not well structured as it pertains to psychiatry in many international medical schools. Students also have fewer chances to observe a senior faculty conduct interviews. IMG residents, therefore, many times lack the opportunity to develop and practice their interviewing skills while in medical school. Furthermore, IMG residents are less

likely to be aware of a CSV before they are in residency. The majority of IMGs are unaware of expectations and policies in residency training because graduate medical education in the United States is very different from several other countries. Foreign IMGs also may have additional challenge of being unaware of formative or constructive feedback. Cultural differences between their home countries and U.S. make this process additionally difficult. Residency training programs should attempt to incorporate measures that would help boost the social support and acculturation of IMGs. [5] In this workshop, we will discuss the challenges unique to IMGs including acculturation, cultural and linguistic differences, and implicit biases due to or without above differences. Participants will be introduced to the significance of successful integration of IMGs into U.S. psychiatry. This interactive workshop will see two faculty who have been in the role of training director present their perspectives on how IMGs can match and succeed in psychiatry residency training with practical examples. Two residents will share their experiences and insights to successful transition to residency and helpful ideas to succeed in residency. Finally, recommendations will be provided aimed at successful transition into residency, successful completion of residency and psychiatric practice.

Inequity in the Addiction Treatment and the Drug Enforcement Systems: Reviewing Psychiatry's Role

Chair: Jacob Elliott Sperber, M.D.

Presenters: Darlene Guerrier, M.D., Navneet Iqbal, M.B.B.S., Kenneth Stewart Thompson, M.D., Ulzibat Shirendeb Person, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) the participant will be able to describe the disproportionate incarceration of African Americans; 2) the participant will be able to explain how social variables increase the occurrence of excessive substance use by African Americans; and 3) the participant will be able to suggest educational interventions for psychiatrists to expand their advocacy to reduce racism in the incarceration system.

SUMMARY:

In the US, African-American men are six times more likely to spend time in prison than other men, largely because of drug enforcement policies and practices. The causes of this difference in imprisonment are largely social, related to poverty, economic disparities, discrimination in education and employment, and other manifestations of institutionalized racism. Society's response to young men caught using drugs is much more criminalizing for poor minority Americans and more medicalizing for middle class addicts, more often white. The "war on drugs" has been a prime contributor to the mass incarceration of the last few decades and its impact has been felt across all of society, but especially in minority communities. Current psychiatric literature focuses largely on the occurrence of addiction in the brain, but the role of brain biology in the occurrence of addiction, in light of these incarceration statistics and other social research, is only one of many factors, most of which are socioeconomic and political. This workshop will review data about these inequities, and look at American psychiatry's role in the forensic and treatment systems for substance users. Is it ethical for psychiatrists to focus largely on biologic and medical questions about addiction, when the evidence shows that factors related to poverty, racism and discrimination have larger effect sizes? Does the passive participation of clinical psychiatrists in the current treatment and forensic responses to substance use meet standards of high professionalism? When does it become part of economic unfairness and institutionalized racism? How should the education of psychiatrists address these concerns?

Minimizing Risk in Psychiatry

Chair: Kristen M. Lambert, Esq., L.I.C.S.W., M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explore common claims against psychiatrists and other behavioral health providers; 2) Discuss current trends in litigation against psychiatrists; 3) Explore issues with documentation and its impact on lawsuits; and 4) Examine liability issue and risk reduction strategies.

SUMMARY:

At some point during a psychiatrist's career he will

likely be involved in a lawsuit-- either as a defendant, a treating physician or as an expert witness. If a psychiatrist is involved in a lawsuit as a defendant, the impact can be significant and can affect the psychiatrist for a number of years. This presentation, provided by risk management for the APA-endorsed liability carrier, will explore common claims, discuss current trends in litigation against psychiatrists, explore issues with documentation and its impact on lawsuits, examine liability issues, provide case examples and identify risk management strategies which could have been implemented to minimize risk.

More Bang Per Byte: Innovative Approaches to Teaching With Digital Video

Chair: Robert N. Averbuch, M.D.

Presenters: Richard Calvin Holbert, M.D., Michael A. Shapiro, M.D., Jennifer A. Davis, D.O., Fei Chen, D.O., Yarelis Guzman-Quinones, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify specific elements of a video clip that make it more effective as a teaching aid; 2) Appreciate the wide range of "teachable" content available via social media and professional resources; 3) Download video clips from YouTube and other online resources; and 4) Insert video clips into a slide presentation via the "drag and drop" approach.

SUMMARY:

The recent explosion of social media and digital technology is making "teachable" video content much more accessible to educators. Academic psychiatrists are increasingly incorporating film, internet, and other media clips into their presentations. Yet not all approaches are equally effective and digital technology is far from straightforward. Incorporation of video into presentations requires some practical digital video know-how and is not as intuitive as many claim. Successful use of video depends on a number of factors, including the length of clips, contextual relevance, timing, emotional valence, and degree of integration with the lecture. When used properly, video clips can increase student interest, enhance learning, and even improve instructor enjoyment

and enthusiasm for teaching. This workshop will begin with a brief discussion to determine how, and to what extent participants are currently using digital video in their teaching endeavors. Following, we will present a wealth of illustrative clips as examples of how media can be successfully incorporated into standard slide presentations. Participants will explore what works and why, as they critique some of the more as well as less effective content. Presenters will encourage participants to consider how they can begin to use this valuable tool of pedagogy in their own didactics and help them identify readily accessible resources for content. This workshop will go on to provide hands-on instruction in the procurement of clips, basic video editing, and incorporation into slide presentations for teaching. Step-by-step instructions will give attendees the knowledge and skills to make use of the vast video resources available to them in everyday media. Additional consideration will be given to potential technical “glitches” and problems frequently encountered and how to overcome these obstacles in live presentations. Beyond its instructive components, this workshop will encourage the exchange of ideas among participants who have already had significant experiences and/or successes with the use of video. Previous iterations have revealed a wealth of “IT pearls” and useful computer tips to help educators become more adept and comfortable with this relatively new, yet invaluable tool of pedagogy.

**Navigating the Opioid Tapering Conversation:
Survival Tools for Providers and Pain Psychology
Principles to Optimize Success**

Chair: Jennifer Hah, M.D.

Presenters: Valerie Jackson, Ph.D., Heather Poupore-King, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the core concepts of motivational interviewing (MI), understand the evidence-based applicability of MI to opioid tapering, and to identify opportunities for further training; 2) Develop an interdisciplinary approach to opioid tapering by incorporating pain psychology principles into patient education, and referring patients to appropriate specialists to optimize

outcomes; and 3) Construct an interdisciplinary approach to opioid tapering with knowledge of existing alternative resources when an interdisciplinary team is not readily available.

SUMMARY:

In the context of the current prescription opioid epidemic, the CDC and professional societies have released guidelines which advocate tapering or discontinuing opioids with lack of improvements in pain or function, development of opioid-related adverse events, or with signs of an opioid use disorder. Despite equivocal evidence regarding the long-term efficacy of opioids in the management of chronic non-cancer pain, opioids continue to be overtly prescribed to improve physical functioning and decrease pain. The need for opioid tapering may contribute to provider hesitancy to prescribe opioids, establish chronic pain care for patients using opioids, and increase opioid doses. Similarly, patients may perceive opioid tapering as a threat to optimal pain management, a source of great emotional distress, or a sign of provider distrust. This session aims to introduce providers to essential tools for navigating the opioid tapering discussion to optimize the chances of long-term success. Motivational interviewing (MI) combines empathic counseling and strategies for eliciting client self-motivational statements to build intrinsic motivation and commitment to positive behavioral change. MI has been researched extensively in the context of substance abuse to improve treatment engagement, treatment outcomes, increase medication adherence, and decrease illicit drug use. Through real-play, case-based discussions, and demonstrations, core concepts of MI will be introduced. Also, current research supporting the use of MI in the context of methadone maintenance, opioid detoxification, and opioid tapering will be presented. Opportunities for further training will be discussed. Despite numerous guidelines for opioid tapering, current practice does not involve a uniform interdisciplinary approach. Outcomes from intensive inpatient and outpatient pain rehabilitation programs conducting opioid tapering with improvements in pain severity, functioning, and mood will be presented to complement the discussion. Basic pain psychology principles spanning cognitive behavioral therapy and acceptance and

commitment therapy will be presented in the context of brief patient education, and appropriate specialist referral for more intensive therapy. Given that a major barrier of implementing interdisciplinary opioid-tapering strategies into clinical practice includes restricted access to resources, a detailed presentation of alternative resources will empower providers when an interdisciplinary team is not readily available. Given current guidelines for opioid tapering, providers must be equipped with skills to navigate patient interactions and optimize long-term outcomes. Through real-play, case-based discussions, and demonstrations, core concepts of MI and principles pain psychology relevant to tapering will be presented. Alternative resources for pain psychology will address implementation barriers.

No Mental Health Without Health? Perspectives and Policies on Preventive Care for Individuals With Severe Mental Illness

Chairs: Alison Hwang, M.D., Ph.D., Christina V. Mangurian, M.D.

Presenters: John W. Newcomer, M.D., Francine Cournois, M.D., Lori E. Raney, M.D., Monique Candace James, M.D.

Discussant: Mark Olfson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review incidence and prevalence of infectious diseases, cardiovascular disease, and gynecologic conditions among persons with severe mental illness; 2) Learn about efforts across the United States to improve screening and management of these conditions among persons with severe mental illness; 3) Evaluate mental health homes as well as other innovative models of care that work to enhance the wellness of people with severe mental illness; and 4) Discuss pragmatic strategies to implement integrated care models in community mental health settings.

SUMMARY:

Individuals with severe mental illnesses die, on average, 25 years earlier than the general population. While most of the morbidity and mortality is attributed to cardiovascular disease, this population also has also been found to have lower

screening rates for infectious diseases and cancers, and limited access to primary care. In this workshop, we invite experts who work at the interface of mental health, primary care, and public health to discuss the evidence base, ramifications for patients and providers, and ways to move forward to provide quality preventative medical care to psychiatric patients. The presenters are clinicians and researchers who have worked extensively on improving HIV treatment, primary care, obstetric and gynecologic services, and diabetes management in mental health settings. They will compare and contrast efforts in New York, Colorado, and California, and discuss factors contributing to geographic variability. Presenters will discuss screening and management guidelines, and offer practical steps for implementing integrated care models in the community mental health context. There will be ample time for audience participation and input, in order to share and develop new approaches to improving overall health for individuals with severe mental illness.

Persons With Intellectual and Developmental Disabilities in the Mental Health System: Treatment and Targeted Services

Chair: Debra A. Pinals, M.D.

Presenters: Danna Mauch, Ph.D., Brian Matthew Hepburn, M.D., Robert J. Fletcher, D.S.W., Mark Jeffrey Hauser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Clarify the systems guiding state behavioral health administrations and state developmental disabilities administrations; 2) Describe the findings of the 2017 technical assistance paper of the National Association of State Mental Health Program Directors; and 3) Discuss confounds in efforts to triage and treat people with intellectual and developmental disabilities and serious mental illness.

SUMMARY:

Individuals with cognitive disabilities or those that meet the federal definition of developmental disability represent a growing population for whom the struggle continues to get timely access to targeted services that effectively address their

behavioral health needs. States are moving to implement reforms through use of Accountable Care Organizations (ACAs) and target under-served populations with complex needs by integrating Behavioral Health (BH) and Long Term Services and Supports (LTSS). These developments place new demands on individual clinicians, provider organizations and state government authorities. This workshop will address these changing demands and focus primarily on those individuals, who meet the criteria of intellectual disability and also suffer from a serious mental illness. Panelists will discuss the clinical and care coordination seen within public behavioral health systems. These challenges can include difficulty parsing complex presentations and arriving at a diagnostic formulations that direct clinicians and administrators towards challenge resolution. Solving challenges associated with navigating among the services provided or paid for by state mental health authorities (SMHAs) and the state developmental disabilities authority (SDDA) is essential to assuring that once differential diagnoses are determined, resources are committed to a good fitting care plan. Without proper assessment, knowledge and training, individuals are at risk for compromised care including polypharmacy and excessive use of restraint. Aggression can also lead to the involvement of criminal courts systems, and then these vulnerable individuals with complex co-occurring conditions may be triaged either into forensic or correctional venues. Adding to these challenges is the paucity of clinicians able to understand the presenting clinical nuances combined with difficulty understanding the cultures and limitations of each state authority. Cumulatively, these issues result in a range of systemic problems such as long stays in settings meant to be used for triage and emergency treatment. Recognizing the reoccurring dilemmas and the need for innovation has led The National Association of State Mental Health Program Directors (NASMHPD) to create a white paper, with stakeholder input, on the complex issues faced by individuals with intellectual and developmental disabilities and mental illness. Speakers will include some authors of this paper, individuals who have served as clinical and administrative leaders across multiple state level agencies working with these individuals. Their experience with treatment and public policy related

to the treatment needs of this under served and vulnerable population of people with serious mental illness and intellectual disability has a long and fraught history, and a lively discussion is anticipated through opportunities for audience participation.

Racial Justice: The Ethical Imperative for Psychiatry

Chairs: Ranna I. Parekh, M.D., Rebecca W. Brendel, M.D., J.D.

Presenters: Mohammed R. Milad, Ph.D., Ezra E. H. Griffith, M.D., Anna Rachel Weissman, M.D., Kali Denise Cyrus, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify specific roots of racism in psychiatry; 2) Recognize the ethical and professional tools physicians use to combat racism; 3) Demonstrate the organizational challenges to addressing racism; and 4) Consider strategies to dismantle racism in psychiatric systems.

SUMMARY:

While racial disparities in mental health have long been recognized, a growing body of literature now implicates racism as the root cause. Yet most psychiatrists are not trained to recognize or address this cardinal social determinant of mental health. Commitment to racial justice is fundamental to the ethical practice of psychiatry, going beyond the professional code of conduct. Professional membership organizations are in an ideal position to educate and train their membership and other relevant stakeholders about antiracism work, including the principles of cultural sensitivity and competency, health equity and workforce diversity. This workshop introduces the neurological basis of interpersonal and internalized racism and identifies structural racism in mental health care delivery systems. The panel will explore the ethical basis for the pursuit of racial equity in psychiatry. Using a model developed in a leading educational program, participants will learn about the role of residencies in training psychiatrists to identify and challenge racism. Finally, this workshop invites attendees to share other ways professional organizations can address issues discussed in this workshop with a special focus on race and racism.

Sex, Drugs, and Rock ‘n’ Roll: Connecting Musician Suicide and Resilience to Everyday Practice

Chairs: Nita V. Bhatt, M.D., M.P.H., Allison E. Cowan, M.D.

Presenters: Meera Menon, M.D., William Robert Clark, M.D., Michole Ann Deesing, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the contagion effect of suicide specifically regarding musician suicide; 2) Understand specific career trajectories of famous musicians in the “27 Club”, the informal name for the group of musicians and artists who died at age 27; 3) Illustrate resilience with case studies of musicians who were able to continue successful careers including Bruce Springsteen and members of the Rolling Stones; 4) Understand factors that drive patients to desperate acts such as drugs and suicide when they seem “to have it all”; and 5) Formulate techniques that can benefit clinical practice, not just rock stars.

SUMMARY:

During the APA’s 2017 Annual Meeting, media outlets reported that Chris Cornell had died by suicide. He was someone who--from the outside--seemed like he had the world at his feet. The famous guitarist and vocalist for the legendary Seattle grunge band Soundgarden was married for 13 years, the father of three children, a philanthropist, and actively touring with his band. Chris Cornell was someone who had survived the grunge scene while others such as Kurt Cobain from Nirvana and Layne Staley from Alice in Chains had not. In this workshop, we will examine the known factors surrounding Cornell’s death, and the death of his friend and touring mate, Chester Bennington, lead singer of Linkin Park. We will discuss the contagion effect of suicide. Among members of the “27 Club”, which included artists from Janis Joplin to Jimi Hendrix, career trajectories and psychosocial factors contributed to the seemingly high rates of substance use and mental illness. Through small group discussion, attendees will relate these individuals to their own clinical practices. Video clips of interviews will be used to provide examples of resiliency. For example, a portion of an interview with Bruce

Springsteen will be played in which he describes his understanding of his own resilience. We will again break into small groups to discuss building resilience in rock stars as well as in our own clinical practice. At no point will we seek to diagnose those people who are not our patients. We will only apply publicly known facts to facilitate a broader discussion of psychiatry.

The “Crazed Gunman” Myth: Examining Mental Illness and Firearm Violence

Chair: Reena Kapoor, M.D.

Presenters: Amanda Kingston, M.D., Madelon Baranoski, Ph.D., Maya Prabhu, M.D., LL.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review recent legislation that limits firearm access for individuals with mental illness in the United States; 2) Examine existing evidence about the relationship between mental illness, gun violence, and suicide; and 3) Learn about new data from the presenters’ research on insanity acquittees and gun violence in Connecticut.

SUMMARY:

In response to high-profile mass shootings, many states have enacted legislation that limits access to firearms for people with mental illness. These measures are often framed as a “common sense” approach to stopping gun violence, but the evidence supporting them is less robust than one might imagine. In this symposium, we closely examine the relationship between mental illness and dangerous actions involving firearms, including violence and suicide. We seek to move past politics and ideology, instead focusing on a scholarly exploration of data that can guide policy and legislation in this controversial area. We begin by reviewing recent state laws that arose in response to Sandy Hook and other mass shootings, as well as long-standing, national prohibitions on gun access for individuals with mental illness. We then examine data about the outcome of these laws and their impact on preventing gun violence. Next, we turn to novel research by the presenters. We present new findings about the relationship between mental illness, violence, and suicide that using data from the MacArthur Violence Risk Assessment Study. We also

examine the frequency and context of firearm use in crimes that resulted in an insanity acquittal in Connecticut, seeking to explore whether individuals with mental illness are more likely than others to misuse firearms. Finally, we invite symposium participants to engage in a discussion of future directions for policy and research.

Why Can't We Break Through? The Glass Ceiling in Academic Medicine

Chair: Kari M. Wolf, M.D.

Presenter: Jane Agnes Ripperger-Suhler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify; 2) Synthesize; and 3) Brainstorm.

SUMMARY:

Women comprise about half of medical school matriculates but represent only 21% of medical school professors and only 16% of medical school deans. Frequently, work-life balance issues and lack of female mentorship are identified as the primary factors impacting the limited female representation at the uppermost echelons of academic. While those are important factors, this workshop will explore the structural and implicit biases that are present in higher education and their impact on promotion for women. We will apply studies of gender bias in academia to the medical school environment to identify other manifestations of bias that are often overlooked in discussions surrounding the gender disparity in academic medicine. We will also explore how the imposter effect impacts women and specifically how it manifests in academics. And finally, we will identify strategies to mitigate and overcome these biases to create a system to allow women to break through the glass ceiling. During this interactive workshop, participants will participate in a number of small group exercises including: self-reflection exercises to explore one's own biases; identify the detrimental effects of these biases at the individual and organizational level; and develop strategies to combat bias so that organizations/departments become a nurturing environment where women and men have equal opportunities for promotion and career advancement.

Workforce Development for Public Psychiatry: Innovative Strategies to Deepen and Broaden the Pool

Chair: Jeanne Laura Steiner, D.O.

Presenters: Ayana Jordan, M.D., Ph.D., Rebecca Miller, Ph.D., Michelle Silva, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify key elements of a "vertical" or traditional pipeline for workforce development; 2) Implement creative strategies to enhance training opportunities for college and medical students, as well as for residents and fellow; and 3) Identify elements of a "horizontal" system to expand the workforce, and adopt strategies to expand community partnerships.

SUMMARY:

This workshop is designed for mental health practitioners, educators, and administrators who are interested in exchanging ideas about innovative strategies to address the shortage of mental health professionals in the public sector. The faculty will conceptualize two significant pathways to workforce development: the traditional or "vertical" pipeline including APRN's, medical students, psychology and psychiatry residents and fellows, and a "horizontal" pipeline of non-traditional community partners. They will present examples of creative initiatives within the traditional track to "deepen the pool" by attracting and inspiring students and trainees, including programs for college students and special tracks within residencies. They will discuss the evolution of Fellowships in Public Psychiatry and provide data on the successful implementation of a program with highly positive outcomes for recruitment into public sector positions. The second area of emphasis for this workshop is the conceptualization and implementation of opportunities to broaden or expand the workforce in a "horizontal" framework, by working with community stakeholders and partners who are not typically engaged in the delivery of mental health services or who do not have adequate resources to provide services on their own. Examples include programs to train and hire peer support staff, successful models of collaborative care in primary

care settings, a regional Latino behavioral health initiative to optimize the effectiveness of scarce resources (i.e. bilingual and bicultural mental health providers), and an innovative program to train community clergy to recognize and initiate treatment for substance use disorders. The workshop chair and speakers will encourage and provide ample time for open discussion and sharing of ideas with participants. The workshop is sponsored by the Division of Public Psychiatry of the Yale University School of Medicine.

You Be the Neurologist: Making Sense of TBI Through Case Discussions

Chairs: Josepha A. Cheong, M.D., David FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participant will be able to identify definitions of severity for traumatic brain injury (mild, moderate + severe); 2) Participant will be able to identify typical symptoms of TBI; and 3) Participant will be able to identify and apply additional diagnostic tests or consultations to diagnose a patient with TBI.

SUMMARY:

Mild TBI is defined clinically. This clinical definition has an expected set of symptoms and an expected time course of recovery from these symptoms. The clinic definition will be presented and discussed in this session. However, not all patients presenting with a diagnosis of mild TBI have mild TBI. Some patients may have moderate to severe TBI based on imaging. Some patients may have additional diagnoses which confuse the diagnostic workup and prevent resolution of symptoms or result in suboptimal diagnostic approaches. Cases with a presenting diagnosis of "mild TBI" are reviewed with a brief history, imaging as appropriate, other diagnostic tests and test results as indicated, a final diagnosis, treatment and outcome. This session is intended to be interactive with "what should the next step be?" for both diagnosis and treatment as part of the workshop.

Autism Spectrum, Internet Crime, and Culpability

Chair: Kenneth Jay Weiss, M.D.

Presenters: Melissa S. DeFilippis, M.D., Mary Cohen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Be better equipped to educate judges, juries, and attorneys on the differences in social cognition among persons on the autism spectrum; 2) Contribute to a model of an alternate criminal defense by suggesting ways to testify; 3) Increase knowledge of the behaviors of persons with Autism Spectrum Disorder that may negatively influence judges and jurors; and 4) Identify how autism spectrum characteristics put individuals at greater risk for internet crimes.

SUMMARY:

Autism Spectrum Disorder (ASD) is associated with features such as deficits in social cognition, inappropriate affect, and specialized interests. Due to lack of socialized sexual development, some persons with ASD turn to online sources. Self-education in sex, coupled with collecting and sharing information online, can lead to serious criminal consequences, such as distribution of child pornography charges. Such charges, especially within federal jurisdiction, are not always amenable to negotiation. The insanity defense may not be applicable in cases with defendants with ASD, especially in higher functioning forms of the diagnosis without accompanying intellectual disability. Despite this, the diagnosis should be considered as an aspect of their defense. Confounding mitigation is that persons with ASD seem to lack remorse or an appreciation for the victims of child pornography. In this workshop, the presenters, using video clips, case studies, and interactive examples of a rehabilitative program, will explore ways to educate prosecutors, judges, and juries in the manifestations of ASD, so that the condition can be used in mitigation or toward a diversionary program. Participants will be asked to discuss the question of whether deficits in the social cognition of ASD might qualify as a "defect of reason" in an insanity defense.

Care of the Psychiatrist: From Analysis to Zolof

Chair: Jabari Tahir Jones, M.D.

Presenters: Shana R. Levy, M.D., Jo Ellen Brainin-

Rodriguez, M.D., Tara C. Collins, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Extend clinical awareness of Emotional Competence and its role in your practice; 2) Recall the 3 distinct Dimensions of Emotionally Competent Responses; 3) Apply The 10-Step Feeling Management Tool to a current personal or professional situation; and 4) Encourage integration of Emotional Competence principles into daily practice both personally and professionally.

SUMMARY:

The Equilibrium Dynamics [EQD] program and syllabus is designed to help learners of any age integrate and expand their emotional intelligence knowledge and skills to support productive and satisfying lives, including achieving their best performance at work or home, throughout their lives. Above all, the program and syllabus is intended to be pragmatic and is to be used to deal with actual situations and challenges facing adults from all walks of life. In workshops and seminars, we “walk the issues” through the relevant domains and steps to demonstrate how to use the curriculum to analyze various situations. This process of analysis followed by practice on targeted skills both addresses the chosen issues and serves as a model for future applications of the concepts to new situations. This provides the groundwork for the lifelong process of achieving emotional competence. This means that emotional competence is not just knowledge but actually applied knowledge that directs actions. It is the capacity to access your emotional knowledge and filter it through your thinking and judgment to construct the most effective actions you can think of to take care of your needs and feelings throughout your life. The unusual aspect of the EQD approach to developing emotional competence skills is the comprehensive framework underlying this approach. The seemingly simple framework is unique in its broad base and the fundamentals of its structure. These are both essential to a versatile practice of emotional competence, one that allows for unlimited modifications with changing circumstances. Emotional competence operates simultaneously in three distinct yet overlapping dimensions: The first dimension is the Instant

Response. An emotionally competent instant response requires integrating feelings, thinking and good judgment before every action — including speech. Thinking, Feeling, Judgment and Action are known as “The Big Four” and their coordination underlies all emotionally competent actions. The Instant Response is a vital skill that usually combines both intrapersonal and interpersonal skills and our expertise in this dimension depends on our development of the other two dimensions. The second dimension is the Considered Response. This involves the skills used to make a plan to achieve “the best result for now and later” and carrying out that plan. The Considered Response is the intermediate dimension that uses skills necessary for making thoughtful responses to situations, taking both long and short-term consequences into account. The third dimension is the Developmental Response, our lifelong personal and professional development that both utilizes and improves our emotional competence, providing the foundation for the other two dimensions. Although personal and/or professional development can be ignored for periods of time it must be attended to periodically for lasting success and satisfaction in our lives.

Creating a Flexible, Integrated Approach to Outreach Psychiatry: Models Based on Innovation, Evidence, and Interdisciplinary Collaboration

Chairs: Allison Crawford, M.D., Ph.D., Sanjeev Sockalingam, M.D.

Presenters: Eva Serhal, M.B.A., Donald M. Hilty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the current evidence for models of psychiatric outreach services to rural, remote and underserved areas, including fly-in/drive-in, televideo, and e-behavioral health; 2) Outline a health-systems approach to deciding on the blend of services that will lead to increased access to effective, community-specific care and consider differences between Canada and the United S; 3) Describe technological models which create more effective, timely care and interprofessional education, including stepped and collaborative care with the primary care team; and 4) Understand the Project ECHO Model and how this

telementoring model may be used as a foundation for building capacity and collaboration.

SUMMARY:

Rural and remote regions tend to have both higher incidences of mental health disorders and less access to mental health specialists than urban regions. In this workshop, expertise in outreach services for underserved areas in Canada and the United States will be combined with systematic review of the literature to provide an interdisciplinary, stepped approach to care in underserved communities. Our approach utilizes integrated modalities of in-person, telehealth, telementoring, and e-behavioral health (e-BH) to increase access to and efficiency of mental health services. A continuum of in-person and e-BH care provide versatility to health systems by enabling more patient points-of-entry, matching of patient needs with provider skills, and helping providers work to their full scope of practice. Telepsychiatry is effective and makes collaborative, stepped, and integrated care more feasible, particularly to distant, underserved communities. However, emerging health systems research also suggests that poor systems planning can limit this potential impact (e.g., inadequate needs assessment and evaluation; inequitable allocation of resources; lack of integration among service providers). An integrated approach requires consideration of impact and health systems organization at multiple levels, including: provider engagement and capacity, practice change, patient outcomes, population health, and economic modelling. In this workshop we will work through cases that allow consideration of the relevant literature, while also providing practical opportunities to consider the critical aspects of systems planning, implementation, capacity building, community engagement and evaluation, which are necessary for building an effective clinical outreach service. Crawford will discuss a recent systematic literature review, updating the last 2002 Cochrane review of outreach specialist services. She will also provide an overview of the Northern Psychiatric Outreach Service in Canada, which provides service to remote and underserved areas across Ontario and Nunavut, including the use of clinical models of collaborative care, and use of telepsychiatry. Serhal will draw on her recent research using population health data to

consider how this data can guide systems planning. She will also discuss principles of program implementation throughout the workshop, drawing on our recent research in implementation of ECHO Ontario Mental Health. Sockalingam will describe our successful adaptation of Project ECHO for mental health and will lead the discussion of evaluation and quality improvement. Hilty will discuss the effectiveness and practical dimensions of an e-BH spectrum of care, and will provide the United States context based on his work in outreach in California. Crawford will lead a case discussion of principles and practices of community engagement, including cultural considerations.

Introducing the LOCUS 20: An Updated Version of the Level of Care Utilization System (LOCUS) for Today's Health Care Environment

Chair: Michael A. Flaum, M.D.

Presenters: Wesley E. Sowers, M.D., Joseph John Parks, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe at least one potential use of the LOCUS at the individual client level and one potential use at the system or population level; 2) Become familiar with the practicalities of using the LOCUS in clinical settings through applying it to case examples; and 3) Describe modifications of the LOCUS 20 designed to facilitate and enhance its use in integrated behavioral health and managed care and settings.

SUMMARY:

The Level of Care Utilization System (LOCUS) is an instrument developed by the American Association of Community Psychiatrists (AACP) to assist clinicians, service users and systems to determine the most appropriate level and intensity of service to meet service users identified needs. In this semi-structured instrument, a service user's needs are assessed by assigning ratings from 1 to 5 in each of six dimensions: 1) Risk of Harm, 2) Functional Status, 3) Co-Morbidity, 4) Recovery Environment: (A-Level of Stress, B-Level of Support), 5) Recovery History and 6) Engagement and Recovery Status. Using the scores generated by these ratings, a recommendation is made for one of six levels of

service intensity, each of which is defined by care environment, clinical services, supportive services, and crisis stabilization and prevention services. The instrument has multiple potential uses. At the individual client level it: 1) assesses immediate service needs (e.g., for clients in crisis); 2) monitors the course of recovery and service needs over time; 3) provides valid, value driven guidance to payers for “medical necessity criteria”, the application of which will better meet the needs of clients in real world systems; and 4) informs treatment planning processes. At the system or population level it: 1) clarifies system level resource needs for complex populations over time and helps identify deficits in the service array; 2) assists in the development of bundled payments or case rates for episodes of care for specific clinical conditions; 3) provides a framework for a comprehensive system of clinical management and documentation; and 4) facilitates communication between systems of care regarding service intensity needs. In this workshop we will briefly describe the recently updated “20th anniversary edition” of LOCUS and the rationale for its modifications, with a focus on those designed to enhance its potential role in advancing value based care and integrated services for behavioral health systems. We will consider the advantages of having a commonly employed method that can provide uniformity in assessment processes and coherence in clinical management and documentation of behavioral health services. We will also briefly demonstrate its use and consider some of the practical issues and obstacles to implementation of instruments of this type in our health care systems as they presently exist. We will describe efforts to expand the use of this instrument as a potential standard for the management of behavioral health service needs and resources across the country (and potentially internationally as well). We will invite participants to discuss their own experiences in bridging the chasm between clinical care and resource management (e.g., managed care organizations). We will discuss with them the strategies that may be used to create rational processes for managing care in the changing health care environment.

Matrescence: The Psychological Birth of a Mother From Cognitive and Hormonal Changes to

Intergenerational Psychodynamics

Chair: Alexandra Sacks, M.D.

Presenter: Sylvia Fogel, M.D.

Discussants: Elizabeth M. Fitelson, M.D., Catherine Monk, Ph.D., Rosemary H. Balsam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize how cultural idealization of pregnancy and early motherhood leave many women with unrealistic models of bliss and ease; 2) Understand the common themes that impact a mother’s identity: ambivalence; guilt/shame; fantasy/reality; intergenerational dynamics; 3) Explain the cognitive changes in pregnancy and the postpartum and answer questions from patients on “pregnancy brain” and “mommy brain.”; 4) Describe the common interpersonal challenges of pregnancy/postpartum; help patients through stressors with partners, family, friends and coworkers; and 5) Understand diagnosis of normal adjustment vs. postpartum depression; when to treat psychopathology; how to find resources when treatment is indicated.

SUMMARY:

Much has been written about the stages of psychological growth as adults move forward in their development. Surprisingly, however, very little has been written in the professional psychological literature about how a woman changes emotionally when she becomes a mother. The literature on infant development is robust, as is a growing body of research on postpartum depression. However, even in the absence of pathology, the transition to motherhood, a process anthropologists call “matrescence,” is relatively unexplored. Our culture conveys to women that pregnancy and motherhood are supposed to be natural and instinctive. So when new mothers are experiencing the normal and transient distress of this adjustment, many wonder if they are suffering from Postpartum Depression. As reproductive psychiatrists, we answer questions from thousands of women who ask: if they’re distressed, does that mean they’re depressed? This workshop will be an overview of these themes as described in Dr. Sacks and Birndorf’s forthcoming book *How Come No One Told Me?: The Emotional Guide to Pregnancy and the First Year of*

Motherhood (Simon and Schuster, 2019) The panel is enriched by the expertise of Elizabeth M. Fitelson, MD, the Director of the Women’s Program in the Department of Psychiatry at Columbia University Medical Center (CUMC); Catherine Monk PhD, Director of Research in the Women’s Program in the Department of Psychiatry, CUMC; Sylvia Fogel, MD, Instructor at Harvard University Medical School and expert on psychoanalysis and women’s issues; and Rosemary Balsam, Associate Clinical Professor of Psychiatry at Yale School of Medicine and Author with psychoanalytic expertise on motherhood. Our workshop will introduce participants to the central components of this psychological transition as they relate to the psychodynamics of pregnancy and new motherhood. We will also address the literature on the physiology of pregnancy and the postpartum, and how hormonal change may impact neuroscience. We will provide information regarding the most psychologically charged moments in pregnancy (like decisions about genetic testing and feelings about body changes) through the postpartum (like decisions about childcare and feelings about breastfeeding.) We will also discuss specific clinical examples of how this transition impacts a woman’s interpersonal life and relationships with herself and the outside world. We will address questions about cognitive changes in pregnancy and the postpartum, as well as transient mood shifts that may be hormonally mediated, such as “the baby blues.” Alongside discussion of normal development, participants will learn how to identify symptoms of psychopathology in pregnancy and the postpartum, and when treatment is indicated.

Novel Patient Engagement Strategies for Underserved and Vulnerable Persons With HIV

Chairs: Mary Ann Adler Cohen, M.D., Luis Filipe Gomes Pereira, M.D.

Presenters: Michael B. Maksimowski, M.D., Mallika Lavakumar, M.D., Asma Iqbal, M.D., Kevin Matthew Donnelly-Boylan, M.D.

Co-Authors: Ann Avery, M.D., Allison Webel, Ph.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Apply strategies to improve access to care, retention in care, and outcomes in

four vulnerable populations; 2) Demonstrate knowledge of outcomes in implementing the collaborative care model to underserved and vulnerable populations with HIV; and 3) Apply elements of the collaborative care model that are most likely to lead to successful implementation of care in patients with HIV.

SUMMARY:

As collaborative care becomes increasingly valued within the medical field, psychiatric consultants are poised to bridge gaps in management for patients living with HIV. This may prove to be particularly challenging in treating the underserved and vulnerable populations – specifically patients with depression, immigrants, homeless and co-infected patients. HIV infection is associated with psychiatric illness because of its effects on the brain, social stigmatization, and multidirectional interactions with substance use, mood, and trauma/stress-related disorders. HIV-infected immigrants and homeless/marginally housed individuals are particularly vulnerable populations where sociocultural factors are known barriers to care and have implications in the early diagnosis and adherence to treatment. Finally, HIV/HCV co-infection is increasingly common and leads to far worse outcomes, including lower rates of adherence to care, faster progression of HIV and increased mortality. In this workshop, we present our experiences in treating patients with HIV for the purposes of educating attendings on effective methods of treating this complex and challenging patient population. We anticipate our collaborative care intervention for depression to be feasible to implement and to result in improved depressive symptoms. We will discuss strategies to improve care of documented and undocumented HIV-positive patients by predicting and overcoming sociocultural and structural barriers. We will present a unique, multi-site medical home model created to overcome the many challenges associated with homelessness. And we will review the role of psychiatry in treating the underlying psychiatric comorbidities in HIV/HCV co-infection to improve engagement and adherence.

Our Job and Their Jobs: The Psychiatrist’s Role in Understanding and Determining Patient Work Functioning When Seeking Time Off From Work

Chairs: Paul Pendler, Psy.D., Robert Scott Benson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the importance of describing the interaction of specific impairments with specific job requirements; 2) Develop greater capacity to operationalize concepts such as “workplace stress” in order to assess both one's capacity to function at work and how to provide this information f; 3) Participants will gain expertise using the APA Foundation “Work Function Assessment” tool to augment traditional forms required for disability determination; 4) Appreciate work as part of overall functioning and distinguish psychosocial issues from true impairments and how to discuss with patients; and 5) Increase skills in documenting clinical impressions from a “traditional” psychiatric assessment with the more focused assessment necessary for disability determination.

SUMMARY:

There is a significant financial burden in the labor force associated with psychiatric disability from the workplace. This typically takes the forms of absenteeism & presenteeism (Dewa, Trojanowski, Joosen, & Bonato, 2016). It has become increasingly apparent that psychiatric conditions have become one of the more costly types of absenteeism. Psychiatrists will continue to be confronted with the delicate balance of providing an accurate diagnostic assessment but also expanding their clinical repertoire to address work functioning and impairments. Often this exposure begins during their residency yet other than traditional forensic assessment training there are little guidelines to assist psychiatrists in gaining this clinical competency (Christopher, Boland, Recupero & Phillips, 2010). A recent position statement from the American College of Occupational & Environmental Medicine (ACOEM) concerning the physician's role in helping patients with medical conditions stay at work or return to work (ACOEM, 2017) stresses that the best “medicine” for impaired workers is in fact to return them to work as soon as safely possible. Unfortunately when psychiatric conditions are the primary presenting complaint, potential pitfalls

arising from the delicate balance of advocating for patients with appreciating the importance of the role of work as a restorative function rise more to the surface. The therapeutic relationship widens to now in fact include the patient, the employer and possibly the disability insurance carrier (Mischoulon, 2002). Contemporary understanding of the conflicts between psychiatric conditions and workplace variables can be seen as appreciating the distinction between “psychosocial issues” from psychiatric conditions. Warren (2013) outlines psychosocial issues as a compendium of beliefs, attitudes and perceptions about the workplace and often become the battleground when determining one's suitability to be off work due to medical reasons. Working with the American Psychiatric Association Foundation Partnership for Workplace Mental Health, a checklist tool (“Work Function Assessment”) has been created and shared with various employers as a way to encourage more accurate determination of the impairments preventing one from working. To date this tool has just been placed in public domain and using traditional disability assessment instruments, the workshop will describe how to utilize this checklist to better identify workplace impairments and address the various therapeutic factors that come into play when psychiatrists are placed in a position by their patients to recommend time off from work.

Prescriptions for Solving the Opioid Crisis: Advocacy, Clinical, and Legislative Perspectives

Chairs: Jose P. Vito, M.D., Jeremy Douglas Kidd, M.D., M.P.H.

Presenters: Andrew Kolodny, M.D., Daniel Rollings Karlin, M.D., M.A., Mikael Troubh, Megan Marcinko, M.P.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, participants will be able to explore different types of opioid use disorder treatment options and modalities; 2) Participants will be able to identify legislative and policy challenges in implementing current and new treatment initiatives during the opioid crisis; and 3) Participants will be able to describe several models for delivering opioid

addiction treatment, including incorporating collaborative care and integrated care principles.

SUMMARY:

Nearly 35,000 people across America died of heroin or opioid overdoses in 2015, according to the National Institute on Drug Abuse. That's far more than the combined death tolls of the 9/11 terror attacks (2,977) and Hurricane Katrina (1,836) — two tragedies that resulted in national emergency declarations. Effective medications and behavioral treatment are available for opioid use disorder but the number of people affected continues to rise. This workshop will take an in-depth look at the scope of the opioid epidemic. It will also help attendees become more familiar with the resources and skills needed to develop an effective strategy addressing this epidemic. Dr. Andrew Kolodny is a nationally-recognized expert in both addiction treatment and opioid prescribing policy. He will provide an overview of historical antecedents of contemporary challenges physicians face with regarding to opioid addiction. However, understanding the epidemic is not enough. Medical communities across the nation are attempting to craft strategies to address opioid addiction and to offer treatment to those currently living with addiction. Despite these efforts, the problem remains complex and as such requires a multidisciplinary, multi-pronged approach. We will highlight possible solutions including provider education efforts about safe opioid prescribing and opioid addiction, targeting the full spectrum of physicians from medical students to senior clinicians. We will also focus on programs that collaboratively involve primary care providers, medical specialists, mental health providers, pharmacies, emergency departments, and others to deliver addiction treatment. Addressing the opioid epidemic will also involve policy-makers and legislatures. We will discuss some ongoing policy efforts, highlighting both APA's current role in this process and ways in which individual psychiatrists can contribute. Finally, we will discuss how physicians and treatment centers approach addiction and the ways in which this impacts care. This will include helping psychiatrists maintain a non-judgmental stance that can facilitate effective treatment. We will also discuss how clinical advances, education innovations, and policy changes can be incorporated

into "real world" clinical setting. To accomplish this, Dr. Daniel Karlin will share insights from his experience as an addiction psychiatrist and founder of a network of treatment clinics in Massachusetts. This discussion will include challenges and lessons learned from this experience. Finally, we will end with an opportunity for attendees to ask questions and share their clinical experiences and insights. By bring today "on the ground" clinicians, administrations, and policy makers we can begin to build the advocacy tools and multidisciplinary networks to address this public health crisis.

Treatment of Mild TBI: A Neurology Perspective

Chairs: Josepha A. Cheong, M.D., David FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand multiple areas of impairment/symptoms brought about by mild TBI; 2) Identify pharmacological interventions which are appropriate for treating mild TBI; and 3) identify non-pharmacologic interventions for treating mild TBI.

SUMMARY:

Loss of consciousness or alteration of consciousness for a short duration (less than 30 minutes) is thought to be a relatively benign experience, either in military settings or in civilian settings. The strengths and weaknesses of the current classification system of TBI are reviewed with examples. A proportion of those experiencing brief loss of consciousness or alteration of consciousness (or mild TBI) have chronic adverse symptoms, which are only now being characterized. The magnitude of the problem in both military and civilian areas is discussed. Recent imaging data using conventional anatomical imaging as well as a review of diffusion weighted imaging after mild TBI is also presented to provide better insight as to mechanisms of damage. Current therapeutic approaches. both pharmacologic and non-pharmacologic approaches are discussed.

War and Peace: Understanding the Psychological Stressors Associated With Sustained Peacekeeping Operations (PKOs)

Chairs: Amit K. Gupta, M.D., Haley Brown

Presenters: Amit K. Gupta, M.D., Harish Krishna

Jairam, Elspeth Cameron Ritchie, M.D., M.P.H.
Discussant: Haley Brown

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the transitioning role of international armed forces from warfighting operations to supporting peacekeeping missions; 2) Recognize the fundamental disparity between the core objectives of PKOs and the warfighting function of our Armed Forces; 3) Identify the stressors associated with different aspects of peacekeeping operations and explore their resultant behavioral health impact; and 4) Practice specific case vignettes with role play and determine the most prudent way of addressing these stressors and mitigating their long term effects.

SUMMARY:

Despite multiple advances in technology and international collaborations bringing the world closer together, we continue to see both intrastate and interstate hostilities, arising out of religious, political, ethnic and economic differences. In this changed scenario, peacekeeping operations (PKOs) have become complex politico-military-humanitarian efforts. Soldiers trained for conventional military operations work alongside NGO and contractor civilians in the foreign role of a peacekeeper in an alien land with different cultural values and different geographical needs. These soldiers face volatile and violent situations and are constrained by very rigid international rules in their role as a peacekeeper. This exposure with widely variable demands and more limited ability to respond has the potential to bring to the fore many maladaptive responses. Dimensions of salient psychological stress in PKOs include isolation, ambiguity, powerlessness, boredom, and danger/threat. U.S. military forces have increasingly become involved in a variety of multinational peacekeeping and humanitarian assistance missions since the end of the cold war. In Somalia peace keeping operations, US and multinational forces learned that, it is essential that medical support personnel come prepared to deal with some of the world's most deadly diseases. In Yugoslavia PKOs, the degree of stress experienced in various areas correlated significantly with depression, psychiatric symptoms, and low reported

morale. In Kosovo US Peacekeeping operation personnel responded to stressors in both positive and negative ways. Studies indicated deployment stress could exacerbate preexisting hostility and anger. As our peacekeeping forces redeploy, both our military and community psychiatrists have an obligation to study the psychological factors of PKOs systematically so that we can make a difference at each stage of a deployment cycle. It is necessary for mental health professionals to understand the multiple factors that impinge on the peacekeeping soldier's mind and the emerging patterns of responses thereof. In our workshop, we will explore various clinical vignettes involving PKOs and identify the dimensions of psychological distress. We will then discuss how to minimize any resultant impact on psychological health of the peacekeepers.

Weaving Smoking Cessation Into Acute Psychiatric Care

Chair: Sunil D. Khushalani, M.D.

Presenter: Rachel Smolowitz, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The participant will learn to appreciate the prevalence and impact of tobacco use disorders on individuals suffering from psychiatric and substance use disorders; 2) The participant will learn about challenges to incorporating smoking cessation in the treatment of psychiatric and substance use disorders in acute psychiatric settings; and 3) The participant will learn to bring together a diverse skill set in the service of treatment of tobacco use disorders.

SUMMARY:

Around half a million people die from tobacco related deaths annually. The overall prevalence in the US has dropped substantially since the sixties. This phenomenal drop in the rate of smoking has not been experienced by individuals suffering from mental illnesses and addictions. Seventy to eighty percent of individuals who have both a severe mental illness and an addiction are still smoking. Individual with severe mental illness can die about 20- 25 years earlier, compared to their peers without severe mental illness, in huge measure due to their greater predilection for tobacco use. Behavioral

health care practitioners and environments need to incorporate smoking cessation into routine care, as behavioral healthcare practitioners are best equipped to deal with this challenging situation. There are many good reasons for behavioral health care practitioners to do so. We see our patients often, for longer sessions. We understand their biopsychosocial context and needs. Psychiatrists are educated about the medications that can help tobacco use disorder and are taught about the interactions between smoking and other psychiatric medications. Behavioral health practitioners are also trained in stages of change, motivational interviewing, and a range of psychotherapies which might be helpful to deal with this tough addiction. Many practitioners still hold on to myths about smoking cessation treatment- for example, patients with mental illness are not interested in quitting smoking amongst other myths. The field of psychiatry is beginning to integrate smoking cessation in acute psychiatric settings such as inpatient and partial hospitalization and developing practices to treat smoking cessation as routine aspect of behavioral health care. In this workshop, in addition to speaker presentations, we propose to use interactive discussions around some vignettes, in order to help psychiatrists become competent in this much-needed skill-set. We will also share some examples and methods of how a large health care system incorporated smoking cessation into its environment and work-flows. We shall also describe some challenges along the way and how we dealt with these challenges.

What Is the Zero Suicide Model? What Are the Clinical Practices of the Zero Suicide Model?

Chair: Beth Brodsky, Ph.D.

Presenters: Barbara Stanley, Ph.D., Christa Labouliere, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the Zero Suicide model for suicide prevention; 2) Learn the Assess, Intervene and Monitoring model for Zero Suicide clinical interventions; 3) Become familiar with clinical best practices for suicide risk assessment, safety planning and guidelines for enhanced monitoring for suicide risk; and 4) Understand more about

incorporating best practices for suicide prevention into psychiatric clinical practice.

SUMMARY:

Over the past ten years, deaths by suicide have dramatically increased across the US. In 2015, there were over 44,000 suicide deaths, an increase of 5 % from the previous year and a 20 % increase over the past decade (CDC WISQARS, 2015). The Zero Suicide model is a strategic framework put forth by the National Strategy for Suicide Prevention and created by the National Action Alliance for Suicide Prevention for creating a systematic approach to suicide prevention in the health care system, and it promotes the development and dissemination of evidence-based and best practice interventions for suicide prevention. Yet, standard psychiatric clinical training generally does not include instruction in these best practices, or in any suicide-specific clinical intervention other than basic risk assessment (asking about current suicidal ideation, planning and intent), contracting for safety, and decision making regarding hospitalization. To address this gap, this workshop will familiarize participants with the Zero Suicide Model and its evidence -based, best practice suicide prevention interventions. Barbara Stanley, Ph.D. internationally known suicide prevention researcher, treatment developer and educator, will present an overview of the Zero Suicide initiative, including the Assessment, Intervene, Monitor (AIM) model for clinical management of suicidal behavior, based on evidence- based and best practices for suicide risk assessment, brief intervention, and guidelines for enhanced monitoring within ongoing treatment as well as during the high suicide risk periods of care transition. Beth Brodsky, Ph.D., a nationally known suicide prevention researcher and educator, will present an overview of evidence-based risk assessment procedures, such as the C-SSRS instrument that measures and classifies suicidal ideation, intent and behaviors, as well as other current best practice models (SAFE-T, AMSR, Comprehensive Suicide Risk Assessment), that provide guidelines for clinical approach and inquiry into risk factors other than suicidal ideation and past behaviors. Dr. Stanley will present an overview of the Safety Planning Intervention, a best practice alternative to “contracting for safety”. Christa Labouliere, a nationally known suicide prevention

implementation researcher, will present the “Structured Follow up and Monitoring” framework that provides guidelines for increased contact, outreach and family/supportive network involvement. The workshop will culminate in an open discussion with participants regarding integration of this clinical model into the ongoing practice of clinical psychiatry.

Why We Must Distinguish “Passion” and “Emotion” in Recovery: Historical, Theoretical, and Ethical Issues

Chair: Louis Charland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To provide historical background on the origins of the concept of recovery in 18 and 19th century moral treatment; 2) To analyze the clinical methods employed in the early moral treatment of William Tuke and Philippe Pinel; 3) To analyze the role of passion in early moral treatment and the distinction between “passion” and “emotion” in the clinical methodology of Philippe Pinel; 4) To argue for the relevance of distinguishing “ ” in contemporary clinical thought and practice regarding recovery; and 5) To identify and assess the ethical and practical implications of the proposed additions to contemporary clinical thought and practice regarding recovery.

SUMMARY:

Over the last several hundred years, there has been a marked change in the theoretical vocabulary of the affective sciences. The term “passion” has almost entirely disappeared from psychology and psychopathology, and “emotion” has emerged as the new keyword of the day. For the most part, “passion” has been relegated to the proverbial dustbin of history. However, there are good reasons for challenging this elimination of “passion.” Indeed, “emotion” has severe limitations that can only be resolved by reinstating an appropriate concept of passion. In particular, without an appropriately circumscribed concept of “passion,” contemporary psychology and psychopathology cannot provide an adequate account of emotion regulation. Neither can they provide an adequate account of the organization and duration of complex long-term

affective states and syndromes. The reason is that, properly understood, passions organize emotions. As such, they belong to an entirely different theoretical order – or explanatory theoretical category – than emotions, beliefs, or desires. Failure to appreciate this last point may explain why the psychopathology of the passions has languished since the emotional turn in affective science, despite the introduction of schemas and other promising explanatory structures. There are also important implications here for contemporary clinical thought and practice in the domain of recovery. The absence of a suitable analogue for “passion” that properly differentiates and distinguishes “passion” from “emotion,” makes it impossible to adequately identify and formulate to role that “passion” plays in recovery. Building on the celebrated work of Philippe Pinel and the manner in which he distinguishes “passion” and “emotion” in his own psychopathology and moral treatment, this workshop will endeavour to show that there is much learn by re-examining these early contributions on recovery, particularly from the vantage point of clinical method and ethics.

Women Psychiatrists: Road to Success and Well-Being

Chair: Rashi Aggarwal, M.D.

Presenters: Leah Joan Dickstein, M.D., M.A., Jessica K. Hairston, M.D., Nikole S. Benders-Hadi, M.D., Christina T. Khan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify common challenges in the career paths of women psychiatrists; 2) Discuss societal and self-expectations that help or hamper women psychiatrists in their professional growth; 3) Discuss potential solutions to professional challenges faced by women psychiatrists; and 4) Identify way to balance success and well-being.

SUMMARY:

The last few decades have seen an increase in the total number of women in psychiatry. Despite their increasing numbers, women are underrepresented in leadership roles and face challenges in professional advancement. They are also less likely than men to rise to the highest ranks in the field. Women physicians get paid less than their male

counterparts, have fewer publications, and have more difficulty getting promoted than men. The number of women department chairs in psychiatry (13%) is higher than in departments like surgery (2%) but much lower than in departments like pediatrics (20%) and ObGyn (22%). Psychiatry does have female leadership at the top, current and recent APA presidents being a woman – however, the total proportion of female leaders is still low. Multiple reasons have been proposed to explain this shortage of women in academic and leadership roles. They include societal expectations – being able to juggle a demanding academic or leadership role while being the primary caregiver for family. Further, there are not enough role models of women psychiatrists who successfully manage academic careers and/or leadership roles and family lives. In this workshop we will discuss many of the challenges faced by women psychiatrists in developing professionally. We will also discuss the roles societal expectations and self-expectations play in the lives of professional women. The panel will have an open dialogue about personal experiences as they relate to these issues. The expert panel will offer potential solutions that woman psychiatrists can use to face and resolve these challenges successfully. The speakers will address pathways to success in professional careers and in organized psychiatry. The speakers will also discuss strategies to balance demands of work life with personal life to achieve optimal well-being. The speakers will discuss their experience with success and wellbeing while pursuing an academic career or private practice or using other options like telepsychiatry as a means to maintain a healthy work-life balance.

A Personalized Approach to Obtain Sustainable Treatment Results in Depression

Chairs: Steven Dennis Hollon, Ph.D., Henricus Van

Presenters: Margo de Jonge, Claudi Bockting,

Jacques Barber, Ph.D., Henricus Van

Discussants: Jack Dekker, Steven Dennis Hollon, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the risks of obtaining insufficient sustainable result in the treatment of depression; 2) Understand the risk factors for chronicity and poor response to current evidence

based treatments; 3) Apply the evidence for Preventive Cognitive Therapy to prevent relapse in recurrent depression as compared to maintenance antidepressants, also in remitted patients; 4) Consider preferences for either a psychodynamic or cognitive behavioral approach on a group level and on a personalized level; and 5) Understand the presence of co-morbid PD as personalization factor for psychotherapy, that is to consider adaptations in focus and dosage in treatment resisted depressed patients.

SUMMARY:

In order to obtain better and more sustainable effects in treatment of depressed patients it is advocated we need to adapt treatment towards more personalized approaches. Based on available evidence we will discuss how this can be achieved for patients with depressions including taking very common co-morbid conditions into account like Personality Disorders (PD). Depression is a recurrent disorder for most patients, even more so when progression to complete remission has not been accomplished during acute treatment. It has been demonstrated that Preventive Cognitive Therapy is effective to prevent future relapses and recurrences. The question, however, is whether this is also useful for patients that responded well on CBT during the acute phase. Results of a recent national conducted RCT will be presented showing that PCT has sustainable preventive effects, even after receiving acute CBT. The implications will be discussed. Maintenance treatment with antidepressants (AD) is the leading strategy to prevent relapse and recurrence in individuals with recurrent Major Depressive Disorder. However, it is unclear whether brief cognitive therapy while tapering AD is an effective alternative for maintenance AD. We present results from a recent single-blind multicenter three-arm RCT indicating that PCT might be an alternative for remitted recurrently depressed individuals that wish to stop continuation/maintenance AD. Alongside this trial and past studies the assumption to use the level of chronicity as a personalization factor will be discussed, including treatment matching to prevent relapses. Psychodynamic approaches have always been rather popular among clinicians and patients although it has long been understudied. Nowadays

however in depression, anxiety disorders and PD convincing meta-analytic evidence for PDT has emerged, making the question what works for whom possible to address. Individual studies suggest differential effects in subgroups that could be helpful to formulate personalized advices for individual patients. Depression often co-occurs with personality disorders and the risk for poor outcome of treatment is two times higher in case of co-morbid personality disorders. The question is whether the regular short-term protocols needs to be adapted in approach, dosage and duration to achieve better and more sustainable results. Both from a psychodynamic and cognitive schema focused perspective we will discuss which adaptations are useful and how these could be studied in an RCT context. In conclusion, applying a personalized approach to achieve sustainable effects of PT are promising. Specific targets have been identified, i.e. chronicity and personality pathology. It will be advocated this could result in better and more sustainable results for patients with depressive disorders.

Acceptance and Commitment Therapy for Addictions

Chair: John David Matthews, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) The participant will be able to cite the six processes to achieve “Psychological Flexibility”; 2) The participant will be able to apply the assessment tools, “Practicing Our Way to Stillness (POWS)” and the “Valued Living Questionnaire” in clinical practice; and 3) The participant will learn to apply the “ACT Matrix” and the “Valued Action Worksheet” to assist in moving towards value-based goals.

SUMMARY:

This workshop will be divided into the following three sessions. Session 1 An overview of Acceptance and Commitment Therapy: Acceptance and Commitment Therapy (ACT) is one of the most recent developments among the cognitive behavioral therapies. ACT developed coincidentally with mindfulness based cognitive therapy and dialectic behavioral therapy; together, they make up

the third wave of cognitive and behavioral therapies. Historically, ACT developed from relational frame theory (RFT) which argues that context and experience determine our responses to language and cognition. In ACT, treatment focuses on responding to internal experiences (thoughts, feelings, sensations, images, and memories) based on context rather than content. Thus the goal of treatment is not to change the content of our negative thoughts, as in CBT, but to change our relationships to our negative internal experiences. The aim of ACT is “Psychological Flexibility” which is defined as being aware and allowing negative internal experiences, in the moment, while engaging in value-based actions; one’s experience and values should determine one’s behavior. According to ACT, when negative internal experiences determine one’s actions, there is an intensification and prolongation of one’s pain resulting in avoidance; addiction to substances is a form of avoidance. With avoidance, one’s experience becomes constricted and inflexible.

Session 2 Application of ACT to addictive behaviors: ACT is very consistent with the perspective used for the treatment of addictive disorders and it offers an enhancement to interventions currently used. Historically, the approach used to treat addictive disorders has focused on the whole person, which is a perspective that goes beyond the medical model. The field of addiction treatment has been innovative in this regard compared to the field of mental health. A prime example is the 12-step tradition that focuses on being present, spirituality, values, self-acceptance, compassion towards self and others, honesty, making amends, and community. Research over the past couple of decades has demonstrated effective evidence-based approaches in the areas of acceptance, motivation, mindfulness, and values. In this session, the focus will be on how to achieve psychological flexibility, in the context of having an addiction, by engaging in the six processes that facilitate psychological flexibility including: being present, acceptance, defusion from negative internal experiences, self as context, values clarification, and commitment to value-based actions. The presenter will provide clinical vignettes demonstrating these six processes. Session 3 Clinical Cases: During this last session, the presenter and participants will review cases for which ACT can be applied.

An Update on Geriatric Life Transitions: New Challenges for Older Adults

Chair: Nisha Mehta-Naik, M.D.

Presenters: Caitlin Snow, M.D., M. Katherine Shear, M.D., Robert Abrams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of geriatric life transitions on the mental health of older adults; 2) Recognize the economic challenges faced by older adults, and how age-related cognitive changes may impact financial decision-making; 3) Identify variations in the course of bereavement, and discuss the management of bereavement in geriatric primary care patients; 4) Review the literature regarding the impact of retirement on mental and physical health; and 5) Demonstrate understanding, and engage in a dialogue, regarding common clinical challenges and effective clinical approaches when working with older adults during life transitions.

SUMMARY:

The geriatric population faces unique life transitions, each accompanied by wide-ranging biopsychosocial consequences. Certain life transitions—such as bereavement and retirement— can result in significant shifts in an individual’s financial status, social support structure, physical and mental health(1). Each older adult may cope with life transitions differently, and in some cases such life events can result in positive changes in an individual’s life. However, transitions are often fundamental stressors, which potentially can result in worsened mood and anxiety symptoms(2). In the setting of an aging American population, with increased average life expectancies, it will become progressively more important for psychiatrists to understand the complexities of these life transitions. In this workshop, we will explore common challenges faced by psychiatrists in the evaluation and management of older adults during life transitions. We plan to introduce the topic of geriatric life transitions with an 8 minute short film titled “Father and Daughter” by Michael Dudok De Wit, in which a woman struggles to adapt to different stages of life, particularly aging. We hope to utilize this film to highlight the complexity of life

transitions commonly faced by older adults. We will review the economic burden, and economic challenges, associated with geriatric life transitions. Specifically, we will focus on the impact of age-related cognitive changes on financial decision-making. We will also discuss the course of grief and bereavement in the geriatric population, as well as management of bereavement in the geriatric primary care setting. During this workshop, we will review the literature regarding the impact of retirement on mental and physical health. Furthermore, we will discuss current challenges, and clinical tools, in working with patients through the retirement process. During the workshop, we hope to foster a conversation about working with patients during such life transitions.

Beyond Vital: Psychiatric Technicians in the Operational Military Environment as Applied Integrated Care

Chairs: Miguel Magsaysay Alampay, M.D., Daniel R. May, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role and degree of training of psychiatric technicians in the US Army, Navy, and Air Force; 2) Appreciate the innovative ways in which psychiatric technicians are utilized in the operational military environment; and 3) Describe the ways that the various modes can be applied to the civilian setting.

SUMMARY:

This workshop provides an overview of how psychiatric technicians are trained in the various branches of the military, how this training is being developed upon in operational military environments, and the ways that this model can be applied to civilian settings. Mental health has long been recognized as a significant component of military readiness. Military psychiatrists have utilized an array of modalities drawn from areas of positive psychiatry, group therapy, psychosomatic medicine, psychodrama, forensics, and addiction psychiatry. In the course of this work, psychiatric technicians have come to play crucial roles in triage and management of patients. This is especially true in the operational military environment where resources and access to

other mental health providers is limited. More than taking vital signs or providing assistance in direct line-of-sight watches, psychiatric technicians have been used to facilitate therapy groups, conduct intake assessments, provide individual counseling, and teach psycho-education courses to service members and other healthcare providers. The degree to which the roles of psychiatric technicians have evolved often reflects the unique needs of their environment – Army, Navy, Marine Corps, Air Force - to maximize readiness throughout the active duty military workforce. The presenters highlight how these differences have shaped the innovative ways in which psychiatric technicians are being utilized; and elucidate common themes that have contributed the successful extension of care. Ethical pitfalls, the need for supervision, and importance of ongoing continuing education are also discussed.

Cyberbullying and Online Harassment: Update on Prevalence, Psychiatric Consequences, Screening, and Prevention

Chair: Christopher Francis Ong, M.D.

Presenters: Michael A. Shapiro, M.D., Almari Ginory, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Examine the various subtypes of online harassment; 2) Review current knowledge regarding the prevalence of various subtypes of online harassment; 3) Discuss methods for screening and preventing online harassment; 4) Examine the relationship between cyberbullying and specific psychiatric disorders; and 5) Provide real world examples of online harassment as they pertain to providers and patients.

SUMMARY:

The transition to adolescence brings on a whole new set of life challenges and experiences, arguably the most important of which is the increased emphasis on dating and relationships. While this concept is not new, the ever growing ease of access to the Internet via ubiquitous devices such as mobile phones and tablets is definitely new. With up to 98% of young adults using cell phones in 2013 alone, it begs the question as to how the Internet has changed the way teenagers make the transition into that specific

stage in life where dating and relationships become a higher priority. Over the last few years, there has been there has been significant growth in terms of cyberbullying research not only with regards to children and adolescents, but also adults particularly in the workplace. The purpose of this workshop will be to briefly review the basic fundamentals of cyberbullying regarding various types and prevalence. We will then discuss the results of recent large scale studies that have provided greater insight into the specific risk of developing various psychiatric disorders due to ongoing cyberbullying and online harassment. The continuing development of screening strategies for clinical use and current legislation will be reviewed. We will also present high profile examples of online harassment within the last year occurring worldwide. Finally, as the previous generation of adolescents grows and begins to enter the workforce, we will also discuss the longitudinal impact of previous cyberbullying on early career adults. The goal will be to have an open forum where attendees can ask questions and discuss issues/concerns.

Equine Therapy: Achieving Well-Being With a Centuries-Old Tool

Chair: Diego Coira, M.D.

Presenters: Rafael Coira, M.D., J.D., Dana Spett, M.S.W., Margaret Grady, M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will learn the advantages of equine therapies in the treatment of psychiatric conditions; 2) Participants will learn the principles of equine assisted psychotherapy; 3) Participants will learn how horses improve cognition, balance, movement and mood; and 4) Participants will learn about the neuro-plasticity associated with equine related therapies.

SUMMARY:

Horses have been utilized for centuries for work, war, pleasure and therapy. Although there is not much research done with specific therapies for the treatment of psychiatric disorders, people that have worked with horses know of their therapeutic value. In our workshop we will present evidence from our experience using horses for the treatment of

psychiatric disorders. Two of the authors have (Diego Coira, MD and Dana Spett, MSW) have life long experience with horses. Dr. Coira, Chair of the workshop, will introduce the team and talk about the value of horses improving cognition, quality of life, mood and balance in patients with Schizophrenia, Alzheimer's Disease, mood disorders, anxiety disorders and PTSD. Dana Spett will present using audio visual technology the work that our group does at the farm, Pony Power in northern New Jersey. Margaret Grady, APN will present on the topic of using equine therapies as a tool for mindfulness and to improve quality of life. Rafael Coira, MD, JD will do a case presentation of one of our patients that will serve as the basis for a case discussion with the audience.

Feminism in Psychiatry: Advocating for Women's Leadership and Creating Environments to Support Gender Equality

Chair: Allison Nicole Hoff, M.D.

Presenters: Laya Varghese, D.O., Kathryn Skimming, M.D., M.A., E. Jane Richardson, M.D., Aronica Michele Cotton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand basic feminist theory as it relates to the history of women in psychiatry and current psychiatric practice; 2) Explore ways in which physicians in all areas of medicine are currently helping to support the equal advancement of both women and men via collaborative projects, mentorship and advocacy; and 3) Develop ideas of how to encourage female empowerment among the current generation of psychiatrists.

SUMMARY:

Gender remains a critical component of the complex practice of medicine. There are more women entering medicine than ever before, yet female psychiatrists continue to face challenges in moving into leadership positions and academia. This disparity is more pronounced among female physicians from underrepresented racial and ethnic groups. Current feminist theory may help physicians to more comprehensively address these pervasive challenges. There have been limited forums to

discover and discuss critical gender issues experienced by both women and men. This workshop will provide an opportunity to learn more about current feminist theory and how it relates to the practice of psychiatry. Through deliberate conversation and engaging dialogue, participants will explore ideas for future action that support the development and equal advancement of both female and male psychiatrists.

Fifty Shades of Deviance: Sexual Deviance and the Law

Chair: Sara G. West, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand sexually deviant behavior as described by the DSM-5; 2) To review the Not Guilty by Reason of Insanity (NGRI) plea; and 3) To investigate the intersection of mental illness and criminal sexual behavior.

SUMMARY:

The books and films have drawn the public eye to unusual sexual behavior, but what do we really know? Uncommon sexual practices have gained increasing public awareness and mainstream acceptance in recent years. The shifting of public perception and professional definition of these behaviors can complicate forensic evaluations. Come delve into necrophilia and define and discuss other more obscure examples of sexual deviance, including autoerotic asphyxiation, teratophilia, urophilia and coprophilia. Then let's examine how these practices may arise in forensic cases, including a sanity evaluation illustrating a number of these disorders. As one could argue that feelings of power or sexual gratification could always serve as a rational motive for sexual crimes, let's discuss if the NGRI plea ever even has a role in these circumstances. Finally, we will highlight the ways in which pop culture satiates society's salacious interest in these macabre topics.

Mental Health Reentry Programs

Chair: Priti Ojha, M.D.

Presenters: Lawrence Malak, M.D., Stephanie Martinez, M.D., Ronak Jhaveri, M.D., Priti Ojha, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review background information of the severely mentally ill population in the correctional system; 2) Review current community programs and the role of a walk-in clinic in San Diego; and 3) Review re-entry programs, including Second Chance.

SUMMARY:

With estimates of ten times more patients with serious mental illness (SMI) in jails or prisons than in hospitals, the correctional system has largely replaced inpatient psychiatric care in the last fifty years. Approximately a quarter of inmates have a serious mental illness. Staff training of addressing mental illnesses in this population is limited, as facilities have struggled to address the increased rate of inmate SMI and suicide. Further, as inmates transition out of corrections into the community, most experience limited access to care, leading to high rates of homelessness, recidivism, and emergency room visits. Federal, state, and local agencies have attempted to address these issues. In this workshop, we will review community programs in San Diego and discuss the Second Change program as it has been implemented at UCSD. This program assesses inmates who have been incarcerated due to drug charges and, if appropriate, releases them early on probation and sentenced to re-entry court. They are then admitted to a unique re-entry track of an intensive outpatient program dedicated to co-occurring substance abuse and mental health disorders.

Psychedelic Medicine: History, Current Research, and Their Potential Role in Clinical Practice

Chair: Matthew A. Brown, D.O.

*Presenters: Fernando Espi Forcen, M.D., Ph.D.,
Manuel E. Morales, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the history of the use of psychedelic substances in various cultures throughout the world; 2) Review the research that was conducted prior to the scheduling of psychedelic compounds and also the more modern research over the last decade dubbed the “psychedelic

renaissance”; 3) Understand the risks and benefits of psychedelic medicine; 4) Appreciate the social and cultural impact of psychedelic medicine; and 5) Develop an appreciation for how psychiatric practice may change through the use of psychedelic medicines.

SUMMARY:

Humans have had a relationship with psychedelics for thousands of years with some of the earliest known evidence can be found in the form of cave paintings dating back about 7000 years. Many of the world’s Western religions are said to have been influenced by psychedelic experience. In this workshop we will discuss the evidence for use of psychedelic compounds in traditional and historical use in many cultures throughout the world as well as more modern applications of these agents and their role in treating mental illness. After receiving such positive feedback in regards to our Rapid-Fire Talk on psychedelics last year, we would like to expand our presentation and update with new research as well as give the audience a chance to engage with the material more in an interactive format. In this workshop we will review the history regarding the evidence for use of psychedelic medicines in various cultures throughout time. We will discuss the early research in Western culture that was conducted in the mid-20th century and review results of more recent research into the utility of such agents using various techniques such as neuroimaging to better explain the mechanism of action of psychedelic medicine. We will conclude by engaging the audience in an interactive panel discussion and Q & A to discuss how current psychiatric practice might change in light of the current phase 3 clinical trials and rescheduling of MDMA and Psilocybin if they are indeed FDA approved as is anticipated within the next 5 to 10 years.

Structural Competency in Psychiatric Practice and Training: Clinical Intervention on Social Determinants of Health Inequalities

Chairs: Helena B. Hansen, M.D., Ph.D., Jonathan Metzler, M.D., Ph.D.

Presenters: Laurence Jay Kirmayer, M.D., Robert Mark Rohrbaugh, M.D., Enrico Guanzon Castillo, M.D., Selena Suhail-Sindhu, Joel Braslow, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) By the end of the workshop, participants will be able to describe at least three exemplary cases of clinical practices and training programs that intervene on social determinants of mental health; 2) Participants will be able to identify four common elements of their successful implementation; 3) Participants will be able to describe at least one technique for identifying structural causes of common clinical patient presentations that will apply to their own clinical practice; and 4) Participants will be able to describe at least one potential structural intervention for the common clinical patient presentations that will apply to their own clinical practice.

SUMMARY:

Structural Competency is an emerging approach to clinical training and practice that enables practitioners to intervene on the structural and social determinants of patients health – through collaboration with community organizations, non-health sectors such as schools, housing and law enforcement, and with policy makers to promote mental health. This workshop will present six cases of successful structural competency interventions in psychiatric training and in clinics. These include Vanderbilt University’s Medicine, Health and Society curriculum as well as its Structural Foundations of Health Survey for pre-health students, New York University’s PRECEPT (Program for Residency Education, Community Engagement, and Peer support Training), in which psychiatry residents partner with mental health peers to generate community resource maps and to engage community organizations in patient care, Yale psychiatry residency’s Structural Competency Community Initiative (YSCCI), which increases PGY2 psychiatry resident awareness of the structural challenges to health of the people who reside in the neighborhoods of New Haven, including poverty and job opportunities, food insecurity, education inequality, social exclusion/isolation, housing instability, the criminal justice system, and violence/trauma. UCLA’s psychiatry residency training combines “Critical Thinking Skills” in classroom learning informed by the social sciences and humanities, with Structural Vulnerability

oriented exercises in clinical care including ethnographic field notes and supervision focused on identifying and remediating structural inequality. The roles of physicians and clinical social workers in intervening on social determinants, through political and community advocacy (Indigenous and immigrant mental health in Canada), development of policy innovations (LA County Housing for Health), specialized mental health teams (supportive housing, Assertive Community Treatment, Assisted Outpatient Treatment), and direct screening and action through structurally competent patient care will be discussed.. The workshop will conclude with interactive cases designed to engage the audience in applying the lessons learned from successful cases to common patient presentations in psychiatric clinics that are amenable to structural intervention.

The Meeting of Two Personalities: Managing Countertransference From a CBT and Psychodynamic Perspective

Chair: Diana Kljenak, M.D.

Presenters: Adrienne O. Tan, M.D., Kenneth P. Fung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Examine concepts of transference and countertransference from psychodynamic and CBT perspective; 2) Compare and contrast CBT and psychodynamic approaches to transference and countertransference; and 3) Reflect on and practice using different approaches in managing countertransference in their own practice.

SUMMARY:

“The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed.” C.G. Jung The establishment and maintenance of professional therapeutic relationships is a core component of psychiatric practice. This is highlighted in the psychotherapies given the importance of therapeutic alliance in psychotherapy outcome. Therapeutic alliance involves the mutual influence between patient and physician. Psychiatrists may possess particular expertise in the recognition and management of the personal responses elicited in interactions with patients; that is, countertransference. Both

psychodynamic psychotherapy, from which the original concept of countertransference is derived, and cognitive behavior therapy (CBT) are evidence-based therapies used to effectively treat a number of mental health disorders. Traditionally, CBT has been thought of as a treatment modality that is technique-based and not as concerned with the therapeutic relationship as other forms of psychotherapy. Psychodynamic therapy has been defined and distinguished from other therapeutic approaches by its emphasis on therapeutic relationship and working with transference and countertransference. However, it has been argued that countertransference has become a construct that transcends practitioner's theoretical orientation. In this workshop, the concepts of transference and countertransference will be examined from both psychodynamic and CBT perspective. Case examples will be used to compare and contrast psychodynamic and CBT formulation and techniques to recognize and manage countertransference. Participants will be able to reflect on and practice these techniques in pairs/small groups.

Working With Special Populations in College Psychiatry: Understanding the Needs and Recommendations for Working With Specific Groups of Students

Chair: Amy W. Poon, M.D.

Presenters: Diane Beth Gottlieb, M.D., Leigh Anne White, M.D., Ludmila B. De Faria, M.D., Farha Zaman Abbasi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) . Participants will understand the increased need for mental health treatment on college campuses, and the need for additional knowledge when working with different groups of students; 2) For each special population, participants will identify the risks, vulnerabilities, special treatment considerations, and recommendations for working with each group; 3) Participants will understand the effects of the current political climate on different student groups, and will be able to identify the stressors that students may be experiencing as a result; and 4) Participants will

increase their knowledge base and competency in working with specific groups of college students.

SUMMARY:

There is a growing need for mental health services on college campuses, and the National Survey of Counseling Center Directors reports that 90% agreed that there are greater numbers of students with severe psychological problems. Students feel "overwhelmed," nearly half had felt "so depressed that it was difficult to function," and almost 1 in 10 had "seriously considered suicide." More students take psychiatric medications—at college counseling centers, 24% now take medication, compared with 9% in 1994. In this workshop, we focus on 6 populations of students. Speakers will give rapid-fire presentations discussing the treatment considerations, needs, vulnerabilities, and recommendations for each population. 8 minutes of presentation will be followed by 2 minutes of short, interactive Q & A with the attendees on each topic. After the 1st hour of presentations, 25 minutes is allotted for in-depth conversations with attendees. We will also discuss the current political climate and its impact on a number of these populations. (1) MEDICAL STUDENTS: Higher rates of emotional distress compared to age-matched controls have been found, including more suicidal ideation in medical students, residents, and physicians, compared with the general population. Treatment considerations include privacy concerns, stigma, and transference/countertransference issues. (2) VETERINARY STUDENTS: Veterinarians are a highly trained group of healthcare professionals with an extremely high risk of suicide, estimated to be 3-4x as great as the general population, and 2x as great as other healthcare professionals. Interventions are likely needed at the student level. (3) GRADUATE STUDENTS: Graduate students have reported lower percentages of psychiatric problems compared with undergraduates. Among graduate students however, studies have identified high-risk groups, including Arts & Humanities majors, LGBTQ students, international & undocumented students, and minority students. (4) TRANSGENDER STUDENTS: More than 1/3 of TGNC students reported considering leaving their institution due to the challenging climate. 50% of medical providers have inadequate understanding of transgender student

health needs, 28% of transgender patients experienced provider-related bias issues. There is a great need to improve access to care for these students. (5) MUSLIM STUDENTS: Muslim students face significant threats, and this has increased under the current political climate. Many have experienced recent episodes of bullying, and women who wear Hijab (headscarf) are especially at risk. Policies should be inclusive and respectful of the religious practices of Muslim students. (6) DACA STUDENTS: The Deferred Act for Childhood Arrivals program allowed undocumented students to attend college. Despite the benefits provided under DACA, students struggle with mental health issues due to different factors, including acculturation issues and the current political climate.

Sunday, May 06, 2018

Anti-Racist “Bystander” Interventions: How Might Psychiatrists Respond When Discrimination Occurs in Clinical Settings?

Chair: Jon Wesley Boyd, M.D., Ph.D.

Presenters: Ian Hsu, M.D., Nina Evelyn Sreshta, M.D., Nikhil “Sunny” Patel, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize that psychiatrists commonly encounter clinical situations involving racism or discrimination; 2) Conceptualize the role that psychiatrists might play in mediating these situations, especially as “bystanders”; 3) Consider the privileges psychiatrists wield, and their attendant obligations; and 4) Develop a framework for how to intervene meaningfully in racially charged situations.

SUMMARY:

There is currently a burgeoning nationwide conversation about the need for curriculum in medical education focused on awareness of issues of privilege, racism, and discrimination [1,2]. This need is especially pressing for mental health care providers, who regularly encounter sexism, homophobia, and racism in clinical settings. For example, patients may make racist remarks toward other patients in a group therapy or toward public safety officers in the emergency department. Or, a milieu counselor might make culturally or racially

insensitive remarks about a patient’s family, both in their presence and when they are out of earshot. When such issues arise, patients or clinical staff may look to psychiatrists for leadership, whether psychiatrists are directly involved in the conflict or are “bystanders” (which are increasingly recognized as important contributors to anti-racist efforts [3]). Particularly when involved as a “bystander,” it can be difficult for psychiatrists, especially those in training, to consider if and how to intervene. Thus, reflection on and discussion about how to conceptualize psychiatrists’ roles in these situations might improve our ability to intervene in a meaningful, self-aware way. Led by resident psychiatrists with lived experience navigating these situations, participants in this workshop will engage in a series of small-group discussions based on several clinical vignettes, derived from clinical experience. These vignettes illustrate the complexity of the racially charged situations in which psychiatrists find themselves. Participants will be asked to study how they might improve their handling of these situations whether it is patients, families, nurses, safety officers, milieu staff, or physicians who are victims of racist remarks, stereotypes, or even violence. Participants will discuss how the context of the encounter -- from group therapy settings to long-term individual psychotherapy to emergency departments -- might also affect decisions about intervention. Participants will also consider how manipulative intent, anger, or psychotic states lead to racist language, and how these factors might affect conflict management. The workshop will conclude by reconvening with the larger group to reflect on how the case discussions can shape our clinical practice.

Beyond Borders: Innovative Medical-Legal Partnerships to Assist Refugees and Asylum-Seekers

Chair: Maya Prabhu, M.D., LL.B.

Presenters: Howard V. Zonana, M.D., Chinmoy Gulrajani, M.D., Wendy Parmet, J.D., Linus Chan, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To identify opportunities for psychiatrists and psychiatric trainees to provide consultation to immigration advocates;; 2) To

appreciate the mental health needs of refugees and asylum-seekers before, during and after resettlement to the US;; 3) To enumerate the legal standards for asylum status in the US;; 4) To describe community-based models to deliver mental health care to refugees and asylum seekers including barriers to implementation;; and 5) To Understand the legal and non-legal barriers that cause immigrants to be less likely than persons born in the US to have health insurance.

SUMMARY:

Psychiatrists and attorneys have long worked together to assist asylum-seekers and refugees at various stages of their resettlement process. With a growing number of displaced persons throughout the world, some of whom will seek entrance to the US, the need for such partnerships will only increase; moreover, there is a need to support this population even after resettlement to the US has been finalized. This workshop will describe a range of ways physicians and lawyers can work together in all stages of adjudication, evaluation and adjustment to the US. Howard Zonana MD will discuss a partnership with Yale Law School to train both law students and forensic fellows to work with asylum-seekers who have potential mental health claims; in addition to assistance with formal evaluations, forensic trainees can provide education around interviewing techniques and challenges that can arise in attorney and client relationships. Chinmoy Gulrajani MD will discuss a similar partnership between the University of Minnesota's Law School and Forensic Fellowship. He will also describe an ongoing collaboration between the University of Minnesota's forensic training program and the Florence Project in Arizona as part of "impact litigation" to improve mental health services for individuals in immigration detention. Wendy Parmet JD will examine the policy history of and current status of laws that limit access to healthcare for immigrants including refugees in the US; her presentation will review ethical and normative arguments which oppose an expansion of health services for foreign-born individuals. Maya Prabhu MD LLB will consider successes and barriers to providing mental health care to recently resettled refugees in Connecticut and the role of community partnerships. Linus Chan, JD will discuss the ongoing

legal needs of resettled refugees who become involved with the criminal justice system and who find themselves in once again immigration detention at risk for deportation; he will relate their criminal justice involvement to a variety of psychosocial stressors including ongoing mental health issues, difficulties with acculturation and socioeconomic status.

Beyond the Interview: Applying Smartphone Apps, Sensors, and Web Technology to the Process of Clinical Assessment in Psychiatry

Chair: John Torous, M.D.

Presenters: Ipsit Vihang Vahia, M.D., Paul Summergrad, M.D., Laura Germine, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify when it may be appropriate to use smartphone apps for remote monitoring, medication management, relapse prediction, and augmentation of therapy; 2) Understand how wireless sensors can facilitate remote monitoring of behavioral symptoms, with the aid of machine learning algorithms; 3) List three ways that smartphone sensors can provide useful clinical data for monitoring symptoms mood disorders; 4) Recognize how mobile technology can enable new means of cognitive monitoring; and 5) Identifying the barriers, risk, and benefits to patients in using these new technologies for clinical care.

SUMMARY:

Rapid progress in digital and computing technology underscores the potential of smartphone applications, wearable sensors, and web technology for monitoring and delivering psychiatric care. This session will explore the potential of these digital tools for patient care through presentations on the ability and efficacy of smartphone apps, sensors, and web technology to now capture real-time patient-reported symptoms, behaviors, and physiology, and cognitive states across diverse patient populations and disease states, as well as deliver real-time as-needed psychoeducation. In addition to the capabilities and potential, the symposium will also focus challenges created by these digital psychiatry tools including ethical, legal, and privacy considerations. Finally, we will conclude with a

discussion on using digital psychiatry in clinical care and review how the field can best integrate such new technologies without sacrificing the importance of personalized patient care.

Breastfeeding Mothers and Psychotropic Medications: An Update

Chairs: Mercedes Driscoll, M.D., Rita Rein, M.D.

Presenters: Eric G. Meyer, M.D., Lisa Christine Young, M.D., Lindsay K. Works, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe effective counseling strategies for lactating patient on the optimized timing of psychotropic medications utilizing current guidelines; 2) Describe current guidelines for psychotropic medications in lactating women and the favorable pharmacodynamic/pharmacokinetic profile of medications for breastfeeding; and 3) Demonstrate use of expert resources, including LactMed and Infant Risk, as well as the workshop provided quick reference guide including lactation specific H&P.

SUMMARY:

World health experts encourage breastfeeding but many providers may be hesitant to encourage or recommend breastfeeding to patients who require psychotropic medications. Many new mothers, including those on psychotropic medications, have the desire to breastfeed their infant since it promotes multiple benefits including protective effect against respiratory illnesses, ear infection, gastrointestinal disease, allergies and sudden infant death syndrome (SIDS). Additionally breastfeeding encourages significant mother-infant bonding through the release of oxytocin which can help maintain mental health of the mother. Given the positive maternal and infant health effects of breast feeding and the recent societal positive reinforcement, such as “Breast is Best,” patients may discontinue their psychotropic medications due to concerns of transmission to the infant without proper medical guidance. The use of psychotropic medications during lactation has traditionally been a topic that sparked great debate among providers, patients and societal views which often result in conflicting recommendations. The debate centers

around the potential adverse effects on the infant through breast milk transfer versus the risk of destabilizing the mother. All psychotropic medications cross into the breast milk. Through an interactive workshop, participants will learn about why it may be important for psychiatrists to be educated on breastfeeding and what current researched-based guidelines currently recommend. Multiple choice questions and participant input will be used to incite conversation and exchange of ideas as well as enrich clinical practice. The goal is to encourage psychiatrists to support better outcomes for lactating women and to encourage continued breastfeeding in safe clinical situations where patients may have otherwise chosen to not take a medication and/or stop providing breastmilk for their infant.

Children of Psychiatrists

Chair: Leah Joan Dickstein, M.D., M.A.

Presenters: Michelle B. Riba, M.D., M.S., Madeline Dickstein, Laura A. Weinstein, Eric Fornari, M.D., Isaac E. Gallimore, Cathryn A. Galanter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Hear from children of psychiatrists regarding their experiences growing up in a household where at least one parent or guardian was a psychiatrist; 2) Know about the challenges of parenting from other member psychiatrists; 3) Share ways to improve our abilities to parent, as psychiatrists; and 4) Problem solve with the audience regarding some of the challenges and opportunities of having a parent as a psychiatrist.

SUMMARY:

Michelle Riba, M.D. invited me in 1997 to join her in co-creating and co-chairing a workshop for the 1998 annual APA meeting in Toronto, Canada. Our concerns then, and still now, were based on: what makes a good parent, how do you know when you have erred or succeeded and what could we learn from presenters of all ages, i.e., from 6 year olds to 50+ year olds. Over the past 2 decades we have learned so much from all presenters, as well as attendees from all over the world, who eagerly join in the discussions post-presentations. Our children, across these years, and through their years of

education and work, have, at times, felt burdened by their parents' jobs, both at home when they answered the telephone with a voice requesting to speak to their psychiatrist-parent(s), as well as during all their school and work years when colleagues learned of their parent(s)' careers and asked for help, often 24/7. We wanted to be the best parents we could be, despite the stigma we have carried throughout our careers and still do. Yet each year the audience is so involved with similar questions, experiences and sometimes, very creative ways to interact with their children and feel good about their parental roles and accomplishments that the standing room only assigned rooms despite having tripled in size, draw more attendees and gratitude for what they have learned.

Considerations for Psychiatric Pharmaceutical Supply Chains in the Wake of Harvey and Other Disasters

*Chairs: Elspeth Cameron Ritchie, M.D., M.P.H.,
Dennis M. Sarmiento, M.D.*

*Presenters: Megan Ehret, Kenneth E. Richter, D.O.,
Nicholas Peake*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn what psychiatric medications are needed after a disaster which disrupts the supply chain; 2) Know the negative effects of not having adequate anti-psychotic medication; 3) Learn what medications are helpful to first responders; and 4) Understand pharmaceutical supply chain dynamics.

SUMMARY:

Pharmaceutical supply chains are often focused on medical drugs, such as vaccines and antibiotics. While these are important, also critical are psychiatric medications, such as antipsychotics, anti-anxiety medications, anti-depressants, methadone and sleep aids. The latter are not contained in the CDC stockpiles. In the aftermath of a major disaster, such as Hurricane Katrina, pharmaceutical supply lines are disrupted. Often the wealthier can flee the affected area, and those left in the shelters are the poor, sometimes addicted to opiates or alcohol. Many are also severely mentally ill. A lack of medications to treat withdrawal and addiction

commonly leads to disruptive behavior, which may manifest as confrontations with police, or robbing and stealing to obtain opiates or methadone. A lack of anti-psychotic agents causes hallucinations and delusions to emerge. Withdrawal from alcohol, without benzodiazapines, can be life threatening. First responders often work for long hours, and can have difficulty in sleeping when the shifts are over. For them, short term sleep aids such as Ambien may be very useful. In the longer term, eg weeks to months, many affected residents develop depression, anxiety or PTSD. Anti-depressants may be helpful during this period. In brief, it is critically important for emergency managers to consider psychiatric medications in their planning. There are also parallels in military psychiatry. Being deployed can interrupt an individual's personal supply chain and medical planners must consider which medications to deploy with.

Fact, Fiction, or Fraud: Clinical Documentation in Electronic Health Record Systems

Chair: Seth M. Powsner, M.D.

Presenters: Junji Takeshita, M.D., Carlyle Hung-Lun Chan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review challenges and pitfalls when documenting clinical encounters in common EHR (electronic health record) systems; 2) Identify specific EHR constraints that participants find impede their regular work, if not already mentioned; 3) Demonstrate practical adaptations to EHR constraints; 4) Demonstrate proper coding to bill appropriately based on a clinical encounter and its documentation; and 5) Demonstrate proper coding to bill appropriately based on a clinical encounter and its documentation.

SUMMARY:

In hospital based practices hand written notes have become an anachronism. Even in private practice, federal reimbursement policies and "meaningful use" requirements have pushed the remaining clinical world towards adopting Electronic Health Records (EHRs). This brave new world of electronic documentation is fraught with potential missteps. Our workshop will address some of the promises and

pitfalls of EHR. Fact: Medical records are legal documents. They also serve as vehicles for communicating to other health professionals, and as a way for treating psychiatrists to review past events / decisions. We will discuss who should have access to psychiatric records. We will review in greater detail the various purposes of documentation including legal, HIPAA and special expectations for alcohol and substance abuse populations. We will also examine the role and content of psychotherapy notes. Fiction: Not all entries in daily EHR entries are useful. We will examine uses and abuses of EHRs including: copy-and- paste, drop downs, scripts, intentional omissions, errors, templates, and use of speech recognition software. We will recommend tactics to avoid these traps. We will also explore ways to produce readable, understandable clinical entries. Comprehensible, not just legible notes, are possible. And it is possible to address the needs of a variety of readers, from nursing staff and covering clinicians to utilization review staff. Fraud: While fraud is rarely deliberate, it is no small task to provide proper documentation for a given level of service, to ensure proper billing. Both over-billing and under-billing are genuine causes for concern in any audit. Likewise, auditors may suspect fraud, rather than just keyboard fatigue, when clinical exam findings are copied forward day after day, one progress note to the next. We will review suggestions to substantiate the various levels of service. To reinforce the concepts presented, participants will be provided with cases of simple narratives of patient encounters. Their task will be to document on paper forms formatted to simulate the fixed options of EHR documentation and coding. Then they will share and review these with the presenters and their colleagues to correct misunderstandings and improve their documentation skills. Depending upon the number of participants, we may break into smaller groups.

Future of the DSM: An Update From the DSM Steering Committee

Chair: Paul S. Appelbaum, M.D.

Presenters: Ellen Leibenluft, M.D., Kenneth Seedman Kendler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) To understand the vision for the future revisions of the DSM; 2) To have an awareness of the criteria that must be met for changes to be made to the classification; and 3) To appreciate the process by which revisions will be undertaken.

SUMMARY:

The purpose of this workshop is to introduce the psychiatric community to the APA's vision for the future of the DSM, and the process that has been created to consider iterative changes to the DSM-5. The new process involves making changes on a rolling basis, as warranted by advances in the science of mental disorders. This approach differs from the previous mechanism for making changes to the DSM, which was to revise the manual in its entirety at variable intervals. Although the older approach had the advantage of facilitating standardized communication among users of the classification, it slowed the incorporation of new scientific knowledge into the manual as it emerged. Anyone can initiate the process for consideration of a proposal for changes to the DSM via the DSM-5 website (<https://www.psychiatry.org/psychiatrists/practice/dsm>). Proposed changes may include changes to an existing diagnostic criteria set, addition of a new diagnostic category or specifier, deletion of an existing diagnostic category or specifier, or corrections and clarifications of the existing document. Proposals require the submission of supporting information in a structured format, including the details of the proposed change, reasons for the change, the magnitude of change, data documenting improved validity across a range of validators, evidence of reliability and clinical utility, and consideration of potential deleterious consequences associated with the proposed change. Explicit criteria regarding the type of evidence that is expected to be submitted are available on the website, which also provides an opportunity to upload supporting data. The revision process is overseen by a Steering Committee of experts in psychiatric nosology, research, and practice. The process is also summarized on the website. Five standing Review Committees work with the Steering Committee to review proposals, consider the supporting evidence, and undertake literature

reviews and expert consultations as needed. Steering and Review Committee members have been vetted for conflicts of interest using the same standards as for DSM-5. Proposals that are determined to have sufficient supporting evidence will be posted for public comment. The Steering Committee's recommendations, along with a summary of public comments, will be forwarded to the APA Board of Trustees for final approval. This workshop will review the criteria by which proposed revisions will be judged, and the process that interested clinicians and researchers can follow to submit proposals for revisions. Ample time will be available to interact with the chair and vice-chairs of the Steering Committee.

Grassroots Advocacy: How Medical Students, Residents, and Early Career Psychiatrists Can Affect the Legislative, Regulatory, and Political Process

Chairs: Jose P. Vito, M.D., Sabina Rajesh Bera, M.D., M.Sc.

Presenters: Ledro Justice, M.D., Laura M. Willing, M.D., Sage Bauer

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize that getting involved in the political process at all levels of government as an advocate is essential to protecting the safety of patients and the future of the psychiatric profession; 2) Learn and practice about the value-added government relation services that the APA provides to its members; 3) Learn and recognize more about the Jeanne Spurlock Congressional Fellowship, particularly how the program can provide opportunities for psychiatric residents to work on Capitol Hill in Washington, DC; and 4) Understand and identify concrete ways to become involved in advocacy at the local, state, and national levels while trainees or early career psychiatrists.

SUMMARY:

It is essential for psychiatrists, especially members-in-training, as grassroots advocates to set and shape mental health policy agendas at all levels of the government. Effective grassroots advocacy efforts passed mental health parity laws, defeated scope of practice legislation, and increased Medicare/Medicaid funding in various states over

the years. The crisis in the public mental health care system in our country makes public and government advocacy a crucial mission for all APA members. This workshop will help you become more familiar with the resources and skills needed to develop an effective state strategy for educating the public and influencing local legislatures and other decision-makers about issues such as access to care, the crisis in funding in the public mental health care system, and the impact of scope of practice issues on safe and effective patient care.

Human Trafficking: Focused Evaluation of the Problem and Response in Southern California

Chair: Eric Rafla-Yuan, M.D.

Presenters: Stephanie Martinez, M.D., Lawrence Malak, M.D., Priti Ojha, M.D., Steve Hyun Koh, M.D., Eric Rafla-Yuan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the impact of human trafficking and its relevance for mental health professionals; 2) Discuss different models that have historically been utilized to identify and protect potential victims of human trafficking, including prevention, protection, and prosecution; 3) Review screening protocols and discuss strategies to identify and protect potential victims of human trafficking who come into contact with the healthcare delivery system; 4) Explore the application of a novel, evidence-based, and multi-pronged project that has been designed to serve potential, current, and former victims of human trafficking in San Diego County; and 5) Attendees will learn the importance and impact of engaging local, state, and nationwide stakeholders in these settings in order to make sustainable progress.

SUMMARY:

Human trafficking is a serious crime estimated to affect approximately 20 million individuals in at least 152 countries, with the majority of victims being women and children. Victims are trafficked for a multitude of reasons, including sexual exploitation, domestic servitude, and forced labor. The restriction of movement, deplorable living conditions, and violence and abuse common in human trafficking lead to significant mental health sequelae in

trafficked persons. Additionally, identification of possible victims is difficult, in part because victims seldom self-identify and clinically validated screening tools are lacking. There is an immense need for assistance for victims of human trafficking in Southern California, including San Diego County. It is estimated that the size of the illicit sex economy in San Diego in 2013 was \$810 million dollars and San Diego is ranked by the FBI as one of the nation's 13 highest areas of commercial sexual exploitation of children. Multiple strategies have been utilized to identify and protect potential victims of human trafficking, including prevention, protection, and prosecution. Models in healthcare have mainly addressed providing resources and disseminating services to potential victims. Additionally, health care providers are one of the few professionals likely to interact with trafficking victims while they are still in captivity. UCSD Human Trafficking Screening and Awareness Program (HTSAP) The UCSD Department of Psychiatry, in collaboration with County of San Diego Behavioral Health Services as well as multiple other community partners, has developed the Human Trafficking Screening and Awareness Program (HTSAP) which targets four main objectives: 1) development of strategies to increase identification of human trafficking victims, 2) the implementation of trainings for professionals and community members, 3) the creation of an active coalition aimed at improving outreach and referral services, and 4) the increased awareness of human trafficking. Specific interventions include development and the implementation of evidence based screening protocols, curriculum development, educational trainings, development of a united and powerful coalition, outreach events aimed at engaging both foreign and domestic victims, and dissemination of Look Beneath the Surface and HTSAP designed public awareness campaign materials. In order to effectively monitor the program's progress, performance evaluation criteria have also been developed, which include both quantitative and qualitative milestones. It is our hope that the HTSAP will be a successful and sustainable program in raising awareness for trafficked persons, increase the identification and referral of potential victims to services, and provide instructive outreach. Continuing to engage local,

state, and nationwide stakeholders will be instrumental in reaching these goals.

Improving Access to Psychiatric Care

Chair: Sunil D. Khushalani, M.D.

Presenters: Robert Paul Roca, M.D., M.P.H., Antonio DePaolo

Discussant: Harsh K. Trivedi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session, the participant will be able to describe an overview of access problems in psychiatry and elaborate two reasons for this problem; 2) At the conclusion of this session, the participant will be able to articulate the net impact of access problems in psychiatry; and 3) At the conclusion of this session, the participant will be able to enumerate two performance improvement tools to improve access in psychiatry.

SUMMARY:

As we work towards improving quality, safety and delivery of psychiatric care; make progress towards reducing stigma; and make getting psychiatric care more appealing, the demand for psychiatric services will keep growing. There is currently a huge shortage of appropriate and adequate professional resources on the supply side. The psychiatric work force is also beset with challenges like an aging and an overwhelmed workforce, a great proportion of which is experiencing, or at risk of experiencing burn out. There is also the fact that the current workforce is spending a significant portion of their time in documentation and dealing with administrative burdens, in addition to helping the patient population navigate a highly fragmented health care and social support system. Given a limited number of professionals, these activities take time away from actual patient care and further limit the supply of these valuable resources. All of these convergent forces bring access to psychiatric healthcare in the spotlight. There are long wait times to get into outpatient clinics especially for specialized services like pediatric or geriatric psychiatric care and care for trauma specific treatments or addiction treatment. It is also quite difficult to get into an inpatient psychiatric facility, especially if a patient is

psychotic, aggressive, or struggling with developmental disorders, trauma disorders or co-occurring disorders. A large proportion of the population with mental health issues receives no care, which leads to problems such as boarding in ERs, and delays in getting the appropriate diagnosis and treatment. The burden of care has also shifted to more expensive resources like hospital care, care in ERs, or shifts the costs to jails or prisons. This can also lead to poorer outcomes like suicides, violence, disability, poorer health outcomes, readmissions and homelessness to name a few. Improving access to psychiatric care is critical in order to achieving the Triple Aim- improving care, improving health of the population at a lower per capita cost. In this workshop, we describe a broader overview of the problem; a summary of efforts within an organization to improve access; performance improvement ideas that can help with this challenging problem; and a case study of improving access from a large mental health care system.

Innovations in TMS to Build Well-Being

Chairs: Michelle R. M. Cochran, M.D., Ramotse Saunders, M.D.

Presenters: Richard Pitch, M.D., Richard A. Bermudes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Present clinical research supporting the use of TMS; 2) Present insights into the application of TMS and how it fits into the general psychiatrist's practice; 3) Give short didactics, case examples, and an interactive format to aid attendees in educating their patients, referring or treating patients themselves; 4) Highlight new therapeutic techniques and provide guidance on combining treatments and monitoring patients receiving TMS with validated measures; and 5) Teach workshop attendees how to follow patients during and after treatment and how to best care for patients to retain wellness.

SUMMARY:

Transcranial Magnetic Stimulation (TMS) was cleared by the FDA ten years ago in 2008, for adult patients with depression who have not benefitted from prior antidepressant medication. There are a number of

reasons why the general psychiatrist should be knowledgeable about TMS. There has been a growth in the number of TMS specialty practices internationally and in the United States. TMS is increasingly being studied as a therapeutic tool in many neuropsychiatric conditions (e.g., pain, addictions, depression in bipolar disorder, adolescent depression, PTSD, ADHD, Autism Spectrum Disorders). Furthermore, a significant proportion of patients with major depression treated with antidepressants do not fully respond. In a recent meta-analysis reviewing TMS therapy for major depression, the authors concluded that for patients with major depression who have not responded to two or more antidepressants, TMS is a reasonable treatment approach. Most major private and public insurance plans now have coverage policies for TMS therapy covering over 350 million individuals. Thus, the general psychiatrist will have more patients who have clinical indications and access to this treatment modality. In this workshop, participants will learn how to select patients for TMS therapy, co-manage patients, provide aftercare for patients once they have completed TMS treatment, and understand what to expect from TMS in general. In this workshop participants will learn how to select patients for TMS therapy, co-manage patients receiving TMS, provide aftercare for patients once they have completed TMS treatment and understand what to expect from treatment.

Involuntary Admission: Are We Helping or Causing More Harm?

Chair: Nazanin Alavi, M.D.

Presenters: Farooq Naeem, M.B.B.S., Megan Anne Yang, M.D., Taras Romanovyc Reshetukha, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the advantages of involuntary admission and its role in offering patients the best care available; 2) Understand the disadvantages of involuntary admission and its effect on patient-physician relationship; and 3) Understand methods to improve the quality of care in involuntary admissions.

SUMMARY:

Involuntary hospitalization in those presumed to be

mentally ill has been a common practice for many years and in many societies. Granted that an involuntary hospitalization is at least an unpleasant experience for many patients, the question is that what are the positive results for them and for the public? Although some patients are hospitalized for aggression because of organic problems such as confusion and disorientation, it should be pointed out that two-thirds of the patients are not hospitalized because of dangerousness to others but rather on the basis of the threat they pose to themselves. Although these patients need attention regarding their mental illness, the question is how much these patients will benefit from involuntary admission and what the long-term outcome would be. Many rules and regulation exist for initiating involuntary admission but enforcement of proper conduction of involuntary treatment is still a grey area. There is no standard mechanism employed to ensure that involuntary treatment is being appropriately and justifiably used. Limited research is alarming in regards to regulation and involuntary treatment. As a result, safety and effort to preserve human rights of patients is of major concern today. First Dr Reshetukha and Dr. Yang will talk about advantages of certifying a patient. They will discuss that Mental health acts secure the safety of vulnerable people and help to regain control on their lives. Second Dr Alavi and Dr. Naeem will talk about disadvantages of certifying a patient. They will talk about patients' experiences of violations of autonomy and their feelings about their rights being taken away; not given options and having no say in decisions regarding their treatment. Third Dr. Yang will talk about improving satisfaction with care, in involuntary admissions. She will discuss that patients' characteristic and treatment component could be some of the differences of their satisfaction outcomes. Accordingly, through the recognition of these factors, new treatment approaches could be utilized.

Involving Families in the Assessment and Treatment of Patients in Different Clinical Settings

Chair: Gabor Istvan Keitner, M.D.

Presenters: Ira David Glick, M.D., Carlos E. Sluzki, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the usefulness of including families in the assessment and treatment of patient's problems in a variety of clinical settings; 2) Teach practical ways in which families can be included within the time available; and 3) Help clinicians to feel more comfortable to meet with families.

SUMMARY:

There is consistent evidence that long-term treatment of most psychiatric disorders requires ongoing involvement of the family as part of effective comprehensive care. Family interventions can facilitate recovery from an acute episode and reduce the risk of relapse. Many clinicians, however, are uncomfortable meeting with the families of their patients. When family meetings do take place, the main focus tends to be on the identified patient, gathering more information on his/her presenting problems, family history of mental illness and the availability of social support. Family meetings may also be used by clinicians to give their opinion about the patient's problems and recommendations for treatment. Clinicians worry about meeting with families for fear of breaching patient confidentiality, losing control of the interactive process and becoming embroiled in emotionally charged time consuming side issues. On inpatient units family connections are often made by non-medical allied mental health professionals. In general psychiatrists have very limited training in thinking systemically about patient problems and even less training in conducting family meetings, leaving them uneasy about engaging in a process they do not feel they can control. This is unfortunate as families are usually a very significant resource, not just for information about the patient but also as collaborative participants in the treatment process by helping to create a less stressful home environment and support compliance. This workshop will describe ways to conduct family meetings in inpatient, outpatient and community hospital settings. The focus will be on practical ways to establish a constructive connection with a family, elicit their perspectives on ongoing problems and help them become part of the treatment process. Emphasis will be placed on techniques to keep the interactive process within an acceptable time frame

without alienating the family. There will be time allocated for feedback and questions from participants.

Joining the Conversation: The Role of Psychiatry in Radio

Chair: Carol Ann Bernstein, M.D.

Presenters: Diya Banerjee, M.D., Owen S. Muir, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explore how psychiatrists are involved in radio programming and podcasts today; 2) Identify the strengths and weakness of the medium; 3) Learn about what goes into making and producing audio, and about what opportunities are available; and 4) Practice proposing and creating radio and podcast content.

SUMMARY:

The academic world, like the world in general, is plagued by the problem of silos - these arise when like-minded people create a community in isolation, sharing information that travels through a closed loop. Psychiatry is not immune to this phenomenon, and clinicians often find themselves drowned out in the larger discourse on topics like wellness, suicide and criminality. One way to break through the noise is to employ a different technological medium - in particular, audio programming. This workshop will take a closer look at how psychiatrists are involved in radio and podcast content, and will discuss unique advantages and weaknesses of this format. We will look at specific examples of shows and podcasts, and discuss what practical steps are involved in creating this kind of media. Participants will practice proposing and participating in the creation of audio content, with an emphasis on ways to reach and engage diverse audiences. The speakers in this workshop will include a psychiatrist who runs a radio show, and two clinicians with experience in creating podcasts.

Medical Conditions Mimicking Psychiatric Disorders Versus Psychiatric Disorders Mimicking Medical Conditions: Diagnostic and Treatment Challenges

Chair: Catherine C. Crone, M.D.

Presenters: Thomas Nathan Wise, M.D., Andrew Matz, M.D., Krishna Kishore Kilaru, M.B.B.S., Neda

Kovacevic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To enhance differential diagnostic skills of trainee/psychiatrist through case material to educate attendees about medical conditions that may present with significant psychiatric symptomatology; 2) To enhance differential diagnostic skills of trainee/psychiatrist through case material to educate attendees about psychiatric disorders that may mimic medical conditions; and 3) To improve awareness of trainee/psychiatrist regarding the significant comorbidity between psychiatric and medical conditions.

SUMMARY:

During the course of residency training, significant efforts are made to instruct residents about the recognition and treatment of primary psychiatric disorders such as major depression, bipolar disorder, post-traumatic stress disorder, panic disorder, and schizophrenia. However, exposure to cases that initially appear to be primary psychiatric disorders but are actually due to underlying medical conditions is often lacking, despite their common occurrence. Infections, hypoxia, electrolyte imbalances, endocrine disorders, autoimmune disorders (e.g. lupus, sarcoidosis) neurologic conditions (e.g. epilepsy, multiple sclerosis, delirium /encephalopathy) and medications are just some of the causes of patient presentations that mimic primary psychiatric disorders. Awareness of these "mimics" is needed by both trainee and practicing psychiatrist as patients may otherwise appear to have "treatment-resistant" psychiatric disorders or, of greater concern, actually worsen when given psychotropic medications. An additional area of clinical knowledge that would benefit both residents and psychiatrists out in practice is the recognition and management of psychiatric disorders that mimic medical conditions. Limited exposure to psychosomatic medicine during training may result in lack of experience with conversion disorders, somatization disorders, and factitious disorders. These are patient populations that are often responsible for excessive utilization of medical resources and healthcare dollars as well as being

sources of mounting frustration and misunderstanding for medical colleagues. Requests for psychiatric involvement are not unusual, especially when medical work-ups are negative yet patients persist in their requests for medical/surgical intervention. The following workshop aims to provide with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatoform disorders (medical mimics) in a case-based format with opportunities for questions and discussion with residents, fellows, and attending physicians with experience and/or expertise in psychosomatic medicine patient populations.

**Motivational Interviewing and Addiction 2018:
Learn the Essentials, Practice Your Skills, and Help
Your Patients Change**

Chair: Carla B. Marienfeld, M.D.

Presenters: Petros Levounis, M.D., Bachaar Arnaout, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Contextualize motivational interviewing in the context of current understanding of addiction; 2) Describe the new terminology for the spirit and processes based on the third edition of Motivational Interviewing; 3) Practice the skills and the four processes of Motivational Interviewing in interactive small and large group formats; and 4) Review how to use the new Motivational Interviewing approach in everyday clinical practice.

SUMMARY:

Motivational Interviewing (MI) has been transformational in medical care. Despite being released in 2013, the approach and spirit in the third edition of Motivational Interviewing has only very slowly made its way into the armamentarium of most clinical psychiatrists, even those who work hard to help patients change behaviors. Indeed, the third edition contains a more streamlined four process approach that does not utilize even some of the most famous principles and skills from prior iterations. MI requires continual practice and skill refinement. This workshop seeks to build upon known concepts in MI and update those with the latest terminology, understanding, uses, and skills in

MI using a combination of didactics and interactive large and small group sessions. This will be done contextualized within the realm of addiction treatment and advances in care, but the skills are generalizable to all areas of psychiatry where clinicians are working to help patients change behaviors. MI is of special importance because it can be viewed as the essential clinical skill for engaging patients in treatment and motivating patients to reduce substance use and to follow through with specific behavioral or pharmacological treatments recommended. It is also challenging to master. In their Third Edition (Miller and Rollnick 2013), the dimensions of the Spirit of MI have been refined and expanded, consisting of: Partnership, Acceptance, Compassion, and Evocation. In the conversation toward change, MI utilizes four processes: Engaging, Focusing, Evoking, and Planning. Greater emphasis is needed on preventive health care, and on helping patients to give up destructive substance use and to make other changes toward healthier lifestyles. We need to be more effective at motivating our patients toward healthy behavior. Reinforcing and updating one's knowledge and skills in MI, as MI evolves to be more useful and understood, is an essential part of the basic skills needed by any clinician working to help patients change their behaviors.

**Promoting Mindfulness in Medical Education:
Building Student Well-Being Through Curricular
Innovation**

Chair: Lisa Merlo, Ph.D.

Presenters: Brian K. Cooke, M.D., Melanie Hagen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the current state of medical student distress, burnout, depression, and substance use; 2) Understand the benefits of mindfulness and meditation in the practice of medicine; 3) Participate in various forms of mindful meditation practice; 4) List components of an innovative elective "track" for medical students focusing on mind-body medicine techniques to improve personal wellbeing and patient care; and 5) Describe student feedback following participation in the curriculum.

SUMMARY:

Recent data have highlighted significant levels of distress and low levels of wellbeing among medical students worldwide. Although newly-matriculating medical students generally begin medical school with better mental health than age-matched peers, rates of burnout, depression, and suicidality increase significantly over the course of medical training. Substance use disorders are relatively common, and many medical students lack basic coping skills to manage the challenges of medical school and practice. In this workshop, we will review results of published research, as well as our own statewide study of medical students, to educate the audience regarding the current mental health climate for physicians in training. Barriers to medical student wellbeing will be explicitly discussed. Medical student vignettes and quotations will be used to emphasize key points from the empirical data. Next, the literature on mindfulness, including meditation practice, will be introduced and discussed specifically within the context of benefits for medical practitioners. The audience will be provided in vivo introduction to various forms of meditation and encouraged to reflect on their experiences. This will set the stage for discussion of an innovative curriculum that was developed at Georgetown University School of Medicine and adapted for inclusion at the University of Florida College of Medicine. Logistical and conceptual aspects of the program will be reviewed. Finally, results of a preliminary study assessing medical student response to participation in the innovative curriculum will be presented. Both quantitative and qualitative data indicated that students (N = 16) were satisfied with the course. Indeed, 100% indicated they would “definitely recommend” participation to their peers, and 100% reported that the time commitment (i.e., 22 extra hours of classroom time during the spring semester) was “definitely worth it.” However, results were mixed regarding whether they believed the course should be mandatory for all students. Though some noted that “Any exposure students can get [to mindfulness training] is beneficial,” others noted that, “You have to be in the right mindset to ‘buy in’ to the mentality. Also, the trust in the group is built on the fact that we all chose to be here.” Nevertheless,

students uniformly described a positive benefit to participation. As one student noted, “[It] challenged me in ways I did not expect to be challenged-but certainly needed.” Another said, “It has helped me serve as a more balanced medical student, partner, sister, daughter, and friend. I am better able to use my mind as a thermostat, making adjustments throughout the day as my mood changes and I experience things beyond my control.” These results and others will be discussed, along with suggestions for incorporating a similar program at other institutions. Questions from participants will be encouraged throughout the workshop.

Rediscovering Clozapine: Old Solutions to New Problems

Chairs: Pratik Bahekar, M.B.B.S., Tarah Liana Scanlon, M.D.

Presenters: Richard H. McCarthy, M.D., Srinath Gopinath, M.D., Jeremy David Coplan, M.D., Michele Tortora Pato, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about clozapine's unique mechanism of action, and its relation to salience of symptoms; 2) Understand use of clozapine and why less proportion of population get clozapine trial in the USA than Australia, & China; 3) Learn about the evolution of a single FDA approved registry REMS, in context of psycho-genomics and variable risk of agranulocytosis in different ethnic groups; 4) Recognize and manage side effects, augmentation strategies & decide length of clozapine trial. Under what circumstances could clozapine be tapered off and treatment should be discontinued?; and 5) Identify and address prescriber and consumer bias of clozapine by conducting audience straw poll.

SUMMARY:

Clozapine remains one of most effective treatments for schizophrenia. Curiously, clozapine & dopamine were discovered within a year of each other. Clozapine is finally being ushered into the new millennium with the creation of a unified registry, REMS. There has been a growing interest in the use of Clozapine as indicated by the consistent increase in the number of research publications over the last 5 years. Clozapine accounts for <5% of antipsychotic

prescriptions, despite that 20- 30% of patients are treatment resistant. Panelist will discuss why Clozapine use is so limited in the USA as compared to other countries. Not only is the morbidity & mortality of treatment resistant schizophrenia less with clozapine, due to decline in suicidality, but also studies show that clozapine may also improve general wellbeing. Dopamine plays a role in the mediation of the “salience” of environmental events & internal representation, which is altered by antipsychotics. Specifically, D4 modulates the behavioral acquisition of emotional associative memories. Clozapine demonstrates a higher affinity for the D4 receptor than the D2 receptor. A six-week clozapine trial has shown domain-specific gains on motor & mental speed, visual spatial manipulation & verbal learning. Didactic approach on neurobiology & novel biological strategies will also include augmentation strategies with NAC & use of Fluvoxamine as an adjunct to alter the Clozapine to Norclozapine ratio, to improve working memory. Earlier assessments suggest a relatively low affinity for the D2 receptor & high affinity for the 5-HT2 receptor, resulting in a high 5-HT2/D-2 ratio which most distinguishes clozapine. Fast dissociation from D2 receptors makes it more accommodating of physiological dopamine transmission, permitting an antipsychotic effect without motor side effects, prolactin elevation, or secondary negative symptoms. A relatively unique EPS-free profile in Parkinson’s Disease, which has been attributed not only to clozapine’s low D2 antagonism, but also antagonism (or inverse agonist) activity at the 5-HT2A receptors. Reluctance in prescribing clozapine is due to less experience & knowledge of the medication. By conducting audience straw polls, the panelist’s will identify & address biases towards prescribing clozapine. A discussion will promote an understanding of REMS, in context of psychogenomic & differential ethnic rate of agranulocytosis. We aim to draw a contrast between monitoring mechanisms in other countries who have higher prescription rates & the USA. By fostering further education on “adequate” clozapine trial, management of side effects with a special focus on blood dyscrasias, cardiomyopathy, constipation & discontinuation symptoms, this workshop will attempt to engage the audience by identifying ways to overcome the barriers.

Representation Matters: Diversity Issues in Recruitment

Chair: Qortni Ashli Lang, M.D., M.S.

Presenters: Tresha A. Gibbs, M.D., Robert Osterman Cotes, M.D., Patrice Karen Malone, M.D., Ph.D., M.S.

Discussant: Maria Antonia Oquendo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain increased knowledge about data on representation of underrepresented minorities (URM) in medicine and psychiatry; 2) Identify specific evidence that demonstrates the importance of URM physicians in reducing healthcare disparities and improving patient outcomes; 3) Gain awareness of awareness of specific programs that target URM recruitment at various points in the pipeline including undergraduate, medical school, and residency recruitment; and 4) Identify recruitment strategies for URM that may be applied in residency training programs.

SUMMARY:

The issue of increasing representation of underrepresented minorities (URM) in the physician workforce has been highlighted as a “healthcare crisis.” A more diverse workforce has the potential to improve medical training and reduce healthcare disparities. Physicians from URM are more likely to work in socioeconomically disadvantaged and unreserved communities. Recently the dearth of African American men in medicine as a whole has been of increasing concern, with the rates of recruitment of African American men unchanged from the 1970s. With this workshop we would like to explore the facts related to this issue and also look closer at what is being done in psychiatry to increase recruitment of URM to psychiatry in particular. We will use a multi pronged approach to understand the current recruitment data, discuss what pipeline programs exist, gain insights from the residency recruitment process and hear personal stories from URM psychiatrists through a focused video presentation. The present workshop will seek to educate psychiatrists on the importance of recruiting a diverse workforce and explore current data on recruitment of URM in medicine and psychiatry.

With a focus on recruitment of African American men, we will provide insight into a specific ethnic minority group that has disproportionately experienced health care disparities and is also underrepresented in medicine and psychiatry. During the panel discussion, we will discuss residency recruitment strategies to enhance diversity in the residency class and explore the characteristics of residency programs that have been more successful to this end. The panel will also discuss the role of pipeline programs that exist to recruit more URM students into psychiatry. The panel will highlight challenges and workable strategies to overcome them in order to bring about a more diverse physician workforce.

Saying “Au Revoir” to Career Blahs While Staying in the Game

Chair: Jane Brown Sofair, M.D.

Presenters: Joseph C. Napoli, M.D., Naomi Joyce Weinshenker, M.D., Charles Peter Ciolino, M.D., Laura LoGiudice, Esq.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Comprehend the nature of physician burnout and its public health implications; 2) Understand several entrepreneurial pathways adapted by peers to enrich their own practice of psychiatry; 3) Review risk management and ethical considerations with regard to an additional career pursuit; and 4) Design an entrepreneurial proposal and have received supportive feedback from the co-presenters.

SUMMARY:

The finding that over 50% of physicians are unhappy in their work is receiving due attention of late. A 2015 Mayo Clinic result that 54% percent of U.S. physicians reported at least one symptom of professional burnout, a nine percent increase over three years, is becoming an almost commonplace statistic. (1, 2). Physician wellness programs started some thirty-five years ago were designed to address the needs of the ten percent of truly impaired physicians. (3,4) Wellness, however, has shifted from fixing dysfunction to promoting basic professional survival in an era when many doctors grapple with daily workplace aggravations. These include high

patient volume, excessive paperwork, dwindling insurance re-imbursments, ever evolving healthcare technologies, time consuming re-certification requirements, and the perpetual fear of malpractice lawsuits (5) An allied public health concern is whether there is an association between mounting burnout rates and medical staffing shortages, with the federal government maintaining an additional 2,800 psychiatrists are needed to cover the current mental health care need (6). That said, any such association remains at best speculative and inconclusive. A Canadian study, for example, was null with regard to demonstrating any direct link between degree of commitment to staying on the job and demoralization (7). Efforts toward the prevention of burnout, particularly during residency, are of paramount importance. Studies stratified by years in practice consistently show middle career physicians to be at the highest risk for professional fatigue. One reason may be that expectations are higher than for those just out of training or on the verge of retirement. While burnout antidotes abound, these do not commonly include starting a second career. Moreover, if relatively seasoned physicians feel the need to branch out in order to stay in psychiatry, then the subject matter is worthy of discussion. This workshop will focus on how psychiatrists can manage their own potential for professional fatigue through entrepreneurial pathways. Three co-presenters all active in psychiatric practice, will each describe their own unique and fascinating journey into the areas of 1) television and media, 2) community resiliency coaching, and 3) photography. The fourth presenter, a health care attorney, will then review how to assure that a side business does not pose an ethical or legal dilemma while also exploring social media issues. The final 30 minutes of the workshop will be devoted to inviting audience participants to develop their own entrepreneurial proposals on a worksheet based on the four quadrant model outlined by Manion (8). with supportive coaching offered by the panel.

TD or Not TD: Movement Disorders Every Psychiatrist Should Know

Chairs: Stanley N. Caroff, M.D., E. Cabrina Campbell, M.D.

Presenters: Cynthia Comella, M.D., Jonathan M.

Meyer, M.D., Stewart Factor, D.O.
Discussant: John Michael Kane, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand and state principles for observation and examination of patients presenting with different movement disorders; 2) Identify hypokinetic movement disorders presenting with parkinsonism or tremor; 3) Identify hyperkinetic movement disorders presenting with dystonia, chorea, athetosis and tics; 4) Recognize the range of movement disorders that can present as manifestations of tardive dyskinesia; and 5) Differentiate movement disorders that should and should not be treated as tardive dyskinesia.

SUMMARY:

Tardive dyskinesia (TD) is a polymorphic, hyperkinetic movement disorder associated with prolonged use of antipsychotic and other dopamine antagonist drugs. Although often mild, primarily affecting orofacial musculature, and frequently masked by ongoing antipsychotic treatment, TD is potentially irreversible and may be socially disfiguring and disabling, as well as compromise eating, speaking, swallowing, breathing, or ambulation. Although prevailing evidence suggests that the newer generation of antipsychotic drugs are less likely to cause TD at least compared with older high-potency antipsychotics, the risk of development remains significant. Because TD is diagnosed based on its clinical features, and there is a greater chance of resolution with early diagnosis, recognition of complex TD movements is increasingly important for several reasons; older high-risk antipsychotics are still in use; there is a potential risk for TD even with newer agents in susceptible patients; antipsychotics are more widely marketed and prescribed in the population; and thousands of patients already have TD due to prior antipsychotic exposure. Fortunately, two novel agents that act to reduce dopamine neurotransmission by inhibiting vesicular monoamine transporter-2 (VMAT2) have received FDA approval for treatment of TD based on rigorous randomized controlled trials. Although the effectiveness of these agents will be tested in post-marketing real world application, it is essential for clinicians in practice to relearn the lessons of

diagnosing and managing patients with tardive dyskinesia. A major part of this re-education is to become familiar with recognizing, describing, rating, and classifying movement disorders so as to correctly apply the new treatments for cases of TD likely to respond, and to prevent misuse of these drugs for movements (e.g., parkinsonism, tremor or catatonic behaviors) that are inappropriate or even potentially harmed by VMAT2 inhibition. To broaden awareness and knowledge of movement disorders, and to enhance the proper and safe use of new treatments for TD, we plan to present a clear, concise, practice-based, clinical review of the major features of common movement disorders, highlighting the similarities and key differences between TD and non-TD disorders using video-based case presentations. To facilitate visual recognition skills and active discussion, the panel of experts in neurology and psychiatry will present numerous clinical examples in video format, questioning and challenging participants to use their observational knowledge and skills, and to provide a framework for analyzing movements and distinguishing between the various disorders. Reference to web-based resources for continued learning and practice even after the session will be provided. In addition, ample time for questions and discussion will be allotted between presentations and at a general open panel discussion at the conclusion of the session.

The Impact of Social Media and Societal Change on Young Gay Men's Development: Implications for Intimacy, Sexuality, and Psychotherapy

Chair: Marshall Forstein, M.D.

Presenter: Lawrence M. McGlynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify at least three currently available social media through which young gay men learn about gay sexual opportunities; 2) Identify at least two common psychological conflicts in the developmental process of becoming sexually active; and 3) Describe how accessing sexually explicit material confounds or facilitates the internalization and practice of healthy sexual behaviors.

SUMMARY:

Evolving social norms abetted by new technology are

redefining what is discoverable, desirable, and feasible for young gay men exploring personal realms of intimacy and sexuality. On the one hand, legal recognition of same-sex marriage supports the ideal of long-term relationships and the establishment of families; on the other hand, instant hook-up services, unlimited access to pornography, and a reification of masculinity within some gay social worlds has influenced gay men in more complex positive and negative ways. These influences co-exist with cultural values arising from religious beliefs and ethnic-racial identities. In this multi-dimensional context, young gay men must consider critical questions about identity, intimacy, and sexuality as they embark on a wide array of possible developmental trajectories. Monogamy, open, or polyamorous relationships, multiple sexual partners, or casual encounters remain options for the young man beginning to explore what being gay means to him. Early sexual experience may provoke unprotected sexual behavior in the absence of a consolidation of identity including the development of self-protective coping strategies. The role of substances, sexual abuse and racial and sexual prejudice in the development of a consolidated sexual identity will be explored using the biopsychosocial model. This workshop will explore the impact of social constructs, social media, racial/ethnic and religious contexts on the development of identity of gay men and how conflicts present in the clinical setting. Often there is conflict between ideological constructs and internal comfort that presents in unsafe or risky behavior. Case vignettes will be presented to illustrate some of the issues brought to psychotherapy, with attention to the therapist's countertransference. Most of the workshop will be a discussion of clinical cases and therapeutic interventions.

The Therapeutic Relationship in Cognitive Behavior Therapy

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Prevent problems in the therapeutic relationship, including potential counter-transferential issues; 2) Conceptualize alliance problems according to the cognitive model; 3) Use

the conceptualization to resolve therapeutic ruptures; and 4) Use the therapeutic alliance to help patients improve relationships outside of therapy.

SUMMARY:

Some patients (and therapists) bring distorted beliefs about themselves, their worlds, and other people to the therapy session. As a result of their genetic inheritance, their formative experiences, and the appraisal of their experiences, they develop certain "rules for living" and associated behavioral strategies, which may be adaptive in certain situations but are maladaptive in other contexts. Their dysfunctional beliefs may become activated in the context of psychotherapy and they may employ certain coping strategies which interfere with treatment. Conceptualizing relevant beliefs and strategies is fundamental to planning interventions that can not only strengthen the alliance but that also can be generalized to improve relationships outside of therapy. In addition, specific strategies, such as goal consensus, collaboration, and positive regard, have been demonstrated to be important in building the alliance (Norcross & Wampold, 2011).

American Journal of Psychiatry Residents' Journal: How to Publish a Scholarly Manuscript and Cultivate a Career in Academic Psychiatry

*Chairs: Rachel Brooke Katz, M.D., Oliver Glass, M.D.
Presenters: Anna Kim, M.D., Michelle Chang Liu,
M.D., Erin Campbell Fulchiero, M.D., Shawn E.
McNeil, M.D., Helena Winston, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about opportunities available to medical students, residents, and fellows to first-author, edit and review academic manuscripts early in their careers; 2) Determine which article type would be most conducive explore a chosen topic of interest; 3) Optimize the chances that an author's manuscript gets printed in the Residents' Journal; 4) Meet other young psychiatrists and collaborate with trainees in all stages of training; and 5) Identify a path towards a leadership role and/or publication in the Residents' Journal.

SUMMARY:

The American Journal of Psychiatry-Residents'

Journal is a promising vehicle for trainees to first-author, edit and review manuscripts early in their careers. Academic writing is a challenging and fulfilling form of expression that improves with practice. Publishing in peer-reviewed journals opens opportunities to psychiatrists as they begin establishing their careers; however, most residents finish their training without a peer-reviewed publication. The reasons for this are manifold. We suspect that they include a sense that with all the demands of residency training, writing and publishing an article can seem daunting. Furthermore, once an article is written, many trainees struggle to get their work published. This discrepancy between career desire and perceived opportunity might underlie some of the physician burnout that has become epidemic in modern medical cultures. The Residents' Journal hopes to bridge the gap between aspiration and opportunity by providing psychiatrists at all stages of training with a channel for self-expression. This workshop is designed to acquaint medical students, residents, and fellows with the Residents' Journal, such that they emerge confident that they can author a manuscript in the coming academic year. Trainees will become familiar with common errors encountered during the editing process, which may preclude or delay publication. By the end of the workshop, participants will be able to identify and avoid these setbacks. They will understand the many possibilities that the Residents' Journal affords for leadership and ongoing collaboration. We hope that our participants will be able to describe the mission of the Journal and be able to share criteria for involvement with their colleagues and peers. Psychiatrists in all stages of training will engage with one another to help identify ways for trainees to participate in the writing, editing, and peer review of the Residents' Journal. Pioneers in academic publishing will lead short exercises that help participants develop questions that will become building blocks for publishable manuscripts. The workshop will impart valuable skills and connections that will be useful to trainees as they start to build their careers within psychiatry.

An Overview of Motivational Interviewing as a Platform to Revolutionize Your Clinical Practice

Chair: Michael A. Flaum, M.D.

Presenters: Carla B. Marienfeld, M.D., Brian Hurley, M.D., M.B.A., Florence Chanut, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to explain the meaning of the "paradoxical effects of coercion"; 2) Participants will be able to identify the four core components of the "spirit of MI" and the four metaprocesses in MI; 3) Participants will be able to improve their capacity to make simple and complex reflective listening statements; and 4) Participants will be able to describe the concept of mental health recovery, and its consonance with MI.

SUMMARY:

This workshop will provide an introduction to the basics of Motivational Interviewing (MI), with the goal of stimulating participants to look with fresh eyes at how they see their job, relate to their patients and prioritize how they choose to spend the precious clinical time they have with them. Motivational Interviewing was initially developed as an alternative approach to helping individuals with addictive disorders. Since its introduction in the early 1980's, its effectiveness has been demonstrated across a wide variety of disciplines and issues. Its uptake in general psychiatry (i.e., other than in addiction) has been relatively limited thus far in comparison to many other fields, which is surprising in light of its potential utility in common problems such as medication non-adherence, and in helping patients change a wide variety of other problematic behaviors. The session will introduce participants to the fundamentals of motivational interviewing emphasizing the "paradoxical effect of coercion". This idea leads to what is unique in MI relative to other counseling styles, which is the overt effort to structure the conversation such that it is the patient rather than the clinician who is making the argument for change. The session will include discussion and exercises that demonstrate strategies for doing so, along with some of the other basic techniques of MI, with a focus on reflective listening. Finally, while MI was developed in an effort to help people change problematic behaviors, we will suggest that it can also be a very useful default communication style in working with patients with mental illness. In discussing the core elements of the so-called "spirit

of MI” we will highlight the consonance of those elements with those of a patient-centered, recovery orientation. While this workshop is open to all, it is intended especially for those who have had limited or no prior exposure to motivational interviewing.

Beyond the Emergency: How Law Enforcement and Mental Health Providers Can Collaborate for a More Preventative Approach to Crisis and Public Safety

Chair: Margaret E. Balfour, M.D., Ph.D.

Presenters: Chris Magnus, Jason Winsky

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the importance of collaboration between law enforcement and crisis/emergency psychiatric providers in improving outcomes for patients experiencing a psychiatric emergency; 2) Identify ways in which health systems can tailor their clinical and business processes to support law enforcement and first responders; and 3) Apply the concepts learned in this session to enhance his/her own organization's ability to develop collaborative interventions across the crisis continuum.

SUMMARY:

Individuals experiencing a mental health crisis are at increased risk for contact with law enforcement, often with tragic consequences. While programs like Crisis Intervention Training (CIT) provide law enforcement with tools to respond to individuals in crisis, these interventions are focused on the point emergency response. This workshop will describe strategies mental health providers and law enforcement to collaborate on innovative interventions at other points along the crisis continuum, while balancing the interests of compassionate mental healthcare and public safety. Tucson Police Chief Chris Magnus and Sgt. Jason Winsky will describe the Tucson Police Department's unique Mental Health Support Team (MHST) model, which builds upon the CIT foundation to provide a more proactive and preventative approach. MHST detectives analyze non-criminal cases in order to identify and outreach at-risk individuals before the situation escalates to a crisis, while MHST officers specializing in transports for patients in the civil

commitment/AOT system have completed 1000 transports with zero uses of force and decreased SWAT callouts for suicidal barricaded individuals from 18 per year to just one last year. In addition, we will describe our Regional Training Center of Excellence that disseminates mental health training across dozens of smaller and more rural agencies across southern Arizona. Then, Dr. Margie Balfour with Connections Health Solutions will describe how the mental health system collaborates with law enforcement to support the Tucson Model at both the payer and provider level. The Regional Behavioral Health Authority has created performance incentives to facilitate law enforcement collaboration and specialized services such as clinical co-responders partnered with officers in the field. Providers such as the Crisis Response Center tailor clinical and operational practices to facilitate jail diversion via a “no wrong door” approach in which officers can bring individuals for treatment with a < 10 minute drop off time and no behavioral acuity exclusion criteria. The workshop will contain examples of individual cases as well as operational successes and failures so that other programs can share in our lessons learned. We will conclude with a panel discussion and the opportunity participants to discuss successes and challenges in their communities.

Building Engagement and a Community of Practice to Improve Mental Health Within Primary Care: Innovations Using the Project ECHO Model

Chairs: Allison Crawford, M.D., Ph.D., Sanjeev Sockalingam, M.D.

Presenter: Eva Serhal, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the Project ECHO model and the gaps in healthcare delivery it proposes to solve; 2) Demonstrate how technology can be leveraged to increase engagement and capacity in mental health education; 3) Learn how librarians can be integrated into virtual learning models to support the effective search and use of best-practice evidence; and 4) Describe how innovative learning models such as ECHO can use technology to reinforce learning and identify learning needs.

SUMMARY:

A high proportion of mental health and addictions are managed in primary care; however, primary care providers (PCP) have limited access to psychiatric support. While the rise of collaborative care has provided one answer to this growing need, challenges to building mental health capacity in primary care still exist, particularly in remote and under-serviced areas. Project Extension for Community Healthcare Outcomes (Project ECHO) is a 'Hub' and 'Spoke' tele-mentoring model that uses a virtual community of practice to leverage scarce healthcare resources in rural communities. PCPs connect with a specialist team as well as providers practicing in similar settings to discuss complex real-world patients, share knowledge, and learn best practices in the management of complex chronic illness. The Project ECHO model has been adopted globally for the treatment of various conditions including Hepatitis C, HIV and diabetes; however, its use in mental health and addictions has been limited. The Centre for Addiction and Mental Health (CAMH) and the University of Toronto (UofT) launched the first Canadian Project ECHO focused on mental health care, ECHO Ontario Mental Health. In this workshop, we will describe the Project ECHO model, how it can be used to build specialized mental health capacity in PCPs, and how technology can be leveraged to increase engagement and community building in a virtual milieu. With these innovative approaches, and fidelity to the ECHO model, participants strengthen knowledge transfer and build adaptive expertise over time. The implementation of an online community of practice website, low bandwidth videoconferencing, online user chat functions, and in-session polling software has supported PCPs to engage with one another and with the session materials in an interactive way. In addition, the innovative approach of integrating a librarian on the expert panel has enabled our team the opportunity to provide ongoing support to primary care providers that is responsive to their learning needs. During these sessions, technology is utilized as an innovative approach to engage participants, reinforce learning, and identify new learning needs. Further, the community of practice provides opportunities for between-session learning (e.g., re-watching session videos and reviewing

librarian provided resources) as it reinforces in-session knowledge gains. These knowledge gains are reflected in our pre- and post-ECHO knowledge tests, as part of our broader evaluation framework. At the conclusion of the workshop, participants will be given a toolkit with resources on the ECHO model, engagement considerations, and resources on innovative ways to leverage technology to build cohesive communities of practice at a distance.

Disaster Psychiatry 101: Lessons Learned in Treating Victims of Hurricane Harvey

Chairs: Sophia Banu, M.D., Asim A. Shah, M.D.

Presenters: Jin Yong Han, M.D., Manu Suresh Sharma, M.D., Samuel Devany Scott, M.D., Richard David Heekin, M.D., Asna A. Matin, M.D., Garima Arora, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of psychiatrists and other mental health professionals in treating victims of a large-scale, natural disaster and the importance of interdisciplinary collaboration; 2) Understand the logistics involved in setting up a mental health triage and treatment center in large public evacuation shelters; 3) Understand the prevalence of various psychiatric illnesses, previous trauma experiences, and comorbidities in an evacuation shelter setting; 4) Be able to implement basic emergency psychiatric interventions; and 5) Appreciate the importance of self-care for mental health workers in the aftermath of a disaster.

SUMMARY:

According to the United Nations Office of Disaster Risk Reduction (UNISDR), the United States experienced 472 weather-related disasters between 1995 and 2015. During the same period, weather-related disasters caused 606,000 deaths worldwide and left over 4 billion people homeless or in need of emergency assistance. In late August 2017, southeast Texas endured one of the greatest natural disasters in US history as Hurricane Harvey brought record flooding to coastal and inland areas. Overnight, emergency evacuation shelters at George R. Brown Convention Center and NRG Stadium in Houston had to accommodate more than 10,000

evacuees, many of whom had had their homes destroyed and lives upended. Despite widespread feelings of helplessness in the face of such massive destruction, many in the local and national community, including many psychiatrists and other mental health professionals, stepped up to bring relief to those impacted by the storm. In the evacuation shelter setting, the role of psychiatrists transcends treating individuals for acute exacerbations of pre-existing psychiatric disorders. Psychiatrists also play an important role in educating the community on the acute psychological impacts of trauma as well as long-term sequelae. This includes helping individuals identify warning symptoms which warrant seeking professional assistance. Another important and easily-overlooked function is to coordinate appropriate resources that allow for continuity of care in the post-shelter setting. In this workshop, we will share our experiences and lessons learned in the response to Hurricane Harvey. A team of psychiatrists and other mental health professionals from the UT McGovern School of Medicine and Baylor College of Medicine provided mental healthcare for several hundred evacuees at the George R. Brown Convention Center and NRG Stadium. Our team treated patients with a variety of presentations, including but not limited to: those with adjustment disorders in need of supportive therapy, patients with chronic mental illness destabilized by losing their medications, and psychotic and/or acutely agitated patients disruptive to the general milieu of the shelter and potentially posing a danger to themselves or others. The need to evaluate and treat patients in an expeditious and efficient manner in an improvised setting with limited resources had to be balanced with concern for patient privacy and confidentiality. While both shelters were similar in terms of patient population and presentation, they each presented unique challenges in terms of pharmacy resources, medical records (electronic vs. paper), and volume of patients. Finally, we will discuss the challenges involved in treating low-resource populations, who were disproportionately represented at the emergency shelters, especially as more time elapsed from the immediate disaster.

Exciting the Next Generation of Psychiatrists About Psychotherapy

Chair: Randon Scott Welton, M.D.

Presenters: Thomas N. Franklin, M.D., Meera Menon, M.D., Tana Andre, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recite the evidence supporting the use of psychotherapy in common mental illnesses; 2) Advocate for psychiatrists retaining “psychotherapist” as part of their core identity; 3) Employ strategies to increase the enthusiasm of Early Career Psychiatrists for psychotherapy; and 4) Develop strategies to overcome barriers to life-long growth as a psychotherapist.

SUMMARY:

The percentage of psychiatric appointments which include psychotherapy has dramatically decreased since the 1980s. Increasing numbers of psychiatrists see themselves simply as psychopharmacologists specializing in the practice of biological psychiatry. The biopsychosocial model of psychiatry, however, sees biologically-based evaluations, pharmacology, and biomedical interventions as only part of the psychiatrist’s armamentarium. By neglecting psychosocial interventions, many modern psychiatrists have turned their back on a vast array of powerful tools. This workshop reviews the evidence supporting psychotherapy as a viable and valuable treatment modality for psychiatrists. Participants will identify and discuss changes and trends in medicine that have led to a diminished emphasis on psychotherapy among psychiatrists despite the support for psychotherapy in the medical literature. Much of the decrease in psychiatrists providing psychotherapy may stem from managed care practices and misconceptions about the superiority of pharmacological approaches. Participants will discuss what can be done individually and collectively to challenge and correct these factors. The continued development of psychotherapy skills among Early Career Psychiatrist is critical if “psychotherapist” is to remain a principle component of their professional identity. Resources for continued training in psychotherapy after residency will be reviewed. Attendees will describe barriers that Early Career Psychiatrists face in their efforts to increase their psychotherapy knowledge and skills. Participants will be asked to devise means

of addressing those barriers. The relative benefits of increasing competency in psychotherapy through various means such as enrolling in established training programs, learning privately through targeted reading, and ongoing supervision will be debated. Practical steps facilitating the enhancement of psychotherapy skills after residency training will be outlined. These steps can be a part of life-long learning and can include negotiating sufficient time for a psychotherapy practice, attending continuing medical education, and ongoing mentoring or supervisory relationships. Participants will be asked to contribute their suggestions about how Early Career Psychiatrists can continue to develop improved psychotherapy skills during their careers. Attendees will be encouraged to advocate for psychotherapy by psychiatrists in their immediate sphere of influence, their departments, and their professional societies.

Forcing Autonomy? Involuntary and Nonvoluntary Treatment of Persons With Opioid Addiction

Chair: Dominic Sisti, Ph.D.

Presenters: Arthur Caplan, Ph.D., Jonathan Lukens, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe how addiction undermines patient autonomy and introduce the argument that treatment over objection paradoxically restores autonomy; 2) Present the distinction between involuntary and nonvoluntary treatment for addiction, describing the ethical and legal dimensions of each concept; and 3) Present the current status of involuntary treatment statutes across the country as well as where they are being considered for adoption.

SUMMARY:

The opioid epidemic is now an official National Emergency, having taken a significant human and financial toll. Public health officials, clinicians, and policy makers continue to advocate for harm reduction strategies and a broadening of voluntary treatment opportunities to arrest the progress of the epidemic. In some cases, it is argued that an individual's autonomy has been significantly compromised by their addiction. A variety of

coercive regimes may be used to initiate treatment and maintain compliance. Currently, there are 37 states that allow for the involuntary treatment of persons with substance use disorders. In response to the opioid epidemic policy makers in several states without such statutes have recently introduced legislation that would compel an addict into treatment even over their objection. In this workshop, we will explore a range of ethical arguments for and challenges to the forced treatment of persons with opioid addiction. The central argument we will explore is whether by forcing individuals with addiction to receive treatment, we may in fact confidently assert that we are restoring and respecting their autonomy. We will describe the concept of nonvoluntary treatment as a form of beneficent, coercive treatment that is justified by a reasonable evaluation of a patient's prior values to live in recovery. We will discuss the potential of robust shared-decision making models to address this dilemma. Fiscal and policy challenges regarding involuntary treatment will also be addressed.

Improving Care Transitions and Reducing Behavioral Health Inpatient Readmissions: Applying Lessons Learned From a Large-Scale Learning Collaborative

Chair: Molly T. Finnerty, M.D.

Presenters: Jennifer Grant, M.A., Katrina Vega, Anni Kramer, L.M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe innovative strategies for optimizing care transitions and reducing readmission following behavioral health hospitalizations; 2) Summarize the impact of a hospital learning collaborative on psychiatric readmissions; 3) Identify actionable root causes of behavioral health readmission from the patient and clinician perspectives; and 4) Identify clinical processes and practices that could be implemented by workshop participants.

SUMMARY:

Psychiatric readmissions and lost to follow-up after psychiatric and substance use disorder hospitalization are critical concerns highlighting the

challenge of engaging acutely ill inpatients transitioning to lower levels of care. Only 30-42% of adult psychiatric patients receive care within 7 days of discharge and 49-59% in 30 days (1,2). Individuals who become engaged in community-based care are at decreased risk returning to the hospital (3). Our workshop will introduce participants to the strategies and findings of a large quality collaborative with 45 hospital departments of psychiatry yielding significant reductions in 30 day readmissions. Starting with an overview of the quality collaborative, we will describe the development of the learning collaborative and lessons learned. We will introduce examples of successful hospital implementation plans by treatment setting including emergency departments, inpatient psychiatric and substance units, care management programs, and outpatient services and review the impact of the hospital collaborative on readmission. Based on root cause analysis of 751 patients with readmissions pooled from participating hospitals, we will identify gaps and opportunities for promoting successful transitions. The format of workshop will reflect the learning collaborative experience and include Q&A, straw polling, and opportunities for participants to share their experiences with different implementation strategies designed to optimize care transition from the hospital to the community. Participants will be encouraged to brainstorm additional strategies for addressing the drivers of readmission discussed earlier in the workshop and generate ideas on how to engage caregivers and community-based outpatient behavioral health providers to optimize these transitions and apply strategies to workshop participants' practice setting.

Is There a Doctor on Board? Getting You Prepared for the Most Common Medical and Psychiatric Emergencies on Commercial Airlines

Chairs: Michelle B. Riba, M.D., M.S., Rachel Lipson Glick, M.D.

Presenters: Karen Lommel, D.O., M.S., Steven G. Dickstein, M.D., Debra A. Pinals, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To review common medical and psychiatric emergencies on commercial airlines; 2) To understand when and when not to

respond, what is available on board and how to coordinate with remote resources; 3) To determine how to provide care within scope of practice and within limited confines; 4) To understand the medico-legal issues; and 5) To review some examples.

SUMMARY:

In-flight medical and psychiatric emergencies are fairly common with volunteer medical professionals providing the care, with lack of guidelines and a lack of standardized format. Further, the equipment that is on planes are not standardized. Flight physiology and different conditions make flying quite hazardous and difficult for many patients with pre-existing medical and psychiatric conditions. When there is a request for a doctor on board, there is sometimes discomfort on the part of psychiatrists to respond. This workshop will review the common medical and psychiatric emergencies and symptom clusters and provide an approach to understanding the role and the general approach to these situations. We will also review when you should respond and not respond, what to do if there are other clinicians on board, what you might encounter re equipment, how to get additional help, and how to frame the issues with the inflight crew.

Lies, Damned Lies, and Mental Illness: The Truth About Pathological Lying

Chairs: Vivek Datta, M.D., M.P.H., Richard Lesesne Frierson, M.D.

Presenters: Tania Michaels, B.S., Vivek Datta, M.D., M.P.H., Brian James Holoyda, M.D., M.B.A., M.P.H., Octavio Choi, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Distinguish lying from pathological lying, delusions, confabulation, overvalued ideas, and self-deception; 2) List the psychiatric and neurological disorders associated with pathological lying; 3) Understanding the clinical and forensic significance of Pseudologia fantastica; 4) Distinguish malingering from factitious disorder; and 5) Understand the neuroscience of lying, pathological lying, and potential and limitations of fMRI (functional magnetic resonance imaging) for lie detection.

SUMMARY:

Pseudologia Fantastica (PF) is a form of pathological lying where the individual tells self-aggrandizing stories that test the limits of credulity, with the purpose of shaping others' positive perceptions of the individual rather than financial or material profit. Typically associated with Munchausen's syndrome, a form of factitious disorder, it has also been found in malingering, certain personality disorders, and those with neurological disorders. In this interactive workshop, we will review the differential diagnosis for PF and the importance of distinguishing it from other types of lying, delusions, confabulation, and overvalued ideas. PF has implications for clinical management as well as forensic implications when such individuals find themselves in court. Through case discussions, we will explore the challenges these patients pose to the evaluating clinical and forensic psychiatrist. We will also discuss the often-challenging distinction between factitious and malingered psychiatric symptoms. Finally, we will review the evolving research into the neurobiology of lying in general, pathological lying in particular, and the status of functional magnetic resonance imaging as a tool for lie detection.

Not Eating and Not on the Psychiatric Ward: Managing Anorexia Nervosa From a Psychiatry Consultation-Liaison Perspective—a Multidisciplinary Approach

Chairs: Janna S. Gordon-Elliott, M.D., Evelyn Attia, M.D.

Presenters: Alyson Gorun, M.D., Joanne Garduno, N.P., Ezra Gabbay, M.D., Diego Real de Asua, M.D., Ph.D., Sean Kerrigan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize barriers to treating patients with Anorexia Nervosa admitted to medical settings; 2) Gain skills for providing treatment and management strategies to non-psychiatric teams taking care of patients with Anorexia Nervosa admitted to medical settings; 3) Develop understanding of how to implement effective and efficient psychiatric and medical care to patients with Anorexia Nervosa admitted to medical settings; and 4) Learn to reduce obstructions to care and

other treatment-interfering behaviors of patients with Anorexia Nervosa admitted to medical settings.

SUMMARY:

Anorexia Nervosa (AN) carries high rates of medical complications, functional impairment, and mortality. Medical hospitalization for nutritional and medical stabilization is often necessary before initiating more substantial psychiatric and behavioral treatment. There are currently no formal guidelines designed to assist psychiatric and medical providers manage these patients during this critical period which may take weeks to months. Limitations in knowledge, skills and attitudes related to the behavioral management of patients with AN on the medical service can result in delayed weight gain and suboptimal care. Establishment and dissemination of a framework for management will enhance interdisciplinary cooperation, awareness of clinical pitfalls, and successful implementation of treatment. We will present the case of a young woman with severe AN who was medically admitted for stabilization, and discuss her treatment and associated challenges. This will be done from the perspective of different teams essential to her care. First, the psychiatric consultation-liaison team will present the hospital course from a psychiatric perspective, give a brief overview of AN, and review barriers to appropriate care from the psychiatric perspective including team dynamics, defenses, and countertransference. Second, we will hear from nursing regarding their experience of this patient and barriers to appropriate care including behavioral measures and difficulties implementing these, as well as monitoring the patient effectively for eating disordered behaviors. Third, the medicine team will discuss the case from a medical perspective and the difficulties they encountered effectively managing multiple medical issues and medical crises in an uncooperative patient. Fourth, the medical ethics team will discuss complicated variables at play including surrogate decision-making and legal and ethical principles in the management of an incapacitated patient with behaviors that are both acutely and chronically life-threatening. Fifth, the inpatient eating disorders team will speak about planning for the next stage of treatment, and knowing when to bring in an expert. Attention will be given to what the numerous involved disciplines

and specialties need from their psychiatric colleagues in order to implement good treatment. An interactive session will follow to engage the audience in a brief analysis of a common management quandary that arises for the interdisciplinary team during medical stabilization of a hypothetical patient with AN. A brief, structured guideline for treating the patient with AN on the medical service from the core management perspectives will be presented. An expert discussion led by Dr. Evelyn Attia, Director of the Center for Eating Disorders at New York-Presbyterian Hospital, will follow, including review of practical management strategies.

Psychiatry and U.S. Veterans

Chairs: Elspeth Cameron Ritchie, M.D., M.P.H., John C. Bradley, M.D.

Presenters: Maria D. Llorente, M.D., Harold Stephen Kudler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the strengths and vulnerabilities of the veteran population; 2) Learn how to treat common mental health disorders in the veteran population; 3) Know how symptoms change as the veteran ages; and 4) Understand the consequences of exposures to war, which include PTSD, depression, traumatic brain injury.

SUMMARY:

Approximately 2.7 million veterans have served since 9/11/2001. For these recent veterans, PTSD, TBI and re-integration to the civilian world are major current issues. The veteran population have both specific needs and strengths. The needs revolve around exposures to war, which include PTSD, depression, traumatic brain injury, and other mental and physical sequelae of accidents and combat. These needs may change over time, as the veteran ages. For example, Vietnam veterans are usually in their seventies, and PTSD symptoms often re-emerge as the veteran retires and develops medical problems. Strengths of the veteran population include a strong sense of serving the military and the nation, and access to health care, including in the Veterans Health Administration and to civilian providers. However many civilian providers are not

aware of veteran specific needs. There are many specific clinical issues for the veteran population. They include PTSD, TBI, depression, suicide, homeless veterans, LGBT veterans, the use of opiates and stimulants and other topics.

Psychosis and Violence: Understanding the Risk Factors, Prevention, and Treatment Options

Chair: Gopal Ramesh Vyas, D.O.

Presenters: Bhinna Pearl Park, M.D., Michael Stephen Peroski, D.O., Viviana Alvarez Toro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the risk factors for violence in psychotic conditions; 2) Highlight three different etiologies of psychosis and their risk for violence; 3) Identify specific risk assessment tools, including the Violence Risk Assessment Guide (VRAG) and explain their utility; and 4) Understand the use of antipsychotics, particularly Clozapine, and their role in reducing aggression and violence.

SUMMARY:

Violence is a pervasive problem in our society. Especially during our changing times and shifting portrayals in the media, the relationship between mental illness and violence is often poorly explained. Most individuals suffering from mental illness are not violent; in fact, they are more likely to become victims of violence. However, there is potential for some mentally ill individuals to become violent. Clinicians, as well as the lay public, may have trouble navigating that link, and knowing what risk factors to look for across various settings. This workshop focuses on the intersection between active psychosis and the risk for violence, by examining three separate etiologies of psychosis. The presentation will focus on the risk of violence stemming from psychosis secondary to medical causes, substance use/intoxication, and of primary psychiatric origin. We will discuss each of these three topics through case presentations with a group discussion. The first case that we will present is of a patient with temporal lobe epilepsy who assaulted several hospital staff members in the context of a likely seizure. The second case is of a criminal defendant believed to have a history of substance-induced psychosis who assaulted medical staff in prison as

well as during a forensic evaluation to assess competency. The third case is of a man with a longstanding history of schizophrenia who has had repeated instances of assaultive behavior against healthcare providers due to his chronic paranoid and religious delusional content. We will also review effective evidence-based treatments, specifically Clozapine, and their documented effects on violence reduction. It is our hope that by the end of this workshop mental health professionals will become more comfortable identifying potential risks for violence in psychotic patients, as well as understanding the available evidence-based treatments at hand.

Recent Advances in Neuroscience: This “Stuff” Is Really Cool

Chairs: David A. Ross, M.D., Ph.D., Melissa R. Arbuckle, M.D., Ph.D.

Presenters: Jennifer Buenzle Dwyer, M.D., Ph.D., Erica Baller, M.D., M.S., Noah S. Philip, M.D., Allison C. Waters, Ph.D., Brandon Kitay, M.D., Ph.D., Youngsun Cho, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the relevance of new findings in neuroscience to clinical care and to the future of psychiatry; 2) Answer assessment questions relating to the neurobiology of depression, PTSD, chronic pain, and other cutting edge topics in neuroscience; and 3) Describe resources that can be used to stay up to date with cutting edge findings in neuroscience and psychiatry.

SUMMARY:

Have you ever heard of tDCS and wondered what it is? Or tried to explain to someone how our drugs for depression actually work? Or ruminated on whether chronic pain really is “all in your head”? Over the past two decades, advances in neuroscience have dramatically enhanced our understanding of the brain and of the neurobiological basis of psychiatric illness. Yet keeping pace with such advances remains fraught with challenges: the field is vast and constantly evolving and the clinical relevance is not always clear. Another key barrier to learning neuroscience is the way these findings are communicated outside of the scientific community.

While researchers may receive training and feedback on traditional forms of scientific communication (such as giving scientific talks and writing for journals), relatively little time is devoted to honing the unique skills required to communicate to a broader audience including trainees and other healthcare providers. To address this challenge, the National Neuroscience Curriculum Initiative (NNCI) has developed a series of brief talks focused on recent advances in neuroscience. These talks distill complex topics down to their core concepts and are crafted around a narrative arc which highlights key clinical applications and focuses on why “this ‘stuff’ is really cool.” In this session participants will be introduced to several cutting-edge topics in neuroscience that are transforming our field.

Testosterone and Mood in Psychiatric Patients: Is It Time to Check Levels and Treat?

Chair: Justin Smith, M.D.

Presenters: Ryan Smith, M.D., Jordan Harrison Rosen, M.D., Marie Lyse Turk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the signs and symptoms of hypogonadism in men presenting with psychiatric concerns; 2) Understand the impact that male hypogonadism can have on mood; 3) Choose an appropriate initial evaluation for hypogonadism in men and know when to refer; and 4) Improve depression outcomes through optimization of the gonadal axis.

SUMMARY:

The clinical manifestations of low testosterone in men frequently includes non-specific symptoms that overlap with mood and anxiety disorders often addressed in the outpatient psychiatry setting. However, routine screening for low testosterone is not performed in psychiatric outpatient clinics and therefore the approach to these patients rarely involves testosterone repletion or otherwise restoring the gonadal axis. In fact, many of the treatments for mood and anxiety disorders include medications such as the selective serotonin reuptake inhibitors (SSRI’s), which lower testosterone and often cause sexual dysfunction 1,2,3 There is an urgent and unmet need to improve outcomes in

psychiatric illness. The largest trial of antidepressant efficacy in a diverse outpatient clinical population known as STAR*D found that nearly a third of patients with major depressive disorder, the most common major mood disorder, did not achieve remission after four treatment trials. With each subsequent medication trial, the chance of remission decreased.⁴ Our workshop will review the evidence for the role of hypogonadism in depressive states in men and familiarize participants with current approaches to the assessment and management of hypogonadism. We will also discuss the physiology of testosterone in the brain and potential mechanisms by which it might impact mood. Potential adverse psychiatric effects of testosterone treatment along with the potential for abuse will be reviewed. This workshop will be interactive utilizing case examples, audience participation, and a panel discussion.

The Impact of Racial Trauma and Stigma on HIV+ Individuals and Communities

Chair: Leon Edward Cushenberry, M.D.

Presenters: Daena L. Petersen, M.D., M.P.H., Kenneth Bryan Ashley, M.D., Lawrence M. McGlynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1) Understand the problem of racial-trauma and its impact on HIV+ individuals and communities; 2) 2) Learn about effective models of assessment and intervention; 3) 3) Discuss ways to implement effective models of assessment and care locally; and 4) 4) Analyze individual- and institution-level contributions to stigma.

SUMMARY:

The intersection of HIV + serostatus and racism has been deadly for communities of color in the U.S. CDC data from 2015 indicate that African American and Latino men who have sex with men (MSM) and African American heterosexual men and women represent groups with 4 out of 5 of the highest incidence rates of new cases of HIV in the U.S. Across the country African American and Latino communities are disproportionately impacted by HIV infection rates. According to an article by Carter (2007) Racism and Psychological and Emotional

Injury: Recognizing and Assessing Race-based Traumatic Stress, in mental health centers despite increasing need, ethnic minorities continue to have decreased access to mental health support. It also noted that when they are able to access care they receive substandard care. HIV+ individuals of color are often left in isolation to struggle with the stigma of racism, homophobia, and transphobia. The impact of multiple levels of traumatic stress, while acknowledged by mental health professionals, continues to be inadequately addressed without a prioritized approach to care for these individuals and their communities. This workshop proposes to define the problem of racial trauma in the context of HIV, explore models to effectively assess race-based traumatic stress, and work with participants to understand an effective approach to care for HIV+ individuals struggling with mental health issues resulting from race-based trauma events and stressors in their daily lives.

The Power of the Good: Toward the Prevention of Large-Group Conflict

Chair: Sheila Judge, M.D.

Presenters: Leah Joan Dickstein, M.D., M.A., Henri Parens, M.D.

Discussant: John H. Halpern, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn about a particular kind of moral bravery and the universal value system it entails; 2) Understand key psychological traits that promote compassionate individual action; 3) Identify the principles of the Multi-Trends Theory of Aggression (MTTA); 4) Demonstrate how MTTA explains both individual and large-group conflict, and war in particular; and 5) Define a model of the 3 types of human prejudice and recognize how malignant prejudice leads to large-group conflict and genocide.

SUMMARY:

Our world is fraught with the turmoil of war, genocide, displacement, with millions fleeing injury, hunger, and certain death. In our own land, there is civil unrest, with long-festering sores of hatred and prejudice bursting into divisive discourse and violence. What can one do, as a person, as a

psychiatrist? Is there any place for individual action in the face of what seems an inexorable tide of hostility? How can we understand what is happening in our country and our world, and use it to shape our awareness and responsiveness? The participants will be encouraged to ponder these questions, as they hear of the ethical bravery of some of the hundreds of Holocaust survivors interviewed by Leah Dickstein--people who risked their lives to "do the right thing" for others caught in genocide. 2018 American Association for Social Psychiatry Humanitarian Award recipient Henri Parens will take the participants through the steps of his research which led to the Multi-Trends Theory of Aggression: human beings are not born to destroy; it is excessive psychic pain which generates hostile destructiveness. The clinical application of this powerful and provable finding has had a positive effect on individual growth and well-being. From here we will explore a model of the human experience of prejudice, and how understanding the role of malignant prejudice in large-group conflict and genocide may prevent their occurrence. A lively interaction among panel and participants will be fostered as these concepts are correlated with examples of the power of individual response to allay the fears and hopelessness that can arise in ourselves and our patients in today's atmosphere of prejudice and hostility.

The Psychopharmacology Algorithm Project at the Harvard South Shore Program: An Update on Unipolar Nonpsychotic Depression

Chair: David Neal Osser, M.D.

Presenters: David Neal Osser, M.D., Christoforos Iraklis Giakoumatos, M.D.

Discussant: Robert D. Patterson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Evidence-supported psychopharmacology algorithms could simplify the process of choosing medications especially for clinicians not strongly familiar with the evidence base; 2) Psychopharmacological treatment of major depressive disorder; 3) Psychopharmacological treatment of treatment-resistant major depressive disorder; and 4) Psychopharmacological treatment

of major depressive disorder with other co-morbid medical conditions.

SUMMARY:

BACKGROUND: The Psychopharmacology Algorithm Project at the Harvard South Shore Program was founded in 1993 and it consists of evidence-based recommendations considering efficacy, tolerability and safety. Two previous algorithms for unipolar non-psychotic depression were published a long time ago, in 1993 and 1998. Multiple new studies over the last 19 years suggest that another update is needed. **METHODS:** The references reviewed for the previous algorithms were re-evaluated and a new literature search was conducted to identify studies that would either support or alter the previous recommendations. Other guidelines and algorithms were consulted. We considered exceptions to the main algorithm, such as patients with anxious distress, mixed features, pregnant women, and patients with common medical and psychiatric comorbidities. **ALGORITHM SUMMARY:** For inpatients with severe melancholic depression and acute safety concerns, electroconvulsive therapy (or ketamine if ECT refused or ineffective) may be the first-line treatments. In the absence of an urgent indication, we recommend trial of venlafaxine, mirtazapine or a tricyclic antidepressant. These may be augmented if necessary with lithium or T3 (triiodothyronine). For inpatients with non-melancholic depression and most depressed outpatients, sertraline, escitalopram or bupropion are reasonable first choices. If there is no response, the prescriber (in collaboration with the patient) has many choices for the second trial in this algorithm because there is no clear preference based on evidence, and there are many individual patient considerations to take into account. They may decide to either switch (to one of the above options not previously tried, or to selected evidenced nutrients such as SAMe, or to a dual action agent, or to transcranial magnetic stimulation), or to augment (with selected evidenced nutrients such as l-methylfolate, or second generation antipsychotics, or bupropion + mirtazapine, or lithium/T3). If there is no response to the second medication trial, the patient is considered to have a medication treatment resistant depression. If the patient meets criteria for the atypical features specifier, a monoamine oxidase

inhibitor could be considered. If not, reconsider (for the third trial) some of the same options suggested for the second trial. If the patient has comorbidities such as chronic pain, obsessive-compulsive disorder, or posttraumatic stress disorder, recommendations derive from evidence-based treatments of those disorders. **SESSION CONTENT:** In this workshop, the authors will present the reasoning justifying the sequence of recommended treatments and the specific medications preferred, and there will be ample time for attendees to respond and interact with the presenters.

To Treat or Not to Treat—Is That the Question? The Evaluation and Treatment of Mood Disorders in Case Examples of Pregnant Women

Chair: Kara E. Driscoll, M.D.

Presenter: Dana Reyad Mahmoud, D.O.

Discussant: Crystal T. Clark, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) RECOGNIZE THE BARRIERS TO THE IDENTIFICATION AND TREATMENT OF MOOD DISORDERS DURING PREGNANCY; 2) ENGAGE A PATIENT IN DISCUSSION AND DECISION-MAKING REGARDING HER TREATMENT; and 3) DELIVER EVIDENCE-BASED PSYCHIATRIC CARE TO THIS VULNERABLE AND IMPORTANT POPULATION.

SUMMARY:

Women are particularly vulnerable to the occurrence of mood episodes during the childbearing years. In spite of this, identification of mood disturbance is often delayed and under-treated during pregnancy, particularly as compared to non-pregnant women. As a result, there is a risk of relapse of prior illness or unnecessary prolongation of the identification and treatment of new illness during pregnancy which impacts both mother and her child. Many mental health practitioners and patients feel overwhelmed by the decision-making involved in the care of a pregnant woman with mood disturbance. This workshop is designed to 1) highlight and address some of the barriers to identification and treatment of mood disorders during pregnancy and 2) facilitate better care of the pregnant patient. Attendees will participate in discussion of case examples of pregnant women with mood disorders, focusing on

evaluation, treatment options, and common dilemmas. The workshop leaders and attendees will collaborate in creating an individual treatment plan for each patient. The workshop will highlight common screening tools, risks of treatment versus no treatment, possible exposures during pregnancy, and potential for relapse in those with a history of mood disorders. Workshop leaders and participants will also discuss issues of medication monitoring and dose adjustments secondary to pregnancy metabolism and as well as planning for the postpartum period. Finally, the participants will practice skills for engaging the patient in a discussion about treatment and fostering patient participation in the decision-making. Workshop presenters will incorporate current evidence available for the treatment of mood disorders during pregnancy. At the end of this workshop, the participants will have increased comfort with the individualized evaluation, identification, and treatment of mood disorders in pregnant women.

Women Psychiatrists and Money: Personal Practicalities, Payment, Professional Practice, and Power

Chair: Sarah Yvonne Vinson, M.D.

Presenters: Kasey Gartner, M.B.A., Glenda L. Wrenn, M.D., Andrea M. Brownridge, M.D., J.D., M.H.A., Lara Elizabeth Aycock Frye, M.D., Nzinga Ajabu Harrison, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand basic principles regarding personal financial planning needs of women psychiatrists; 2) Explore the potential impacts of gender in negotiations through panel discussion; 3) Discuss practical considerations regarding private practice and the challenges and opportunities it poses; 4) Identify different approaches to leveraging physician income in the pursuit of advocacy; and 5) Negotiation.

SUMMARY:

The majority of psychiatric residents are women. Though gains continue to be made in terms of representation in the field of psychiatry, and many professions within the larger society, gender inequities with regards to earned income and wealth

persist. Even highly educated women are susceptible to the impact of traditional gender roles on self-advocacy in the form of negotiation or assertiveness in the workplace. Effective procurement and use of monetary resources is a critical aspect of both personal and professional security and development. There is little in the medical or residency training process that addresses this highly relevant issue, let alone its interplay with gender. In this workshop, the interplay of money with women psychiatrists' personal and professional roles will be explored through a variety of perspectives. The psychiatric physician panelists hail from private practice, corporate, academic and public psychiatry contexts, and they will be joined by a Field Director and Financial Advisor from a major financial planning firm. The workshop topics will include practical considerations for women psychiatrists in personal financial planning, negotiation, private practice management, and different approaches to leveraging physician income in the pursuit of advocacy.

Update From the Council on Psychiatry and Law

Chair: Debra A. Pinals, M.D.

Presenters: Reena Kapoor, M.D., Marvin Stanley Swartz, M.D., Patricia Ryan Recupero, M.D., J.D., Robert Lee Trestman, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the different kinds of policy documents produced by the APA (e.g. position statements and resource documents) and the procedures for their review and approval; 2) Describe issues relating to the topic of law enforcement responses to persons with mental illness; 3) Delineate the issues related to APA taking a position in pending judicial cases which relate to the practice of psychiatry and the issues presented by several recent cases; 4) List factors relating to the provision of psychiatric services in correctional facilities; and 5) Describe considerations relating to recent legislation and laws that restrict access to firearms during a mental health crisis.

SUMMARY:

This workshop will provide participants with an overview of the process by which the Council on

Psychiatry and Law develops APA policy documents, such as Position Statements and Resource Documents. The goal of the workshop is to provide an update on recent and ongoing issues that the Council is addressing. This workshop will provide participants with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Pinals will provide an overview of the process, and will discuss ongoing work on an APA resource document regarding law enforcement responses to persons with mental illness. Dr. Swartz will describe the process by which APA determines whether or not to write a "friend of the court" brief in cases which concern the practice of psychiatry or mental health and describe several recent cases in which the APA has considered involvement. Dr. Trestman will discuss the revision of an existing APA position statement regarding the provision of psychiatric services in correctional facilities. Dr. Kapoor will discuss the development of a resource document on legislation that would restrict access to firearms during a mental health crisis. Dr. Recupero will talk about inquiries about diagnosis and treatment of mental disorder in connection with credentialing and licensing. In each area, the Council will elicit feedback from attendees regarding the important policy issues. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

Monday, May 07, 2018

Challenges in Treatment-Refractory Schizophrenia: Management of Comorbidity

Chair: Michael Hwang, M.D.

Presenters: Jeffrey Paul Kahn, M.D., Jean-Pierre Lindenmayer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Diagnosis and symptom assessment of schizophrenia with comorbid disorders; 2) Pharmacological challenges in schizophrenia with comorbid conditions; 3) Psychotherapeutic issues in schizophrenia with comorbid disorders; 4) Multidisciplinary treatment in schizophrenic patients with comorbid conditions; and 5) Research issues of comorbidity in schizophrenia.

SUMMARY:

Schizophrenic spectrum disorder encompasses diverse clinical phenomena with complex biopsychosocial pathogeneses. Such clinical and neurobiological diversity challenges practicing clinicians in their management and meaningful research. Recent advances in neurobiological research and a greater emphasis for less hierarchical, symptom based approach in DSM-5 has significantly increased clinician awareness in diverse comorbid conditions in patients with schizophrenia. The emerging clinical and research evidence in recent years suggests comorbid disorders such as depression, panic and OC symptoms, substance abuse and impulsive control disorders account for far greater share of schizophrenia than previously believed. However, the traditional hierarchical diagnostic belief and complexity of pathogeneses the schizophrenia continue to challenge their clinical management and research endeavors. The available clinical and research evidence suggest specific symptom assessment and multi-disciplinary treatment intervention in schizophrenia with comorbid conditions yield the optimal outcome. The proposed workshop will review the recent advances in assessment and diagnosis of prevalent and challenging comorbid conditions in schizophrenia and discuss the multidisciplinary management. Dr. Lindenmayer will discuss the current diagnostic and treatment issues of substance abuse in schizophrenia. He will review the recent research advances in pharmacological treatment and psychosocial interventions. Dr. Kahn discuss the diagnostic issues and biopsychosocial pathogeneses of panic disorder in schizophrenia. He will discuss the current multidisciplinary treatment and the challenges. Dr. Hwang will review the clinical and research evidence and the biopsychosocial pathogenesis in schizophrenia with comorbid obsessive-compulsive disorder, and discuss current treatment approaches. At end of the presentation participants will be encouraged to share their clinical experience.

**Engaging the Next Generation of Psychiatrists:
Lessons From PsychSIGN**

Chair: Susan W. Lehmann, M.D.

Presenters: Pallavi Joshi, D.O., M.A., Karen Thuy

Duong, D.O., Katherine Alexis Jong, M.D., Robert Rymowicz, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the role of psychiatry interest groups in introducing medical students to psychiatry, providing resources, and connecting them to a professional network; 2) Identify barriers to recruitment and member engagement in their institution's psychiatry interest groups; 3) Discuss several successful strategies and resources, including electronic and social media use, that have revived psychiatry interest groups and increased student engagement; and 4) Identify at least one strategy they plan to implement at the psychiatry interest group at participant's home institutions.

SUMMARY:

As mental health awareness continues to grow, medical students are increasingly interested in psychiatry as a specialty (5.2% of NRMP positions in 2017). Psychiatry student interest groups (SIGs) are often the first introduction medical students have to the field of psychiatry. Members range from students with a cursory interest in psychiatry and those debating between specialties, to those who are applying to psychiatry residency programs. Psych SIGs provide information about career opportunities, host speakers, offer mentorship, and connect members to peers and a professional network. As psychiatry is becoming more competitive, the role of Psych SIGs is more crucial than ever. However, newer or smaller medical schools may lack Psych SIGs, many Psych SIGs are inactive, and all must contend with a membership in constant flux as students graduate on to residency. In this workshop chaired by an expert in medical student education, four former officers of PsychSIGN, APA's national student interest group network, will discuss the challenges to starting PsychSIGs and keeping them active, and offer solutions deriving both from educational research and from personal experience. Participants will break into small groups to identify barriers starting a PsychSIG, or to recruitment and member engagement in their institution's PsychSIGs. The panelists will review strategies and resources for recruitment and scheduling activities that have been successful in reviving groups at both the national

and international level. We will highlight key “pearls” on enhancing the PsychSIG board, increasing the PsychSIG presence in the medical school, and ideas for activities on and off campus. Finally, we will discuss effective use of social and electronic media, such as Facebook, Twitter, and websites in recruitment and communication. By the end of this session, participants will be able to identify at least one strategy they can implement at their institution’s psychiatry interest group and offer an example of a strategy that they have found to be successful to the workshop group.

Geospatial Mapping to Discover Pockets of Innovation in Integrated Care

Chair: Lori E. Raney, M.D.

Presenter: Anissa Lambertino, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the process of data application for geospatial mapping; 2) Discuss approaches to investigating unique “hot spots” including gathering additional data and interviews; and 3) Describe approaches to integrated care that could be applied to your own practice using the Ohio example.

SUMMARY:

Geospatial mapping is a process of using data sets to physically locate patterns of interest and can be applied to health care delivery. Data can be layered on in sequences to answer questions regarding prevalence of disorders, delivery of care (using tools such as prescription data), outcomes and cost. This process can help uncover pockets of innovation when factors line up in the process. This workshop describes in detail a geospatial mapping project that revealed a “hot spot” of data showing depression diagnosis in rural Appalachia. Since this was somewhat unexpected the decision was to see if there treatment was also being provided so data for the state on antidepressant prescribing was layered on an another “hot spot” was discovered at the same location. The next question was to figure how this could be happening given this was located in a rural area and could represent an innovative or progressive approach to integrating primary care and behavioral health and consideration was given

to locating the health care sites that might be contributing to this phenomenon. Since federally qualified health centers (FQHCs) are a common feature of rural health care delivery a map of FQHCs in the state was layered on the existing area and a pattern of one particular health care system with multiple sites across the region. Interviews were conducted with key administrative, primary care and psychiatric staff of the organization and a unique approach to integrated care was uncovered. This workshop will be presented by Anissa Lambertino, an expert in geospatial mapping and Lori Raney, MD who chairs the APA Committed on Integrated Care and helped discover this pocket of innovation.

Hello From the Other Side: A Guide to Working With Biological Parents of Foster Youth

Chair: Caroline Roberts, M.D.

Presenters: Becci Akin, Ph.D., M.S.W., Caroline Roberts, M.D., Suzan Song, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Articulate the nuances of the following terms: foster care, adoptive care, permanency, family reunification; 2) Envision, using clinical cases as a lens, the experience of having a child in foster care from the perspective of a birth parent; 3) Discuss barriers to reunification and ways a psychiatrist can facilitate overcoming them, citing empirical research on addiction in birth parents and severe emotional disturbance in foster youth; and 4) Translate this innovative look at the other side of foster care into the delivery of effective and empathetic care of birth parents in psychiatric settings.

SUMMARY:

In 2014, 653,000 children were in the public foster care system (“Children’s Bureau,” 2017). In the same year, child protective services agencies responded to more victims of neglect (75%) than victims of physical (17%) or sexual (8.3%) abuse. In the vast majority of instances (91.6%), the perpetrators of maltreatment included one or both parents (“Child Maltreatment,” 2016). The Adoption and Safe Families Act of 1997 requires states to make reasonable efforts toward family reunification and requires them to terminate parental rights for foster

youth who have been in care 15 of the previous 22 months. The Practice Parameter for the Assessment and Management of Youth Involved in the Child Welfare System, put forth by the American Academy of Child and Adolescent Psychiatry, advocates for capitalizing on birth parents' strengths and hearing their voices, stating this will lead to better outcomes (Lee, Fouras, & Brown, 2015). When considering foster care, it may be easier for a psychiatrist to empathize with the children than with the biological parents. Achieving reunification and permanency, though, requires that providers understand and address the struggles of both parties. In this workshop, we will guide you in viewing foster care from the other side—the side of the biological parents. To start, we will use clinical cases to examine the experience of having a child in foster care from the perspective of a birth parent. Next, we will examine common barriers to birth parents reclaiming their children. A leading researcher will expand on two barriers particularly relevant to psychiatrists—substance use among birth parents and serious emotional disturbance in foster children. Finally, a child and adolescent psychiatrist with expertise in the field will share practical knowledge and clinical pearls on working together with foster youth and their birth parents.

How Private Insurance Fails Those With Mental Illness: The Case for Single-Payer Health Care

Chairs: Jon Wesley Boyd, M.D., Ph.D., Steven Samuel Sharfstein, M.D.

Presenters: Leslie Hartley Gise, M.D., Monica Malowney, M.P.H., Stephen Brooks Kemble, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session participants should be able to appreciate how the current health care system disproportionately penalizes psychiatrists and their patients. ; 2) At the conclusion of this session participants should be able to understand how private insurers have affected the practice of psychiatry; 3) At the conclusion of this session participants should be able to appreciate the changes in mental health spending versus total health spending over the past thirty years; and 4) At the conclusion of this session participants should be able to understand how a single payer national

health program would offer universal coverage with higher quality and lower costs. .

SUMMARY:

There is broad consensus that our health care system should provide quality, affordable health care for all. Despite lofty aspirations, the ACA has failed to deliver improved outcomes, lower costs or universal coverage. Additionally, the ACA has disproportionately adversely affected psychiatrists and patients with mental health problems. There is not consensus on how to proceed. This workshop will examine alternatives including a publicly-funded single payer national health program. Of the 30 million people who are uninsured at present, psychiatric patients are over-represented. With a single payer system, everyone would automatically be covered at birth, including psychiatric patients. Half of psychiatrists don't accept insurance primarily because of low reimbursement which is a barrier to access to mental health services. With single payer, a doctors' group, like the AMA, would be included in negotiations of standardized, reasonable rates so psychiatrists would participate. Data indicate that poor health outcomes—as well as premature death—are linked to lack of insurance. With universal coverage, our health outcomes would improve and be comparable to other developed countries. The US spends twice as much on health care as other developed countries. In addition, public funds are used to subsidize private insurers who have singled out mental health care for scrutiny and tactics that are designed to prevent individuals from receiving needed care. Insurers also do what they can to shift the practice of psychiatry away from psychotherapy toward psychopharmacology. Even though insurers act like mental health treatment will break the bank, mental health spending has stayed at 1% of GDP since 1986 while total health spending has climbed from 10% to 17% of GDP. Psychiatrists currently spend the highest percentage (over 20%) of their time on administration compared to other specialties, something that would likely improve were we to implement a single-payer system. Finally, replacing our inefficient, multi-payer, private insurance system with a publicly-funded national health program, like an expanded and improved Medicare for all, would also save at least \$400 billion annually by slashing the administrative waste

associated with the private insurance industry. The savings would be enough to cover all the uninsured and upgrade benefits, including psychotherapy, for everyone else.

Mental Health Professionals in the Era of Deteriorating Climate Conditions: Do We Have an Ethical Duty to Warn and Protect?

Chairs: Lise Conway Van Susteren, M.D., H. Steven Moffic, M.D.

Presenters: David Alan Pollack, M.D., Janet Lisa Lewis, M.D., Elizabeth Haase, M.D., Sara Gorman, Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the ethical and legal precedents for a duty to warn and protect against climate change as well as opposing values and traditions within psychiatry; 2) Identify specific psychiatric impacts from climate change and appreciate the cascading psychosocial emotional toll; 3) Identify at risk populations and describe the impacts of climate change; 4) Appreciate the need for and identify conditions that promote “resilience”; and 5) Describe empowering actions that can be undertaken in clinical, organizational, and academic settings and with patients to promote mental health and well being in the face of climate change.

SUMMARY:

In response to the growing impacts of climate change, psychiatrists and other mental health professionals will increasingly be called upon to help address this urgent public health threat and social justice issue. In assessing our role, what will we need to consider? This workshop will address this question and related questions in three sections: Section I of this workshop will provide an overview of the accelerating mental health toll from the impacts of climate change as well as the ego defense mechanisms in play around the acceptance of climate as a crisis. Both the direct mental health impacts - for which we have studies linking climate to psychiatric disorders - and the indirect impacts - often overlooked and hard to measure - will be reviewed. The disproportionate effects of climate change on vulnerable populations, including the

mentally ill, will be highlighted. Section II will look at ethical and legal precedents that serve to guide our actions, assisting us in evaluating the appropriateness and necessity of our speaking up on this issue. The American Psychiatric Association’s Principles of Medical Ethics, legal precedents in the United States and globally will be particularly explored, as will the use of one’s own values in advocacy on public health and social justice issues. Discussion will highlight balancing the potential danger of overstepping our boundaries with the danger of not speaking up in a time of crisis. In the first break out session, participants will discuss the unique challenges doctors and mental health professionals face in bringing up the topic of climate and mental health in clinical, academic, organizational and public settings, providing participants the opportunity to discuss these nuanced and sometimes contentious issues. Section III will review the “good news”, a broadening focus on what psychiatrists can do to reduce future harm to our climate and build resilience both in individuals and in communities. Existing successful efforts in these realms such as the “greening” of practices and “transformational resilience” training will be presented as models. This will be followed by a brainstorming breakout session organized by interest (e.g. direct patient care, the community setting, at risk populations) to discuss and to propose new “best practices”. The conclusions and questions raised within each group will be shared and discussed with the larger group. Psychiatrists bring unique skills and expertise to the public health and social justice crises of climate change. This workshop will raise our awareness of these issues, of the medical, social and legal precedents that underscore a call to action, and productive ways to help. Brainstorming with colleagues deepens our understanding of the complexities and rewards that come from doing this work.

Motivational Interviewing—It’s Not Just About Drugs Anymore: How to Apply MI Techniques to a Wide Range of Behaviors in Adolescence

*Chairs: Brandon Johnson, M.D., Jennifer Herring
Presenter: Shilpa Taufique, Ph.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Understand the range of clinical presentations where MI techniques can be implemented; 2) Identify specific MI interventions that can be used in the context of an adolescent's stage of change; and 3) Demonstrate effective implementation of MI techniques through role-play activity.

SUMMARY:

Adolescents can present with a wide range of maladaptive behaviors including substance use, self-injury, risky sexual behaviors, intense interpersonal relationships, etc. It is often these behaviors that catch the attention of others in their lives, which precipitates the adolescent's presentation to treatment and frequent ambivalence around engagement. The Transtheoretical Model (TTM) of behavior change is the framework in which many clinicians approach the treatment of addiction (Prochaska & DiClemente, 1984). In this model, various stages of change are identified as landmarks in the cycle of changing specific behaviors. Using this framework, a series of interventions under the umbrella of Motivational Interviewing (MI) have been developed to facilitate movement toward shifting maladaptive behaviors (Miller & Rollnick, 2002). More typically, these interventions are used in the treatment of substance use disorders, but their utility goes far beyond this limited set of problems and can be applied to any targeted behavior. While using interventions targeted directly at the adolescent can be highly effective, oftentimes the systems around them can be stuck in a pattern of behavior that perpetuates the maladaptive behaviors in the adolescent. This may take the form of lack of parental engagement in treatment, inappropriate school response to symptoms of mental illness, or even differing approaches taken by the treatment team and ancillary services. Similar motivational interviewing techniques can be used across the patient system to precipitate behavior change in the identified patient. In this workshop attendees will learn about the TTM and how it applies to using MI with high risk adolescents. Presenters are staff from the Comprehensive Adolescent Rehabilitation and Education Service (CARES), which uses an MI approach to engage adolescents in identifying behaviors to change and understanding this process through a four week

motivation group that outlines the stages of change. CARES staff will present clinical scenarios as examples where MI techniques can be implemented with adolescents and those involved in their care based upon motivation for change as well as the severity and type of high risk behaviors being targeted. Attendees will have the opportunity to practice these techniques with the specific goal to engage adolescents in the process of making behavior change.

Psychiatric Effects of the Long War

Chairs: Elspeth Cameron Ritchie, M.D., M.P.H., John C. Bradley, M.D.

Presenters: Dennis M. Sarmiento, M.D., Christopher S. Nelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn the psychological and physical consequences of the wars since 9/11; 2) Know both FDA approved and innovative treatments for PTSD; 3) Understand how to manage side-effects of psychiatric medication in our service members and veterans; and 4) Know programs that the US military is using to mitigate the effects of the long war.

SUMMARY:

The Long War began with 9/11. PTSD, traumatic brain injury (TBI), and suicide have emerged over the last 15 years of war as monumental issues for our servicemembers, veterans, and their families. About 2.7 million service members have served in Iraq, Afghanistan, and other locations. About 15% of those who have been in combat have PTSD symptoms. During the wars in Afghanistan and Iraq, unanticipated and extended deployments were extremely taxing for military families. The U.S. military has developed many programs to prepare servicemembers for combat and to treat those with combat-related PTSD and depression. These will be described here in more detail. The wars are now winding down. Re-integration with home is a continuing problem with barriers to care and stigma. The rising suicide rate among servicemembers and veterans has been a major concern for all in the military. The combination of unit and individual risk factors for suicide 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. Opioid addiction is a growing problem. Fortunately, there are emerging effective treatments for PTSD and TBI. Established evidence-based therapies are effective in most cases, but only if the servicemember completes the treatment. We have also learned clinical pearls for treating those with PTSD. Medication, psychotherapy, and alternative treatments are all helpful. While only two SSRIs (sertraline and paroxetine) are FDA approved, many others are commonly used. We have found bupropion especially useful. However, many servicemembers are noncompliant, either because they dislike the therapy or develop sexual side effects to medications. There are strategies to decrease the sexual side effects. Off-label use of medications can be very helpful for PTSD and TBI, including second-generation antipsychotics for PTSD and stimulants for TBI. Poly pharmacy will likely be beneficial. Innovative, but not yet scientifically understood, approaches include acupuncture, stellate ganglion block, mindfulness, canine therapy, equine therapy, and others that help engage the patient. This forum will briefly describe psychological reactions to war and reintegration and emerging strategies for treatment. Important programs in the military will be outlined.

So You Want to Get Published? How to Maximize Acceptance of Your Article

Chair: Jacqueline Maus Feldman, M.D.

Presenters: Curtis N. Adams, M.D., Margaret E. Balfour, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Meet with the editors of the Community Mental Health Journal; 2) Understand strategies to maximize acceptance of submissions to publications; 3) Understand the philosophy of the Community Mental Health Journal; and 4) Understand mechanics of the submission and review process.

SUMMARY:

As psychiatrists and other mental health care providers move to advance their careers, they are

often advised to enhance their publication trajectory. Understanding the standards for article submission can enhance the submission process, and maximize an author's chance of acceptance. By meeting with the editors of a peer-reviewed journal (Community Mental Health Journal) and listening to stories of successes and failures, the audience will comprehend the importance of discerning the philosophy of a journal (what kind of articles are being sought), the mechanics of submission, the need to follow instructions, and the challenge of responding to reviewer comments. The audience will have opportunities to engage in a question and answer session regarding their own submission and publishing conundrums, and should complete the session possessing strategies that make writing and submitting articles easier and more successful.

Special Populations on Inpatient Psychiatric Units: Pregnant Patients, VIP Patients, and "Palliative" Psychiatric Cases

Chairs: Benjamin Brody, M.D., Julie B. Penzner, M.D.

Presenter: Michael F. Walton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the complicating social factors of working with pregnant patients, VIPs, and "palliative" patients; 2) Understand the common reactions or countertransferences that special patient populations may evoke in the inpatient psychiatrist; and 3) Appreciate that addressing special patient characteristics apart from diagnosis at the outset of treatment will improve and streamline inpatient care.

SUMMARY:

Inpatient psychiatrists need to be familiar with not only major forms of mental illness but also unique personal characteristics that may complicate inpatient treatment. In this workshop, we focus on special populations that commonly cause anxiety in the treatment physician: pregnant patients, VIPs, and "palliative" cases, or patients who have an extensive history of poor treatment response. Perinatal mental illness is a common complication of pregnancy. Women with serious forms of mental illness may overestimate risks of teratogenicity associated with psychotropic medications, leading to

abrupt medication discontinuation and high risk of relapse. Caring for these women requires the psychiatrist to be familiar with pregnancy safety data for major psychotropic medications, to collaborate with an obstetrical team for prenatal care, and to conduct an expanded safety assessment addressing refractory forms of psychosis may require protracted admission until the onset of labor to ensure a safe delivery. VIP patients have long been recognized as presenting special challenges for inpatient psychiatrists. Celebrity or notoriety, access to enormous wealth or social connections, unreasonable expectations, and demands from family members, anxious administrators, and the patients themselves can create a vortex of distractions that impede the primary job of addressing acute psychopathology. A frequent pitfall is the demand for special privileges or deviation from typical safety protocols. Is the goal of caring for the VIP to provide the same care as everyone else? Or to treat them as a special needs group that requires a form of cultural sensitivity? Patients with an extensive history of poor treatment response can evoke a sense of helplessness, pessimism, or dread in the treating psychiatrist. These patients may have limited identity apart from the sick role, spend little of their time outside of institutional settings, and have frayed or absent psychological, social and family resources after years of illness. Comprehensively addressing their problems in an acute care model is unrealistic, and the focus of care must shift. Lessons from the recovery movement are helpful but may be insufficient. An alternative may be to borrow from the palliative care model, focusing on the patient's comfort, setting realistic goals, and eliminating unnecessary discomforts. Shifting the goals of care in "palliative" inpatient cases can ease the burden of illness in the patient and also reduce caregiver fatigue. Mastering the demands of these special populations will help inpatient psychiatrists, ultimately, to work in all special circumstances and improve their satisfaction with their work. We offer case examples, literature review, and interactive discussion about the complexities of inpatient care in special populations.

Understanding Tarasoff Duties

Chair: Tobias Diamond Wasser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the distinctions between various types of Tarasoff laws; 2) Understand how to identify the relevant Tarasoff law in their jurisdiction; 3) Demonstrate an understanding of the available options when a patient verbalizes a threat to an identifiable victim; and 4) Apply this understanding to clinical encounters with patients.

SUMMARY:

The mid-1970's landmark Tarasoff cases created a responsibility for psychiatrists to warn third parties of a patient's threats. Most psychiatrists have familiarized themselves with the story of Tatiana Tarasoff and the general idea of Tarasoff warnings – i.e. if a patient verbalizes a threat against another person, the treating psychiatrist may need to warn the potential victim. This duty may seem straightforward, but in practice, managing a patient's threats requires nuanced legal, ethical, and practical understanding of the local requirements and the patient's clinical circumstances. Questions arise, such as which factors guide decision-making in these cases and what exact duty the psychiatrist owes to a third party. Does the psychiatrist have a duty or warn or to protect? What's the difference? Who sets the standards? What options are available to fulfill the psychiatrist's responsibilities? In this workshop, we will address these and other questions that arise when a patient makes threats against a third party. We will begin by briefly reviewing the history of the Tarasoff case and subsequent court decisions and statutes, which define the scope of a psychiatrist's responsibilities. We will provide participants with a basic framework for understanding Tarasoff duties by reviewing the distinctions between types of Tarasoff laws (e.g. permissive vs. mandatory), variation in duties between states, and legal limits to Tarasoff duties. Participants will learn practical guidelines for clinical risk assessment of patients who have made threats against a third party. Finally, we will outline the various management strategies, including Tarasoff warnings, that may fulfill psychiatrists' professional obligation to their patients and third parties. The workshop will utilize role-play exercises to provide participants with practical experience evaluating and

responding to patient threats. Participants will break into small groups where they will be presented with challenging clinical case vignettes. Each small group will be asked to take on the role of the psychiatrist in the case and to choose a course of action. Finally, the groups will reconvene to discuss how each small group chose to respond to the clinical cases and the rationale behind their decision-making. While this workshop is designed with trainees and students in mind, it will also provide an excellent review of Tarasoff duties for more senior psychiatrists.

When Physicians Die by Suicide: Insights From Their Survivors

Chair: Michael F. Myers, M.D.

Presenters: Carla Fine, Sarah Ann Smith, M.D., Susan Solovay, Karen Kallberg Miday, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Delineate the reasons why physicians are an at risk group for suicide; 2) List the changes in the physician's functioning and behavior before he/she died as recalled by their surviving family members; 3) Discuss the recommendations made by survivors of physician suicide loss to clinicians, medical schools and residency programs, medical organizations and other stakeholders in the medical workplace; and 4) Anticipate what survivors of physician suicide are looking for when they consult psychiatrists for treatment.

SUMMARY:

It is estimated that 300-400 physicians die by suicide each year in the United States. We have increasing research on this tragic subject, especially the role of individual factors (burnout, depression, substance use, medical illness, perfectionism, extreme loss) and systemic factors (overwork, lawsuits, medical licensing and hospital privileging disclosures) but most families, colleagues and therapists of physicians have been excluded from these studies. In this workshop, four survivors will enlighten us with their observations and recommendations. Carla Fine, a writer, lost her husband Dr. Harry Reiss, a 43-year-old urologist, in 1989. She will talk about how the stigma of suicide in the medical community defines the mourning process for those who are left behind, including family members as well as patients and

colleagues. She will also offer practical suggestions on treating survivors of suicide loss and discuss ways that mental health professionals and survivors can work together to break the silence surrounding physician suicide. Dr. Karen Miday, a psychiatrist, lost her son, Dr. Greg Miday, an oncology fellow, to suicide in 2012. She will draw upon her deceased son's experience with his state's Physicians Health Program to discuss the obstacles doctors face in seeking appropriate and confidential mental health care. She will also explore how the threat of loss of medical licensure, perceived or real, may become the final catalyst for physician suicide. Dr. Sarah Smith, a senior resident in Psychiatry, lost her father, Dr Stephen Smith, an emergency medicine physician, in 2017. She will discuss the ways that stigma towards mental health in medicine affects physicians' perceptions of their own distress, creates barriers to individual physicians seeking help, and impedes organizational change and research. Susan Shaffer Solovay, lost her brother Ben, a well-known orthopedic surgeon, in 2015. Recalling his repeated statement to her "Game over" in one of their last telephone calls, she ruefully wishes it was "Game intermission." She will talk about the many medical and psychological factors in Ben's life that came together in a perfect storm and her concerns about the specifics of his psychiatric treatment which may have worsened his broken and desperate state. More than one third of the time will be protected for discussion. Audience members are invited to engage with the speakers in their quest to reduce suicide in physicians.

Assessing Career Opportunities: A Workshop for Residents and Fellows

Chair: Tobias Diamond Wasser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify relevant variables to consider when assessing potential career opportunities; 2) Demonstrate an understanding of different pathways for continued involvement in academics and professional organizations during one's career; and 3) Synthesize this information with their own personal goals and values in assessing potential career opportunities.

SUMMARY:

During the course of residency and fellowship, trainees are tasked with learning a large volume of knowledge in the various sub-components of psychiatric practice and must develop a specialized skill set to translate this knowledge into practice. However, despite thorough psychiatric training, there are practical elements to making the transition from trainee to practicing psychiatrist that new graduates may not be prepared for. Further, trainees are often not prepared for how to assess the multitude of career opportunities available to them and measure the value of these opportunities in the context of their own professional and personal goals. In this interactive workshop, the presenter will take participants through a simulated job search, from exploring career opportunities through the final stages of contract negotiation. Participants will first review the various components of career opportunities which are important to consider in a job search, will consider which factors are most important to them in their individual search and will be provided nationally representative data about important components of career opportunities in psychiatry (e.g. salary, patient care responsibilities, etc.). Participants will then be presented with hypothetical career opportunities and will consider what additional information they need to determine which opportunities feel worthwhile to further explore. From there, participants will be given the opportunity to role play the interview and negotiation process, with tips and feedback provided by the presenter and peers. Finally, various pathways for continuing involvement in academic and professional organizations will be further discussed. This workshop will utilize didactic, small group and role play to engage participants in an interactive experience which will leave them feeling more prepared for exploring opportunities and planning their future career. While this workshop is designed with trainees in mind, it will also provide an excellent review for those considering a change in career who wish to explore their options in an informed manner.

Avoiding Transition Cliffs: Navigating the Gap Between Child and Adult Mental Health Services for Transitional Age Youth

Chairs: Azeesat Babajide, M.D., Tresha A. Gibbs, M.D.

Presenters: Timothy C. Van Deusen, M.D., Deborah A. Bilder, M.D., Cristiane Duarte, Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define the period of young adulthood; 2) Discuss imminent challenges faced by transition age youth in the public mental health system and by those with developmental disabilities; 3) Describe useful additions to the general psychiatric assessment of young adults from the perspective of child and adolescent psychiatrists; and 4) Identify helpful treatment strategies to engage young adults and facilitate a successful transition.

SUMMARY:

Young adulthood spans 18 and 25 years of age. This period is characterized by great change and challenges as young adults establish independence and consolidate their identity. During this time, studies have shown rates of psychopathology increase while use of mental health services decrease. Many young adults who accessed mental health services in childhood or adolescence face “transition cliffs” upon reaching the age of majority. This issue is magnified for subgroups with additional needs such as patients with developmental disabilities and those navigating public systems. Because of these factors, young adults are a particularly vulnerable population. However, many psychiatrists are unaware of the challenges and opportunities specific to this population. Specific challenges faced by young adults in the public system include the discontinuation of state-funded housing, education, insurance coverage in the absence of social and family support, and navigating a complex mental health system. Transition age youth with developmental disabilities may face different obstacles in these same domains. Their disability typically necessitates prolonged, if not indefinite, caregiving. Adults with disabilities may also face misperceptions of their interests, desires, and needs as an adult. Additionally, the IDEA Act entitles young adults to a public education through 21 years of age with the post high school programming often geared towards developing skills

for independent living and employment. In addition, educational goals are often different for the young adult with developmental disabilities. This talk is relevant for both adult and child/adolescent psychiatrists who are interested in deepening their knowledge and awareness of the needs and opportunities available to this population.

Catatonia: An Approach to Diagnosis and Treatment

Chairs: James K. Rustad, M.D., Vineeth John, M.D., M.B.A.

Presenters: Devendra Singh Thakur, M.D., Robert Scott, M.D., Ph.D., H. Samuel Landsman, M.D., Patrick Ho, M.D., William Tate Schleyer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide historical background for the diagnosis of catatonia; 2) Establish differential diagnosis of catatonia and identify underlying potentially life-threatening causes of catatonia; 3) Perform standardized examination of catatonia: Bush-Francis Catatonia Rating Scale (BFCRS); 4) Understand theories of the neuroscience and pathophysiology of catatonia; and 5) Review management strategies for catatonia in clinical practice.

SUMMARY:

From Kahlbaum, Kraepelin, and Bleuler to Fink, Francis, and Fricchione, the field of psychiatry has evolved the understanding of the fascinating phenomena that constitute the catatonic syndrome. Catatonia is a complex and easily misdiagnosed condition that can be lethal despite existence of well-established diagnostic methods and effective treatment. Catatonia is a syndrome which occurs not only in patients with psychiatric illness (e.g., mood disorders, schizophrenia), but also in those with neurological diseases and other medical conditions. Clinicians must be vigilant for neuromedical etiologies of catatonia, as it is a syndrome found among patients with infections, endocrine disorders, metabolic derangements, and neurologic disorders. Thus, proper diagnosis and treatment of catatonia requires the full utilization of the physician's medical and mental health training background. Our workshop will discuss the changes in our

understanding of catatonia over time from both a clinical and neurobiological perspective. The misguided "catatonia = schizophrenia" equation has persisted in modern medicine and put patients at risk for being administered dopamine antagonists (used to treat schizophrenia); these agents have precipitated neuroleptic malignant syndrome in patients with catatonia. We will present a case to illustrate how psychodynamic and psychosocial etiologies (e.g., history of adverse childhood experience) can clearly predispose individuals to the development of catatonic states. One highlight of our workshop will involve an interactive portion where attendees will have the opportunity to perform the Bush-Francis Standardized Examination for Catatonia.

How to Decrease Length of Stay in the Emergency Department for Psychiatric Patients

Chair: Itai Danovitch, M.D., M.B.A.

Presenters: Waguhih W. Ishak, M.D., Monika Chaudhry, M.D., Sam Torbati, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Gain knowledge about the reasons why psychiatric patients have longer ED length of stay; 2) Acquire practical knowledge about the strategies that could be utilized to shorten ED length of stay; and 3) Learn how to apply gained strategies to match them up to own setting in decrease ED length of stay.

SUMMARY:

It is well-established that psychiatric patients have extended waiting times in the emergency department of general hospitals. According to recent studies, psychiatric patients have to wait 4-5 times as long their medical counterparts for a hospital admission. Studies show that the average ED length of stay (ED-LOS) for medically admitted patients is around 4 hours vs. 16 hours for psychiatric patients and 4 hours for medically transferred patients vs. 21 hours for psychiatric patients. Strategies to decrease ED-LOS for psychiatric patients will be presented with pros and cons, including findings from research studies as well as best practice including workshop attendees experiences. The audience will be engaged in a lively debate about the best strategies

to use and how to match them to participants own clinical settings.

Incorporating Licensed Nurse Practitioners and NP Students Into Clinical Practice

Chair: Lawrence Malak, M.D.

Presenters: Jessica Lynn Thackaberry, M.D., Steve Hyun Koh, M.D., Alex Sietsma, M.S.N.

Discussants: Amy Lisdahl, Elena Burpee

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge on the background, education, and variations of current scope of practice for Nurse Practitioners through the country; 2) Understand the role of a Nurse Practitioner regarding collaboration across disciplines as well as collaboration across training sites throughout the country; 3) Understand how licensed Nurse Practitioners and students have been incorporated into the department of psychiatry and other clinical training programs at a major academic center; and 4) Demonstrate appropriate use for a licensed NP or student in their practice setting.

SUMMARY:

The need for psychiatric care and mental health providers continues to grow and access to care remains limited in many communities across the country. Some studies and reports demonstrate a need for as many as 45,000 additional psychiatrists to satisfy the demands of our patients. This is an overwhelming need for our patients and our systems of care. Couple that with the difficulty in increasing residency slots and our field having 50% of providers over age 55, clearly psychiatrists alone will not meet this daunting need. This demand for more providers to treat patients with unmet mental health needs creates a unique opportunity to cross train other multidisciplinary providers into psychiatric training sites and clinical practice. There has been much discussion regarding the appropriate role of Nurse Practitioners in Psychiatry. NPs are not a replacement for Psychiatrists but are meant to work in collaboration to increase access to care for patients in need. However, the role of an NP varies per state causing confusion for other disciplines. The education and experience required to become an NP is often misunderstood by other providers. NP

students often have a difficult time establishing clinical training sites and preceptors as many Psychiatrists are unsure of how to appropriately incorporate them into their practice. Without compensation from nursing schools, this task seems time consuming and financially burdensome. This workshop will provide a review of Psychiatric NP education and practice role including legal considerations and variations between states. It will outline how UCSD department of psychiatry has successfully implemented a Psychiatric NP student training program and has incorporated licensed Psychiatric NPs. It will address the many advantages and concerns surrounding NP practice. A large portion of the workshop will include a panel of providers from different disciplines and states to engage in a discussion with the audience. Panel members will be available to answer questions and provide guidance to those participants looking to incorporate licensed NPs or students into their practices and training programs.

Inside the Matrix: A Workshop on the Ethics, Evaluation, and Opportunity of Mental Health Video Games

Chairs: Christopher T. Flinton, M.D., Kevin Mauclair Simon, M.D.

Presenters: Emily Wu, M.D., Bruce Alexander Fage, M.D., Helena Winston, M.D., Nadejda Beshpalova, M.D., Sarah E. Baker, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify opportunities for clinicians to incorporate video games into their practice; 2) Appreciate standards for evaluating video games; 3) Understand the evidence base supporting the use of video games in clinical practice; 4) Reflect the challenges in implementing technology in regard to access to care; and 5) Explore controversies about video games, including ethical and legal considerations.

SUMMARY:

The video game industry is expected to become worth over \$100 billion dollars this year, with half of the US population and 95% of American adolescents using video games on a regular basis. With the exploding popularity and accessibility of video

games, researchers and clinicians have begun to consider how to adapt this technology to health-related causes, including behavioral health care. Existing evidence in other fields suggests that video games can enhance treatment compliance, facilitate interactions in the chronically ill, and train cognitive and social skills. The research on specific behavioral health care interventions is less robust. Currently there are thousands of mobile apps whose capabilities can include assessment of behavioral health symptoms, the collection of behavioral data such as exercise and medication use, and guidance in meditation. Many of these apps operate much like video games, and there is hope that video game technology could be adapted for use in psychiatry. Lack of familiarity with video games; questions about privacy, safety, and efficacy; and uncertain payment models serve as barriers to their incorporation into mental health services. Concerns about internet gaming disorder and a possible linkage between video games, attention deficits, and violence must be addressed before video games are embraced by the psychiatric community. Meanwhile, further development of this new technology could improve assessment and treatment, while consideration of unique finance models may improve access for high-need populations. This workshop will attempt to address gaps in knowledge in regard to video games in psychiatry and consider risks, benefits, and ethical implications of this technology. A group discussion will use a case-based approach to allow participants to further explore ethical dilemmas. An approach to the evaluation of video games for their quality and usefulness will be reviewed, followed by another group discussion about potential ways to incorporate this technology into everyday psychiatric practice.

Media Matters: Communication Essentials for Patient Advocacy

Chairs: Jeremy Douglas Kidd, M.D., M.P.H., Jessica Gold, M.D., M.S.

Presenters: Eugene Victor Beresin, M.D., Rebecca W. Brendel, M.D., J.D., Lindsay Holmes

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the role of psychiatrists as both communicators to the lay public

and advocates for patients with mental illnesses or substance use disorders; 2) Identify opportunities for psychiatrists to participate in public discussions about mental health issues; 3) Understand professional and ethical issues relevant to psychiatrists advocating in the media; and 4) Identify strategies for increasing the effectiveness of media advocacy efforts by psychiatrists.

SUMMARY:

From television and newspapers to online media, mental illness and substance use disorders are frequently featured in articles, interviews, and blog posts. Contemporary conversations surrounding the opioid epidemic, gun control, celebrity suicide deaths, and healthcare reform have raised the profile of psychiatric illness. Unfortunately, mental health issues are often discussed using sensationalized or misleading language [1]. This creates media narratives that are stigmatizing of both our profession and our patients. Psychiatrists are needed to respond to such narratives and to spark new conversations that empower patients and promote evidence-based treatment. Despite the unique perspectives and expertise psychiatrists can contribute to public conversations about mental illness, media outlets often rely on non-psychiatrists for analysis and commentary. One potential reason for this is that medical education does not routinely include training in effectively communicating with policy makers or the lay public. Psychiatrists often do not know where to start, or even that they can be part of these conversations. Doing so can also raise ethical issues that require training to understand. This workshop seeks to address these knowledge gaps. This interactive, skills-focused workshop will provide attendees with an overview of different types of media advocacy by first focusing on coverage of the opioid epidemic. As a group, attendees will discuss their reactions to a sampling of articles and videos, including what perspectives they feel are missing, misleading, or in need of expansion. We will then broaden the conversation to include a panel of experts, including a Harvard psychiatrist currently engaged in media advocacy and Lindsay Holmes, Senior Wellness Editor at the Huffington Post. Ms. Holmes will share her perspective from working with clinical experts and provide an "insider viewpoint" of how psychiatrists

can be part of media conversations on issues that affect our patients and our profession. Dr. Rebecca Brendel share insights regarding ethical issues that can arise in advocacy. The co-authors of this workshop will also share their experiences engaging in media advocacy during psychiatric training, having written pieces for The New York Times and Huffington Post. The second half of the workshop will consist of a structured small group exercise focused on a current topic of interest to both psychiatry and the media. Facilitated by one of our experts, each group will consider whether and how to respond to this issue; including types of media, relevant professional/ethical considerations, and how they might frame their response. Each facilitator will approach the issue from their unique background and area of expertise. Groups will then come reconvene to present their “advocacy road-maps,” including any anticipated challenges or additional questions. Our goal is to showcase the variety of different options psychiatrists have at their disposal when acting as advocates, allowing attendees to choose those that best fit their personal style, area of expertise, and comfort-level.

Moral Distress and Psychiatry Residency Training

Chairs: Joseph Ed Thornton, M.D., Jacqueline A. Hobbs, M.D.

Presenters: Fei Chen, D.O., Maanasi H. Chandarana, D.O., Jessica Marie Khan, M.D.

Discussant: Uma Suryadevara, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define Moral Distress; 2) Describe relationship of moral injury, burnout and patient outcomes; 3) Describe case examples illustrating potential moral injury; 4) Present processes for psychiatry residents to recognize and mitigate moral injury; and 5) Discuss the dialectics of moral injury and conscience rights.

SUMMARY:

Moral distress is described as the uneasiness a health care professional feels when their practices are contrary to their sense of right and wrong (1) . Moral distress does not lead to burnout from a singular experience but rather repetitive smoldering experiences of not being true to oneself. In order to

combat moral distress, practitioners have to learn how to speak up, address these offenses against conscience and to seek resolution within and ethical culture of care (2, 3). Another expert panel recognized that teaching ethics to health care practitioners is essential to protecting professionalism and professional behavior (4). We present 3 cases for discussion. The cases will be reviewed along the following questions: What was your distress? What your goal was for the care situation? What course of actions did you think you could pursue to resolve the conflict? What systemic changes do you recommend? Case 1 describes the dilemma of a psychiatry consultation team attempting to guide multiple teams that are managing a complex geriatric patient often with conflicting interventions. Case 2 describes the distress in balancing duty to protect a patient, respecting the patient’s legal autonomy and potential misuse of involuntary commitment laws to compensate a perceived deficiency by other agencies. Case 3 presents issues in confronting a treatment team that is most interested in transferring a patient to the psychiatry service rather than to pursue medical treatment on a difficult person. Proposed interventions to mitigate moral distress are also conflicting. One developed strategy is to train professionals moral courage, eg provide skills for speaking up in clinical situations (5) Yet another group contends that the language of moral courage is a subliminal blaming the victim for lack of courage (6). Adding to the complexity is the observation that our moral convictions have disparate roots (7). These moral roots can lead to conflict with predominant social norms leading to the assertion that some moral convictions have no place in the practice of medicine (8). Even among these disparate views of ethics, there is a consensus that the leadership of a health care system has a responsibility for developing ethical behaviors and promoting moral defense as part of their duties to the persons served in order to promote safe health care (9,10). The United States Veterans Health Affairs has developed a national program of integrated ethics that fosters a defense against moral injury (11) The panel will apply the principles of integrated ethics as a means to build resiliency against moral distress, burnout and compromised patient safety.

New Technologies for Neuroscience and the Law

Chair: Nubia G. Lluberes-Rincon, M.D.

Presenter: Sasha Davenport

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To present new, recently published findings about decision making traits that appear to be predictive of criminal reoffense and compare against existing risk assessment measures; 2) To update the findings with reoffense statistics on the probationers in the year since article submission; 3) to describe new and ongoing collaborations with psychiatrists, psychologists, and other mental health professionals to include the new mobile tablet assessment in their forensic work; and 4) To elucidate the role of the psychiatrist in the development and use of new technologies in correctional psychiatry.

SUMMARY:

Houston-based Center for Science and Law (CSL) has recently published a peer-reviewed article in *Criminal Justice & Behavior* that presents results from mobile tablet software that uses gamified neurocognitive tests to measure several decision-making traits typically associated with criminal reoffense. They have identified significant differences that can deliver assessments of future dangerousness. After collaborating with Harris County's probation assessments department, they found that combining the tablet metrics with their structured interview style risk assessment yielded better predictions than the interview assessment alone. Thanks to the use of portable electronic devices, they have helped the department optimize the way they collect, categorize, and share information. If more agencies can follow a similar philosophy, we can empower large-scale data analysis with the potential to reveal patterns to navigate pre-sentencing and post-sentencing treatment decisions. Join us for a walk through preliminary results, hear an update about reoffense rates in our sample in the year since submission, play our mobile and rapid decision-making games, and receive your own risk score individually.

Post-Graduate Education for the 21st Century:

Incorporating Integrated-Care Opportunities Into Residency Training

Chairs: Mira Zein, M.D., M.P.H., Jose P. Vito, M.D.

Presenters: Jaskanwar S. Batra, M.D., Lianne Kimberley Morris Smith, M.D., Joseph Z. Lux, M.D., Mark V. Bradley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explore different types of integrated care models and their application in diverse systems of care; 2) Identify challenges in implementing new integrated care initiatives in a psychiatry residency; and 3) Use existing collaborative and reverse integrated care frameworks to build resident opportunities.

SUMMARY:

Integrated care models are an evidenced-based method for providing medical and behavioral health services (1, 2). The AIMS Center Collaborative Care model has extensive data in the scientific literature demonstrating improvement of markers of mental and physical health when compared to traditional models of care (2). Studies of a reverse integration model - providing medical services within a psychiatric clinic, is associated with improved quality indicators, such as better blood pressure, lipid, and A1c control, and improved rates of preventative services delivered (3-5). HIV treatment has been at the forefront of integrating comprehensive services: the Ryan White HIV/AIDS Program helped establish specialty clinics that provide medical and psychiatric care, support services, and medication (6, 7) Studies have shown that patients receiving care in integrated care HIV specialty clinics are linked with improved engagement in treatment (6, 8, 9). On the inpatient setting, having an embedded psychiatrist co-managing care with medical teams has been shown to decrease length of stay (10, 11). The psychiatry residency at NYU School of Medicine has diverse sites that span multiple systems of care, including a public, city hospital (Bellevue Hospital), forensic and civilian state hospitals (Manhattan Psychiatric Center - MPC), a federal system (VA), and private hospitals and clinics (NYU Langone Health). Each system has varying levels of already existing integrated care opportunities. The goals of the NYU resident-driven Integrated Care Working Group

(ICWG) are to advance changes in the resident educational curriculum, create clinical electives, invest in research and quality improvement projects, and increase inter-specialty collaboration. This workshop brings together a panel of psychiatrists that work in these various systems and integrated care models, and have helped the ICWG create immersive and educational opportunities. After a brief introduction, Dr. Zein a PGY4 resident, will talk about the initiatives that the group has completed to date and future goals. Dr. Lux, the head of Collaborative Care at Bellevue Hospital, will then discuss how residents participate in current models of Collaborative Care and integrated HIV specialty care in a busy public hospital system. Dr. Morris-Smith, the director of the MPC Outpatient Clinic, will discuss providing residents exposure to the reverse integration model practiced within the state and city systems. Dr. Batra, the Medical Director of Ambulatory Behavioral Health Services for NYU Langone Health-Brooklyn will discuss with Dr. Zein their current pilot project to implement Collaborative Care at one of the busiest medical clinics in the NYU system as part of a resident elective. Finally, Dr. Bradley, the head of consultation psychiatry at the Manhattan VA and director of the NYU Psychosomatic Medicine fellowship will discuss the current project at the Manhattan VA trialing the embedded psychiatrist model.

Protecting Youth Online: The Law, the Risks, and Clinicians' Roles

Chairs: Swathi Krishna, M.D., Caitlin Rose Costello, M.D.

Presenters: Gabrielle L. Shapiro, M.D., Paul Mark Elizondo, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To familiarize attendees with the types of risky online activities by youth and their prevalence in the underage patient population; 2) To familiarize attendees with the legal status of juveniles' social media use and legal consequences of sharing personal information and interacting online; 3) To highlight particularly concerning risks and consequences of online behavior, including cyberbullying and sexting; 4) To introduce attendees to the unique benefits and risks of various new social

media platforms; and 5) To provide clinicians with tools to use in helping their patients safely navigate their online lives.

SUMMARY:

Social media use has become integral to the lives of young people, bringing with it both benefits and risks. Social networking services can enhance their social connections and support networks, provide them with valuable information, and promote their identity formation and sense of belonging. At the same time, interacting and sharing personal information online exposes them to risks including cyberbullying, legal consequences from sexting, exposure to online predators and exposing information to unintended audiences which could impact their plans for the future. Parents and clinicians are often unaware of the social media sites children are using and of the risks unique to each platform, how they are interacting on these sites, or the risk-taking behaviors they are engaging in online. There is limited legal protection for youth interacting online. While a federal law provides some protection to children under age 13, teenagers are vulnerable to many potential legal consequences of sharing personal information online. Despite recognition in many other legal contexts of the immature decision-making skills of adolescents compared to adults, the legal system has not afforded the same consideration to developmental issues when considering online behavior. Online risk-taking behavior can also have serious social consequences for young people, including those associated with cyberbullying and sexting. In recent years, the growth of cyberbullying has become a looming safety concern for young people, with detrimental effects on their mental health and even documented suicides. Sexting is associated with other risk-taking behavior, exploitation of girls, and negative outcomes including bullying, social isolation, depression, and even suicide. With the advent new social media tools, different risks emerge as each platform has different features and different opportunities both for enrichment. Our workshop will provide an interactive session where participants will have the opportunity to learn about current social media platforms, interact in discussion groups about legal cases, learn how to create guidelines for assessing internet use in minors, and learn ways to

adequately counsel parents about their children's internet use. The use of social media is integral to the lives of young people today and its role continues to expand. Navigating the online world safely, productively, and positively requires awareness of the social, mental health, and legal risks of online interaction, appropriate monitoring, and the fostering of mature online decision-making skills. Clinicians have a crucial role to play in assessing their patients' online behaviors, providing education about risks and collaboration around online decision-making, and guiding patients and families toward safe and fulfilling online engagement.

Suicide Risk Assessment in the Emergency Room

Chair: Taras Romanovyc Reshetukha, M.D.

Presenters: Nazanin Alavi, M.D., Mir N. Mazhar, M.D., Christine Lavolette

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize most important suicide risk predictors; 2) Identify suicide risk predictors that are commonly missed in emergency room; 3) Introduce brief educational intervention and suicide risk assessment prompt to improve assessments of suicidal patients; and 4) Recognized and manage medico-legal pitfalls of suicide risk assessment.

SUMMARY:

Suicidal behaviour including suicidal ideations, attempts, and self-harm remains the most common reason for presentation to the Emergency Room (ER). Suicide is responsible for close to 800,000 deaths annually. Also many predictors of suicide have been identified, completed suicide remains essentially unpredictable by current tools and measures. Clinicians continue to face difficulties in integrating and applying risk factors assessing suicidal patients and often are concerned about medico-legal implications if a patient completes suicide after leaving ER. This workshop is supported by evidence from our studies that looks into main predictors of imminent suicidal behaviour based on physician's opinion, chart review and brief educational interventions with the aim to improve suicide risk assessment. In didactic component of our workshop we will review general approach to

suicide risk assessment, address risk factors that are considered important by Emergency Physicians and Psychiatrists when assessing Suicide Risk and their opinion about what factors influence their decision while assessing these patients. Suicide predictors that are commonly missed at the time of assessment by both physicians' group will be identified through the chart review of documented risk assessments. Presenters will introduce a tool "Suicide RAP (Risk Assessment Prompt)" aimed to help physicians remember the important suicide risk factors that are commonly missed in the assessments. Lastly, we provide an overview of evidence-based interventions that reduce suicide risk. In the discussion component we will talk about practical aspects of integration of risk factors when assessing suicidal patients. Presenters will discuss with participants medico-legal pitfalls of managing suicidal patients in ER and documentation of suicide assessments.

The Time Is Now for Change: Using Urgency to Create Revolutionary Social Justice Education in the Yale Psychiatry Residency Program

Chairs: Kali Denise Cyrus, M.D., M.P.H., Ayana Jordan, M.D., Ph.D.

Presenters: Andrea Diaz Stransky, M.D., Flavia Alecia Ruth De Souza, M.D., Walter Mathis, M.D., Lilanthi Balasuriya, M.D., M.M.S.

Discussant: Robert Mark Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss three ways that physicians contribute to health care disparities; 2) Identify three shortcomings of traditional cultural competence approaches to reducing health care disparities; 3) Understand how a sense of urgency can allow for revolutionary changes in educational practices; 4) Describe the three-pronged educational approach used by Yale to help trainees reduce health care disparities; and 5) Brainstorm one idea for a revolutionary educational idea to take back to your residency program.

SUMMARY:

The ways in which physicians unwittingly contribute to health care disparities has been widely publicized since the landmark 2002 Institute of Medicine report, Unequal Treatment. However, medical

education has failed to produce a strong body of approaches that consistently and effectively enhance how students, residents, and faculty better understand the factors that cause and perpetuate these disparities. Undoubtedly, there are significant barriers to this aspect of curricular development. But, in this tense sociopolitical climate, evidenced by increases in hate crimes documented by civil rights organizations like the Southern Poverty Law Center, producing psychiatrists with competence in understanding and intervening against health disparities is more important than ever. In a political climate where society's attention to inequality is heightened, a sense of urgency emerges, urgency which is well documented in the business field to be fertile ground for the creation of transformational change. The Yale Psychiatry Residency Program has attempted to seize this opportunity by creating and implementing the Social Justice and Health Equity Curriculum. To engage residents with variable learning styles, personality characteristics, and academic interests, we used diverse pedagogical approaches, teaching modalities, and a three-part curriculum focused on structural competency, the social sciences to understand the human experience, and methods of advocacy for the underserved. Through didactics and non-voyeuristic immersion in the immediate community, residents explore how school system zoning, bus routes, and city planning lead to structurally imposed inequality. In collaboration with local social science experts, residents will learn how concepts like conflict theory, manifest in everyday life through a lens of the arts & humanities. Lastly, by recognizing the diversity of interests within learners, we introduce the multitude of ways that we as psychiatrists can advocate for our community in non-traditional ways through writing Op-Eds, interacting with legislators, or using interventional psychiatry. With these curricular innovations, we hope to prevent the creation of another generation of well-meaning psychiatrists who unintentionally perpetuate health care disparities. Through this workshop, we will guide you through our curriculum development process and, through active audience engagement, invite you to seize the sense of urgency and start your own process for this very important movement.

Top 10 Geriatric Psychiatry Issues for the General

Psychiatrist: An Update

Chair: Josepha A. Cheong, M.D.

Presenters: Iqbal Ahmed, M.D., Shilpa Srinivasan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to identify and address various ethical issues in the care of patients with neurocognitive disorders; 2) Participants will be able to diagnose and address various causes of insomnia in the geriatric population; 3) Participants will be able to diagnose and manage behavioral symptoms of neurocognitive disorders with pharmacological and non-pharmacological intervention; 4) Participants will be able to identify and address various levels of substance use in the geriatric population; and 5) Participants will be able to identify and manage neurocognitive disorders in geriatric patients in a general psychiatry setting.

SUMMARY:

With the ever-increasing population of adults over the age of 65, the population of elderly patients in a general psychiatry practice is growing exponentially as well. 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 rapidly increasing number of patients with cognitive disorders and behavioral disorders secondary to chronic medical illnesses. Given the usual multiple medical co-morbidities, as well as age-related metabolic changes, the geriatric patient with psychiatric illness may present unique challenges for the general psychiatrists. This interactive workshop 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 interactive session will use pertinent clinical cases to stimulate the active participation of the learners.

A Resident Primer for the Evaluation and Treatment of LGBTQ+ Patients

Chairs: Almari Ginory, D.O., Virmarie Diaz Fernandez, M.D.

Presenters: Marnie Mireya Stefan, M.D., France M. Leandre, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Acknowledge how behavioral health integration in primary care settings can improve LGBTQ+ patients access, engagement and health outcomes; 2) Knowledge of the behavioral health care disparities found in LGBTQ+ populations and implement recommended assessment and treatment modalities; 3) Understand how to approach the behavioral health care of LGBTQ+ people in an inclusive rather than exclusive manner; 4) Provide quality care to the LGBTQ population by using strategies for collection of sexual orientation and gender identity data in clinical settings, creating a welcoming environment of care; and 5) Implement ways of overcoming barriers to providing better care to LGBTQ population in their clinical practice.

SUMMARY:

Despite advancements in LGBTQ+ acceptance and government policies, a third of the LGBTQ+ community reported being “invisible” to their providers. This invisibility masks disparities and impedes the provision of important health care services to a population in need. The LGBTQ+ community faces numerous barriers to health care, including poor communication, presumptions, clinicians lack of knowledge about their health needs, and poor provision of care. For a number of LGBTQ+ people, living as a stigmatized minority can cause excessive stress, leading to mood disorders, suicidal ideation and unhealthy coping behaviors, including unsafe sex or substance abuse, at a higher prevalence than the general population. Since LGBTQ+ people have particular physical and behavioral health needs, it is very important for providers to create a welcoming, inclusive environment of care. The LGBTQ+ population face worse health outcomes due to barriers to care, lack of comfort in disclosing sexual orientation and gender identity which precludes providers from offering appropriate education and counseling for reduction of risk behaviors, and prior negative healthcare experiences which may prevent this population from seeking future healthcare. Clinicians should ask open ended questions, mirroring the

terms and pronouns patients use to describe themselves rather than making assumptions about sexual orientation or gender identity based on appearance or sexual behavior. Additionally, for residents it is an ACGME requirement that residents demonstrate sensitivity and responsiveness to a diverse patient population which include diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. Part of the workshop will focus on this aspect of residency training. Throughout the workshop will discuss recommended questions as well as strategies of acquiring an open, non-judgmental sexual and social history in order to build trust with LGBTQ+ patients. We will provide case examples to foster discussion among attendees acknowledging the most common mental health diagnosis in the LGBTQ+ population, possible behavioral side effects of hormonal therapy and different approaches towards LGBTQ+ families.

Along the Watch Tower: Supervising CBT With Youth

Chair: Robert Friedberg, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Attendees will recognize the core elements of CBT with youth; 2) Attendees will learn the basic principles associated with CBT supervision; 3) Attendees will gain greater familiarity with the best practices of CBT supervision; 4) Attendees will increase their awareness of ways to evaluate supervisees' clinical performance; and 5) Attendees will be exposed to various practices to deal with several problem situations.

SUMMARY:

Child psychiatrists predominantly learn to conduct psychotherapy through supervision and experiential learning. Further, patient care and training experiences are dependent on receipt of good supervision. However, the literature regarding best practices on supervision is limited. Supervisors tend to train supervisees in ways they were supervised which may be problematic or ineffective. This workshop aims to fill this gap in training by providing supervisors with a tool kit of recommended best practices for supervising CBT with youth. Modular approaches to CBT with youth are gaining in

popularity. Psychoeducation, target monitoring, basic behavioral tasks, cognitive restructuring and exposures/behavioral experiments represent CBT's golden nuggets. Additionally, CBT supervision involves learning the prototypical session structure characterized by mood check-ins, agenda setting, processing session content, assigning homework, and eliciting patient feedback. All these tasks need to be done with collaborative empiricism and guided discovery. Accordingly, supervisees need to acquire competencies in these practices. Supervision as the pedagogical engine for acquiring these competencies includes didactic instruction, experiential learning, and self-reflection. The best practices for teaching these clinical methods include supervisor modeling, behavioral rehearsal, the Socratic Method and receiving regular on-going feedback from either live supervision or reviews of video/audiotapes. Finally, progress is regularly evaluated via various rating scales. The workshop begins with explication of the basic rudiments which characterize supervision with CBT with youth. Various methods for teaching case conceptualization and facilitating behavioral rehearsal are explained. Ways to make best use of live supervision and review of video/audiotaped sessions are illustrated. Methods for dealing with supervisees' thoughts and feelings associated with psychotherapeutic work are demonstrated. Attendees also will learn techniques to teach trainees' to tolerate negative emotional arousal and ambiguity. Various new generation rating scales will be presented and methods for integrating their use in supervision will be illustrated. Finally, procedures for helping supervisees avoid common errors such as working with superficial cognitions, lack of focus in sessions, maintaining therapeutic momentum in sessions, and avoiding conceptual drift are emphasized. Attendees will leave the session with several practical tools that they can carry back to their clinical settings.

Calling Upon Your Resilience to Build Well-Being and Prevent Burnout

Chair: Joseph C. Napoli, M.D.

Presenters: Rashi Aggarwal, M.D., V. Alex Kehayan, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) appreciate that burnout and compassion fatigue can inflict physicians; 2) enumerate 12 characteristics of individual resilience; 3) self-assess their resilience; and 4) draw upon aspects of resiliency that were internalized via Active Collaborative Experiential Learning.

SUMMARY:

"Working Toward Wellness: Exploring Burnout and Resilience in Physicians" leads a Psychiatric News "From the President" column by the American Psychiatric Association President Anita Everett, MD. This workshop captures the essence of Dr Everett's essay and her Annual Meeting theme – Building Wellbeing Through Innovation – by focusing on burnout, resiliency and wellbeing. What is the risk to physicians by their being faced with ever increasing and burdensome demands and requirements? What is the risk to physicians by their being empathic and giving clinical care? How can these risks be reduced? What are the building blocks of building wellbeing? This workshop will provide answers via interactive presentations and Active Collaborative Experiential Learning (ACEL). Although experiential learning is a tried and true method with a long history, it is being applied innovatively to building resilience. People know burnout when they experience it but what is resiliency or resilience? A definition will be given and 12 characteristics of individual resilience will be described. Next, aspects of resilience will be highlighted in order to explain various resiliency exercises in which the participants will engage. Then the participants will form concentric circles and carry out another exercise to enhance their resilience. The participants will regroup to discuss their experiences in doing the learning exercises. Finally, the participants will perform an exercise that accentuates the positive and illustrates five themes of building resilience.

Clinical Approaches to Optimize CBT in Your Practice

Chair: Anne Sophie Boulanger Couture, M.D.

Presenters: Thanh-Lan Ngo, M.D., M.Sc., Virginie Dore Gauthier, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Use a clinical scale assessing

suitability for CBT to guide patients selection and therefore optimize clinical outcomes of short-term CBT in your clinical setting; 2) Understand how working with the patient's partner can improve outcomes; and 3) Apply mindfulness skills to decrease suicidal ruminations (Mindfulness based cognitive therapy with people at risk for suicide).

SUMMARY:

CBT is well established as a first line treatment for most mental disorders. Since most psychiatrists are now familiar with or competent in CBT, the question is no longer how to deliver the basics but how to address the challenges of therapy and optimize the outcomes, clinically and administratively. As psychiatrists delivering psychotherapy to a wide range of disorders in a tertiary center, we are particularly interested in understanding and implementing clinical approaches to optimize the outcomes of CBT in mental health settings. In this workshop, we will discuss 3 approaches that can be quite easily integrated to most clinician's practice of CBT with adults. First, we will introduce a clinical rating scale (Suitability for Short-Term Cognitive Therapy Rating Scale, Safran and al.; 1990) and discuss how it can be used during a clinical assessment to establish whether a patient is a good candidate for short-term CBT. Secondly, the core skills of couples CBT will be demonstrated through the presentation of a clinical case, in order to demonstrate the potential benefits of including family members during psychotherapy. Finally, we will present the rationale for offering a mindfulness approach to patients at risk for suicide and will invite participants to practice a short exercise themselves. Participants will have the opportunity to discuss the relevance and implementation of the aforementioned clinical skills.

Discharge Against Patient's Wishes: A Rationale Approach

Chair: Kenneth Michael Certa, M.D.

Presenters: Kathleen Clare Dougherty, M.D., Daniel J. Helman, M.D., Ariela D. Green, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe situations when care desired by patients is inappropriate; 2) Develop a

checklist for documentation of decision-making when there is a disagreement between patient and treatment team; and 3) Review strategies for interaction with patients to minimize likelihood of problematic post-discharge behavior.

SUMMARY:

Delivering appropriate care sometimes put caregivers in conflict with what patients want. There are many situations when patients desire care that is either unnecessary or not in their best interest. This is particularly true in emergency services where the housing and care aspects of hospitalization can be alluring. The interest of patients, hospitalized psychiatrically or otherwise, to extend their stay can occur for many reasons. It may be related to unrealistic expectations of what can be accomplished by hospitalization, or simply the desire to delay having to face life circumstances that led to the hospitalization for as long as possible. In many cases the discharge plan is less than what patients hope for, especially concerning housing or other supports, and there is an expectation that more time will lead to what the patient desires. At times hospitalized patients place demands on the treatment team which cannot be met--for greater pain control, or the ability to smoke tobacco or other substances, or inappropriate diet choices, for example. These demands can result in what is sometimes termed an "administrative discharge." In such cases, in emergency rooms, general floors and inpatient psychiatric units, the threat of harm to self or others is a development which can lead to serious questioning of readiness for discharge. Many times patients assume that such threatened actions guarantee hospitalization. It can be tempting to see working with a patient who should be discharged but is refusing as a battle. As psychiatrists we recognize that this is not the type of conflict in which we or our patients should engage, since nurturing a treatment alliance is paramount to good clinical care. Our panel will present specific techniques, scripts, and contingencies to increase the chance of a continued partnership, and to reduce the chance of an angry patient engaging in activity to demonstrate that we were unwise in our decision. As always, an important part of any clinical interaction is documentation of the reasoning behind the decision. Important points in the

decision-making process should be addressed, including reasoning why discharge is indicated and hospitalization problematic, and why threats must be taken as part of the whole picture. Having a template in mind enables us as clinicians to reduce our own stress and help prevent our patients from hurting us by successful lawsuit. Specifics of patients being escorted out by security, consideration for filing criminal charges if threats progress to acts of violence to others or property and managing notification of family/friends/other caretakers will also be addressed.

Emerging Ethics Challenges in Forensic Psychiatry and Neurology

Chair: William Connor Darby, M.D.

Presenters: Robert Weinstock, M.D., Ryan Darby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the neuropsychiatric symptoms in frontotemporal dementia; 2) Identify proper use versus misuse of neuropsychiatric data in forensic settings; 3) Demonstrate how to analyze this dilemma using the presented framework; and 4) Provide a rationale for how neuropsychiatric symptoms affect criminal responsibility.

SUMMARY:

Challenging situations arise regarding determining criminal responsibility when persons with behavioral variant frontotemporal dementia commit crimes. This issue is particularly topical as increasing numbers of people are diagnosed with frontotemporal dementia. A hypothetical case will be presented involving a person diagnosed with behavioral variant frontotemporal dementia who is charged with capital murder and is pleading not guilty by reason insanity. First, we discuss the basic concepts of moral and legal responsibility, and how neuropsychiatric diseases might impact responsibility for crimes. Next, we outline the relevant questions psychiatrists should focus on when asked to testify in criminal cases involving persons with neuropsychiatric disorders. We then discuss important limitations and controversies regarding presenting neuropsychiatric data in a

forensic setting. For example, we will highlight the valid use versus potential misuse of neuroimaging and neuropsychological tests that can measure legally relevant domains. A framework for assessing complex dilemmas will be presented and audience members will be asked to apply this to the hypothetical situation. The audience will be asked to identify the relevant considerations, to assign weight and balance them to reach the best conclusion regarding whether this person's neuropsychiatric symptoms meet the insanity criteria. Audience members will be polled throughout the presentation regarding various facets of the case and what the psychiatrist should or should not do. The speakers in this workshop include two forensic psychiatrists and one forensic neurobehavioral neurologist who collaborate on academic projects related to moral decision-making and ethics challenges in forensic work.

Exploring Influences of an Ethical Approach in the Assessment of Decision-Making Capacity in Complex Cases

Chair: Maya Prabhu, M.D., LL.B.

Presenters: Kamalika Roy, M.D., Varma Penumetcha, M.D., Mark Alan Oldham, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Differentiate between principle-based and case-based approaches in assessment of medical decision-making capacity; 2) Describe the four cardinal ethical principles of autonomy, beneficence, non-maleficence, and justice; 3) Understand and acknowledge variations in results of capacity evaluation done by different clinicians in gray area cases; 4) Recognize the role of ethical understanding in the variation of results; and 5) Determine an appropriate reconciliation of ethical theories and principals on a rational basis to further clinical management.

SUMMARY:

Introduction: In the challenging role of assessing a patient's capacity to make an informed medical decision complex and unique interactions between patient's clinical and psycho-social context can create ethical dilemmas that are not easily settled with a traditional deontological approach of

“principlism.” On the other hand, the casuistic or case-based approach may be relatively unstructured and invites the risk of relativism based on shared expectations and values, sometimes not aligning with the cardinal ethical principles such as beneficence and justice. A recent study demonstrated the results of a capacity evaluation might vary across profession and subspecialty training¹ but did not explore the reasons for such variation. A separate study found variable quantity and quality of training in capacity evaluation assessment in a large university setting², suggesting there might be a gap in understanding and integration of the ethical theories and legal standards in performing capacity evaluations. In this workshop, we present three cases involving gray areas of medical decision-making capacity to discuss the nuances of capacity evaluation in complex clinical situations and the possible reasons for variable results and dilemma among physicians. Methods: This workshop will be of principal interest to consultation-liaison and forensic psychiatrists and all other psychiatrists who are routinely consulted for capacity evaluations by non-psychiatric providers in ethically challenging situations. Three case vignettes of complex, multi-layered clinical scenarios will be presented and will be accessible through the American Psychiatric Association app for audience review. Attendees will be asked to render their opinion of capacity or incapacity on each of three vignettes. Panelists will discuss the basis for different ethical and moral theories and approaches after which respondents will be divided into small groups based on their opinion of capacity/incapacity. Respondents’ reasoning for their opinion will be explored applying theoretical models (principlism vs casuistic) and ethical principles (e.g. beneficence, autonomy). Small-group discussion will be guided using prepared questions for each vignette as a discussion guide. These questions will pertain to the assessors’ knowledge and application of ethical and moral theories, with intent to explore the determinants of their assessments. Finally panelists will discuss integrative approach for capacity evaluation in gray area cases. Discussion: Modern research finds surprising variability among experienced clinicians in assessing complex medical decision-making cases. Whereas differences in training may explain a part of this variability, we

anticipate that clinician’s knowledge and application of ethical model might also play a key role. Understanding the determinants of capacity evaluation will provide greater insights into the complex process in the gray area cases.

For Good Measure: Integrating Measurement-Based Care Into Clinical Practice Through Innovative Technology

Chair: Whitney E. Black, M.D.

Presenters: Corey Fagan, Ph.D., Carol Rockhill, M.D., Sonia Thomas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explain the rationale for measurement-based care; 2) Identify and state four barriers, facilitators, or solutions to implementing measurement-based care; 3) Apply knowledge of implementing measurement-based care through technology by demonstrating the use of one measurement feedback system; and 4) Apply knowledge of measurement-based care to clinical work by demonstrating how to collaboratively discuss PROM data with patients.

SUMMARY:

Measurement-based care (MBC), the routine monitoring of mental health treatment progress using evidence-based patient reported outcome measures (PROM), improves outcomes (e.g., patient symptoms and function) and optimizes treatment times. MBC is now considered an evidence-based practice in its own right. A recent RCT explored the use of measurement-based feedback for the treatment of depression and found a dosage effect, with higher frequency of structured feedback to clinicians leading to greater improvement for patients in shorter periods of time. The frequent feedback on patient response to treatment likely prompted clinicians to pivot treatment more quickly and frequently than clinicians randomized to the standard care group. While the majority of research suggests small to moderate effect sizes (comparable to those of other evidence-based treatments), limitations in the literature will be discussed. The greatest challenge in MBC now lies in its implementation. For MBC to be effective, it must integrate with workflow and not add undue burden

for patients, clinicians, or administrators. Measurement feedback system (MFS) technology automates the process and overcomes many barriers to MBC implementation, allowing clinicians to instantly receive frequent, structured, evidence-based feedback on patient progress. Literature on the benefits of MBC will be presented. Instructors will present data on implementation from multiple youth and adult focused treatment sites, including discussion regarding barriers, solutions and facilitators of MBC implementation into clinical practice. Instructors will then demonstrate the use of one cloud-based HIPAA-compliant MFS (Owl Outcomes or “the Owl”). The instructors will then role-play using PROM data to collaboratively discuss treatment progress in a developmentally sensitive manner with patients. Participants may then role-play, with guidance and feedback from the instructors, followed by time for questions and answers.

From Telepsych to Texting: How Technological Innovations Can Improve Well-Being

Chair: Kristin S. Budde, M.D., M.P.H.

Presenter: Seth Feuerstein, M.D., J.D.

Discussants: Kathryn M. Salisbury, Ph.D., Lynn Hamilton, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify three new technologies that can augment or provide psychiatric care; 2) Compare different types of technologies and their relevance to particular patient groups; 3) Discuss the existing clinical evidence for each type of new technology; and 4) Describe ways to integrate these technologies into daily patient care.

SUMMARY:

In recent years, mobile devices and apps have allowed psychiatric care, cognitive behavioral therapy, coaching, and new treatments to be provided on digital platforms. The existing literature suggests digital therapies (e.g. online CBT, telepsychiatry, and text therapy) are effective in treating substance use, depression, and other psychiatric diagnoses. But as these technologies advance, it can be difficult to determine how to integrate these innovations into the daily practice.

This workshop will discuss three broad categories of innovation: telepsychiatry (‘office’ visits using video technology), mobile-assisted psychotherapy (therapy via calls or texting), and fully digitized care delivery platforms (e.g. computerized CBT). This workshop will provide an overview of recent advances in each category, focusing on evidence base and real-world applications. Discussion will focus on how new innovations can complement existing systems, expanding access to care and improving outcomes.

Getting to Zero New HIV Infections: The Science, Psychosocial Issues, and Role of Mental Health Providers

Chairs: Marshall Forstein, M.D., Kenneth Bryan Ashley, M.D.

Presenter: Daena L. Petersen, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define PrEP [pre-exposure prophylaxis] and the ART’s [antiretroviral treatments] that are currently available for PrEP; 2) Identify populations at risk for HIV that might benefit from PrEP; 3) Formulate a clinical situation in which PrEP might be appropriate and safe; 4) Identify two potential adverse outcomes of population use of PrEP; and 5) Identify at least two co- occurring conditions in which PrEP might be problematic.

SUMMARY:

HIV continues to be a world wide epidemic. In the United States, approximately 40,000 new infections occur yearly, with the major incidence in MSM’s (men who have sex with men). Men of color, and women, are disproportionately infected. Sexually active people continue to participate in unprotected sex in spite of having knowledge about the use of condoms. The advent of multi drug treatment for HIV that has increased health and longevity among those infected has had the effect of decreasing the sense of fear and anxiety about acquiring HIV as a life threatening disease. Young people who have not experienced the scourge of HIV in their peer communities often believe that if they get infected they “ simply need to take medication”. Based on a few studies in the US and in Africa, antiretroviral medication has been shown to effectively block infection by HIV if taken daily [pre-exposure

prophylaxis-PrEP]. Studies show significant effectiveness for preventing HIV with good adherence to PrEP/ Given the enormous impact of HIV on at risk populations both the CDC and the World Health Organization recommend PrEP for “high risk” individuals who are serologically tested to be HIV negative. These population based recommendations do not adequately assess the impact of PrEP on individuals with regards to psychological readiness, capacity for adequate adherence to daily dosing, and potential for increasing risk taking behavior. Antiretroviral therapy for people infected with HIV that suppresses viral replication has already been shown to have a significant impact on reducing the transmission of HIV from HIV infected to non-infected. Concerns have been voiced about spending resources on PrEP rather than on treatment for those already infected, especially in resource poor nations. This Workshop will present a few brief presentations on the science of PrEP, the translation of the research into clinical practice, the psychotherapeutic, social policy issues, and the ethical implications of using costly medications in healthy people. The long term unintended consequences will be discussed as social, political, intrapsychic and public health issues. The following questions will be raised in brief presentations: 1-How effective is PrEP when used in the clinical setting compared to research protocols? What variables in the protocols might not be present in the clinical setting? 2-What social, psychological and financial issues must be considered from applying research findings to a specific clinical situation? 3- How will the use of PrEP affect decision making and risk taking among a variety of MSM’s? 4- How will resources applied to PrEP affect the access to care and treatment for people infected with HIV? 5-How should psychiatrists and mental health clinicians incorporate PrEP into an ongoing treatment for high-risk individuals? What countertransference issues might arise?

High-Yield Cognitive Behavior Therapy for Brief Sessions

Chair: Donna Marie Sudak, M.D.

Presenters: Jesse H. Wright, M.D., Judith Beck, Ph.D., Mario Mangiardi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Identify CBT methods that can be delivered effectively in treatment sessions lasting less than 50 minutes; 2) 2. Recognize strategies for enhancing the efficiency of CBT in brief sessions; 3) 3. Describe key methods of integrating CBT with pharmacotherapy in brief sessions; 4) 4. Practice several interventions that are useful to manage depression and anxiety; and 5) 5.

Employ adherence enhancement, behavioral activation, thought records and coping strategies for hallucinations in briefer sessions.

SUMMARY:

In modern clinical practice, most psychiatrists spend the majority of their time with patients in sessions that are shorter than the traditional “50-minute hour.” Yet, traditional psychotherapy training emphasizes full-length 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.

Integrating Addiction Treatment into Primary Care: Opportunities for Psychiatrists

Chair: Dongchan Park, M.D.

Presenters: Brian Hurley, M.D., M.B.A., Hector Colon-Rivera, M.D., Jaesu Han, M.D., Adina Bowe, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Examine the current evidences for integrating substance use disorder treatment into primary care; 2) List the current individual and systematic barriers primary care physicians face in incorporating substance use disorder treatment; and 3) Describe future efforts that are targeted at improving communication between addiction psychiatry and primary care physicians.

SUMMARY:

There is a substantial body of evidence for providing

screening, intervention, and referral for substance use disorder (SUD) in primary care clinics. They are efficacious, cost-effective, and expand access for treatment for substance use disorder. Smoking cessation, particularly, has been well embraced by primary care physicians, who have recognized the importance and effectiveness of treatment available in primary care clinics. For example, 90% of all smoking cessation services in the UK are provided in general practice setting. On the contrary, despite the recent efforts to increase access for treatment for alcohol and opioid use disorder, the collaborative care model for other SUDs remains underutilized. Primary care physicians, even after they get X-waivered training, tend to end up not prescribing buprenorphine for opioid use disorder. Similarly, utilization of pharmacotherapy for alcohol use disorder in primary care setting continues to be low. To explain the sub-optimal utilization rate for the collaborative care model, various barriers to integrating substance use disorder treatment into primary care have been identified in the literatures, both at the systematic and individual level. Lack of institutional support, informational deficits and negative attitudes were recognized barriers at the provider level, and were suggested to be targets for future interventions. It will be imperative to understand what primary care physicians everyday in their work settings before determining how to approach those barriers. This workshop will briefly evaluate the existing evidence for collaborative care model for SUD treatment in primary care settings, and identify the barriers to integration of SUD treatment into primary care. Double-boarded psychiatrists in internal medicine/psychiatry and family medicine/psychiatry will lead workshop participants in an interactive simulation and role-playing of a typical primary care visit and facilitate a discussion on why providing treatment for AUD and OUD are more challenging than providing treatment for other conditions. Participants will then be asked to develop different strategies to address both the systematic and individual challenges in improving access for SUD treatment.

Maintenance of Certification (MOC): A New Hope

Chairs: Robert Joseph Boland, M.D., Joan M. Anzia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Articulate the rationale behind continuing education; 2) Offer feedback and current and potential MOC models; and 3) Consider obstacles to effective MOC and consider ways to overcome those.

SUMMARY:

Maintenance of Certification (MOC) is a staple of all medical specialties, however it continues to cause controversy and elicit emotions among many psychiatrists. Most professionals agree with the basic rationale, that once formal training is finished, psychiatrists should demonstrate that they are continuing to practice life-long learning. The devil is, however, in the details – for MOC to be effective, the process should be relevant and meaningful to a psychiatrist’s practice. The American Board of Psychiatry and Neurology (ABPN) has implemented a process of MOC for many years, and in response to feedback has begun a pilot program to test an alternative approach to the part 3 (10-year exam) portion of MOC using a journal article-based assessment option. The process of developing this option is underway, and this workshop will be an opportunity for members help brainstorm and give feedback regarding the planned pilot. The workshop leaders, two current directors of the ABPN who are involved in the MOC pilot program, will begin with a review of the history of continuing certification and discuss the rationale behind MOC. This will be followed by a small group breakout session, in which we will discuss both obstacles to effective MOC and potential solutions. We will briefly discuss the science of adult learning and then apply that to the current framework for MOC and discuss both positive aspects and problem areas. We will end by considering optimal steps going forward.

Patients and Personal Firearms: Approaches to the Physician-Patient Conversation to Reduce Risk

Chair: James Curtis West, M.D.

Presenters: Sonya A. Lewis, M.D., M.P.H., Matthew N. Goldenberg, M.D., M.Sc., Janee Noel Mestrovich, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Understand the principles of safe storage of personal firearms and how these practices affect risk; 2) Recognize potential barriers to communication about safe practices and consider strategies to shift to a constructive dialogue with patients; and 3) Consider challenges to behavioral change around personal firearms and apply communication techniques to overcome these challenges.

SUMMARY:

Physicians have a responsibility to promote the health of the patients they serve. This includes counseling on health risks associated with many different lifestyle choices that patients may make. Each year approximately 30,000 people in the United States die as a result of firearms. Roughly two-thirds of these deaths are due to suicide. With approximately 35 percent of the United States population owning guns and keeping them in their home, it is important that physicians understand how to better serve this population, and how to counsel them about health risks associated with firearms and how these patients can take steps to mitigate that risk. In 2014 the APA issued its Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services. This statement recognized “the critical public health need for action to promote safe communities and reduce morbidity and mortality due to firearm-related violence.” It went on to state, “The APA views the broader problem of firearm-related injury as a public health issue and supports interventions that reduce the risk of such harm.” Individual physician-patient interactions are one area where every physician is in a position to reduce the risk of harm, but some may not feel empowered to conduct these conversations or may lack the necessary knowledge to properly counsel patients. This workshop will provide information to enable psychiatrists to have constructive conversations with their patients on basic principles of firearm safety. We will review the magnitude of gun violence as a public health risk, discuss the principles of safe storage and alternative storage plans at times of increased risk. We will also consider barriers to communicating with patients about firearms and offer strategies to overcome these. We will conclude with a discussion of specific techniques, using

motivational interviewing principles, to help patients make informed risk decisions.

Posttraumatic Stress Disorder in United States Air Force Aviators and Special Forces

Chairs: Terry Correll, Ryan P. Peirson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate how extensive combat exposure and repeated deployments predispose USAF aviators and special forces to developing PTSD; 2) Understand how the USAF extensively evaluates and treats PTSD in aviators and special forces; 3) Describe results obtained by studying aviators and special forces who have developed PTSD; and 4) Examine the impact of allowing maintenance psychotropic antidepressants, psychotherapy, and performance of duty with subclinical symptoms of PTSD.

SUMMARY:

This workshop will examine posttraumatic stress disorder (PTSD) in United States Air Force (USAF) aviators and special forces. Both groups are uniquely positioned to experience significant trauma via extensive combat exposure, especially over the last few decades with ongoing conflicts throughout the world and recurring deployments. When PTSD is suspected or diagnosed in Airmen, the USAF mandates top-notch evaluation, treatment, and thorough study of every impacted individual. State-of-the-art treatment plans are required to potentially include psychotherapy, healthy lifestyle interventions, and psychotropic medication(s), or other appropriate somatic treatments. If the service member is able to continue performing his/her primary duties while getting treatment, the USAF supports this approach. When necessary, the service member can be taken out of their primary USAF duties to allow full treatment and resolution of symptoms to occur. The Aeromedical Consultation Service (ACS) for the USAF has oversight on all aviators and special forces impacted by PTSD. They manage a mandatory USAF study of all aviators and special forces who are diagnosed with PTSD. Two of the primary psychiatrists who work in the ACS will lead this workshop.

Promoting Well-Being Among Women in the Current Political and Social Environment

Chairs: Jorien Gemma Campbell, M.D., Christina V. Mangurian, M.D.

Presenters: Renee Leslie Binder, M.D., Elizabeth M. Fitelson, M.D., Maureen Sayres Van Niel, M.D.

Discussants: Helena B. Hansen, M.D., Ph.D., Louisa Olushoga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify three reasons why the current U.S. political and social environment heightens the risk of mental health issues among women; 2) Discuss relevant clinical cases that highlight how the current political climate has impacted the mental health of women and develop a differential diagnosis of each woman's presentation; and 3) Describe two effective strategies for promoting wellbeing among women in the current political and social environment.

SUMMARY:

Women have demonstrated their proven abilities as leaders and agents of change; however, the current U.S. political climate reminds us that there are still many obstacles facing women. The objectifying and merchandising comments about women made by the President Trump and others who have felt empowered to speak out because of his example are well-known. Moreover, women continue to be largely marginalized from the political sphere -- the picture of the president surrounded almost exclusively by men while signing an executive order with serious consequences for women's reproductive health access worldwide was an alarming visual. The recent presidential campaign and current administration has given rise to fear and anxiety among women. An August 2016 national survey found that 52 percent of women surveyed reported that the presidential election was a significant source of stress (American Psychological Association, 2017). Traditionally vulnerable groups -- including female minorities and immigrants -- are facing increased stress under a wave of perceived threats, targeted hostility, and fear of losing services, which suggests that the current sociopolitical climate will negatively affect the mental and physical health

of marginalized groups (Williams and Medlock, 2017). For many survivors of sexual assault, Donald Trump's remarks on women's bodies, sexist comments, and the 2005 "Access Hollywood" video, in which he openly brags about grabbing and groping women, triggered many women to relive their own painful experiences. Sexual assault is widespread and occurs with disturbing frequency. One in five women will experience rape during her lifetime and 91% of the victims of rape and sexual assault are female (Black et al., 2011; Rennison, 2002). The high prevalence of sexual violence against women is frightening given that it operates as a risk factor for a wide range of women's mental health problems, including depression, substance use, PTSD, and suicide (Campbell and Soeken, 1999; Creamer et al., 2001). For many women, their ability to function, work, and feel safe has become disrupted. The American Psychiatric Association Council of Minority Mental Health and Health Disparities has partnered with the Division of Diversity and Health Equity and the Women's Caucus to develop a toolkit to help providers address the negative impact on women's mental health in the current U.S. political and social environment. It will be highlighted throughout this workshop. Our workshop will first present the impact of the political climate on women as described above. The remainder of the workshop will be interactive, utilizing clinical vignettes to give participants the opportunity to develop a rich differential diagnosis and pragmatic treatment plan including a large focus on advocacy and policymaking. This workshop has support of the Council on Minority Mental Health and Health Disparities and the Women's Caucus.

Promoting Well-Being of African Americans: Tools to Treat Mental Health Needs and Promote Well-Being During the Current Political and Social Climate

Chairs: Jean-Marie E. Alves-Bradford, M.D., Carine M. Nzodom, M.D.

Presenters: Kimberly A. Gordon-Achebe, M.D., Michelle P. Durham, M.D., M.P.H., Latoya Sheree Comer Frolov, M.D., M.P.H.

Discussants: Altha J. Stewart, M.D., Rahn K. Bailey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the impact of the current social and political climate on the mental health of African Americans; 2) Identify 3 risk factors of the African American population for mental health problems; 3) Provide 3 tools to assist in treating and promote wellbeing in African American children and adults; and 4) Identify 3 resources to increase knowledge about the African American population.

SUMMARY:

Over the course of American history, African Americans have suffered from physical, sexual, emotional, psychological trauma during enslavement, Jim Crow, and the civil rights movement (Aymer 2016). Alexander (2004) proposes that cultural trauma occurs when there is a collective agreement that members have been mistreated, and it shapes their identity. Both overt and covert acts of racism act to influence the psyche of African Americans. Numerous recent cases of police brutality and the current political climate including the white supremacy movement, violence in Charlottesville and President Trump's response demonstrate that there continues to be explicit and implicit biases against African Americans. Acts of covert racism are experienced in the form of microaggressions or slights wherein the recipient has an intuitive sense that an act of prejudice occurred during the interaction. Charkraborty & McKenzie (2002) propose that the experiencing of frequent microaggressions serves as a conduit for chronic stress. Racism, including institutional racism, racial bias and discrimination lead to worse social determinants of health and contribute to poor physical and mental health among racial/ethnic minority populations (Jones CP 2008). APA members have reported an increase in their patients suffering from stress, anxiety, mood symptoms and trauma related to the change in the U.S. political and social environment. This workshop will provide up-to-date information and scientific evidence to help psychiatrists and other health care providers in treating African American children and adults. Participants will learn how the current social and political climate impacts the mental health of African Americans. Participants will hopefully better understand the struggle that African Americans face

and its origin. Panelists will provide tools and resources to assist psychiatrists and other mental health professionals in promoting wellbeing and treating the mental health needs of African American children and adults. Through case presentation and break out groups, participants will practice matching which tools and treatments are best used in specific cases. Participants will be able to identify resources for future learning and use.

Psychiatry in the General Hospital: Needs, Innovations, and Challenges From the Early Career Perspective

Chair: Janna S. Gordon-Elliott, M.D.

Presenters: Elena Friedman, M.D., Liliya Gershengoren, M.D., M.P.H., Anna Salajegheh, M.D., Anna L. Dickerman, M.D., Brian Eiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand evidence-based systems of psychiatric treatment in medical settings; 2) Recognize ways to develop and implement changes in psychiatric care delivery in medical settings; 3) Develop skills relevant to beginning a new psychiatric liaison in a medical service; and 4) Learn about educational and technological advances that can be implemented in the psychiatric treatment of medically ill patients.

SUMMARY:

The separation of medical care and mental health care does not sufficiently meet the needs of the growing number of patients necessitating psychiatric treatment. Mental illness and substance use disorders commonly co-occur with medical conditions, adding further complexity to the management of patients in inpatient and outpatient settings. A traditional model of addressing mental health and medical needs in isolation remains the norm, though increasingly unfeasible and impractical. Approaches, including integrated and collaborative care, have developed to address the psychiatric needs of patients in medical settings, offering improved treatment access, quality, and cost-effectiveness, as well as opportunities for innovation in treatment delivery and clinical education. Our presentation will provide a framework for understanding the range of treatment

models for psychiatric treatment within medical settings. We will offer perspectives from early career psychiatrists to illustrate development and improvement of psychiatric treatment delivery in an academic medical center, within inpatient and ambulatory settings. Discussion will include treatment delivery innovations, from direct patient-care to use of technology, such as tele-health; opportunities to improve clinical care, staff satisfaction, and education; and challenges faced in implementing such changes, from institutional “culture” that may resist change, to system barriers that limit feasibility. Emphasis will be given to ways for junior faculty to conceptualize and implement interventions within their institutions. Dr. Friedman will provide an overview of psychiatric treatment models in medical settings. Dr. Gershengoren will describe her role as an embedded psychiatrist in an inpatient medical service, outlining opportunities for improving staff and trainee education, and delivery of care. Dr. Salajegheh will review the model of the dedicated psychiatrist in a transplant program, including how best to meet the needs of clinicians and patients. Dr. Dickerman will present the development of a new psychiatric liaison in a busy medical department, highlighting opportunities for implementing an evidence-based model, and the challenges faced in establishing the structure and function of the role. Dr. Eiss, an internist in both inpatient and ambulatory settings, will offer his perspective on models of treatment for the growing psychiatric needs of his patients. An interactive session will follow, involving audience participation to discuss a proposed scenario related to providing psychiatric treatment in the medical setting. Dr. Gordon-Elliott will present concluding comments, offering a systematic way of thinking about developing innovations in models of treatment within a medical system, with a focus on the early career psychiatrist; a panel discussion will follow.

Refusal of Lifesaving Medical Treatment Motivated by Suicidal Ideation: Ethical, Legal, and Clinical Issues

Chair: Ramaswamy Viswanathan, M.D., D.Sc.

Presenters: Paul S. Appelbaum, M.D., Damir Huremovic, M.D., Aron Pinkhasov, M.D., Paulo Marcelo Gondim Sales, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Know the ethical issues surrounding the legalization of physician-assisted suicide for intractable depression in some countries; 2) Learn the importance of uncovering the motivation for treatment refusal when a patient who appears to be competent refuses life-saving treatment; 3) Become knowledgeable about the clinical approach to take when patients use their medical condition in the service of suicidal intent; 4) Become aware of the complexities involved in decisional capacity assessments in depressed patients who refuse needed medical treatments; and 5) Consider evolving, novel methods such as intravenous ketamine infusion to rapidly improve depression, when depression is clouding the patient’s judgment in a medical situation.

SUMMARY:

About one-sixth of psychiatric consultation requests in many general hospitals are for medical decisional capacity assessments. When a patient cognitively understands what is explained to him, but is depressed, there are no clear guidelines as to how to factor that emotional state into the consultant’s assessment of the patient’s decisional capacity. The situation becomes even more complex when a patient refuses an urgent, life-saving medical procedure, as a way of abetting his desire to die. The consultant has to determine if this desire to die is due to the emotional burden of the physical illness alone, or is mainly due to the emotional burden of a mental illness. In some countries physician-assisted suicide for patients with intractable depression is permissible. In the United States it is against the law and against the ethical code of many professional societies. Should one’s approach to refusal of life-saving medical treatment motivated by depression be similar to one’s approach to a patient requesting assistance in suicide because of suffering from a depressive disorder? Is such a patient’s decisional capacity considered impaired even if he meets all the other criteria for intact capacity? Can a consultant find the same patient as having capacity to accept a procedure, but not for refusing it? Is one’s right to refuse treatment negated when the motivation is suicidality? What are the options when one cannot get a prompt judicial hearing? Should

one consider off-label use of ketamine to try to quickly albeit transiently ameliorate depression and reassess decisional capacity? The proposed workshop will explore these issues using case examples, provided by the panelists as well as the audience. We will start with presenting a case where an elderly patient with intractable depression, and alienated from family, was placed on an external cardiac pacemaker on an emergency basis to save his life. It needed to be replaced by a permanent pacemaker within 6 days because of medical safety. The patient refused a permanent pacemaker. He understood what was explained to him. The first psychiatric consultant determined that he had intact medical decisional capacity to refuse the placement of a permanent pacemaker. Another consultant learnt from the patient that two weeks prior to the medical hospitalization, the patient had gone to the roof of a building to attempt suicide, but he did not have the courage to do it; his current intent was that the refusal of the placement of the pacemaker would let him die; he mentioned "soul pain" as the reason for his desire to die. This consultant opined that the patient's decisional capacity for refusal of pacemaker placement was impaired because it was motivated by suicidal intent, even though the patient's understanding was intact. We will discuss the complex issues we faced and the outcome.

Severe Mental Illness and the Death Penalty

Chair: Megan E. Testa, M.D.

Presenters: Joy E. Stankowski, M.D., Jennifer L. Piel, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand current standards for application of the death penalty to people with severe mental illness and know the standard for competence to be executed; 2) Know the consultative questions that psychiatrists are asked in capital cases, and understand the ethical issues involved in participation; 3) Understand the rationale behind the exclusion of juveniles and individuals with intellectual disabilities from eligibility for the death penalty; and 4) Know about legislative efforts currently taking place across the US to exclude individuals with severe mental illness from the death penalty.

SUMMARY:

The United States is one of the only countries that imposes death as a penalty for certain high-level criminal offenses. Thirty-one states and the U.S. Government use the death penalty, and there are currently over 2800 people on death rows across the country. While capital punishment is a legal practice in most of the country, implementation of the death penalty in the U.S. has not been without controversy, particularly over the past several decades. Many drug manufacturers have been refusing to allow states to purchase their products for use in lethal injections on the basis of moral objections, leaving many states without the necessary supplies to carry out executions and struggling to find new methods to end condemned prisoners' lives. Public concern is mounting regarding capital punishment due to concerns about cost and fairness in implementation. The U.S. Supreme Court has heard many cases challenging the constitutionality of the death penalty as many opponents of capital punishment argue that it violates the eighth amendment of the constitution, which guarantees protection against cruel and unusual punishment. While the Supreme Court has never made a ruling that ended capital punishment, it has ruled that imposition of death does violate the eighth amendment rights of certain classes of U.S. citizens. In 2002, the Supreme Court ruled that executing individuals with intellectual disability violated the U.S. constitution. Following that, in 2005, the Supreme Court ruled that executing juveniles violated the U.S. constitution. Despite controversy and challenges, executions continue to occur in the U.S., and many of those who face execution have mental illness. Individuals with mental illness are overrepresented in the criminal justice system generally, and it is estimated that as many as 20% of death row inmates suffer from mental illness. Psychiatrists are often consulted in those death penalty cases to answer a number of consultative questions for the courts. Psychiatrists may be asked to evaluate competence to stand trial or insanity for defendants who are charged with capital offenses. They may be consulted in the sentencing phase of trials to determine if mitigating or aggravating factors exist in cases in which mentally ill defendants have been convicted of

death-eligible crimes. Finally, they may be consulted to evaluate a death row inmate's competence for execution. During this workshop, presenters will discuss the state of capital punishment in the U.S. today. They will discuss the consultative issues that are asked of psychiatrists in death penalty cases in which defendants have mental illness. They will use case examples to illustrate the ethical issues that come up with involvement in capital cases. Finally, they will discuss current legislative efforts across the country to exempt individuals with severe mental illness from eligibility for capital punishment.

Strategies and Tips for Taking Care of Patients With Advanced Medical Illness in an Outpatient Setting

Chair: Vanessa Torres Llenza, M.D.

Presenters: Sermsak Lolak, M.D., Michael Robert Clark, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize common physical symptoms such as pain, fatigue, nausea in patients with advanced medical illness and how they relate to the patient's psychiatric symptoms, and vice versa; 2) Understand the basic etiology of those symptoms and psychopharmacological strategies to manage them, including potential significant drug-drug interactions; and 3) Develop a comprehensive management plan in collaboration with other medical providers to address the patient's symptoms and improve quality of life.

SUMMARY:

Patients with advanced medical illness, such as advanced cancer or end-stage organ failure, often have comorbid psychiatric syndromes, such as depression, anxiety, cognitive deficits, sleep issues, and also symptoms secondary to pain. Psychiatrists are frequently among multiple specialists that evaluate and follow the patients in the clinics, and these patients are invariably on multiple medications. Many long-term psychiatric patients also eventually developed advanced illness such as metastatic cancer which can affect their psychiatric management. Physical symptoms, such as pain, fatigue, insomnia, nausea, and confusion in this patient population are common and negatively affecting the patient's quality of life and emotional

symptoms such as depression or anxiety. The etiology of physical symptoms can be multifactorial, including secondary to their primary illness, complications or side effects from medical treatment, psychiatric illness, or combination of above, which makes the management of this patient population challenging for a general psychiatrist. Although these cases are commonly seen by Psychosomatic Medicine/Consultation-Liaison psychiatrists in the hospital, more often than not it is the general psychiatrists who manage these patients longitudinally in an outpatient setting. In this workshop, the presenters seek to review common psychiatric management topics that are relevant for a general psychiatrist seeing patients with advanced medical illness in the outpatient setting. We will focus on giving audience practical strategies and tips on 1. Assessment and differential diagnosis of common symptoms, such as depression, anxiety, insomnia in patients with advanced medical illness. 2. Management of patients who have significant pain issues 3. Evaluation and management of common physical symptoms such as fatigue, nausea, cognitive dysfunction 4. Common drug-drug interactions between psychotropics and other medications. 5. Dealing with grief, death and dying, and existential issues at the end of life. Brief didactics, case vignettes, audience participation, real-time polling, and active discussion and Q&A will be utilized in this interactive workshop to assist the participants with the skills and knowledge of strategies for managing this challenging patient population.

The Bridge Between Administrative Psychiatry and Research on Outcome Measurement and New Technology

Chairs: Victor Buwalda, M.D., Sy Atezaz Saeed, M.D., M.S.

Presenters: Sy Atezaz Saeed, M.D., M.S., Victor Buwalda, M.D., William E. Narrow, M.D., William E. Narrow, M.D., John Torous, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will gain knowledge on leadership issues to improve treatment outcomes at the Systems Level; 2) The participants will learn about the ethical challenges and pitfalls in the field of app (software application) development; 3) The

participant will gain insight into the results of a study on patients' smart phone ownership and interest in mobile apps to monitor the symptoms of their mental health conditions; 4) The participant will understand the preliminary results of the USA Field Trial on DSM-5 patient-reported measures embedded in a mobile application; and 5) At the end of the symposium the participants will have knowledge of the advantages and pitfalls of the implementation of new technological systems and methods for mental health care.

SUMMARY:

An administrative psychiatrist is one whose work meets the definition of Administrative Psychiatry as conceptualized by the GAP Committee on Administration and Leadership (GAP, submitted). Administrative psychiatry focuses on the role of psychiatrists within and outside healthcare organizations and systems as they participate in the design, creation, direction, assessment, and maintenance of various mental health enterprises. These tasks and responsibilities are usually carried out in collaboration with other professionals such as fiscal managers, insurers, governments, community organizations, and patients. Among the aims of administrative psychiatry are fostering optimal treatment quality and outcomes, reducing unnecessary costs, and enhancing patient experience, based on ethical principles. Administrative psychiatry encompasses multiple roles including administration, management, and leadership. This workshop aims to address research in the field administrative psychiatry in a combination of using of new technology and new outcome measures that will lower the response burden of the consumer and clinician, that will empower the first and will foster optimal treatment quality and outcomes, reducing unnecessary costs and enhances patient experience as mentioned above. The first presenter will address the need for narrowing the gap between science and practice in which treatment outcome at a systems level can play an important role. The second presenter will lecture about narrowing the gap by explaining the current desire of using smartphones by consumers with psychiatric and addiction disorders to support their treatment process and enhance their autonomy. The third presenter will address the development of a

newly developed device that will support this desire of consumers to become more empowered and take back their responsibilities. The fourth presenter will focus on the results of a pilot study on the use of Patient-Reported Measures in a Mobile Application in the US. Finally, the discussant of the workshop will offer a commentary on what has been said during the workshop and provide some advice for the future.

A New Wrinkle to Consider: Understanding Personality Traits in Cognitive Decline and Neurocognitive Disorders

Chairs: Kristina Frances Victoria Zdanys, M.D., David Carl Steffens, M.D.

Presenters: Sarah A. Nguyen, M.D., Camille Alvarado, D.O., Neha Jain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe how personality interacts with depression and other factors to affect cognitive decline; 2) Recognize how personality influences the care of dementia patients in non-psychiatric settings; 3) Conceptualize behavioral and psychological symptoms of dementia (BPSD) through a model that incorporates pre-morbid personality; and 4) Use case examples to identify ways in which understanding personality may impact treatment of patients with neurocognitive disorder, with emphasis on management of BPSD.

SUMMARY:

Although the prevalence of personality disorders in later life is lower than in younger populations (Schuster et al. 2013), personality traits may persist throughout the life cycle. Patients with neurocognitive disorders often display personality changes, and it can be difficult to discern what symptoms are related to a pre-existing personality pathology vs. the dementia (Oxman 2015). There is evidence that dementia patients as a group largely maintain their personality through the duration of the illness (Cronfalk et al. 2017). There is limited research exploring the relationship between personality and neurocognitive disorders, but there is evidence that premorbid personality may be associated with time to clinical manifestation of dementia (Terracciano et al. 2013, Snitz et al. 2015).

Personality traits, such as neuroticism and extraversion, may moderate the relationship between APOE e4 genotype and cognitive outcomes in older adults with Alzheimer's disease (Dar-Nimrod et al. 2012). Vulnerability to stress, observed in patients with neuroticism, is associated with cognitive decline in late-life depression as well (Manning et al. 2017). Behavioral and psychological symptoms of dementia (BPSD) present significant clinical challenges in the treatment of patients with neurocognitive disorders. There are mixed findings regarding how premorbid personality influences the presentation of BPSD (Zielin & McCabe 2016; Archer et al. 2007), and premorbid personality may impact the presentation of BPSD differently depending on diagnosis (Tabata et al. 2017). Personality trait clusters have also been associated with BPSD in Alzheimer's disease (Prior et al. 2016). Non-demented patients with a variety of personality pathologies present challenges in primary care settings, including complications of medical treatment and difficult doctor-patient relationships (Gross et al. 2002), leading to misunderstandings and exhaustion (Nowlis 1990). Life stressors in older age, such as transition from independent living to higher levels of care, may magnify personality traits and result in behaviors that disrupt the environment (Rosowsky & Gurian 1992). In this workshop, we posit that personality pathology among patients with neurocognitive disorder contributes to the presentation of BPSD and impacts the doctor-patient relationship and care in a variety of clinical settings. It follows that caregivers, physicians, and other members of the care team should be educated about the role of personality in neurocognitive disorders, and that future treatment approaches for BPSD be tailored to address the personality components of these presentations. We will illustrate this by case vignettes from our own clinical experience and will invite audience members to share examples from their own practices. Through this discussion, we will identify common themes and begin to explore innovative approaches that will positively impact quality of care.

Addressing Asian Mental Health and Well-Being During This Challenging Political Climate

Chair: Albert S. Yeung, M.D.

Presenters: Wai Lun Alan Fung, M.D., Anish Ranjan

Dube, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the barriers for Asian Americans with mood and anxiety disorders in accessing mental health treatment; 2) Demonstrate the effectiveness of using culturally sensitive collaborative treatment for engaging and treating depressed Asian Americans in primary care settings; 3) Understand the importance of interactive computerized screening of insomnia, anxiety and depression, and the role of spirituality in enhancing well-being in integrated care; and 4) Understand how cultural identify and ethnic embeddedness protect Asian Americans against mental disorders.

SUMMARY:

There are tremendous disparities in the treatment of mental illnesses among Asian Americans. Recent political climate of viewing non-European immigrants and people of color as outsiders has contributed to increased anxiety and depression among Asians immigrants. Mental illnesses among Asian Americans are frequently under-recognized and under-treated. This can in part be attributed to their illness beliefs and help-seeking behaviors. Asian Americans who suffer from mood disorders tend to focus on physical symptoms and under-reported mood and anxiety symptoms. When depressed, Asians tend to seek help from primary care physicians, lay people and alternative medical practices, but rarely utilize mental health services. To improve recognition and treatment engagement of Asian Americans with depression, the Culturally Sensitive Collaborative Treatment (CSCT) was developed and tested (Yeung et al., 2010). CSCT adds a cultural component to the Katon et al.'s (1995) Collaborative Care Model by incorporating a culturally sensitive component to assess patients' illness beliefs and introduce treatment of depression in a way that is compatible with their belief systems. The CSCT program has been shown to be effective in increase in treatment engagement and treatment outcomes among depressed Chinese immigrants in primary care. Additional topics of relevance to the detection and treatment of mental health issues and the general enhancement of wellbeing in Asians will also be discussed: i) the use

of an interactive computerized screening tool in primary care settings for detecting mental health issues; ii) the role of spirituality and potential impact of collaborations with spiritual care professionals in enhancing mental health care provision; iii) the use of the Engagement Interview Protocol to conduct culturally sensitive interview, iv) cultural identity and ethnic embeddedness as protective and a factor in promoting resilience.

Breaking Bad: Challenges in Psycho-Oncology and Palliative Psychiatry

Chair: Isabel N. Schuermeyer, M.D.

Presenters: Sarah E. Parsons, D.O., Syma Ali Dar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify psychopharmacologic contraindications in patients undergoing chemotherapy and develop safe treatment plans; 2) Recognize the implications of the American College of Surgeons mandate to screen all cancer patients for distress and best ways for psychiatrists to be involved in this process; and 3) Diagnose and treat the psychiatric symptoms that present during the dying process.

SUMMARY:

Psychiatrists are often called upon to evaluate and treat cancer patients that are presenting with either return of a prior psychiatric illness or new onset of psychiatric symptoms. Further, as patients are dying, new psychiatric symptoms can develop and cause significant distress to both patient and their family. The American College of Surgeons mandate that all cancer patient have distress screening caused many cancer centers to review their procedures and develop a plan to address this when it went into effect in 2015. Psychiatrists can have a large role in how cancer centers will revise this process and should be involved. There are many options on how to screen and this will be reviewed. In this session, the contraindications that are commonly seen between chemotherapeutics and psychiatric illness will be reviewed and then during the discussion, ways of managing symptoms safely will be discussed. Patients in the palliative care setting face other types

of psychiatric symptoms that can be addressed by psychiatrists.

Building a Network of Future Leaders in Organized Psychiatry #mentorshipgoals

Chairs: Steven M. Starks, M.D., Uyen-Khanh Quang-Dang, M.D., M.S.

Presenters: Hector Colon-Rivera, M.D., Jeremy Douglas Kidd, M.D., M.P.H., Rachel Robitz, M.D., Sejal Patel, Vabren Watts, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Explain types of mentorship relationships – their strengths and limitations – and the role of sponsorship in professional development; 2) Appreciate goal-setting as a device that strengthens and sustains mentorship relationships; 3) Describe common setbacks in mentorship relationships and strategies to overcome these barriers; 4) Appreciate how the APA's formal mentorship program supports the professional development of leaders in organized psychiatry; and 5) Foster skills to effectively implement organizational mentorship.

SUMMARY:

Mentorship is a key component of the structures of businesses, institutions and organizations. In academic medical centers, formal mentorship has been shown to improve recruitment and retention, enhance faculty development and aid in faculty promotion. Mentorship augments these systems in various ways and benefits both mentee and mentor. Mentors may receive support in their clinical practice and research efforts while mentees find these relationships career-enhancing and report greater satisfaction. Mentorship in training programs has been associated with specialty and academic-career choices. There may be challenges in cultivating these relationships. Barriers that may develop in these bidirectional relationships often relate to miscommunication, mismatching and unmet or unheard mentee needs. As in other dyadic relationships there are developmental stages and milestones that continue to mature and evolve. Mentorship of medical students, residents, fellows and early-career psychiatrists have taken various forms within the APA. In its programming, APA/APAF

fellowships have provided role models, coaching and formal training and support. Alumni of these fellowships have developed into leaders in medicine and within the Association; fellowship highlights include an emphasis on diversity, underserved groups, subspecialty training and community and public psychiatry. Core aspects of the APA/APAF fellowships are formalized training, peer mentorship, network families and legacy promotion. More recently, the Association has sought to formalize its mentorship programming with a specific emphasis on sponsorship and direct advocacy. [This interactive workshop will highlight the APA's efforts at professional development and sponsorship of medical students, residents, fellows and early-career psychiatrists. Our speakers are alumni of four APA/APAF fellowship programs (Leadership, Diversity Leadership, Public Psychiatry and SAMHSA). To enhance audience participation, presenters will offer personal reflections and encourage large-group problem-solving. Our program will provide an overview of both traditional and innovative mentorship models. This presentation will include a discussion of mentorship relationships (informal and formal) and organizational sponsorship, will address the barriers inherent in some mentorship models and will review strategies for successful implementation. We will highlight the Association's newly-developed mentorship model with an introduction of the APA Mentorship Program (and its initial outcomes) facilitated by the program manager for the APA Division of Diversity and Health Equity.] We will provide tools to avoid missteps and augment benefits for mentees and mentors alike.

Catalyzing Creativity and Innovation in Psychiatry

Chair: Bethany Halbreich

Presenter: Uriel Halbreich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Better understand the origins of creativity and how this affects their work; 2) Possess a newfound awareness of methods to increase creative capacity within their work; and 3) Acquire a set of applicable tools to utilize within their work.

SUMMARY:

Science is a creative quest. The scientific method itself revolves around solving to prove an idea. Dudley Herschbach, who won a Nobel Prize for combining a tool in psychics with his research in chemistry, understands that science is a creative adventure. "You're exploring a question we don't have answers to," he says. "That's the challenge, the adventure in it." Creativity and Innovation in science are necessities in today's world. It is time for us to best situate ourselves within the rapidly changing landscape, and accelerate our pathway towards achieving the most creative version of our scientific work. In this workshop, we will explore the fundamentals of creativity and how they relate to the biological, social, psychological and spiritual processes of human cognition and behavior, with a focus on the interdisciplinary implications of creativity in psychiatry. We will explore ways in which we can enhance creativity and facilitate innovative thinking, and then we will workshop methods to amplify each individual's innate creative process using tools like design-thinking, and cutting-edge innovative techniques to spark creative approaches to problem-solving. Bethany Halbreich, the course director, is an Entrepreneur in Residence at TED, an Innovation and Creativity Consultant to PepsiCo, and works with communities around the world to increase their creative capacity. Professor Uriel Halbreich, the course's co-director, is a world-renowned psychiatrist who has spent his career immersed in interdisciplinary collaboration within the scientific field, and will speak to the neuroscience of creativity: brain regions, cognitive functions, and behaviors associated with the creative process.

Challenges in Cognitive Behavior Therapy: Overcoming Barriers to Effective Treatment

Chair: Donna Marie Sudak, M.D.

Presenters: David Allan Casey, M.D., Judith Beck, Ph.D., Jesse H. Wright, M.D., Stephanie Taormina, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Detail key strategies for overcoming common challenges to effective

implementation of cognitive-behavior therapy; 2) Describe common problems in implementation of successful cognitive-behavior therapy; and 3) Develop CBT formulations to address barriers to effective treatment.

SUMMARY:

Experienced cognitive-behavior therapists who are authors of widely used writings and videos on CBT will discuss common challenges in delivering effective treatment and invite participants to present dilemmas they have encountered in implementing CBT. The initial focus of the workshop will be on modifications of CBT for patients who have chronic cognitive and behavioral patterns that may impeded the progress of treatment. An open forum will follow in which participants can share their experiences in treating difficult cases and receive suggestions from session leaders and other participants. Flexibility, creativity, and persistence will be emphasized in finding solutions to treatment challenges.

Decisional Capacity: Contemporary Update

Chair: Maria L. Tiamson-Kassab, M.D.

Presenters: Diana M. Robinson, M.D., Kathleen A. Sheehan, M.D., Ph.D., Mira Zein, M.D., M.P.H., Mary Ann Adler Cohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Provide guidance to other clinicians in assessing capacity; 2) 2. Utilize strategies to enhance a patient's understanding of their medical and treatment options while obtaining informed consent; 3) 3. Review capacity assessment instruments and when they are useful; 4) 4. Discuss the concept of dispositional capacity; and 5) 5. Outline an integrated approach to assessing capacity.

SUMMARY:

Decisional capacity determination is a frequent cause for medical and surgical teams requesting a consultation-liaison psychiatry evaluation and is an important area for the general psychiatrist when this issue arises on medical outpatients. Although psychiatrists are not required to determine a patient's capacity, other specialties frequently

request psychiatry's input for challenging cases and cases with significant repercussions. Thus, developing a standard approach to decisional and dispositional capacity cases is of both clinical and medicolegal importance. Many neuropsychiatric illnesses are associated with diminished decisional capacity, but having a psychiatric illness does not mean a patient is incapable. Treatment of psychiatric illness can improve patients' decisional capacity. Specific interview techniques can be utilized to enhance patients' understanding of risks, benefits, and side effects in the context of decisional capacity determinations. Several research-supported decisional capacity-specific instruments may assist the clinician in the assessment of decisional capacity. In addition to decisional capacity for acceptance or rejection of a single medical/surgical procedure (the more familiar context for decisional capacity determinations) which is grounded in the concepts of informed consent, we use the novel term "dispositional capacity" to refer to the assessment of the patients' ability to accept or reject supervised placement. Dispositional capacity determinations may need secondary consultation with occupational therapy and social work to ascertain the patients' ability to function in vivo. In this workshop, the presenters will summarize the current literature on decisional capacity and offer a pragmatic clinical approach to both types of capacity determinations based on best practice recommendations. Participants will develop an integrated approach to assessing capacity, which combines psychiatric interviewing, cognitive assessment skills, and capacity evaluation instruments when appropriate. In addition to short didactic talks, participants will have the opportunity to apply their knowledge to clinical cases through small groups focusing on common capacity dilemmas with the speakers facilitating the discussion. We will debrief by coming back as a large group and discuss our conversations with the speakers acting as moderators.

Emotional Support Animals: From Afghans to Zebras

Chair: Curley L. Bonds, M.D.

Presenters: Bernard M. Bierman, M.D., Jennifer A. Boisvert, Ph.D., David W. Callander, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Present the existing evidence for the clinical utility of Emotional Support Animals (ESAs), and the clinical value of incorporating animals in the treatment of specific psychiatric disorders; 2) Understand some of the ethical/legal issues and requirements for ESAs vs. Service Animals (SAs); 3) Review the development of policies for providing ESA letters, and allowing ESAs into public and work spaces; 4) Understand the potential clinical conflicts of interest and liabilities from providing ESA letters to patients; and 5) Discuss some of the potential risks associated with allowing ESAs into public and work spaces.

SUMMARY:

Emotional support animals (ESAs) and other service animals (SAs) have grown in popularity in recent years. A study by researchers at the University of California Davis reported a 10-fold increase in the number of animals used for psychiatric services from 2002-2012. This trend has generated many clinical and medico-legal questions about how to manage appropriately requests to provide letters of certification when patients request them. Presenters will discuss the potential for role conflicts and adverse legal actions when providing ESA letters, along with the potential risks associated with allowing ESAs into public and work spaces. This workshop will provide the participant with information about ethical and legal issues, notably the legal distinction between ESAs and SAs and the limited body of empirical research supporting their clinical utility. The session will address ethical guidelines and legal policies/regulations including the Americans with American Disabilities Act (ADA) for the use of ESAs. It will also consider the clinical value of incorporating animals in the treatment of specific psychiatric disorders. Interactive clinical scenarios will be presented that will equip the participant with tools necessary to make informed decisions about how ESAs may be incorporated into treatment plans for specific conditions and diagnoses. The evidence for animal-assisted therapies (AAT) (e.g. therapy dogs) and the clinical indications for animals who are trained to perform a specific function will be reviewed. Controversies surrounding false representations of pets as ESAs to obtain entitlements will be explored.

From AIDS to HIV and the Stigma: The Evolution of Mental Health Services for the LGBT Population at GMHC in This Epidemic Period

Chair: Lawrence Bryskin, M.D.

Presenter: Sean McKenna

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Develop a mental health clinic to serve the LGBT community living with HIV and AIDs; 2) Recognize the present needs and benefits provided in designating services for the LGBT community; 3) Recognize the current issues of the LGBT community and how they are addressed clinically, administratively, politically, and holistically; and 4) Understand how this model may be utilized for the mental health needs of other communities struggling with HIV and AIDs or other disadvantaged populations.

SUMMARY:

In 1981, six gay men gathered together and raised \$7,000 to start the Gay Men's Health Crisis, the world's first AIDs service organization. From when the epidemic first emerged, people with AIDs were struggling with the psychological stress of an AIDs diagnosis and the dementia complex resulting from it, fueled by stigma, e.g. discrimination, anxiety, despair and confusion. Short term counseling was set up. In the 36th year of the HIV/AIDs epidemic, the consequences continue to effect this population including the stigma and discrimination which have far reaching effects for those living with this condition, especially in the LGBT community. The GMHC Carl Jacobs Mental Health Clinic services those who have been shunned by family, friends, and those who have received poor treatment while having trouble accessing necessary services locally. The continuing struggle with mental health and substance use remains an issue. GMHC provides a safe nonjudgmental environment to provide for LGBT who, empowered with support, information, and a sense of community are be able to develop healthy behavior and build relationships with experiences with the support of the clinical staff which understands the distinct needs of these individuals from diverse backgrounds, cultures, and identities. The mental health clinic services include

individual, couple, family, and group psychotherapy. The aim of the mental health clinic is to provide holistic services that address not only the client's mental health and substance use needs, but social, spiritual, and health concerns as well.

Innovative Approaches to Foster High-Quality Emergency Psychiatric Services

Chairs: Kenneth Hung, M.D., Maria Mirabela Bodic, M.D.

Presenters: Derek Orchard, D.O., Hardeep Singh, M.D., Flavio Casoy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review literature and published best practices on emergency psychiatry quality metrics; 2) Present approaches to reduce frequent returns to psychiatric emergency services; 3) Present innovative partnership between Medical ER, local County Mental Health Service, and Telepsychiatry Company to create high-quality psychiatric emergency services in a rural setting; 4) Present approaches to minimize use of physical restraints; and 5) Foster audience discussion on experiences and opinions around emergency psychiatry.

SUMMARY:

With the reduction in inpatient psychiatric beds and the volume and fiscal pressure in outpatient mental health systems, psychiatric emergency services increasingly have a larger role to play in the delivery of not only emergency, but also chronic, mental health care. Adding to the difficulty is major comorbidity of addiction and medical illnesses, acute housing crises, and lack of coordination between different local, state, non-profit, and correctional agencies who share responsibility for caring for individuals with serious mental illness. In most hospitals, psychiatric emergency services are delivered in the medical emergency rooms. However, in very many parts of the country, there are no psychiatrists in Medical ERs and the care falls solely to overburdened Medical ER staff who often feel ill prepared to recommend psychotropic treatment or to lift psychiatric holds; treatment is therefore delayed as staff try to locate inpatient beds. Given the paucity of referral sources in many parts of the country and the comorbidity of

addiction, emergency psychiatric services often become "revolving doors" for patients whose presenting symptoms are due to both underlying psychiatric illness and addiction, resulting in numerous inadequate trials of medications, poor follow up, significant expense, poor patient outcomes, and feelings of futility and resentment amongst the staff. Patients are often brought involuntarily to psychiatric emergency services. Frustration at coercion, along with underlying psychiatric, addiction, and personality symptoms, often place the patient at risk for self-harm or violence. These are extreme episodes where staff must physically restrain patients. Restraints greatly contribute to a dehumanizing experience for the patient and place both patient and staff at risk of injury. Effective prevention of physical restraints is critical to enhance the patient experience and safety. Our workshop will explore published best practices in emergency psychiatric services and the (very limited) available quality metrics. We will also present successful projects that significantly reduced patient readmission after discharge from the ER or associated inpatient unit and dramatically reduced physical restraints. We will also present a three-way partnership between a rural medical ER, the local county mental health agency responsible for inpatient and outpatient care, and a telepsychiatry company that consistently delivers timely, quality ER-based interventions that limit length of stay and link patients to the appropriate level of care.

Research Literacy in Psychiatry: How to Critically Appraise the Scientific Literature

Chair: Diana Clarke

Presenter: Debra Gibson

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the basic study designs, concepts and statistics used in psychiatric research; 2) Identify why it is important to the individual psychiatrist to be able to understand scientific literature and interpret study concepts, design, and statistics; 3) Discuss and critically appraise the scientific literature; and 4) Identify gaps in literature in a practical sense, to have greater access to evidence-based care and informed clinical decisions.

SUMMARY:

The overall goal of the research literacy in psychiatry workshop is to help participants understand what it means to critically appraise the scientific literature. Throughout the session, participants will be introduced to the basic concepts, study designs, and statistics in psychiatric research that will enable them to read and understand the scientific literature and appreciate the importance of being able to critically appraise the literature. Time will be allotted for participants to read a scientific article for discussion. The session will utilize a “journal club”-style interactive format in which methodological and statistical issues will be introduced and discussed on a section-by-section basis as they pertain to the scientific article. After the introduction of methodological and statistical issues related to each section, participants will be given 2-3 minutes to read that respective section of the article. Participants then will discuss the article, view it with a critical eye, and analyze and apply concepts learned. In summary, participants will learn how to appraise the scientific literature in a critical, thorough, and systematic manner. Not only will this workshop help attendees stay abreast of changes in the field and identify gaps in the literature; in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions.

Resident-Led Quality Improvement: Challenges and Opportunities During Training

Chairs: Richard Balon, M.D., Nicole Stromberg, M.D.

Presenters: Musa Yilanli, M.D., Umair A. Daimee, M.D., Anindita Chakraborty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss the importance of quality improvement as a core competence through resident education; 2) Teaching of the principles of Quality improvement projects and PDSA cycle; 3) Practice using PDSA cycles in a psychiatric setting, and address potential problems during clinical or learning environment for residents; 4) Discuss potential benefits to integrate quality improvement into resident curriculum; and 5) Practice residents and faculty work together on team-based QI projects.

SUMMARY:

The Accreditation Council for Graduate Medical Education (ACGME) program requirements mandate that residency programs formally teach quality improvement (QI) concepts and skills as part of the practice-based learning and improvement core competency however residents and faculties come across multiple barriers to implement this concept to resident training. These barriers including, but not limited to, lack of trained faculty, residents knowledge, lack of leadership, hard to maintaining balance with clinical responsibility and limited resources. Thus, most of the residents were not able to opportunity to engage Quality improvement project or they underestimate the importance of this concept during their training. The good news is that with these challenges come additional opportunities. The present workshop will focus on teaching basic concept of Quality improvement and assess opportunities during residency training. We will share examples of different challenges from Veterans Affairs Hospital and effective ways to handle these problems. Team discussion will be designed with resident and faculty together on random QI projects. Audiences will participate in an interactive seminar to review the elements of Quality improvement using shared experiences to drive the discussion. The speakers in this workshop will include two attending psychiatrist, one of them is the director of medical education at Detroit VA hospital and another attending is program director of Chief Resident in Quality and Patient Safety Fellowship Program and program director of general psychiatry program at Wayne State University, two psychiatry residents who work together with numerous QI projects.

Re-Solving the Puzzle of Psychiatric Readmissions: Variables Versus Predictors

Chair: Francisco Quintana, Ph.D.

Presenters: Xenia Aponte, M.D., Victor Guzman, M.D., Alina C. Gonzalez-Mayo, M.D., Carlos Larrauri, Adriana E. Foster, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define patient variables that predict hospital readmission in psychiatric patients;

2) Discuss evidenced based methods/practices shown to help reduce reemission rates, length of stay, and psychiatric symptoms; 3) Recognize the intricate impact of hospital readmissions on patients and their families; and 4) Develop a strategy to incorporate practices discussed in the workshop in their own practice settings.

SUMMARY:

Nearly one fourth of adults in the United States suffer from a mental health or substance use disorder. Of people who suffer from mental illness, some of them may at some point need to be hospitalized to stabilize their conditions. The Agency for Healthcare Research and Quality 2014 data shows the rate of psychiatric hospitalizations on the rise, increasing by 20% since 2005, faster than any other type of hospitalization. Even more concerning than rates of hospitalizations are the growing rates of potentially avoidable psychiatric hospital readmissions. It is estimated that 20%-50% of patients with severe mental illness discharged from a psychiatric unit are readmitted within 12-months. These readmission statistics are not only alarming, but they also highlight the limitations of the broader network of mental health services in reducing the negative impact (e.g., disruptions, demoralization) of hospitalization on individuals trying to recover from mental illness. In this workshop, we will present some of the challenges and successes in preventing psychiatric readmissions in an inpatient unit, including the recognition of patient-level characteristics that increase the likelihood of readmission (e.g, a history of repeated and shorter psychiatric hospitalizations, homelessness, psychiatric co-morbidity with substance use disorders or serious general medical conditions). We will also engage the workshop participants in a discussion of cases that illustrate how these and other variables become actual predictors of readmission in individual patients in community mental health, Veterans Affairs and academic health settings. Treatment team members throughout the continuum of care, including the attending physician, psychiatry residents, and a psychologist will share their perspectives on the topic. Further, workshop participants will have the opportunity to hear a personal account by a peer-advocate and member of the National Alliance on Mental Illness Board of

Directors on the impact of psychiatric readmissions on patients and their families. Finally, various empirically validated methods to prevent psychiatric readmissions will be highlighted. During the workshop, participants will be encouraged to form small discussion groups, where they will voice their opinions and provide solutions to the various issues raised by the panel related to the psychiatric readmission phenomenon.

Safety Alert: Boundary Violations in a Forensic Setting

Chair: Joy E. Stankowski, M.D.

Presenters: Stephen Noffsinger, M.D., Cortney Kohberger

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) 1. Describe boundary violations in a forensic hospital setting; 2) 2.

Recognize the harm that boundary violations can cause not only for the patient, but also for the therapist, other patients, and other staff; 3) 3. Identify factors in forensic hospital settings that magnify the risk associated with boundary violations; and 4) 4. Discuss methods of addressing and preventing violations through staff education and training.

SUMMARY:

Defining and maintaining appropriate boundaries in a patient-therapist relationship can be a challenge. While some boundaries are clear-cut—such as ethical and policy prohibitions against sexual contact—other boundary crossings are more nebulous. For example, some might argue that physical contact is never appropriate, but giving a hug to an elderly grieving widow could be therapeutic. Hugging a young personality disordered patient, however, might have different consequences. Context, therefore, is a critical factor in helping determine which potential boundary crossings remain within the standard of good practice, and which fall outside of good care, potentially leading to negative outcomes. The ability to recognize these differences is especially important in the context of a forensic psychiatric hospital unit, where negative outcomes can be magnified due to the high prevalence of patient

factors such as past criminal behavior, personality and substance use disorders, correctional experience, history of trauma, and long length of hospital stay. Our workshop will enable participants to understand and identify the impact of boundary violations on both patients and staff in a forensic inpatient hospital setting. Using several case studies taken from the files of a large state forensic hospital system, participants will discuss examples of boundary crossings vs. violations, and identify risk factors present in each case. The workshop will then showcase a training program on maintaining appropriate boundaries initiated for staff at one state forensic hospital. Speakers for this workshop are three forensic psychiatrists with extensive experience working in forensic hospital settings.

Safety Planning With the Suicidal Patient: A Basic Tool for Preventing Suicide and Managing Risk

Chair: Barbara Stanley, Ph.D.

Presenters: Gregory Brown, Ph.D., Yael Holoshitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To describe and practice the basic steps in developing a high quality safety plan; 2) To learn how to present the safety planning process to make it most effective; 3) To learn how safety planning fits into the treatment of suicidal patients; and 4) To distinguish between safety planning and no-suicide contracts.

SUMMARY:

Safety planning has become an important component of helping suicidal patients manage their suicidal ideation and prevent suicide attempts. The Joint Commission standards include safety plans or crisis plans for suicidal patients as a key component of managing suicide risk. Suicidal patients have reported that it help to save their lives by providing strategies to weather a suicidal crisis. Yet most clinicians have limited expertise in developing effective safety plans with patients. Often their plans include only a crisis hotline number and directions to go to an emergency room if suicidal. Sometimes clinicians still use “no suicide contracts” which have been found to be ineffective. The safety planning process has developed where we now have

empirically supported safety plan interventions. There are also studies showing that the quality of safety plans has an impact on further psychiatric hospitalization and subsequent suicidal behavior. This interactive workshop will teach participants how to develop high quality safety plans using the Safety Planning Intervention (Stanley & Brown, 2008, 2012) developed by two of the workshop leaders (Dr. Gregory Brown and Dr. Barbara Stanley). The Stanley-Brown Safety Planning Intervention is the most widely used safety plan therapeutic intervention both nationally and internationally, is identified as a best practice on the Registry of Best Practices for Suicide Prevention organized by the Suicide Prevention Resource Center, and is used in emergency rooms, in outpatient settings and on inpatient units. The Stanley-Brown Safety Planning Intervention consists of six steps: 1. identification of warning signs; 2. internal coping strategies to use during a suicidal crisis; 3. social supports as distractions from the suicidal crisis; 4. social supports to resolve the crisis; 5. professional and crisis hotline contacts; and 6. reducing access to lethal means. The workshop will combine didactic approaches with use of video demonstration, material, role plays and participant polls on “good” vs “poor” approaches to safety planning. Participants will have the opportunity to use the safety plan intervention form and discuss obstacles to implementation of the intervention. Dr. Yael Holoshitz, a psychiatrist who works extensively with psychotic patients, will help participants learn to adapt the intervention for this population.

Systems Change Innovations in Psychiatry: Using Technology and Stakeholder Engagement for Meaningful Quality Improvement

Chair: Frank G. Fortunati, M.D., J.D.

Presenters: Luming Li, M.D., Tobias Diamond Wasser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Discuss how to use technology and stakeholder engagement to improve clinical quality and compliance of national metrics; 2) Use principles from psychology, implementation science, and business to discuss organizational structure and leadership behaviors that can influence quality

improvement projects; and 3) Synthesize innovative approaches to quality improvement challenges by identifying important resources and human capital for systems change.

SUMMARY:

Quality improvement and patient safety are important facets of clinical medicine, especially after public attention to books such as the Checklist Manifesto and Crossing the Quality Chasm were published and drew significant public attention to medical errors and quality deficiencies. Within psychiatry, a national quality improvement initiative known as the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) is currently the standard for guiding inpatient psychiatrists and hospital administrators on specific metrics used for benchmarking clinical performance. These metrics are watched closely by organizations such as the American Hospital Association (AHA) and the Centers for Medicare and Medicaid Services (CMS), and made public so that individual performance by a psychiatric hospital can be viewed by consumers of healthcare. In addition, these metrics are now tied to reimbursement for hospitals paid by Medicare and Medicaid, as emphasized by the Affordable Care Act. Many inpatient psychiatric hospitals and psychiatrists need to keep up-to-date and find creative solutions to adhere to compliance metrics, especially since there are many metrics and limited time for documentation. In this session, we will discuss the experiences for engaging psychiatric residents and senior hospital administrators at Yale New Haven-Psychiatric Hospital around quality improvement projects, and how the behavioral health service line has addressed and coordinated adherence to 11 complex metrics (including documenting reason for admission, medication instructions, etc.). We will also discuss the leadership structure that has allowed our system to efficiently transmit of patient records to the next level provider within 24 hours, and the complicated interpersonal dynamics at play for coordinating the adoption of meaningful changes in clinical practices. We will discuss the development of a semi-automated electronic health record (EHR) tool to address transition record metrics (as related to IPFQR), and the subsequent process that has led to strengthening teamwork, transparency, and

benchmarking of practices across 5 psychiatric inpatient units and throughout our hospital system. The stakeholders involved in the project include compliance abstractors, psychiatric hospital administrators, nursing staff, social workers, and residents. The implementation of the tool has involved concepts of anticipatory guidance, strong leadership alliance, structural organization, and effective execution, which can be applied to quality improvement projects in a variety of settings. The workshop will also include an interactive portion that encourages audience participants for form small groups to discuss a challenging quality improvement problem and possible solutions.

The Fourth Industrial Revolution and Telepsychiatry in the UK

Chairs: Cyrus A. Abbasian, M.D., Zainab Kikelomo Imam, M.B.B.S.

Presenters: David Robert Bickerton, M.B.B.S., Wiktor Lucjan Kulik, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Learn how telepsychiatry can revolutionise patient wellbeing; 2) Recognise the charitable potential telepsychiatry has, with every professional now being able to contribute to global mental health; 3) Learn how subspecialties can develop within the generic telepsychiatry model - focus on addictions, forensics, primary care and women's health; 4) Identify potential patients by the Case Series of those accessing telepsychiatry; and 5) Develop innovative ideas on how to incorporate technology into your own practice.

SUMMARY:

The fourth industrial revolution will have significant repercussions in healthcare and for wellbeing. It has given providers the opportunity of making mental health both available and affordable worldwide. We shall present the innovative steps taken to develop an online psychiatry service in the UK. Our session will also cover potential problems and pitfalls, barriers and limitations to telepsychiatry, including how these can be overcome. We will ask all participants to think of ideas on how technology can improve their practice. As examples we will run through individual cases and case series of the

patients accessing our telepsychiatry service. We will also incorporate service evaluation and patient feedback data. Family physicians have limited experience in the management of addictions, in particular with comorbidity. Many patients face stigma and barriers to treatment, as traditional services are mainly directed towards severe, injecting and complex drug users. We have a confidential and accessible telepsychiatry service for the assessment of addictions. Offering online treatments for addictions can be more challenging however; so our initial focus has been mild cases and those with dual diagnosis. We are developing an online supervised consumption service and will discuss our supervised maintenance orodispersible buprenorphine feasibility study. Mental health provisions remain neglected among racial minorities. We will encourage participants develop ideas on making services more inclusive using technology, particularly building culturally sensitive psychiatry services for women. Also we will assist developing participant's ideas on what innovative charitable works they can be involved in, including for psychiatric support being provided across the world. In discussions we will incorporate how telepsychiatry has affected the UK criminal justice system and will provide the perspective of an inner city family physician who has become a psychiatrist, and then has incorporated telepsychiatry into his practice. Overall this session will help participants build wellbeing through innovation, the theme of the 2018 Annual Meeting. All Presenters are Consultant Psychiatrists and Partners with www.psychiatry-uk.com.

The Gun Talk: How to Have Effective and Meaningful Conversations With Patients and Families About Firearms

Chair: John S. Rozel, M.D.

Presenters: Layla Soliman, M.D., Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the legal context and public health impact of firearm access in the United States; 2) Assess firearm access, storage and handling habits, and violence risk; 3) Apply effective -- and avoid ineffective -- techniques for counseling about gun safety using motivational interviewing

and cross cultural models; and 4) Consider effective, risk-conscious approaches to documenting discussions with patients and families about firearms.

SUMMARY:

How do you ask about access to guns? How do you counsel about gun safety? How do you engage patients and families who do not want to talk openly about gun issues? Cutting through the media and political rhetoric to deliver a clinically effective and evidence-based intervention can be a daunting task. Adding to this challenge, discussing firearms may amount to cross-cultural work without the psychiatrist even being aware that there is a cultural divide impacting the quality of their assessment and the impact of their intervention. Nonetheless, assessing, documenting, and counseling about access to firearms is a vital clinical skill for psychiatrists while there is surprisingly little guidance available on effective strategies and tactics. Adapting lessons from cross-cultural psychiatry and motivational interviewing, this workshop will help professionals better understand firearms, culture, public health and policy, and the pragmatics of effectively asking and talking about firearms with consumers and their families. By prioritizing the goal of engagement and shifting the conceptual target to safer storage, psychiatrists may be more successful in helping patients and families manage the risks of firearm access. Special attention will be paid to the legal and cultural factors that make firearm access uniquely ubiquitous in the United States and fundamental concepts and terminology for the firearms novitiate. Detailed and scalable interview approaches to identify access, use, and storage of firearms will be explored. Specific questioning strategies for higher risk patients and more resistant patients and families will also be offered. Participants will have the opportunity to participate in structured role play exercises during the workshop to practice their new skills and knowledge in a controlled environment.

Treatment of Addiction and/or Mental Health Conditions in Health Care Providers: Best Practices and Legal Considerations

Chairs: Matthew Goldenberg, D.O., Karen A. Miotto, M.D.

Presenters: Kevin Cauley, P.C., Gregory Skipper

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Further participants understanding of the critical components and considerations regarding treating a healthcare provider with a substance use disorder or mental health condition; 2) Provide participants with a better understanding of risk factors for and tools to decrease physician behavioral issues, suicide and burnout; and 3) Discuss the legal considerations when treating a healthcare provider with addiction or mental health conditions.

SUMMARY:

Physician burnout and suicide rates are at their highest levels and steadily climbing. Workload, electronic medical records, decreased time with patients and poor work-life balance have all been proposed as possible contributors to the epidemic of physician burnout. In contrast, physicians have the same rates of mental illness (such as depression and anxiety) and substance abuse as the general population. However, the substance physicians tend to abuse are alcohol and prescription medications (v.s. illicit substances for the general pop). With all of these factors colliding into “Physician Health,” it is no surprise that physician well-being committees are commonly tasked with assessing a “troubled physician”. Burnout and suicide are not limited to seasoned members of the field of medicine. Medical students and residents have burnout levels as high as 50%. We are just now starting to uncover the epidemic of medical student and resident suicide rates. An intensive diagnostic evaluation of a physician is a repetitively new concept. Prior to the 1990’s Physicians were confronted and in many cases forced into treatment. Currently, the practice is to encourage a physician suspected of having a substance abuse, mental health or behavioral problem into a minimum 72 hour diagnostic evaluation to uncover whether or not they need treatment. Physicians face similar barriers to treatment as the general population such as shame. However, they also face barriers such as fear of losing their careers, losing medical malpractice coverage, losing credentialing/hospital privileges and more if they are diagnosed with mental illness or

substance abuse. Therefore, the delivery and quality of a treatment and monitoring for a healthcare providers is critical. Our workshop will cover the current healthcare environment and the epidemiological and other risk factors that physicians face when recovering from addiction and mental health conditions. We will discuss the treatment process of when a healthcare provider (a colleague, staff member or resident/medical student) needs treatment including the intensity of treatment, levels of care, medication vs. non-medication treatment options, time needed off of work and other important considerations. Finally, in great detail we will cover the process of ongoing monitoring to assure the healthcare provider is safe to return and to continue to practice after receiving treatment. We will provide an interactive experience for the audience to help them incorporate a better understanding of both physician health and thorough treatment into their practice or into the medical institution. Legal consideration and concerns will be discussed and best practices will be provided.

Tuesday, May 08, 2018

13 Reasons Why Not: The Role of Suicide Portrayal on Suicide Risk Among Young Adults

Chair: Nicole A. Guanci, M.D.

Presenters: Zain Khalid, M.D., Hanan Khairalla, M.D., Kalliopi S. Nissirios, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the evidence relating news and entertainment media portrayals of suicide to actual suicide rates and discuss explanations for the ‘Werther’ and ‘Papageno’ Effects; 2) Analyze specific narrative and formal features of the show “13 Reasons Why” that lend themselves to a possible ‘Werther effect’; 3) Describe how evolving patterns of media consumption, especially among young people impact suicidal behavior and are an evolving risk for today’s youth; 4) Discuss techniques for clinicians to help patients process the portrayals of suicide in the context of increasing media exposure; and 5) Recognize the role of mental health professionals in collaborating with media personnel and public

health policy officials in developing ethical guidelines on responsible media depiction of suicide.

SUMMARY:

An association between fictional depictions of suicide and imitative self-harm has been hypothesized since the late 18th century when Johann Wolfgang von Goethe's portrayal of a suicidal protagonist in 'The Sorrows of Young Werther' triggered a spate of emulation suicides across Europe. This phenomenon of observers copying suicidal behavior, now known as the "Werther Effect," has since received substantial empirical validation. While most studies report a stronger effect of news stories of suicide on copycat suicides, contagion from fiction has also been extensively documented. This effect is of particular concern among susceptible youths, as suicide is now the second leading cause of death in this population. The public health significance of the Werther Effect was highlighted in the Surgeon General's report on Mental Health in 1999. The issue of media influence on suicide is of special importance for mental health professionals now because of recent trends in media content and viewer habits. Young people report 6 hours or more a day of media exposure, and an increasing number of media portrayals of suicide now involve characters younger than age 25. Streaming services allow for an immersive 'binge watching' experience that can be more potent in influencing modeling behavior. The Netflix series "13 Reasons Why" about teen suicide became the most tweeted show of 2017 and has since generated widespread concern for its potential impact on suicidal behavior. A recent investigation by Ayers et al. noted a significant increase in internet searches suggestive of suicidal ideation since the show's release, an observation we find reflected in our clinical experiences in the ED. In this workshop we will review "13 reasons Why" with regard to the dramatization of teen suicide. We will analyze the show's content to include commentary on the depiction of teenage experiences such as bullying, addiction, sexual assault, poverty of adult guidance and support and suicide with a primary goal of raising awareness among clinicians about media influence on suicide that not only pertains to a child and adolescent population, but has implications for adult patients as well. We will also discuss features

contributing to a Werther Effect, that can be extrapolated from this series to include other media, school, and community coverage of topics related to suicide, such as simplification of the causes of suicide, glamorization of suicide, portrayal of counselors and adults as uncomprehending, incompetent or unavailable, and the choice to include a graphic portrayal of a suicide attempt. Using a proposed explanation for the Werther effect in social learning theory we will also identify how portrayals of suicide can best be reframed to assist patients in processing such information in a way that decreases risk. Finally, we plan to highlight the need for collaborative regulative efforts to implement guidelines on responsible media portrayal of suicide.

A Cognitive Behavioral Approach to Weight Loss and Maintenance

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Teach dieters specific "predieting" cognitive and behavioral skills; 2) Keep motivation high long-term; and 3) Facilitate permanent changes in eating.

SUMMARY:

A growing body of research demonstrates that cognitive behavioral techniques are an important part of a weight loss and maintenance program, in addition to exercise and changes in eating (see, for example, Stahre & Hallstrom, 2005; Shaw et al, 2005; Werrij et al, 2009; Spahn et al, 2010; Cooper et al, 2010). An important element that is often underemphasized in weight loss programs is the role of dysfunctional cognitions. While most people can change their eating behavior in the short-run, they generally revert back to old eating habits unless they make lasting changes in their thinking. This interactive workshop presents a step-by-step approach to teach dieters specific skills and help them respond to negative thoughts that interfere with implementing these skills every day. Participants will learn how to engage the client and how to solve common practical problems. They will learn how to teach clients to develop realistic expectations, motivate themselves daily, reduce their fear of (and tolerate) hunger, manage cravings,

use alternate strategies to cope with negative emotion, and get back on track immediately when they make a mistake. Techniques will be presented to help dieters respond to dysfunctional beliefs related to deprivation, unfairness, discouragement, and disappointment, and continually rehearse responses to key automatic thoughts that undermine their motivation and sense of self-efficacy. Acceptance techniques will also be emphasized as dieters come to grips with the necessity of making permanent changes and maintaining a realistic, not an “ideal” weight that they can sustain for their lifetime.

Addressing the Emerging Crisis in the Care of Older Adults With Schizophrenia: New Paradigm and Treatment Models

Chairs: Carl Ira Cohen, M.D., Deborah Gustafson, Ph.D., M.S.

Presenter: Heather Leutwyler, Ph.D., R.N.

Discussant: Tarek K. Rajji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To appreciate the national/international changes in the demographics and care needs of older adults with schizophrenia; 2) To appreciate how recent longitudinal studies have altered our understanding of the outcome and course of schizophrenia in later life; 3) To learn about new models of care for enhancing various outcome domains in older adults with schizophrenia; and 4) To learn about the impact of long-term psychotropic medication and prospects for reducing or eliminating medication in later life.

SUMMARY:

In the United States, by 2025, 1.1 million people or about one-fourth of all persons with schizophrenia will be age 55 and over. Globally, the number of persons aged 60 and over will double by 2050 with estimates reaching over 10 million persons. A crisis looms as research and clinical programs have not kept pace with these demographic shifts; e.g., less than 1% of the literature on schizophrenia has been devoted to older adults. In this session, a multi-disciplinary international group of researchers will highlight recent epidemiological and clinical studies in this area, discuss limitations in the literature, and

identify where new investigative efforts should be directed. We will examine how longitudinal studies support the emergence of a new paradigm that conceptualizes outcome of schizophrenia in later life as a more dynamic process comprising diverse, predominantly non-overlapping indicators and heterogeneous outcomes. Contrary to the prevailing literature, schizophrenia is not quiescent or static in later life but each outcome measure shows considerable fluctuations (one-fourth to two-fifths of persons), and there is a range of favorable outcomes across various domains. We will discuss how the fluctuation in the course and heterogeneity of outcome fit within the recovery model and gerontological models of accelerated and paradoxical aging. Based on this paradigmatic shift, we will describe new biological and psychosocial interventions and model programs for this population that target various outcome indices such as cognition, social skills, life quality, and physical self-maintenance. Finally, we will describe new investigative efforts in psychopharmacology including the long-term impact of medications and the possibility of lowering dosages and/or discontinuing medications.

Addressing the Opioid Epidemic: Medication-Assisted Treatment and Twelve-Step-Based Rehabilitation—Compatible or Not?

Chair: Marc Galanter, M.D.

Presenters: John Adam Fromson, M.D., Richard K. Ries, M.D., A. Kenison Roy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe clinical areas of complementarity and conflict between Twelve Step and medication-assisted treatment; 2) Identify practice areas of participants where Twelve Step/medication-assisted treatment can be more effectively applied; and 3) Apply techniques for complementarity of Twelve Step/medication-assisted treatment in their practices.

SUMMARY:

Both Twelve-Step-based approaches and buprenorphine maintenance are options for rehabilitation of opioid addicts. Each has advantages and shortcomings in effectiveness in this clinical role,

but each is usually applied separately. Given the many respective clinical settings where these approaches are applied, it is important to ascertain whether there are ways to offer both modalities in parallel, or in an integrated manner. A deficit in integration across Twelve-Step and medication-oriented clinicians arose historically because the TS approach emerged in the 1930s, at a time when there were no medications available to support rehabilitation of persons with alcohol dependency. It was only over ensuing decades that medications for promoting abstinence from alcohol and other dependency-producing drugs became available to patients. Many psychiatrists are experienced in prescribing maintenance medications like buprenorphine and Vivitrol. They are less acquainted with how Twelve Step approaches can be useful in rehabilitating such patients or, conversely, can present barriers to compliance with medication regimens. We plan to improve participants' skill to deal with these issues in clinical practice. This workshop will consist of four seven-minute presentations regarding the Twelve Step/buprenorphine issue. Each presentation will be followed by exchanges between the respective speakers and workshop participants. Presentations: Residential Rehabilitation Settings (Galanter); Physician Recovery Programs (Fromson); Pain Management (Roy); Twelve Step Facilitation Trainings (Ries). The remaining 45 minutes will consist of discussion regarding options for clinical application of the issues presented by the speakers. Discussion: Clinical Issues Relating to the Use of Buprenorphine Along with Twelve Step Approaches. Participants will break into four separate work groups to address the four respective areas presented by the speakers. Their task will be to develop practical techniques for clinicians in these practice settings, with a rapporteur summarizing for the entire workshop attendee group the techniques they framed for clinical application, followed by discussion between the attendees and speakers.

Beyond Gotham City: SUPERPOWERS for Psychiatric Hospitals

Chair: Julie A. Niedermier, M.D.

Presenters: Scott J. Gspandl, M.D., Nichole Yarbrough, Leah Davison

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify SUPERPOWERS: Strategies Used to Produce Efficacious Results in Patient Outcomes, Wellbeing, Efficiency, Restraint, & Satisfaction; 2) Review principles essential to clinical, fiscal, and organizational success of psychiatric hospitals; and 3) Exchange ideas, best practices, and challenges encountered in various acute care settings that may jeopardize or enhance patient, individual, or organizational wellbeing.

SUMMARY:

Providing quality, evidence-based, patient-focused acute psychiatric care in the setting of increasing workplace violence, exceedingly scarce hospital beds, a nationwide opiate public health emergency, and diminishing resources has presented numerous challenges to traditional inpatient psychiatric hospitals in academic, private, and public sectors. This workshop will explore an academic medical center's journey to address opportunities and implement strategies that provide evidence of tangible gains using patient outcome metrics and satisfaction scores, measures of employee wellbeing, hospital length of stay, and rates of restraint and seclusion. Discussion about innovations and synergies in education and clinical care, engagement and team functioning, leadership strategies, evidence-based practices, and quality improvement will be emphasized. Participants will be encouraged to share their own institutional challenges and triumphs with the interdisciplinary panel during the workshop. Identifying organizational challenges • Cultural disconnect of leadership, clinical management, and day-to-day experiences of employees • Concerning trends with seclusion and restraint of inpatients, corresponding with staff injury and diminished workplace engagement • Static patient satisfaction and experience results • Lag in implementation of evidence-based practices to optimize patient outcomes • Increasing length of stay and demand for hospital beds and related fiscal implications Implementation • System-wide trauma-informed care initiatives: staff education about trauma, policy revisions, environmental changes, cultural attitudinal shifts; utilization of trauma-informed care principles and preventative tools with patients; mechanism for peer support, debriefing,

quality review • Leadership engagement: commitment to safety, increased visibility and implementation of Free Talk Fridays, change of medical director, Magnet journey • Emphasis on patients as consumers: patient engagement and experience initiatives: levels of care, environmental services, introductory brochure, food quality, team communication • Evidence-based care: clozapine, long-acting injectable, and medication-assisted treatment rates; behavioral and treatment planning; medical stability; Harding Care and Quality Care Outcomes Conferences • Strategies to help address patient flow (morning interdisciplinary huddles, teletracking, and stabilize demand (additions to workforce, Crisis Assessment Linkage & Management) Outcomes • A consistent mission-driven focus and cohesive message from physician and nursing leadership; • Aggression parameters of patients has steadily declined; • Staff injuries reduced, improved workplace engagement, Magnet journey; • After being largely unchanged for years, patient experience ratings have improved considerably; • Evidence indicative of enhanced patient outcomes; • Reduced hospital length of stay and fiscal indicators

“Conflict” in Consultation: Psychodynamic Considerations in Consultation-Liaison Psychiatry

Chairs: Simriti Chaudhry, M.D., Robert Weinrieb, M.D.

Presenters: Janna S. Gordon-Elliott, M.D., Henry Robert Bleier, M.D., M.B.A., Anna L. Dickerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize common psychodynamic issues that arise in the treatment of patients with chronic disease; 2) Develop skills for identifying and managing maladaptive treatment group dynamics that arise in medical settings; 3) Understand how patient and provider psychodynamic processes may influence treatment outcomes; and 4) Learn a framework for developing a psychodynamically informed brief treatment for patients in the medical setting.

SUMMARY:

The consultation-liaison psychiatrist faces complex clinical situations in which psychodynamic theory

can inform therapeutic approaches. Medical illness, as well as, treatment in medical settings place stress on defenses, prompting resilience or regression, depending on the situation, the timing, and the psychological resources and limitations of the individual and others involved. While behavioral and supportive interventions are most commonly utilized in addressing maladaptive responses in medically ill patients, a psychodynamic formulation in the context of the current medical presentation can inform the consulting psychiatrist, diagnostically and therapeutically. Illness and the complexity of medical treatment can similarly contribute to dysfunction in clinical team dynamics, with implications on quality of care, provider morale, and patient outcomes. The workshop will begin with a general discussion of the psychodynamic issues relevant to chronic medical illness, such as dependency, attachment, and body integrity. Second, the topic of transplant psychiatry will be used to demonstrate dynamic processes common to a specific medical subpopulation. We will discuss how countertransference and transference inform the transplant process, with potential impact on medical outcomes. Third, we will discuss dynamic processes that can develop among providers in the course of clinical care, often as a response to medical and psychological pathology of the patient, with the potential to influence and interfere with treatment. The underlying meaning behind typical consult requests, like the question of a patient’s “capacity”, will be reviewed. The final presentation will offer an example of a brief psychodynamic treatment developed to address a common condition seen by the consultation-liaison psychiatrist, conversion disorder. The audience will learn a framework for utilizing psychodynamic principles in a practical and time-limited way within an acute medical setting. An interactive session will follow, involving audience participation to identify relevant psychodynamic processes and treatment approaches in response to a proposed hypothetical scenario seen by the psychiatrist in a medical context. A facilitated discussion and opportunity for audience questions will conclude the workshop.

Culture Is Psychiatry: Challenges and Opportunities in Teaching About Sociocultural Issues in Residency Training

Chair: Justin A. Chen, M.D.

Presenters: Nhi-Ha T. Trinh, M.D., M.P.H., Priya Sehgal, M.D., M.A., Josepha A. Immanuel, M.D., Auralyd Padilla, M.D.
Discussant: Ranna I. Parekh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the challenges and opportunities of teaching trainees about sociocultural issues in psychiatry; 2) Learn about the development and implementation of sociocultural psychiatry curricula at several different adult psychiatry residency training programs; and 3) Gain hands-on experience in small-group breakout sessions with sociocultural psychiatry teaching topics tailored for psychiatric educators.

SUMMARY:

The US population seems to be fracturing at an accelerating rate along fault lines of group identity. The first quarter of 2017 saw a major surge in hate and bias-motivated crimes that later escalated into physical skirmishes in Charlottesville, VA. Meanwhile, both sides of the political divide have debated concepts related to identity in increasingly heated terms, especially in places of learning such as universities. Discussions of privilege and microaggressions are greeted with derisive criticisms of “PC policing” and “sensitive snowflakes.” It is into this charged environment that today’s psychiatric trainees are entering practice. Issues of identity have always been crucial in psychiatry since patients’ thoughts, feelings, and behaviors are necessarily embedded within, and informed by, larger sociocultural constructs such as race, sexuality, politics, spirituality, etc. Psychiatric clinicians must be aware of the impact exerted by these complex and intersecting systems on patients’ experience and interpretation of symptoms and those same symptoms’ diagnosis by medical professionals. Additionally, trainees may be confronted for the first time with the stress of addressing these complex and potentially charged topics with patients who possess contrasting viewpoints or who may outright reject a clinician from a different background. Feelings of inadequacy can contribute to a feeling of burnout, particularly among those from racial or sexual minority backgrounds. Despite the clear need for solid education and guidance in this area,

teaching these concepts can be a tremendous challenge. As recent events demonstrate, discussions around identity can quickly become fraught. Invoking the concept of “privilege” may provoke defensiveness in the majority group. The sociocultural systems described above are vast, and beyond the scope of most day-to-day clinical practice. Additionally, psychiatric teachers themselves may not be familiar with sociocultural concepts in psychiatry, since these issues have not been traditionally taught. Nonetheless, if Rudolph Virchow was correct that one of the goals of medicine is to “point out social problems and to attempt their theoretical solution,” then psychiatric educators have a duty to acquaint themselves with the core concepts of sociocultural psychiatry, and pass them along to the next generation of clinicians. This workshop tackles these subjects head-on, in a manner informed by theory but grounded in experience and practice. In this session, psychiatric educators from three adult psychiatry residency training programs will present their experiences teaching sociocultural concepts and grappling with sensitive topics to trainees in different clinical environments. Participants will be invited to gain hands-on experience with these topics in small groups, and will gain ideas for implementation within their own institutions. A significant portion of this workshop will be interactive and experiential.

Demystifying Pharmacotherapies for Youth With Opioid Use Disorder

Chair: Geetha Subramaniam, M.D.

Presenters: Marc Fishman, M.D., Joseph Lee, Amy M. Yule, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Become knowledgeable about FDA approved medications for treatment of opioid use disorder (OUD) & their mechanisms of action; 2) Be able to state the prevalence of opioid misuse, OUD and overdose, co-occurring psychiatric disorders along with poor access to evidence-based treatments; 3) Learn how to effectively use pharmacological agents in the treatment of OUD, in the context of developmental, co-occurring mental and family needs; 4) Learn about waiver requirements to be able to prescribe buprenorphine

formulations in your office; and 5) Be able to access freely available resources for high quality mentoring from experts, to assist you with treating patients with OUD.

SUMMARY:

Past- year non-medical use of opioid analgesics among 12th graders has decreased to 5% from a high of 10-12%, a few years ago. However, the opioid epidemic has not spared teenagers, as the 2015 overdose death rate among 15-19-year-olds has increased by 19% since 2014, driven mostly by heroin overdoses. Despite these alarming statistics, many youth with OUD are not receiving evidence-based and effective pharmacological treatment and are seldom treated by psychiatrists/child psychiatrists. This workshop aims to highlight the evidence-base and focus on practical tips and implementation strategies to help you become familiar with these treatment modalities. The speakers will provide an overview of the use of medication in the context of developmental needs of the youth patient, as well as address issues such as stigma, adherence/retention issues and the management of comorbid psychiatric conditions for the successful management of OUD youth, and review high-quality mentoring/coaching opportunities to facilitate the adoption of such treatments into practice. The presenters will also address commonly cited barriers such as lack of knowledge/training, stigma and complexity of these patients expanding your knowledge and skills to treat this underserved population. This will be followed by an interactive discussion session that will address audience questions and concerns. This workshop will be led by 3 experts: all are addiction psychiatrists with research and clinical expertise in the use of buprenorphine and naltrexone in adolescents and young adults to decrease craving and relapse to opioids. These adolescent addiction psychiatric experts will, via case discussions, provide you with case-based learning opportunities targeting induction, maintenance, management of complex comorbid psychiatric and medical conditions, and address of families in the care of these youth.

Enhancing Wellness and Resilience in the Prevention of Physician Burnout and Suicide

Chair: Maria L. Tiamson-Kassab, M.D.

Presenters: Sidney Zisook, M.D., Christine Moutier, M.D., Constance Guille, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand unique vulnerabilities and triggers underlying physician burnout and suicide; 2) Identify some of the novel interventions medical organizations and programs are advancing to reduce burnout and prevent suicide among medical students, residents and practicing physicians; 3) Utilize tools and strategies that promote engagement in wellbeing and resilience; and 4) Employ personal strategies to calibrate work-life balance.

SUMMARY:

In recent years, the medical literature, social media and surveys of every kind have focused attention on the prevalence of physician burnout, depression and suicide. Studies have shown that the prevalence of burnout in physicians is increasing. This does not just apply to physicians in practice but also medical students, interns and residents. Untreated depression and suicidal ideation are at least as common, if not more so, in the medical profession than in the general population. Unfortunately, fear of reprisal, loss of career, stigma/shame, the unspoken medical culture, and work-life imbalances have kept medical students and physicians from getting the help they need. Some have treated themselves or sought consult from psychiatrist friends instead of getting professional help. With increased recognition of these challenges, there has been a proliferation of wellness programs and creative interventions for burnout, suicide prevention and managing work-life balance. Health organizations, institutions and individual students, trainees and physicians share a responsibility in addressing and preventing physician burnout and suicide. This workshop aims to discuss specific interventions that have been proven successful as well as some of the more innovative programs that have been implemented to promote resilience and wellness, achieve more balanced work-life integration and ultimately to prevent physician burnout and suicide. We will specifically discuss the enhanced Healers' Education, Assessment and Referral (HEAR) program which has been recognized

nationally and replicated in other institutions, a web based cognitive behavior therapy intervention for the prevention of suicide and other programs that promote tools to build resilience and promote engagement in physician wellbeing efforts. Our facilitated group discussion will engage panelists and participants into sharing their individual challenges, barriers and strategies to creating optimal life-work balance.

Ethical Issues for Psychiatrists in the Treatment of Transgender Persons

Chair: Edmund Grant Howe, M.D.

Presenter: Shannon Christine Ford, M.D.

Discussant: David Benedek, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe what psychiatrists should do when they know that they may be asked to serve in two conflicting roles, namely, as therapists and as persons screening transgender persons for medical intervention; 2) Understand what psychiatrists should do when transgender persons want to have irreversible surgery but, due to their circumstances, are unable to live before surgery as their preferred gender; 3) Explore optimal ways of responding to colleagues who have moral or religious views that may get in the way of their being able to treat transgender persons optimally; 4) Explore whether psychiatrists' ethical obligations when transgender persons want breast augmentation or chest contouring surgery; and 5) Explore psychiatrists' ethical obligations when transgender persons want reproductive options such as semen and egg preservation without this decision going to an ethics committee.

SUMMARY:

Psychiatrists may encounter several ethical questions when transgender persons come to them seeking help. These questions range from what psychiatrists should do when they may have role conflicts such as to offer therapy at one time, but at a later time, offer recommendations regarding surgery, whether transgender persons should always have to live as the gender they are prior to having irreversible surgery, how psychiatrists should advise colleagues who have moral or religious views that

would impair their ability to treat transgender persons, and how psychiatrists should respond when transgender persons want reproductive options such as sperm and egg preservation or assistance in having biologically related offspring without having to discuss this with an ethics committee, and how psychiatrists should respond when transgender persons want breast augmentation or chest contouring surgery, again, without the involvement of an ethics committee. After each of these questions is raised, a psychiatrist on the panel will respond. Then this question will be addressed to the attendees. The core ethical conflict underlying each of these questions will be emphasized in that taken together they will represent most of the kinds of ethical conflicts likely to arise for psychiatrists when they are treating transgender persons. During the last half of this session, those attending will be invited to present other ethical issues that have arisen for them. The purpose of this session is to identify and discuss some of the core ethical questions that may arise for psychiatrists treating transgender persons. It is hoped that through and after this discussion, psychiatrists may be able if seeing these persons to feel more confident when ethical issues arise and to be able to more optimally proceed.

Finding Your Match: The Process of Obtaining Residency and Fellowship Positions

Chair: Panagiota Korenis, M.D.

Presenters: Muhammad Zeshan, M.D., Jessica Bayner, M.D., Sadiq Naveed, M.D., Sabina Fink, M.D., Darmant Bhullar, M.D.

Discussant: Luisa S. Gonzalez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide insight about applying for psychiatry residency and fellowship programs; 2) Offer advice about how to be a competitive applicant; 3) Teach strategies to help applicants match into programs that meet their career goals; and 4) Highlight important factors to consider while applying to and ranking programs.

SUMMARY:

Applying to a residency or fellowship program is often a daunting process, which involves a

complicated set of strategies and decisions. Unfamiliarity with the system and misunderstandings about what is expected from applicants can lead to frustration, stress, and avoidable mistakes. According to the ERAS data, 1878 US and Canadian Medical graduates (USGs), 3361 International Medical Graduates (IMGs), and 310 osteopathic graduates (DOs) applied for a psychiatry residency position in 2017. As per the National Resident Matching Program (NRMP) survey results, program directors (PD) consider the following top five factors for selecting an applicant to interview: Dean's Letter or MSPE (92%), personal statement (95%), letters of recommendation in the given specialty (90%), perceived commitment to the specialty (89%), and USMLE Step 1 and Step 2 scores (81%). PDs rank applicants based on their interpersonal skills (96%), interactions with faculty during one's interview and visit (94%), feedback from current residents (87%), and perceived commitment to specialty (86%). In turn, residency applicants are noted to make rank order lists based on following top five factors: overall goodness of fit, interview day experience, geographical locations, quality of residents in the program, and work/life balance. During residency, important factors in assessing residents' success consist of clinical competency, quality of patient care, professionalism, ethics, and communication skills. While in training, it is important for a resident to identify any affinity for a subspecialty, which can help guide the path towards pursuing a fellowship. The main goal of this workshop is to add insight about the residency and fellowship match, and help applicants improve their chances of getting into their desired programs.

From Violent Victimization to Empowerment: Prevalence, Risk Factors, and Effectiveness of Two New Interventions to Prevent Future Victimization

Chair: Henricus Van

Presenters: Liselotte de Mooij, Marleen de Waal, Carolien Christ, Margo de Jonge, Anna Goudriaan

Discussant: Jack Dekker

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the high prevalence of recent violent victimization among both common and severe mental disorders and its risk factors; 2)

Gain confidence in discussing experiences of recent victimization in daily clinical practice; 3) Know how to reduce risk of victimization in chronic psychiatric patients with co-morbid substance use disorders by improving adaptive street skills, emotion regulation and interpersonal behavior; and 4) Experience an internet-based training for depressed patients focused on preventing victimization with use of videomaterial and practicing online exercises.

SUMMARY:

It is well known that psychiatric patients are at risk to be victims of physical and sexual assault, which interferes with treatment outcome. In addition, victimized patients appear to be prone to future revictimization of different types of violence. Unfortunately, this revictimization often goes unnoticed, as both patient and clinicians appear to be hesitant to discuss this topic. Barriers for clinicians can be discomfort, lack of time and experience in responding to violence or lack of availability of effective interventions. Patients may be ashamed or think the doctor will not be interested. If mental health professionals knew more about risk factors for victimization and possibilities to decrease patients' vulnerability, they would be able to both recognize victimization and support patients to prevent future victimization. In this workshop, the up-to-date evidence regarding prevalence and prevention of violent victimization - both in patients with common and severe mental disorders - is provided. First, we will show that patients with a severe mental illness are 2.7 times more likely to be a victim of a violent crime compared to the general population. A younger age and symptoms of disorganization are associated with risk of recent violent victimization. Second, we present the Self-wise, Other-wise, Streetwise (SOS) training, a 12 session group-based training to reduce victimization in chronic patients with co-morbid addiction. Participants will experience how adaptive street skills, emotion regulation skills and social skills can be improved by practicing elements of the training. Preliminary results of a new RCT indicate that the SOS-training is feasible for these patients and reduces victimization. Third, we will present an internet-based Emotion Regulation training (iERT), aimed at preventing violent revictimization in depressed patients. Participants will experience iERT

by watching videos and practicing with online exercises. Finally, the question how the relationship between mental health disorders and victimization might be explained will be addressed in a brainstorm session with the public. Does victimization aggravate psychiatric symptoms? To what extent is the increased victimization risk of psychiatric patients a “state” or “trait”? Our recent study on victimization in remitted, previously depressed patients offers an evidence-based perspective on these questions. We provide new insights in the complex relationship between mental health disorders and victimization, in which sense of mastery seems to be a risk factor. In conclusion, knowing the prevalence and risk factors of violent victimization among psychiatric patients is the first important step towards recognition and prevention of future victimization. Moreover, insight into the opportunities to effectively reduce the vulnerability for (re)victimization will be helpful for all clinicians.

Identity Narrative: An Early Biological Framework for Autobiographical Memory in Trauma Survival

Chair: Andrei Novac, M.D.

Presenter: Margaret C. Tuttle, M.D.

Discussant: Barton Jerome Blinder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Incorporation of Identity Narrative as a sub-type of autobiographical memory; 2) Understanding implicit nature and components of Identity Narrative; 3) Understanding the neuroscience behind Identity Narrative, language acquisition and attachment; and 4) Learning about the role of Identity Narrative and autobiography in surviving adverse life events.

SUMMARY:

The authors are proposing the notion of Identity Narrative (IdN) as a set of implicit memories acquired throughout life and consolidated according to a gradient of emotional valence. IdN may constitute an implicit scaffolding of autobiographical memory, a form of declarative, episodic memory. In turn, autobiographical memory is known to have a significant role in identity self-regulation and socialization. The presenters, three experienced psychiatrists and members of the Caucus on

Psychotherapy, will discuss how IdN first emerges during the first three years of life and parallels life-long growth and development. It is of special importance in trauma healing and may be embedded in a larger, biological substrate of social affiliation. The authors propose that life events have a molding effect on IdN through at least four mechanisms: sudden insight and awareness with events of special significance; memory consolidation through high emotional valence; high frequency and repetition of events; and prolonged exposure and duration of life events. Biological correlates with language acquisition, attachment and development will be discussed.

Innovative Pathways to Mental Health Equity: Closing the Gaps Using Social Ecological Approaches to Leverage Technology and Promote Structural Change

Chairs: Nicolas E. Barcelo, M.D., Enrico Guanzon Castillo, M.D.

Presenters: Christina V. Mangurian, M.D., Glenda L. Wrenn, M.D., Kevin Mauclair Simon, M.D., Maria Gabriela Aguilera Nunez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand disparities in health outcomes for patients with mental illness as multifactorial / multilevel (structural, social, and patient level); 2) Discuss the social-ecological framework as relevant to creating interventions dedicated to health equity; 3) Identify novel, intersectoral interventions - including technological, interdisciplinary, community-based, and policy-level change; and 4) Discuss future directions for continued reform in care delivery as well as barriers to implementation.

SUMMARY:

More than 20 years since the Surgeon General’s Report on Mental Illness, urging US healthcare to better address the unique needs of patients with mental illness, significant inequity persists. This inequity includes differences in psychiatric diagnosis and treatment,^{1–3} as well as disparities in non-psychiatric / medical health outcomes.^{4–6} Studies have shown that mental health and health disparities are due to 1) systems-level issues, such as

access to health insurance and evidence-based treatments, 2) patient-level issues, such as stigma and distrust of services, and 3) social determinants including housing, food availability, and transportation.^{7–10} This workshop will explore the underlying processes contributing to disparities in health for patients with mental illness and from vulnerable populations. It will begin by defining the social-ecological framework, a paradigm emphasizing the interrelations of environmental conditions, social institutions, and sources of health care services.¹¹ According to this definition, discussants will explore novel, intersectoral interventions that successfully deliver care beyond the scope of traditional use. At the clinical level, and bringing together technology and community barriers to care, a speaker will present research on data mining efforts in EHR technologies to identify social determinants of health.¹² At the interdisciplinary level, to emphasize the influence of social determinants of health in the successful bridging of care across levels of acuity, a speaker will discuss the team model utilized at Grady Behavioral Health Clinic in Atlanta to facilitate successful inpatient discharges. At the health care organization level, as an example of care coordination in non-integrated clinical settings, a speaker will address innovations in referrals and consults technology utilized in the San Francisco Dept of Public Health.^{5,6,13} At the community level, a speaker will identify successful tailoring of integrated clinics to address stigma towards mental illness within African American communities.^{14,15} At the policy level, a speaker will review emerging policies and specialized services in Los Angeles County and nationally that aim to address mental health and social inequities.⁹ Panelists will emphasize the interconnectedness between levels of intervention (from technologies, to clinics, to disciplines, to systems, to state and national policy), each with equally important roles and essential to the integrity of holistic efforts dedicated to the elimination of inequity in health. Participants will have the opportunity to learn from the experience of each speaker regarding the hurdles encountered prior to and following implementation of each intervention and reflect on the suitability of these opportunities to their home institutions.

Making a Parody of Parity? An Annual Update on the Continuing Struggle for Equitable Mental Health Care Coverage in the U.S.

Chairs: Daniel Knoepfelmacher, M.D., Susan Gaber Lazar, M.D.

Presenters: Eric Martin Plakun, M.D., Meiram Bendat, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the current state of parity implementation and legal efforts to enforce parity laws; 2) Understand how insurance companies define the concept of “medical necessity” to privilege short term cost savings over clinically effective treatment standards; 3) Understand the often ignored research base supporting psychotherapy; 4) Develop utilization review standards that are ethical and consistent with the parity law when functioning as a utilization management psychiatrist; and 5) Conduct more effective insurance utilization reviews by using the parity law and knowing associated ethical issues.

SUMMARY:

Since the passage of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, nationwide efforts to guarantee (and circumvent) equitable insurance coverage for mental health care have persisted in earnest. Over the past year we have seen multiple efforts in Congress to repeal the Affordable Care Act, including those that would remove mental health coverage as an essential benefit. This workshop will provide an update on the continuing struggle for equitable coverage of mental health care. We will highlight how insurance companies have failed to meet parity standards, review recent developments in Congress and in the courts, and provide a forum to discuss what future changes may come. Our panel will discuss issues related to “medical necessity,” specifically how this term has been used by insurers to favor short term cost savings over “clinical effectiveness.” We will review how insurers systematically neglect crucial psychiatric interventions, including standard psychotherapy modalities and long-term residential treatment. One panelist will present a summary of published research highlighting the cost-

effectiveness of psychodynamic treatments, a modality for which insurers routinely deny sufficient coverage. Another panelist will explore how medical necessity is based on “generally accepted standards” for treatment, and whether these are best determined by insurers or clinicians. Additionally, we will update the audience about multiple, ongoing class action suits aimed at enforcing parity through court rulings. Our goal is to generate a productive group discussion about parity, a topic that lies at the critical intersection between mental healthcare, politics, business, and the law.

Managing ADHD in Special Populations: The U.S. Army, the National Football League, and Major League Baseball

Chair: Erik Frost, M.D.

Presenters: William David Rumbaugh, M.D., Adam Lee Hunzeker, M.D., David R. McDuff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the historical context of performance enhancing drugs in a military setting; 2) Understand current US military policy regarding military readiness and deployability for soldiers diagnosed with Attention Deficit Hyperactivity Disorder (ADHD); 3) Understand the therapeutic use exemption (TUE) process for professional athletics; and 4) Better understand the informed consent process as it relates to occupational implications when prescribing stimulants to these special populations.

SUMMARY:

Attention Deficit Hyperactivity Disorder (ADHD) impacts between 4-5 percent of adults in the US. As of 2010, the population of individuals serving on active duty in one of the five branches of military service was 1.4 million with an additional 818,000 serving on reserve or National Guard status. ADHD affects a large number of these individuals, and the choice of treatment modality can directly affect their duty status and have significant career implications. Unfortunately, many civilian prescribers operating outside of the military health care system may be unaware of how their prescribing and documentation may affect a soldier’s career. Military duty implications should be a part of the informed

consent process prior to starting a stimulant medication for all active duty and reserve/National Guard. The present workshop will summarize these implications including the deployment waiver process, special duties to include flight status, and general considerations when treating soldiers. Similarly, professional and collegiate athletics have varying restrictions on the use of stimulant medication to treat ADHD. The workshop will focus in particular on the policies in Major League Baseball and the National Football League providing practical working knowledge of the Therapeutic Use Exemption (TUE) process. While the population of athletes participating at this elite level numbers in the hundreds, these principals apply to all levels of athletics. By better understanding these processes, prescribers will be able to more effectively educate their patients and improve the informed consent process.

Promoting Wellness in Physicians-in-Training in Psychiatry

Chairs: Nicole M. Benson, M.D., Deanna Constance Chaukos, M.D.

Presenters: Carol Ann Bernstein, M.D., James Joseph Hudziak, M.D., Richard Fredric Summers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize that the main contributors to burnout come from the learning environment and systemic problems; and that wellness, on the other hand, has diverse contributors (individual and environmental); 2) Recognize contributors to stress and well-being for physicians-in-training; 3) Understand an approach to local environmental changes that address physician well-being; 4) Understand national and organization level changes that are happening through the APA and the ACGME; and 5) Discuss strategies for promoting wellness in your own institutions at trainee, program, and organizational levels.

SUMMARY:

Depression and burnout among trainees in medical specialties has become an increasing concern, not just in training programs, but in the healthcare system as a whole. Studies have described increased rates of depression and worse quality of life in

trainees who report feelings of burnout. In addition, patient care by trainees with depression may be compromised because studies show higher rates of perceived medical errors by these physicians-in-training compared to trainees without depression. During this workshop, examples of situations that trainees report increase stress in their work and personal lives will be presented including clinical and patient responsibilities, work-related time pressures, high acuity clinical services, and interactions with difficult or particularly sick patients. During this workshop, participants will be asked to contribute their own experience in assessing stress levels among their trainees and colleagues. This workshop will also present data on how physicians-in-training promote their own wellness. Some physicians-in-training report engaging in activities to improve their well-being, including cooking, eating, and drinking coffee, socializing outside of work, and exercising. Participants in this workshop will be asked to share observations and suggestions for successful types of activities that their trainees and colleagues have used to ameliorate stress. Because of the pervasive nature of this problem, institutions are taking a closer look at their own system and have attempted to implement programs to help reduce burnout and improve wellness in their trainees. Types of interventions that have shown success will be described, including curricular and organizational changes and programs to provide the trainees skills for relieving stress. Examples of techniques for promoting well-being and demonstrations of methods and activities will be conducted with participants. The goal of the workshop is to promote a discussion on ways training programs and organizations can facilitate wellness for their own physicians and trainees.

Psychiatry in the Courts: APA Confronts Legal Issues of Concern to the Field

Chair: Marvin Stanley Swartz, M.D.

Presenters: Paul S. Appelbaum, M.D., Howard V. Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases; 2) Appreciate

the issues involved in expanding the Tarasoff-type duties of mental health professionals; 3) Discuss the issues involved in application of the death penalty in cases involving mental illness or intellectual disability; and 4) Appreciate the issues involving the appropriateness of involuntary treatment programs for sexually violent individuals.

SUMMARY:

The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year, and to provide their input concerning APA's role in these cases. Three cases will be summarized and the issues they raise will be addressed: 1) *Volk v. DeMeerleer* involves the the violent acts of a mentally ill person toward third parties while under treatment by a psychiatrist in the State of Washington. The case raises the prospect of expanded Tarasoff-type duties for psychiatrists.; 2) *Karsjens v. Jesson*, a Minnesota case challenging the appropriateness of this involuntary commitment treatment program for sexually violent individuals. This case raises questions of whether involuntary commitment is legally permitted under such circumstances; 3) *McWilliams v. Dunn*, an Alabama case challenging whether the defendant received all the assistance to which *Ake v. Oklahoma* entitled him. Since new cases are likely to arise before the annual meeting, the Committee may substitute a current issue on its agenda for one of these cases. Feedback from the participants in the workshop will be encouraged.

Psychotropic Drug-Induced Weight Gain and/or Metabolic Syndrome: Recognition and Management

Chairs: Chin B. Eap, Ph.D., Christoph U. Correll, M.D.

Presenters: Chin B. Eap, Ph.D., Christoph U. Correll, M.D., Peter Manu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the major health consequences associated with psychotropic drug-induced weight gain and metabolic complications; 2)

Plan clinical measures to monitor and minimize such effects; and 3) Identify the promises and pitfalls of genetic tests for predicting metabolic worsening.

SUMMARY:

Weight gain and obesity are important health problems associated with psychiatric disorders and/or with psychotropic drug treatments. This may have major clinical consequences considering that obesity can lead to the development of other components of the metabolic syndrome such as dyslipidemia, hypertension and type 2 diabetes, which may ultimately lead to the development of cardiovascular diseases, reducing patients' quality of life and increasing mortality in psychiatric populations. Psychotropic medications, such as antipsychotics (most atypical but also some classical antipsychotics), mood stabilizers (e.g. lithium, valproate) and some antidepressants (e.g. tricyclic antidepressants, mirtazapine) can increase the risk of cardiometabolic disorders. Our workshop will remind participants about the prevalence, causes, pathways, and clinical consequences of cardiometabolic disturbances in psychiatry. Clinical recommendations from expert panels to monitor and minimize such effects will be presented and discussed. There are considerable inter-individual variations in metabolic effects associated with psychotropic drugs, regardless of the type of medication. This variability can be explained in part by the combination of clinical and genetic risk factors. Such factors will be presented and the potential usefulness of predictive tests, also including genetic information, will be examined. During our workshop, we will provide participants with clinical cases, which will be discussed with the speakers in order to help participants to integrate the information into their daily routine.

Using Motivational Interviewing in Working With Patients With Serious Mental Illness Who Are Nonadherent With Needed Treatment

Chair: Michael A. Flaum, M.D.

Presenters: Florence Chanut, M.D., Brian Hurley, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will be able to

recognize the core differences between an MI approach and that of a typical "medical model" approach; 2) Participants will be able to articulate the difference between discord and ambivalence around the issue of medication non-adherence; 3) Participants will be able to discuss how treatment non-adherence would be addressed with an MI approach in a patient with prominent paranoia; 4) Participants will be able to describe what modifications in an MI approach may be necessary in working with patients who are prominently disorganized; and 5) Participants will be able to conceptualize mental health recovery and identify areas of resonance between recovery and with the spirit of motivational interviewing.

SUMMARY:

This workshop will explore the benefits and challenges of using a motivational interviewing (MI)-consistent approach with patients with serious mental illness (SMI), focusing on the problem of non-adherence with treatment. While the workshop is open to all, it will be best suited for those who have had at least some familiarity with Motivational Interviewing (MI). We will begin with a very brief basic overview of MI, including how it differs from a traditional "medical model" approach, and the fundamental rationale for that difference. This will involve discussion of the centrality of the so-called "paradoxical effect of coercion". We will then discuss how this approach may apply to those who are non-treatment-adherent, focusing on patients with three types of prototypical psychopathology: 1) patients who are prominently paranoid; 2) those that are prominently disorganized; and 3) those with prominent emotional intensity/lability. Within the discussion of each prototype, we will describe how various aspects of MI may apply in the context of addressing non-adherence to treatment, and what modifications from a traditional MI approach may be useful. This will include discussion of the four "meta-processes of MI" (i.e., engagement, focusing, evoking and planning) and how navigating these processes may differ across different types of psychopathology. We will also focus on paying particular attention to the difference between discord and ambivalence, and how these may be handled. The session will also include a brief discussion on mental health recovery and of how MI

may provide a practical foundation for enhancing recovery-oriented, person-centered care in this population.

Are We There Yet? Feminism, Gender Disparities, and Why It Matters

Chairs: Navneet K. Sidhu, M.D., Nada Logan Stotland, M.D., M.P.H.

Presenters: Susan J. Hatters-Friedman, M.D., Renee M. Sorrentino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the current legislation relevant to psychiatric evaluations in pregnant women for civil commitment, administration of medications during pregnancy, gender disparities in sexual offenses and; 2) Recognize various barriers and challenges to women's health; and 3) Discuss the underlying ethical principles and dilemmas in these evaluations.

SUMMARY:

Feminism as a movement dominated the moral and social psyche in the 20th century leading to legislative victories ranging from voting rights to reproductive rights. Most people in the developed world and many physicians may consider the issues highlighted by the various waves of feminism as fully resolved. After all, women, arguably, enjoy greater freedoms than ever before. As physicians and mental health providers, what is our role in women's health today? Consider the state laws related to civil commitment of pregnant women. Several states including Wisconsin, Minnesota, North Dakota, South Dakota and Oklahoma have passed laws that allow judicial commitment of a chemically dependent woman to prevent fetal harm. For example, in Minnesota, any "interested person" can seek judicial commitment of a pregnant woman if there is clear and convincing evidence that the pregnant woman's use of alcohol poses a substantial risk to the fetus. Such laws advocate commitment of otherwise mentally competent individuals, raising questions of autonomy, the extent of the *parens patriae* power of the state, and women's agency. Dr. Sidhu will discuss these laws and their impact on practice. Women seeking abortion today face similar challenges. According to the Guttmacher Institute,

29 of the 35 states that mandate pre-abortion counseling require the use of state approved written materials. The state thus effectively steps into the patient-physician relationship. This can easily affect the fundamental principles of informed consent, confidentiality and privacy. Dr. Stotland will discuss the current challenges in the area of reproductive health. When a pregnant woman is acutely mentally unwell, and involuntary psychiatric medications are considered, many issues come into consideration, including the health of the mother and of the fetus, the rights of the mother and of the fetus, and whose rights take precedence. Some psychiatric medications have potential teratogenic effects and known risks. Available data regarding atypical antipsychotic agents in pregnancy is relatively reassuring. Yet, the risks of untreated mania or psychosis—on both the mother and fetus/ infant—may be quite significant. These cases merit ethical and legal consideration of the rights of the mother and the infant, as well as their best interest. Dr. Hatters-Friedman will focus on these aspects of treatment. Conversely, women may sometimes benefit from prevailing social stereotypes. Female sexual offenders are poorly understood. The majority of sex offender research is limited to male sex offenders. Paraphilic disorders are almost exclusively diagnosed in males. One possible explanation for the gender disparity in sexual offending is because female sex offenders are often overlooked. Dr. Sorrentino will explore these gender disparities in sexual offenses and paraphilic disorders with a focus on the ethical implications of gender biases.

Become a CPT Coding Wizard: An Interactive Case-Based Workshop to Master New and Complex Coding Situations for Psychiatrists

Chair: Gregory G. Harris, M.D., M.P.H.

Presenters: Patrick Ying, M.D., Jeremy Seth Musher, M.D., Sarah E. Parsons, D.O., Ronald M. Burd, M.D., Junji Takeshita, M.D., Allan A. Anderson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of this session the participant will be able to identify the appropriate CPT code to describe new billing opportunities for services they provide; 2) At the

conclusion of this session the participant will understand the documentation requirements associated with billing for services in those settings; and 3) At the conclusion of this session the participant will understand the latest changes in CPT coding and documentation and the importance of monitoring future changes.

SUMMARY:

In this advanced coding workshop, experts from the Committee on RBRVS, Codes and Reimbursements will go beyond the basics of outpatient coding and focus on more complex scenarios as well as important coding changes, including the collaborative care codes. Drawn from actual inquiries from the APA Practice Management Helpline, interactions with CMS and other regulatory bodies, and experiences with third-party audits, case scenarios will be presented that will highlight practice locations such as inpatient, emergency room, consultation and nursing homes as well as telephone and telepsychiatry visits. In addition, cases will highlight rule changes that allow for new opportunities such as collaborative care codes, prolonged services codes, integrating screening tools, and transitional care codes. Following each case, questions will be posed to participants, and using audience-response technology, attendees will be able to assess their own knowledge of CPT coding and guide the level of discussion of the cases. Finally, at least a third of the workshop will be dedicated participants presenting their own cases and questions to the panel of coding experts. The workshop presenters are national experts in the area of CPT coding and documentation for psychiatric services. Several hold appointed positions on the AMA CPT Advisory Committee and AMA/Specialty Society RVS Update Committee (RUC). All are experienced billing/coding and documentation educators and members of the APA Committee on RBRVS, Codes and Reimbursements.

Black and White: The Cost of Unexamined Racial Bias

Chair: Jai Chetan Gandhi, M.D.

Presenter: Nicole Ilana Sussman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Understand the role of racial bias in our clinical encounters and health care outcomes; 2) Recognize methods of counteracting racial bias and discrimination; and 3) Develop strategies to discuss and address race, bias, and discrimination with trainees.

SUMMARY:

Race has a clear and unequivocal impact on health care outcomes. Despite the Institute of Medicine's declaration these disparate outcomes were "unacceptable" in 2002 (1), frank discussions about race in clinical care continue to be rare. As medicine and psychiatry charge forward with elaborate discussions of the biological underpinnings of disease, we risk losing sight of the devastating impact of the interplay between race and physician bias. The cost of this oversight is exceedingly clear: minorities are at higher risk for involuntary treatment, are disproportionately diagnosed with psychotic disorders, and less likely to access mental health care. (2, 3, 4) This workshop invites an exploration of the critical "hidden curriculum," and its role in identifying discriminatory behaviors and examining biases. The workshop begins with a brief overview of the current literature on health care disparities, followed by a small and large group discussion to examine the attendees' experience of race and discrimination. Subsequently, we explore the evidence base for diminishing bias, and leverage small and large group discussions to evaluate how these methods can be implemented by medical professionals, especially in teaching roles. Through a synthesis of the group discussion, attendees will leave the workshop with concrete strategies to address racial bias.

Caring for My Patients by Caring for Me: Focusing on Provider Wellness to Improve Our Patients' Outcomes

Chairs: Judy Kovell, M.D., Antoinette Lenton, M.D.

Presenters: Peter Gertonson, D.O., Rachel M.

Sullivan, M.D., Helene Satz

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand industry-wide factors that contribute to provider burn-out and detract from wellness; 2) Discuss personal and

institutional factors that support or detract from wellness; 3) Highlight the importance of wellness as a method of thriving in healthcare; 4) Review available wellness/burn-out assessment tools and steps to develop a wellness program in your organization; and 5) Develop practical interventions for individuals, teams and organizations that we can use today.

SUMMARY:

Medical provider burn-out and physician suicide are hot topics in the lay-press with annual survey reports listing medical specialties by burn-out rates. National organizations such as the National Institute of Health (NIH), The Joint Commission (JC) and the Accreditation Counsel for Graduate Medical Education (ACGME) have recognized the negative impact provider burnout has on patient safety, outcomes and healthcare costs. As a result, organizations such as these have put significant emphasis on the need for national level leadership involvement to improve provider wellness. The most recent AGCME Residency Review Council has made the Designated Institutional Official (DIO) and Residency Program Directors responsible for the wellness of both Residents and Faculty. Second-hand trauma and empathetic patient involvement put Behavioral Health providers at high risk factors for burn-out. As RHC-P embraces the behaviors of a High Reliability Organization, we as individual providers and leaders must understand the impact provider burn-out has on patient outcomes and the cost of health care. We must also understand that true wellness is not the same as a lack of burn-out. Only by understanding the factors inherent to our profession and organization that lead to burn-out can we move to a culture of wellness. This panel/workshop will focus on helping participants understand the need for a culture of wellness, identify organizational practices that may undermine provider wellness and take practical steps to improving personal, team and organizational wellness.

Complementary and Integrative Medicine for Residents: An Introduction

Chair: Lila E. Massoumi, M.D.

Presenter: Patricia Lynn Gerbarg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe past and present terminology when referring to nonmainstream therapies; 2) Discuss the prevalence of CIM usage in the general and psychiatric populations; 3) Recognize the limitations and controversies regarding CIM treatments, including evidence-base, drug-supplement interactions, and supplement quality; 4) Describe the four most useful CIM treatments in psychiatric practice; and 5) Access resources for further learning about CIM.

SUMMARY:

This workshop will provide an introductory overview of Integrative Medicine in Psychiatry. Dr. Massoumi, chair of the APA Caucus on Complementary & Integrative Medicine (CIM), will clarify the evolving terminology to describe this growing medical field, along with the underlying tenets that guide its practice. Statistics from the National Health Interview Survey on the use of CIM in the general population, will be contrasted to the higher prevalence of CIM among the psychiatric population. Barriers to clinician use of CIM will be discussed, including insufficient funding of non-patentable products, concerns about supplement quality and supplement-drug interactions, liability concerns, and lack of training. Dr. Gerbarg will discuss the potential for interactions between prescription drugs and the herbs and supplements most commonly used in psychiatric practice. Evaluating the evidence and minimizing adverse events will be emphasized. She will describe how to integrate the four most useful CAIM treatments into psychiatric practice: Rhodiola rosea, S-adenosylmethionine, melatonin, and voluntarily regulated breathing practices. Choosing best quality supplements, risks, benefits and augmentation strategies will be discussed. Resources for further learning will be provided.

Connecting Millennial Medical Students and Geriatric Patients: How Do We Bridge the Gap?

Chair: Susan W. Lehmann, M.D.

Presenters: Mary Carol Blazek, M.D., W. Bogan Brooks, M.D., Dennis Popeo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Participants will be able to describe key characteristics of the millennial generation; 2) Participants will be able to describe two strategies for improving medical student communication skills with geriatric patients; 3) Participants will be able to discuss an adult learning theory which could be applied to curricular design for millennial medical students; 4) Participants will be able to identify two negative consequences of current teaching practices about aging and geriatrics on medical students; and 5) Participants will be able to discuss 2 ways to change curriculum design related to geriatrics to more effectively connect with millennial medical student learners.

SUMMARY:

With the rapid aging of the U.S. population and projected shortage of geriatric psychiatrists, all medical students today need to be prepared to address the mental health needs of older patients. Yet, existing generation gaps between students and faculty and between students and older patients may hinder both learning and effective clinical engagement. Today's medical students are mostly comprised of "millennials" born between 1981 and 2001. Life experiences unique to the millennial generation have shaped their attitudes towards aging as well as expectations and beliefs regarding learning. These cohort characteristics are quite different from the distinguishing traits of Generation X that preceded the Millennial generation, and from the Baby Boomer generation, both of whom comprise current medical school faculty. It is crucial that medical school educators understand the attitudes, behaviors, and learning styles of their millennial students in order to improve teaching about older patients and to better inspire interest in geriatric care. In this workshop, Dr. Dennis Popeo will discuss the concept of generational differences and will present data describing essential characteristics of the millennial generation. Dr. Mary Blazek will review research findings that support effective teaching methods for millennial learners related to current trends in curricular revision at US medical schools. Dr. W. Bogan Brooks will discuss strategies for engaging millennial medical students with older patients and facilitating better communication with older patients. Dr. Susan Lehmann will discuss the implications of current

research on millennial learning for medical school educators and will present tips for developing more effective curricula in aging and geriatric mental health. The panel of experts will engage the audience participants in discussion about their experiences and best practices for teaching millennial medical students about older patients.

Cultural Competency and Cultural Nuances: How to Avoid Treatment Failures and Professional Burnout

Chair: Silvia Wybert Olarte, M.D.

Presenters: Courtney Saw, M.D., Lourdes M.

Dominguez, M.D., Sherry Katz-Bearnot, M.D.

Discussant: Richa Bhatia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of cultural competence concepts as they apply to subgroups within a given diverse population; 2) Demonstrate knowledge of how to apply these nuances to enhance treatment outcomes; and 3) Understand how recognizing cultural variations within given culturally defined groups can prevent professional burnout.

SUMMARY:

Traditionally cultural competency refers to the ability of members from different ethnic and or racial groups to relate and communicate in a meaningful and successful manner due to mutual knowledge of their specific behavioral patterns and beliefs systems. This ability to enhance mutual communication through sound knowledge of the other's language, beliefs, values, customs and institutions showing respect for the differences is crucial for positive outcomes in the delivery of health systems, especially mental health systems . The experience of burnout in professionals serving a diverse cultural population can be related to the frustration experienced by both professional and client due to lack of mutual awareness of cultural differences and its impact on treatment outcome. In spite of evident improvement in the cultural competence of professionals within the health care delivery systems , cultural competency about given cultural groups is understood as if these groups were homogeneous and with no nuances. This workshop will address the cultural diversity that exists within a

group that while thought of as diverse in reference to the host culture, is considered homogeneous from within. Nuances and differences within each group will be discussed by participants mainly using clinical material Courtney Saw MD will present her work with adolescent and young adult transgender/gender non-conforming individuals in the academic medical setting. Lourdes Dominguez MD will discuss her work with female police officers in NYC, of Latina descent and lesbian sexual orientation. Finally Sherry Katz Bearnot MD will discuss her work with multiple members of extended family groups of an orthodox Hassidic community in NY State. Short clinical vignettes and focused theoretical information will be used to facilitate active participation and discussion from the floor.

How to Get Promoted: Putting Together Powerful Promotion Portfolios

Chair: Marcia L. Verduin, M.D.

Presenters: Robert Joseph Boland, M.D., Patrick T. O'Neill, M.D., Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify appropriate individuals to serve as external reviewers/letter writers in preparation of a promotion portfolio; 2) Identify strategies to facilitate an external reviewer writing the best possible assessment of one's portfolio; and 3) Recognize common pitfalls and best practices in writing, reading, and interpreting letters for faculty promotion and tenure.

SUMMARY:

The promotion and tenure process is often daunting for faculty. The process is further complicated by significant variation in promotion and tenure policies from one institution to another. One nearly universal practice is the need for external reviewers to write letters of assessment of the candidate's accomplishments and qualifications for promotion. This workshop is designed to enhance the knowledge and skills of junior, mid-career, and senior faculty, and to facilitate discussion and within-workshop mentoring between faculty seeking promotion and those reviewing promotion portfolios. We will cover strategies for selecting and contacting external reviewers, best practices in

writing effective letters for promotion, and a practical approach to reading and interpreting letters when serving on promotion committees. By design, the workshop presenters are all senior career faculty with extensive experience with the promotion process, not only in their own careers, but also as external reviewers and members of selection and promotion committees.

How to Improve Access and Effectiveness of Treatment for Borderline Personality Disorders: A Nation-Wide Service Reform in the Netherlands

Chairs: Ellen Willemsen, Joost Hutsebaut

Presenters: Miep Koch, Helga Aalders, Marlies Soleman

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the clinical relevance of common features of effective treatments for borderline personality disorders (BPD); 2) Provide insight in a nation-wide implementation program of a generalist treatment framework for BPD; 3) Demonstrate training tools, including online support, video demonstration, manualized protocols and train-the-trainer courses; 4) Illustrate service reforms by discussing a specific case (service, team); and 5) Demonstrate quality assurance by discussing audit results in teams.

SUMMARY:

Borderline personality disorder is a common and severe mental disorder, resulting in reduced life expectancy, reduced life quality and major health care costs due to frequent crises and use of multiple services. Although several international guidelines recommend evidence-based treatments (e.g. Dialectical Behavior Therapy, Mentalization-based Treatment), a gap study demonstrated massive under-treatment of BPD, mainly due to insufficient availability of well-trained therapists (Hermens et al. 2011). As a consequence, most patients with BPD receive unstructured and therefore sub-optimal treatment. In order to improve treatment quality and enhance uniformity for treatment services for BPD, the Centre of Expertise on Personality Disorders in the Netherlands has developed a 'Generalist Treatment framework for BPD', which outlines specific common features relevant to

effective treatment for BPD. This has led to a service reform in 16 mental healthcare institutions in the Netherlands, restructuring treatment programs and teams in accordance with the outlined common features. In this workshop we will discuss the background and context for this major project, including the rationale for a Generalist Treatment approach. We will also outline the common features and service reforms implied by the Generalist Treatment for BPD. Next, we will discuss the simultaneous implementation in the participating mental health institutes, demonstrating training materials and online support. Participants will be involved by using training films and discussing a concrete case illustration, demonstrating service changes. Finally, the workshop will focus on the issue of quality assurance, by discussing methods and providing results from a large multi-centre audit, conducted in participating institutions. Throughout the workshop we will highlight the benefits of a shared bottom-up approach to service reforms which results in an increased coverage of treatment programs for a broad group of patients with BPD and a better overall effectiveness. Moreover, we will highlight the feasibility of a generalist approach in terms of training and expected service reforms, as compared to specialist approaches.

Ketamine for Pain and Depression Initiative

Chair: Waguih W. Ishak, M.D.

Presenters: Brigitte Vanle, Ph.D., Jonathan Dang, Charles Louy, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Acquire knowledge about current management of treatment-resistant chronic pain + depression; 2) Share and discuss two ketamine protocols used by experts at Cedars-Sina; 3) Present pilot clinical data of ketamine effectiveness for treatment-resistant chronic pain + depression; and 4) Discuss ongoing challenges of ketamine in terms of effectiveness and implementation.

SUMMARY:

The use of ketamine to treat depression has received recent attention as a popular alternative therapeutic due to its rapid onset effectiveness and high

response rate for treatment-resistant depression. However, ketamine produces hallucinogenic side effects and the current IV route of administration may be impractical for outpatient settings. There is a great need for alternative and practical methods of ketamine administration. Previous studies have focused on treating either pain or depression separately. However, we commonly observe and treat pain and depression in our inpatient population. Our workshop will introduce participants to a novel treatment for comorbid pain and depression. We will provide a brief introduction regarding existing therapeutics in the management of pain and depression, novel properties and mechanism of action of ketamine. We will have expert panelists who prescribe ketamine and participate in the Ketamine for Pain & Depression Initiative at Cedars-Sinai Medical Center (CSMC) and share their protocols. The pilot data documenting changes in pain and depressive symptoms after ketamine infusions will be shared with the audience.

Managing Behavioral and Psychological Symptoms of Dementia in the Era of Black Box Warnings

Chair: Rajesh R. Tampi, M.D., M.S.

Presenters: Juan Joseph Young, M.D., Silpa Balachandran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To describe the epidemiology, neurobiology, assessment of individuals with BPSD; 2) To discuss the management of individuals with BPSD; and 3) To elaborate on the recent controversies in the treatment of individuals BPSD.

SUMMARY:

Dementias are the most common neurodegenerative conditions in human beings. As we age, the incidence and prevalence of dementias increase. Currently in the United States, there are over 5 million individuals with dementias. This number is projected to rise to over 11 million over the next thirty years. Despite emerging data on various important aspects of dementia, the diagnosis and management of these disorders is not standardized. The data on the management dementias is still limited with none of the pharmacotherapeutic agents available in the market

showing any longer term benefits. Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. In this symposium, we will discuss the epidemiology, neurobiology, assessment and management of individuals with BPSD. We will also provide an evidence based guideline to assess and manage these individuals. Finally, we will elaborate on the recent controversies in the treatment of individuals with BPSD.

Mandatory Opioid Prescriber Education: Saving Lives? Or Wasting Time?

Chair: Carl Erik Fisher, M.D.

Presenter: Steven Kenny Hoge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the range of policy responses to the opioid overdose epidemic; 2) Appreciate the role of prescriber behavior in fueling opioid use disorders; 3) Understand the debate around mandatory provider education, including the possible benefits and risks of such initiatives; 4) Discuss the range of mandatory prescriber education initiatives already in place in different jurisdictions; and 5) Appreciate the legal, ethical, and policy questions arising from government-mandated prescriber education.

SUMMARY:

Physicians and lawmakers are struggling to find effective policy responses to the opioid overdose epidemic. One important aim is to reduce the number of substandard or otherwise unnecessary

opioid prescriptions, so several policy responses attempt to influence physician prescribing practices; for example, through education or prescription monitoring programs. Recently, some states have instituted mandatory prescriber education, such as mandatory CME and opioid-related courses, and there is now debate over whether such education should be mandated nationwide. The topic of mandatory provider education regarding opioids is of central importance to all practicing physicians, particularly psychiatrists, who encounter a high level of substance use disorder comorbidity. Physicians in all jurisdictions must be familiar with the arguments for and against such initiatives in order to take an informed position and participate in the local legislative process. In the workshop, participants will be engaged in discussion and debate around this complex and multifaceted issue. The debate over mandatory education invokes a number of questions, from the pragmatic (ie, does it work?) to deeper considerations touching on professionalism and legal/forensic issues. For example, traditionally, standards of care evolve from the bottom up, arising over time due to the actions of professionals themselves. However, mandatory provider education, including education that requires specific content, is an arguably new instance of governmental efforts to directly drive changes in the standard of care. As such, one criticism is that mandatory education has the potential risk to affect the nature of the physician-patient interaction. These changes could emphasize societal interests (decreasing diversion) at the expense of undermining the traditional fiduciary doctor-patient relationship. Furthermore, this new mandatory content could cause confusion among physicians over which opioid prescribing practices are now mandated by law and which are only recommended or advisory. Could mandatory education open physicians to new kinds of malpractice challenges? Mandatory provider education is not without risks to the practice of medicine. The key question will be whether those risks are justified in light of the present public health crisis. The speakers in this workshop will include a seasoned expert in psychiatry and law and a practicing psychiatrist double boarded in addiction medicine and forensics. Brief presentations of the scholarly literature (empirical studies, policy surveys, and legal and

ethical analysis) and case examples will alternate with guided Q&As and audience discussion around the key policy, legal, and ethical issues at play.

Media Literacy Is the New Black

Chairs: Jessica Gold, M.D., M.S., Diana M. Robinson, M.D.

Presenters: Kathryn Skimming, M.D., M.A., Laura J. Pientka, D.O., Adjoa Smalls-Mantey, M.D., D.Phil., Megan Christine Riddle, M.D., Ph.D., M.S., Michael Henri Langley-Degroot, M.D., Ebony M. Dix, M.D., Rona Hu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe media literacy and how to process psychiatric topics in popular media; 2) Promote productive dialogue on mental health issues with various stakeholders; and 3) Critique the role of the psychiatrist as a media consultant and the responsibility of a psychiatrist to construct the public narrative around psychiatric topics in the media.

SUMMARY:

With the constant bombardment of psychiatric topics on the news, on social media, and on Netflix, as psychiatrists we are becoming accustomed to patients, friends, and even the media itself asking for our take on the topics at hand. We often feel ill prepared to answer their questions, especially given the pace at which media changes. But, what is our role and responsibility in these conversations? Even still, is it possible to be a leader in psychiatry while keeping oneself and one's practice separate from the media component? This workshop seeks to address these questions and provide applicable skills for psychiatrists to navigate the intersection of media and psychiatry. We will address the interaction of psychiatrists with the media at three levels: the individual, the interpersonal, and the public. The first part of the workshop will focus on the individual with a brief didactic overview of media literacy as it pertains to psychiatrists. The second part, focusing on the interpersonal, will include how to discuss these pieces with key groups. We will break out into small groups, focusing on the psychiatric media topic du jour, and each group will discuss how to explain the media piece to different stakeholders, such as patients, adolescents/families,

other doctors, and the general public. Finally, we will consider the role of the psychiatrist as a media consultant, or rather question, what is our responsibility to not just respond to the messages and pieces that come out but actually try to craft them ourselves. We will hear from psychiatrists who have consulted for the media including Rona Hu MD about the experience and the pros and cons of working in this role. We will then have a discussion/Q and A session about whether psychiatrists should be in this role and the ethical challenges of doing so. The goal of this workshop is to have participants leave understanding how to incorporate the media into their lives, their practice and conversations with patients, and their interactions with the public as well.

Mind the Gap: Can Delivery of Integrated Care in Community Mental Health Centers Mitigate Health Disparities in Adults With Serious Mental Illness?

Chair: Marshall Forstein, M.D.

Presenters: Miriam C. Tepper, M.D., Jennifer Greenwold, M.D., Benjamin Cook, Ph.D., Ana Progovac, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate a clear understanding of disparities in mortality and healthcare quality experienced by adults with serious mental illness (SMI); 2) Understand key elements of the integrated 'Behavioral Health Home' model of care; 3) Demonstrate possible mechanisms by which the 'Behavioral Health Home model serves the whole health needs of adults with SMI; and 4) Identify at least 1 strategy clinicians can incorporate into their own practice to improve the overall health of their patients with SMI.

SUMMARY:

It is well known that adults with serious mental illness (SMI) face a substantial mortality gap compared with the general population, yet health outcomes have not improved despite widespread knowledge of this disparity. Interventions that integrate behavioral health services into primary care settings improve screening and treatment rates for patients with milder mental health needs, but they are not designed to effectively reach people

with SMI. One alternative approach to addressing health risks in this population is the Behavioral Health Home (BHH) model, which provides enhanced access to medical services, care coordination, care transition support, and health promotion activities in a community mental health setting. Yet there is much that remains unknown about this model. In this workshop we will describe the origin of the BHH design and the current evidence base for its effectiveness. We will then describe a pilot BHH program that was implemented in a safety net health system, including details on the program's structure and clinical components. We will present findings from a mixed-methods evaluation of the program, which includes a rigorous quasi-experimental analysis of electronic health record data and qualitative findings from semi-structured interviews. Quantitative analysis demonstrated that during its first year of implementation, the BHH program was associated with significant reductions in emergency department visits and psychiatric hospitalizations, along with more preventive screenings for diabetes. The reductions in acute service utilization resulted from less repeat utilization among those with at least one such encounter. Based on these results, we conclude that integrated BHH programs in mental health settings hold promise for improving quality of care, health care spending, and equity in health outcomes for adults with SMI. We will discuss the implications of these findings in terms of next steps for studying BHH interventions and replication of the BHH model in diverse settings. We will frame this discussion within the context of the healthcare's movement toward alternative payment models, such as Accountable Care Organizations (ACOs), and in particular consider how financial incentives might align with treatment and social support needs for this high-cost population. This workshop will seek to engage participants in a lively discussion around strategies for incorporating health promotion into routine practice, and how to remain hopeful in the face of challenging odds.

Religious/Spiritual Commitments and Psychiatric Practice: A Global Forum on Rethinking the 2006 APA Resource Document in Enhancing Patient Well-Being

Chairs: Wai Lun Alan Fung, M.D., John Raymond

Peteet, M.D.

Presenters: Christopher Cook, M.D., Ph.D., Peter Verhagen, M.D., Alexander Moreira-Almeida, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To provide an overview of the history of various initiatives and official documents by the American Psychiatric Association related to spirituality/religion and psychiatry; 2) To illustrate the rationales and processes of the recent development of position statements on spirituality/religion and psychiatry by national and international psychiatric organizations; and 3) To discuss about the merits and next steps for the revision of the 2006 APA resource document and potential development of an APA position statement on spirituality/religion and psychiatry.

SUMMARY:

In 1990, in response to concerns about boundary violations, the APA approved ethical guidelines for psychiatrists dealing with spiritual and religious issues. These were expanded and revised in the 2006 APA Resource Document on Religious/Spiritual Commitments and Psychiatric Practice (committee chaired by Dr. Peteet), which recommended that psychiatrists (a) respect their patients' commitments, (b) avoid imposing their own values/commitments onto patients, and (c) foster recovery by making treatment decisions in ways that respect and take into meaningful consideration their patients' cultural, religious/spiritual, and personal ideals. Over the past decade, psychiatrists have devoted increasing scholarly and practical attention to the clinical importance of religion/spirituality (R/S). Systematic reviews of the scientific literature have identified more than 3,000 empirical studies investigating the relationship between R/S and health. R/S values, beliefs and practices remain relevant to most of the world population, and surveys have shown that most patients would like to have their R/S concerns addressed in their care. In recognition of these developments, in 2013 the Royal College of Psychiatrists, UK published Recommendations for Psychiatrists on Spirituality and Religion, authored by Dr. Christopher C. H. Cook on behalf of the Spirituality and Psychiatry Special Interest Group. This position statement discusses

both definitions and the evidence base supporting its recommendations for clinical practice and training. In 2016, the World Psychiatric Association (WPA) published its own Position Statement on Spirituality and Religion in Psychiatry (Moreira-Almeida et al, 2016). The statement notes that R/S has significant implications for prevalence (especially depressive and substance use disorders), diagnosis (e.g., differentiation between spiritual experiences and mental disorders), treatment (e.g., help seeking behavior, compliance, mindfulness, complementary therapies), outcomes (e.g., recovering and suicide) and prevention, as well as for quality of life and wellbeing. It also notes that while there is evidence that R/S is usually associated with better health outcomes, it may also cause harm (e.g., treatment refusal, intolerance, negative religious coping). Seven comprehensive and specific recommendations for psychiatrists in dealing with R/S follow. In this workshop, following an overall introduction by Dr. Fung, the principal authors of these documents (Drs. Cook, Moreira- Almeida, Peteet and Verhagen) will present on their respective position statements. This will be followed by a discussion among the presenters and members of the audience about the development and impact of these statements as the first step in formulating suggested revisions of the 2006 APA Resource Document, and the potential development of an APA position statement on R/S in psychiatry. The overall goal is to enhance quality of care and patient well-being.

Thirteen Reasons Why: Unintended Consequences of Media Depiction of Suicide

Chair: Kelly Blankenship, D.O.

Presenter: Elizabeth DeRose Kowal, M.D.

Discussants: Suzie C. Nelson, M.D., Julia C. Jackson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the ubiquity of this series as well as the impact of presenting graphic depictions of suicide to young audiences; 2) Demonstrate the connection between popular media presentations and subsequent psychological effects and human behavior; 3) Understand the perilous position of romanticizing suicide as a means for fulfilling revenge fantasies and perpetuating

change; and 4) Provide clinicians with tools for discussing this series/topics with their patients, families, and wider audiences.

SUMMARY:

A show with the accolades of generating the most tweets in 2017 and prompting over 600,000 news reports, *Thirteen Reasons Why* presents 13 hours surrounding a portion of the life and then the tragic death by suicide of a high schooler who has been the victim of slut-shaming, loneliness, and sexual assault. In capturing the audience with the point-of-view of a protagonist who might have “saved” her and presenting each episode as a mystery opening up each new Pandora’s box of the peers who had contributed to her demise, it harkens the idea that suicide could be the game-changer for a community, that it can be justified and therefore fulfill revenge fantasies for a marginalized person or group. The potential for the unfortunate message of glorification of death by suicide and the promise of living in infamy as a martyr for effecting change through suicide is the counterpoint for the intent of the show producers and creators, which was to generate discussion about suicide in order to fulfill the aim of suicide prevention. Imitation of suicidal behavior following media coverage of suicides increases with conditions such as younger age of the viewer and identification of the person committing suicide. While *13 Reasons* depicts fictional characters, the power of fictional media is that it creates greater engagement with the viewer by connecting memory and emotional valence with a greater “state of absorption, concentration, and attention.” Indeed, “no other art form pervades the consciousness of the individual to the same extent and with such power as cinema.” The potential for thousands of young viewers to identify with the show’s character is profound; this is particularly true for those who have felt marginalized, been bullied, or survived trauma. In the 19 days following the series release, online suicide queries increased by 19%, including both queries indicative of efforts to prevent suicide such as hotline number access, but also concerning increases in queries such as “how to commit suicide.” That searches for suicide methods increased following the series release is highly concerning for increased rates of suicide attempts, since both suicide search trends and media coverage

of suicides are correlated with suicide attempts. Such facts should be considered as being beyond mere statistics, however, and are the basis for this in-depth discussion of the impact of this particular media device on the current 15-24 year-old age population, for which suicide is the 2nd leading cause of death. This workshop directly tackles the power of media and influence on suicide and addresses ways that mental health professionals can discuss this with patients and families to mitigate potential harmful effects.

Violence and Suicide: What Role Should Involuntary Treatment Play?

Chair: Dinah Miller, M.D.

Presenters: Marvin Stanley Swartz, M.D., Paul Nestadt, M.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) to explore the relationship between first-episode psychosis and risk violence, and consider the implications for involuntary commitment; 2) Participants will recognize the important role of firearm access in determining the difference between a suicide attempt and a completed suicide; 3) Participants will be able to discuss the evidence that involuntary outpatient can reduce violence; and 4) Participants will understand some of the complexities of involuntary treatment.

SUMMARY:

In clinical practice, we all agree that involuntary hospitalization is sometimes necessary to prevent a very ill person from harming himself or others. The practice of involuntarily treating patients, however, is fraught with controversy. Proponents of involuntary treatment assert that it can be helpful in preventing homelessness, incarceration, violence, suicide, and mass murder. These are big topics for a single session; we will focus on just a few aspects of the question of whether involuntary care has a role for both the individual and as a public health measure to prevent suicide and violence. Dr. Appelbaum will present a recent study on violence in first-episode psychosis. Dr. Nestadt will talk about suicide in terms of attempts and completion and how the accessibility of firearms impacts. Dr. Swartz will talk about involuntary outpatient commitment

and the role this controversial practice plays in preventing violence. Dr. Miller will draw these topics together in a discussion of the pros and cons of involuntary treatment and its impact on the patient.

Yoga-Mindfulness and Sound-Healing to Prevent Burnout, Compassion Fatigue, and Secondary Stress in Psychiatrists and Mental Health Providers

Chair: Alex Nicholas Sabo, M.D.

Presenter: Mary B. O'Malley, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) define the three elements of burnout and rates of burnout in physicians; 2) understand a randomized trial of CBT vs. Yoga that improved burnout and depression in mental health providers; 3) understand four elements of the yoga mindfulness program that mitigated burnout; 4) choose at least one sound healing practice that might be useful for self care and your own clinical work; and 5) provide one theory of how sound-healing works.

SUMMARY:

Burnout, compassion fatigue and secondary stress threaten the health and engagement of health care workers in the United States. At least 50% of physicians (Shanafelt TD et al, JAMA, 2017) 34% of nurses and 60% of all health care workers report burnout. Burnout is associated with higher rates of medical errors and litigation in health care and lower levels of engagement, provider satisfaction and staff retention, and it has been identified as a serious threat to achieving the Triple Aim of health care reform (Bodenheimer T, Sinsky C, Annals of Family Medicine, 2014). A recent meta-analysis indicated that some interventions show promise in decreasing burnout (West CP et al: Lancet, 2016). Our randomized trial of Kripalu Yoga-Meditation v. CBT for stress reduction in frontline providers showed improvement in both interventions (Riley KE et al, Journal of Workplace Behavioral Health, 2016). Since the randomized trial was encouraging, BMC implemented a 10-week yoga-mindfulness program and other mindfulness training opportunities for physicians, nurses, managers, residents and other staff. More than 200 physician and nursing leaders and managers have participated in at least one of

the 10-week training programs, and more than 500 employees have participated in one or more of the retreats or focused workshops. A recent survey of managers indicated that more than 70 percent identified the use of their breath training when facing highly stressful situations. Measures of burnout, compassion fatigue and secondary stress have also improved. Sound can be used in all forms for healing: all musical instruments, tuning forks, quartz crystal bowls, and our voice, just to name a few. Music is widely used for our 'healing' or inspiration---we can quickly shift gears emotionally when we listen to a piece of music we like or dislike, and sometimes are brought instantly to an entirely new way of feeling or seeing with music that is especially deep for us. Knowing how powerful music and sound can be, this year we added sound-healing as another intervention to reduce stress and promote well-being in ourselves and our staff. Workshop presenters are psychiatrists, one also a yoga teacher, and the other a neuroscientist and interfaith minister who teaches sound-healing. Participants will be invited to participate in brief yoga-mindfulness and sound-healing experiences and discuss how they may want to use these approaches for their own self care, for their staff and possibly their patients.

A Resident's Guide to Borderline Personality Disorder: From the Experts (Part I of II)

Chair: John Gunder Gunderson, M.D.

Presenters: Marianne Seligson Goodman, M.D., Robin Kissell, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Assess suicide risk and determine appropriate level of care.

SUMMARY:

This is a repeat of a series of popular workshops held in New Orleans in 2010, Philadelphia in 2012, San Francisco in 2013, New York in 2014, Toronto in

2015, Atlanta in 2016, and San Diego in 2017. Those resident-only workshops were very successful, with high levels of attendance (>100 each session) and engagement. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization, with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

Advocacy 101

Chair: Patrick S. Runnels, M.D.

Presenters: David A. Lowenthal, M.D., Steve Hyun Koh, M.D., Rustin Dakota Carter, M.D., Rachel Melissa Talley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe how a bill becomes a law; 2) Learn skills to effectively communicate with lawmakers in order to impact the development of legislation; 3) Develop a plan for offering advocacy training at the district branch level; and 4) Identify opportunities to collaborate with other stakeholders in both advocacy trainings and legislative meetings.

SUMMARY:

As psychiatrists, we advocate on behalf of our patients on a regular basis, communicating with insurers, school systems, employers and other members of the health care team. Yet most psychiatrists have not had experience advocating within the legislative arena. Lack of time, training or experience, as well as skepticism about the impact of advocacy are frequently cited as reasons for not getting involved in advocacy. Experience demonstrates that advocacy need not take a lot of time and having a voice in the legislative process is crucial to protecting physician scope of practice and improving patient access to care. As the saying goes, "If you're not at the table, then you're on the menu." A specific skill set is required to effectively communicate with lawmakers, balancing an understanding of policy with politics. The Council on Advocacy and Government Relations (CAGR) and the Department of Government Relations (DGR) have developed a series of tools to engage members in developing advocacy competency. These materials will be presented in this workshop using a train the trainer model. All APA members are invited; no prior advocacy experience is required. In addition, APA District Branches are invited to identify a member to participate in this workshop and then be prepared to work with DB leadership to develop advocacy training at the state level.

De-Incentivizing Disability: Providing Long-Term Care Without Promoting Long-Term Illness

Chair: Daniel C. Hart, M.D.

Presenters: Erika M. Zavyalov, D.O., Elspeth Cameron

Ritchie, M.D., M.P.H., Daniel M. Gade, Ph.D., M.P.A., David E. Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Engage with individuals suffering from PTSD to set realistic expectations that include and amplify the possibility of restoration of health; 2) Capture the down-stream effects of the PTSD diagnosis on patient health and provider burnout within the current veterans disability compensation program; 3) Grasp the clinical implications of disability policy and identify the corresponding impact of clinical decisions on the disability program at large; and 4) Describe policies and procedures shown to create a more positive and rehabilitative approach to PTSD.

SUMMARY:

Background: The veterans disability compensation (VDC) system is key to the ongoing care and vitality of many who have been wounded in military service to the nation. For some, the wounds are visible and permanently disabling. For others, PTSD, the fourth most prevalent disability in post 9-11 veterans, is an invisible wound that follows courses of chronicity that vary by individual(1). Clinicians engaging in expectation-setting conversations with patients face a double-edged sword when discussing the course of PTSD in light of VDC. How do we have conversations with patients that amplify the expectation of a return to health? How do we encourage those receiving disability pay to continue in restorative treatment? On one hand, the sensitive and long-term implications of this conversation can tempt one to pass it off to the next provider; this may prolong physical/mental disability, expose the patient to repetitive and more-than-necessary testing and treatment, and cause excessive costs to our health care systems. On the other hand, the decision to award disability to the PTSD diagnosis has been shown to result in less compliance with therapy and less productive reentry into the workforce(2). Content: This workshop will deliver the firsthand accounts of providers dealing with these tough questions on a daily basis both in the military health care system and in Veterans Affairs. It will provide both small group and digitally interactive means of strategizing counter-burnout techniques for

providers “in the trenches.” It will address policy (current and future) and highlight a more positive and rehabilitative approach to PTSD and disability.

Establishing Projects in Collaboration With Psychiatric Residents From Other Countries

Chair: Héctor Saiz

Presenters: Miguel Ángel Álvarez de Mon, Anna Szczepielniak, Howard Ryland, M.B.B.S., Victor Pereira

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of the European Federation of Psychiatric Trainees and the capacity this organization has to create spaces; 2) Provide the residents of their own country with ideas in order to start a National Trainee Association or to make the best use of it if it exists; and 3) Understand the history, vision and activities of European Federation of Psychiatric Trainees and consider opportunities for further international collaboration between early career psychiatrists.

SUMMARY:

Introduction: The European Federation of Psychiatric Trainees (EFPT) is the first international professional organization for postgraduate trainees in medicine of its kind. Since its foundation in the early 1990s it has grown to become a formally recognized independent umbrella organization for almost forty national trainee associations from across Europe. EFPT’s goals are: to explore the diversity and richness of the current training of psychiatrists in Europe, to support the development of national trainees’ organizations in all European countries, to promote and represent internationally the views of the trainees in all branches of psychiatry and to translate the discussions of trainees into action at a local level to improve training. The Federation’s current activities include conducting international research on issues affecting trainees, running a highly successful exchange program, collaborating with other key stakeholders to influence policy on training and working to establish national trainee associations in Europe and worldwide (For more information please visit www.efpt.eu.) Results: we would like to explain with our experience how enriching this initiatives are. This workshop will

introduce to the listeners the concept of National Trainees Associations (NTAs) and the European and worldwide experience, and create a forum of international-perspective discussion with listeners about the opportunities of the NTAs in the world and the possibility of introducing this model into new countries.

Holistic Management of Anxiety Disorders

Chair: Sudha Prathikanti, M.D.

Presenters: Selena Chan, D.O., Albert Ning Zhou, M.D., Yvette R. Kaunismaki, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define key elements of an integrative psychiatry approach to treating anxiety disorders; 2) Identify patients likely to be good candidates for an integrative psychiatry approach; 3) Outline potential risks/benefits/contraindications associated with complementary therapies for anxiety presented in this workshop; 4) Identify relevant licensing or professional safety boards for community practitioners of complementary therapies presented in workshop, and independent labs testing safety/quality of nutraceuticals; and 5) Summarize medicolegal issues and safeguards related to use of complementary therapies in clinical practice.

SUMMARY:

The general public in the United States continues to show remarkable interest in the use of complementary and “holistic” therapies for healthcare, particularly for the treatment of mood and anxiety disorders [1-3]. For example, 44% of adults with neuropsychiatric symptoms use complementary therapies, in comparison to 30% of adults without neuropsychiatric symptoms [4]. Even among children in the United States, 12% use complementary healthcare, with approximately half of these children having neuropsychiatric symptoms such as anxiety, insomnia and attentional deficits [3]. In this context, it is vital for psychiatrists to understand the strengths and weaknesses of complementary, alternative and integrative modalities. Moreover, as more patients seek out physicians who offer integrative healthcare, psychiatrists may be well-advised to give thoughtful

consideration to which non-conventional therapies—if any—to incorporate into their own practices. While many psychiatrists may have heard of some complementary therapies for mental health care, they often have a very vague understanding of the “nuts and bolts” of potentially incorporating such therapies into patient care. This workshop aims to address this need, with a very clinical orientation that demonstrates to the audience key elements of implementing an integrative psychiatry approach.

Hope Modules: Managing “Normal Suffering” When Stressors Are Severe, Chronic, or Uncontrollable

Chair: James Lamont Griffith, M.D.

Presenter: Jacqueline Posada, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Distinguish “normal suffering” as demoralization, spiritual crises, and other normal syndromes of distress, from psychopathological diagnoses such as depression or PTSD; 2) Describe the design of hope modules as brief psychotherapeutic interventions for sustaining hope, strengthening resilience to stress, and buffering “normal suffering.”; 3) Conduct an assessment, formulation, and hope-building intervention to help a demoralized person to cope assertively with adversity; 4) Articulate how hope modules can fill a practice gap for persons struggling with “normal suffering” from chronic, severe, or uncontrollable stressors; and 5) Discuss how executive functions, social cognition, and emotion regulation support assertive coping responses in response to adversities.

SUMMARY:

Many in otherwise good mental health live under duress from medical illnesses, war, social injustice, or other adversities. Acute traumas compound with chronic stressors, such as stigma, poor healthcare, inadequate schools, and unsafe living conditions. Most adverse impacts on mental health manifest as normal syndromes of distress, rather than psychopathological diagnoses of PTSD or depression. This “normal suffering” includes demoralization, grief, spiritual crises, and alienation from loss of familiar identities. Hope Modules are brief psychotherapeutic interventions for helping persons

under duress to sustain hope, strengthen resilience to stress, and buffer “normal suffering.” Hope modules package skill sets for assessment, formulation, and intervention around single evidence-based hope practices. They optimize ease of use by non-technical language and minimal steps from assessment to intervention. Assessment of hope-building competencies enables specific modules to be best matched to a person’s strengths and specific predicament. Hope-building interventions can be improvised within the flow of other clinical work without organizing a separate, formal psychotherapy. Although conceptual simplicity is emphasized in clinical encounters, hope modules are based upon a complex understanding of functional brain circuits that provide the neural infrastructure for assertive coping responses. Specific hope modules optimize executive functions, social cognition, and emotion regulation, utilizing interplay of these neural networks to increase capacity for assertive coping responses. Clinical reasoning is thus conducted at the level of functional brain circuitry, akin to NIMH Research Domain Criteria (RDoC’s). This workshop will illustrate assessment, formulation, and intervention using clinical illustrations that draw from 14 hope modules: (1) executive functions (pathways-thinking, agency-thinking), (2) social cognition (relational coping utilizing attachment, confiding, group role, social network, altruistic relationship), (3) core identities (personal, family/work group, impersonal identities), or (4) emotion regulation (unloading stressors; managing “attrition stressors” such as uncertainty, ambiguity, waiting; adopting emotion regulation practices, such as yoga, mindfulness, spiritual practices; or utilizing executive functions or relational coping to achieve emotion regulation). Hope modules fill a practice gap by providing brief psychotherapeutic interventions that: (1) can bolster coping of normal persons who struggle with “normal suffering” from chronic, severe, or uncontrollable stressors; (2) can be embedded within primary care, case management, or other non-psychotherapeutic clinical encounters without necessity of a separate psychotherapy; (3) are usable by clinicians with limited psychotherapy training; (4) demonstrate how cognitive and social neuroscience research can be translated into pragmatic clinical interventions.

How Many Lawyers Does It Take to Change a Mental Health System? Reflections on Medical-Legal Partnerships in Behavioral Health Settings

Chair: Ruth S. Shim, M.D., M.P.H.

Presenters: Mallory Curran, Aleah Gathings, Jennifer Falk Havens, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify the key characteristics of Medical-Legal Partnerships (MLPs) in addressing the social determinants of mental health; 2) Consider the role of MLPs in improving mental health outcomes on patient, clinical, and population levels; and 3) Develop an action plan to start an MLP in your own clinical setting.

SUMMARY:

The social determinants of mental health are responsible for many of the mental health inequities and poor outcomes for people with mental illnesses. With increasing recognition of the significance of the social determinants of mental health, an urgent question has come to the fore: What can we do about them? One answer has come from an unexpected source: patient-centered lawyers, partnering with psychiatrists and other behavioral health professionals. Medical-Legal Partnership (MLP), which integrates lawyers into the health care team, is an innovative model that has had a significant impact in a variety of medical specialties--and is increasingly expanding into behavioral health settings. This creative solution to addressing the social determinants of mental health involves behavioral health professionals partnering with civil legal services lawyers to address the social factors that contribute to poor mental health outcomes. Successful examples include fighting illegal evictions, enforcing disability anti-discrimination laws, and ensuring appropriate special education and other school-based services for students with mental health problems. This workshop will discuss the benefits, challenges, and opportunities of MLPs, including the impact of MLP interventions at the individual, clinic, and population levels. Psychiatrists and lawyers affiliated with successful MLP models throughout the United States will present case examples on how MLPs have benefited patients,

transformed clinical practice, and provided a pathway to effect policy change. Presenters will also discuss concrete ways that participants can develop MLPs in their own behavioral health clinical settings, in order to improve mental health outcomes of participants' own patient populations.

Implementing an SBIRT Training Program Across Multiple Disciplines

Chair: Victoria Balkoski, M.D.

Presenters: Mark Lukowitsky, M.D., Nicole Bromley, Psy.D., Jeffrey Winseman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To use and interpret two screening tools for assessing substance use; 2) To use basic motivational interviewing techniques for motivating patients to cut back on substance use; 3) Practice SBIRT and receive feedback on their effectiveness in using SBIRT skills; and 4) To understand the elements needed to implement an SBIRT training program for students and faculty in various disciplines.

SUMMARY:

The abuse and misuse of alcohol, tobacco, and drugs (both illicit and prescription) in the United States is associated with higher rates of morbidity and mortality than any other preventable disease (Ericson, 2001). Unfortunately, health providers often fail to assess and intervene in problems stemming from substance abuse and often lack the competency to assess and manage alcohol and drug related problems (Cape et al., 2006). Furthermore, research suggests that many clinicians feel underprepared to diagnose and treat addiction (Center on Addiction and Substance Abuse, 2000). Stigmatizing attitudes and beliefs towards people with substance use disorders further compound this problem by negatively impacting the delivery of treatment. Screening, Brief Intervention, and Referral to Treatment (SBIRT) was developed as an evidence-based system for providing early detection and treatment of substance use disorders. It relies on the use of validated screening instruments and motivational interviewing techniques to educate patients around substance misuse and to negotiate a goal for reducing risky substance use. Funded by two

SAMSHA training grants, our SBIRT team has been training students and faculty in the delivery of SBIRT since 2008. To date we have trained over 800 students, trainees and faculty within a variety of disciplines including Psychiatry, Family Medicine, Nursing, Pharmaceutical Sciences, Physician Assistant and Medical Students. In this workshop we will provide some of the lessons learned in training students and faculty in SBIRT and some of the findings from our SBIRT research program which highlighted the biases and stigmas held by trainees toward patients with substance abuse problems. We will also present an abbreviated version of our SBIRT training protocol that will include videos and didactics on the elements of good and bad SBIRT interventions. The workshop will culminate in an experiential exercise where audience members will have the opportunity to practice SBIRT skills through role plays.

Improving Suicide Risk Management Skills

Chair: John C. Bradley, M.D.

Presenters: Brett J. Schneider, M.D., James Curtis West, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appraise the scope & quality of available evidence to date for the bio-psycho-social factors related to Suicide and Suicide Prevention so that providers can select appropriate treatments; 2) Develop improved skills in Suicide Risk Assessment by learning how to perform Suicide Risk Stratification to determine the appropriate setting of care to best manage the acute risk of suicide; 3) Understand the evidence base for suicide-focused medication- and psycho-therapies to reduce risk of suicide attempt in your patient; 4) Develop an understanding of how Safety Planning can reduce the risk of suicide re-attempt and allow for the safe discharge from the hospital setting; and 5) Develop skill in managing the risk of firearms and improving firearms safety in the home.

SUMMARY:

Suicide is the 11th leading cause of death in the United States amongst all age groups and the 3rd leading cause of death in young adults. It is the leading cause of morbidity, mortality and clinical risk

in psychiatric practice and the leading cause of tort litigation for mental health clinicians. Suicide risk stratification is complex and often difficult to perform in the increasingly brief clinical encounters throughout to continuum of healthcare settings. The positive prediction of suicidal behaviors and death by suicide is even more complex still. This workshop will describe the work of national experts in Suicidology to develop a clinical practice guideline for the assessment and management of suicidal behaviors that guides the care of patients presenting to primary care, specialty care, emergency care, and mental health care settings. While the focus is on military and veteran populations, the recommendations can be generalized to wider populations. We will describe the Guideline development process, review the literature that served as the basis for the recommendations of the Guideline, and present the recommendations for the assessment of suicide risk and prediction of self-directed violence and the referral and treatment recommendations for patients at risk. A Recovery Model will be described in detail and used to guide clinical decision making. The myriad risk factors, protective factors, and warning signs that have been validated in the literature will be reviewed and incorporated into a risk assessment tool that will guide the clinical care. A collaborative assessment strategy will be offered to aid in the clinical assessment of the interpersonal, psychodynamic, cognitive, and behavioral factors that lead to the hopelessness and perceived burdensomeness that drives suicidal feelings. The factors that lead to isolation, withdrawal, and the creation of barriers to help-seeking behavior will be discussed and understood. This workshop will use clinical vignettes and role-playing to improve clinical assessment skills and the introduction of a patient-centered approach to reducing the risk of suicide attempt. We will focus attention on the developing literature of firearms safety planning and risk management at a tool of engagement and collaboration with families and community resources. A model for instilling hope and recovery will be offered to reduce barriers to treatment and engage the patient with the positive expectation of healing.

Making Your Presentation More Interactive: The Better Way!

Chair: Jonathan S. Davine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the superiority of interactive group teaching versus a traditional didactic model in changing physician behaviour; 2) Use and participate in different group activities that enhance interactive group teaching; and 3) Maximize the use of “Hollywood” film clips and audiovisual patient events to enhance group teaching.

SUMMARY:

Educational literature has shown us that traditional presentations usually are not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we look at factors that can enhance interaction, including room arrangements, proper needs assessment, and methods to facilitate interactive discussions. The group will have an interactive component, which will involve participating in different group activities, such as “Buzz Groups”, “Think-Pair-Share”, and “Stand Up and Be Counted”, which enhance small group interaction. The use of commercial films to enhance educational presentations has been coined “cinemeducation”. We will discuss techniques to help use films as teaching tools. We will also comment on how to maximize the use of audiovisual tapes of patient encounters as a teaching tool. This will also involve direct viewing of an audiovisual tape to illustrate these principles.

Successful Career Planning for Women

Chair: Gail Erlick Robinson, M.D.

Presenter: Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVE:

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 trade-offs ; 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 “self-promotion” by letting others know about their successes. This workshop run by two experienced leaders in psychiatry will provide tools and insights necessary for successful career planning.

Sustaining Joy in Our Practice: A Workshop on Vicarious Trauma, Burnout, and Resilience

Chair: Gertie D. Quitangon, M.D.

Presenters: Mark Evces, Ph.D., Gertie D. Quitangon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize vicarious trauma, burnout, and secondary traumatization; 2) Understand the development of vicarious trauma; 3) Identify risks associated with vicarious trauma; 4) Understand the concept of resilience and 5) Identify individual strategies to increase resilience and enhance professional quality of life; 5) Identify organizational approaches to address vicarious trauma and promote resilience.

SUMMARY:

Around the world, mental health clinicians experience secondary trauma exposure in the process of empathic engagement with patients. Listening to narratives of pain, suffering, fear, and terror can lead to vicarious trauma, or lasting negative changes in beliefs about the self, the world, and others. Such changes can manifest as disruption of positive beliefs in trust, intimacy, safety, self-esteem and control, decreased work productivity, cynicism and loss of meaning at work, poor work-life

boundaries, diminished feelings of satisfaction and personal accomplishment, avoidance of work with severely traumatized clients, and withdrawal and isolation from colleagues. This workshop examines pathways to vicarious trauma and the impact of our work on our lives. We define a trauma informed perspective and delve deeper into the nuances of overlapping work impact concepts such as burnout and compassion fatigue. We identify risk factors and offer tools for screening and self-assessment. We explore the concept of resilience as an active process of thriving and growth. Antithetical to vicarious trauma, resilience refers to a process of positive transformation and empowerment from the therapeutic alliance with our patients, sometimes referred to as vicarious resilience or post traumatic growth. We identify protective factors for resilient clinicians and pathways to promote resilience. We recommend individualized resilience plans that enhance professional quality of life. We discuss organizational strategies to prevent, recognize, and address vicarious trauma in accordance with an overarching trauma informed care approach. A culture of safety for both patients and providers is proposed by redefining quality of care and its implications for positive provider and organizational outcomes such as recruitment and retention, professional satisfaction, work engagement, productivity, and financial performance.

Trauma and Criminal Justice System Involvement Among Community Mental Health Clients

Chair: Megan E. Testa, M.D.

Presenters: Nzinga Ajabu Harrison, M.D., Tiffany A. Cooke, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the traumatic effects that mass incarceration and mandatory sentencing laws for drug-related offenses have had on urban communities; 2) Understand how the practice of felony disenfranchisement impedes community integration for mental health clients with criminal backgrounds; 3) Understand the negative attitudes towards the criminal justice system that are commonly held in urban communities; and 4) Understand the principles of providing trauma-

informed care to mental health clients with criminal justice system involvement.

SUMMARY:

U.S. social changes that began in the 1970's - including mental health and criminal justice reforms - have had significant impact on urban communities. The effects of these reforms continue to present challenges for psychiatrists in community mental health. At a time when people with serious mental illnesses were being released from state hospitals to an underfunded community mental health system, "tough on crime" social reforms - including zero tolerance policies for poverty-related crimes, mandatory sentencing laws for drug-related offenses, and harshening of community control sanctions - were enacted. Social scientists created the term "mass incarceration" to refer to the dramatic increase in the U.S. prison population that started in the mid-1980's and continued for decades to follow. As rates of incarceration increased dramatically, individuals with mental illness and addictions contributed to prison populations at disproportionately high rates. Therefore, psychiatrists in community mental health work will inevitably work with a large number of clients who have experienced recurrent police encounters, arrests, and criminal court proceedings. Many clients on community mental health center (CMHC) caseloads have spent significant amounts of time in the inherently traumatic environments of jail and prison and have developed correctional adaptations that, when brought with them into the community, can complicate treatment. Many CMHC clients are under supervision of the criminal justice system while living in the community after release from jail (probation) or prison (parole), and even those who do not have formal ties to the criminal justice system carry criminal backgrounds that impede their ability to secure employment, housing, and successfully reintegrate to the community. Finally, many people living in urban communities served by CMHCs hold negative attitudes about law enforcement and the criminal justice system, including fear of being targeted and victimized. Presenters will discuss Trauma and Criminal Justice System Involvement Among Community Mental Health Clients, with the goal of helping participants better serve their criminal justice system involved clients from a

trauma-informed perspective. Presenters will use media clips and case discussions to illustrate how sociolegal issues become important areas for clinical attention in the practice of community psychiatry. Presenters will discuss ways in which clients' experiences with the criminal justice system color their views of authority figures, including psychiatrists. Finally, presenters will provide practical guidelines for providers including tips for helping clients who express fear and mistrust of the criminal justice system, and will discuss motivational interviewing techniques that can be used to help clients maintain compliance with mental health treatment, meet requirements of community control, and pursue their goals for community integration.

Who's Going to Step in When I Step Out? Creating a Succession Plan in Your Organization

Chair: Kari M. Wolf, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define succession planning and its importance in academic medicine and healthcare; 2) Describe the value of a systematic leadership development plan; 3) Compare and contrast models of leadership development inside and outside of healthcare; 4) Construct a systematic plan to develop leaders within your own department/organization; and 5) Explore changes you must make to take on new leadership responsibilities.

SUMMARY:

The American Management Association 2011 survey identified that 71% of senior leaders "rendered leadership succession more important than ever before." However, Allison Vaillancourt, Vice President for HR and Institutional Effectiveness at the University of Arizona recently explained the dearth of succession planning in academia by stating, "Succession planning strikes many people [in higher education] as slotting and favoritism. We just have a huge commitment to the competitive process for positions."

(<http://www.universitybusiness.com/article/higher-ed-succession-planning-who-will-follow-leader>) With 55% of psychiatrists over the age of 55 (making us

the second oldest group of physicians), we know that much of our most experienced educators will be turning over in the coming years. How do we prepare departments to smoothly transition our educational leadership roles to newer (often fresh out of training) members of the department? Historically, educators have stayed in place for decades. When we trained, the faculty had been there for years and would be there far into the future. Today, we live in a time of unprecedented upheaval in healthcare and academic medicine—turnover as people become frustrated, incentives change, new regulations emerge, life brings unexpected twists and turns, and our workforce ages. As a result, we need to prepare for a healthcare and educational environment organized and implemented by the next generation of leaders. How do we systematically prepare junior physicians for this role? What are the key ingredients that led to our own success as leaders? The business community recognizes the importance of leadership development and succession planning. However healthcare and academia lag behind in both our understanding of its importance and the implementation of leadership development programs. This interactive workshop will provide a review of why leadership development is important in healthcare and academia and discuss strategies to implement a leadership development program in your home institution. We will highlight the "call to arms" necessitating that we think about succession planning so the legacy of outstanding education can continue in the collective departments represented in the audience as all of us consider transitions to new roles. Further, this workshop will provide tips and tools to enhance one's own success as the participant takes on leadership roles throughout his/her career. Teaching modalities will include presentation, large group discussion, and small group discussion using Liberating Structures.

Women of Color and Intersectionality

Chair: Ranna I. Parekh, M.D.

Presenters: Kali Denise Cyrus, M.D., M.P.H., Helena B. Hansen, M.D., Ph.D., Tanuja Gandhi, M.D., Vabren Watts, Ph.D., Tatiana Claridad, Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Discuss intersectionality; its origin and evolving definitions; 2) Give an overview of the US Civil Rights, Women's Suffrage, and LGBTQ Movements and their impact on women of color; 3) Review relevance of intersectional minority statuses for women in health care; and 4) Application of intersectionality for health care membership organizations like APA.

SUMMARY:

First discussed in the 1980's by civil rights advocate Kimberlé Crenshaw, "intersectionality" is a term used to describe overlapping social identities and oppression/discrimination towards those identities. For example, racial/ethnic minority women who identify as LGBTQ may face combined racism, sexism, and homophobia. At the 2017 Conversations on Diversity sponsored by APA's Division of Diversity and Health Equity, it was suggested that a dialogue addressing intersectionality among health care professionals would be valuable to APA members. This workshop will discuss the concept of intersectionality as it pertains to women of color and its application to health care. The focus will be the experiences of women physicians in the workplace. This workshop will utilize didactics, panel discussion, and audience response to examine the impact of intersectionality on physician wellbeing.

A Resident's Guide to Borderline Personality Disorder: From the Experts (Part II of II)

Chair: John Gunder Gunderson, M.D.

Presenters: Marianne Seligson Goodman, M.D., Robin Kissell, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

SUMMARY:

This is a repeat of a series of popular workshops held in New Orleans in 2010, Philadelphia in 2012, San

Francisco in 2013, New York in 2014, Toronto in 2015, Atlanta in 2016, and San Diego in 2017. Those resident-only workshops were very successful, with high levels of attendance (>100 each session) and engagement. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization, with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

Adjustment Disorders: Conceptualizing Pathological Stress in the NYC Jail System

Chair: Elizabeth B. Ford, M.D.

Presenters: Bipin Raj Subedi, M.D., Semmie Kim, M.P.H., Lauren Stossel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the development of the adjustment disorder diagnosis and summarize literature on community prevalence and comorbidities; 2) Explore the different utility and function of this diagnosis in jail-based versus community settings; 3) Present data on the prevalence and associated demographic, clinical and legal factors of adjustment disorder, as well as treatment trends, in a New York City jail population; and 4) Identify several reasons why the adjustment disorders diagnosis is more complex in a jail setting as opposed to a community setting.

SUMMARY:

Adjustment disorders, now classified in DSM-5 as trauma- and stressor-related disorders, have been a common, but ambiguous set of diagnoses since their introduction into psychiatry. The diagnostic criteria for adjustment disorders specify that, among other factors, symptoms occur within 3 months of the onset of identifiable stressor(s), are time-limited, and the distress caused is out of proportion with expected reactions to the stressor(s). The prevalence of adjustment disorders appears to vary widely by patient population, with estimates ranging from 11% to 35% in community settings. However, there is no US-based literature that reports on the prevalence and accompanying clinical implications in correctional settings. Adjustment disorders pose a particularly challenging diagnostic question for clinicians caring for patients in jails and prisons, where the definition of a pathological response to a stressor such as incarceration becomes more difficult to define. Anxiety, fear, disrupted sleep, and irritability may be expected and “normal” responses to the rapid and forced removal from one’s community and loss of both privacy and autonomy. This question becomes even more complex when we consider the known social and clinical vulnerabilities associated with incarcerated individuals. This

workshop aims to better understand the use of the adjustment disorders diagnosis and the treatment of individuals with this diagnosis in a correctional setting, using data obtained from the New York City jail system. We will begin by providing a brief history of the diagnosis as reflected through the past and current versions of the DSM, then review the literature regarding the prevalence, comorbidities and potential diagnostic overlap with other psychiatric diagnoses. A discussion of the unique stressors associated with incarceration, which are different from community settings, will follow. We will then present data from a retrospective review of 36,526 unique individuals incarcerated in the New York City jail system between May 2011 and June 2015 who were identified to have mental health needs. The point prevalence of adjustment disorders in this population was 42.1%. Among those with a diagnosis, many had a co-occurring psychiatric condition, including disorders related to substance use (81.1%), mood (45.7%), personality (28.6%), insomnia (13.9%), and post-traumatic stress (12.6%). The highest proportion of the diagnosed group were charged with violent felonies (35.8%), and 19.1% were jailed for 6 to 12 months. In a smaller group of 169 patients who received only an adjustment disorders diagnosis, younger age at incarceration and total length of stay in jail were significantly associated with receiving the diagnosis. These results and several clinical vignettes will serve as the basis for discussion about the utility of adjustment disorders in the jail setting, ways to improve diagnostic accuracy, and options for feasible and appropriate treatment.

Advocacy 101: How to Advocate for Social Justice Change for Our Patients and Our Profession

Chair: Kari M. Wolf, M.D.

Presenters: Jane Agnes Ripperger-Suhler, M.D., Laura Shea, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe venues where we have the opportunity to influence policy; 2) Apply stories and statistics to create an “elevator speech” on your chosen topic; and 3) Practice delivering an elevator speech on an advocacy topic.

SUMMARY:

In these challenging times, psychiatrists (and other medical professionals) often feel ill-equipped to influence policy and advocacy that affects their patients and their professional lives. While professional societies play a profound role in advocating for our profession, we are often left feeling like we want to do something, but don't know how to begin. Advocacy efforts are often directed toward politicians. In this workshop we will briefly address advocacy with politicians but will also explore other people and groups to target to expand our impact. According to the Association for Progressive Communication's approach to advocacy, "Much depends on the character, approach and credibility of those seeking change and the receptiveness of those they are seeking to persuade. Advocacy is inherently political and an understanding of political dynamics is at the heart of effective advocacy.¹" In this experiential workshop, we will brainstorm ways that we can affect policy through individual or small group actions by exploring ways to augment our credibility, enhance the receptiveness of our audience, combine storytelling with data to underscore our message, practice delivering a short pitch to our audience, and review opportunities to use social media as an advocacy platform.

Cognitive Behavior Therapy for Older Adults

Chair: David Allan Casey, M.D.

Presenter: Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the special challenges of CBT for older adult patients; 2) Participants will learn how to successfully apply CBT for elders, especially behavioral activation and related techniques; and 3) Participants will learn how to creatively modify CBT for elderly patients while maintaining the integrity of the treatment.

SUMMARY:

CBT is a well researched method of psychotherapy for depression, anxiety disorders, and other conditions. It is best known as an individual treatment but has been modified for couple and

group therapy. It has been applied to a wide variety of patient groups. In this workshop we will use lecture, case discussion, and role play to illustrate how CBT can be applied to the older adult patient, particularly depression and anxiety disorders. While maintaining the integrity of CBT, a variety of approaches and modifications can be made specifically for elderly patients. While some cognitively intact elders do not require a specialized approach, many suffer from cognitive deficits, overwhelming grief, social isolation, and physical illness which must be taken into account. A substantial group of depressed older adults have severe psychomotor retardation and a self-reinforcing sense of hopelessness and helplessness that can be approached through the perspective of behavioral activation and related techniques such as activity scheduling. In this workshop, two very experienced cognitive therapists with expertise in working with this group of patients will give a brief didactic presentation, followed by a discussion of actual cases. The presenters will solicit case material from the audience/participants for further illustration. Role play will be utilized to illustrate the methods described. This is primarily an experiential workshop. The presenters have extensive experience with this type of workshop. The presenters include Dr Jesse Wright, author of the best-selling APA book "Learning Cognitive Therapy, an Illustrated Guide" as well as numerous other texts and publications on depression and CBT. The other presenter, Dr. David Casey, is a geriatric psychiatrist with more than 30 years of experience in using CBT with elderly patients.

**Combating Learner Mistreatment Through Film:
Practicing Radical Empathy**

Chair: Judith L. Lewis, M.D.

*Presenters: David Yonatan Harari, M.D., M.S.,
Nathalie Feldman, M.D., David Adams*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Better understand both learner and faculty perspectives on challenges encountered in the learning environment; 2) Identify dynamics in the learning environment that contribute to learner mistreatment; and 3) List 3 ways they plan to

personally change their approach to learners and/or faculty in the learning environment.

SUMMARY:

Over the last decade, medical schools have become increasingly aware of the high rates of medical student mistreatment that occurs predominantly in the clinical years. However, despite increased awareness and the development of strategies to combat the problem, rates have not significantly declined (1). Even some decade-long institutional strategies have led to failure (2). Still in 2016, 40% of all graduating students endorse at least one episode of mistreatment during their medical school years (3) and the rates in residents are equally high (4). Indeed, it is a problem deeply embedded in the culture of medicine throughout the world (5). By contributing to physician burn out and adversely affecting the mental health of providers, mistreatment negatively impacts patient care (6) and is a costly problem (7). It is therefore imperative that we address the problem at multiple levels. At the University of Vermont Medical Center, we developed a curriculum using two short, high quality films portraying the perspective of learners (8) and the perspective of teachers/staff (9), as elicited from focus groups. It is our belief that instructional dialogue across diverse groups, such as that generated by our film/discussion format (10), is necessary to promote the kind of emotional learning necessary for lasting change. In this workshop, we will ask participants to suspend their own reactions and practice “radical empathy” during the viewing of these two films, alternatively identifying with learners and then with staff/faculty/nurses. Film scenarios will be discussed in small groups and then the larger group will debrief these discussions and arrive at some “best practices” aimed at bridging the learner-faculty divide. Workshop leaders will link reflections generated from the audience to larger themes elicited from audiences across different specialties, learner levels, and institutions. Each participant will be encouraged to examine their assumptions and consider what changes they might personally enact as a result of this workshop. Finally, the workshop leaders will present current mistreatment rates and the state of mistreatment prevention in medical education.

Conversations on Diversity

Chairs: Vabren Watts, Ph.D., Ranna I. Parekh, M.D.
Presenters: Saul Levin, M.D., M.P.A., Anita Smith Everett, M.D., Altha J. Stewart, M.D., Eric Yarbrough, M.D., Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To give APA members an opportunity to share experiences, history, and perspectives about diversity in organized psychiatry; 2) To develop strategies to increase diversity and inclusion among all APA members; 3) To discuss how health care and patient demographics are impacted by diversity; and 4) To share ideas that will help APA better serve its minority and underrepresented (M/UR) constituents, patients and communities.

SUMMARY:

Conversations on Diversity was created in 2015 to provide a setting where APA members could share experiences, histories, and perspectives about diversity. The program serves to help American Psychiatric Association (APA) and the Division of Diversity and Health Equity (DDHE) customize goals and programming centered around diversity. Participant feedback is used to assist APA/DDHE develop initiatives aimed to better serve members, patients and their families who are a part of M/UR groups. The event has evolved as a platform for members to increase awareness of inclusion and cultural competence and highlights diversity as a key driver of health care and institutional excellence.

Effective State Advocacy: Improving Network Adequacy and Increasing Narcan Access Laws in Connecticut

Chair: Katherine Gershman Kennedy, M.D.
Presenters: Luming Li, M.D., Nkemka Esiobu, M.D., M.P.H., Jessica Elizabeth Isom, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Engage audience members around mental health advocacy topics such as the opioid crisis and network adequacy, and identify local opportunities for grassroots advocacy efforts; 2) Offer a case example of successful advocacy

initiatives within Connecticut by a group of motivated and focused residents with a passion for policy change; and 3) Discuss about possible barriers and solutions for engaging in advocacy work and challenge audience members to synthesize solutions.

SUMMARY:

Mental health advocacy is necessary in order to preserve and expand access to care and provide social justice and parity for those with serious mental illness. However, effective advocacy is daunting task. How can interested individuals or groups advocate in a meaningful way? How are successful social change campaigns created? Despite technological advances helping to people to better connect, some social change campaigns are more effective than others. In this session, we will describe the creation of a mobilized group of advocates in the Department of Psychiatry at Yale, and how a small group of motivated residents/fellows were able to effectively lobby at the Connecticut state level to pass a law on network adequacy and mental health access, as well as help pass a law to curb the opioid crisis. We will describe how we were able to mobilize resources, engage faculty mentors, gain departmental recognition, and effectively lobby and testify in front of the Connecticut State Congress. The aim of this session is to help participants understand the characteristics that make grassroots advocacy campaigns successful, and gain skills to mobilize effectively within their communities and social networks. To do so, presenters will share case examples of successful national and state-level policy initiatives, offer a conceptual framework for activism, and provide an opportunity to actively participate.

Ethical Dilemmas in Psychiatric Practice

Chair: Ezra E. H. Griffith, M.D.

Presenters: Marvin H. Firestone, M.D., Richard P. Martinez, M.D., Stephen C. Scheiber, M.D., Charles Dike

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize ethical dilemmas and common situations that may signal professional risk; 2) Understand available resources; 3) Identify

boundary issues and conflicts of interest; and 4) Identify practical resolutions to ethical dilemmas.

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.

It Takes a Village: A New Era of Women Leadership in the Oldest of Boys' Clubs—Opportunities to Thrive in the VA Mental Health Care System

Chair: Margo Chrstiane Funk, M.D., M.A.

Presenters: Rosa Ruggiero, M.S.N., Nicole Miller, Psy.D., Laura Bridges, L.C.S.W., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At the conclusion of the session, the participant will be able to describe opportunities for innovation, collaboration, advocacy and flexibility afforded by women leadership styles; 2) At the conclusion of this session, the participant will be able to list myths about paternalism in the VA Healthcare System; 3) At the conclusion of the session, the participant will be able to theorize about the intrinsic value of women leading the design and implementation of socialized medicine using the VA as a model; 4) At the conclusion of the session, the participant will be able to describe advantages of working within the VA Mental Health system, including career-family balance and job satisfaction; and 5) At the conclusion of the session, the participant will be able to formulate both a personal and collective vision for women leadership opportunities within VA Mental Health and beyond.

SUMMARY:

The VA Healthcare System is one of the largest in the United States, serving approximately six-million Veterans annually. The VA is steeped in a long tradition of military culture, with value placed on hierarchy and chain-of-command. On the surface, the system is paternalistic and male-driven. However, the modern VA is seeing more women healthcare providers and increasing numbers of women in leadership. In fact, the VA is ripe with opportunity for women interested in leading change and innovation. In this interactive workshop, we will describe opportunities for innovation, collaboration, advocacy and flexibility afforded by women leadership styles. We will discuss advantages of working within the VA Mental Health system, including career-family balance, job satisfaction, promotion of self-care, and personal empowerment. We will also assist participants in the formulation both a personal and collective vision for women leadership opportunities within VA Mental Health and beyond.

Medical Cannabis: What Psychiatrists Should Know

Chair: David Alan Gorelick, M.D., Ph.D.

Presenters: Kevin Patrick Hill, M.D., M.H.S., Arthur Robinson Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the differences between federal law and the various state laws governing medical cannabis; 2) Be familiar with the clinical indications for medical cannabis and the levels of scientific evidence supporting them; 3) Recognize the different clinical effects associated with various cannabis routes of administration and THC and cannabidiol concentrations; 4) Identify potential patients for whom medical cannabis might be indicated or contraindicated; and 5) Be familiar with potential public health consequences of medical cannabis use.

SUMMARY:

Use of cannabis for medicinal purposes (medical cannabis) has a centuries-long history in the US and throughout the world, but has been illegal in the US at the federal level since 1937. Cannabis and all cannabinoids are classified in Schedule I of the Controlled Substances Act (CSA), meaning that they

are considered to have a “high potential for abuse,” “no currently accepted medical use in treatment,” and “a lack of accepted safety for use” (21 U.S. Code § 812). In contrast, state-level interest in medical cannabis has been growing over the past 2 decades. As of March, 2018, 29 states and the District of Columbia have medical cannabis programs that are legal under state law. Another 11 states have laws allowing use of cannabidiol (or “low-THC” cannabis) to treat seizures. However, most US physicians, including psychiatrists, receive little or no training about medical cannabis. Thus, they have inadequate knowledge and expertise to respond appropriately to patients who are interested in medical cannabis, to recommend it to patients who might benefit, or to discourage its use by patients for whom it would not be therapeutic. The present workshop aims to fill this knowledge gap through interactive presentations by 3 nationally known experts. Each presentation will serve as a focus for discussion among presenters and attendees, culminating in a discussion of presented case vignettes and then general discussion. The workshop will describe the difference between “prescribing” a medication under federal law vs. “recommending” or “authorizing” medical cannabis under state law, the major medical and psychiatric conditions for which medical cannabis can be recommended (most commonly pain, cancer, multiple sclerosis or muscle spasm, seizures, nausea and vomiting, HIV/AIDS, glaucoma, post-traumatic stress disorder, agitation associated with Alzheimer’s disease), the current scientific evidence supporting those indications, major side-effects associated with medical cannabis (e.g., dizziness, dry mouth, fatigue, drowsiness, euphoria, disorientation, confusion, loss of balance, motor incoordination, hallucinations), and potential public health consequences (e.g., increased motor vehicle accidents, diversion and increased misuse of cannabis, decreased use of opiate analgesics). We will also review the practical clinical pharmacology of medical cannabis, including the advantages and disadvantages of various routes of administration (smoked, inhalation of vapor, oral), cannabis strains with varying concentrations of THC, cannabidiol (CBD), THC:CBD ratios, and various doses. Workshop attendees will then apply this information to discussion of several case vignettes of patients interested in taking medical cannabis.

Non-Neurotypical or Disordered? Nomenclature, Stigma, and the Future

Chair: Vasilis K. Pozios, M.D.

Presenters: Praveen R. Kambam, M.D., Jeff Trexler, Christy Duan

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the historical origins of a neurodiversity paradigm-based nomenclature; 2) Recognize advantages and limitations to a neurodiversity paradigm-based nomenclature, especially with respect to impacts on stigma and mental health advocacy; and 3) Appreciate the rationale of some individuals with lived mental health experience who use a neurodiversity paradigm-based nomenclature to describe themselves.

SUMMARY:

Originally born from the Autism Rights Movement, the Neurodiversity Movement is a social justice movement seeking equality for those that consider themselves neurodivergent. In fact, in the past few years, there's been a trend for people with lived mental health experience to describe themselves as non-neurotypical or neurodivergent, instead of as having a mental disorder. But is utilizing a neurodiversity paradigm at odds with disorder-based models? What are the pros and cons of using such nomenclature? Does describing lived mental health experience as a neurotype do a disservice to those with disabilities? Whether you conceptualize a person who is neurodivergent as part of social variance or as having a mental illness (regardless of the use of person-first or disability-first language), does the problem of ableism persist? Ultimately, how does nomenclature impact stigma and advocacy related to psychiatric disorders and their treatment? This workshop will feature a lively panel discussion, presenting diverse perspectives on this controversial topic. (In addition to the listed panelists, attempts will be made to invite a member of the DSM-5 Autism Spectrum Disorder workgroup and a neurodiversity paradigm advocate as discussants.)

Of Podcasts and Pins: How to Implement a "Dude—Me, Too" Wellness Day to Model Physician and

Trainee Self-Care

Chair: Julie A. Chilton, M.D.

Presenters: Owen S. Muir, M.D., Nathaniel G. Sharon, M.D., Lara J. Cox, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review the research that exists about wellness issues in psychiatrists; 2) Discuss why psychiatrists might be vulnerable to higher rates of stress and mental health issues than other physicians; 3) Give four examples of how psychiatrists have used their own self care in ways to destigmatize accessing care as physicians; 4) Discuss with audience how residency programs and organizations could implement a "Dude--Me, Too" Day modeling physician self care at their institutions; and 5) Discuss with audience how residency programs and organizations can use the Self-Disclosure podcast as part of a wellness seminar modeling physician self-care.

SUMMARY:

Psychiatrists are an integral part of the medical system, but research shows they have high rates of depression and suicide compared to their medical colleagues. Since the 1960's literature has explored the occurrence and causes of mental health issues in physicians in general and psychiatrists, in particular. Stigma, licensing issues, and concern about reputation and confidentiality, have long been obstacles to care for doctors. Until established physicians begin to model that self-care is more than acceptable, but also vital to being a good doctor, the implicit teachings of the hidden curriculum will continue to prevent medical students and trainees from seeking help when they struggle. Dr. Chilton is a child psychiatrist who began a peer support group for medical students with mental health issues in medical school. She will present the background literature review on mental health in psychiatrists that she conducted as a member of the American Psychiatric Association (APA) Board of Trustees Ad Hoc Workgroup on Physician Wellbeing and Burnout. She will also discuss the recently launched wellness mentorship initiative, "Dude, Me, Too", which is a campaign to encourage established physicians to share their stories of self care and personal growth with medical students and trainees, and was

featured in a recent JAACAP Clinical Perspectives. Dr. Muir is a child psychiatrist and medical director of Brooklyn Minds. During his child and adolescent training at NYU, he was awarded the Rudin Fellowship in Ethics and Humanities for his work on “Self-disclosure: a narrative journalism podcast about mental health and recovery.” This project features conversations with people in recovery from mental illness, and as part of project Dr. Muir discloses his own history of bipolar disorder. The show, produced in the style of “Radiolab” from WNYC Radio has been in production with NPR staff and features interviews with co-panelists Lara J. Cox M.S., M.D. and Nathaniel Sharon, M.D. Dr. Sharon is a child and adult psychiatrist, working in New Mexico and California, who experienced mental health challenges throughout medical training, and saw firsthand multiple barriers to care and mental health stigma in the medical field. He is committed to reducing the stigma of mental health care perpetuated by the medical system, in particular the stigma physicians face by the very system they work in. Dr. Cox is a forensic psychiatry fellow at NYU and a child, adolescent, and adult psychiatrist at Brooklyn Minds. Early in medical school she wrote an anonymous piece for National Depression Screening Day, but became increasingly convinced that the only way to fight stigma within the medical community is for physicians to talk openly about taking care of their mental health, and now regards her recent podcast episode as a gift of hope.

Psychiatry’s Value in Value-Based Care: NYS DSRIP and Behavioral Health Integration

*Chairs: Sabina Lim, M.D., M.P.H., Arshad Rahim
Presenter: Edwidge Thomas*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify and understand key federal and state quality and outcome metrics for people with behavioral health conditions; 2) Identify provider and practice-level changes needed to support value based care; and 3) Identify and propose solutions for provider and system-level challenges to behavioral health integration.

SUMMARY:

The value of addressing mental health and substance

use disorder conditions has been identified as a critical component of success in the new era of value-based care. Operationalization of this value, however, is still in significant development and evolution. The New York State Delivery System Reform Incentive Program (DSRIP), New York State’s federal waiver program to fundamentally redesign the NYS health care system to a sustainable VBP-driven system, is now in its third year of implementation. DSRIP has a major focus on mental illness and substance use disorders, and this third year represents a major milestone in the state glidepath towards VBP for behavioral health providers. This is the time when high level goals of integration must become concretized with real world clinical and operational workflows, provider practice changes, and real adoption of true culture change. Primary Care and Behavioral Health integration is no longer a “project”, but real practices which must meet various HEDIS and other state-identified quality and outcome metrics. The Mount Sinai Performing Provider System (MSPPS) is one of the largest networks in DSRIP, with a heavy focus on the behavioral health population in our PPS. We will review MSPPS’s performance in utilization, quality, and outcome metrics; the critical importance of behavioral and physical health integration and collaboration at provider, practice, micro- and macro-system levels; and the strategic execution and operationalization of integrated care delivery -- which ultimately must be fundamentally viewed and based on the patient, not just the provider, perspective. We will also discuss challenges in measurement methodology for a population with significant attribution turnover.

Suicide During Transition of Care: What Can Clinicians Do to Lower Suicide Rate?

*Chair: Muhammad Hassan Majeed, M.D.
Presenters: Muhammad Zeshan, M.D., Sadiq Naveed, M.D., Muhammad Khalid Zafar, M.D., Qasim Raza, M.D., Salman Majeed, M.D., Ahmar Mannan Butt, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the importance of post-discharge time in patients at risk of suicide; 2) Identify the risk and protective factors in the form of

a clinically useful formulation; 3) Provide information about suicide risk to the patients being discharged from care; 4) Explain the modern technology that can assist in assessment and crisis management planning; and 5) Summarize the negative and positive roles of websites, apps, social media and impact on suicidal behavior.

SUMMARY:

Suicide is the 10th leading cause of all deaths and the second leading cause of death in ages 10 - 34. According to the Centers for Disease Control and Prevention, the suicide rate has risen by 25% from 10.5 in 1999 to 13.4 per 100,000 people in 2014, despite better and widely available mental health services. WHO estimates that the worldwide suicide rate was 11.4 per 100,000 in 2012. In recent years there has been a sharp increase in suicide especially among adolescent girls. Several other socio-demographic factors influence suicide attempts, such as gender, age, marital status, education, past suicide attempts, mood disorders, anxiety disorders, psychosis and substance use disorders, Among many other known risk factors are suicidal ideation and plans and, at the other extreme, impulsive attempts. The immediate post-discharge period is a known high risk of suicide among psychiatric patients. A recent Australian study estimates that the rate for completed suicide immediately following discharge from treatment was 484 per 100,000 persons per year. In the three months following discharge from in-patient settings carries even higher rates, with 1132 attempts per 100,000. About 3% of patients in the US, categorized as being at high risk, can be expected to commit suicide in the year after discharge. There are several identifiable protective methods to minimize the risk of suicide; modification activity includes arranging follow-up appointments, giving prescriptions at the time of discharge, phone call follow-ups. Cyberbullying and suicide-promoting websites are some of the new challenges facing clinicians with very limited data to describe their impact on suicidal behavior. The presenters will discuss the risks in the immediate post-discharge period from care, the role of clinicians in this period, and other follow-up planning in helping to reduce suicide in the high-risk period. They will also discuss the impact of websites, social media and electronic applications which can influence suicide in

vulnerable populations. The presenters will also demonstrate the use of phone calls and web based applications that can help reduce the suicide risk during the high-risk period.

Surfing the Big Waves: Working With Difficult Affect in Psychotherapy With CBT and ACT

Chair: Kenneth P. Fung, M.D.

Presenters: Diana Kljenak, M.D., Ari E. Zaretsky, M.D., Kenneth P. Fung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify challenging affect that arises during therapy and formulate an understanding of this from a CBT or ACT perspective; 2) Develop an approach towards working with difficult affect using CBT and ACT techniques; and 3) Discuss cultural considerations that may inform the use of appropriate therapeutic techniques to address difficult affect.

SUMMARY:

In psychotherapy, challenging affect, ranging from attraction to anger to hate to hopelessness, may arise in the therapist, the patient, or both. The abrupt emergence of such intense affect in therapy may catch even a seasoned therapist off-guard, leading to therapeutic impasse or rupture in the therapeutic relationship. Successful negotiation of these heated moments, on the other hand, may potentially facilitate therapeutic progress and strengthen the therapeutic alliance. In this workshop, we will examine an approach to deal with these emotionally charged moments in therapy from a Cognitive Behavioral Therapy (CBT) and an Acceptance and Commitment Therapy (ACT) perspective. Both CBT and ACT are evidence-based psychotherapies for a variety of clinical conditions. Further, their techniques may be selectively employed in an integrated way by therapists of other modalities. This workshop will highlight the application of specific CBT and ACT techniques for these challenging clinical situations. With CBT, de-centering and core CBT skills can be harnessed to effectively manage difficult exchanges, uncovering core schemas that drive problematic patterns of behaviors. Alternatively, ACT metaphors and interventions may be helpful for grounding,

defusion, or values clarification, leading to increased psychological flexibility. Participants in this workshop will be engaged in role-plays and interactive exercises to explore and practice the use of CBT and ACT techniques to manage intense affect. Furthermore, a cultural competent approach will be integrated in the workshop to facilitate the examination of cultural and other psychosocial issues that may be embedded in these clinical challenges and dynamics.

Test Your Knowledge Psychiatry Quiz Game

Chair: Ana T. Turner, M.D.

Presenter: Robert N. Averbuch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify and Describe DSM5 criteria for both high and low frequency psychiatric diagnoses; 2) Describe pathophysiology, epidemiology, and treatment of various psychiatric diagnoses; 3) Identify important historical facts in the field of psychiatry; and 4) Express novel ways to remember differentials and treatment algorithms.

SUMMARY:

In 1933, consensus was reached between major physician, hospital, and medical education and examination groups of the time to establish a uniform system for specialty boards to administer examinations developed by experts from within specialties. The result was the formation of the Advisory Board for Medical Specialties (ABMS) which in 2000 created the maintenance of certification (MOC[®]) process to address the increasing complexity of medical science, health care approaches, and systems, in order to promote excellence in practice and to reduce preventable medical errors.

Psychiatrists not only have a need to keep up with MOC requirements, but also master learning and maintaining knowledge of a continually advancing medical specialty. Studies have noted that human learning is based in part on reinforcement and that competition between groups of learners increases the level of participation. When studied in the fields of mathematics and computer science, competitive games were also noted to promote greater interactivity, collaboration within groups and increased motivation for self-directed learning. Thus,

we propose a 90 minute highly interactive workshop to quiz attendees on various aspects of the field. We will utilize novel mnemonics, video clips, and visual aids to help audience members learn key differentials and treatment algorithms, frequently and infrequently encountered diagnostic criteria, pathophysiology, epidemiology, and treatment of various psychiatric diagnoses and psychiatric emergencies, as well as important historical facts in the field of psychiatry. This quiz game offers audience members a chance to anonymously test their knowledge compared to the entire group via PollEverywhere software, allowing them to self-assess where their medical proficiencies and deficiencies lie, all the while reviewing important concepts of psychiatry.

Wednesday, May 09, 2018

Avoiding Diagnostic Thought Errors: Teaching Diagnostic Reasoning Skills and the Mitigation of Cognitive Error

Chairs: Adam Lee Hunzeker, M.D., Rohul Amin, M.D.

Presenters: Jarred A Hagan, D.O., Allison Margaret Brown Webb, M.D., Vincent F. Capaldi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the concepts of illness script and problem representation in the diagnostic process; 2) Summarize the 2 advantages and 2 disadvantages of heuristics in clinical reasoning; 3) Recognize at least 3 types of cognitive biases from provided clinical vignette cases; and 4) Demonstrate 2 types of cognitive strategies to reduce cognitive biases in provided clinical vignette cases using the provided cognitive de-biasing strategies card.

SUMMARY:

Diagnostic ambiguity is commonplace in psychiatric practice. With limited etiological understanding behind the illnesses that we treat, it can be a daunting task to diagnostically approach a complex patient. Incorrect treatments and diagnosis can be costly and dangerous. To avoid diagnostic pitfalls it is paramount to employ carefully constructed diagnostic cognitive processes. Data has shown that through education, diagnostic reasoning skills can be improved. These approaches are the target of

diagnostic reasoning. Through education via acquired knowledge and skills, the aim is to decrease diagnostic thought errors. This workshop is intended as a primer for psychiatric medical students, interns, residents, and practicing psychiatrists who have not been exposed to this topic. The aim of this workshop is to be deliverable in a single 90 minute session in order to make it easier for educators, such as program directors, in teaching these concepts. The presentation will consist of a brief didactic session (knowledge portion of the topic) followed by small group sessions (skills portion of the topic) led by discussion on clinical vignettes incorporating complex medical-psychiatric patients. These cases will highlight various cognitive biases and anchor points that can contribute to diagnostic error. Psychiatric learners are used to meta-cognitive approaches in clinical settings. However, psychiatric trainees are lagging other medical specialties in discussing these topics related to their diagnostic reasoning and acumen. These are especially important in psychiatry given the evolving nature of our specialty.

CPT Codes: Understand and Thrive!

Chairs: Vikram N. Shah, M.D., Nancy Gregowicz, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate a working knowledge of the CPT codes that are relevant to their practice; 2) Understand the documentation requirements for the CPT codes so as to withstand an audit; and 3) Recognize when a billing code is inappropriate for the clinical services provided based on a review of sample audits from a managed care company.

SUMMARY:

Although the 2013 CPT code revisions attempt to better align both the time spent in the clinical encounter and the conceptual complexity of the visit, many clinicians find this new, complex algorithmic approach to coding to be time consuming, bewildering, and frustrating. This workshop is presented by managed care coding experts who will provide participants with an understanding of the process, rationale, and application of the numerous CPT codes so that they

can then 1) choose the appropriate CPT code to accurately reflect their clinical work based on their practice setting; 2) maximize their reimbursement; and 3) ensure that their documentation is sufficiently rigorous to meet the requirements of a potential managed care audit. Coding tips regarding 15 minute, 20 minute, 30 minute and 60 minute outpatient visits will be discussed. CMS comparative billing reports will be reviewed. Publication of this data offers a unique opportunity to the psychiatrists to compare their billing practices with nationwide averages. To enhance their understanding and skills at optimizing their reimbursement correctly, they will play the role of auditors reviewing samples of notes from patients' charts. They will also discuss examples of well-documented cases and managed care reviewers' feedback on those cases that do not meet the documentation standards. Participants will be given ample time to present their cases for review and feedback. By the completion of the workshop, clinicians should thoroughly understand how best to represent their clinical work using the appropriate CPT codes with insight and ease.

Digital Mental Health Innovations for Minority Populations: A Potential Solution to Fulfill Unmet Needs

*Chairs: Emily Wu, M.D., Dora-Linda Wang, M.D.
Presenters: Steven Richard Chan, M.D., M.B.A., Jorge Rodriguez, Kevin Mauclair Simon, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify sociocultural barriers that hinder minority populations from seeking mental health services; 2) Understand the importance and challenges of providing culturally-responsive diagnoses and treatments for minorities with mental illness; 3) Demonstrate examples of culturally-adapted technology innovations that are currently available for minority mental health improvement; and 4) Discuss the feasibility, efficacy, and pitfalls of potential culturally-responsive technology innovations targeting different minority communities.

SUMMARY:

The development of effective treatments for minority populations is important because

psychological treatment disparities persist between minorities and their Caucasian counterparts. Minorities are less likely to seek psychological services than European Americans (Snowden & Yamada, 2005). Some have also posited that the reliance of Western standards and assessments of mental disorders might result in lower reliability and validity for accurate diagnoses among minorities (Takeuchi et al. 2007). Moreover, structural barriers have hindered racial and ethnic minorities from seeking counseling and treatment. Many minorities from lower socioeconomic backgrounds are not aware of local mental health services, or face access barriers due to geographic limitations, language, multiple jobs, inability to get time off for medical appointments, lack of childcare, or a lack of transportation (Loo, Tong, and True 1989). There has been little research to address how to best improve outreach and communication strategies for ensuring access to mental health care for this population. Hence, to reduce treatment disparities it is essential to develop integrated treatment modalities that are culturally and linguistically responsive. As health information technology has become prevalent in U.S. society, emerging data has revealed interest and feasibility of utilizing mobile technologies to reduce health disparities and to improve engagement with the health care system among low-income minorities (Swindle et al., 2014). In this interactive workshop, we will first introduce participants to sociocultural factors hindering minority populations, including Asian Americans, African Americans, and Hispanic populations, from seeking appropriate mental health services. Then we will use live demo or video simulation to demonstrate current available culturally-adapted mental health technology innovations, such as smartphone applications and translation technologies, that may offer practical suggestions to address and resolve expected challenges successfully. We will then use storyboard to facilitate discussion about the advantages and pitfalls of implementing various technology interventions in minority mental health care. Lastly, we will brainstorm potential culturally-oriented innovations to address specific mental health needs among minority communities.

Discharge Planning Practices and Transitions to Community-Based Care Following Discharge From

Hospital Psychiatric Units

Chair: Thomas Edward Smith, M.D.

Presenter: Morgan Haselden

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand current standards regarding routine and intensive discharge planning practices for hospitalized individuals with serious mental illnesses; 2) Understand adherence to discharge planning practices in a statewide system of care, including the patient and hospital predictors of who is more likely to receive specific practices; and 3) Understand the impact of routine discharge planning practices on patients' transitions to aftercare, along with the patient, hospital, and service system characteristics that influence the impact.

SUMMARY:

Individuals with serious mental illnesses who receive inpatient psychiatric treatment are at high risk of experiencing adverse events and poor outcomes during the period immediately following discharge. These risks are especially concerning given the low rates of successful transitions from hospital to outpatient psychiatric care in this population. Studies have shown that only 30% of adults with Medicaid receive follow-up care within seven days of a psychiatric hospitalization and that only 50% receive such care within 30 days of hospital discharge. Not surprisingly, payers and accrediting bodies have looked to hospitals to implement discharge planning practices to increase the rate of timely transition to outpatient treatment. Routine discharge planning practices include: 1) communicating with outpatient providers regarding treatment plans; 2) scheduling timely appointments for outpatient follow-up care; and 3) forwarding case summaries to outpatient providers. Although these practices are widely endorsed as a standard of care for hospitalized patients, there is little empirical research documenting the extent to which these practices are provided in routine care and whether they influence care transitions. In 2016, we conducted a preliminary study which examined associations between routine discharge planning practices and time to treatment follow-up after discharge for 17,053 psychiatric discharges. Hospital

providers reported completing at least one of the three discharge planning practices for 85% of discharges. Individuals who received all three discharge planning practices had a higher likelihood of follow-up and kept their first outpatient follow-up visit at almost twice the speed compared with individuals who received none of the practices (hazard ratio=1.96, p,.001). We will present follow-up analyses on a database of 32,891 discharges and 19,585 unique patients. We will report the prevalence of discharge planning activities and patient and hospital predictors of who is more likely to receive specific practices. We will present planned analyses that will examine the impact of discharge planning activities, controlling for patient, hospital, aftercare provider, and system of care variables known to impact care transitions. The analyses will provide a comprehensive view of the impact of key hospital provider discharge planning activities and will identify sub-groups of patients who are likely to need more intensive care transition interventions.

From Concept to Publication: A Hands on Workshop With *Psychiatric Services* Journal Editors

Chair: Lisa Dixon, M.D.

Presenters: Stephen Mark Goldfinger, M.D., Regina Bussing, M.D., Steven Samuel Sharfstein, M.D., Francine Cournos, M.D., Marcela V. Horvitz-Lennon, M.D., Thomas S. Stroup, M.D., M.P.H., Jeffrey Lee Geller, M.D., M.P.H., Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To understand the review and editorial process in writing for journals; 2) To understand how to use critical review to improve papers submitted for publication; and 3) To understand how to respond to reviewers' critiques.

SUMMARY:

Writing for professional journals and other outlets can increase your professional impact and reputation and be a source of personal and professional satisfaction. For those with formal research training, or those working in academic centers where there are colleagues with whom one can collaborate, preparing a manuscript for publication is a routine part of one's job. For many others, working in clinical settings or as

administrative leaders, the process of translating one's ideas to a publishable submission can be a mysterious and daunting process. This workshop will provide hands-on, specific and personalized guidance for potential authors who want to translate their programs, insights, clinical or administrative expertise into a submission for the *Psychiatric Services* journal. Lisa Dixon, the editor-in-chief, along with members of the editorial board, will provide general, and then individualized feedback to attendees. Unlike many workshops which are mini-symposia, we will actively work with attendees on their manuscripts. Attendees are encouraged to bring their ideas, or preferably, a 750-word draft of their submission to the workshop. We will begin by selecting one or two manuscripts and going over, in detail, a review similar to what would be provided by the journal after a formal submission. After laying the foundation of the sorts of issues we as editors routinely engage in, the group will break up into smaller workgroups. Attendees will be able to work directly with individual authors and receive critiques, feedback and guidance on the work they brought with them. Mentoring will continue after the workshop, with the editors committed to continuing to work with authors in helping them polish their work for eventual formal submission and publication. We believe this is an exciting and unique learning opportunity and hope you'll join us in this special workshop session.

Game of Thrones, Jessica Jones, and Bachelor in Paradise: Clinical Application of the Theory of Rape Culture

Chairs: Allison E. Cowan, M.D., Nita V. Bhatt, M.D., M.P.H.

Presenters: Julie P. Gentile, M.D., Meera Menon, M.D., Nimisha Thuluvath, M.D., Brandon Withers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the theoretical aspects of rape culture; 2) Identify ways that rape culture is harmful to all people, not only women; 3) Evaluate components of rape culture in popular television programs using video clips and straw-polling to facilitate large group discussion; and 4) Demonstrate steps to counteract rape culture in clinical settings

including college mental health, medication management, prison, and military psychiatry in break-out groups.

SUMMARY:

While the term rape culture has existed since the 1970's, it has only recently entered the mainstream. It is used to describe a society that has normalized sexual violence (Herman) and expects that "sexual violence is a fact of life, inevitable as death or taxes" (Buchwald et al). This culture is carried out by our society as a whole, having significant impact on the lives of our patients who have been the victims and survivors of sexual assault. Examples of rape culture include trivialization of sexual assault, blaming the victim, and perpetuating rape myths, e.g. men cannot be raped and women bear the responsibility to avoid rape. Popular culture is commonly implicated in rape culture. To elucidate this phenomenon, we will examine three popular television shows. Since its HBO debut, Game of Thrones has received criticism for its depiction of rape and sexual assault. The Netflix superhero show, Jessica Jones, deals explicitly with sexually coercive relationships and recovery from them. Finally, in the summer of 2017, ABC's reality dating show, Bachelor in Paradise, was temporarily shut down after allegations of sexual misconduct. When production resumed, subsequent episodes were used to discuss the concept of sexual consent and the ongoing sequelae of the allegations in the lives of the contestants. In identifying and describing rape culture, we are better able to combat it. During our workshop, we will show video clips from each of these television programs and use straw-polling to facilitate large group discussion in order to dissect aspects of rape culture. We will then break into small groups to discuss cases in clinical settings including college mental health, medication management clinics, prisons, and military psychiatry. After these small group discussions, the larger group will reconvene to discuss each case and discuss the ways psychiatry can recognize and counteract rape culture.

Narcissism in the American Psyche: Historical and Clinical Perspectives

Chair: Ravi Chandra, M.D.

Presenters: Glen Owens Gabbard, M.D., Mark

Epstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand and describe historical observations on narcissism; 2) Understand social media's positive and negative influences on personality; 3) Understand clinical issues related to narcissism; and 4) Describe clinical and Buddhist remedies for narcissism.

SUMMARY:

American culture is fundamentally different now than it was 50 years ago, potentially creating generational differences in personality traits, attitudes, and behaviors. Much of this change can be understood as a cultural shift toward individualism, a system that places more emphasis on the self and less on others. Individualism has been a significant archetype of the American psyche throughout history, and self-centered individual and group identity has become a significant social issue. Studies find that Americans are now more extraverted, narcissistic, and confident and less connected to others through both personal contact and civic engagement. With its emphasis on attention-seeking and electronic communication, social media may have hastened these trends in recent years. The implications for society and individual mental health of an increase in narcissistic traits and change in quality of relationships are profound and far-reaching. Understanding the historical and social context of narcissism can help clinicians understand the challenges their patients face, and guide them towards appropriate remedies. American culture has been obsessed with narcissism for many decades, and societal norms and values have shifted towards self-centeredness. In the modern day, social media often amplifies narcissism, even as we seek to create online community. The implications for society and individual mental health of an increase in narcissistic traits and a change in quality of relationships are profound. Glen Gabbard provides clinical and theoretical expertise on narcissism. Mark Epstein reflects on the emergence of mindfulness as a treatment for narcissism and offers a perspective colored by both Buddhist and psychodynamic thought. Ravi Chandra provides perspectives on

social media and the archetypes of the American psyche.

Neuromodulation Primer for Residents: An Introduction to ECT, TMS, DBS, and the Future

Chair: Richard Calvin Holbert, M.D.

Presenters: Kohl Mitchell Mayberry, D.O., Khurshid A. Khurshid, M.D., Uma Suryadevara, M.D., Robert N. Averbuch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To discuss the clinical effects of ECT; 2) To review the clinical effects of TMS; 3) To explain the motor threshold; 4) To review the clinical and research applications of DBS in OCD and depression; and 5) To summarize current neuromodulation research techniques.

SUMMARY:

As more research becomes available, non-pharmacological, device-mediated interventions for treatment-resistant psychiatric illnesses are increasingly being utilized clinically and examined in research protocols. Residents need to have an understanding of brain stimulation treatment alternatives as they will have patients who would benefit from these treatments or may be the ones conducting them. In addition, residents must demonstrate ACGME milestones related to electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and other emerging neuromodulation therapies prior to graduation. ECT has been available in the USA since the 1940's. ECT remains the most effective therapy for treatment-resistant depression. We will review subtypes of ECT, indications, risks, dose parameters, and efficacy for each. A special focus will be on the cognitive side effects and efficacy with case examples to promote discussion. TMS induces electrical stimulation through an electromagnetic coil producing small alternating currents to the brain. It is FDA approved for treatment-resistant depression, and research is ongoing for uses in other psychiatric conditions. We will discuss the indications, side effects, and neurobiological effects of TMS. Additionally, we will review how to determine the motor threshold, a necessary step in finding the treatment location and intensity of treatment. Lastly, we will discuss

innovative protocols and review disorders in which TMS research is occurring. Deep brain stimulation (DBS) has been used in movement disorders, in particular Parkinson's disease, for many years but has only recently made its way into psychiatric disorders. It has received the most attention in OCD and depression. We will cover how an OCD patient is chosen for DBS, what expertise the treatment team should have, the basics of stereotaxic surgery, how to program the stimulator for optimal benefit and a typical course of treatment. The anatomy and specifics of programming of the most common target for DBS in OCD will be covered. We will discuss side effects, data on efficacy and safety. DBS is used for depression as well and we will review the neuroanatomy and implantation sites reviewing the current literature. Finally, the ethical considerations of brain surgery on psychiatric patients will be presented to foster discussion on this issue. Lastly, we will focus on cutting-edge neuromodulation research including transcranial Direct Current Stimulation (tDCS), Magnetic Seizure Therapy (MST), and neuromodulation in children and adolescents. The workshop leaders have significant experience in the use of neuromodulation therapies both clinically and in research protocols as well as educating resident physicians. Patient case examples will be presented to allow for group discussions and active participation. An open forum will occur to ask questions.

Parental Leave: Luxury or Necessity?

Chair: Richa Bhatia, M.D.

Presenters: Simha Esther Ravven, M.D., Malkah T. Notman, M.D., Carine M. Nzodom, M.D., Christina V. Mangurian, M.D., Christine E. Wittmann, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand legislative efforts on parental leave; 2) Recognize the impact of parental leave on infant and child emotional, cognitive, and physical development; 3) Demonstrate an understanding of the impact of lacking parental leave on maternal mental health as well as on special populations; 4) Understand potential effects of paternal leave on child, parental and family well-being; and 5) Recognize the benefits and systemic challenges that paid parental leave for

physicians presents for the physician and their employer.

SUMMARY:

The United States is one of 3 out of 196 countries in the world that does not have a federally mandated policy guaranteeing paid parental leave post-childbirth. Millions of mothers are forced to return to work days after giving birth. Because it is not guaranteed, and often unavailable, paid parental leave is treated as more of a luxury than a necessity. This workshop will explore the evidence on paid parental leave and its impact on mental health and general well-being. We will engage the audience in the question: Is paid parental leave a luxury or a necessity? This workshop will guide discussion on the practical implications of paid leave on a population health basis, as well as on physician career development. A systematic review of evidence on paid parental leave supports the idea that parental leave is imperative for mental and physical health and functioning of children and families. Lack of parental leave increases risk of maternal depression, and is associated with negative affect in a mother's interaction towards her infant. Childbirth marks one of the most prominent changes or stressors to a family unit, even in families with optimal circumstances. Having a viable option for a parent to take paid leave during this crucial period can profoundly impact the health and stability of individual family members and the family unit as a whole. Several studies have shown that when women don't have access to paid leave, maternal mental health suffers, particularly through increased risk of postpartum depression. The positive effects of paid leave may be far-reaching. A recent study found that longer paid maternity leave was linked with a reduction in late life depression by about 14%. Paid maternity leave has been associated with decreased risk of pre-term birth, infant mortality, young child mortality, and higher neuro-cognitive development and long-term achievement for children. Paid maternity leave has been associated with higher rates and duration of breastfeeding. Studies have shown mental and physical health benefits for mother and child associated with breastfeeding. Studies reveal that paid parental leave is linked with increased employee retention, job satisfaction and higher rates of return to work

for women a year after childbirth. 86.9 % of employers from a California survey noted that the Paid Family Leave Program did not lead to any 'cost increases'. Psychiatrists and other health care professionals may already have a sense that paid parental leave supports parents. This workshop aims to expand knowledge, through dynamic discussion, on the evidence base and practical issues related to paid parental leave from public health and individual perspectives. This workshop will help participants become conversant in the concrete benefits of paid parental leave in order to apply this information to patient care, institutional leadership, shaping policy, or to inform one's own choices and trajectory.

Risk Management Considerations When Practicing Addiction Psychiatry

Chair: Kristen M. Lambert, Esq., L.I.C.S.W., M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize ethical, policy and legal considerations when practicing addiction psychiatry; 2) Understand risk management and liability exposures when practicing addiction psychiatry; 3) Explore risk management considerations when treating high risk populations; 4) Understand professional, boundary, and safety and security considerations if utilizing telepsychiatry in addiction treatment; and 5) Discuss case examples and identify risk mitigation strategies.

SUMMARY:

Unique liability risks exist for the psychiatrist practicing addiction psychiatry. In addition to understanding and treating complex clinical issues, psychiatrists must understand and comply with a myriad of federal and state laws. Liability issues to consider include adhering to federal and state substance use privacy laws, documentation principles, collaborating with other providers, treating patients who may be non-compliant, interacting with federal and state agencies, maintaining appropriate certification and licensure, as well as the importance of creating/maintaining office policies and procedures. This session will address these issues and will demonstrate through the use of case examples, potential circumstances

that may increase the psychiatrist's liability exposure and how to mitigate such exposures.

Structural Imaging and Electrophysiology of the Retina as a Window to the Pathophysiology of Psychiatric Disorders

Chairs: Steven Silverstein, Ph.D., Emanuel Bubl, M.D.

Presenter: Pamela Butler

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review evidence of thinning of retinal layers in psychotic and mood disorders, as demonstrated by optical coherence tomography (OCT); 2) Review evidence of abnormal activity in retinal cell layers in psychotic disorders, mood disorders, autism spectrum disorders, and ADHD, as demonstrated by electroretinography (ERG); 3) Review evidence of the effects of common co-morbid medical diseases (e.g., diabetes, hypertension) on structure and function of the retina in people with psychiatric disorders; 4) Review evidence on the use of retinal electrophysiology to identify people at risk for serious mental illness; and 5) Review evidence on the relationships between retinal structural and functional changes in mental illness, and visual perceptual changes.

SUMMARY:

Changes in the structure and/or function of the retina have recently been identified in a number of psychiatric disorders (e.g., schizophrenia, depression, ADHD). Because the retina is part of the central nervous system that, like the brain, emerges from the neural tube early in development, understanding the nature of these changes in structure (e.g., thinning of retinal layers; enlargement of the optic nerve head) and function (e.g., reduced responsiveness of photoreceptor, bipolar cells, and/or retinal ganglion cells to visual stimuli; prolonged latencies in retinal cell responses) has the potential to inform us about parallel changes in brain structure and function. This has been demonstrated already for several neurological disorders, including multiple sclerosis, Parkinson's disease, and Alzheimer's disease. The purpose of this workshop is to review evidence of changes in retinal structure and function in those psychiatric disorders in which the issues have been most studied, and to

discuss what these changes reveal about the pathophysiology of psychotic and mood disorders, in addition to autism-spectrum disorders and attention deficit-hyperactivity disorder. We will demonstrate that examination of the retina in these disorders provides information on, among other factors, risk status, phase of illness, illness progression, dopamine system activity, and the neural basis of specific symptoms (e.g., positive and negative symptoms in schizophrenia; reward sensitivity; depression). We will review current technologies for performing these studies, and also discuss potential confounds to interpretation of data at the individual patient and group level. These include specific effects of medications and systemic disease (e.g., diabetes, hypertension). We will then discuss the potential benefits of retinal evaluations in routine clinical care, and in clinical trial contexts. Finally, hot topics in retinal evaluation, and next steps in the development of its application to psychiatry will be discussed.

Successful Aging of Physicians: Promoting Wellness Through Wisdom

Chair: Jack W. Bonner, M.D.

Presenter: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the effects of aging on physician performance; 2) Identify the role of wisdom in promoting wellness in later life; 3) identify different strategies for successful aging with or without retirement; and 4) choose one role model of an aging physician that appeals to the audience member/s at a personal level.

SUMMARY:

As the world is graying, the need for physicians is growing. The number of all actively licensed physicians in the US over age 60 increased by almost a third in four short years - from 24% to 31% in 2014, suggesting that many older physicians are deferring retirement. Is that good news or bad news? Some reports have suggested an association between increasing physician age and poorer clinical performance/quality of care. However, such association is complex and influenced by multiple factors, and overall published data are mixed and

inconclusive. Other potential concerns include professional burnout and depression, which can be associated with deterioration in the physician-patient relationship and decrease in the quantity and quality of care. This is, however, an incomplete and biased perspective. Recent studies have found that late-career physicians are generally more satisfied with life and have lower rates of distress than early and mid-career physicians. I will discuss some prime examples of successful aging of active and wise physicians as well as describing pathways other than continuing to practice or retire. Retirement may be a necessary or optimal strategy for some physicians. For many, their occupation is not a job, but a career or a calling, for which motivation to continue working is intrinsic. Encouraging a positive sense of engagement through work enhances their self-perceived successful again. Older physicians bring valuable skills, clinical expertise, wisdom and life experiences that can be obtained only through years of practice. Senior physicians are critical to training new generations of physicians, and can be a great inspiration to other professionals. Various positive role models will be presented, including a retired physician, one who continues clinical practice, and one who engages in new activities helpful to others. The audience members will be asked to discuss the pros and cons of each from their personal viewpoint. This session will be highly interactive. Questions will be invited throughout the talk. The presentation, which will include multiple illustrations, graphics, and photos, and less text, will have several natural breaks by themes, and at these times, the audience will be encouraged to have an open dialogue.

The New York City/State and Mount Sinai Health System Behavioral Health Crisis Pilot: A New Model for Behavioral Health Crisis Response

Chair: Sabina Lim, M.D., M.P.H.

Presenters: Premeet Singh, M.D., Anitha Iyer, Ph.D., Kristina Monti, L.C.S.W., Madeline Gray

Discussant: Christopher Smith, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe key components of behavioral health crisis response models; 2) Identify systems and provider level challenges in

coordinating crisis response; and 3) Identify key metrics to define success in similar models.

SUMMARY:

Diverse and highly responsive outpatient and community-based behavioral health services can be a critical contributor to reducing excessive emergency department visits for people with behavioral health conditions. Models which include such a proactive and highly coordinated system of responding to behavioral health crises in the community, as well as proactive outreach to people at high risk of future crises, are needed to reduce reliance on emergency and inpatient levels of care. The Mount Sinai Health System, in collaboration with the New York State Office of Mental Hygiene (OMH), New York State Office of Alcoholism and Substance Use Services (OASAS), and New York City Department of Health and Mental Hygiene (DOHMH), are in the midst of a multi-year pilot to develop and test a new model of crisis response and outreach for people with behavioral health conditions in New York City. The pilot focuses on re-designing a community mobile crisis team's response time and scope; crisis triage; developing a network of clinical, housing/shelter, and social support providers to provide a more diverse spectrum of services for people pre- and post-crisis; and testing out tailored tracks for services to address both "true" crises vs. "pre-crisis". Leadership from the Mount Sinai Health System, OMH, OASAS, DOHMH, and NYC Well (NYC's free and confidential centralized information/support/referral service for people with behavioral health needs/crises) will provide an overview of the pilot goals, operations, and performance in the first year of the pilot. We will review other state models of crisis response, and review both successes and challenges in our pilot. We will also discuss the importance of this unique collaboration between an academic health care system, multiple government agencies, and community-based providers, and the value this brings to ensure success in improving outcomes for people with behavioral health conditions.

When Addiction Hits Home: Addiction in Our Own Families, Stigma in Addiction, and the Use of AA in One Family's Recovery

Chair: Amy W. Poon, M.D.

Presenters: Ludmila B. De Faria, M.D., Kim D. Bullock, M.D., Zoraida Rossi, Brian Poon

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Participants will understand the extent of substance use disorders, and how this can personally affect our lives as psychiatrists and those of our colleagues; 2) Participants will understand the challenges and countertransference issues that may arise when a psychiatrist has a family member struggling with addiction; 3) Participants will identify ways stigma interferes with patients' recovery, ways stigma in addiction can be reduced, and ways stigma affects healthcare providers' treatment of patients with addiction; 4) Participants will learn the latest research on 12-step groups as a potential treatment modality for addiction, and the firsthand experiences of two people who are a part of Alcoholics Anonymous; and 5) Participants will consider becoming more open about acknowledging and speaking about addiction in their families, as this helps to reduce stigma.

SUMMARY:

21 million people in the U.S. (8.8%) suffer from substance use disorders, with only 1 in 10 getting treatment. 1 in 7 people will develop this problem in their lifetime. In 2014, while ~38,000 people died from car accidents, ~50,000 people died from overdoses. Given this, the likelihood that psychiatrists will have a family member with addiction is fairly high. However, this subject is not often discussed within our profession. In this workshop, 3 psychiatrists discuss personal stories of family members who struggle with addiction. As psychiatrists, our dual roles of also trying to be supportive family members can be challenging: trying to help loved ones get treatment; dealing with stigma and a wide range of emotions ourselves (sadness, shame, embarrassment, helplessness, etc.); maintaining healthy boundaries; avoiding becoming our family member's "rescuer;" coping with disruptions while in training or practice as a psychiatrist; and seeking support and maintaining self-care to stay emotionally healthy. We will also discuss the stigma that people with addiction face, which is associated with lower rates of seeking help, undertreatment, and social exclusion. Studies have

also shown that healthcare providers can have stigmatizing attitudes towards patients with addiction. The psychiatrists will explore this, as well as how having a family member with addiction has affected our work and countertransference towards patients. Effective strategies for addressing social stigma include communicating positive stories of people with substance use disorders. For changing stigma at a structural level, contact-based training and education programs targeting professionals are effective. We will address both in our workshop, as our presentation will include the stories of 2 family members who are in their 7th year of recovery with the help of Alcoholics Anonymous (AA). They have taken volunteer leadership positions, including serving as sponsors to other people struggling with addiction. They are willing to share their personal stories of addiction and recovery, as well as their experience of having a family member who is a psychiatrist. We will emphasize that the path to recovery is unique to each individual and AA will not be helpful to all addicts or alcoholics. However, there is also recent research into the mechanisms of behavior change in AA, which we will review-- it concluded that AA "appears to be an effective clinical and public health ally that aids addiction recovery through its ability to mobilize therapeutic mechanisms similar to those mobilized in formal treatment, but is able to do this for free over the long term in the communities in which people live." We will end with a Q & A session with the panel. There is an especially unique educational opportunity for attendees to ask questions about AA from people who are active participants in AA and learn more about this potential treatment modality from consumers' perspectives.

"Why Don't the Police Just Shoot Them in the Leg?": Law Enforcement, Psychiatry, and People Living With Mental Illness

Chairs: Nils Rosenbaum, M.D., Mauricio Tohen, M.D., D.P.H., M.B.A.

Presenters: Dany BouRaad, M.D., Nancy Louise Martin, M.D., Matthew Tinney, Benjamin Melendrez

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the extensive overlap between law enforcement and psychiatric

patients; 2) Identify and discuss specific cases in which there were both tragic and successful outcomes; 3) Identify specific innovative programs that help mental health providers and law enforcement work together in a productive manner and how these programs can potentially save money; 4) Recognize what is taught to police officers about mental health interactions, and how individual providers can best communicate with Law Enforcement; and 5) Understand the utility and limitations of less than lethal police force.

SUMMARY:

“Why not shoot them in the leg?” is a common question asked when people living with mental illness have deadly encounters with law enforcement. Lack of understanding and misconceptions between law enforcement, the general public, and psychiatrists are commonplace (1). Law enforcement has become a primary contact for people living with severe mental illness. Too many of our patients have ended up arrested or incarcerated. The psychiatric profession should consider expanding its role within law enforcement agencies and looking for innovative partnerships. Separate cultures, costs, and differing goals between law enforcement and psychiatry have hampered their collaboration. Providers can learn to work with law enforcement to more successfully triage people living with complex medical, psychiatric, and co-occurring disorders in ways that law enforcement or providers working independently cannot. This workshop will review models of law enforcement mental health provider collaborations. During the workshop, we will discuss our experience with training of police officers, police tactics when interacting with people living with mental illness, models for inclusive collaboration, and provide lapel video of successful and unsuccessful law enforcement mental health interactions for discussion.

Autism Spectrum Disorder: Clinical Pearls for Practice

Chair: Nina M. Tioleco, M.D.

Presenters: Agnes Whitaker, Hannah Reed, Nicole Turygin, Katharine Stratigos

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe autism spectrum disorder (ASD) and its relevance to psychiatric practice with adults; 2) Know what to ask during the psychiatric evaluation in order to assess for the possible presence and/or impact of ASD; 3) Know important considerations in diagnosing and treating (especially with medications) co-morbid psychiatric disorders; 4) Know the indications for behavioral treatment versus medication management versus both to address diagnostically nonspecific problem behaviors such as aggression and self-injury; and 5) Recognize when a crisis is occurring in the life of adult with ASD (and his/her support system) and involve assistive community resources.

SUMMARY:

Autism spectrum disorder (ASD), a neurodevelopmental disorder, is estimated to affect 1% of adults. However, clinical training in the assessment and treatment of ASD is often lacking in general psychiatry training programs. This workshop will provide psychiatrists who primarily work with adults a roadmap for systematic consideration of known or possible ASD in their evaluation and treatment of patients. Caveats and consideration in evaluating and treating comorbid psychiatric disorders, such as schizophrenia, bipolar disorder, obsessive-compulsive disorder and ADHD. Diagnostically nonspecific problem behaviors such as aggression and self-injury will also be covered. An approach to deciding whether to initiate psychopharmacologic or behavioral treatment or both will be described. Finally, we will discuss the role of the psychiatrist in recognizing and helping to manage a crisis in the life of a patient with ASD and his/her caretakers. Information on resources in the wider state and national community will be provided. The format of the presentation will be highly interactive, including videos and presentations by experienced clinicians.

Intensive Multimodal Treatment for Refractory Depression in Young Adults

Chair: Jerry L. Halverson, M.D.

Presenter: Rachel Leonard

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) Recognize the imperative to treat refractory depression to remission in young adults; 2) Understand common comorbidities that may lead to difficult to treat depression in young adults; 3) Use behavioral activation techniques in treatment of young adults with depression; and 4) Understand the use of somatic treatments such as medication and TMS in young adults.

SUMMARY:

Depression is a common and deadly illness found in all ages. Difficult to treat depression can exact a particularly devastating toll on young adults as they are transitioning through the important life changes and experiences that mark that time of life. Depression can lead to failure to achieve milestones which can have life long consequences, We will discuss the importance of proper diagnosis and treatment of depression in young adults and the complexity of treatment and comorbidities that exacerbate the depression and the dysfunction. We will start by discussing the problem of depression in young adults. We will then discuss difficult to treat depression and some of the the challenges of misdiagnosis and comorbidities. We will then discuss the treatment approach that we found excellent benefit with- addressing comorbidities in evidence based fashion, behavioral activation therapy and somatic treatments such as medications and transcranial magnetic stimulation. We will discuss outcomes and have a case based lead discussion of treatment of depression in young adults.

Legal and Ethical Issues of Pregnancy Management in Schizophrenics: The Dilemma of Affording Autonomy Versus Beneficence

Chairs: Sanya Virani, M.D., M.P.H., Lama Bazzi, M.D.

Presenters: Elie Aoun, M.D., Steven Kenny Hoge, M.D.

Discussant: Yassir Osama Mahgoub, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize legal standards governing informed consent in patients with a mental illness affecting their capacity to make medical decisions and major differences between states; 2) Identify challenges faced by psychiatrists when evaluating capacity of psychotic pregnant

patients to consent to treatment affecting both the patient and the fetus during pregnancy; 3) Discuss current standards of care governing obstetric and psychiatric care in psychotic pregnant patients and gain awareness of the lack of data/consensus on best practices in this specific patient; and 4) Understand the application of substituted judgement, best interest standards, legal guardianship, and health care proxy laws as they relate to psychotic pregnant patients requiring surgical procedures.

SUMMARY:

Although the presence of a psychiatric disorder does not automatically make a patient unable to consent to treatment, psychosis can chronically and variably impair a pregnant woman's medical decision making capacity. When compared to the general population, psychosis increases negative pregnancy outcomes, with higher rates of obstetric complications, congenital malformations and postnatal death. Pregnant patients with psychiatric disorders, especially psychotic denial of pregnancy, pose unique challenges to treatment teams attempting to obtain informed consent for medical and surgical interventions. Medical decisions made by the mother will affect both the patient and the unborn child. Surgical interventions, including termination of pregnancy or delivery by C-section require careful capacity assessment and well established informed consent as the risks of such interventions are greater. Legal standards vary across the country and no general consensus exists to guide care in complex cases. Current practices are modeled on a handful of case reports and extrapolation of standards established for geriatric populations mostly suffering from dementia and neurocognitive issues. While neurocognitive issues tend to be irreversible, psychosis, when treated can resolve. Therefore, ascertaining that the patient is competently making decisions is of tantamount importance and can have lasting impact. Participants will be presented with a challenging case of psychotic denial of twin pregnancy and the panel will outline the ethical, legal and treatment issues faced in psychiatric, medical, and obstetric decision making. The participants will brainstorm to identify solutions for the challenges presented after being provided legal standards to guide the discussion. The presenters

will also explain the course of action taken in this case. The speakers in this workshop will include forensic psychiatrists with expertise in the area of informed consent as well as the psychiatrists who provided care in this case.

Mental Health Provider's Primer Regarding Terminology, Lessons, and Resources on Sexual Orientation and Gender Identity and Expression

Chair: Richard Randall Pleak, M.D.

Presenters: Muhammad Zeshan, M.D., Amina Hanif, M.D., Muhammad Hassan Majeed, M.D., Juan A.L. Rivolta, M.D.

Discussant: Panagiota Korenis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review terms/definitions and common health challenges faced by LGBTQ community; 2) Emphasize importance of using gender neutral and non-judgmental language during our routine clinical practice; 3) Provide information about available resources that a clinician can refer/recommend a patient to obtain appropriate services; 4) Discuss ideas to make LGBTQ friendly working environment in our hospitals; and 5) Learn some short and practical techniques that they can practice with their peers during the workshop.

SUMMARY:

Transgender, queer, questioning, intersex, asexual, allies, two-spirits, and pansexual (LGBTQQIAA2SP) community frequently suffers from discrimination and disparity in physical and mental health treatment. This discrimination may lead to greater mental health burden and poor treatment outcomes in this population. The providers need education about providing sensitive and caring care to these patients in a non-discriminatory fashion. There is a great variety in etiology and presentation of LGBTQ individuals' needs regarding mental and physical health services. While it is known that the LGBTQ community is particularly vulnerable to depression, anxiety disorders, suicide, substance use, sexually transmitted diseases, social isolation, and homelessness, few studies exist assessing how effective providers are in treating this unique population. Although updated national guidelines exist for the medical care of this minority

population, awareness of those guidelines in training physicians is limited. Because of lack of adequate formal training for physicians regarding sensitive and caring approach towards LGBTQ community, their health needs and risk factors, clinicians particularly residents may find it challenging to provide appropriate care to this community without making them isolated, rejected, or even discriminated. During this workshop, the speakers will have an interactive interview with a standardized patient to demonstrate the interview skills to the audience. The participants will also be able to participate in Q & A session as well. The goal of this workshop is to provide further education to physicians, with a focus on clinicians in training in order to improve the quality of care provided to the LGBTQ community with the longitudinal goal being to decrease the disparities suffered by this minority group

New Approaches to an Old Problem: Targeting Eating Behavior to Improve Outcomes in Anorexia Nervosa

Chair: Joanna E. Steinglass, M.D.

Presenters: Blair Williams Uniacke, M.D., Deborah Glasofer, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the integral relationship between eating behavior and prognosis in Anorexia Nervosa (AN); 2) Describe two innovative behavioral approaches for targeting eating behavior in treatment of AN; and 3) Demonstrate competence in the practical implementation of behavioral approaches to modifying eating behavior in AN.

SUMMARY:

Affecting approximately 1% of women across all socioeconomic classes, Anorexia Nervosa (AN) is among the most lethal of all psychiatric disorders and notoriously difficult to treat. Relapse rates are high, with nearly 50% of hospitalized patients re-hospitalized after one year. Pharmacologic interventions have been disappointing. While behavioral treatments are effective in structured inpatient and day program settings, outpatient psychotherapies for adults remain challenging. To improve outcomes, innovative mechanism-based approaches to treatment are needed. In this

workshop, we will focus on two psychological and behavioral phenomena that likely impact prognosis, and then discuss two behaviorally-oriented approaches that address these features, and may be useful tools to improve outcomes. First, we will discuss obsessionality, a commonly observed feature of AN, and relate this psychological feature to actual eating behavior, as well as to prognosis. Next, we will describe two behavioral approaches that have been adapted to modify eating behavior in AN. Exposure therapy and response prevention (EXRP) for AN, is based on exposure therapy for OCD and anxiety disorders, and addresses maladaptive eating behavior by targeting eating-related fear and anxiety. Regulating emotions and changing habits (REACH) is grounded in habit reversal therapy, and aims to alter automatic, behavioral routines by increasing awareness of cues. Through presentation of illustrative case material, role play and small group discussion using clinical vignettes, participants will learn about and gain confidence in the practical implementation of behavioral approaches to treating individuals with AN.

Open Access Publishing: Should We Be Grateful or Careful?

Chair: Pankaj Lamba, M.D.

Presenters: Venkata B. Kolli, M.D., Taral R. Sharma, M.D., M.B.A., Pankaj Lamba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the origin, evolution and impact of open-access scholarly journals and publishers; 2) Appreciate concerns and 'predatory' practices of some journals; 3) Learn means of appraising an open access publisher credibility; and 4) Discuss open access and promotion and tenure evaluation plans.

SUMMARY:

Open-access (OA) journals provide an immediate and free-access of the published material through the Web. Unlike the traditional model where reader/library is charged for accessing the published material; in an OA publication model, fees is charged to the author(s) or research fund. This model is becoming the dominant player in the field of scholarly publication as it has tremendous potential:

expanded access for all to the latest work; lower publication cost. Thus, several funding agencies are now requiring that funded-work be published either in OA journals (gold open-access) or made immediately available through, freely accessible, online repositories, such as library-managed ones (green open-access). Seizing the opportunity of profit, some publishers have used the author-pay up front (the "gold" model), to create businesses. Sadly, not all of them are following the high standards upheld in research and publishing ethics. They publish for financial gains at the expense of quality and are sometimes exploit the unwary scholars. Most academics receive frequent email requests from OA publishers. The tag line of such emails is "we recognize your merit and contribution to the field" and encourage you to submit an article or become presenter on "any subject of your choice." Such invitations are tempting but they could become a costly endeavor leading to harassment and unnecessary legal concerns. The problem has mushroomed to such proportion that the Federal Trade Commission (FTC) published a consumer education report in August 2016, "Academics and scientists: Beware of predatory journal publishers." 'Predatory' is defined as those publishers that charge fees to publish, but that do not offer standard publishing services. Lastly, we cannot end this discussion without reflecting on the impact of OA model on the dossiers submitted and reviewed by promotion and tenure (P&T) committees. During the workshop, we will engage the participants to share their current and past involvement and experiences with OA publishers, while exploring the merits and concerns as mentioned above. We will present a review of literature on the utilization and trend of publishing in OA journals. We will discuss tools to appraise the quality of OA journals and the participants will learn to recognize the predatory publishers. We will also suggest precautions in dealing with the predatory publisher. Based on the material presented and discussed during the workshop: participants will appreciate the benefit versus risk of submitting their work in an OA journal; department chairs and P&T committee members will be able to use the information in assessing their current departmental policies on OA publications and presentations.

Radical Collaboration? Key Features of Successful Cooperation Between Psychiatrists and Law Enforcement in the Prevention of Violent Radicalization

Chair: René Zegerius

Presenters: Christel Grimbergen, Wilco Tuinebreijer, Thijs Fassaert

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of psychiatrists and psychiatric nurses in a diversion program aimed at violent radicalization; 2) Recognize key-features of a productive collaboration between public health and law enforcement in general; and 3) Know how to cope with political pressure that comes with the process of achieving such collaborations.

SUMMARY:

There is an ongoing discussion about the extent to which psychiatry as a discipline can and/or should make a contribution to prevent terrorism and other forms of violent radical behavior. The political dimension plays an important role in how psychiatrists are deployed in this complicated societal problem. Despite sharp discussions between the policy makers and psychiatrists and psychiatric nurses from the public health service (GGD) in Amsterdam, we have taken a clear role in this matter. It is our job to make sure that people who are suspected of violent radicalization are screened for mental illnesses and – if necessary – guided to appropriate health services. By doing so, we build on experiences from previous approaches at the intersection of health and law enforcement in which the GGD is involved and which focus on tackling violent crime and severe harassment between neighbors, respectively. Time and again, target populations of these diversion programs have shown an accumulation of addictive behavior and psychiatric disorders, in combination with social problems and somatic conditions. For example, the point-prevalence of any psychiatric disorder (including addiction and personality disorders) in an Amsterdam population of violent offenders is nearly 70% (1). This, in combination with them lacking adequate coping skills and their tendency to

inadequately use (i.e. avoid) regular health services, explains why the GGD – as a public health service – engages with these vulnerable groups. During this workshop we will focus on the role of the Amsterdam public health service in the diversion program that aims at preventing violent radicalization. In addition we will take a look at other diversion programs, both in Amsterdam and Paris, thus taking the opportunity to identify key-features of productive collaboration between public health, law enforcement and the community, as far as the role of the psychiatrist is concerned. These features will be presented using examples from both practice, research and policy.

Rebuilding the Asylum: The Ethics of Architecture

Chair: Dominic Sisti, Ph.D.

Presenters: Philip Candilis, M.D., Marc Shaw, Thomas Bruce Shaver, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Provide background on the architectural movements that predated the modern Saint Elizabeths Hospital, from custodial to curative, Kirkbride to cottage planned; 2) Describe the values that governed the building of Washington DC's new state hospital, from the valuation of natural light, private spaces, and green technologies, to humanizing security features; 3) Explore the cost-benefit considerations that govern the building and updating of forensic and state facilities, including the fundamental trade-offs that affect both security and liberty; and 4) Describe the ethical tensions related to ensuring patient dignity and safety.

SUMMARY:

There has been renewed attention to the possibility that more psychiatric hospitals should be constructed to provide high quality, ethically administered inpatient care to individuals who need it. Meanwhile, existing psychiatric hospitals are being retrofitted to meet standards of safety while aiming to also enhance patient autonomy. These projects—whether privately or publically financed—must also balance financial constraints against larger ideals. This workshop will explore the complex ethical challenges in designing or redesigning a psychiatric hospital that provides quality, ethically

informed, and fully integrated inpatient psychiatric and medical care. The panelists are an architect of health care facilities, two psychiatrists, and a medical ethicist. Their presentations will center on the redesign of one of the nation's oldest psychiatric facilities, St. Elizabeths Hospital in Washington DC.

Simulated Patient Encounters: A Laboratory for Clinical Training and Professional Growth in Residency Training

Chair: Alexander C. L. Lerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) At conclusion, participant will be able to: Develop mental status and diagnostic data interactive patterns or "transactions" between clinicians and simulated subjects in videotaped inter; 2) At conclusion, participant will be able to: Identify different outcomes in sim interview scenarios conducted by different clinicians; 3) At conclusion, participant will be able to: Apply rating scales to produce standardized data from patient interviews; 4) At conclusion, participant will be able to: Identify improved clinician attunement, and formulation-directed interviewing leads to superior outcomes; and 5) At conclusion, participant will be able to: Develop sim patient scenarios and rating instruments as unique educational and competency assessment tools.

SUMMARY:

The Conduct of the diagnostic interview remains an essential skill for a psychiatrist, alongside pharmacology, neuroscience, molecular genetics and the other core domains which make up the foundation of the profession. Unlike other areas of knowledge, interviewing can't be learned from a book; nor are the deeper levels of clinical skill easily standardized or assessed. Clinicians in training regularly confront vexing questions: • How do we understand a patient becomes flirtatious during an interview? • What can it mean for a clinician to become confused and self-conscious during the interview? • How do you engage a patient who is too ashamed of their actions to give you an accurate history? • By what means can an IMG clinician turn a patient's expressed racism into a diagnostic tool? • How do you tell when a patient is lying? These are a

few examples of the questions that arise for a clinician who moves beyond templates and rating scales to the core mission of the psychiatric interview, namely, to understand who a patient is, what their fears and preconceptions of the diagnostic interview are, what their experience of the human-to-human contact is like. An interview guided by these core questions will be able to begin to engage all others. IN THIS WORKSHOP we will engage participants in a hands-on demonstration of a series of challenging interview scenarios in which professional actors portray ambivalent, suicidal or psychotic patients, interviewed by psychiatric trainees at a range of levels of training and experience. We will examine a range of interviewer interventions and their success or failure in deepening the interview, and examine how the interviewer's emotional response or "countertransference" to the patient's material can be transformed into a powerful diagnostic tool. We will examine how "transactional" patterns of clinician-patient interaction can both improve diagnostic assessment and guide the conduct of the interview. THE SECOND PHASE of the workshop will focus on use of simulated patient interviews in assessment of resident clinical competence, and as a means of teaching skills in empathy, confrontation, and cross-cultural psychiatry. Audience members will participate in hands-on exercises scoring a sample interview for a) eliciting basic information; b) empathy and rapport; c) use of advanced interviewing techniques (e.g. confrontation, formulation-guided interviewing); and success or failure in eliciting critical information. THE THIRD PHASE of the workshop will focus on instructions and guidance on the design of advanced simulated patient interviews and assessment tools. An open discussion will focus on how to tailor SPI's to specific educational goals, such as how to teach attunement and empathy, and how to recruit clinicians-in-training to assess SPI interviews, and how to use the assessment process itself as a teaching tool.

Stimulant Misuse Among High School and College Students: Strategies for Prevention, Screening, and Treatment

Chair: Hector Colon-Rivera, M.D.

Presenters: Deepa Camenga, M.D., M.H.S., Srinivas Muvvala, M.D., M.P.H., Shashwat A. Pandhi, M.D.,

M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize the risk factors that predispose adolescents to stimulant diversion, misuse and use disorders and the protective factors that lead to resilience; 2) List the potential health effects of stimulant misuse and use disorder; 3) Explain strategies for the prevention and treatment of stimulant misuse and use disorder; and 4) Demonstrate skill in screening adolescents and young adults for stimulant diversion, misuse and/or use disorder.

SUMMARY:

Adolescence is a period of rapid growth and neurodevelopment, during which the inherent drive to excel socially, academically and athletically is balanced by the biologic and social vulnerability to drug experimentation, initiation, and the development of addiction. Prescription stimulant drugs are the third most misused prescription drug among high school and college students in the U.S. In 2015, about 874,000 adolescents and young adults reported past-month misuse of prescription stimulants in the past month, which is defined as “use in any way not directed by a doctor”. Students with and without ADHD misuse prescription stimulants to promote academic performance, accelerate weight loss, increase energy and wakefulness, induce euphoria, and regulate affect. A recent meta-analysis demonstrated that up to 17% of U.S. college students report at least one episode of stimulant misuse, and stimulant misuse is associated with the development of other substance use disorders. Currently, the health care provider’s capacity to identify and respond to adolescent and young adults at risk for stimulant use disorder is limited at best. Overall, it remains inconclusive whether prevention, screening and treatment strategies can be effectively optimized to prevent stimulant misuse in student populations. Nonetheless, adolescents with stimulant use disorders have complex needs, presenting with higher rates of psychiatric and medical comorbidities (i.e. depression, anxiety, and extreme fatigue (“crash”)), polysubstance use, and academic difficulty. Cognitive/behavioral strategies are

available but underutilized. Summary of the workshop: This workshop will discuss strategies for prevention, screening, evaluation, and referral to treatment of adolescent and young adults with, or at risk for, stimulant misuse and use disorders. Presenters will discuss the latest evidence on the epidemiology, health effects, and treatment of stimulant misuse and use disorders.

The Cobbler’s Children: Dealing With Mental Illnesses in Our Own Families

Chair: Julia Bess Frank, M.D.

Presenters: Catherine Lynn Harrison-Restelli, M.D., Mitchell Joseph Cohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Reflect upon the experience of combining professional and personal concerns about a family member; 2) Describe challenges of pursuing treatment for adolescents with mental/behavioral disorders; 3) Describe the impact upon one’s own psychiatric practice of parenting a troubled adolescent; and 4) Provide a forum for psychiatrists dealing with family illness.

SUMMARY:

This is a modified version of a workshop given at three previous annual meetings. While psychiatrists’ children are not, as pop psychology suggests, uniquely prone to mental disorders, neither are they immune to them. When a family member does become ill, psychiatrists may be quicker than others to recognize signs of disturbance, yet inhibited from intervening for fear of misdiagnosing a problem or misapplying elements of their training. Stigma attached to the family factors in mental illness may also inhibit mental health professionals from turning to friends or colleagues for support. The disorders themselves threaten the lives and well being of the affected person and everyone else in the family. The outcome of care is never certain. While the situation of family mental illness causes great stress, knowing what to expect and that recovery is possible helps restore equilibrium. For the psychiatrist in the family, accepting and working through the difficulties may enhance empathy, insight and the capacity to modify behaviors in the service of therapeutic goals. Three psychiatrists whose children

have had serious behavioral disorders (eating disorder, aggressive behavior, mood disorder) will interview one another in round robin fashion, inviting participants to offer comments and questions about the shared and unique problems of acknowledgement, communication with a non psychiatrist partner, and involvement as a parent with the mental health system. Open discussion of the presenters' experience may serve to reduce the stigma and isolation that attend dealing with chronic psychiatric problems in close family members.

Transplant Psychiatry: Ethical and Clinical Challenges

Chairs: Mark Jay Ehrenreich, M.D., Kathryn Skimming, M.D., M.A.

Presenters: Alaina N. Morgan-James, M.D., David Brian Glovinsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the role of a psychiatrist on a transplant team; 2) Identify the components and importance of the pre-transplant psychiatric evaluation; 3) Discuss the ethical issues involved in screening of transplant recipients; 4) Identify the ethical issues that arise in evaluating organ donors; and 5) Discuss the unique issues raised by face transplantation.

SUMMARY:

Psychiatric and psychosocial evaluation is an essential component in the selection of transplant recipients and donors. Patient adherence to medications, appointments, and sobriety are major factors in predicting long term successful outcome to the transplantation. The importance of appropriate screening is further increased by the fact that the number of people awaiting transplants far exceeds the number of available organs. Medical advances are extending the reach of transplant surgery beyond the typical solid organs to include the face, hand and upper extremity, uterus, and even possibly the head. The non-lifesaving nature of these surgeries raises additional ethical and clinical issues for the psychiatrist and the transplant team. We will review the role of the psychiatrist on the transplant team and the components of the pre-transplant psychiatric evaluation. The relevant literature in the

area will be briefly discussed. Cases will be presented that pose ethical and clinical challenges for the consulting psychiatrist. These will include the unique aspects of the face transplant evaluation, liver transplantation in patients with active substance abuse, and a case of misattributed paternity in a living kidney donor. Participants in the workshop will engage in an active discussion of the underlying ethical principles that are raised by these complex cases, thereby developing a way to approach similar cases in their own practices.

"13 Reasons Why"... or Why Not: The Impact of Adolescent Youth Suicide Portrayal in the Media on Youth Mental Health and Contagion

Chair: Lila Aboueid, D.O.

Presenters: Madelyn Gould, M.D., Ph.D., Victor Israel Schwartz, M.D., Dan Reidenberg, Psy.D.

Discussant: Steven N. Adelsheim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify trends in adolescent suicide portrayal in the media using the Netflix series '13 Reasons Why' as a backdrop; 2) Discuss mental health implications of suicidal portrayal on susceptible youth; 3) Review recent efforts to address concerns raised by '13 Reasons Why' on youth mental health and suicide risk; and 4) Formulate possible opportunities and interventions to address the disconnect between media portrayal and current psychiatric recommendations of suicide depiction by the media.

SUMMARY:

Since the release of the Netflix series, '13 Reasons Why' on March 31, 2017, many concerns has been raised regarding the appropriateness of this series for young, susceptible viewers. The content, originally adapted from a fictional novel Thirteen Reasons Why by Jay Asher, attempts to address many childhood/adolescent subjects including rape, bullying, substance use, as well as suicide. The series ends with a graphic depiction of the main character taking her own life by cutting her arms with a razor while in a bathtub. Research has shown that the more sensational the media portrayal or reporting, and the more prominent the story's attention, the higher the risk for suicide contagion. Depictions of

suicide and related behaviors that do not conform with national guidelines for media may have particular lasting and strong effect on vulnerable youth. The release of this series has reignited the need for further discussion about how social media can influence suicide ideation, rates, and trends, as well as ways to increase the possibility that different media will choose to follow the current guidelines. With the second season of the show, anticipated to be released sometime in 2018, many of the same themes and trends will likely reemerge, reinforcing the need for the medical community to formulate methods to address the disconnect between medial portrayal and current psychiatric recommendations in suicide portrayal and education. This workshop will address the above concerns and serve as a platform for critical discussion and formulation of methods and suggestions to potentially improve partnerships with the media around guideline implementation. The workshop speakers include the national experts in the field of youth suicide prevention, clinicians directly involved with the review and critique of the show, and national experts on suicide, media, and contagion.

A Little Song, a Good Poem, a Fine Picture, and a Few Reasonable Words: The Arts and Humanities in the Practice of Psychotherapy

Chair: Christopher M. Wilk, M.D.

Presenters: Hinda F. Dubin, M.D., Christopher William Teixeira Miller, M.D., Mark Jay Ehrenreich, M.D., Milena Goldshmidt, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Recognize that the humanities and art play an important role in the practice of psychotherapy; 2) Develop an appreciation for the use of symbolism, metaphor, and allegory in the practice of psychotherapy; 3) Understand cultural stories and messages as they relate to psychotherapy; 4) Understand the importance of nuances in everyday language and how language influences the practice of psychotherapy; and 5) Improve the ability to relate and elicit a narrative in the practice of psychotherapy.

SUMMARY:

In Wilhelm Meister's Apprenticeship, Johann

Wolfgang von Goethe implored that "one ought, every day at least, to hear a little song, read a good poem, see a fine picture, and, if it were possible, to speak a few reasonable words." In the context of the emphasis of biological innovations and treatment in psychiatry, it is essential that psychiatrists maintain a holistic perspective, particularly in the practice of psychotherapy. After a successful and popular two-week pilot course in our residency training program, we developed a five-week course designed to expose advanced (PGY4) psychiatry residents to the arts and humanities as they relate to the practice of psychotherapy. Each session was dedicated to a specific topic area, including literature, poetry, music, art, and film. Our rationale was that literature and poetry promote knowledge of the nature of the narrative; music communicates emotion and develops observational skill; visual art enhances attention to imagery; movies and theater promote the understanding of cultural stories. Before and after the course, we assessed trainees' appreciation for the arts and humanities with an eight-item survey. A brief discussion of the results of the course survey will be presented in this workshop. The workshop will provide a microcosm of modalities and content from that course. We provide excerpts and examples from each of the arts and humanities explored in the course and offer a qualitative description of how these materials can be used in psychotherapy. We invite an open discussion of several specific examples, including: metaphors such as bridges; stories such as Aesop's Fables and the Myths of Sisyphus and Daedalus and Icarus; archetypal figures such as the Wise Old Man and the Hero; musical selections such as John Adams' Short Ride in a Fast Machine and Simon and Garfunkel's Sounds of Silence; visual art such as Winslow Homer's The Fog Warning and Pablo Picasso's Françoise Gilot with Paloma and Claude. We also discuss cultural icons related to transference and countertransference. Our goal for the workshop is to generate discussion regarding the use of the arts and humanities in medical education, particularly as it relates to psychiatry and psychotherapy. Participants will have the opportunity to present and discuss metaphors and cultural stories from their own practice, and opportunities will be provided to role play the use of metaphor in the practice of psychotherapy.

Assessment and Management of Substance Use Disorders in the Oncology Setting: Use Cases and Consultation

Chairs: Carla B. Marienfeld, M.D., Maria L. Tiamson-Kassab, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the challenges of assessing for substance disorders in the oncology setting; 2) Review considerations and methods for determining if substance use is a disorder; 3) Understand the approach to managing the substance use disorder when the patient needs the drug for treatment; and 4) Manage the challenges of substance use disorders when they interfere with primary disease directed therapies.

SUMMARY:

In the oncology setting, substance use disorders can cause distress for the patient, family members, and providers caring for them. This can interfere with important disease directed and palliative treatments and opportunities for life closure. With the changed landscape of cancer survival, cancer pain management is changing. Opioid misuse and substance use are growing problems among cancer patients. The dilemma is particularly challenging when the disease requires the use of highly reinforcing substances. This workshop will use case based and video presentations with audience response questions given by a clinically active consultation-liaison psychiatrist in the oncology setting. An addiction psychiatrist will provide diagnostic and treatment guidance and commentary for these cases. The presentation of cases will be interactive. There will be time in the end for group discussion.

Constant Contact? Practical and Ethical Implications of Digital Medicine for the Patient-Psychiatrist Relationship

Chair: Laura Bodin Dunn, M.D.

Presenter: John Torous, M.D.

Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant

should be able to: 1) 1. Define the emerging category of “digital medicine” within digital health, and describe three examples of digital medicine technologies; 2) 2. Identify three emerging ethical issues accompanying digital medicine innovations in the context of psychiatry; and 3) 3. Describe an ethical framework to guide decision making and safeguard the patient-psychiatrist relationship within the realm of digital medicine technologies.

SUMMARY:

Digital health, as defined by the FDA, is a very broad term that includes “mobile health, health information technology, wearable devices, telehealth, telemedicine, and personalized medicine.” Digital medicine encompasses a subset of digital health, and has been defined as those forms of digital “technology and...products that are undergoing rigorous clinical validation and/or that ultimately will have a direct impact on diagnosing, preventing, monitoring or treating a disease, condition or syndrome.” [Elenko E, Underwood L, Zohar D. Defining digital medicine. *Nature Biotechnology* 33, 456-461, 2015] As digital medicine companies—often in collaboration with or as projects by traditional pharmaceutical companies—continue to develop, test, and market innovative ways to diagnose, monitor, and treat disease, an emerging set of both practical and ethical implications of these technological advances will confront psychiatrists. For example, there are numerous questions about how these technologies may affect the patient-psychiatrist relationship. Will patients’ perceptions of being in virtual “constant contact” with their clinician impact the relationship in positive or negative ways? Will their trust in their clinician be impacted? Will clinicians be willing or able to track their patients’ data, given the already high burden placed on clinicians by electronic health records and other documentation requirements? What are the psychiatrist’s ethical obligations and potential liability raised by the ability to track patients’ psychiatric symptoms, health behaviors, and medication adherence? In addition, the ability of patients to share many types of health and behavior data with their clinicians raises new concerns about patient privacy and confidentiality. Moreover, questions of informed consent to data sharing and health and behavior tracking will arise, such as how

much should patients be able to understand about the possible uses of their personal information, and how will that understanding be assessed? Another set of questions centers around clinician obligations to monitor and act on the vast amount of patient health data that could potentially be shared with them. Finally, little is known about whether digital medicine will lead to demonstrably improved patient outcomes. In this session, experts in psychiatric and medical ethics, and digital and mobile health, will discuss the practical and ethical implications of emerging digital medicine technologies and applications for the field of psychiatry. The audience will be engaged in discussion via case vignettes designed to stimulate discussion of these challenging issues. The workshop will offer an interactive session with leading thinkers on the subject that will expose attendees to the new technologies coming down the pipeline that may forever change their practice.

Decision Making: Models, Contexts, Cases, and Cultures

Chair: Michelle Therssen Joy, M.D.

Presenters: Karla Campanella, M.D., Michelle Therssen Joy, M.D., Judith Katz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) To explore different models of collaborative decision making; 2) To understand sociocultural impact on different models of decision making; 3) To understand the history and purpose of powers of attorney and advanced directives; 4) To gain familiarity with digital tools for supported decision making; and 5) To discuss ethics of complicated decision making and shared approaches to such cases.

SUMMARY:

Informed consent and patient involvement in decisions about care comprise the heart of medical treatment. However the situation can quickly become complex and call for additional models of decision making. This workshop will explore decision making in psychiatry through the lens of different models, contexts, cases, and cultures Dr. Joy will discuss the socioloegal history of different instruments for substituted decision making including the power of attorney and advanced

directive in both medical and psychiatric contexts. Dr. Katz will explore various models and tools for shared decision making related to the use of medication and levels of care including hospitalization. She will look at Common Ground, SAMHSA online tools that patients can use to aid in decision making and prepare reports for their med management visits, and tools for assessing the degree to which we are using shared decision making from the physician and client perspective. Drawing from her extensive experience working with the Amish and Mennonite communities, Dr. Campanella will discuss the potential role of culture in shared decision making and the ways that these Plain communities involve family in psychiatric care.

Divine Inspiration, Unusual Beliefs, and Psychotic Thought: Sorting Through the Haze

Chair: Kayla L. Fisher, M.D., J.D.

Presenters: Stephen Noffsinger, M.D., Shree Nitya Sarathy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review applicable Constitutional and case law pertaining to religious liberties and freedom of speech; 2) Discuss approaches to differentiate religious belief from psychotic thought; 3) Analyze methods of distinguishing unusual belief from delusion; and 4) Examine the analysis applied to the perpetrator in the Elizabeth Smart case.

SUMMARY:

As religious practices and sociopolitical viewpoints have become more diverse, psychiatrists increasingly find themselves evaluating patients who espouse beliefs unfamiliar to them. Such patients often pose diagnostic dilemmas and treatment challenges. Constitutional provisions protect freedom of religion and speech, yet case law demonstrates these freedoms are not absolute. Approaches can be employed to help differentiate religious and unusual beliefs from psychotic thoughts. Utilizing these methods can assist psychiatrists in proper diagnosis. In the Elizabeth Smart case, the evaluation of the perpetrator centered around questions of mental illness vs. religious belief. A review of this case demonstrates how methods for distinguishing

religious belief from psychotic thought can be employed.

Forgotten No More: A Practical Guide to Treating Patients With Intellectual Disability and Mental Illness

Chairs: Nita V. Bhatt, M.D., M.P.H., Julie P. Gentile, M.D.

Presenters: Allison E. Cowan, M.D., David Dixon, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the history of ID patients suffering from mental illness; 2) Practice identifying and treating mental illness in the ID population; and 3) Identify common legal, behavioral, medical, and psychological issues encountered in ID psychiatry.

SUMMARY:

Historically, patients suffering from mental illness and those with intellectual disability (ID) were seen as “mental defectives” and “less than human.” In modern times, the stigma associated with mental illness and ID has diminished though it is still present. Society is moving away from the institutionalization of patients with ID and practitioners are more commonly treating patients with ID in the community setting. Due to limited experience treating ID patients, many clinicians feel inadequately prepared to address the complexities in this patient population. Common psychiatric illnesses as well as medical illness can often present differently. Participants will be shown video clips of psychiatric illnesses and behavioral issues commonly encountered in the ID population. Participants will break into small groups and discuss case scenarios pertaining to legal, behavioral, and medical comorbidities. The speakers in this workshop consist of a total of five members including two psychiatrists who treat ID patients on an outpatient basis and also serve as consultants to psychiatrists at state hospitals, a psychiatrist working with ID patients at a state hospital, two outpatient psychiatrists, one of whom is also a lawyer, and a resident who treats ID patients on an outpatient basis. At the conclusion of this presentation, attendees will be provided with a booklet providing practitioners with expanded

information on treating patients with ID and mental illness to serve as a resource in their own practice.

Hidden in Plain Sight: Human Trafficking and the Role of Psychiatry Training

Chair: Leigh Meldrum

Presenters: Amy Fehrmann, Christopher Scovell, D.O., Mariam Elizabeth Faris, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand human trafficking and its impact on the mental health of victims and survivors; 2) Demonstrate the importance of trainee education and routine screening to identify victims and survivors of human trafficking; and 3) Provide practical interventions for new psychiatrists and trainees to employ when treating a victim or survivor of human trafficking.

SUMMARY:

The United Nations defines human trafficking as the recruitment, transportation, transfer, harboring, or receipt of persons by improper means (such as force, abduction, fraud, or coercion) for an improper purpose including forced labor or sexual exploitation. Globally, human trafficking profits are estimated to be \$150 billion dollars per year and represents the second highest grossing criminal enterprise. Some estimate that over 200,000 people are trafficking within the United States each year, largely for sexual exploitation. It is estimated that upwards of 87% of human trafficking survivors in the United States reported that they were evaluated in a healthcare facility at least once while trafficked. In addition, it has been shown that victims of human trafficking suffer higher rates of depression, post-traumatic stress disorder, dissociative disorders and substance use disorders. Given the high rate of psychiatric co-morbidities and frequent utilization of healthcare services, resident psychiatrists are in a unique position to identify victims or persons at-risk of being trafficked and provide interventions. Working in psychiatry in Baltimore, Maryland, it is not uncommon to encounter patients who have been victims or survivors of human trafficking, particularly within the sex trade. Maryland’s Central Eastern location makes it ideal for trafficking given it’s close proximity to several international airports

and as well as its location along the I-95 interstate. Working as psychiatry trainees in Baltimore, we have had the opportunity to serve this population but have also discovered there to be insufficient training on this profound psychosocial issue. It became apparent that psychiatry trainees in particular are well positioned to make a tangible impact, as residents are often working the frontline of many clinical centers. Our goal for this workshop is explore innovative ways to educate psychiatry trainees on human trafficking and to propose different screening methods in a psychiatric setting.

How to Bring Psychiatric Training to Law Enforcement in Your Community: An Innovative Approach

Chair: Nils Rosenbaum, M.D.

Presenters: Nancy Louise Martin, M.D., Benjamin Melendrez, Matthew Tinney

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify psychiatry's role in promoting community well-being through partnerships with law enforcement; 2) Understand the gaps in mental health training for law enforcement and current data on police interactions with people living with mental illness; 3) Understand the practical utility of psychiatry led training for law enforcement; and 4) Participate in and understand the process of law enforcement case presentations facilitated by a psychiatry team.

SUMMARY:

The closure of long-term psychiatric treatment facilities coupled with high rates of mental illness and limited funding of mental health services has resulted in frequent, high-risk interactions between law enforcement and persons living with mental illness. More commonly law enforcement agencies have become our communities' de facto mental health providers. Yet for police departments across the country, there has been inconsistent, unstandardized training which focuses on the interactions of people living with mental illness. Instead law enforcement training has tended to focus on command and control and officer safety. When a psychiatric patient has contact with law enforcement, their non-compliance can too often

result in the use of force. Even among law enforcement agencies that have training, departments are hindered by a lack of consistent guidance for best practices in the field for mental health, and have insufficient access to subject matter experts available when dealing with challenging cases. This workshop will introduce participants to an innovative model that is expanding the reach of psychiatry and impacting the way law enforcement interacts with people living with mental illness. Participants will hear from a panel of psychiatrists and Crisis Intervention Team (CIT) detectives involved in the CIT ECHO clinic, a collaboration that aims to give law enforcement access to psychiatrists that is otherwise impossible. The CIT ECHO clinic uses the University of New Mexico's Project ECHO® model, an evidence-based videoconferencing model designed to link primary care physicians to a network of healthcare specialists in order to receive ongoing mentoring and feedback on complex patient cases (Arora et al 2011). Panel members will discuss their efforts to improve law enforcement interactions with people living with mental illness; foster connections with the mental health system; and raise the level of community policing. During the workshop panelists will review gaps in mental health training for law enforcement and explain how psychiatrists are filling these gaps. An interactive online poll will walk participants through current data on police interactions with people living with mental illness. In the second half of this workshop attendees will participate in live, virtual demonstrations of case presentations between a law enforcement officer and psychiatry team.

Informed Consent Dialogues: How to Talk the Talk and Walk the Walk

Chair: Naalla D. Schreiber, M.D.

Presenters: Anita Kumar Chang, D.O., Michael J. Peterson, M.D., Ph.D.

Discussants: Henry Robert Bleier, M.D., M.B.A., Mary Ann Adler Cohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Identify at least 7 domains that should be reviewed in an ideal informed consent dialogue; 2) Practice delivering the key components

of an informed consent dialogue; 3) Understand in theory how and why they should adapt the informed consent dialogue based on a “sliding scale” of informed consent; 4) Practice ways to modify the informed consent dialogue to address patient specific factors; and 5) Understand how to harness placebo effects and avoid nocebo effects when implementing the process of informed consent.

SUMMARY:

The utilization of informed consent in every field of medicine is one key way for physicians to honor the fundamental ethical value of patient autonomy. The application of informed consent is through the physician patient dialogue. It is crucial for psychiatrists to develop the skills needed to engage patients or their designated surrogates in the informed consent dialogue. Unfortunately, while there is much emphasis in medical and psychiatric training on the value of informed consent and much time dedicated to the assessment of patients’ decisional capacity, minimal effort is expended to teach trainees and early career psychiatrists how to develop a thorough informed consent discussion. It is particularly important for psychiatrists to understand the breadth of information that should be discussed in a typical informed consent dialogue. It is also essential that psychiatrists appreciate when and how they should modify this conversation to incorporate patient specific factors. Clinicians need also be aware of the competing roles of placebo and nocebo effects and how they can harness these to promote healing and minimize harm. These factors should be balanced against the crucial goals of promoting voluntariness and avoiding coercion. In this workshop, we will cover basic theories of the doctor-patient relationship and how these dictate different models of informed consent. We will identify the information that an ideal informed consent dialogue should contain and coin a new phrase, the “sliding scale” of informed consent, to delineate how this discussion can be modified for specific clinical situations including psychosis, severe anxiety, and cognitive dysfunction. The workshop leaders will act out live snippets of inadequate informed consent dialogues with a treatment-refractory depressed and melancholic patient who is being offered ECT versus a monoamine oxidase inhibitor. The audience will be invited to critique

each snippet and identify any discernible problems with the informed consent dialogue. The workshop attendees will then be divided in half and each subgroup will grapple with a different informed consent scenario during which workshop participants will either play the doctor or the patient. One scenario will focus on how to discuss informed consent for benzodiazepines and selective serotonin reuptake inhibitors in a young woman of child-bearing age. The other scenario will focus on agitation in an elderly patient with dementia and how to modify the informed consent for a distraught surrogate, including a review of the black box warning for antipsychotics in dementia. The workshop leaders will walk around to each dyad and provide personalized feedback on ways to adapt and modify a standard informed consent dialogue for that clinical scenario.

Mental Health, Human Rights, and Striving for Peace During Conflict

Chair: Ricardo Restrepo, M.D.

Presenters: Homer Venters, M.D., Ricardo Restrepo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the relationships between society and mental illness, human rights and peace processes during conflict and post conflict times; 2) Identify the importance of individuals and representatives for achieving global changes regarding mental health, human rights and peace processes; 3) Describe some initiatives during conflict times and their potential impact on mental health and human rights when formulating a peace transition; and 4) Understand how a peaceful process moves from theory to reality, and the various implications of change.

SUMMARY:

Despite increasing access to immediate information, understanding the impact of armed conflicts in multiple regions and the intersection between war and peace does not receive the attention required from our society. Distracting elements such as superficial politics undermine the work and commitment of individuals, organizations and a few governments working in favor of mental health,

human rights and their impact in the implementation of processes for ending armed conflicts. The ambivalences of transparency discourses and practices in the digital age also have consequences on the individuals and organizations working in favor of Human Rights. Decades of ongoing conflicts in two different regions in the world will be reviewed. The unrest circumstances in Syria in the Middle East and Colombia in Latin America have exposed millions of people through generations to chronic and cumulative stress. Colombia continues to be the country with most internally displaced people in the world with 6.9 million uprooted citizens and counting, according to the United Nations refugee agency compared with Syria with 6.6 million. In these two regions displacement is mainly caused by ongoing clashes between the military, and either oppositional groups, leftist guerrilla groups and/or right-wing paramilitary successor groups. Each time a conflict occurs in the world, the physical wounds are visible while the mental health consequences of it can be in silence for years. Does torture evoke a predictable constellation of signs and symptoms? Which are its sequelae?, Is the country able to talk openly about the mental health consequences during and after the conflict?, What is the role as citizens when we know an armed conflict exists? As a society, are we ready to forgive what we thought was unforgivable? We begin by describing the background, statistics and consequences of conflicts in these two regions of the world. Then we will review the implementation, impact and results of working in a project as an organization and its consequences inside the society and the clinicians involved. We will then discuss the steps taken by humanitarian multinational project training Physicians and Lawyers in Syria and the importance of developing trust between people from different backgrounds, cultural, gender and sociopolitical differences among others. We will review the results of this collaborative project transformed into an NGO working in human rights. Finally we will hear from El Museo de la Memoria en Medellín , Colombia, one of the most interesting social laboratories inside a country suffering from one of the longest in the Western Hemisphere. We will discuss the importance of other institutions in order to contribute to the comprehension and overcoming of

the armed conflict and the diverse kinds of violence of Medellín, Antioquia and Colombia from different scenarios of open, reflexive and plural dialogue.

Neurocognitive and Decision-Making Impairments in Patients With Comorbid Diabetes Mellitus and Depression

Chairs: James K. Rustad, M.D., Vanessa L. Padilla, M.D.

Presenters: Robert Scott, M.D., Ph.D., H. Samuel Landsman, M.D., Devendra Singh Thakur, M.D., Patrick Ho, M.D., William Tate Schleyer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand that depression is a risk factor for accelerated cognitive decline and dementia in patients with type 2 diabetes; 2) Identify that deficiencies in the decision-making of patients with diabetes or their caregivers contribute to treatment non-adherence and poorer metabolic control; and 3) Demonstrate knowledge about screening tools available for deficits in hippocampal-based memory performance, executive functioning, and decision-making.

SUMMARY:

Diabetes mellitus is a highly prevalent, chronic disease that requires multi-specialty care combined with patient self-management, family support, and education to prevent or delay morbidity and mortality. There is an increased prevalence of major depressive disorder in patients diagnosed with diabetes. Moreover, antecedent depression and depressive symptoms are an independent risk factor for development of type 2 diabetes. Diabetes and depression are well-recognized risk factors for accelerated cognitive decline and dementia. Indeed, depression is a risk factor for accelerated cognitive decline and dementia in patients with type 2 diabetes. Impairments in decision-making may contribute to treatment nonadherence in patients with diabetes and depression. Decreased adherence to prescribed treatment is a major clinical challenge leading to increased healthcare costs, medical complications, hospitalizations, and fatal outcomes. The objective of our workshop is to help clinicians working with patients with diabetes to understand and undermine factors leading to decreased

treatment adherence. We will stress the importance of listening to patients and offering them practical, personalized “real world” advice. We will review relevant treatments (e.g., Cognitive Behavioral Therapy for Adherence, Shared Diabetes Appointments) that are designed to empower patients in the management of their diabetes.

Reducing Compassion Fatigue by Treating More Patients? A New Perspective on Accelerated Resolution Therapy

Chair: Wendi M. Waits, M.D.

Presenter: Megan T. Marumoto, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the risks posed by compassion fatigue and burnout in today's healthcare environment; 2) List three ways in which Accelerated Resolution Therapy decreases compassion fatigue; and 3) Describe changes in compassion fatigue reported by providers trained in Accelerated Resolution Therapy.

SUMMARY:

In this workshop, we will discuss how the use of Accelerated Resolution Therapy (ART) has the potential to reduce compassion fatigue and improve provider resilience, while offering patients a novel and effective way to treat a variety of conditions. Audience members will be introduced to the basics of ART, features of ART that distinguish it from traditional cognitive and exposure-based therapies, the specific methods by which ART can decrease compassion fatigue, and ways to incorporate the resilience-building elements of ART into a contemporary psychiatric practice. Presenters will also review feedback from providers who have been trained in ART.

Responding to the Impact of Suicide on Clinicians

Chair: Eric Martin Plakun, M.D.

Presenter: Jane Tillman

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Enumerate clinician responses to patient suicide; 2) Implement practical steps for responding to patient suicide from the personal,

collegial, clinical, educational, administrative and medico-legal perspectives; 3) Design a curriculum to educate and support trainees around their unique vulnerabilities to the experience of patient suicide; and 4) List recommendations for responding to the family of a patient who suicides.

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Nevertheless, mental health clinicians often have less direct experience with patient death than clinicians from other environments. Each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric physicians 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 surveys the literature on the impact of patient suicide on clinicians, while also offering results from an empirical study carried out by one of the presenters demonstrating 8 experiences frequently shared by clinicians who have a patient commit suicide: [1] Initial shock; [2] grief and sadness; [3] changed relationships with colleagues; [4] experiences of dissociation from the event; [5] grandiosity, shame and humiliation; [6] crises of faith in treatment; [7] fear of litigation; and [8] an effect on work with other patients. Recommendations derived from this and other studies are offered to help guide individually affected clinicians, but also their colleagues, as well as trainees, supervisors, 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 includes ample time for interactive but anonymous discussion with participants about their own experiences with patient suicide—a feature of this workshop that has been valued by participants in the past.

Risk Assessment and Management Up Close and Personal: Guidelines for Practice

Chairs: Madelon Baranoski, Ph.D., Tanuja Gandhi, M.D.

Presenter: Reena Kapoor, M.D.

Discussant: Maya Prabhu, M.D., LL.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Review advantages and limitations of assessment measures and techniques relevant to clinical practice and treatment decisions; 2) Explore risk management strategies applicable to special conditions: Early Psychosis, Delusional disorders, Adolescence and Forensic patients; 3) Understand the effects of culture, socio-economic conditions and personality on risk formulations; and 4) Develop and incorporate risk trajectories based on standard measures, collateral information, and guided clinical assessment to inform psychiatric admission and discharge decisions.

SUMMARY:

Assessment and management of risk for violence and self-harm underpin treatment decisions and level of care decisions. Although the base rate of violence and suicide among psychiatric patients is low, the risk of aggression challenges psychiatry and fuels the stigma of mental illness. Research has established factors associated with higher rates of violent behavior based on population studies and has contributed to standard measures of characterological (static) risk. More recent investigations have focused on dynamic risk factors related to varying conditions and effects of treatments. Hybrid measures combine both static and dynamic factors. Although these measures can inform clinical assessments, the psychiatric interview and treating relationship are the primary methods of determining risk for individual patients. In this panel, we will discuss and review relevant research and risk measures, and use this information as the foundation to formulate individualized risk trajectories to inform treatment, admission and discharge decisions. Through case presentations we will present and address the challenges of special patient groups including patients who are delusional, are in early stages of psychosis, and in forensic settings. We will also present approaches to assess the vulnerability for violence; for example, behavioral techniques like psychiatric stress tests, anticipatory risk management, and family and community collaboration. Lastly, the panel will

describe the influence of culture, social/economic, and personality on risk and its assessment and management. Collectively, the panelists will translate the research into practical clinical applications relevant to inpatient and outpatient psychiatry.

A Clinician's Guide to Personality Disorders

Assessment: The Structured Interview of Personality Organization-R (STIPO-R) and the LPOq Self-Report

Chair: Eve Caligor, M.D.

Presenters: Barry Stern, Ph.D., Emanuele Preti

Discussant: John Clarkin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Employ the STIPO as an assessment tool in the clinical evaluation of patients with personality disorders; 2) Employ the LPOq as a screening tool in personality disorder assessment; 3) Apply the construct of “level of personality organization” to the classification of personality disorders; 4) Demonstrate familiarity with the research base linking STIPO assessment to clinical outcome; and 5) Understand the link between the STIPO classification of personality disorders and the Levels of Personality Functioning Scale (LPFS) in the Alternative Model for Personality Disorders of the DSM-5.

SUMMARY:

Clinicians are confronted with many challenges when dealing with the assessment of personality disorders, personality pathology, and personality functioning. The Structured Interview of Personality Organization-Revised (STIPO-R) is a semi-structured interview that guides the clinical evaluation of personality disorders, providing a diagnosis that informs treatment planning and predicts clinical course. STIPO assessment focuses on the domains of self and interpersonal functioning, defenses, moral functioning, and quality of aggression. Moreover, a new self-report instrument, the Level of Personality Organization Questionnaire (LPOq) allows clinicians and researchers to assess these domains in large populations. This workshop will provide participants with an introduction to the STIPO interview, demonstrating its use in clinical practice. Participants

will also learn how to use and score the LPOq as a screening instrument. We will, in addition, present data illustrating the clinical utility of the STIPO and application of STIPO assessment to the DSM5 Level of Personality Functioning Scale (LPFS). This interactive workshop will involve participants in discussion of a videotaped STIPO interview and will provide participants opportunity to discuss diagnostic challenges encountered in their own clinical work.

A Novel Inpatient Group Treatment for Suicidal Patients

Chairs: Yael Holoshitz, M.D., Barbara Stanley, Ph.D.
Presenters: Ravi B. Desilva, M.D., Sarah Gilbert

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Demonstrate an understanding of the unique high-risk period for suicide after discharge from inpatient psychiatric hospitalization; 2) Understand the clinical importance of an inpatient targeted intervention to address suicidal ideation or behavior directly; 3) Understand the structure and function of the Suicide Prevention Group Treatment-Inpatient (SPGT-I); 4) Practice implementing skills from this novel treatment, through interactive role-play; and 5) Consider ways to enhance inpatient suicide prevention in his/her home institution and brainstorm challenges to implementation.

SUMMARY:

Acutely suicidal patients are often admitted to inpatient psychiatry units for immediate treatment and observation when outpatient safety cannot be assured (Davidson, Olson-Madden, Betz, & Allen, 2014). Despite achieving stabilization during hospitalization, the period immediately following hospital discharge continues to be an extremely high-risk time, wherein repeated attempts and death by suicide occur (Granboulan, Roudot, Thoraval, Lemerle, & Alvin, 2001). Given that a large proportion of psychiatric inpatients are admitted after a suicide attempt or escalating suicidal ideation, targeting aims of the inpatient period of stay may prove essential in reducing national suicide rates. Interestingly, while there are some pilot studies, such as Post-Admission Cognitive Therapy (PACT; Ghahramanlou-Holloway et al, 2012) there

are no empirically supported inpatient treatments for suicidal patients. In response to this pressing need, we have developed the Suicide Prevention Group Treatment-Inpatient (SPGT-I). This intervention is a modularized, group-based suicide prevention intervention for patients admitted to a psychiatric inpatient unit following a suicide attempt or suicidal crisis. The intervention is based on empirically supported psychotherapeutic approaches to suicide prevention, and includes four skills-based, one-hour modules: 1) Safety Planning Intervention; 2) Wellness Kit (Reducing Vulnerability to Depression and Suicide); 3) Hope Kit; 4) Psychoeducation on Depression and Suicide Risk Factors (Stanley & Brown, 2012). The group format allows for efficient delivery of the intervention on inpatient units, where therapeutic treatment is often delivered in groups. In this workshop, a panel of speakers will review the content and format of the SPGT-I, discuss implementation including various clinical and structural challenges, and present data collected over 18 months of piloting this intervention on a psychiatric inpatient unit at Columbia University Medical Center, which reflect the positive feasibility and acceptability of the SPGT-I. An interactive panel of the key players involved in creating this novel intervention will provide demonstrations and clinical vignettes to highlight its utility. The speakers in this panel will each bring a unique perspective to this intervention, and will include the treatment developer, the inpatient unit head who oversaw implementation, and the clinician who ran these groups on the units. Attendees of this workshop will have the opportunity to engage in role play of different skills, and brainstorm ways to incorporate these skills into their clinical practice.

Coming to America: Examining Psychosis in Migrant Populations in the Forensic Setting

Chairs: David Christopher Mancini, M.D., Ann L. Hackman, M.D.
Presenters: Danae Nicole DiRocco, M.D., Avinash Ramprashad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Define and understand forensic and psychiatric terminology as it pertains to migrant populations; 2) Examine psychosis in migrant

populations, particularly understanding cultural influences on the descriptions of psychotic symptoms and the contribution of trauma; 3) Recognize ways in which migrants are more likely to interact with forensic institutions, and complications in navigating the forensic system; 4) Demonstrate how best to overcome potential language barriers, as well as the potential benefits and pitfalls of these services; and 5) Identify and explore how to address specific psychosocial issues that arise for migrant populations, as well as ways to reduce barriers to care.

SUMMARY:

In the United States, migrant populations (and their descendants) represent a larger portion of psychiatric patients than native-born individuals. Within this unique group of individuals, a significant portion are found in both the forensic psychiatric setting and the criminal detention setting, often carrying psychiatric diagnoses with components of psychosis. As junior psychiatric residents, we had the opportunity to work with many such individuals in various clinical settings which draw from various urban and underserved areas around Maryland, including state forensic facilities and our university ACT team. There were a variety of unique challenges in working with these individuals including language barriers, an unfamiliar legal system, and culturally-based beliefs around psychiatric diagnosis and treatment. While there is an extensive cultural psychiatry literature base, there is relatively little written about challenges related to various migrant populations in the US, and equally little about culturally-informed treatment in forensic settings. Based on limited research primarily out of Europe, psychotic disorders appear overrepresented in migrant groups as compared to native-born counterparts, and may be overrepresented in migrant groups treated in forensic psychiatric facilities. In turn, there is a greater likelihood for migrants to be psychiatrically committed or to be put on mental health probation versus their non-migrant counterparts. In this workshop, we will describe case examples of migrants in various psychiatric settings (including forensic psychiatry) and the challenges associated with their presentation, stabilization and treatment. We will strive to identify risk factors and vulnerabilities of

migrants, both related to increased risk for severe mental illness and subsequently their involvement with the legal system, after coming to a new country. We will attempt to explain these phenomena not just as they relate to first and second generation migrants, but also to unique populations such as refugees. We will review the available literature and explore with our audience ways in which we can provide more effective treatment for these vulnerable populations.

Dynamic Therapy With Self-Destructive Borderline Patients: An Alliance-Based Intervention for Suicide

Chairs: Eric Martin Plakun, M.D., Samar S. Habl, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Utilize principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients; 2) Understand the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference; and 3) Understand shared elements in treating self-destructive borderline patients derived by an expert consensus panel study of behavioral and dynamic psychotherapies.

SUMMARY:

Psychotherapy with suicidal and self-destructive borderline patients is recognized as a formidable clinical challenge. Several manualized behavioral and psychodynamic therapies have been found efficacious in treatment, but few clinicians achieve mastery of even one of the manualized therapies. This workshop includes review of 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from non-lethal self-destructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) non-punitively interpret the patient's aggression in considering ending the

therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (9) provide an opportunity for repair. These principles are noted to be congruent with shared therapy elements identified by an expert consensus panel review of behavioral and psychodynamic treatment approaches to suicidal patients with borderline personality disorder. After the presentation the remaining time will be used for an interactive discussion of case material. Although the workshop organizer 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.

Evaluating Physician Impairment From a Psychiatric Perspective

Chair: Stephen Noffsinger, M.D.

Presenters: Ian C. Lamoureux, M.D., Drew Calhoun

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the roles of state medical boards, hospital executive committees and private disability insurers in referring physicians for impairment evaluations; 2) Understand personality traits, symptoms and behaviors among physicians that may lead to an impairment evaluation; 3) Understand the rules and procedures that state medical boards use to evaluate alleged physician impairment; and 4) Develop skills to accurately evaluate allegedly impaired physicians.

SUMMARY:

The public commonly perceives healthcare providers as stable, well-composed and competent; yet healthcare professionals, especially physicians, have an increased prevalence of depressive disorders, substance misuse, problematic personality traits and occupational stress that may impact their ability to competently practice medicine. Allegedly impaired physicians may be referred by state medical boards, hospital executive committees or disability insurers to the psychiatrist for a fitness-to-practice evaluation. Psychiatrists must be able to conduct an

accurate and reliable fitness-to-practice evaluation. Unfit practitioners may negligently or recklessly harm patients, incur civil liability, and damage their professional standing. In contrast, mistakenly concluding that a healthcare professional is unfit may result in the practitioner suffering undeserved stigma, reputation damage, economic loss, difficulty obtaining a license or employment, and may deprive the community of a competent practitioner. This presentation will discuss methods to evaluate potentially disabling psychological and behavioral symptoms, statutory regulation of the unfit physician, and the potential legal liabilities facing the forensic evaluator. Vignettes will illustrate the dilemmas the forensic evaluator may encounter. Audience participation will be achieved by the speakers presenting and discussion with the audience a number of de-identified vignettes illustrating physician fitness-for-duty evaluations.

If You Are Not Thinking of Becoming a Medical Director at a Health Insurance Company, Perhaps You Should Be: Managed Care as a Clinical Practice

Chair: Juliana Ibanga Ekong, M.D.

Presenters: Elizabeth M. Oudens, M.D., Aron Halfin, M.D., William G. Wood, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand why psychiatrists become health insurance medical doctors in spite of their reservations about managed care; 2) Explain what formal and informal roles psychiatrists play within Health Insurance/Managed Care Organizations; and 3) Discuss the ways in which clinical decision-making is important to health insurance organizations/members, and why it is critical to have psychiatrists with clinical experience as decision; 5) Evaluate whether a role as a health insurance psychiatrist/clinician is appropriate for them.

SUMMARY:

Health Insurance or Managed Care remains a critical avenue of influencing clinical health outcomes. Decisions about what benefits are made available, how those benefits are administered and what kinds clinical networks are available to the patient can greatly influence the health of populations, not to

mention individual patients, and as such demand good and loud psychiatric voices at the managed care table to help provide guidance and leadership. Furthermore, psychiatrists are typically the final voice around decisions involving complicated care for patients with mental health illness – only licensed medical doctors can decline authorization for requested care. Psychiatrists with sound clinical experience and an ability to problem solve and help a fragmented system find options become crucial to optimal outcomes. During this workshop, the viewpoints of psychiatrists at various stages in their careers, who chose to join managed care will be presented with a lively discussion of the successes and limitations of their choices. Clinical innovations driven by psychiatrists at such companies will be discussed as a means to highlighting how psychiatry is practiced in a managed care company. Participants will be encouraged to discuss challenges (and successes) that they have had or continue to have with Managed Care Companies and the panel will provide advice for resolution.

Innovations in Access: Psychiatric Services at the NF/SG VAMC

Chair: Ana T. Turner, M.D.

Presenters: Joseph Ed Thornton, M.D., Stephen J. Welch, M.D., Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe opening access to mental health care for both providers and patients through Primary Care-Mental Health Integration; 2) Identify several unique strategies to allow increased access to emergency mental health services; and 3) Explain how paradoxical changes can improve inpatient psychiatry bed utilization.

SUMMARY:

In April 2016 Undersecretary for Health Dr. David Shulkin required mental health services be available same-day when necessary at all Veterans Affairs (VA) health care facilities throughout the United States. Our North Florida/South Georgia Veterans Health System (NFSG VHS) has come up with several unique processes that have helped us improve access to thousands of veterans and ensure they can access mental health services through “no wrong door.” A

major initiative to open access for both patients and providers has been our Primary Care-Mental Health Integration. PC-MHI integrates mental health staff into each primary care team to provide services for depression, anxiety, PTSD, substance use and other mental health care needs without needing a referral to a specialty mental health clinic. We will spend the first 25minutes describing our implementation of PC-MHI and how to offer both provider education and Veteran-centered care. Interactive polling software will be used to help keep audience engaged with discussion questions throughout, followed by 5 minutes for questions from the audience. The next 25minutes will be spent describing opening access in atypical Veteran populations, with interactive audience polling throughout. In June 2017 the VA tasked all health care facilities to provide emergency mental health coverage to former service members with other-than-honorable (OTH) administrative discharges. Research shows that post-traumatic stress disorder and other mental health conditions can lead to behaviors such as substance abuse or going “AWOL” (away without leave), which, in turn, can result in OTH discharge. This discharge classification usually makes service members ineligible for most benefits provided by the VA by federal statute. Under the new initiative, they may receive up to 90 days of inpatient, residential or outpatient care for a “mental health emergency.” We will discuss how we have met this goal with community partners along with our unique on site processes. This includes opening access through integration of our Suicide Prevention Coordination and Veterans Crisis Line throughout the VHS, and our VA Office of Inspector General-praised approach for meeting core measures on hospital discharge planning and 7-day post-discharge follow ups. There will then be 5minutes for audience questions. Perhaps most innovative has been our strategy to allow access to our acute care inpatient psychiatry treatment. We have taken the idea of “working smarter not harder” to a new level by utilizing Erlang’s Law and Queuing theory to predict and adjust to inpatient psychiatry hospitalization demand. By convincing administration to paradoxically close two inpatient beds, we have been able to increase bed utilization. This allows more patients to receive care in-house and decreasing our community care needs.

Integrated Behavioral Health Care: A Global Approach

Chairs: Elizabeth L. Chapman, M.D., Vivian Blotnick Pender, M.D.

Presenters: Lan Chi Le Vo, M.D., Houssam Raai, M.D., Pamela Carolina Montano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the burden of disease from common mental disorders (anxiety and depression) worldwide as well as in the United States, and current gaps in treatment; 2) Describe current models of Integrated Behavioral Health Care being implemented in New York City, particularly those that serve low-income and ethnically diverse populations; 3) Demonstrate the applicability of Integrated Behavioral Health Care in global settings to increase accessibility and sustainability of mental health treatment; and 4) Understand the APA's role at the United Nations in supporting the dissemination of key topics in psychiatry to an international audience, and fostering global mental health partnerships.

SUMMARY:

Mental disorders are common worldwide and can be significantly disabling, affecting various aspects of people's lives. Although they are to some extent invisible disabilities, the World Health Organization ranks anxiety and depression among the most disabling conditions in terms of Years Lived with Disability (YLD), leading to high health care costs and significant loss of productivity. Meanwhile there is a large gap in psychiatric care. In the United States, for example, only one in five adults with mental illness receives specialist treatment, with up to 60% of psychiatric care provided by Primary Care Physicians (PCPs). The traditional system of care is fragmented and inefficient. Integrated Care models, which are being increasingly used to address both medical and behavioral health conditions, attempt to bridge this gap. Integrated Behavioral Health models place mental health providers in primary care settings, with PCPs treating common mental disorders with support from case managers and psychiatrists. With the global shortage of mental health providers and the stigma accompanying psychiatric disorders,

Integrated Care enables improved screening and treatment rates, while reducing health care costs. Some Integrated Care models are leveraging technology to extend the reach of services and enhance patient awareness, understanding of and adherence to treatment. The American Psychiatric Association (APA) recognizes the importance of Integrated Care in enhancing awareness of psychiatry and psychiatric care and maximizing treatment resources at an international level. The APA supported a panel presentation to introduce the topic of Integrated Behavioral Health Care to the international community, at the Conference of State Parties at the United Nations (UN) in June 2017. This symposium builds on that presentation by first describing Integrated Care models currently implemented in New York City, including in low resource and transcultural settings. We will then discuss the applicability of Integrated Behavioral Health models in a global context. The APA's presence at the UN resulted in an initiative to organize a program to help providers in Afghanistan to better recognize and manage mental disorders. The final part of our presentation will outline that initiative and discuss future directions for APA partnerships to advance Global Mental Health. As our experience shows, Integrated Care models are proving to be successful and cost-effective in bridging the gap in treatment of mental disorders in the United States, and are emerging as a leading example to different countries working to provide a more inclusive approach to psychiatric care.

Psychedelic Drugs in the 21st Century: Tuning in to New Challenges and Opportunities

Chair: Paul J. Rosenfield, M.D.

Presenters: Kathleen Bryer Levy, D.O., Prameet Singh, M.D., Silvia Franco Corso, M.D., Rachael Heyden, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Describe the history of psychedelic drugs in psychiatry and popular culture; 2) Understand the neuropsychiatric and psychological effects of psychedelic drugs; and 3) Recognize potential therapeutic uses as well as risks of psychedelic drugs in psychiatry.

Emiliya Zhivotovskaya

SUMMARY:

While hallucinogenic substances have been used for thousands of years, interest in their medicinal value rose after the synthesis of LSD in the 1940s. While research on LSD and other hallucinogens was initiated in the 1950s and 60s, these drugs were controversial for their part in the countercultural revolution and the research did not come to fruition. By the 1970s, a societal and governmental backlash against psychedelics and their proponents who urged people to “tune in, turn on and drop out” created legal obstacles preventing further clinical research. One exception, ketamine, was approved for use as an anesthetic and is still in active use. Since the early 1990s and more recently, drugs such as LSD, psilocybin, mescaline, and ayahuasca, as well as ketamine, have re-emerged as candidates for psychiatric research and are being studied for a range of conditions from treatment-resistant depression and anxiety to addiction and post-traumatic stress disorder, as well as psychological distress related to cancer and dying. Recent research evidence points to the promising potential of these drugs, and also elucidates some of the risks. This workshop will review the rise of psychedelic drugs in the US and the early proponents’ broad claims for their capacity to expand the mind and consciousness. We will describe the modern re-emergence of these drugs and new insights about their posited mechanisms of action such as short-term serotonin 2A agonism followed by expression of neurotrophic factors, or NMDA receptor inhibition in the case of ketamine. We will explore the psychological effects, such as enhancing mindfulness, that may play a role in their therapeutic effects. There are still obstacles to performing research but a more unbiased approach, with rigorous research methodology, can clarify the role these powerful drugs may play in expanding our treatment options for a range of mental illnesses and states of psychological distress.

Trial of Positive Psychiatry in Comorbid Attention-Deficit/Hyperactivity Disorder With Posttraumatic Stress Disorder

Chair: Naser Ahmadi, M.D., Ph.D.

Presenters: Mohammed A. Molla, M.D., Garth Jon Olando, M.D., Ph.D., Robert S. Pynoos, M.D., M.P.H.,

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) • The current findings reveal that PP is associated with improving PTSD and ADHD symptoms; 2) • PP is associated with increase in wellbeing, vascular function, and reducing inflammation in adolescent with comorbid ADHD and PTSD; 3) • This highlights the importance the dual role PP in addressing vulnerable symptoms as well as enhancing wellbeing in youth with ADHD and PTSD; and 4) • This warrants future study evaluating the role of early PP in preventing PTSD and ADHD related psychosomatic disorders.

SUMMARY:

Objective: Comorbid attention deficit hyperactive disorder (ADHD) with posttraumatic stress disorder (PTSD) in children is associated with the higher rates of psychiatric comorbidity and psychosocial dysfunction in adulthood. Recent studies revealed that positive psychiatry (PP) can decrease symptoms of adversity, psychopathology and increase well-being in youth. This study investigates the impact of PP on vascular function, inflammation, well-being and ADHD and PTSD symptoms in adolescents with comorbid ADHD and PTSD. Methods: Eleven adolescents (age:11±3yo(range:10-15yo): 50% female), after obtaining informed consent from parents as well as informed assent from adolescent, randomized to: group PP(n=5) or group cognitive behavioral therapy (CBT) (n=6). 8 participants (PP: n=4, CBT: n=4) completed twice weekly intervention for 6-weeks trial. Vascular function – measured as temperature rebound (TR) by reactive hyperemia procedure using Digital Thermal Monitoring (DTM)-, C reactive protein(CRP), homocysteine, and neuropsychiatric measures (i.e. SNAP questionnaire, PERMA, gratitude, posttraumatic growth inventory, Connor–Davidson resilience scale, Clinician Administered PTSD Scale (CAPS) children version, were measured at baseline and 6th week. The group PP interventions include Posttraumatic Growth, Resilience, Gratitude, Optimism, Self-compassion, Self-regulation, Personal Strength, Growth mindset and connectedness, Life satisfaction and meaningful life, Values, purpose and Wellbeing. Results: At

follow up, a significant improvement in CAPS-CA, SNAP, and vascular function of both PP and CBT groups noted, compared to baseline that was more robust in PP group ($p < 0.05$). at 6th week, a significant decrease in Homocysteine and CRP, as well as increase in PERMA, gratitude, resilience, and posttraumatic growth inventory in PP group, but not in CBT group, was noted. A significant relation between decrease in CAPS, SNAP and increase in vascular function, as well as decrease in homocysteine noted. Furthermore, A direct relation between increase in PERMA, gratitude, resilience, and posttraumatic growth inventory with increase in vascular function and decrease in homocysteine noted. The most robust improvement was noted in positive connectedness including new possibilities, appreciation of life, personal strength and relating to others ($p < 0.05$) Conclusions: The current findings reveal that PP is associated with improving PTSD and ADHD symptoms, as well as increase in wellbeing, vascular function, and reducing inflammation in adolescent with comorbid ADHD and PTSD. This highlights the importance the dual role PP in addressing vulnerable symptoms as well as enhancing wellbeing in youth with ADHD and PTSD; warranting future study evaluating the role of early PP in preventing PTSD and ADHD related psychosomatic disorders.